DEVELOPING CORPORATE ENTREPRENEURSHIP IN THE NATIONAL HEALTH SERVICE: A STUDY OF A LARGE EAST MIDLANDS TRUST

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ABSTRACT

The goal of this dissertation is to motivate a cognitive based view of corporate entrepreneurship (CE) propagation. In doing so, it advocates that the literature requires a more in-depth view of how organisational members choose to instigate or participate in entrepreneurial behaviour within the organisation confines. In addition to what organisational contextual factors bear on this decision making process. As such I move away from the top-down organisational level of analysis perspective that dominates the field and re-focus on the 'individual in CE.' To achieve this, I draw on socio-cognitive perspectives and the growing body of work on cognitive mechanisms in entrepreneurship research (Baron, 1998). Specifically, I utilise the entrepreneurial cognition entrepreneurial intentions (EI) as the best predictor of entrepreneurial behaviour and the EI formation model Shapero's Entrepreneurial Event (SEE), (Krueger, 1993; Shapero, 1982) to understand how organisational members choose to act entrepreneurially.

This research is interpretive in nature. A qualitative single case study with 3 embedded units and two data collection phases was employed to explore the Large East Midlands Trust (LEMT), a large acute hospital in the publically funded National Health Service (NHS). LEMT represents an unconventional setting for CE research, which is traditionally conducted in the private sector. However, the aftermath of the 2008 economic crisis has compelled public institutions such as the NHS to become more entrepreneurial (DH, 2010; Darzi, 2008). The main analytical techniques employed are within-case and cross-unit pattern analysis to elicit findings on this unusual organisational context and how its members are moved from CE inaction to CE action.

The findings of this research indicate that top-down inducements do not move LEMT's organisational members to CE action. Primarily, because there is an underlying cognitive infrastructure represented by organisational member's multiple social identities: (1) NHS identity and (2) professional identity that impede the emergence of CE. Probing these NHS and professional identities further revealed them to be resistant to change. However, my findings indicate

that if interrupted by a precipitating event, professional identity can be reformed via identity work processes, which facilitate the emergence of CE activity.

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LIST OF ABBREVIATIONS

ABBREVIATION	TERM
ABS	Association of Business Schools
A&E	Accident & Emergency
AHP	Allied Health Professional
CBU	Clinical Business Unit
CCG	Clinical Commissioning Group
CE	Corporate Entrepreneurship
CEI	Corporate Entrepreneurial Intentions
CEO	Chief Executive Officer
CV	Corporate Venturing
DH	Department of Health
ET&P	Entrepreneurship Theory and Practice
ECV	External Corporate Venturing
EI	Entrepreneurial Intentions
EO	Entrepreneurial Orientation
FT	Foundation Trust
HCP	Healthcare Professional
IBP	Integrated Business Plan
IT	Identity Theory
ICV	Internal Corporate Venturing
JBV	Journal of Business Venturing
JCV	Joint Corporate Venturing
JPIM	Journal of Product Innovation Management
LEMT	Large East Midlands Trust
NHS	National Health Service
NPM	New Public Management
PJV	Pathology Joint Venture
PCT	Primary Care Trust
PD	Physiotherapy Department

ABBREVIATION	TERM
PRS	Pulmonary Rehabilitation Service
R&D	Research and Development
RT	Respiratory Team
SCT	Self Categorisation Theory
SE	Strategic Entrepreneurship
SEE	Shapero's Entrepreneurial Event
SIT	Social Identity Theory
SIA	Social Identity Approach
SMJ	Strategic Management Journal
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UK	United Kingdom
USA	United States of America

CHAPTER 1: INTRODUCTION

This introductory chapter presents an overview of the thesis titled, *'Developing Corporate Entrepreneurship in the National Health Service,'* that are discussed over the course of the next remaining nine chapters. Since the intent of this chapter is to merely familiarise the reader with the domain of the research topic, detailed definitions of constructs are addressed here. Likewise, citations in support of text are limited, intended to aid in continuity in thought and understanding. This chapter is divided into 7 sections. Section 1.2 discusses my study's alternative approach to *corporate entrepreneurship* (CE) research. I move away from the disproportionate focus on the organisational-level of analysis generally found in the CE literature to re-focus on the individual-level. In taking this position I align with those CE researchers who propose that it is the human element's involvement in the CE process that ultimately evokes or sustains an organisation's competitive advantage (Corbett, Covin, O'Connor & Tucci, 2013). This suggests that CE propagation is the burden of *all* organisational members, managerial and non-managerial (Wales, Monsen & Mckelvie, 2011; Ireland, Covin & Kuratko, 2009). As such in Section 1.3, I introduce the entrepreneurial cognition known as *entrepreneurial intentions* (EI) to understand *how* these organisational members choose to act entrepreneurially within the organisation's confines. Section 1.4 introduces identity as an emergent theoretical lens that bears on organisational members' CE choice. The remaining 4 sections will cover (1) the research context, (2) research objectives, (3) intended research contributions and (4) an overview of the remainder of the thesis.

1.1 Corporate Entrepreneurship

Traditionally, entrepreneurship research uses two primary levels of analysis, individual and organisational. The majority of research has focused on the organisational level and is generally known as corporate entrepreneurship (CE). This topic has recently been the focus of many contemporary reviews and books (*cf.* Corbett et al., 2013; Kuratko & Audretsch, 2009; Narayanan, Yang, & Zahra, 2009; Phan, Wright, Ucbasaran, & Tan, 2009; Dess, Ireland,

Zahra, Floyd, Janney & Lane, 2003). CE is divided into two basic categories: new venture creation and the strategic renewal of large mature organisations (Sharma & Chrisman, 1999; Guth & Ginsberg, 1990). Contributions from scholars within the body of extant research have framed these two CE activities as potential means for revitalising large established companies (Kelley, Peters, & Colarelli O'Connor, 2009; Phan et al., 2009; Zahra & Covin, 1995; Stopford & Baden-Fuller, 1994; Burgelman, 1983). The revitalising nature of CE activities enables an organisation to secure and sustain its competitive advantage, ultimately increasing its growth and performance in dynamic and hostile economic environments (Zahra & Covin, 1995; Burgelman, 1983, 1985).

Despite these beneficial outcomes, scholars have argued that it is very complex and difficult to successfully propagate and manage CE activities in incumbent firms (Hill & Birkinshaw, 2008; Burgelman & Välikangas, 2005). As such, there is a significant amount of research on the factors affecting an organisation's ability to engage in entrepreneurial behaviour and their relationship with CE outcomes (Morris, Kuratko & Covin, 2011). Typically, most of these CE studies use a top-down approach in which top management teams induce CE through processes, structures, cultures, resources, capabilities and reward systems needed to promote CE (Morris et al., 2011; Hornsby, Kuratko, Shepherd & Bott, 2009; Lumpkin & Dess, 2001; Floyd & Lane, 2000; Barringer & Bluedorn 1999; Hambrick & Mason, 1984). This research has shed light on how organisations identify and subsequently exploit entrepreneurial opportunities by better utilising and deploying their resources within structures and internal organisational environments conducive to CE. In principle at least, these inducements result in the formalisation of procedures and organisational routines that support CE throughout the entire organisation (Phan et al., 2009; Zahra & Filatotchev, 2004).

Other researchers have sought to investigate the challenge of propagating and managing CE via the less utilised bottom-up approach (Ireland et al., 2009; Burgelman, 1983). Bottom-up approaches to CE focus on instances in which CE activities are propagated in an informal and improvisational manner by

individual organisational members (Zahra & Filatotchev, 2004; Zahra, Nielsen & Bogner, 1999). As such, the organisation's entrepreneurial activities are often nurtured by the skills, knowledge, creativity, imagination and alertness to opportunities of its employees, who are not necessarily a part of the formal management hierarchy (Daily & Dalton, 1992). This is in contrast to the planned and purpose-built organisational support system of the top-down approach presented above. This suggests that all organisational members should be able to recognise the importance of opportunities for new venture creation or the need for strategic renewal in their organisation (Ireland et al., 2009; Kuratko et al., 2005; Volberda, Baden-Fuller & van den Bosch, 2001).

CE scholars recognise that both top-down and bottom-up approaches to CE are important. Yet, comparatively, the bottom-up approach is plagued by a lack of comprehensive knowledge surrounding how organisational members choose to act entrepreneurially or why they might do so. As such the individual's decision to act entrepreneurially has been dubbed by some scholars as one of the long-standing 'black boxes' that pervades CE research (Corbett et al. 2013; Dess et al., 2003; Krueger, 2000). Thus much like its parent construct, entrepreneurship, CE continues to search for theories that can shed light on how and why organisational members make the decision to act entrepreneurially within the organisation's boundaries. This rekindles what Schumpeter posited in 1934, that understanding individual action is critical to understanding the enactment of CE. Krueger (2000) supports this view that CE requires more rigorous theory application to understand individual organisational members' entrepreneurial choices. Most recently, Corbett et al. (2013) continue to advocate that the individual level of analysis is an empirical imperative for driving the field forward.

In this thesis I 'assume the mantle' from my fellow CE researchers to understand the 'individual in CE.' I propose that CE hinges on individual organisational members' cognitive and mental models that can facilitate or hinder how they envision changes in circumstance, reconceptualise existing on-going activities and learn from prior experiences (Zahra, Filatotchev, & Wright, 2009). Consequently, I have chosen to apply the entrepreneurial

cognition of entrepreneurial intentions (EI) to study this problem, as an individual's intentions are fundamental to their decision to act entrepreneurially on behalf of their organisation (Bird, 1988; Katz & Gartner, 1988), especially in organisations where there are no (or no history of) CE-propagating routines and procedures incorporated into the organisation itself.

1.2 Corporate Entrepreneurial Intention Formation

As highlighted in Section 1.1, CE covers two main phenomena and researchers have sought to understand how they come about. Though CE research is relatively mature with a significant amount of research on the antecedents and outcomes of CE at the organisational level (Morris et al., 2011), how individual organisational members decide to participate in CE activities or not remains largely under-examined and largely theoretical (Krueger & Brazeal, 1994; Shapero, 1981; Sheppard & Krueger, 2002). The study of entrepreneurial cognitions has started to make some in-roads into CE, via the general entrepreneurship domain, to aid in understanding individual corporate entrepreneurial choice. Entrepreneurial cognitions are a group of cognitive mechanisms that originate from the psychology, social psychology and sociology disciplines that have been found to be amenable to the entrepreneurship domain (Ardichvili, Cardozo & Ray, 2003; Mitchell, Busenitz, Lant, McDougall, Morse & Smith 2002; Gaglio & Katz, 2001). These authors have found entrepreneurial cognitions to be particularly useful in explaining entrepreneurial choice as they precede entrepreneurial behaviour. Understanding why entrepreneurial behaviour emerges has become central to moving the entrepreneurship paradigm forward since prior studies on the 'special' personality traits of the entrepreneur have proven inadequate at predicting entrepreneurial action (Hatten, 1997; Gartner, 1988).

For this study I have employed the entrepreneurial cognition, EI, which has been found to be the best predictor of entrepreneurial behaviour, (Krueger, Reilly, & Carsrud, 2000; Krueger, 1993; Ajzen, 1987; Shapero, 1982). In entrepreneurship research, EI formation models have been found to be particularly coherent, parsimonious, highly generalisable and robust for

understanding and predicting an individual's intentions to create a new venture (Krueger et al., 2000). Further, the parsimonious nature of EI models is very useful for understanding barriers to entrepreneurial decisions (Krueger, 2000). As such, scholars have deployed EI models that incorporate influencing factors based on various personal or situational contexts to better explain how EI formation is hindered or facilitated at the individual level (Prodan & Drnovsek, 2010; Lee & Wong, 2004; Peterman & Kennedy, 2003).

In this study I advance that an individuals' EI can be crucial to explaining a large mature organisations' ability (or inability) to enact CE from the bottom-up for two reasons. First, EI models can aptly capture the organisational members' attitudes toward CE activity at *all* levels including the autonomous, 'grass-root' CE initiatives that occur irrespective of top-manager's involvement. This is especially relevant as all organisational members have a responsibility to identify and exploit opportunities on behalf of their organisation (Wales et al. 2011; Ireland et al., 2009). Second, EI models can contribute to our understanding of the organisational environmental factors that can encourage or discourage an individual to enact CE. Thus, my research aims to contribute to the very limited research on EI formation in the organisational context or corporate entrepreneurial intentions (CEI) formation. Additionally, I will investigate the organisational context for any factors that may influence individual employee's decisions to act entrepreneurially and barriers to forming such an intention.

1.3 Identity: An Emergent Perspective on Corporate Entrepreneurship & Corporate Entrepreneurial Intention Formation

Corbett et al. (2013) state that enquiry into processes that centre on the entrepreneurial choice of organisational members is essential to moving the field forward. One construct that has been extensively used to understand individual organisational member's behaviours emerged through the qualitative-inductive research methodology (Chapter 6) used in this study: *identity*. Identity has become a popular lens through which a wide array of

phenomena can be explored. The frequency with which organisation scholars are addressing identity from a multitude of perspectives including, professional (Goodrick & Raey, 2010; Ibarra & Barbulescu 2010; Pratt, Rockmann & Kaufmann, 2006) and organisational (Sveningsson & Alvesson, 2003; Alvesson Ashcroft & Thomas, 2008) is increasing. More recently, there had been a nascent knowledge space devoted to the identity-entrepreneurship nexus (Murnieks, Mosakowski & Cardon, 2012; Hoang & Gimeno, 2010, Watson, 2009). Identity is a social construct, which describes the subjective nature of meanings and experience within societal structures (Mead, 1934, Alvesson, 2003, Hogg et al, 1995). Identity poses two central questions, the first of which goes to self-concept and elicits the question, "Who am I?" The second question goes to the behaviours in which an individual engages to confirm this self-concept and as such asks the question "How should I act?" Essentially identity motivates behavioural attempts to confirm or verify its existence reflective of a collection of deeply held beliefs and values (Burke & Stets, 1999; McCall & Simmons, 1966). As such, identity can provide much insight into the 'individual in CE' especially in light of Krueger's (2007) proposition that beliefs and values have role in governing a person's entrepreneurial choice(s) via cognitive structures such as entrepreneurial attitudes and EI presented above in Section 1.3.

1.4 Research Context of the Investigation

My thesis seeks to understand the 'individual in CE.' Specifically, I aim to examine how the individual chooses to act entrepreneurially in their organisation. However, both the CE and EI literatures have limitations due to the contexts in which they have been conceptualised and empirically investigated. As covered previously, CE has built its knowledge base on large established organisations. However, the samples of large established organisations used in CE research are usually drawn from private sector organisations based in high growth industries such as technology (Phan et al., 2009). Correspondingly, the conceptualisations of the 11 CE models reviewed in Chapter 2 are based on commercial organisations whose structures, strategies and processes are at the discretion of the top management team,

board of directors and shareholders. Further, commercial enterprises are designed with one specific objective: to improve firm financial performance and the wealth of its owners, which are usually reflected in monetary metrics and outcomes. However, some researchers recognise that there is a growing expectation that organisations not considered to be traditionally entrepreneurial must adopt these entrepreneurial behaviours and translate them into strategies and policies that will guide the organisation in securing its future (Phan et al., 2009). This becomes particularly poignant in the aftermath of the 2008 economic crisis and extends a challenge to private and public sector organisations alike.

Similarly**,** EI research has been limited in its contextual application. The EI construct has been primarily developed in the individual entrepreneur(ship) domain. Consequently, EI has been conceptualised and operationalised to focus on the individual in wider society's choice to start a new venture or embark on an entrepreneurial career path (Krueger, 1993; Bird, 1988) rather than to participate in CE. Therefore, the study of EI is preoccupied with individuals who are not constrained by the specific tasks and duties of their jobs within an organisation. A second limitation of the EI literature arises as samples selected for EI studies have been criticised for using student subjects, as proxies for potential entrepreneurs or business executives (Robinson, Huefner & Hunt 1991; Copeland, Francia & Strawse, 1974). Thus, management scholars have called for the investigation of EI using more diverse samples to improve the generalisability of EI formation frameworks. Some researchers have responded to this gap in the EI literature by looking at academic EI at European universities (Prodran & Drnovsek, 2010). Kautonen, Luoto & Tornikoski (2010) examined employees in three contexts including public sector, blue collar and small business. This trend to improve contextual variation and explore its contingencies in CE and EI research represents another area where my thesis will contribute contextual depth and richness in findings. Large organisations have the capacity to present many obstacles as well as inducements for entrepreneurial behaviour. Their histories and legacies also present additional contextual factors that may act upon an individual's cognition in arriving at their intention to be entrepreneurial or not.

More specifically, my investigation of how individual organisational members choose to act entrepreneurially will take place in the National Health Service (NHS). The NHS is a publicly funded universal healthcare system established in 1948 and eventually rolled out across all of the United Kingdom (UK). The NHS is cited as the 5th largest workforce in the world with just over 1 million employees spread across England, Scotland, Wales and Northern Ireland (BBC News, 2012). These employees work in primary care units, acute care hospitals or commissioning groups. My study will focus on a large NHS England acute service provider in the East Midlands. For the sake of anonymity this organisation will be renamed, Large East Midlands Trust (LEMT), as a single in-depth case study using qualitative methods including, semi-structured interviews, participant observation and document gathering over 2 phases of data collection.

The NHS is both an appropriate and unique context for CE and EI research for one main reason. The NHS is a taxation-funded public sector institution. It could be argued that studying CE in a public sector is an oxymoron as the lack of profit motive and competition resigns CE outcomes such as competitive advantage and improved financial performance to near irrelevancy. However, CE can still provide a useful phenomenological framework for public sector organisations as researchers consider CE to be a moderate form of entrepreneurship (Morris et al., 2011). This accounts for organisations that over their life-cycles can become both structurally and socially hostile to forms of newness, such as those introduced by CE activities (Morris et al., 2011; Kanter, 1983). Also, the intention of CE to rejuvenate and revitalise organisations are highly relevant themes to the NHS. Particularly, when one considers that since its inception in 1948, the NHS has undergone several major reforms known as New Public Management (NPM) (Hood, 1991). The past 35 years of NPM reform has sought to modernise the service through the introduction of private sector management techniques and culture such as of marketisation, efficiency, quality benchmarks, performance indicators, decentralisation, managerialism and accountability (Hughes, 2003; Lane, 2002; Hood, 1991).

Yet, public sector organisations, such as the NHS, are especially notorious in the management literature in general and entrepreneurship–CE literature in particular as being invariably hostile to entrepreneurial activity. This is chiefly because public sector organisations like LEMT-NHS develop complex systems of bureaucracy which limit managerial autonomy; exhibit excessively hierarchical management structures and low organicity, which are identified in the CE literature as major barriers to informal and formal CE initiatives (Morris et al., 2011; Bellone & Goerl, 1992; Mintzberg, 1996). Therefore, how individual organisational members navigate and perceive these less-than-encouraging public sector organisational characteristics represent a fruitful avenue for CE and EI enquiry.

Further, as previously stated, CE is regarded as a positive phenomenon as it can improve performance (beyond the financial alone). As such, the literature tends to assume that individual organisational members hold CE activity in the same regard (Zahra & Covin, 1995). However, this assumption does not necessarily transfer to public sector organisations like the NHS where the notion of entrepreneurs as domineering, ruthless and dangerous rogue operators lacking in the necessary integrity to handle public funds or hold to traditions, still pervades (Currie, Humphreys, Ucbasaran & McManus, 2008; deLeon & Denhardt, 2000; Terry, 1998; Bellone & Goerl, 1992). In turn, the full gamut of entrepreneurial behaviours such as, strategic entrepreneurial visioning and opportunity identification and exploitation (Ireland et al., 2009), are not necessarily held in high regard by civil servants which suggests that their CEI formation maybe be hindered in some way.

1.5 Research Objectives

To best probe the propagation of CE, I have chosen to use a bottom-up approach thereby changing the level of analysis from the organisation as is conventionally studied to that of the individual employee. I investigate how individual organisational members make decisions to act entrepreneurially using EI formation models and the organisational contextual factors that can

potentially influence their CE decision. The many gaps in the literature have guided me to one central research question:

How can corporate entrepreneurship be implemented in the National Health Service and what are the barriers and facilitators to its enactment?

Based on the research question and the gaps in the literature, this research is guided by three objectives:

1. To understand how the individual chooses to engage with CE in a large mature organisation;
2. To apply EI formation models to the organisational context as a possible framework to draw out understanding of how individual organisational members make the entrepreneurial choice; and
3. To identify and examine the contextual factors from the LEMT case study that can hinder or facilitate EI formation in the organisational context, or what might be thought of as CEI formation.

1.6 Research Contributions

Management research has a duality in its purpose: it must be of a scholarly quality for academics and yet be relevant to managerial readership (Pettigrew, 2001; Watson, 2001). This suggests that management researchers need to contribute to academic theory *about* management as well as provide information *to* management. My study makes several contributions to understanding how CE enactment can come about via EI formation in the NHS context, both theoretically and practically. The limited volume of previous research allows my thesis to make a contribution to knowledge and theory development by significantly extending the bodies of knowledge in relation to a number of the literature gaps mentioned thus far.

First, any investigation into bottom-up approaches to CE research where the individual is the main level of analysis is an important contribution as the ‘individual in CE’ continues to be one of the least examined areas (Corbett et al., 2013). Although recent articles appearing in entrepreneurship and general

management journals indicate a growing interest, the treatment of the individual level of analysis in the extant CE literature continues to be inconsistent. Thus, my research contributes to the extension of the theoretical understanding of how individual organisational members are and can be purveyors of CE activity in large mature organisations. Further, where the individual has been considered in the extant literature, it has concentrated on individuals with management remits in the organisation. To redress this balance, my research will intersect with the emerging trend in CE research, which posits that CE must be studied over multiple levels of analysis as CE is not only the responsibility of management but all organisational members (Corbett et al., 2013; Wales et al., 2011; Ireland et al., 2009).

Second, this study contributes by building theory around the enactment of CE phenomena, which some researchers have stated requires more rigorous theory application. My dissertation achieves this by applying EI formation theory and the emergent identity lens to aid in understanding individual organisational members' entrepreneurial choice, which is hardly ever explicated by researchers (Corbett et al., 2013; Monsen, 2005; Sheppard & Krueger, 2002; Krueger & Brazeal, 1994; Shapero, 1981). Few researchers such as Ireland et al. (2009) have only attempted to propose the use of entrepreneurial cognitions as a possible explanation quite generally. As such, I bring some specificity to Ireland's et al.'s (2009) work by integrating an explicit entrepreneurial cognition that subsumes an individual organisational member's beliefs, values and attitudes about CE.

Third, my study tackles the generalisability constraint of the both CE and EI literatures. CE research has almost exclusively been generated in the commercial sector whereas the EI literature is almost always based on an individual's entrepreneurial decision to start a new venture or embark on an entrepreneurial career path on his or her own. Instead, my study provides contextual variation on several levels. For CE it is its application to a non-commercial context. For EI it is its deployment in the public sector context as well as the organisational context. Collectively, these contextual considerations allow me to extricate factors that are specific to the NHS-

LEMT organisational environment that could potentially act as barriers and facilitators of CE propagation as influencers of organisational members' formation of corporate CEI (Fini, Grimaldi, Marzocchi & Sobrero, 2010). Further, this will allow me to examine the applicability of EI formation models in an organisational setting when the objective of EI formation is CE. Ultimately, this will contribute to both the limited conceptual and empirical data on the construct I have previously called CEI.

Fourth, while it is widely acknowledged in literature the CE is difficult to propagate, contributory factors have almost exclusively been conceptualised from a top-down perspective. Issues that have been advanced include, but are not limited to, growth paradox, ambidexterity, resource allocation and strategic fit (Burgers, Jansen, Van den Bosch & Volberda, 2009; Kuratko, 2009). However, as I have reiterated, this project is conceived at the individual level of analysis. As such, I aim to contribute bottom-up perspectives on why CE can prove to be an elusive organisational state. I utilise the emergent identity-related strands to amplify my focus on the 'individual in CE' to investigate how organisational members navigate and manage issues surrounding self in a workplace context (Chapter 4). In doing so I explicate the influence of identity on CEI formation and the individual decision to act entrepreneurially in the organisational context.

Finally, in more practical terms, by providing insight into how CEI emerges practitioners can use these findings to better develop processes that allow them to target and augment specific contextual factors that can facilitate or hinder CEI formation. Also my research reveals crucial points during the CEI formation process, when the individual is more amenable to participating in CE, that the organisation can capitalise on. Taken together, once the CEI formation process is understood practitioners can potentially develop bespoke CE facilitating routines, processes and strategies that are truly reflective of their workforce. This is especially important in the given NHS context where inculcating entrepreneurial behaviours in the existing workforce is imperative when one considers that *60% of staff who will deliver NHS services in 10 years are already working in healthcare* (Darzi, 2008, p.8).

1.7 Organisation of the Thesis

This chapter has introduced my thesis by outlining my research objectives and the significance of my study. The blueprint for the rest of this thesis is presented in Figure 1 below. Chapters 2, 3, 4 and 5 constitute detailed supporting literature reviews of the CE literature, EI literature, identity and NHS context respectively. Chapter 2 is a critical review of eleven CE models that essentially summarise how CE researchers have attempted to understand CE propagation and enactment from the top-down and bottom-up. Chapter 3 presents the EI literature, starting with a systematic review of thirty-six EI papers and ending with a critique of EI formation models from a CE perspective to define boundaries and concepts for exploration in data collection. Chapter 4 provides additional theoretical foundations for this thesis through a review of the key debates, theories and concepts related to the emergence of identity through the induction process. Chapter 5 highlights the NHS as a special contextual variant through an overview of the policy, politics and history of this public sector organisation.

Chapter 6 is the start of the empirical portion of this thesis. It brings together the individual level focus of this thesis from the CE, EI and identity literatures. It also details the research design considerations and analysis procedures to best probe and extract findings from the unique context presented by the NHS-LEMT case. Chapters 7, 8 and 9 present empirical findings obtained from the data and discusses their implication for the CE paradigm and CEI formation. Chapter 7 relates to the overall 'state of CE in LEMT' and the contextual factors that emerged as barriers to CEI formation. Chapter 8 showcases how changes in circumstances create opportunities to shift and disrupt barriers to CEI formation. Chapter 8 then presents the processes by which individual organisational members chose to manage these changing circumstances so that CEI were or were not formed. My final chapter, Chapter 10, summarises my research, theoretical conclusions and the empirical implications I drew from the results. Additionally, this chapter outlines the study's limitations and

directions for future research in the area of the ‘individual in CE’ and CEI formation.

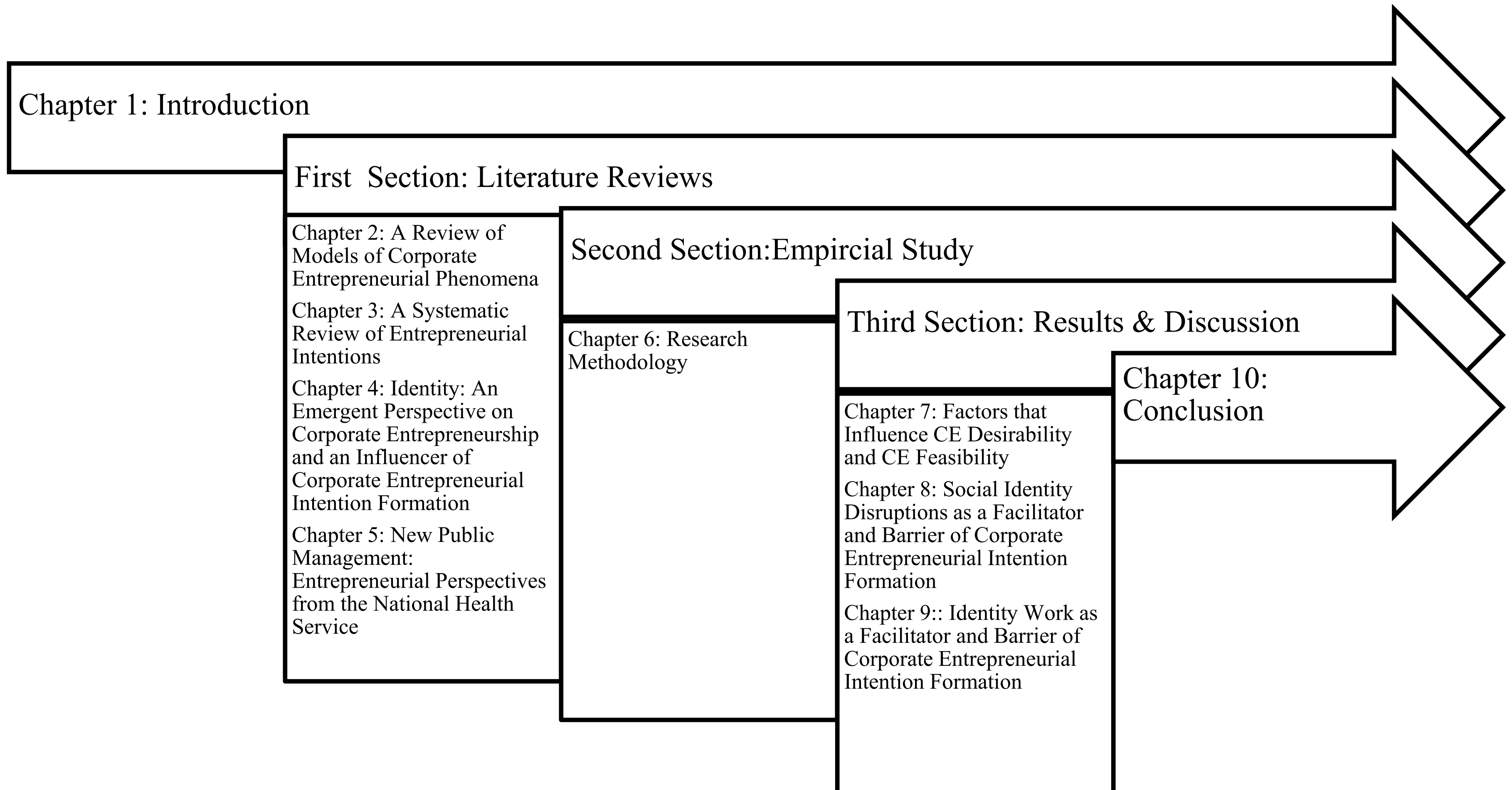


Figure 1: Thesis Research Structure

CHAPTER 2: A REVIEW OF MODELS OF CORPORATE ENTREPRENEURIAL PHENOMENA

2.1 Introduction

Over the past 35 years CE has developed into a central concept in entrepreneurship research (Corbett, Covin, O'Connor & Tucci, 2013). The CE literature enhances the general entrepreneurship literature as it specifically explores how entrepreneurship can occur *within organisations*. CE has been has been commonly touted by both executives and researchers as an effective strategic option for organisations seeking to revitalise and renew themselves and improve their financial performance (Antoncic & Hisrich, 2001; Zahra & Covin, 1995) Consequently, CE propagation has been accepted on faith as an inherently desirable pursuit for established organisations (Zahra & Covin, 1995). CE research has become even more pertinent as organisations are expected to remain viable and improve performance in increasingly competitive and financially constrained environments in the aftermath of the 2008 global economic crisis. As such there is a growing expectation that organisations not considered to be traditionally entrepreneurial, such as public sector organisations, must adopt pro-CE strategies and policies that will guide the organisation in securing its future (Phan, Wright, Ucbasaran, & Tan, 2009).

CE scholars have reached a general consensus on the positive nature of the CE-organisational performance relationship. As such, a pool of knowledge has emerged in the past 40 years of CE research that mainly highlights the specific organisational level mechanisms in the organisational context that facilitate CE (Hornsby, Kuratko, Holt & Wales, 2013). However, the existing empirical literature reveals significantly less attention has been paid to the individual level analysis to sufficiently explain how organisational members chose to facilitate (or conversely challenge) CE enactment (Wales et al., 2013; Monsen, Patzelt & Saxton, 2010; Hornsby, Kuratko & Zahra, 2002). As such the corporate entrepreneurial organisation continues to be described as a 'black box' (Dess et al., 2003; Krueger, 2000).

In this chapter I aim to review the diverse and extensive multiplicity of CE models that have be conceptualised and operationalised in the extant literature as possible approaches to encouraging CE. To best appraise these models my literature review will be divided into three substantive sections. Section 2.2 provides an overview of CE definitions, concepts and phenomena to provide clarity and consistency to the diverse array of terminology used in the CE domain. Section 2.3 will form the backbone of this chapter and provide a systematic breakdown of each of the 11 models of CE found in the literature and will do so in two ways. First, I will present (1) the *conditions* that engender CE, in Table 4 and Section 2.3.1, (2) various *processes* that facilitate CE in Table 5 and Section 2.3.2 and (3) the *outcomes* of CE in Table 6, Section 2.3.3. Second, each sub-section will be disaggregated by levels of analysis, specifically (1) the external environment, (2) the organisational and (3) the individual. Finally, Section 2.4 will conclude this chapter by highlighting the limitations of the CE models as well as my intended contribution to the CE literature.

2.2 The Corporate Entrepreneurship Domain: Clarifying Definitions & Phenomena

As I introduced above, management scholars are paying greater attention to CE research. This is evidenced by the growing number of CE (and related) special editions in Grade 4 journals that have an interest in entrepreneurship, as ranked in the Academic Journal Quality Guide (Version 4) published by the Association of Business Schools (ABS, 2010). This is presented in Table 1 below. Additionally Table 1 also shows that CE research has accelerated as the majority of these CE special editions have been published in the past 5 years.

Collectively, these special editions punctuate the CE literature by summarising the current state of CE research to aid in systematically developing the CE paradigm. In doing so these special editions indicate that the majority of CE research sits within two specific lines of enquiry. First, over the past few decades, innovation has been recognised as an essential source of sustained competitive advantage for organisations (Covin & Slevin, 2002). As such, CE research has sought to crystallise the various forms of innovation that occur in the

organisational context to define CE's domain. As such, some CE special editions have summarised the conceptual and empirical body of research devoted to defining and describing a variety of CE related concepts and phenomena based on innovation. For instance, Guth & Ginsberg in the SMJ 1990 special edition describe CE as consisting of two main innovation phenomena: *corporate venturing* (new venture creation) and *strategic renewal* (renewal of the key ideas on which the organisation is built). Further, other special editions have directed CE scholars to take more fine-grained approaches to these CE phenomena by extracting and defining two alternative supporting conceptualisations of entrepreneurship at the organisational level.

Year	Journal	Construct
2013	Journal of Product Innovation Management (JPIM)	Corporate Entrepreneurship
2011	Entrepreneurship Theory & Practice (ET&P)	Entrepreneurial Orientation
2009	Entrepreneurship Theory & Practice (ET&P)	Strategic Entrepreneurship
2009	Journal of Business Venturing (JBV)	Corporate Entrepreneurship
1999	Entrepreneurship Theory & Practice (ET&P)	Corporate Entrepreneurship
1990	Strategic Management Journal (SMJ)	Corporate Entrepreneurship

Table 1: Special Issue Journals on Corporate Entrepreneurship and Related Constructs in Academic Journal Quality Guide

The first, *strategic entrepreneurship* (SE), aligns with and expands strategic renewal (Covin & Miles in ET&P 1999; Kuratko & Audretsch, 2009). The second, *entrepreneurial orientation* (EO), represents a collection of CE decision-making processes (Covin & Lumpkin in ET&P, 2011; Lumpkin & Dess, 1996). The definitions and descriptions of these CE phenomena will be discussed in the remainder of Sections 2.2 and 2.3.

Second, the maturation of the CE literature has also prompted the emergence of what Corbett et al. (2013) call an *'advocacy orientation'* (p. 816). From this

approach researchers have focused on demonstrating the usefulness of CE in creating sustained competitive advantage within an organisation. This has led to a continuous stream of supporting empirical and conceptual articles across a range of mainstream contemporary management journals to build the CE knowledge base. This trend is demonstrated by the extensive number of studies exploring the relevance of CE including, CE-outcome relationships (Zahra & Covin, 1995; Antoncic & Hisrich, 2001), moderators of the CE-firm performance relationship (Burgers et al., 2009; Monsen et al., 2009) and organisational antecedents of CE (Hornsby et al., 2013). These relationships will be discussed in detail in Section 2.3.

2.2.1 Definitional Issues in Corporate Entrepreneurship

In the 1980s there were on-going debates about what terminology should be used by researchers to best define CE. CE's definitional ambiguity has been summarised and extensively discussed by Sharma & Chrisman in their 1999 paper where they compiled an extensive list of CE-related definitions. Sharma & Chrisman (1999) argue the inconsistency in CE definitions largely stemmed from the need for any definition constructed to reflect the multiple phenomena active in CE at any one time (Guth & Ginsberg, 1990). These phenomena will be detailed in Section 2.2.2. In an attempt to simplify CE definitions, Covin & Miles (1999) proposed that the term CE should be reserved for instances where entire organisations, rather than individuals or parts of firms, act in ways that are generally 'entrepreneurial.' However, many scholars recognise that such an 'organisation only' perspective is quite limited and could potentially stifle CE's purview in terms of future research problems as the field evolved (Floyd & Lane 2000; Burgelman, 1983). The disadvantage of an 'organisation only' perspective is particularly evident when one considers that many of the CE definitions assembled by Sharma & Chrisman (1999) indicate that individuals play an integral role in introducing, initiating and implementing CE in the organisation (Chung & Gibbons, 1997; Vesper, 1984; Pinchot, 1985). Krueger (2000) reminds CE scholars that it is organisational members and not the organisation by itself that initiate and lead CE activities (such as opportunity recognition, for example).

The literature reflects this organisation-versus-individual inconsistency by expressing CE on a dichotomous spectrum. On one end of the spectrum, CE can be *informal* and *autonomous* (Zahra, Nielsen & Bogner, 1999). That is, innovation is created and led by an employee's own free volition without prompting, expectation or permission from higher management. This indicates the existence of bottom-up CE enactment in the organisation or what Burgelman (1983a) calls '*autonomous strategic initiatives'* (p. 241), where individuals transform their ideas into the collective action of the organisation (Chung & Gibbons, 1997; Vesper, 1984). Conversely the other end of the spectrum, *formal* and *induced* CE, is characterised by top-down enactment (Zahra, Nielsen & Bogner, 1999). The organisation through its strategies, structures and processes encourage new resource combinations and innovation to incite the generation and extension of the organisation's competencies to exploit corresponding (new) opportunities (Covin & Slevin, 1991). This top-down versus bottom-up approach to CE indicates that researchers potentially have a choice of three levels of analysis when interrogating the CE construct, namely (1) the organisational level, (2) the individual level or (3) the aggregate/team level. This suggests from its nascent stages CE was set to progress beyond its primary organisation level of analysis to include the individual or groups of individuals acting entrepreneurially within the organisation.

One definition that has been used consistently in the literature over the last 15 years (Corbett et al. 2013; Hoskisson, Covin, Volberda & Johnson, 2011; Burgers et al., 2009; Ireland, Covin & Kuratko, 2009; Dess et al., 2003) is that of Sharma and Chrisman (1999). Sharma & Chrisman's (1999) definition of CE places it in a contemporary management context while simultaneously assimilating the aforementioned induced-versus-autonomous perspectives of CE:

> *The process whereby an individual or a group of individuals, in association with an existing organisation, create a new organisation or instigate renewal or innovation within that organisation* (p. 18)

Finally, this definition also signals towards three very specific *CE phenomena*, which are most commonly denoted in the literature: *innovation*, *corporate*

venturing and *renewal activities*. These phenomena will be discussed in greater detail in the Section 2.2.2 below. Therefore I will adopt Sharma & Chrisman's (1999) definition throughout my thesis.

2.2.2 Corporate Entrepreneurship Phenomena

An assortment of terms has been used over the past 40 years of CE research to encompass the observable phenomena that constitute the basis of CE. Some of these include: *frame-breaking change* (Stopford & Badden- Fuller (1994), *intrapreneuring*, (Antoncic & Hisrich, 2001; Pinchot, 1985; Russell, 1999; Covin & Miles, 1999), *entrepreneurial management* (Stevenson & Jarillo, 1990) and *entrepreneurial posture* (Brown et al., 2001; Covin & Slevin, 1991). From the diversity of the terminology it can be deduced that a significant level of dissonance existed around what CE entailed exactly; especially as CE's operationalisation has equated it with one or a combination of (1) product or process innovation (Covin & Miles, 1999) (2) market development (Jennings & Lumpkin, 1989) or (3) risk-taking propensity (Miller, 1983; Zahra, 1991). However Guth & Ginsberg's (1990) contribution to the expansion of the strategic management paradigm provided a clear framework for CE. The authors distilled three phenomena that are neatly subsumed in Sharma & Chrisman's (1999) definition and are now consistently used in CE research. These include: (1) *innovation*; (2) *corporate venturing* (CV), where new organisations are created within or external to the existing organisation; and (3) *renewal activities*, where the same characteristics that laid the early foundations of the firm's success are re-booted. Each of the aforementioned categories has distinct characteristics that will be described and discussed in the following sub-sections to simplify the inner workings of CE.

2.2.2.1 Innovation

Innovation has been established as an inextricable core concept in the field of entrepreneurship by one of it seminal thinkers Joseph Schumpeter (1942; 1939; 1934). Sharma & Chrisman (1999) draw on CE's entrepreneurship origins (Hoskisson et al. 2011) to derive a CE typology that utilises what they brand as *'innovation of the Schumpeterian variety'* (p. 19). Schumpeterian innovation is

characterised as disruptive, radical, dramatic departures from the modus operandi, typically representing the start of the technological change cycle. Schumpeterian innovation is considered extremely difficult to achieve and is thus very rare, yet it is crucial to an organisation's long-term competitive advantage (Dunlap-Hinkler, Kotabe & Mudambi, 2011). Stopford & Baden-Fuller (1994) documented this radical innovation in the strategy literature as a form of CE, calling it *'frame-breaking change.'* The authors elaborated on this form of CE stating it involves new combinations of factors of production. In turn these new combinations are capable of so greatly impacting an industry that transformation is not only limited to the organisation but also infuses and significantly adjusts the competitive environment.

Innovation however, is viewed to exist on a continuum that specifies the extremes of change, technological or otherwise. Thus, where radical innovation represents a starting point, incremental innovations build on the prevailing designs produced by a radical innovation. Incremental innovation encompasses the evolution of radical innovations as time passes, including the introduction of new features, extensions or variations to improve production efficiency, service or product quality (Kuratko & Welsch, 2001). While an extensive body of literature on innovation exists, a large portion focuses on exploring this dichotomy only. Dunlap-Hinkler et al. (2011) however suggest that a new line of enquiry into the heterogeneous nature of incremental innovation is needed to capture the many shades of grey between the extremes.

Taking the above into consideration, contemporary definitions of innovation generally embrace the innovation continuum, defining innovation as the successful implementation of creative ideas that result in bringing something into new use (Sawyer & Griffin, 1993; Rogers, 1962). CE however, is specifically concerned with various forms of market-opportunity driven newness that ultimately result in a positive effect on firm performance in the short to long term (Dess et al., 2003). It is this newness that acts upon the strategies, structures and processes of an organisation and has varying potential outcomes. As such, scholars and practitioners advocate that organisations and its members should not innovate sporadically, but often, quickly and efficiently to ensure future economic

rents are realised from customers purchasing or using these new and improved products or services.

Innovation however, does not exist as an isolated entity in the CE domain. Rather it sits at the heart of the other two CE phenomena of new business creation and renewal activities, as both occur in direct response to change induced by innovation. As such innovation manifests itself in CE in two ways. First, some new product, service or process emerges and a decision is taken to build a new business around it, known as *corporate venturing* (CV). Second, some innovation born of a continuous cycle of identification, modification, refinement and implementation is utilised to *renew* organisational products, services, operations and interactions (Covin & Miles 1999; Dess et al, 1999; Brazeal & Herbert, 1999). Essentially, in tandem with innovation, new business creation and renewal activities result in new patterns of resource deployment and capability development that enable the organisation to be more competitive in the market place (Brazeal & Herbert, 1999).

2.2.2.2 New Business Creation

When organisations chose to invest in and/or create a new business this refers to the act of CV mentioned previously in Section 2.2 (Narayanan, Yang, & Zahra, 2009; Sharma & Chrisman, 1999; Burgelman, 1983). The creation of these new business ventures tends to be related and aligned to the organisation's existing business portfolio. However, integration determines how these new ventures are categorised in terms of its *internal* versus *external* manifestations. When new ventures are developed as distinct organisational units that are separate to the incumbent organisation, this is called external CV (ECV). Another form of ECV indicated in the literature is joint CV (JVC) when one established organisation co-invests with one or more external established partner organisations to create an external business interest (Covin & Miles, 2007). Conversely when the new venture is created inside the incumbent's domain and boundaries the term internal CV (ICV) is applied (Burgelman, 1983).

CV can play an important role in how an organisation manages innovation. ICV, JCV and ECV each provide an outlet through which innovations can be expressed in the market place or respond to the innovation imperative of particular industries, such as technology. The literature reflects four general themes that indicate how CV configurations can contribute to the overall success of the incumbent's innovation. First, CV enables an organisation to leverage its core competencies in its chosen product-market arena thereby creating and extracting value (Burgelman & Doz, 2001). Second, CV allows for the stockpiling of new resources and capabilities that create new combinations that extend the organisation's reach in the acquirement of new opportunities for pursuit (Kanter, 1989). Third, CV is also a means by which an organisation can catapult itself from a declining domain resulting in a new core business with new opportunities (Donahoe et al, 2001). Last, CV is an opportunity for organisational learning through the exploration of new business domains that may be of interest in the future (Dess et al., 2003).

These CV configurations represent the substantial literature on CV as a possible CE based strategic option from the organisational level. However, scholars have argued it is both difficult and complicated to manage CV activities in large mature organisations (Burgers et al., 2009; Hill & Birkinshaw, 2005; Burgelman & Valikangas, 2005). Burgelman (1983) argues that these difficulties stem from a lack of clarity surrounding how or the actual processes by which, individual organisational members chose to lead or participate in CV, especially as process research in large mature organisations is difficult and costly to conduct. As such, Burgelman's (1983) longitudinal processual study represents one of the earliest attempts at documenting this form of CE from the individual level. This represents a major contribution to the limited 'individual in CE' line of inquiry. Burgelman's (1983) findings strongly suggest that the autonomous strategic CE initiatives of individual organisational members are one of the most important resources for an organisation seeking to revitalise and renew itself. Despite its importance, strategic initiatives may not directly align with the organisation's current strategic portfolio (Burgers et al., 2009). This creates dilemmas for both managerial and non-managerial organisational members around resource procurement and deployment, managerial support, career and reputational risk

and which may potentially impact their decision to act as a corporate entrepreneur (Hornsby, Naffziger, Kuratko & Montagno, 1993; Burgelman, 1983).

2.2.2.3 Renewal Activities

Renewal activities were primarily documented in the early CE literature as entailing any efforts that brought about a significant change to the strategy or structure of an organisation at the business and corporate level by revitalising the initial founding ideas upon which the organisation was built (Sharma & Chrisman, 1999; Guth & Ginsberg, 1990). These renewal efforts are always exclusively restricted to and reside within the organisation, thereby altering interactions within the organisation as well as how the organisation interacts with the external environment.

Chandy & Tellis (2000), coined the term 'the incumbent's curse' to describe organisations that have become *so enamoured with their success or so hampered by their bureaucracy that they fail to introduce the next generation of radically new products* (p. 2). As such, renewal activities can be employed by organisations as a pervasive tactic, to infiltrate sections of, or the entirety of, an organisation via its structure, strategy and processes with an entrepreneurial philosophy. This overrides the inherent inertial forces that can accrue under the status quo (Floyd & Lane, 2000; Burgers et al., 2009). Additionally and similar to CV, renewal activities can incite an organisation to close the gap between existing core competencies and what the industry standards demand for the future (Burgelman, 1994; 1991).

Renewal activities however, were considered to be somewhat generalist and ambiguous as they only provide a description of outcomes and no explicitly defined basis for what it entails (Hill & Hlavacek, 1972; Peterson & Berger, 1971). As such, more recent CE conceptualisations have been expanded to become more precise about what renewal activities entail. Morris, Kuratko, & Covin (2011) and Phan et al., (2009) propose a new category of renewal phenomena as representing part CE, collectively known as- *strategic entrepreneurship* (SE). Five forms of SE (see Table 2) are currently recognised in

the literature: *strategic renewal, sustained regeneration, domain redefinition, organisational rejuvenation* and *business model reconstruction* (Kuratko & Audretsch, 2009; Ireland, Hitt & Sirmon, 2003; Covin & Miles, 1999). The five forms of SE adhere to the original internally focused strategic renewal initiatives that do not necessarily involve CV. As such, SE provides a more specific and integrative view of renewal phenomena by stipulating the (1) focus of renewal, (2) type of innovation, (3) locus of innovation, (4) frequency of occurrence of innovation and (5) outcomes of innovation, Table 2. Further, Table 2 demonstrates that within SE the locus of innovation can be the strategies, products, services, structures, processes, capabilities or business model of the organisation so the organisation is transformed relative to itself or its industry standards (Kuratko & Audretsch, 2009).

Researchers contend that like CV, SE is also complex and difficult to create and sustain (Floyd & Lane 2000; Covin & Miles, 1999). Furthermore, though SE represents a potentially fruitful line of inquiry into CE, it still remains a largely under-researched area with largely descriptive studies and conceptual articles (Kuratko & Audretsch, 2009; Ireland et al, 2009; Dess et al. 2003). As such, the treatment of the 'individual in CE' remains quite inconsistent at this time, although some researchers have conceptually linked some SE forms to managerial roles (Dess et al. 2003; Floyd & Lane 2000).

Table 2: Types of Renewal Activities Captured under SE

Types of SE	Definition	Focus of renewal	Type of innovation	Locus of innovation	Locus of change	Outcomes	Frequency
Strategic Renewal	"Where a firm seeks to redefine its relationship with its markets or industry competitors by fundamentally altering how it competes." (Covin & Miles, 1999, p. 52)	How organisation competes	Not specified	New strategies used to better align organisation with external environment	Transformation of organisation itself	Redefinition of organisation-market relationship	Low
Sustained Regeneration	"The firm regularly and continuously introduces new products and services or enters new markets." (Covin & Miles, 1999, p. 51)	Capacity for innovation	Continuous and incremental innovation	Products and services	Organisation itself via culture, processes, structures that support innovation	Continuous new product introductions to existing and new markets	High
Domain Redefinition	"The organisation proactively creates a new product-market arena that others have not recognised or actively sought to exploit." (Covin & Miles, 1999, p. 54)	Exploration of potential markets	Not specified	Product and service categories	Organisation's interface with external market	First or early mover advantage in a new market. New industry or redefine boundaries of industry	Low
Organisational Rejuvenation	"The organisation seeks to sustain or improve its competitive standing by altering its internal processes, structures and/or capabilities." (Covin & Miles, 1999, p. 52)	Improving the execution of internal processes, structures and capabilities	Process and administrative innovations	Core attribute(s) of the organisational operations	Transformation of organisation itself	Renewal of the organisation's operations so it is distinguished from the rest of the industry	Low to moderate
Business Model Reconstruction	"The phenomenon whereby the firm designs or redesigns its core business model(s) in order to improve operational efficiencies or otherwise differentiate itself from industry competitors in ways valued by the market." (Kuratko & Audretsch 2009, p. 10)	Business model, that is how value is delivered to the customer at an appropriate cost	Structural innovation	Redesign of core business model of organisation	Organisation's interface with external market	Differentiation of organisation from industry competitors	Low

Thus far I have outlined the CE domain by presenting definitional issues and explicating the various phenomena it encompasses. However in the JPIM (2013) CE special edition, Corbett et al.'s (2013) introductory article cited that studies that describe CE phenomenon (Covin & Miles, 1999; Guth & Ginsberg, 1990) or demonstrate performance benefit for a myriad of firms (Zahra & Covin, 1995; Stopford &Baden-Fuller, 1994; Antoncic & Hisrich, 2001) are less likely to move the field forward. Primarily because these types of studies do not address the contemporary issue that sustaining an organisation's competitive advantage is growing increasingly difficult due to globalisation, technological change and increasing competitive intensity (Corbett et al., 2013). Thus authors advocate that researchers should turn their attention towards exploring the nuances of (1) *why* organisations may choose to develop CE initiatives and (2) under *what* circumstances these attempts could be successful (Corbett et al., 2013; Wales et al. 2011; Monsen et al., 2009). In essence, the authors suggest a new research trajectory for CE research and call for an in-depth investigation into the internal conditions and processes by which CE evolves or those that predict CE adoption. As such, the remainder of this chapter will be devoted to reviewing 11 CE models proposed by scholars as frameworks for understanding how CE can emerge in an organisation.

2.3 A Review of Corporate Entrepreneurship Models

Thus far I have explained the CE domain by first presenting CE definitions followed by the three major CE phenomena upon which these definitions are based. As I introduced in Section 2.2, it is widely accepted that CE is considered to be a potentially worthy means of revitalisation for organisations by promoting and sustaining innovation activity that may lead to superior performance (Antoncic & Hisrich, 2001; Schollhammer, 1982; Dess et al. 2003; Zahra & Covin, 1995; Covin & Miles, 1999). Naturally, scholars have sought to understand how CE can be propagated in organisations. As such, a recurrent and prominent theme in the CE literature from the early 1980's to the present is an array of CE models (see Table 3). These models seek to illustrate *why* CE occurs, *how* CE occurs and *what happens* when CE occurs. Correspondingly, the CE research agenda is populated with an abundance of conceptual articles and

empirical studies that present an array of constructs and explore the relationships between them.

I have selected eleven models for review based on the following criteria: (1) they include the dimensions of CE from Section 2.2.2; (2) they reflect the 'mind-set' of an entrepreneurial organisation; and (3) have been featured in management journals rated as Grade 4 in the Academic Journal Quality Guide, (ABS, 2010). Having summarised the eleven models in Table 3, it can be seen that scholars acknowledge the heterogeneity of CE. Some models cover all of CE in general (Ireland et al., 2009) whereas others focus on one aspect of CE such as strategic renewal (Floyd & Lane, 2000) or CV (Burgelman, 1983). To best discuss the concepts contained within these models and to highlight the similarities and differences between these models and the limitations of each model, I will review each of them over three common categories. These categories emerged based on two types of models commonly used in CE (1) cause-and-effect models, which are most common and (2) process models. The first category consists of *conditions* that engender CE, contained in Table 4 and Section 2.3.1. The second category will consist of the various *processes* that are active in CE, found in Table 5 and Section 2.3.2. The third category is *CE outcomes* and is discussed in Table 6 and Section 2.3.3.

Author/Year	CE Phenomena Investigated	Appendix
Ireland et al., (2009)	Corporate Entrepreneurship	Appendix 11
Kuratko et al., (2005)	Corporate Entrepreneurship	Appendix 10
Dess et al., (2003)	Strategic Entrepreneurship	Appendix 9
Antoncic & Hisrich (2001)	Corporate Entrepreneurship	Appendix 8
Floyd & Lane (2000)	Strategic Renewal	Appendix 7
Zahra et al., (1999)	Corporate Entrepreneurship	Appendix 6
Lumpkin & Dess (1996)	Entrepreneurial Orientation	Appendix 5
Hornsby et al., (1993)	Corporate Venturing	Appendix 4
Covin & Slevin (1991)	Entrepreneurial Orientation	Appendix 3
Guth & Ginsberg (1990)	Corporate Entrepreneurship	Appendix 2
Burgelman (1983)	Corporate Venturing (Internal)	Appendix 1

Table 3: Corporate Entrepreneurship Models under Review

2.3.1 Conditions that Engender Corporate Entrepreneurship

As introduced above, some CE models use a cause-and-effect format. Of the 11 models under review, 8 of them use this design (Ireland et al., 2009; Kuratko et al., 2005; Antoncic & Hisrich, 2001; Zahra et al., 1999; Lumpkin & Dess; 1996; Hornsby et al., 1993; Covin & Slevin, 1991; Guth & Ginsberg, 1990). This section will be devoted to discussing what scholars consider to be the causes or conditions that can prompt an organisation to adopt CE. Based on a review of literature in the areas of CE and organisational innovation, Schindehutte, Morris & Kuratko (2000) identified no less than 40 key *triggers* or precipitating events (Hornsby et al., 1993) that prompt CE activity. As I analysed and compared these 8 models it became clear that the myriad of conditions they propose are stratified across three levels of analysis, the external environment, organisation and individual (see Table 4). I will discuss these pro-CE conditions below.

2.3.1.1 Conditions that Engender Corporate Entrepreneurship: External Environmental Level

Arguably, the greatest pressure that presses organisations to institute CE comes from changes in the external environment (Ireland et al., 2009). Stopford & Baden-Fuller (1994) conducted a longitudinal study of the CE initiatives of ten organisations in four European industries and found that,

> *Troubled firms in hostile environments can shed past behaviours, adopt policies fostering entrepreneurship and accumulate innovative resource bundles that provide a platform on which industry leadership can be built* (p.1).

Zahra (1991) contended that increased environmental hostility, dynamism and heterogeneity require organisations to develop and implement CE strategies. Comparably, Lumpkin & Dess (1996) recommended that organisations in a rapidly changing competitive environment may benefit greatly by propagating CE (in this instance through an entrepreneurial orientation).

Author/Year	Conditions that Engender Corporate Entrepreneurship		
	Individual Level	**Internal Level**	**External Level**
Guth & Ginsberg (1990)	Not considered	Organisation Conduct/Form Structure Process Core Values/Beliefs Strategic Leaders Characteristics Values/Beliefs Behaviour	Competitive Technological Social Political
Covin & Slevin (1991)	Not considered	Strategic Variables Mission strategy Business practices and competitive tactics Internal Variables Top management values and philosophies Organisational resources and competencies Organisational culture Organisational structure	Technological sophistication Dynamism Hostility Industry life cycle stage
Hornsby et al. (1993)	Risk-taking Desire for Autonomy Need for Achievement Goal Orientation Internal locus of Control	Management Support Autonomy/ Work Discretion Rewards/ Reinforcement Time Availability Organisational Boundaries Precipitating Events	Precipitating Events
Lumpkin & Dess (1996)	Not considered	Size Structure Strategy Strategy making process Resources Culture Top management team characteristics	Dynamism Munificence Complexity Industry characteristics
Zahra et al. (1999)	Not considered	Internal Organisational Variables	External Environment
Antoncic & Hisrich (2001)	Not considered	Communication Formal Controls Environmental Scanning Organisational Support Competition-related Values Person-related values	Dynamism Technological opportunities Industry growth Demand for new products Unfavourability of change Competitive Rivalry
Kuratko et al. (2005)	Not considered	Management Support Autonomy/ Work Discretion Rewards/ Reinforcement Time Availability Organisational Boundaries	Not specified
Ireland et al. (2009)	Individual Entrepreneurial Cognitions Entrepreneurial Beliefs Entrepreneurial Attitudes Entrepreneurial Values	Structure Culture Resources/ Capabilities Reward Systems Entrepreneurial Strategic Vision	Competitive Intensity Technological Change Product-Market Fragmentation Product-Market Emergence

Table 4: Conditions that Engender Corporate Entrepreneurship

Correspondingly, 8 of the 11 models under review include external environmental conditions as pivotal in prompting CE (Ireland et al., 2009; Kuratko et al., 2005; Antoncic & Hisrich, 2001; Zahra et al., 1999; Lumpkin & Dess; 1996; Hornsby et al., 1993; Covin & Slevin, 1991; Guth & Ginsberg, 1990). External environmental conditions are usually cited as encompassing the general economic, sociocultural and political forces that are at work. As such, the list of environmental conditions that can trigger entrepreneurial activity in established firms is quite extensive as illustrated in Table 4. Largely, the external environmental conditions included in CE models are framed as munificent (favourable) or hostile (unfavourable). I will discuss some of the more common favourable or unfavourable external factors used throughout CE models.

Munificence (Zahra, 1993) is a multidimensional concept used to include dynamism, technological opportunities, industry growth and the demand for new products, which generally favour CE. Dynamism, defined as the perceived instability and continuing changes in the markets an organisation serves has been used in the CE model conceptualisations of Covin & Slevin (1991), Lumpkin & Dess (1996) and Antoncic & Hisrisch (2001). These authors propose that opportunities are created in a firm's markets due to increased dynamism and as such the environment is viewed as conducive to CE (Zahra, 1991). Similarly, technological change (Guth & Ginsberg; Covin & Slevin, 1991; Antoncic & Hisrich, 2001; Ireland et al., 2009) has been consistently viewed as favourable to propagating CE as it creates a situation where an organisation's competitive advantage is short-lived. In turn the organisation must continuously innovate to stay relevant in their industry and ahead of their competitors. Further, technological change can be a response to the demand for new products, which is another important pro-CE factor (Ireland et al., 2009; Antoncic & Hisrich, 2001). Demand for new products can contribute to increased environmental heterogeneity by creating opportunities for successful new product or service introductions. These new product/service based value propositions then mirror market needs more closely and allow organisations to gain a stronger competitive position. This is particularly relevant to industries that are in a growth phase as high market growth was proposed to be related to the success of start-ups such as corporate ventures (Hobson & Morrison, 1983).

Similarly, environmental conditions characterised as hostile tend to create threats for the organisation that can also encourage CE (Covin & Slevin, 1991, 1989). Competition is often cited in CE models as a major indicator of environmental hostility (Guth & Ginsberg, 1990; Antoncic & Hisrich, 2001; Ireland et al., 2009). Porter (1980) specifies that competition is the result of an organisation's attempts to differentiate itself from other organisations in the same industry by creating and exploiting some basis for competitive advantage. This frequently translates into the organisation aggressively pursuing the innovation imperative discussed above, which forms the basis of all CE phenomena discussed in Section 2.2.2.1, or risk succumbing to its rivals.

2.3.1.2 Conditions that Engender Corporate Entrepreneurship: Organisational Level

In addition to the external environmental conditions considered above, certain internal or organisational factors have also been conceptualised as CE triggers (Hornsby et al., 1993). More commonly however the CE models under review frame organisational conditions as those that can *facilitate* CE (Ireland et al., 2009; Kuratko et al., 2005; Antoncic & Hisrich, 2001; Zahra et al., 1999; Lumpkin & Dess; 1996; Hornsby et al., 1993; Covin & Slevin, 1991; Guth & Ginsberg, 1990). This view has emerged due in large part to the natural stagnation an organisation experiences as it progresses through the organisational life cycle (Kuratko, 2009; Adizes, 1989; Grenier, 1972). Customarily, each stage of the life cycle is characterised by growth and prosperity until a crisis point is reached and forces management to challenge the status quo and make decisions to progress the organisation to the next stage (Floyd & Lane, 2000; Grenier, 1972). There is however a caveat to these decision-making iterations led by top management. Mainly, the process tends to result in the development of complex organisational architecture that breeds bureaucracy and limits communication, creativity and innovation, which are an anathema to CE uptake and to its sustainability (Dess, Lumpkin & McGee, 1999). This alludes to a paradox in the CE literature. That is, while organisations adopt CE as a strategy for combating hostile environments or to take advantage of munificent external environmental conditions, the organisation itself may actually act as a hostile environment in itself towards the

creativity and innovation required for CE (Sharma & Chrisman, 1999; Burgelman, 1983).

As such, some CE researchers have indicated that creating an effective architecture is often the most difficult part of developing a successful CE programme within the organisation (Garvin, 2002). Organisational architecture is a multifaceted term used to depict an organisational context that exhibits particular attributes, which together or separately facilitate CE (Ireland et al., 2009; Dess et al., 1999). Organisational architecture has three components according to Dess et al. (1999): *hardware*, *software* and *people*. I will discuss the hardware and software components in more detail below, whereas the people component will be addressed subsequently in Section 2.3.1.3, which addresses the individual level specifically.

The *hardware* component of organisational architecture encompasses organisational features such as *structure* and *communication systems*. Structure has been defined as the arrangement of authority, communication and workflow relationship in an organisation (Ireland et al., 2009) and has been included in 7 of 11 CE models under review (Ireland et al., 2009; Antoncic & Hisrich, 2001; Lumpkin & Dess; 1996; Covin & Slevin, 1991; Guth & Ginsberg, 1990). From very early on scholars such as Lawrence & Lorsch (1967) and Mintzberg (1979) have empirically linked structural features to innovation activity in organisations. The CE literature proposes there are two structural features in particular that can foster CE: *organicity* (Burns & Stalker, 1961) and *boundarylessness* (Devanna & Tichy, 1990).

Organicity is characterised as the extent to which an organisation displays decentralised decision making, minimises formal hierarchies by encouraging expertise-, rather than position-, based power and process flexibility with minimal interference from rules and policies. This is counter to traditional organisations that have been described as mechanistic with highly centralised and formal vertical interactions and specialised differentiation between functions (Burns & Stalker, 1961). Aspects of structural organicity have been linked to an

organisation's inclination to utilise CE by authors such as, Miller & Friesen (1984), Covin & Slevin (1988) and Barrett & Weinstein (1998).

On the other hand, boundarylessness is directed at creating a fluid and porous organisation to improve communication. In addition to also having fewer management layers, boundaryless organisations also propagate more interdisciplinary teams, empower frontline employees, smaller work units and open communication vertically and laterally. Hornsby et al., (1993) state that organisational boundaries real or imagined prevent organisational members from looking at the 'bigger picture' resulting in narrow job descriptions and rigid performance standards. As such, a barrier free organisational structure has been touted as critical to building an entrepreneurial organisation according to scholars (Slevin & Covin, 1990; Hisrisch & Peters, 1986; Knight, 1986).

The second component of an entrepreneurial organisational architecture, '*software*,' has also been consistently used in the models included in this literature review. Organisational software is usually described as the intangible elements of the organisation including *culture, top-management team characteristics* and *entrepreneurial strategic vision* (Dess et al. 1999). Culture has been used in the Covin & Slevin, (1991), Lumpkin & Dess (1996) and Ireland et al. (2009) models as an overarching term for the values, beliefs, attitudes, expectations and assumptions shared by employees that are perpetuated from one generation of employees to the next. As such culture is a major factor in determining the norms for appropriate behaviour within the organisation (Wheelen & Hunger, 1988). Kanter's (1982) study has demonstrated that a firm's innovative capacity is affected by its cultural attributes. Similarly Burgelman & Sayles (1986) and Miller & Friesen (1984) indicate culture can encourage or discourage the extent to which an organisation exhibits business-related risk taking or proactiveness. *Management support* (the willingness of top-level managers to facilitate and support entrepreneurial behaviour, by championing and deploying resources) and *work discretion* (the willingness of top-level managers to tolerate failure, provide decision-making latitude and freedom) have been found to foster cultures that promote entrepreneurial behaviour amongst middle-level managers (Hornsby et al., 2002). As such both these dimensions have been

included in the Hornsby et al. (1993) and Kuratko et al. (2005) models. Further, both these dimensions have been recently used in the development of the Corporate Entrepreneurship Assessment Instrument, which assesses the readiness of private and public sector organisations to engage in CE (Horsnby et al., 2013)

Some CE models however have chosen to concentrate on the minutiae of culture by specifically focusing on values, beliefs and attitudes only (Guth & Ginsberg, 1990; Antoncic & Hisrich, 2001; Ireland et al., 2009). This approach has influenced CE research in two ways. I will discuss the first effect in the remainder of this section and the second in Section 2.3.1.3 below. First, this fine-grained approach goes beyond indicating appropriate behaviour in the organisation. Instead by concentrating on values, beliefs and attitudes these authors tap in to the relatively new line of inquiry: entrepreneurial cognitions (Gartner, 1988; Baron, 1998; Busenitz, 1997), defined by Mitchell (2002) as,

> *The knowledge structures that people use to make assessments, judgements or decisions involving opportunity evaluation, venture creation and growth.* (p. 97)

This entrepreneurial cognitions approach has made some inroads into CE research to advance our understanding of how the top management team and middle managers that act in lieu of the traditional entrepreneur role make decisions that direct the organisation. Certain executives will be much more inclined than others to choose entrepreneurial-type postures for their firms regardless of the external environmental conditions discussed in Section 2.3.1.1 (Gerstein & Reisman, 1983). As such the choice to incorporate CE suggests the top-management team can be characterised as having pro-CE values reflecting their beliefs on how their organisation should be managed. Similarly, Dalziel, Gentry & Bowerman (2011) found choosing the characteristics of both executive and non-executive directors can help direct spending as well as the efficiency of that spending, which are critical to determining the direction of both innovation and CE in large established organisations. This supports the perspective discussed in Section 2.3.1.2 that advocates that the CE message must flow from the top (Higdon, 2000).

The pro-CE values, beliefs and attitudes of top management are often summarised in and conveyed to employees via the organisation's entrepreneurial strategic vision (Ireland et al., 2009; Covin & Slevin, 1991; Guth & Ginsbery, 1990). An entrepreneurial strategic vision or entrepreneurial mind-set (McGrath & MacMillan, 2000) reflects an organisation's commitment to innovation and the entrepreneurial process that captures the benefits of uncertainty. CE scholars suggest that employees can and often do act in response to the strategic vision espoused by top-level managers (Ireland & Hitt, 1999; Collins & Porras, 1996). Primarily because, a pro-CE strategic vision signals to organisational members that the top management team values, encourages and is willing to guide, their CE efforts.

2.3.1.3 Conditions that Engender Corporate Entrepreneurship: Individual Level

As I introduced in Section 2.3.1.2 above, organisational architecture plays a major role in CE uptake via its three components. The first two components, hardware and software have been discussed in Section 2.3.1.2. I will now address the third organisational architecture component: people in the remainder of this section. In Section 2.2.2, I stated that CE enactment has a dual nature as it can occur from the top-down or bottom-up. The top-down or formal CE approach has been explained in Section 2.3.1.2 where top-level managers play a crucial role in choosing to craft a strategic vision for their organisation that promotes entrepreneurial behaviours. Conversely, bottom up approaches are more conducive to understanding the role of all organisational members, managerial or non-managerial, who on their own or in a team initiate CE activities such as the pursuit of interesting opportunities (Wales et al. 2011; Ireland et al., 2009; Zahra, 1991). As discussed in Section 2.2.2.1, Burgelman's (1983) findings indicate that the autonomous strategic initiatives of individuals may be one of the most significant sources of organisational renewal. Despite such an endorsement it can be seen from Table 4 that the role of individual organisational members as triggers or facilitators of CE activities is represented in only 2 of the 11 models under review (Ireland et al., 2009; Hornsby et al., 1993).

Hornsby et al.’s (1993) model, although criticised for its limited focus, is the only model that solely seeks to understand the role of ‘individuals in CE.’ The authors argue that CE is more likely to occur if organisational members display certain characteristics: *risk-taking propensity*, *desire for autonomy*, *need for achievement*, *goal orientation* and *internal locus of control*. In turn the organisation has a duty to itself to actively pursue, nurture and train these individuals to lead its CE activities. Ireland et al.’s model (2009) however, differs from Hornsby et al.’s (1993) in two ways. First, Ireland et al. (2009) like Hornsby et al. (1993) suggests organisational members should display specific characteristics to act as a CE antecedent. However, Ireland et al.’s model posits that the characteristics individual organisational members should display are the pro-CE beliefs, values and attitudes presented in Section 2.3.1.2. As such, pro-CE cognitions are not solely the domain of top-level managers but *all* organisational members to foster decisions and actions in favour of opportunity evaluation, venture creation and growth. Quite succinctly, Schendel & Hofer (1979) stated,

> *A model that fails to place entrepreneurial choice at the centre of the managerial universe is one that is incapable of providing a mechanism for renewing the firm beyond its originally intended purpose.* (p. 6)

Second, Ireland et al.’s (2009) model avoids the parsimony of the Hornsby et al., (1993) model by assimilating Burgelman’s (1983) findings, in that it conceptualises CE over multiple levels of analysis: the *organisation*, *top-level managers* and *organisational members*, see Appendix 11. This disaggregation of the top-level manager and organisational member levels of analysis is indicative of calls from CE scholars to improve the field’s theoretical and empirical comprehension of the manner in which *all* individuals at *all* hierarchical levels contribute to their organisation’s CE efforts (Corbett et al., 2013; Hitt, Ireland, Sirmon, & Trahms, 2011; Wales et al, 2011).

Though the individual is considered to be an important dynamic within the CE process (Corbett et al., 2013; Burgelman, 1983), over the years, this level of analysis has been often side-lined by CE researchers (Corbett et al., 2013; Andrews, 1980; Barnard, 1938). Even when the individual is considered in CE

research, its examination predominantly centres on organisational members with managerial remits (usually top and middle managers) who advocate the CE cognitions and actions that guide the current execution and future strategic direction of the organisation. For instance, Van Doorn, Jansen, Van den Bosch, & Volberda's (2013) paper recognises EO cannot be adequately understood as a driver of firm performance without considering the role of a firm's senior team. Similarly Hornsby et al. (2002) and Nonaka & Takeuchi (1995) highlight the importance of middle-level managers to innovation as their central organisational position allows them to gather and absorb innovative ideas from inside and outside the firm. Consequently, 'individual in CE' research that expressly focuses on non-management personnel, in keeping with Ireland et al.'s (2009) proposition, remains 'thin' at best. This is despite scholars such as Wales et al. (2011) who state that since organisational members are tasked with implementing the entrepreneurial strategic vision of top managers and identifying and exploiting new opportunities they represent a crucial link between strategy and organisational performance. Therefore non-managerial employees should receive more attention from CE researchers.

2.3.2 Corporate Entrepreneurship Processes

Generally, processes are concerned with the established and usually routine set of procedures that facilitate the transformation of organisational functions (Lumpkin & Dess, 1996; Burgelman, 1985). Comparatively, little is known about CE processes when the abundance of the CE antecedent-outcome literature in Section 2.3.1 is considered. Recognising that CE processes were less understood Burgelman (1983) designed a qualitative longitudinal processual study to generate a process model of internal corporate venturing. Interest in CE process research seemed to increase as evidenced from 1996 when Lumpkin & Dess, building on Covin & Slevin's (1991) entrepreneurial posture construct, conceptualised EO as,

> *The processes, practices and decision-making activities that lead to new entry.* p. 136.

Other CE researchers followed this trend and began conceptualising CE models as wholly process-driven or included processes as a translational element between CE antecedents and CE outcomes. As such, of the 11 models under review, only 3 of them are described as process models by their authors, (Floyd & Lane, 2000; Hornsby et al., 1993; Burgelman, 1983). However, a further 5 models include processes in their conceptualisations, (Ireland et al., 2009; Kuratko et al., 2005; Dess et al., 2003; Zahra et al., 1999; Lumpkin & Dess, 1996).

This section will be devoted to discussing CE processes in particular. My analysis of the 8 CE models has yielded 20 CE processes, Table 5, that transform the antecedents of CE discussed in Section 2.3.1 into the CE outcomes that will be covered subsequently in Section 2.3.3. Further, these CE processes naturally disaggregated into 5 process categories: (1) *evaluative* (Kuratko et al., 2005; Hornsby et al., 1993), (2) *learning* (Dess et al., 2003; Zahra et al, 1999), (3) *entrepreneurial* (Ireland et al., 2009; Kuratko et al., 2005; Lumpkin & Dess, 1996), (4) *corporate venturing* (Hornsby et al., 1993; Burgelman, 1983) and (5) *strategic renewal* (Floyd & Lane, 2000). Further, some authors followed Burgelman's (1983) suggestion that CE processes needed to be conceptualised over multiple levels of analysis. As such, Table 5 separates these processes over 2 levels of analysis: *the organisation* (Section 2.3.2.1) and *individual* (Section, 2.3.2.2), which I will use to structure my discussion.

Author/Year	Processes in Corporate Entrepreneurship			
	Individual Level	Definitions	Organisational Level	Definitions
Burgelman (1983)	Core Processes		Not Specified	
	Definition	This process encompasses the activities involved in articulating technical-economic aspects of an ICV project. p. 229		
	Impetus	The process whereby support is gained and maintained for an ICV project within an organisation. p. 229		
	Overlaying Processes			
	Strategic Context	The process through which the current corporate strategy is extended to accommodate the new business activities resulting from an ICV project that fell outside the scope of the current corporate strategy. p.229		
	Structural Context	This process encompasses the various organisational and administrative mechanisms put in place by corporate management to implement the current corporate strategy. p.229		

Table 5: Processes that Facilitate Corporate Entrepreneurship

Author/Year	Processes in Corporate Entrepreneurship			
	Individual Level	**Definitions**	**Organisational Level**	**Definitions**
Lumpkin & Dess (1996)	Autonomy	The independent actions of an individual or a team in bringing forward an idea or a vision and carrying it through to completion. p.149	Innovativeness	A reflection of a firm's tendency to engage and support new ideas, novelty, experimentation and creative processes that may result in new products, services or technology processes. p.142
			Proactiveness	"Processes aimed at anticipating and acting on future needs by seeking opportunities that may or may not be related to the present line of operations, introduction of new products or brands ahead of competition, strategically eliminating operations which are in the mature or declining stage of the life cycle. p.146
			Risk-taking	A reflection of a firm's proclivity to assume any type of risk be it in the form of finances, resource allocation or venturing into unfamiliar arenas. p.144
			Competitive Aggressiveness	A firm's propensity to directly and intensely challenge its competitors to achieve entry or improve position. p. 148

Author/Year	Processes in Corporate Entrepreneurship			
	Individual Level	**Definitions**	**Organisational Level**	**Definitions**
Zahra et al. (1999)	Not Specified		Organisational Learning	Organisational learning is a capability allowing firms to create knowledge as the source of improved performance (Hitt & Ireland, 2000, p.355)
			Knowledge Integration	Process whereby knowledge generated via organisational learning is made useful by integrating it with appropriate organisation function. p.180
Floyd & Lane (2000)	Competence Deployment	"The synoptic process wherein managers deeply resources to venture into new product market arenas to reinforce an existing product market position. p.156	Not Specified	
	Competence Modification	The process wherein managers recognise the need for change; question the organisation's existing strategy and/or competencies; and encourage emergent, adaptive behaviour. p.156		
	Competence Definition	The process wherein managers encourage experimentation with new skills and exploration of new market opportunities. p.156		

Author/Year	Processes in Corporate Entrepreneurship			
	Individual Level	Definitions	Organisational Level	Definitions
Dess et al. (2003)	Not specified		*Organisational Learning*	
			Acquisitive Learning	Process whereby a firm gains access to and subsequently internalises pre-existing knowledge from its external environment. P.356
			Experimental Learning	The process whereby a firm generates knowledge that is distinctive to it. P.356
Kuratko et al. (2005)	Middle Managers Entrepreneurial Behaviours	Endorse, refine & shepherd entrepreneurial opportunity	Not specified	
		Identify, acquire, and deploy resources needed to pursue entrepreneurial opportunities		
Ireland et al. (2009)	Entrepreneurial Processes & Behaviours		Not specified	
	Opportunity Recognition	"The process through which ideas for potentially profitable new business ventures are identified by specific persons." (Shane & Venktaraman, 2000).		
	Opportunity Exploitation	Those activities and investments committed to gain returns from the new product arising from the opportunity through the building of efficient business systems for full-scale operations." (Shane & Venktaraman, 2000).		

2.3.2.1 Corporate Entrepreneurship Processes: Organisational Level

As one would expect in keeping with the CE paradigm where the organisation is the dominant unit of analysis, Table 5 exhibits that the CE processes proffered by scholars exist at the organisational level. These 8 organisational level CE processes that facilitate the transformation of large, complex organisations to entrepreneurial ones have been categorised as: learning and entrepreneurial processes.

Two models posit that learning processes are required for organisations to achieve their CE potential (Dess et al., 2003; Zahra et al., 1999). CE learning processes achieve this by facilitating the relationships between the development of new types of knowledge as CE activities are undertaken to acquire new competencies, or improve existing ones which in turn improve organisational performance. The Zahra et al. (1999) and Dess et al. (2003) models are similar in that they both include the organisational learning process. The authors advocate that organisational learning processes are profound as they can increase an organisation's CE abilities such as assessing markets and commercialising knowledge-intensive product, process and service innovations (Kanter, 1985).

The models differ however in that they offer varying levels of detail. First, Dess et al.'s (2003) recognises that the multidimensionality of CE can complicate the relationship between CE and knowledge outcomes. As such, the authors look specifically at how learning processes impact the SE phenomena, Table 2, under CE. Conversely, Zahra et al.'s (1999) model looks at the role of organisational learning in formal and informal uptake of CE in general. Second Dess et al. (2003) disaggregates organisational learning into acquisitive and experimental learning and links both processes to specific SE phenomena. Last, Zahra et al.'s (1999) model goes further than Dess et al.'s (2003) in that it includes a knowledge integration process, which shows how CE is sustained by integrating new knowledge with suitable organisational tasks.

The second category of CE processes used in CE models at the organisational level was the entrepreneurial processes. Organisation level entrepreneurial

processes comprised of 4 of the 5 EO processes: innovation, proactiveness, risk-taking and competitive aggressiveness, (Lumpkin & Dess, 1996) (see Table 5). Comparatively these four processes have received substantial conceptual and empirical attention, when other CE processes are considered. More than 100 studies of EO have been conducted, which has led to wide acceptance of the conceptual meaning and relevance of the concept (Rauch, Wiklund & Lumpkin 2009). Rauch et al. (2009) meta-analysis indicates that the correlation of EO with performance is significant and that this relationship is robust. Thus, these entrepreneurial processes exemplify one of the few areas in entrepreneurship research where an extensive body of knowledge is developing though, primarily at the organisational level.

2.3.2.2 Corporate Entrepreneurship Processes: Individual Level

Table 5 indicates that there are 11 CE processes operating at the individual level across the 7 of 11 models under review. The inclusion of these individual level processes indicates that despite the inconsistent treatment of the individual organisational members (Corbett et al., 2013), they are inextricably linked to and play an integral role in the workings of CE. The individual processes fall into 4 CE process categories: evaluative, entrepreneurial, corporate venturing and strategic renewal.

Similar to Dess et al., (2003), in Section 2.3.2.1 above, some of the individual level CE processes were targeted at how specific CE phenomena emerged in an organisation: internal corporate venturing (Burgelman, 1983; Hornsby et al., 1993) and strategic renewal (Floyd & Lane, 2000). Despite focusing on 2 different CE phenomena, the Burgelman (1983) and Floyd & Lane (2000) models are quite similar. Unlike the majority of CE models under review, the Burgelman (1983) and Floyd & Lane (2000) models are unconcerned with CE antecedents or outcomes. Instead, both models focus on presenting their respective CE processes to portray how the processes actually occur in the organisation by attributing them to specific levels of management. For instance, Floyd & Lane (2000) propose that operating-level managers simultaneously assimilate relevant information gained from outside the firm while responding to the strategic

decisions of top-level managers, communicated to them by to middle-level managers. Conversely, the Hornsby et al. (1993) model while it also focuses on the internal corporate venturing process; it does not use multiple management levels. Rather Hornsby et al.'s (1993) distinguishes that their model concentrates on organisational members in general and the CE antecedents that influence their decision to act entrepreneurially.

This decision-making facet of Hornsby et al.'s (1993) model leads to the second category of individual level CE processes: evaluative processes which include the Hornsby et al.'s (1993) model and its derivative conceptualised by Kuratko et al., (2005). Generally, to make a decision an individual is required to evaluate some set of factors or circumstances they are presented with. From an individual standpoint the Hornsby et al. (1993) model suggests the individual must evaluate the organisation himself or herself and precipitating events before the decision to act entrepreneurially can emerge. Similarly, Kuratko et al.'s (2005) model also requires middle managers to make an evaluation. However, the authors propose that middle managers evaluate possible CE outcomes (Section 2.3.3, Table 6) as positive, neutral, or negative to decide whether they will act entrepreneurially on behalf of the organisation.

The fourth and final category of individual level CE processes used in CE models is the entrepreneurial process category. The fifth EO dimension from Lumpkin & Dess' (1996) model, autonomy, ties in with Burgelman's (1983) view that CE is the result of the autonomous actions of organisational members required to bring the organisation's vision and new ideas to fruition. Kuratko et al. (2005) specifically elaborate on the entrepreneurial processes middle managers participate in to assist the organisation in achieving its CE goals, Table 5. For instance, middle managers are expected to endorse opportunities similar to the impetus process put forward by Burgelman (1983) to support and maintain CE initiatives. Ireland et al. (2009) like Hornsby et al. (1993) also focus on general organisational members. Ireland et al. (2009) draw directly on what Shane & Venkataraman (2000) cite as the defining characteristics of entrepreneurship: *opportunity recognition* and *opportunity exploitation*. The authors propose that both these processes are the domain of all organisational members and not just

top or middle level managers. This subsumes perspectives that CE could be a combination of individual initiatives driven from the bottom-up or as well as induced from the top-down.

2.3.3 Corporate Entrepreneurship Outcomes

Thus far in my review of the 11 CE models, I have covered the *conditions* that engender CE, Table 4 and Section 2.3.1 and the various *processes* that are active in CE, Table 5 and Section 2.3.2. These pro-CE conditions and processes are usually adopted by organisations with the expectation that they will improve organisational performance (Zahra & Covin, 1995). As such CE outcomes, Table 6, have been included in all of the 11 CE models under review and represent the final CE concept for consideration in this literature review.

Comparable to the CE conditions and processes researchers have also sought to investigate CE outcomes over two levels of analysis: the individual (Kuratko et al., 2005; Horsnby et al., 1993) and organisational (Ireland et al., 2009; Kuratko et al., 2005; Dess et al., 2003; Antoncic & Hisrich, 2001; Floyd & Lane, 2000; Zahra et al., 1999; Lumpkin & Dess, 1996; Hornsby et al., 1993; Covin & Slevin, 1991; Guth & Ginsberg; 1990; Burgelman, 1983). I use these levels of analysis to structure my discussion.

Author/Year	Outcomes of Corporate Entrepreneurship	
	Individual Level	**Organisational Level**
Burgelman (1983a)	Not considered	Decision regarding integration of ICV project
Guth & Ginsberg (1990)	Not considered	Organisation Performance
		Effectiveness
		Efficiency
		Stakeholder Satisfaction
		Firm Performance
Covin & Slevin (1991)	Not considered	Firm Performance
Hornsby et al. (1993)	Decision to act intrapreneurially	Decision to implement idea
Lumpkin & Dess (1996)	Not considered	Performance
		Sales Growth
		Market Share
		Profitability
		Overall Performance
		Stakeholder Satisfaction
Zahra et al. (1999)	Not considered	New Knowledge
		Competence Development
		Performance: Financial Non-financial
Floyd & Lane (2000)	Not considered	Inertial forces in the established strategy of company are overcome
Antoncic & Hisrich (2001)	Not considered	Performance
		Growth
		Profitability
Dess et al. (2003)	Not considered	Knowledge
		Technical: Specialised
		Integrative: Combinative
		Exploitative: Use
Kuratko et al. (2005)	Possible Outcomes: Negative, Positive, Neutral	Possible Outcomes: Negative, Positive, Neutral
	Promotion	Emergence of a pro-entrepreneurial organisational culture
	Career derailment	Re-establishment of competitive advantage
	Reassignment within the corporation	Diversification into new product-market arenas
	Development of political skills	Economic losses
	Establishment of a new social network	Enhancement of innovation capability
	Enhanced self-image	Strategic drifting away from core business
	Financial rewards	Broadening of Corporate Technology Portfolio
	Scorn of more conservative organisational members	Enhanced reputation among shareholders
Ireland et al. (2009)	Not specified	Competitive Capability
		Strategic Repositioning

Table 6: Corporate Entrepreneurship Outcomes

2.3.3.1 Corporate Entrepreneurship Outcomes: Organisational Level

Similar to its parent construct entrepreneurship, CE research has adopted the well-established performance indicators usually used in strategic management (Venkataraman, 1997). Consequently, organisational level CE outcomes have been conceptualised as improved organisational performance represented by the lucrative financial gains made possible through the pursuit of opportunity and developing new bases for competitive advantage in 6 of the 11 models under review. Multiple studies have established that CE activities have a positive impact on the financial performance index of organisations, specifically the growth and profitability indicators. For instance, Zahra & Covin (1995) collected data from three different samples over a seven-year period and their results indicate that CE had a positive impact on financial measures of company performance over time. This suggests CE is an effective means for improving financial performance in the long-term. Similarly, in their cross-cultural study Antoncic & Hisrich (2001) found CE to be positively and significantly related to both growth and profitability.

While improved financial performance is a useful and desirable CE outcome, the other 5 models included in this literature review recognise it is not the only meaningful effect of CE activities. Table 6 indicates that the traditional financial performance outcomes of CE activities co-exist with more contemporary, non-financial outcomes specific to the CE field. The Dess et al., (2003) and Zahra et al., (1999) models acknowledge an increasing number of organisations rely on additional forms of capital such as human, social and intellectual to create knowledge-based resources and competencies. Leveraging these varied categories of capital generates opportunities for knowledge creation and exploitation within CE activities. Alternatively, the process perspective taken by Floyd & Lane, (2000), Hornsby et al., (1993) and Burgleman, (1983) prioritises the importance of the organisation's decision to act entrepreneurially as a key CE outcome.

Last, Kuratko et al. (2005) and Ireland et al. (2009) also offer CE outcomes that are not necessarily related to performance. However, how the authors conceptualise their respective CE outcomes is of particular interest. Specifically, while both models acknowledge the widely accepted positive relationship between CE and performance, they do *not* assume these outcomes are necessarily positive. For instance, Ireland et al., (2009) recognise that strategic repositioning and competitive capability only disrupt the industry status quo. As such, they offer the caveat that with such disruptions there will inevitably be industry winners and losers that include the organisation that has been involved in CE. Following this notion that CE outcomes can exist on a spectrum, the Kurakto et al. (2005) model proposes a myriad of possible negative, neutral or positive organisational level CE outcomes.

2.3.3.2 Corporate Entrepreneurship Outcomes: Individual Level

Krueger (2000) states that organisations do not innovate; rather, it is the individuals within those organisations that innovate. Despite the importance of the individual in effecting CE, it can be seen throughout Sections 2.3.1 and 2.3.2 that the amount of conceptual and empirical papers available on this level of analysis is limited. The treatment of the individual where CE outcomes are concerned is no exception, Table 6. As such, individual level CE outcomes have only been included in 2 of the 11 CE models under review (Kuratko et al., 2005; Hornsby et al., 1993).

Hornsby et al.'s (1993) model also proposes that the individual's choice to act as a corporate entrepreneur is the step in the CE process before the organisation as a whole becomes involved and renders its decision to implement an individual's idea. As previously stated Kuratko et al.'s (2005) model is a derivative of Hornsby et al.'s (1993). This model also proposes that individual level CE outcomes also exist on a continuum where they can be evaluated as negative, neutral or positive. Thus, organisational members do not only focus on what is good for the organisation but also how the choice to act entrepreneurially may affect their status and position in the organisation.

2.4 Conclusion

The 11 CE models that have been reviewed throughout this chapter constitute a major contribution to the CE literature. CE models provide comprehensive conceptualisations of CE via the (1) *conditions* that engender CE (Table 4 and Section 2.3.1), (2) various *processes* that facilitate CE (Table 5 and Section 2.3.2) and (3) *outcomes* of CE (Table 6 and Section 2.3.3). These models also provide an array of frameworks and perspectives upon which the extant empirical bank of CE knowledge is predicated and have guided CE research by extricating an extensive list of relevant constructs and propositions for exploration. In doing so, CE researchers have attempted to shed light on the inner workings of the entrepreneurial organisation or what Dess et al (2003) describe as the 'CE black box.'

Yet the CE 'black box' persists for several reasons. First, though CE models represent a major contribution to understanding organisational level entrepreneurship, it is also indicative of a major limitation in the CE literature. That is, to date the CE literature has been consistently focused on understanding the organisational level of analysis. Extant research has focused mainly on organisational conditions that can foster CE as well as how the external environment can prompt the organisation to adopt CE. By comparison the available conceptualisations and empirics related to how the individual actor chooses to act entrepreneurially is limited. Further, where the individual is considered in CE enactment the literature has mainly focused on individuals in the organisation's formal management hierarchy. This is contrary to the perspective that CE is the responsibility of every organisational member (Wales et al., 2011; Ireland et al, 2009; Hornsby et al. 1993). Thus, this thesis will focus on the individual level of analysis and contribute to bottom-up and informal perspectives on CE. This is also in keeping with the emerging trend in some models of CE to use multiple levels of analysis to better understand CE across the organisation (Ireland et al, 2009).

Additionally, all CE models with the exception of Kuratko et al. (2005) and Ireland et al., (2009) posit CE will benefit the organisation in some way. This

intimates the literature assumes that organisational members view CE as inherently good for the organisation or for their career. In turn they will automatically engage with pro-CE conditions and act entrepreneurially. This represents another area that is not adequately addressed in the CE literature: what are the mechanisms by which organisational members chose to participate in or facilitate CE.

To best address these gaps I utilise the Ireland et al. (2009) model, illustrated in Figure 2, as a guiding framework for two reasons. First, Ireland et al. (2009) recognise that all organisational members in addition to top-level managers have a part to play in CE. Second, their model signals to individual entrepreneurial cognitive mechanisms as a means for organisational members to successfully translate pro- CE conditions into actual CE activity. In Chapter 3, I will introduce one such entrepreneurial cognition, known as entrepreneurial intentions, as a possible useful mechanism to better understand how individuals participate in CE.

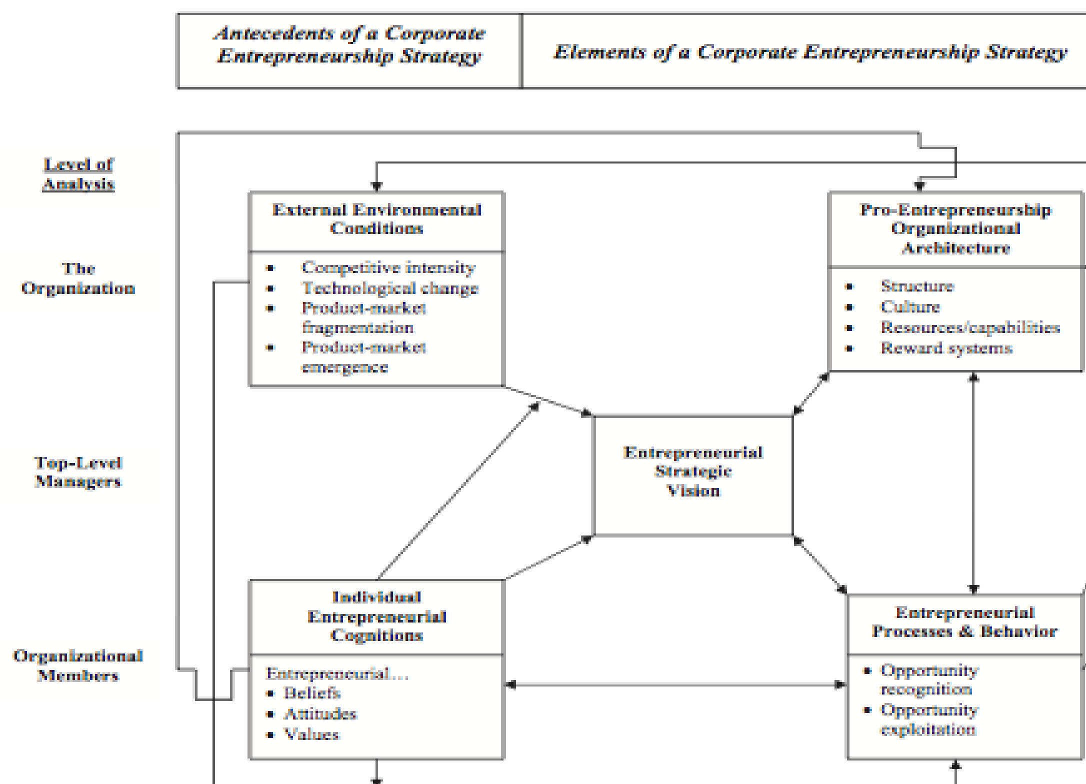


Figure 2: *Excerpt from Ireland et al.'s (2009) Model of Corporate Entrepreneurship Strategy that will act as a Framework for this Thesis*

CHAPTER 3: A SYSTEMATIC REVIEW OF ENTREPRENEURIAL INTENTIONS

3.1 Introduction

In this chapter I take a voluntaristic approach to CE and refocus on the individual level of analysis, which Corbett et al., (2013) have stated is essential to driving the CE field forward. To achieve this I consider how individual organisational members choose to enact CE, using the entrepreneurial cognition, entrepreneurial intentions (EI). EI are considered to be the best predictor of entrepreneurial behaviour. I perform a systematic review of the EI literature and select an EI formation model that is consistently robust in both explanatory power and predictive validity specifically for entrepreneurial behaviour, known as Shapero's Entrepreneurial Event (SEE) (Shapero, 1982; Krueger et al, 2000; Krueger, 2000). From a managerial perspective however, these models only offer a parsimonious mechanism for diagnosing barriers to entrepreneurial activity (Krueger, 2000). As such, I also consider the various contextual (personal and situational) factors that may exert influence on an individual's EI.

3.2 Entrepreneurial Cognitions

The notion that entrepreneurs are different from the rest of the general population formed the basis of much of entrepreneurship research in the 1960's and 1970's. Unfortunately, much of this research was directed at understanding the personality traits of this 'special individual,' which yielded disappointing results. Hatten in (1997) remarked that,

> *The conclusions of 30 years of research indicate that there are no personality characteristics that predict who will be a successful entrepreneur…successful small business owners and entrepreneurs come in every shape, size, colour and from all backgrounds.* (p. 40)

Gartner's (1988) subsequent proposal to focus on what an entrepreneur does led researchers to anticipate that if any variations that separated the entrepreneur were to be found, it would be via how entrepreneurs think and make decisions (Baron; 1998; Busenitz & Barney, 1997). CE has, much like its parent construct, entrepreneurship, focused on the characteristics of entrepreneurial organisations and the outcomes of their activity. While I acknowledge that significant contributions have been made to understand organisational level entrepreneurship through structure, strategy, process, culture and resources, I propose that CE as a discipline stands to benefit from a similar cognitive psychology based enquiry. This has the potential to further illuminate the agency of the organisational actors in driving CE, as cognitions lead to how people make decisions, in this case deciding to act entrepreneurially within the organisational confines. As Barney (1991) remarks, the right cognitive approach in the right context can represent a source of improved organisation performance.

Mitchell, Busenitz, Lant, McDougall, Morse & Smith (2002) define entrepreneurial cognitions as,

> *The knowledge structures that people use to make assessments, judgments, or decisions involving opportunity evaluation, venture creation and growth.* (p. 97)

Many conceptual bridges between entrepreneurship and human cognition have been developed. Examples of these cognitions as studied in entrepreneurship literature include, knowledge (Ardichvili et al., 2003), expert scripts (Mitchell et al., 2000), alertness (Gaglio & Katz, 2001), intentions (Shepherd & Krueger, 2002), cognitive mechanisms (Baron, 1998) and cognitive infrastructure (Krueger, 2000).

This chapter aims to focus on the specific socio-cognitive process of *entrepreneurial intentions* (EI), its formation and its implications for CE. Jenkins and Johnson (1997) refer to the existence of opposing theoretical perspectives when entrepreneurial ventures are considered, namely deterministic versus voluntaristic. The deterministic view is consistent with the conclusions drawn

from the CE literature in Chapter 2, where entrepreneurial outcomes are the result of relationships between the organisation and the environment, relegating the individual and their intentions as incidental to entrepreneurial success. However, within this thesis I assert that organisations themselves are not entrepreneurial per se. Rather, it is the organisational members operating within organisational confines that chose to act entrepreneurially as a result of some stimuli: internal or external, personal or situational. They are therefore the point of origin for any CE initiatives. As such, I subscribe to the latter voluntaristic position, which places primacy on the EI of individuals (Astley & Van de Ven, 1983; Schumpeter, 1934).

3.3 Entrepreneurial Intentions as the Best Predictor of Entrepreneurial Behaviour

Ajzen (1991) states,

> *As a general rule, the stronger the intention to engage in a (planned) behaviour, the more likely should be its performance.* (p. 181)

Krueger (1993; 1994) theorised the entrepreneurial process is essentially a sequence of tasks involved in the creation of a new venture aligning it with the social psychology category of planned behaviour (Ajzen, 1991; 1987). However, this thesis focuses not on behaviour but rather the specific psychological precursor of EI to the entrepreneurial process, which captures the motivational factors, such as attitudes, that guide behaviour (Shepherd & Krueger, 2002). Lee & Wong (2004) state that without intentions, action is unlikely. Hence, as far as the entrepreneurial process is concerned, EI is crucial as an initial conduit for any subsequent related actions and events (Jenkins & Johnson, 1997; Crant, 1996; Boyd & Vozikis, 1994; Krueger, 1993; Krueger & Carsrud, 1993; Katz & Gartner, 1988; Bird, 1988, 1992). Within the scope of this thesis, EI represents a very valuable construct in understanding why CE behaviours do or do not occur.

Several definitions of EI exist in the literature, contained in Table 7, which can be described in some cases as somewhat abstract or too specific. However, as this

thesis is grounded in CE, Shepherd & Krueger's (2002) definition offers the most utility despite its limitation. Shepherd & Krueger (2002) capture the motivational element regarding why entrepreneurs act and suggests that intentions are formed. Additionally, it delineates specific outcomes of entrepreneurial behaviour that are applicable to CE. Bird (1988) extends the applicability of EI to CE to include renewal activities, where EI not only creates new foundations and principles upon which an organisation is built, but can redirect and revitalise these founding values that made the organisation novel at inception and govern an existing venture's future direction. Whether at the individual or organisation level, intentionality is fundamental to the entrepreneurial process (Dimov, 2007; Bird 1988).

Author	Definition	Limitation
Zhao et al. (2010, p. 384)	*The behavioural intention to become an entrepreneur.*	Individual has an explicit interest choosing an entrepreneurial career as an organisation founder without remaining affiliated to an existing organisation.
Hmieleski & Corbett (2006, p.48)	*Intention towards starting a high-growth business.*	Limits the context to which EI can be applied to traditional commercial organisations.
Shepherd & Krueger (2002, p. 170)	*Motivational attitudes to bring into existence future, goods, services and new ventures.*	Refers to market driven opportunity only.
Jenkins & Johnson (1997, p. 896)	*The desires and ideas of the individual, outcomes with the performance of the business.*	Literature assumes a progression from EI to business outcomes.
Bird (1988, p. 443)	*EI aimed at creating a new venture or creating new values in existing ventures*	Does not capture the individual motivation.

Table 7: Existing Definitions of Entrepreneurial Intentions

To better understand EI, I have conducted a systematic literature review to document core research that has been carried out and published in the most influential journals to date. This will aid in signposting the evolution of the field and illuminating what is known about EI while exposing gaps in the literature for my pursuit.

3.4 Systematic Review Methodology

I conducted this review in a manner adapted from the methodology set out by Tranfield, Denyer & Smart (2003) who argue that systematic reviews provide the most efficient and high quality method for identifying and evaluating extensive literatures. I contend that this methodology is also valuable in casting a wide enough net capable of capturing smaller literature bodies like EI, whose sources are spread across several subject areas as indicated in Table 8. As such, I started with a preliminary scoping exercise, which proved to be an iterative process of definition, clarification and refinement (Clarke & Oxman, 2001). I started with the search terms '*entrepreneurship'* and '*intentions'* as a process of exploration, discovery and development that yielded a number of papers, chapters and conference proceedings. This familiarisation process influenced the choice to use a combined phrase search for *'entrepreneurial intentions'* for the second, formal systematic search as it revealed the commonness of the individual words 'entrepreneurship' and 'intentions.' This second search prompted me to conduct a third search for the combined search term '*desirability and feasibility'* as these factors represent key elements in the phenomenon of interest.

All searches were conducted using 7 databases for scholarly business publications, including *ProQuest, Science Direct, EBSCO, International Bibliography of the Social Sciences, Oxford Reference Online, EconLit* and *Wiley.* This search yielded 143 results for EI and 164 for desirability and feasibility. As this review is part of a doctoral thesis, it was important that the sources selected from the search results were of a high quality, relevant and current. Thus, sources selected for review were restricted to original empirical and conceptual academic research papers, so that other types of publications, such as book reviews, were eliminated. The results were then subjected to a second round of quality scrutiny to see which of the retained papers originated from journals ranked as Grade 3 or Grade 4 in the 22 subject categories classified by the Academic Journal Quality Guide (Version 4) published by the Association of Business Schools (ABS, 2010). Lastly, to ensure relevance, papers that were retained for further use were required to meet the following criteria:

1. A main focus on EI and contributes to knowledge and understanding of EI as a predictor of entrepreneurial behaviour.
2. Models of EI formation and antecedents of EI.
3. Contextual influencers of EI antecedents, personal or situational.

In lieu of the data extraction forms recommended by Tranfield et al. (2003) to reduce bias and human error in the review process, I developed Table 9 to record key details about the articles retained. Finally, to achieve research synthesis according to Murlow (1994), I used a narrative review as the most appropriate method to summarise, integrate and where possible collate findings from the different studies in the subsequent sections.

Subject Fields in ABS Quality Journal Guide (2010)	Journal	Total Number of Articles Reviewed	Conceptual	Empirical
Entrepreneurship and Small Business	Entrepreneurship Theory & Practice	14	5	9
	Journal of Business Venturing	7	2	5
	Journal of Small Business Management	2	X	2
	Entrepreneurship and Regional Development	1	X	1
	International Small Business Journal	3	X	3
General Management	Journal of Management	1	X	1
	Journal of Management Studies	1	X	1
	Academy of Management Review	1	X	1
Marketing	Journal of Business Research	1	X	1
Psychology	Journal of Applied Psychology	2	X	2
Innovation & Technology Change Management	R& D Management	1	X	1
	Technovation	1	X	1
Organisational Studies	Journal of Vocational Behaviour	1	X	1
		36	**7**	**29**

Table 8: Articles Yielded from Literature Search by Subject Field

3.5 Evolution of the Entrepreneurial Intentions Field

The emergence of EI interest succeeds the aforementioned personality traits approach to studying the entrepreneur. The literature reviewed revealed that EI research has been occurring for over three decades with a steady stream of research conducted by researchers to advance knowledge. Shapero authored one of the earliest articles, referenced in at least 20 of the articles reviewed, in 1975. Several conceptual papers mark the initial wave of EI research, which sought to solidify the connection between entrepreneurship and intentions and its social psychology roots (Boyd & Vozikis, 1994; Krueger & Brazeal, 1994; Bird, 1988;). Simultaneously, empirical investigation was conducted to support these conceptual links in an attempt to validate and compare the abilities of these intention models to predict entrepreneurial behaviours (Kolvereid, 1997; Crant 1996; Krueger, 1993).

The last 10 years clearly indicate acceleration in scholarly interest in EI with 19 empirical articles being published in reputable, scholarly journals. These empirical papers heed the call of earlier researchers to probe for factors that may have indirect influence on entrepreneurial behaviour via EI. This represented a major milestone for EI research for several reasons. Firstly, it allowed for the compilation of a substantial list of independent variables that could play a role in how individuals formed EI such as demographics, gender, efficacy, macro-environment and socialisation processes (Zhao, Seibert & Lumpkin 2010; Kautonen et al., 2010; Gupta, Turban Wasti & Sikdar, 2009; Gupta, Turban & Bhawe, 2008; Frank, Lueger & Korunka, 2007; Zhao, Hills & Seibert, 2005). Secondly, it allowed researchers to disentangle these larger, multifaceted concepts into smaller units that allow for singular or multiple applications of these 'micro' concepts to provide in-depth understanding of how they affect intentions. Lastly, the study of intentions has opened a new pathway to scrutinise the entrepreneurial personality by assessing its effects on intentions.

3.6 Key Themes in the Entrepreneurial Intentions Literature

The ensuing sections aim to collate the key features of the empirical and conceptual articles in Table 9. To this end, I will first look at the theoretical bases used in the EI literature in Section 3.6.1. This will be followed by an overview of the two dominant EI paradigms that have emerged in the literature in Section 3.6.2.

3.6.1 Theories Commonly Used in Entrepreneurial Intentions Research

Entrepreneurship research in general has been criticised for having inadequate theoretical bases or for even being a-theoretical in some cases (Zahra, 2007; Shane & Venkataraman, 2000; Douglas & Sheppard, 1999). However, overall this review suggests that EI as a line of enquiry holds great promise as a basis for theory application and extension, finding the study of EI to be theoretically rich and diverse, Table 9. Both conceptual and empirical articles use a variety of theories including demand and supply theory (Griffiths, Kickul & Carsud, 2009), rational choice theory (Douglas & Shepherd, 2002; 1999), stereotype activation theory (Gupta et al., 2008; 2009), social cognitive theory (Zhao et al., 2005), resource dependence theory and population ecology theory (Begley & Tan, 2001), behaviour theory (Shepherd & Krueger, 2002; Krueger, et al., 2000; Krueger, 2000; Kolvereid, 1997) and social learning theory (Wilson, Kickul, Marlino, Barbosa & Griffiths 2007). Collectively, these theories make a two-fold contribution discussed below.

First, some theories highlight how stable individual characteristics such as gender, self-efficacy, self-concept and personality influence EI**.** Gender and its associated stereotypes have been found to impact EI (Gupta et al., 2009; 2008; Wilson, 2007; Zhao et al., 2005). Gupta et al. (2009) found gender to be significantly related to EI such that women were less likely to become entrepreneurs than men. While, Zhao et al.'s (2005) study indicated entrepreneurial self-efficacy to be significantly related to EI, Wilson et al. (2007) found females showed significantly lower entrepreneurial efficacy than males. Lee & Wong's (2004)

used career anchors (Schein, 1978) developed over the course of one's career as a manifestation of self-concept to understand the extent to which they influence EI. As would be expected, the security anchor had a negative effect on EI as this anchor represents an individual who is fundamentally risk averse and requires an organisation that provides career stability. Additionally, persons with a technical anchor, which focuses on gaining technical expertise, also had negative effect on EI. Furthermore, Kuckertz & Wagner's (2010) study indicated individuals working in applied research such as new product development were found to be more likely to have EI.

As previously mentioned, the 'special' entrepreneurial personality was once an area of much focus in entrepreneurship research. Resurgence in researcher interest has occurred by framing personality as influencing EI. Using a well-known construct in the entrepreneurship literature, Crant (1996) empirically demonstrates using the Proactive Personality Scale that proactivity is positively associated with EI with the complete model accounting for 31% of variance in EI. Zhao et al.'s (2010) meta-analysis showed that personality traits can influence behaviour indirectly through EI. Frank et al.'s (2007) study found consistency with Zhao et al.'s (2010) findings that 20% of the variance in the origins of EI can be explained by personality traits. However, Frank et al. (2007) also highlight that to meaningfully assess the value of personality, additional influencing factors such as environment, resources and other situational factors must be taken into account.

This links to the second theme where some theories have used EI as a means of closing the gap between the individual and the macro environment. Griffiths et al. (2009) found that government, through its policies and practices, establishes perceptions of how opportunities and market spaces are created and exploited by individuals. Begley & Tan (2001) look at how perceptions of seven politico-economic dimensions of munificence and carrying capacity affect desirability and feasibility to start a new business in thirteen countries.

The theoretical diversity of EI research indicates that the theoretical and conceptual development of EI has kept abreast of its empirical treatment. This

signals that an individual's EI remains a robust and consistent predictor of entrepreneurial behaviour even as it accommodates a multitude of influencing factors. To better understand the influencing effect of these factors on EI, in Section 3.6.2 below, I present the two dominant models by which EI are actually formed.

3.6.2 Dominant Models of Entrepreneurial Intention Formation

Amidst this onslaught of theoretical lenses, two models of EI formation have emerged as dominant theoretical paradigms, as can be seen in Table 9. The first is the *Theory of Planned Behaviour* (TPB) developed in social psychology by Ajzen (1991). The second framework, *Shapero's Entrepreneurial Event* (SEE) was developed in the individual entrepreneurship domain by Shapero (1982). The subsequent sections will address these models in further detail with an in-depth description of TPB and SEE and their respective components. First, I will describe the general intention formation mechanism, by which the TPB and SEE models operate.

General intentions have been conceptualised as being a function of beliefs and values that direct subsequent behaviour (Armitage & Conner, 2001; Fishbein & Ajzen, 1975). Just as intentions precede behaviour, intentions are preceded by and formed through a combination of attitudes towards performing a given behaviour. In turn behavioural intention emerges as an immediate determinant of behaviour, Figure 3.

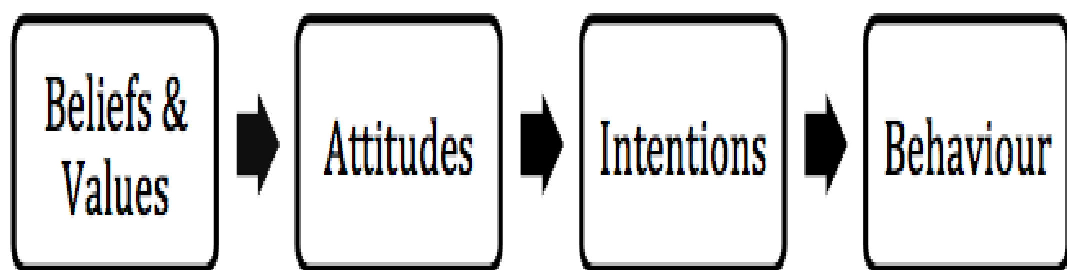


Figure 3: General Cognitive Pathway for Behavioural Intention Formation

Numerous definitions for attitudes exist in the psychology literature (Ireland et al., 2009; Zimbardo et al., 1999; Osgood & Tannebaum, 1955). Collectively however, these definitions define attitudes as evaluative judgements to various stimuli occurring in the environment. As such, attitudes can be favourable, unfavourable or neutral. Additionally, attitudes have been characterised in psychology literature as a dynamic element of human behaviour and are expected to change over time as a function of experience (Ireland et al., 2009), suggesting that attitudes are relatively malleable and can be influenced; these influencers will be covered in Section 3.6.3.

There is little variance in how the TPB and SEE paradigms, through this belief-attitude-intention-behaviour mechanism are depicted in the literature, on account of the robust consistency and replicability of the models. The succeeding section will address these models in detail.

3.6.2.1 Ajzen's Theory of Planned Behaviour (TPB)

TPB represents a natural evolution of Ajzen & Fishbein's (1980, 1975) theory of reasoned action (TRA) as it takes into account behaviours in situations where actors do not have complete behavioural control (Ajzen, 1991). As such, TPB now isolates three antecedents, compared to TRA's two, of intention, as depicted in Figure 4.

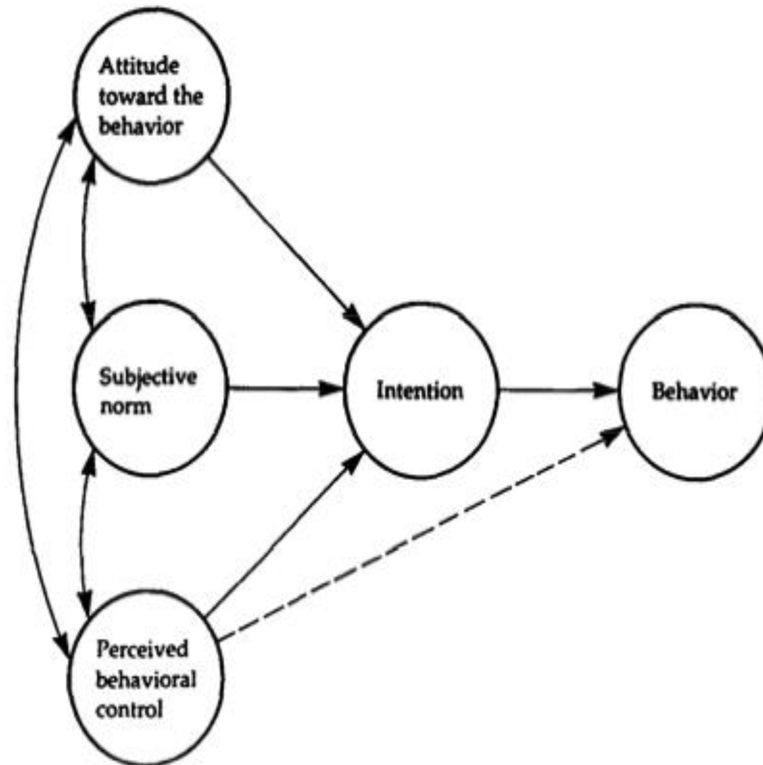


Figure 4: Theory of Planned Behaviour

The first two aspects reflect the perceived desirability of performing a particular behaviour, namely *personal attitude towards the behaviour* and *perceived social norms*. The third aligns itself with the perceived feasibility of performing a behaviour, *perceived behavioural control* and speaks to perceptions that behaviour to a certain extent is personally controllable.

In TPB an individual's attitude towards performing a particular behaviour is analogous to expectancy and is an indicator of personal desirability to performing some behaviour (Fitzsimmons & Douglas, 2010). This attitude is both dependent on the expectations and beliefs of the individual and the personal impacts of behavioural outcomes. The second component of desirability represents perceived social norms and links to perceptions of what influential persons in an actor's life think about performing a particular behaviour. These normative beliefs manifest their strength through motivation to comply with these influential individuals. However, this effect of social norms is greatly dissipated for subjects with a high internal *locus of control* (Ajzen 1987) or a strong orientation toward taking action (Bagozzi, Baumgartner & Yi 1992). Ajzen (1991) argues the addition of the third

predictive component, perceived behavioural control, overlaps Bandura's (1986) view of perceived self-efficacy, which is defined as an individual's confidence in his or her ability to successfully perform entrepreneurial roles and tasks (Zhao et al., 2005). However, this interchangeability has received criticism suggesting that self-efficacy and perceived behavioural control are not entirely synonymous. Self-efficacy is more concerned with cognitive perceptions of control based on internal control factors, whereas perceived behavioural control also reflects more general, external factors.

TPB has been widely deployed to understand and predict socially significant behaviours in a number of areas including health-related practices, health belief model and protection motivation theory (Armitage & Conner, 2001; Conner & Norman, 1996a), sustainable agriculture (Fielding, Terry, Masser & Hogg, 2009) and recycling (Terry, Hogg & White, 1999). Essentially, TPB provides a parsimonious model for understanding and predicting how information and motivation influence behaviour (Manstead & Parker, 1995). Conversely, many researchers argue that, for more complex behaviours and contexts, other variables may be important for understanding and predicting these complex behaviours (Pierro, Mannetti, & Livi, 2003; Cook, Kerr, & Moore, 2002; Biddle, Bank, & Slavings, 1987). When the complex NHS context combined with the intricacies of the entrepreneurial process are considered, entrepreneurial behaviour most certainly warrants the inclusion of additional variables to extend the model. This will be elaborated on in succeeding sections.

3.6.2.2 Shapero's Entrepreneurial Event (SEE)

As an intention model, developed specific to the domain of entrepreneurship by Shapero in (1982), SEE has always employed additional influencing variables. In SEE, EI to create a venture stem from *perceptions of desirability, perceptions of feasibility* and from a *propensity to act* upon opportunities, as depicted in Figure 5.

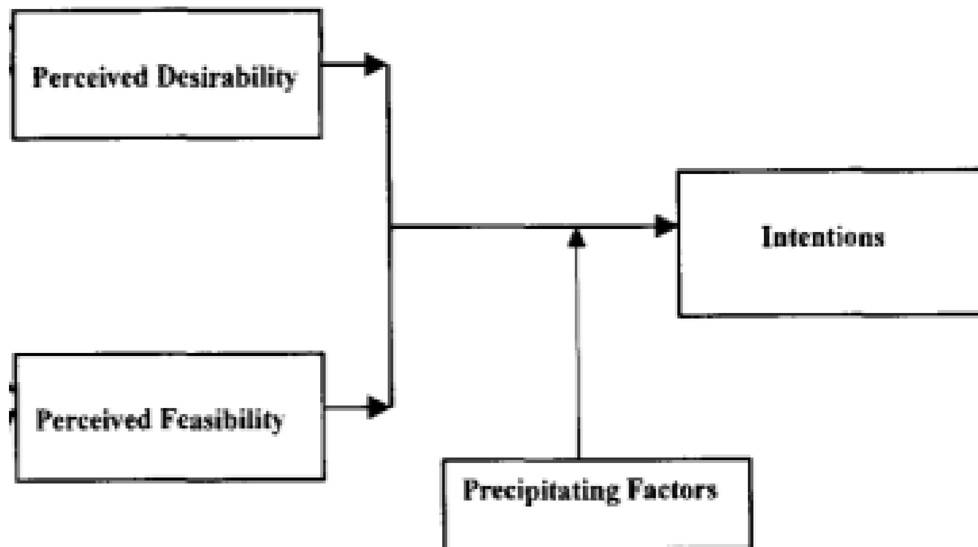


Figure 5: Shapero's Entrepreneurial Event

In his model, Shapero assumes human behaviour is guided by inertia. That is, until some precipitating event displaces this inertia to prompt a change in behaviour. In turn, the actor scans the environment for 'credible' alternative opportunities in an attempt to select the most beneficial one. However, this benefit is individual-specific and like Douglas & Shepherd's (1999) findings in their utility maximisation study, diverges from rational choice. Rather, this benefit may only be relevant to a particular individual and not obvious to the outside observer (Katz, 1992). Credibility describes a behaviour that is both desirable and feasible which upon interaction with the third component of the model, propensity to act, results in an entrepreneurial action. In Krueger's (1993) study, perceived feasibility, perceived desirability and the propensity to act account for well over half the variance in intentions toward entrepreneurship; feasibility perceptions explained the most variance.

The propensity to act represents the volitional aspects of intention. That is, a personal disposition to act on one's decisions and depends on control perceptions such as the desire to gain control by taking action. Though as can be seen in Table 9 this component is underutilised. Perceived desirability is defined as the personal attractiveness of entrepreneurial behaviour and takes both intra-personal and extra-personal impacts into account. Conversely, perceived feasibility is a

measure of whether an individual thinks they are personally capable of performing these entrepreneurial behaviours (Shapero, 1982). Shapero cemented these concepts empirically by proposing a testable eight-item inventory of questions aimed at distinctive facets of perceived desirability and feasibility, such as using perceived feasibility antecedents like self-efficacy to assess beliefs about whether one can personally execute a given task. For instance, some questions used antecedents of perceived feasibility like self-efficacy to assess beliefs about whether one can personally execute tasks.

While the majority of research is focused on the direct effect of desirability and feasibility on EI or the indirect effect of contextual factors on the former, Fitzsimmons & Douglas (2010) bring a unique and much needed perspective on the interaction between desirability and feasibility in the formation of EI in the SEE model. They found that not only did desirability and feasibility interact but also the interaction was both negative and significant in its relationship to EI, in support of their hypotheses. These results indicate that high perceived desirability and high-perceived feasibility are mutually exclusive in the formation of EI. As such, while both high perceived desirability and high perceived feasibility intuitively lead to high EI, intentions can remain sufficiently high even when there are combinations of high or low perceived desirability and perceived feasibility. These findings suggest that EI can exist on a spectrum from high EI to low EI and the authors summarise these varying EI levels in their proposed typology of entrepreneurs, Figure 6. This EI spectrum is a useful perspective for my bottom-up study of CE as it accommodates the notion that organisational members would have varying EI levels. For instance, in the NHS context one could deduce that individuals who choose to work in a non-profit setting will have low desirability and low feasibility and are thus non-entrepreneurs. However it also accommodates instances where organisational members may meet some threshold where EI are sufficiently high for CE action to ensue.

Perceived Feasibility	Low Perceived Desirability	High Perceived Desirability
High	**Accidental entrepreneur** (sufficiently high intention)	**Natural entrepreneur** (very high intention)
Low	**Non-entrepreneur** (low intention)	**Inevitable entrepreneur** (sufficiently high intention)

Figure 6: Proposed Typology of Entrepreneurs from Fitzsimmons & Douglas (2010)

3.7 Factors that Influence Entrepreneurial Intention Formation

As previously discussed, the merit of EI research lay in the knowledge that intentions toward a planned behaviour acts as a crucial antecedent of that behaviour. It follows that understanding the elements capable of influencing an individual's attitudes in EI formation in the entrepreneurship process is of great importance. Sections 3.7.1, 3.7.2 and 3.7.3 will proffer the *contexts of intentionality* (Bird, 1988), largely categorised as situational or personal factors (Krueger, 2000; 1993). However, the main content in partnership with Table 10 will primarily focus on those factors that indirectly affect EI through the functional components of TPB and SEE.

3.7.1 Entrepreneurial Intentions and Personal Influencing Factors

From the literature it becomes clear that personal factors refer to the collective aspects that make up the individual and predispose them to form EI. These include, socialisation processes or experience, personality, competencies, thought processes and self-efficacy. The work in this area remains largely empirical and has been summarised below.

Socialisation as described by Van Maanen (1976) is a complex and dynamic process where an individual selects skills, values, norms and beliefs, which in

turn shape their personal identity. Socialisation processes covered in the literature include work history where individuals are introduced and subsequently learn to effectively operate in professional and organisational roles (Merton, 1963; Van Maanen, 1976; Van Maanen & Schein, 1979). Work history in turn can affect an individual's belief that they may be able to successfully start a business. Kautonen et al.'s (2011) findings indicate that a career in 'blue collar' industrial work had a negative impact on EI. Furthermore, this relationship was mediated by low perceptions of self-efficacy as well as a lack of support for enterprising behaviour in their reference group, the latter highlighting the utility of social norms. They also found that the effect of work history is amplified in the latter stages of their career. Conversely, Kolvereid (1996) found that prior self-employment experience had a positive effect on EI via attitudes. Carr & Sequiera (2007) also frame family experiences as another powerful socialisation process. Results suggest a significant direct and indirect effect of prior family business exposure on EI, via mediators including attitudes towards business ownership, perceived family support and entrepreneurial self-efficacy. Kolvereid (1996) also found family background has the same indirect effect on EI in their study.

Krueger (1993) introduces an additional facet to the work history scenario by looking at how prior entrepreneurial experiences affect desirability and feasibility. They found that perceived feasibility was significantly and positively associated with breadth of prior entrepreneurial exposure while the 'positiveness' of the prior experience was significantly and positively associated with desirability. Peterman & Kennedy's (2003) study investigates the effect of enterprise education courses using SEE. The authors reported higher perceptions of desirability and feasibility for starting a business after the course. These authors, like Krueger (1993), also look at 'positiveness' and breadth of experience in their study. However unlike Krueger, they found that breadth of experience was not significantly related to perceived feasibility. Additionally perceived desirability and feasibility were correlated in the Peterman & Kennedy (2003) study, whereas they were not related in Krueger's study. These could be attributed to (1) issues within the study's research design where the propensity to act was omitted as a variable in the model tested and (2) sampling; the age of the students tested.

As previously mentioned, the entrepreneurial personality was once an area of much focus in entrepreneurship research. Resurgence in researcher interest has occurred by framing personality as indirectly influencing EI via its functional antecedents. Luthje & Franke (2003) reveal that the personality traits, specifically risk-taking propensity and internal locus of control, show a strong and indirect effect on EI via entrepreneurial attitudes. The Obschonka, Silbereisen & Schmitt-Rodermund (2010) study finds a positive relationship between entrepreneurial personality and EI.

Further, Bird & Jelinek (1988) theorise the entrepreneur's role as leader, to propose five competencies (1) structuring resources; (2) maintaining flexible focus on business issues; (3) developing temporal agility; (4) behavioural flexibility; and (5) influencing others to commit resources. Obschonka et al.'s (2010) adopt a life span developmental approach and find support that entrepreneurship can be promoted in adolescence via early entrepreneurial competencies like leadership and commercial activities. Bird (1988) conceptualises entrepreneurial thinking styles as underlying structures that support EI. The author refers to the interplay of rational and intuitive thinking with personal contexts like prior entrepreneurial experience, personality characteristics, need for control and abilities in predisposing individuals to EI. Bird goes further and addresses the EI-behaviour relationship (see Figure 3), associating rational thinking with behaviours such as the creation of formal business plans and opportunity analysis and intuitive thinking with opportunistic behaviour based on 'hunches,' vision and feelings of a venture's potential.

Lastly, Krueger et al. (2000) showed self-efficacy and feasibility to be co-related and, when combined with desirability and a propensity to act, significantly predicted EI. Self-efficacy is defined as one's belief in his or her ability to succeed in specific situations, based on self-perception and external experiences (Bandura, 1986). However self-efficacy is domain specific (Bandura, 1997; 1992; 1989) thus a person can have high self-efficacy in one area, but low self-efficacy in another. As such, the literature is quite specific when referring to *entrepreneurial self-efficacy* (ESE) which Chen, Greene, & Crick (1998) define as an individual's belief that they are capable of successfully performing various entrepreneurship-related roles and tasks. In their study Prodran & Drnovsek (2010) use ESE in lieu

of perceived behavioural control and found ESE is positively associated with academic EI, as well as EI's most important predictor. Carr & Sequiera (2007) also found entrepreneurial self-efficacy mediated the relationship between family experiences and EI. Self-efficacy and work history can be seen as most relevant to this thesis. The domain-specific nature of the former and socialisation process of the latter, may prove challenging and reduce perceived feasibility when the highly specialised and institutionalised nature of NHS employees and moreover clinicians, is considered.

3.7.2 Entrepreneurial Intentions and Situational Influencing Factors

As personal characteristics influence individual EI, so can the characteristics of a particular situation (Reynolds, 1991). Situational factors arise from the social, cultural, political or economic environment in which the individual is operating (Bird, 1988). Though there has been little research that views EI as rooted in these aforementioned contexts (Griffiths et al., 2011), what work exists is primarily empirical, the emerging themes of which are presented below.

Culture has been included in EI models (Boyd & Vozikis, 1994; Bird, 1998). However, empirical deployment in EI models has been rare even though culture is first, a motivator of behaviour that varies from one country to the next and second, mediates economic and institutional conditions and entrepreneurship (George & Zahra, 2002; Busenitz et al., 2000). The only study looking at national culture used the TPB as its framework and found that national culture exerted itself on social norms. This provided support for their hypothesis that a more collectivist national culture could potentially increase the effect of social norms (Linan & Chen, 2009). This potentially has implications for public sector organisations, which are under the purview of the government. Furthermore, Radu & Redien-Collot (2008) look specifically at the French national context and the role of public discourse in the French Press in influencing EI. The authors identify three main categories of media discourse that potentially influence EI antecedents (1) legitimacy discourse impacts EI through desirability (2)

accessibility discourse impacts EI through feasibility and (3) normativity discourse, which affects appropriateness of prescriptive values and beliefs.

Douglas & Sheppard (1999) draw on entrepreneurship's roots in economics to conceptualise entrepreneurial career intentions as a utility maximising response. They theorise that occupational utility is dependent on attitudes toward contextual factors such as income, work conditions, risk exposure, independence and required effort. Furthermore, they postulate that a positive attitude toward the four previously mentioned factors is neither necessary nor sufficient for a person to want to be an entrepreneur. This position is atypical to economic perspectives on rationality and profit making. It illuminates the dynamics of the 'black box' of the entrepreneur's mind and what factors govern their decision and assessment process. Of their posited factors, Douglas & Sheppard's (2002) empirical test found that people only consider income independence and risk when evaluating a career option. Moreover, their findings can be linked to two major factors in the entrepreneurial orientation (EO) construct: autonomy and risk-taking. The authors find that the intention to be an entrepreneur is stronger for individuals with positive attitudes towards risk and independence while income was not a significant determinant. This has implications for how employers motivate employees to not only participate in CE activities but remain within the organisation as well.

3.7.3 Entrepreneurial Intentions and the Organisation

As it can be deduced, the organisational context can be categorised as a situational factor. However, based on this thesis' grounding in CE, any research that links EI and the organisation will be extricated and considered separately. When the body of EI literature is considered, it is obvious that it is very much weighted in the application of EI models to individual-level entrepreneurship and the act of venture creation. However, an emergent research stream has incorporated the translation of EI models to the domain of CE where *corporate venturing* (CV) along with *renewal activities* (RA) are key phenomena as presented in Chapter 2. This contextual perspective on EI remains sorely under-researched with the few papers in this area being largely conceptual to highlight

two streams of enquiry into *corporate entrepreneurial intentions* (CEI) discussed below.

The first stream looks at organisation and industry specific characteristics and practices that can impact EI formation. Prodran & Drnovsek (2010) investigate academic EI formation in their dual university study. The authors adjust the TPB framework to align personal networks with social norms and role models with attitudes and found them both to be positively related to academic EI. Additionally, it was found that for the university context the number of patents, applied research and industry cooperation were also positively related to and directly impact academic EI (a departure from the indirect path of the other factors discussed). This line of enquiry goes directly to this thesis' governing research question regarding the NHS context and what context-specific and unique characteristics potentially impact EI formation.

The second research stream concentrates on levels of analysis aside from the obvious organisation-level in CE. These papers highlight the team level as well as the individual level of analysis, which is the basis of this thesis (Davidsson & Wiklund, 2001; Hitt, Beamish, Jackson & Mathieu, 2007; Ireland & Webb, 2007). Lee, Wong, Foo & Leung (2011) extend the EI literature by introducing a multilevel perspective to understanding the factors that may influence EI. These authors provide a fine-grained perspective as they acknowledge that work context can produce organisational and individual EI influencing factors. Lee et al. (2011) examine the individual-level factors of innovation orientation, job satisfaction and self-efficacy in addition to organisational-level factors of innovative climate and technical excellence incentives and their effect on desirability. They found that a restrictive innovation climate in an organisation would negatively affect its members with a high innovation orientation. This in turn indirectly affected the EI to start a new business as individuals sought to improve their job satisfaction. While Lee et al.'s (2011) study is the only empirical paper found that addresses multiple levels of analysis, it only deals with individual's EI to start a new venture on their own, separate to the organisation.

In their conceptual paper, Krueger & Brazeal (1994) focus on the individual-level of analysis. The authors propose that if an organisation wants to increase the quality and quantity of their corporate entrepreneurs to instigate CE, it is crucial for the organisation to identify the antecedents of the entrepreneurial potential in its individual organisational members. They build on Shapero (1981) who stated, potential entrepreneurs are crucial in propagating a resilient, 'self-renewing' economic environment. This resilience requires a supply of potential entrepreneurs to emerge and take the initiative when a personally attractive opportunity presents itself in the organisation. Taking such initiative helps the local economy or parent organisation adapt to and survive in the dynamic world.

Sheppard & Krueger (2002) focus on the aggregate team level of analysis to understand which factors from the corporate environment may influence EI formation in teams, as they are central to making an organisation entrepreneurial. Jelinek & Litterer (1995) state that understanding organisational entrepreneurship requires a

> *cognitive paradigm that focuses on both individual sense-making and collective decision processes.* (p. 137),

as information processing in groups differ from that of individuals (Weick, 1979). One distinctive difference is that teams are a social artefact created via socially collective processing and therefore are by no means a straightforward combination of individual members' cognitions. This collective processing holds implications for the efficacy construct and its influence on EI formation. Bandura (1997) uses the term *collective efficacy* to refer to,

> *A team's belief in their conjoint capabilities to organise and execute the courses of action required to produce given levels of attainment.* (p. 477).

When compared to self-efficacy, research on collective efficacy is far less developed; however, it does provide some useful insights. Whitney (1994) states that perceptions of effectiveness are higher for a team with high collective efficacy; resulting in a work pattern where they persist in the pursuit of the goals

they choose (Cannon-Bowers, Tannenbaum, Salas, & Volpe, 1995; Hodges & Carron, 1992). Several studies have demonstrated a link between collective efficacy and team performance (Prussia & Kinicki, 1996; Little & Madigan, 1994; Earley, 1993; Hodges & Carron, 1992;) where successful performance strengthens the initial judgment of collective efficacy through positive outcome feedback. Conversely, a team with low efficacy can become caught in a self-fulfilling prophecy where low performance lowers efficacy (Silver & Bufanio, 1996). On a final note, collective efficacy is conceptualised as being just as context specific as self-efficacy (Guzzo, Yost, Campbell & Shea, 1993; Bandura, 1986). While this aggregate-level of analysis perspective offers fruitful future research direction for CE-EI research, it is not the focus of this thesis, which aims to focus on the individual-level.

Though lacking in empirics, the authors covered above advance EI's conceptual development and drive the paradigm forward by firmly linking EI formation to CE research. This has been achieved by considering the specific organisational contingencies, including multiple levels of analysis and organisational specific contextual factors that should be accommodated when the target of EI formation is CE. In the next section I will strengthen the EI-CE link and further define my study's theoretical framework by considering the EI models, TPB (Section 3.6.2.1) and SEE (Section 3.6.2.2) from a CE perspective.

3.8 A Critique of the Theory of Planned Behaviour and Shapero's Entrepreneurial Event from a Corporate Entrepreneurship Perspective

Thus far, I have presented a myriad of theoretical approaches to studying EI and the dominant paradigms of EI formation: TPB and SEE. Additionally, the personal and situational contexts that interact both indirectly and directly with EI in the dominant models have been covered. However, only one of these models can be used in the scope of this thesis. To determine which model will be used, this section aims to cast a critical eye on both models and determine which has the greatest utility in its application to the individual-level of analysis in CE.

Though TPB and SEE emerge from different disciplines, social psychology and entrepreneurship respectively, many parallels can be drawn between their intention antecedents. Both contain conceptually similar notions of self-efficacy, perceived behavioural control in TPB; perceived feasibility in SEE. Additionally, TPB's attitude towards behaviour and subjective norms measures correspond to SEE's perceived desirability. Lastly, contextual influences in both models do not directly affect intentions or behaviour but rather operate through intentions antecedents, specifically entrepreneurial attitudes.

Krueger (1993) noted that research into intentions in general was dominated by models based on the socio-cognitive TPB and this trend extended to EI despite the existence of the entrepreneurship based SEE. In response to this, Krueger tested SEE and found significant support for the model's propositions regarding how EI are derived. Furthermore, in 2000, Krueger et al. conducted a direct comparison of these two competing paradigms where they found support for both models. However, when assessed on a component-by-component basis, SEE appeared to have greater utility for assessing EI than TPB. This raises questions that the literature does not address regarding Krueger's observation of TPB as the leading framework. The remaining portion of this section will attempt to shed light on this observation by viewing TPB and SEE from a CE perspective.

As previously stated in Chapter 2, entrepreneurship research is dependent on the individual as a level of analysis. The choice of this thesis to focus on the 'individual in CE' offers an explanation for the superiority of SEE over TPB in CE matters for two reasons. First, as discussed earlier in Section 3.6.2.1, the effect of the subjective norm component is dissipated when an individual has a strong locus of control or sense of self. It can be argued that becoming a corporate entrepreneur requires a 'special individual' who the extant research describes as having a strong internal locus of control or strong sense of self that not only fuels entrepreneurial action (Hemingway, 2005; Hytti, 2005; Krueger et al., 2000) but also gives rise to them seeing themselves as a distinctive out-group (McGrath & MacMillan, 1992). It is these individuals who can be categorised according to Fitzsimmons & Douglas' (2010) typology, Figure 6, as natural, inevitable or accidental entrepreneurs in the organisation confines. This suggests that corporate

entrepreneurs can strongly distinguish themselves from other organisational members through their distinct beliefs, values, attitudes and perceptions of self-concept with respect to CE.

This turns the spotlight on the second reason why SEE may have more explanatory power than TBP where the 'individual in CE' is concerned. Specifically, how the TPB and SEE models deviate in terms of 'action' to carry out behaviour. Krueger & Brazeal (1994) point out an individual can have great potential for entrepreneurship and at the same time not have corresponding entrepreneurial intentions, implying that appropriate attitudes, behavioural control and social norms may not be enough. While TPB's perceived behavioural control component is equivalent to feasibility, it accounts for behaviour from a locus of control perspective; that is, the overall belief in the power of one's action across a myriad of situations and not entrepreneurship specifically (Wilson et al., 2007). Conversely, this perceived behavioural control refers to behaviours that are partially influenced by some external, non-internally motivated source thereby limiting one's locus of control. However, being developed from an entrepreneurship point of view, SEE assumes a volitional element to intentions through the propensity to act as crucial. Krueger (1993) argues that an individual is unlikely to have a fully formed intention towards behaviour if there is no likelihood of action. In CE this propensity to act becomes even more essential as it propels the corporate entrepreneur to act despite the organisation acting as a hostile environment to entrepreneurship (see Section 2.3.1.2). This hostility, as would be expected, is only proliferated in monolithic, bureaucratic public sector organisations like the NHS (an in-depth contextual discussion of the NHS is forthcoming in Chapter 5).

Taking the aforementioned into account, (1) restraining the prominence of social norms and (2) promoting the propensity to act, I submit, SEE will be the paradigm adhered to for the duration of this thesis. Its advantage lies in the assumption that the behaviours being predicted are entrepreneurial at the onset of the model's conception and require a pre-existing preparedness to identify, accept and pursue opportunity (Ireland et al., 2009; Brazeal & Krueger, 1994; Reynolds, 1992; Shapero, 1982). Finally, to guide this research I have adapted a definition

of EI and entrepreneurial attitudes that precede EI formation to the CE domain. I have defined corporate entrepreneurial intentions (CEI) as the motivational attitudes to instigate renewal or bring new ventures into existence. CEI formation is the function of two motivational attitudes: (1) CE desirability and (2) CE feasibility. CE desirability is the degree to which organisational members find the prospect of strategic entrepreneurship, corporate venturing and entrepreneurial orientation to be attractive. CE feasibility is the degree to which an individual believes they are personally capable of behaving like a corporate entrepreneur or participating in CE activity.

3.9 Conclusion

So what can be drawn from this review? I have deduced four main points. First, EI has proven to be a reliable and valid predictor of entrepreneurial behaviours (Krueger et al., 2000). Second, EI models provide both an apt and proficient lens for understanding how individuals are moved to action, reflected in the substantial portion of empirical and conceptual articles in Table 9. A third observation is that in a significant portion of the work conducted, EI refers to the individual's decision to pursue an entrepreneurial career path or start a new venture on his or her own. As such, the CEI of individual organisational members as they choose to act entrepreneurially within the organisational context remains under-researched and largely theoretical. This reveals the gap in the literature that will be pursued within this thesis' parameters.

Watson (2009) states that entrepreneurial action can only be fully understood if it is viewed as something that individuals have to fully engage in. When this proposition is considered in conjunction with the somewhat decontextualised, functionalist, top-down approaches to CE that promise improved performance, it signals that individuals within the organisation inherently perceive CE activities in a positive manner. However, this is not the case within the public sector organisations like the NHS. The notion of entrepreneurs as domineering, ruthless and dangerous rogue operators lacking in the necessary integrity to handle public funds or hold to traditions, still pervades (Currie et al. 2008; DeLeon & Denhardt,

2000; Terry, 1998; Bellone & Goerl, 1992). Further, the extent to which attempts to introduce enterprise culture via NPM and post-NPM reforms (an in depth discussion of NPM is forthcoming in Chapter 5), especially in the aftermath of the 2008 economic crisis, have been successful continues to be debated (Currie et al., 2010; McNulty & Ferlie, 2004). In turn, the full gamut of entrepreneurial behaviours is not necessarily regarded as desirable much less feasible, potentially signalling to organisation member's anti-CE perceptions where they have no intention of participating in CE behaviour.

Still, the CE model of choice for this thesis, Figure 2, Ireland et al. (2009) proposes that organisations, which are characterised as having an entrepreneurial orientation, participate in three central behaviours across two levels of analysis (1) *strategic entrepreneurial vision* at the top level managers level, (2*) opportunity identification* by all organisation members and (3) *opportunity exploitation* also by all organisation members. The model also depicts these behaviours as being linked to beliefs, values and attitudes as antecedents of CE strategy. This suggests that EI models and more specifically SEE, are suitable for integration into Ireland et al.'s (2009) CE model, Figure 7 below.

This culminates into the fourth point and major recurrent theme in EI research. Entrepreneurship researchers acknowledge the parsimonious nature of intention formation models for more complex decisions like embarking on the entrepreneurial process. However, the EI articles reviewed indicate that researchers mitigate for this parsimony by compiling an extensive list of personal and situational factors that exert influence on EI (directly or indirectly). Following in the footsteps of these authors, I propose the expansion of the SEE model to include CEI influencers inductively derived from the LEMT context.

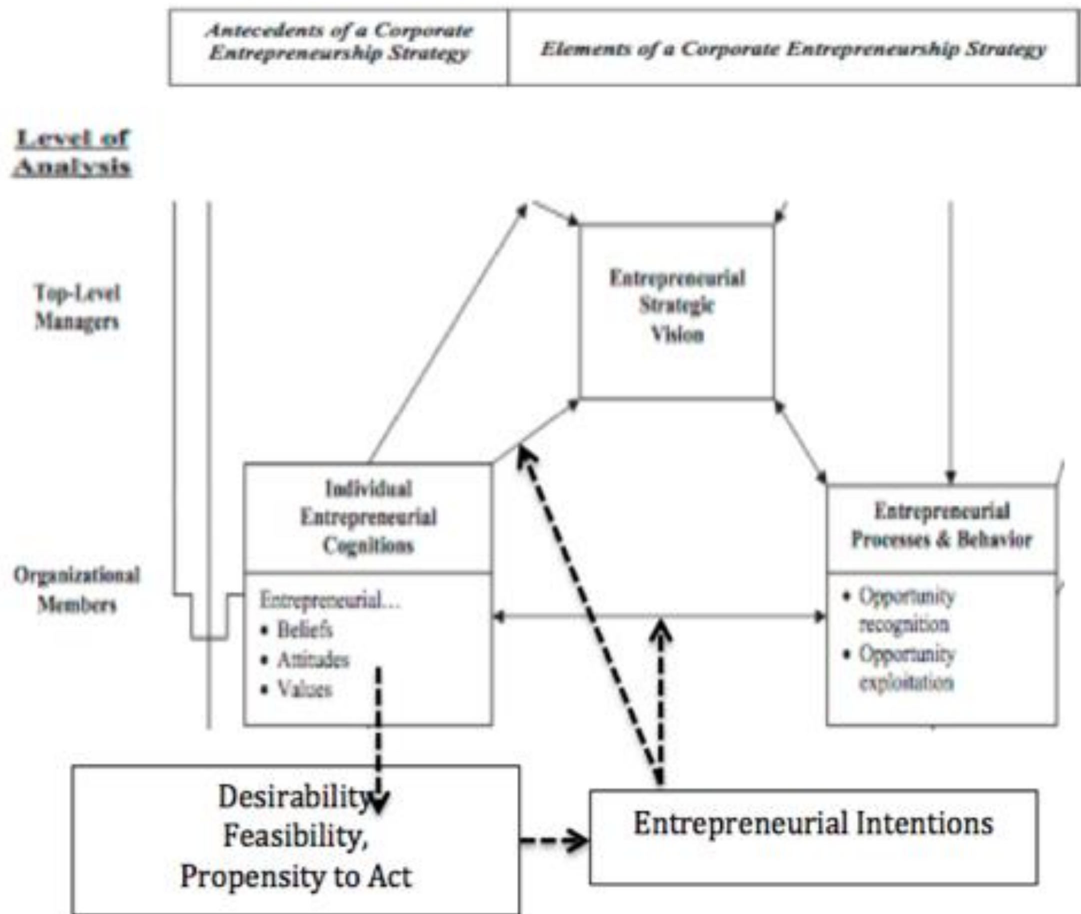


Figure 7: The Proposed Role of Shapero's Entrepreneurial Event in an Excerpt of Ireland et al.'s (2009) Model of Corporate Entrepreneurship Strategy

Author	Type of Paper	Key Concepts/Variables	Relevance/Contribution	Theoretical or Literature Base	Core Paper
Lee et al (2011)	E*	Innovative Climate, Technical Excellence Incentives, Innovation Orientation, Job Satisfaction, Self-Efficacy	Influence of organizational & Individual factors on EI	**Shapero's Entrepreneurial Event,** Person-`Environment Fit	Y
Fitzsimmons & Douglas (2010)	E	Desirability, Feasibility	Negative interaction effect between these two main antecedents of intentions	**Shapero's Entrepreneurial Event,** Expectancy Theory, Regulatory Focus Theory	Y
Prodran & Drnovsek (2010)	E	Entrepreneurial self-efficacy, personal networks, perceived role models, number of years at academic institution, patents, type of research	Conceptual model of academic entrepreneurial intentions with empirical testing of said model	**Theory of Planned Behaviour**, Psychology, Social Psychology Theory	Y
Kautonen et al (2010)	E	"Blue collar" worker, public sector employee, small business employee	Influence of work history on EI in 20-49 and 50-64 year olds	**Theory of Planned Behaviour,** Work History, Socialisation Processes	Y
Obschonka et al (2010)	E	Entrepreneurial personality, control beliefs, adolescent entrepreneurial competence	Life span developmental approach to entrepreneurship research. Two types of EI: "conditional" and "unconditional"	**Theory of Planned Behaviour**, Personality Traits	Y
Zhao et al (2010)	E	"Big Five" personality profile,	Relationship of personality to EI and entrepreneurial performance	Career Choice, Person-Environment Fit, Social Cognitive Theory	N
Kurkertz & Wagner (2010)	E	Sustainability orientation, perceived barriers and support, propensity to innovate, attitudes to entrepreneurship	Effect of sustainability orientation on EI	**Theory of Planned Behaviour,** Entrepreneurship Theory, Sustainable Entrepreneurship	Y

Table 9: Summary of Entrepreneurial Intentions Studies

Author	Type of Paper	Key Concepts/Variables	Relevance/Contribution	Theoretical or Literature Base	Core Paper
Griffiths et al (2009)	E	Culture of entrepreneurship, gross domestic product per capita, transactional impediments, corruption	Macro-level and contextual factors that influence EI	Cultural, Socio-political and Economic Environment, Demand and Supply Theory	N
Linan & Chen (2009)	E	Human and demographic variables, two cultural settings	Builds an EI questionnaire. Cross-cultural applications	**Theory of Planned Behaviour,** Culture, Motivation	Y
Gupta et al (2009)	E	Gender-role stereotype, gender identification	Role of socially constructed gender-role stereotypes and gender identification on EI. Cross-cultural application	Socialisation, Processes, Stereotype Activation Theory	N
Radu & Redien-Collot (2008)	**E**	Public Discourse in the media, social representation of entrepreneurs.	How discourse influences perceptions of desirability and feasibility	**Shapero's Entrepreneurial Event,** Cultural Context	**Y**
Gupta et al (2008)	E	Masculine and feminine stereotype, nullified stereotype condition	Effect of gender stereotype activation on EI	Stereotype Activation Theory, Gender in Entrepreneurship	N
Carr & Sequeira (2007)	E	Prior family business experience, entrepreneurial self-efficacy, perceived family support, attitude to business ownership	Family experiences influences EI	**Theory of Planned Behaviour,** Socialisation Processes	Y
Wilson et al (2007)	E	Gender, self-efficacy, intentions, entrepreneurship education	Relationship between gender, entrepreneurial self-efficacy and career intentions. Effect of entrepreneurship education on self-efficacy	Career Choice, Self-efficacy, Gender, Education, Social Learning Theory	N

Author	Type of Paper	Key Concepts/Variables	Relevance/Contribution	Theoretical or Literature Base	Core Paper
Frank et al (2007)	E	Personality, process, environment	Varying roles of personality factors in business start-up intentions, start-up and business success	Personality Traits	N
Hmieleski & Corbett (2006)	E	Motivation, cognitive style, social models, improvisation proclivity	Relationship between improvisation and EI	Personality Traits	N
Zhao et al (2005)	E	Perceptions of formal learning, entrepreneurial experience, risk propensity, gender	Investigate the mediating role of self-efficacy the development of EI	Social-cognitive theory	N
Begley et al (2005)	E	Access to financing, government regulation, market opportunities, support services, skilled labour, personal connections, competitive conditions	Perceptions of politico-economic resources impact on interest in starting a business. Cross-cultural application	Resource Dependence Theory, Population Ecology Theory	N
Lee & Wong (2004)	E	Career Anchors	Investigate the effect of career anchors on EI and types of businesses participants intended to found	Career Anchors, Psychological Theory (not specified)	N
Luthje & Franke (2003)	E	Risk-taking propensity, personality traits, contextual factors, attitude toward entrepreneurship	Investigate whether steady personal dispositions or contextual conditions impact EI	**Theory of Planned Behaviour**, Psychological Theory, Sociological Theory (not specified)	Y

Author	Type of Paper	Key Concepts/Variables	Relevance / Contribution	Theoretical or Literature Base	Core Paper
Peterman & Kennedy (2003)	E	Education, Positiveness and Breath of Entrepreneurial Experience	Effects on EI via desirability and feasibility	**Shapero's Entrepreneurial Event,** Self-efficacy Theory	Y
Shepherd & Krueger (2002)	C	Perceptions of desirability and feasibility at the team and individual level	Adaptation of intention-based model to the CE domain	**Shapero's Entrepreneurial Event,** Corporate Entrepreneurship, Group Entrepreneurial Cognitions	Y
Douglas & Shepherd (2002)	E	Income, independence, risk, work effort	Entrepreneurship career choice intentions as a utility maximising response. How attitudes impact EI	Economics, Rational Choice Theory	N
Krueger et al (2000)	E	Desirability, Feasibility, Perceived Behavioural Control. Attitude towards Behaviour, Social Norms	Compares two leading intention based models in terms of their ability to predict EI	**Theory of Planned Behaviour, Shapero's Entrepreneurial Event,** Social Cognitive Theory	Y
Krueger (2000)		Opportunity, Cognitive Infrastructure	EI based model of cognitive infrastructures that support or inhibit individual's perception of opportunity	**Shapero's Entrepreneurial Event,** Entrepreneurial Cognitions	Y
Douglas & Shepherd (1999)	C	Utility maximisation response	Economic model of career decision based on maximal utility	Economics, Rational Choice Theory	N
Baron (1998)	C	Counterfactual thinking, affect infusion, attribution styles, planning fallacy, escalation of commitment/self-justification	Proposes the utility of cognitive processes in entrepreneurship and links it with human cognition literature	Entrepreneurial Cognitions, General Management, Cognitive Theory	N
Jenkins & Johnson (1997)	E	Coherence, customer, performance measures, innovation, control. Causal mapping	Relationship between EI and business outcome.	Strategic management, Cognitive Theory (not specified)	N

Author	Type of Paper	Key Concepts/Variables	Relevance / Contribution	Theoretical or Literature Base	Core Paper
Kolvereid (1997)	E	Demographic characteristics: family background, gender, self employment experience,	Effect of demographic characteristics on EI	**Theory of Planned Behaviour,** Career choice	Y
Crant (1996)	E	Proactive personality scale	Effect of a proactive personality on entrepreneurial career choice intentions	Career choice, Personality Traits	N
Boyd & Vozikis (1994)	C	Self-efficacy	Extension of Bird (1988) model of intentionality to include self-efficacy	Social Learning Theory	N
Bird (1988)	E	Contexts of Intentionality, entrepreneur's thinking style	Proposes a model of intentionality	Cognitive Theory (not specified)	N
Bird & Jelinek (1988)	C	Structuring resources, vision and focus, temporal agility, behavioural flexibility, influencing others	Presents a model of entrepreneurial intentions based on entrepreneurial competencies	Competencies, Attribution Theory, Expectancy Theory, Linguistic Theory	N

*** E = Empirical, C = Conceptual; + Y = Yes (Core Paper); N = No (Not Core Paper) EI = Entrepreneurial Intentions, CE = Corporate Entrepreneurship; Bold: Dominant EI Paradigm**

			Shapero's Entrepreneurial Event				Theory of Planned Behaviour		
			Antecedents with direct effect on Intentions				Antecedents with direct effect on Intentions		
Author(s)	Construct	Factors with an indirect effect on intentions via antecedents (Pre-Antecedents)	Desirability	Feasibility	Propensity to Act	Additional comments	Attitude towards a Behaviour	Perceived Behavioural Control	Subjective Norm
Lee et al (2011)	Organizational	Innovative Climate	Positive effect	No effect	Not tested	Intra- and extra-personal factors interact			
		Technical Excellence Incentives	Positive effect	No effect					
	Individual	Innovation Orientation	Mediating effect	No effect					
		Job Satisfaction	Mediating Effect	No effect					
		Self-Efficacy	Mediating effect	Positive effect					

Table 10: Situational and Personal Factors that Indirectly Influence EI via the Attitude Components of SEE and TPB

			Shapero's Entrepreneurial Event				Theory of Planned Behaviour		
			Antecedents with direct effect on Intentions				Antecedents with direct effect on Intentions		
Author(s)	**Construct**	**Factors with an indirect effect on intentions via antecedents (Pre-Antecedents)**	**Desirability**	**Feasibility**	**Propensity to Act**	**Additional comments**	**Attitude towards a Behaviour**	**Perceived Behavioural Control**	**Subjective Norm**
Prodran & Drnovsek (2010)	Academic Entrepreneurial Intentions at 2 universities	Entrepreneurial Self-Efficacy				Contextual factors conceptualised as antecedents of EI ATB=Perceived Role Models PBC=E'rial Self- Efficacy SN=Personal Networks Patents, Applied research and Industry cooperation found to have a direct impact on EI	No relationship	Positively related	No relationship
		Personal Networks					No relationship	No relationship	Positively related
		Perceived Role models					Positively related	No relationship	No relationship

			Shapero's Entrepreneurial Event				Theory of Planned Behaviour		
			Antecedents with direct effect on Intentions				Antecedents with direct effect on Intentions		
Author(s)	**Construct**	**Factors with an indirect effect on intentions via antecedents**	**Desirability**	**Feasibility**	**Propensity to Act**	**Additional comments**	**Attitude towards a Behaviour**	**Perceived Behavioural Control**	**Subjective Norm**
Kautonen et al (2010)	Career History	Industrial Worker					No effect	Fully mediated	Fully Mediated
		Public Sector Employee					No effect	No effect	No effect
		Small Business Employee					No effect	No effect	No effect
	Age segments	Prime 20-40					No effect	No effect	No effect
		Third 50-64					No effect	No effect	Partially mediated

			Shapero's Entrepreneurial Event Antecedents with direct effect on Intentions				Theory of Planned Behaviour Antecedents with direct effect on Intentions		
Author(s)	**Construct**	**Factors with an indirect effect on intentions via antecedents**	**Desirability**	**Feasibility**	**Propensity to Act**	**Additional comments**	**Attitude towards a Behaviour**	**Perceived Behavioural Control**	**Subjective Norm**
Obschonka et al (2010)	Developmental Outcomes	Entrepreneurial Competencies in Adolescence				Conditional	N/A	Positive Effect	N/A
						Unconditional intentions	N/A	Positive Effect	N/A
		Personality				Conditional	N/A	No effect (No direct path)	N/A
						Unconditional intentions	N/A	No effect (No direct path)	N/A
						Taiwan		Strongest Predictor	

			Shapero's Entrepreneurial Event Antecedents with direct effect on Intentions				Theory of Planned Behaviour Antecedents with direct effect on Intentions		
Author(s)	**Construct**	**Factors with an indirect effect on intentions via antecedents**	**Desirability**	**Feasibility**	**Propensity to Act**	**Additional comments**	**Attitude towards a Behaviour**	**Perceived Behavioural Control**	**Subjective Norm**
Linan & Chen (2009)	Cross-Cultural Application	Culture				Spain	Strongest Predictor		
Radu & Redien-Collot (2008)	Social Representation of Entrepreneurs in the press	French Press	Limited positive effect	Limited positive effect	Not tested	Qualitative Study: Discourse Analysis			
Carr & Sequeira (2007)	Prior Family Business Experience						Positive Effect	Positive Effect	Positive Effect
Luthje & Franke (2003)	Personality Traits	Risk Taking Propensity					Positive Effect		
		Internal Locus of Control					Positive Effect		
Peterman & Kennedy (2003)	Education	Entrepreneurship Education	Positive Effect	Positive Effect	N/A	Broadness and positiveness of experience Positively affected participation in education programme			

CHAPTER 4: IDENTITY: AN EMERGENT PERSPECTIVE ON CORPORATE ENTREPRENEURSHIP AND AN INFLUENCER OF CORPORATE ENTREPRENEURIAL INTENTION FORMATION

4.1 Introduction

My inductive analysis (Miles & Huberman, 1984) led me to relate my findings to several emergent strands of identity-centric research that provide additional theoretical foundations for this thesis. These strands reveal identity is a complex and multifaceted contextual factor. As such, the purpose of this chapter is to consider the key debates surrounding identity through a review of the extant literature. This includes what identity is, theories of identity, types of identity (role, professional, organisational, hybrid), identity tension, identity work and its various forms (narratives, provisional selves, resistance). Of particular relevance is identity that can be attributed to an individual's membership to multiple social groups such as an organisation or a profession, using the Social Identity Approach (SIA), which combines Social Identity Theory (SIT) and Self Categorisation Theory (SCT). I then link these identity concepts to the CE literature to bring greater focus and exploratory power to understanding the 'individual in CE' and how social identity may influence organisational members entrepreneurial choice via CEI formation.

4.2 The Concept of Identity

Identity is a social construct, which describes the subjective nature of meanings and experience within societal structures (Alvesson, 2003; Hogg, Terry & White 1995; Mead, 1934). Identity poses two questions central to self-concept. The first of which is, 'who am I?' The second question goes to the behaviours an individual engages in to confirm this self-concept and as such asks the question 'how should I act?' Essentially, identity motivates behavioural attempts to confirm or verify its existence (Burke & Stets, 1999; McCall & Simmons, 1966).

Many perspectives have been advanced to answer these questions and explain an individual's identity. The predominant approach has been to distinguish between personal identity and social identity (Watson, 2007; Ibarra, 1999; Ashforth & Mael, 1989; Gecas, 1982).

Conceptualisations of self-identity that have placed more emphasis on personal identity focus on the internal aspects of human identity and relates to the individual's own notion of who and what they are. It considers an individual's behaviours and conduct as a reflection of the personal traits and characteristics that they as well as others attribute to them (Watson, 2007; Ibarra, 1999). Other perspectives have focused on social identities, which capture the outward or social facing aspects of self-identity, which are of particular relevance to this study. Watson (2007) argues that to best garner a sense for who individuals understand themselves to be, the influence of cultural, discursive or institutional notions of the self should be considered. These social identities may take different forms including social roles and group memberships.

4.3 Theories of Identity: Identity Theory & the Social Identity Approach

Two dominant theories have been advanced that highlight how identity can mediate the relationship between an individual's behaviour and social structure: Identity Theory (IT) Stryker & Burke (2000) and Social Identity Theory (SIT) (Tajfel & Turner, 1979). Hogg et al. (1995) and Stryker & Burke (2000) have been pivotal in both collating the similarities and explicating the differences between these two perspectives, which I elaborate on below.

IT has its roots in sociology and proposes that the self consists of distinct self-defined components, each of which is a manifestation of the role positions that an individual occupies in society (Stryker & Serpe, 1982; Stryker, 1968). As such, IT is based on *role* identification, which are the self-referent conceptions, cognitions, or definitions that people apply to themselves because of the role positions they occupy. Role identities represent a set of expected and appropriate behaviours that materialise through an individual's interaction with valued others as they direct

their environment and control the resources for which the role has responsibility (Ashforth, 2001; Stets & Burke, 2000). In this sense people come to know themselves by interacting with others (Stets & Burke, 2000; Mead, 1934). Therefore, self concept will vary based on the *different roles* people may occupy such as, father, husband and healthcare worker (Stryker, 1987).

SIT however, originates in social psychology (Hogg, Terry, & White, 1995; Hogg, 1993; Tajfel & Turner, 1979) and is concerned with *group* identification. As such, an individual considers their self to be a member of a valued social group and views things from the group's perspective even if they are not in direct contact with the group (Ashforth & Mael, 1989). SIT proposes group members utilise two cognitive processes to maintain and manage the in-group's image: *categorisation* and *self-enhancement*. Self-enhancement seeks to behaviourally and perceptually favour the in-group over the out-group. Categorisation on the other hand continuously stresses the differences between the in-group and out-group, in addition to the similarities among in-group member's normative behaviours.

While SIT is considered a highly valuable perspective, some scholars note that SIT does not offer an understanding of the impact of an individual's capacity or salience on the group's behaviour (Haslam, Ellemers, Reicher, Reynolds & Schmitt, 2010). These theoretical gaps are addressed by combining SIT with Self Categorisation Theory (SCT). The amalgamation of SIT and SCT is broadly known in the literature as the Social Identity Approach (SIA) (Hogg & Terry, 2001). SCT augments SIT by exploring the formation of psychological groups after the development of a social identity. Turner, Hogg, Oakes, Reicher & Wetherell (1987) indicated SCT loans clarity to the uptake of the shared social norms and values of a group. This enables a fundamental transformation of not only an individual's behaviour and identity but also the resulting in-group identification and collective action and expectations. To achieve this, group members utilise the *depersonalisation* process to categorise themselves and others through identification with group prototypes. The process aids social influence as it changes unique individuals into interchangeable representations of a social group prototype. This further cements group action as members act

stereotypically to achieve group goals (Turner et al., 1987). A strong identification with the group enhances this process by reducing intergroup conflict while increasing its social influence (Haslam, 2004, Turner et al., 1987).

The stereotypical aspects of a group prototype are a representation of what the members identify with and seek to replicate. Identification with these prototypes reinforces shared attitudes and ideals and results in consistent group behaviour and identity (Hogg & Terry 2001; 2000). By stressing in-group similarities and out-group dissimilarities to the prototype, members are able to define increasingly idiosyncratic groups. Ultimately, identification with the group prototype may increase individual member's self esteem and social validation (Hogg & Terry 2000). Lastly, what is prototypical for a particular group is contingent on the context in which the group is embedded.

4.4 Multiple Social Identities

The social self is considered to be an all-encompassing concept consisting of many layers of identification that more or less overlap (Stets & Burke, 2000; Hogg et al., 1995). For instance, consider one's identity when an individual belongs to a particular demographic group, an organisation and a profession. Organisational and professional identities constitute two of these layers that provide the emergent theoretical basis for this thesis with implications for organisational members CEI formation. I will discuss both of these below.

4.4.1 Organisational Identity

Organisational identity has been a central concept within the organisational literature when issues of identity are considered (Brown, 2001). Broadly, it captures the commonly shared and collective understanding of the defining characteristics and values of an organisation that is held by its members. It reflects how organisational members think and feel about as well as perceive their organisation. As such, the organisational literature has long since been preoccupied by organisational members commitment to or identification with their organisation (Brown & Starkey, 2000; Elsbach & Kramer, 1996).

Additionally,, many studies have sought to understand the relationship between organisations and its members at various level in its hierarchy (Dutton, Dukerich & Harquail, 1994: Ashforth & Mael, 1989).

Albert & Whetten's (1985) influential and widely used characterisation of organisational identity states that it represents all that is, central, enduring and distinctive about an organisation's character. This suggests that core organisational features can be largely resistant to fleeting organisational trends as they have been developed and embedded in the organisation's historical maturation. As such, it is common in the identity literature, to conceptualise organisational identity as stable and durable (Albert & Whetten, 1985**).** This is primarily due the enduring meanings, significance and expressed values organisational members attach to what they believe an organisation to be, which has implications for organisational change such as the introduction of CE. There has been growing support however, for the proposition that this stability may not be as steadfast (Gioia, Schultz & Corley, 2000; Whetten & Godfrey, 1998; Ashforth & Mael, 1996). Especially, in the face of increasingly turbulent economic environments characterised by munificence, dynamism and public perceptions of the organisation, which have all been presented in Chapter 2 as pro-CE conditions. Therefore, the examination of organisational identity should allow for some notion of fluidity in it is conceptualisation.

4.4.2 Professional Identity

Society's notable professions have emerged as groups that have acquired and are able to leverage some esoteric subject matter such as, medicine, law, or accounting for example (MacDonald, 1995; Carr-Saunders & Wilson, 1933). These professionals are able to apply this specialist knowledge to societal problems and create monetary and non-monetary value in return. Accordingly, professional identity is defined as the constellation of attributes, beliefs and values people use to define themselves in specialised, skill and education based occupations or vocations (Ibarra, 1999; Schein, 1978). Professional identity influences self-definition as it positions an individual in society via the relationships formed with others and how others view professionals. This is

traditionally reflected in the higher levels of prestige, privilege and autonomy that society affords professionals who have unique knowledge and skills than non-professionals (Gecas & Burke, 1995; Larson, 1977). While professional identity is an established concept in sociological and organisational studies, relatively little is known about how professional identities are constructed (Ibarra, 1999). This is problematic when one considers that professionals are critical to the performance of routine organisational functions (Ibarra, 1999). Even more so, when extended to professionals who may choose or are prompted to take on new functions such as CE activity as part of their work. As such, scholars have sort to rectify this limitation by devoting much attention to understanding the nature of professional identity, that is, its stability or malleability.

Some scholars, have described professional identity as highly robust and resistant, so it does not change or subsume new behaviours quickly or easily (Chreim, Williams & Hinings, 2007). This resilience can be attributed in part to the legitimacy one finds in being a professional. Legitimacy provides the foundation for what Abbott (1988) calls professional jurisdiction. This captures both the authority that goes with having command of specialist knowledge as well as the importance of complying with the recognised rules, standards, traditions and behaviours of a chosen profession (Goodrick & Raey, 2010; Tajfel, 1978). Professional legitimacy is further reinforced in the organisational context as it establishes the interactions that are the basis of the organisation's structure thereby framing the occupational hierarchy within (Abbott, 1988). Notably, the varying levels of scientific expertise or unique skill sets for different professional groups can result in the emergence of dominant professions that attain and maintain their position in the organisational hierarchy (Larson, 1990).

Alternative perspectives on the nature of professional identity suggest it is more malleable or adaptable (Ibarra & Barbulescu 2010; Pratt et al., 2006; Ibarra, 1999). The general consensus in the socialisation literature indicates that professionals will adapt their work content or more simply 'what you do' as a professional over time as their career progresses (Pratt et al., 2006; Ibarra, 1999). Work content is developed during the socialisation period required by traditional professional training thereby facilitating identity construction. While establishing

work content makes for a stable professional identity, this conceptualisation allows for the possibility that professional identity stability can be undermined. Career progression requires the individual to incorporate new behaviours, skills, attitudes and relationships that in turn may produce changes to the conception of their professional self. How this evolutionary process of identity adaptation occurs however, is not yet fully understood. Thus, isolating the processes by which individuals construct new versions of their professional identity represents a knowledge space of great interest to researchers (Ibarra & Barbulescu 2010; Kreiner, Hollensbe & Sheep, 2006; Pratt et al., 2006; Ibarra, 1999).

4.4.2.1 Professional Hybrids

One line of enquiry into the resistant and yet changing nature of professional identity has led to an increased focus on the emergence of what are known as professional hybrids in professionalised organisations such healthcare organisations, which are the context for this thesis (O'Reilly & Reed 2010; Hartley & Allison 2000). Professional hybrids are defined as professional individuals who move between different organisational groups where they take on managerial roles that still require them to retain influence in and operate as legitimate members their professional group (McGirven, Currie, Ferlie, Fitzgerald & Waring, 2015; Tummers, Steijn & Bekkers, 2012; O'Reilly & Reed 2010). The ability of hybrids to alternate between these two distinct functions where they align professional and organisational demands is indicative of how valuable hybrids can be to these organisations (Ferlie, Fitzgerald, Wood & Hawkins 2005; Noordegraaf & Van Der Meulen 2008; Llewellyn, 2001). Existing research on professional hybrids seeks to understand how their emergence can be facilitated or what can hinder it. For instance, how professionals attempt to reduce both the resistance to change and the conflict created between their commitment to prototypical professional identities and the uptake of managerial duties (Ibarra & Barbulescu 2010; O'Reilly & Reed 2010; Chreim et al., 2007; Pratt et al. 2006; Hartley & Allison 2000; Ibarra 1999). What remains vague in the extant literature however, is how hybridity associated conflicts are managed so that professional identity can be changed so new identities emerge (Croft, Currie & Lockett, 2015).

4.4.2.2 Professional Identity & Healthcare Organisations

To understand how identity can aid in the exploration of how individual organisational members form CEI, I have positioned my empirical work in the context of healthcare systems, specifically the English NHS. Healthcare organisations are considered to be quintessentially professionalised as they provide an environment where the socialisation processes necessary to transform individuals into professionals readily occur. As such, these organisations and the professionals who work within them have been the focus of much research on professional identity construction (Pratt et al., 2006; Doolin, 2002; Cohen & Musson, 2000). These studies document the evolution of these professions and the values, belief and work content attributed to each of these professional identities, which I present below.

A limitation within this approach however, is that the majority of research focuses on doctors (Croft et al., 2015). Doctors are an exceptional professional group in healthcare organisations. Their professional significance emerges early on, as entry to this profession is carefully guarded as selection for medical school favours the academically elite. Also, as socialisation and training is long, arduous and highly structured, it instils individual mastery of knowledge and fosters professional dominance (Pratt, et al. 2006; Freidson, 1970). In turn, doctors accumulate a considerable level of clinical autonomy due to their respected scientific knowledge base and technical skill, which affords them control over diagnosis, treatment and care evaluation work content.

However, the successful provision of healthcare services requires other professional groups. Nurses for instance, are an essential, recognisable and traditional professional group with a fundamental ideological reliance on work content based on ‘caring.’ Paradoxically, attempts to conduct ‘scientific’ research into the non-quantifiable area of nursing care have resulted in poor and limited studies (Merkouris, Papathanassoglou & Lemonidou, 2004; Beck, 1999; Baggott, 1998; Morgan, Calan & Manning, 1995). Diefenbach, (2009) has found this has potentially undervalued the contribution of nurses and resulted in the profession’s low social appreciation. This is further compounded by the continued dominance

of medicine, where nurses are encouraged to commit to and perpetuate an excessively idealised professional image and stereotypical ideals as passive, obedient, altruistic carers (Goodrick & Reay 2010). Thus, as a professional group nurses have been largely neglected in the literature (Croft et al., 2015).

Less traditional groups are also charged with healthcare provision such as allied health professionals (AHPs) and healthcare scientists. Regarding the former, AHPs are primarily charged with rehabilitative and therapeutic work. Unlike nursing, the allied health professions are considered to have a strong allegiance with medicine via the profession's knowledge of anatomy, physiology, psychology, the use of technical equipment and a high level of educational attainment (Turner, 2001). This distinct knowledge base and expertise has served to establish security in and legitimise the collective AHP identity (Baxter & Brumfitt 2008). This in turn has enabled AHPs to work effectively within diverse teams as they exhibit higher comfort levels with the dynamic nature of multi-disciplinary teams (Baxter & Brumfitt 2008, Nancarrow, 2004; Booth & Hewison 2002).

With respect to the latter, healthcare scientist's work content consists of exploratory and confirmatory diagnostic testing in healthcare organisations. Similar to AHPs, healthcare scientists have a strong affiliation with medicine. Since many healthcare scientist functions are carried out by doctors and require the esoteric knowledge associated with various medicinal disciplines (Modernising Scientific Careers, 2010). Hallworth, Hyde, Cumming & Peake (2002) highlight however, that these duties and knowledge do not necessarily constitute a profession, which can serve to undermine its status. This is amplified by the relegation of healthcare scientists to the 'second-line' where they have little to no patient contact, though in the NHS 80% of all diagnoses can be attributed to their work. However, this is being remedied by the plans set out in Modernising Scientific Careers (2010) to institute the relevant professional examinations associated with legitimate professional bodies such as the Royal College of Pathologists and Academy of Medical Royal Colleges to further define and endorse health science as a recognised profession.

More recently, the exposure of professionalised public sector organisations, like the NHS, to New Public Management (NPM) reforms have introduced managers to carryout non-clinical managerial and administrative functions (O'Reilly & Reed 2010). Under these reforms, NHS managers are charged with leading cost cutting and efficiency initiatives, quality improvement with an emphasis on accountability through performance outcomes (Ferlie & Steane, 2002; Hood, 1991). These non-clinical managers (referred to as managers hereafter) however, are embedded in a historical context where the values of clinically based professionals are paramount and sacrosanct (Iedema, Degeling, Braithwaite & White, 2003). Thus, the implementation of these directives can place managers at odds with the clinical professions. This is further compounded by the view that while charged with authority in the organisation's formal management structure they are not seen as having specialist skill sets comparable to that of clinical professionals. A thorough account of the key elements and assumptions of NPM and its influence on professionals will be addressed in Chapter 5.

4.4.3 Managing Multiple Social Identities

Both IT and SIT link social structure to individual behaviour. However, SIT considers this link in greater detail via the multiple social identities and group memberships that an individual has, an area which IT does not satisfactorily consider (Ashforth & Johnson, 2001). Hogg & Terry (2001) state multiple social identities have an impact on an individual's behaviour and identification with in-groups and attitudes towards out-groups. Though possessing these multiple social identities and group memberships can create conflict between the respective prescriptive and proscriptive behaviours, beliefs and values for each category. Two views exist on how individuals manage these discrepancies.

First, Ashforth & Mael (1989) suggest individuals compartmentalise and segregate conflicting identities. However, this customarily results in double standards. Whereas other scholars propose the internalisation of identities into hierarchies of (1) *salience* reflective of an individual's readiness to act out an identity in a given scenario Ashforth & Johnson (2001). and (2) *centrality* reflective of the relative importance that an individual places upon a focal identity

compared to other identities (Murnieks, et al., 2012; McCall & Simmons, 1966). These hierarchies resolve identity conflict by allowing the individual to utilise different identities dependent on the context. In this manner while any one identity is salient or central at a particular time, they all remain inter-linked by exerting reciprocal influence. For example, Dutton et al. (1994) found that individual identity may be negatively impacted by organisational identity if organisational identification is strong and the individual perceives that their organisation's image is unfavourable.

4.5 Identities in Transition: Identity Tension, Authenticity & Credibility

From the above debates on the stability or fluidity of identity, hybridity and the existence of multiple identities, it can be deduced that understanding an individual's self-conception by focusing on a single archetypical or prescribed role or group identity (such as the healthcare professions presented in Section 4.4.2.2 above) alone may be problematic and simplistic. The modern world presents conditions that cause disruptions to self-concept such as, fragmented society, technological change, risk or the competing professional and organisational demands of 'managerialst' structures such as NPM. Some scholars have recognised these conditions as contributory to the erosion of prototypical identities that have traditionally been clearly demarcated through one's profession or employer (Giddens, 1991; Taylor, 1991).

It has been suggested that these conditions of modernity can cause identity tension as an individual is confronted with and struggles to balance multiple identity demands (Beech, Gilmore, Cochrane & Greig, 2012; Michlewski, 2008). For instance, an individual who is committed to an over-idealised nurse archetype may take issue with what are perceived as incompatible NPM objectives, can experience identity tension (Currie, Koteyko & Nerlich, 2009). As such, some scholars have started to document types of identity tension that can exist (Beech et al., 2012). Portrayals of identity tension in the literature indicate that identity demands can be experienced as contradictory or incompatible creating ambiguity and paradox for the individual (Kreiner et al., 2006; Knights & Willmott, 1999).

Understandably, identity tension is often characterised by some corresponding emotional and cognitive arousal (Kreiner et al., 2006; Alvesson & Willmott, 2002; Knights & Willmott, 1999).

Much research has sought to capture the manifestation of this ambiguity and paradox in individuals as their identification with multiple groups are eroded by change. These studies have contributed numerous concepts such as, identity threats (Tedeschi & Melburg, 1984), identity conflict (Roberts, 2005), devaluation and self-esteem (Ellemers, Spears, & Doosje, 2002; Breakwell, 1986; Tajfel, 1978) and legitimacy (Ellemers et al., 2002; Breakwell, 1986). However, yet again, where these studies have been conducted within healthcare organisations, medical professions have been the focus (Croft et al., 2015). Beyond this group there has been little research that has investigated the way other healthcare professionals, such as nurses, AHPs, healthcare scientists and managers, experience identity tension when faced with these disruptions.

Two identity-related concepts in particular were brought to my attention through my back and forth data analysis process (Miles & Huberman, 1984): (in)authenticity and credibility. Roberts (2005) states that individuals often attempt to maintain authenticity and build credibility concurrently. Authenticity refers to an individual's pursuit to live their life in a manner that is true to who they believe them self to be (Taylor, 1991). Costas & Flemming (2009) associate it with elements of originality, morality, freedom, a responsibility to one's self to act morally and inclusively towards others as they pursue who they believe themselves to be. Consider the identity confirming beliefs, values and work content encapsulated by a professional or organisational identity. These enable individuals to realise targets and perform work that aligns with a sense of who the individual is as a member of a professional group or organisation (Dutton, Roberts, & Bednar, 2010; Hall, 1971). This authenticity in turn manifests as integrity in their social identity (Pratt et al., 2006). Inauthenticity however, arises when there is a level of incongruence between the external expression of the aforementioned internally held experiences, thoughts, emotions, needs, wants, preferences, values or beliefs that define the authentic self (Roberts, 2005; Harter, 2002). It has been likened to deception, which increases an individual's cognitive

load as they must deal constantly with this inconsistency (Baumeister, 1999). Where an individual's ability to behave authentically is inhibited, employment can be identity-damaging (Costas & Fleming, 2009) or they maybe prompted to dis-identify from their profession (Pratt, 2000) with actions such as resigning.

The integrity afforded by authenticity is key as it is reflective of the expected or assumed credibility of the claims an individual makes about who they are. Credibility captures the extent to which others believe an individual's presentation of their personal or social identity is a reasonably accurate portrayal of his or her attributes (Schlenker, 1985). Research shows that credibility is essential to the social construction of identity because others must honour a person's identity claims in a given context (Foldy, 2003; Bartel & Dutton, 2001; Baumeister, 1999; Alvesson & Billing, 1998; Goffman, 1959). Identity claims increase credibility as they utilise references and details of socialisation, education, skills, history and tradition to enrich the illustration of the individual's professional or organisational self (Roberts, 2005; Ashforth & Mael, 1996). However, conditions of modernity can prompt changes in social context and corresponding relationships so that new identity claims can appear less credible as they may not support a prototypical identity or be convincingly portrayed by an individual. Taken together, where an identity that is perceived by the self and others as both inauthentic and non-credible, the individual is prone to experience negative consequences on their relationships, wellbeing and performance (Roberts, 2005).

4.6 Identity Work

Amidst conditions of modernity and the impact of varying demands on the self, individuals still require a consistent conception of who they are to be effective social actors (Watson, 2008; Krueger, 2007; Alvesson & Willmot, 2002). To achieve this Watson (2008) argues that seeking a coherent sense of self is something to be 'worked at.' This signals to a major line of enquiry on identity construction and/or adaptation that is born of the self-doubt, increased psychological load, existential worry and the scepticism when faced with others

and the struggle to establish a consistent sense of self: identity work (Alvesson, Ashcraft & Thomas, 2008; Watson, 2008; Kuhn; 2006).

Kuhn (2006) defines identity work as,

> *concentrating on actors' efforts to create a coherent sense of self in response to the multiple and perhaps conflicting scripts, roles and subject positions encountered in both work and non-work activity'* (p. 1341).

It subsumes the interpretive processes by which individuals form, repair, maintain, strengthen or revise their social identities in social contexts where they work to understand and perhaps influence, their various social identities (Sveningsson & Alvesson, 2003; Dickie, 2003; Ibarra, 1999; Van Maanen, 1997). Thus, identity work characterises identity construction as more complex than simply adopting a role or identifying with a group. Rather, identity work advocates a more dynamic and problematic view of how individuals construct an identity, which meaningfully situates them in the social world, versus the fixed, coherent and stable perspective discussed above (Pratt et al., 2006; Karreman & Alvesson, 2001; Mead, 1934).

4.6.1 Forms of Identity Work: Provisional Selves, Narratives, Resistance & the Emergence of Sensemaking as an Identity Work Process

Scholars have advanced various forms of identity work. Some involve physical or tangible displays of dress (uniforms for instance), office decor and personal objects (Kreiner et al., 2006; Pratt et al., 2006; Elsbach, 2003; Ibarra, 1999). Other forms of identity work manifest as more cognitively based strategies. Some include distancing the self from unfavourable identity attributes (Costas & Fleming, 2009), ideological shifts and social comparison (Ashforth & Kreiner, 1999), reflexivity (Cunliffe, 2002), attempting to optimally balance multiple identities (as discussed in Section 4.4.3 above) (Kreiner et al., 2006). Three identity work strategies that are theoretically relevant based on my findings are, experimenting with provisional selves (Ibarra, 1999), the use of narratives (Ibarra

& Barbulescu, 2010; Pratt et al., 2006; Sveningsson & Alvesson, 2003; Van Maanen, 1998) and resistance (Thomas & Davies, 2005).

With respect to provisional selves Ibarra (1999) draws on Stryker's (1980) proposition that the self can also be anticipatory. The individual considers, works to become and validate some future-oriented self they want (or do not want) to be. Thus, identity then also becomes concerned with questions of 'who I want or can be.' These possible or provisional selves serve as cognitive filters that allow the individual to weigh desirable or undesirable versions of the self that predict, incentivise and determine future behaviour in the individual's environment (Markus & Nurius, 1986). Provisional selves can serve as benchmarks, so that as one 'becomes' they can judge whether their behaviour as appropriate or in keeping with the identity they want to become (Ibarra, 1999).

Some scholars however, consider the self as being reflectively understood by the person in terms of her or his biography or self-constituting narrative of life (Brown, 2001; Giddens, 1991). *As such, identity work can occur through the construction of narratives that* subsume an individual's internalised and evolving life story as an ongoing integration of the reconstructed past with imagined future to provide the self with some degree of unity and purpose. Narratives as identity work use language effectively and persuasively in a myriad of ways, such as giving accounts, story telling, justifying actions, disclaimers and motive specific terminology, to explicate the identity problems an individual may face prior, during or after some life event (Pratt et al., 2006; Sveningsson & Alvesson, 2003; Van Maanen, 1998). As such, narrative identity studies have paid a great deal of attention to psychological adaptation and the construction of life stories that feature themes of personal agency and exploration (Ibarra & Barbulescu, 2010).

Finally, resistance is another possible identity work strategy that can be used in response to identity tensions (Bewes, 1997). Giddens (1991) argues that there maybe times when the modern world presents events that are so disruptive an individual may deem them too problematic or contradictory to meaningfully assimilate into their self concept. Resisting these disruptions is an opportunity for the individual to subvert and shift meanings to maintain a legitimate identity

consistent with their long-term narrative of life (Guy & Banim, 2000). Resistance may take the form of cynicism, which implies a refusal to engage with the social context (Bewes, 1997). Giddens (1990) proposes that despite disappointment with the circumstances created by disruptions an individual will continue to replicate the status quo and not change their behaviour. However, some forms of resistance are still considered to be under researched (Thomas & Davies, 2005). More specifically, contextualised forms resistance as well as those that present as routine, subtle and informal (Flemming & Sewell, 2002; Knights & McCabe, 2000).

Traditionally, perspectives on individual resistance take a pessimistic, passive and deterministic view where the self is pitted again some repressive authority (Thomas & Davies, 2005; McNay, 2000). In organisational studies this is usually framed as employees versus management control. Yet, scholars have observed there are few studies exploring how either of these groups actually resists change (Willmott, 1997; Alvesson & Willmott, 1996). Further, Thomas & Davies (2005) argue that this dualistic view of resistance is too simplistic. Instead, they propose that resistance is far more complex and multidirectional as it is stimulated by the ambiguity and contradictions created when the individual experiences identity tensions. This multidirectional characterisation represents an emerging area of research that seeks to understand the multitude of motivations individuals derive from critical reflection on their identities that would prompt them to resist.

It can be seen, the literature on identity work is substantial and the process has been envisioned from a multitude of perspectives. However, while the collection of identity work processes presented above represents a significant contribution to this line of inquiry, it is by no means exhaustive. As such, the processes by which people construct or adapt identities within themselves and in symphony with others in changing circumstances continue to be a burgeoning area of research (McGivern et al., 2015; Ibarra & Barbulescu, 2010; Alvesson et al., 2008; Lutgen-Sandvik, 2008; Kreiner et al., 2006; Pratt et al., 2006; Ibarra, 1999; Elsbach & Kramer, 1996). As such, my inductive analysis (Miles & Huberman, 1984) led me to relate my findings to an emergent concept that contributes to this

body of work that seeks to understand the complex ways in which individuals work to manage identity: *sensemaking* (Weick, 1995).

Sensemaking has been advanced as a means by which identity construction can occur. Identity construction processes like identity work have been hypothesised as an iterative process of sensemaking influenced by conditions of modernity and self-concept (Ibarra, 1999; Ashford & Taylor, 1990). Gendron & Spira (2010) propose that sensemaking and identity work are inextricably linked, as identity is key to translating how an individual experiences the resultant tension associated with conditions of modernity to develop new ways of thinking and acting. However, before I further expound on the link between sensemaking and identity work in Section 4.6.1.2 below, I first present the concept of sensemaking in Section 4.6.1.1.

4.6.1.1 The Concept of Sensemaking

Sensemaking has been defined as an individual's attempt to produce stability amidst continuous change by seeking explanations to justify their actions. Sensemaking, in other words, is an act of turning circumstances,

> *...into a situation that is comprehended explicitly in words and that serves as a springboard to action,* (Weick, Sutcliffe & Obsfeld, 2005; Taylor & Van Every, 2000, p. 409).

To respond to the continuity of change, the sensemaking process has been characterised as an on-going effort (Gephart, Topal & Zhan, 2010; Weick, 1995; Swann, 1984) by the individual to understand reality and context retrospectively (Louis, 1980), immediately and concurrently (Schroeder, Van de Ven, Scudder & Pouey, 1989) and prospectively (Cornelissen & Clarke, 2010).

So how do people make sense of an event or construct a sensible situation? The consensus in the sensemaking literature is that knowledge has a key function in how people make sense and what they make sense of. Weick (1995) proposes that

individuals can and do engage in two kinds of sensemaking that are dependent on two types of knowledge. The first is intersubjective sensemaking, which is,

> *essential for exploring new depths in an area for creating new connections among ideas for imagining new kinds of activities* (Dougherty, Borrelli, Munir & O'Sullivan, 2000, p.324).

Individuals strive to make sense of new and tacit knowledge gathered from changes in the environment, like technological change or new strategic paths such as policy change. By communicating their interpretations of these events they are able to discern what its attributes are as well as their varying perspectives on these events (Dougherty et al., 2000; Weick, 1995). However, the new cannot be made sense of without the old, that is, an individual's existing knowledge can aid in giving order to any new knowledge that has been accumulated. As such, the second kind of sensemaking according to Dougherty et al. (2000) is generically subjective sensemaking, which helps people make sense of codified or articulated knowledge that is already present in in the existing mental models, roles, norms, values, beliefs, routines and actions that they share.

Within the organisational context, Dougherty et al. (2000) found that utilising intersubjective and generically subjective sensemaking can impact the development of new products by linking the organisation's existing technological knowledge to changing environmental conditions. This is relevant from a CE perspective in that sensemaking can enable an existing organisation to assimilate new knowledge that can then be transformed into innovations, which are the basis of SE and CV. Dougherty et al.'s (2000) work, also makes a second significant contribution by de-anthropomorphising the organisation. In doing so, these authors recognise that it is the individual organisational members' sensemaking that drives idea generation, research, new product development and the management of these products under conditions of uncertainty. As such, sensemaking can be used as a framework for organisational members to,

> *comprehend, understand, explain, attribute, extrapolate and predict*, *environmental stimuli* (Starbuck & Milliken, 1988, p. 51)

This focus on the individual level of analysis is central to this present study, which aims to understand the 'individual in CE.'

Where both types of sensemaking suggest it is mainly a thinking process, scholars have indicated it is a cognitive mechanism so that it is an action processes as well. Gioia & Chittipeddi's (1991) study of strategic change yielded findings that established sensemaking as an individual activity that involved,

> *cycles of cognition and action* (p.443)

Louis' (1980) sociological perspective on sensemaking views it as a process whereby individuals use retrospective stories (similar to narratives) to explain and interpret the new (surprises that warrant explanation) and their subsequent behaviour. Schroder et al. (1989) contend that some kind of shock (similar to the precipitating events present in the SEE model in Chapter 3) stimulates people to pay attention and take a novel and appropriate action. Writing from an entrepreneurship perspective Cornelissen & Clarke (2010) argue sensemaking is also,

> *...prospective in the context of new ventures*, (p. 542)

That is, entrepreneurs show foresight as they use sensemaking to identify potential future opportunities and market conditions that require them to act to realise value creation. This is a useful perspective when one considers that CE can only emerge if organisational members recognise the need for organisational renewal and subsequently act to instigate renewal. Further, entrepreneurs are also able to communicate and make these future opportunities understood by others (Lounsbury & Glynn, 2001; Hill & Levenhagen, 1995).

4.6.1.2 Sensemaking as an Identity Work Process

In demarcating the conceptual domain of sensemaking, Weick (1995) states that on-going sensemaking is grounded in identity construction processes such as

identity work. Cunliffe & Coupland (2012) effectively summarise sensemaking as embodied efforts to figure out '*who we are'* and *'what to do.'* As such, sensemaking is prompted by three self-derived needs to determine and sustain the construction of a changing self-concept. The first is self-enhancement where one seeks and maintains a positive cognitive and affective sense of self. The second is a need for consistency and continuity. The third is to maintain or increase self-efficacy (discussed in Section 3.7.1), that is, one's belief in one's ability to succeed in specific situations based on self-perception and external experiences (Bandura, 1986).

It follows that identity construction processes such as identity work have been linked to sensemaking, as the self (consider the existing esoteric knowledge a professional obtains through education and socialisation can be utilised in generically subjective sensemaking) can influence how people organise changing circumstances (Mills, 2003). Coopey, Keegan & Emler (1997) advocate that in these new circumstances an individual struggles for identity consistency by contemplating the *'who I am?'* and *'what I do?*' questions which are essential to self-concept. Moreover, Weick et al. (2005) state that sensemaking captures the changing nature of self by bringing about future oriented questions of *'who I am now?'* and *'what should I do now?'* amidst new circumstances. In turn, individuals can lend meaning to existence and propel themselves to action. As the individual makes sense, they are able to organise,

> *the intrinsic flux of human action, to channel it toward certain ends, to give it a particular shape, through generalising and institutionalising particular meanings and rules* (Tsoukas & Chia 2002, p. 570).

This converts events into a plausible and understandable sequence to create a rational narrative. It is in these plausible narratives that identities emerge and the individual decides *'what should I do now?'* (Weick, 2012; Cunliffe & Coupland, 2012).

Consequently, the individual can establish new meanings and new patterns of behaviours. This suggests that sensemaking can act as an identity work

mechanism allowing individuals to re-craft their self-concept and ultimately re-establish a consistent sense of self. Though this organising process can be an individual activity, as an identity work process it takes into account that individuals do not make sense alone. An individual's identity is a discursive construction forged through a process of interaction as one presents some part of their self to others as they try to decide which self is appropriate in a given circumstance. Therefore, an individual's identity is formed and altered in part by (1) the cues they take from others, (2) how they believe others view the world and (3) the conduct of others based on these beliefs.

4.6.1.3 Sensemaking Mechanisms in the Identity Work Process: Noticing & Bracketing, Labelling & Communication

Though sensemaking is grounded in identity construction processes such as identity work, this nexus says little about how the process of organising and interpreting actually occurs. Consequently, scholars have sought to distil the moments or patterns of sensemaking that facilitate identity work. Maclean, Harvey & Chia (2012) demonstrate how sensemaking occurs through stages consisting of locating, meaning-making and becoming. Jeong & Brower (2008) propose that practitioner sensemaking develops through the three stages of noticing, interpretation and action, which varies based on their social relational contexts. Gendron & Spiro (2010) identify four interpretive patterns that characterise identity work: disillusion, resentfulness, rationalisation and hopefulness. Weick et al. (2005) provide a valuable contribution that refreshes the sensemaking domain by compiling a comprehensive descriptive framework of essential sensemaking mechanisms, so that individuals can make their world more orderly. Three basic moments in the sensemaking process that bore on identity work were brought to my attention through the induction process, Section 6.6.3 (Miles & Huberman, 1984): noticing & bracketing, labelling and communication.

4.6.1.3-1 Noticing & Bracketing in Sensemaking Identity Work

According to Weick et al. (2005) noticing and bracketing is the incipient stage of sensemaking. It is where individuals in changing circumstances extract cues and *'forcibly carve out'* the new meanings or interpretations that will guide their new course of action (such as being entrepreneurial on behalf of the organisation)

(Weick et al., 2005; Chia, 2000). This appears to be a particularly useful mechanism for selecting a course of action from the multiple identity demands associated with identity tension. Noticing and bracketing is guided by existing mental models, which represent an individual's current knowledge (used in generically subjective sensemaking) acquired during through life experience, such as, organisational or professional socialisation and personal backgrounds (Taylor & Van Every, 2000). Klein, Phillips, Rall & Peluso (2009) state mental models can guide noticing and bracketing as it augments an individual's ability to notice what is new in their changing circumstances. As actors are oriented towards the new, they are able to establish new mental models that can prompt the search for what is now expected of them (Weick, 1995). These new mental models will assist in guiding and shaping the new beliefs, values and behaviours the individual will adopt or relinquish as they adapt an existing identity or construct a new identity.

4.6.1.3-2 Labelling in Sensemaking Identity Work

Another organising feature in sensemaking is labelling. Chia, (2000) suggests labelling can be used by individuals as a strategy to stabilise evolving circumstances through,

> *differentiation, identification, classification, regularising and routinisation of the obdurate into a form similar to functional deployment,* (which suggests) *plausible acts of managing, coordinating and distributing* (p. 517).

In other words, labels organise events by providing individuals with a set of cognitive categories with corresponding behavioural typologies (Tsoukas & Chia, 2002; Weick, 2001). A particular label starts organising events as it generates homogeneity by prompting individuals to think and act in the manner the label suggests whenever it is deployed. Over time, this results in the systematic attachment of particular behaviours to particular actors in a given setting; for example, consider organisations that customarily use agreed upon labels, like doctor or nurse, to establish stable entities (Weick, 2001).

Yet, the cognitive and behavioural categories designated by labels are considered to have a high level of plasticity as they are socially defined by local circumstances (such as a professionalised organisation). Plasticity endows labels with a radial structure where categories are characterised by prototypic and peripheral features (Tsoukas & Chia 2002). If individuals adhere to the prototypic features of the category, stable behaviour is established and an unchanged identity persists. However, peripheral features tend to be more equivocal, making action less predictable, stable, consistent or definitive. This can be consequential for organising, as new circumstances may require individuals to participate in these unfamiliar peripheral behaviours. This can be reflective of identity work as the incorporation of new behaviours maybe indicative of the revision of actor's identity, such as changing work content.

4.6.1.3-2 Communication in Sensemaking Identity Work

Communication is another mechanism used to make sense and has been defined as the,

> *interactive talk that draws on the resources of language to formulate and exchange via symbolically encoded representations of circumstances* (Weick et al., 2005, p. 413).

Scholars with an interest in sensemaking devote much of their focus to talk, discourse and conversation as language constructs organise and (temporarily) stabilise reality (Maclean et al., 2012). Communication is representative of the view that sensemaking like identity work is never solitary (Weick et al. 2005; 1995). Rather, it is a powerful means by which social contact between the self and others is governed. Individuals present some contextually relevant version of their identity to convey what they think and how they should proceed in new circumstances. This highlights the importance of others in determining the self and what the self does, (Lutgen-Sandvik, 2008). During these patterns of two-way communication individuals are essentially talking events into existence by organising them into an understandable sequence (Taylor & Van Every 2000). Encoded in these communications is a basis for some new course of action to cope with new circumstances. This enables organisational members to translate

and marry their tacit knowledge pools into more usable forms such as policies, strategies or action plans that are relevant to the organisation.

4.7 Identity Perspectives on Corporate Entrepreneurship & Corporate Entrepreneurial Intention Formation

Recently, the value of identity concepts, such as those described throughout the sections above, in the field of entrepreneurship have been acknowledged by scholars. For examples of such works, please see Table 11. Within this nascent research stream, these identity-related constructs have provided frameworks for marking out founder identity typologies (Fauchart & Gruber, 2011; Cardon, Wincent, Singh & Drnovsek, 2009), for example. Other scholars have posited the usefulness of the different theories of identity as a means for furthering our understanding of entrepreneurship and improving theory development in the domain (Farmer, Yao, & Kung-McIntyre, 2011; Fauchart & Gruber, 2011; Hoang & Gimeno, 2010; Shepherd & Haynie, 2009; Navis & Glynn, 2007). In other studies, scholars have found that identity can guide various strategic decisions as well as the outcomes of entrepreneurial behaviour (Farmer et al., 2011; Fauchart & Gruber, 2011; Hoang & Gimeno, 2010; Navis & Glynn, 2007).

Author	Type of Paper	Key Concepts/Variables	Relevance/Contribution	Theoretical or Literature Base
Murnieks et al (2012)	E* Quant	Entrepreneurial Identity, Entrepreneurial Passion	Relationship between identity centrality and passion versus the relationship between identity salience and passion	General Management, Passion, Identity, Entrepreneurship
Hoang & Gimeno (2010)	C	Founder Role Identity, Career Transitions	How identity centrality and complexity affect individuals' ability to exit a work role in order to undertake founding activities	Entrepreneurship, New Venture Creation
Watson (2009)	E Qual	Entrepreneurial Selves, Entrepreneurship Discourse, Family Business, Identity Work	Linking and understanding the 'self' and 'social' aspects of entrepreneurs' identity work as influenced by societal discourse	Entrepreneurship
Shepherd & Haynie (2009)	C	Optimal Distinctiveness Theory, Entrepreneurial Identity	Develop and model strategies appropriate for managing multiple identities	Entrepreneurship
Cardon et al (2009)	C	Entrepreneurial Passion, Entrepreneurial Role Identity, Entrepreneurial Effectiveness	Conceptualising the nature of entrepreneurial passion associated with salient entrepreneurial role identities	General Management, Entrepreneurship, Passion
Farmer et al (2009)	E Quant	Entrepreneurial Identity Aspiration, Prior Entrepreneurial Experience	A model describing antecedents and outcomes of entrepreneur identity aspirations	Entrepreneurship
Navis & Glynn (2007)	C	Entrepreneurial Identity, Legitimacy, Investor Sense-making, Market Context,	Conceptual model focusing on the construction of the entrepreneurial identity and its effects on the interpretations and assessments of interested investors	General Management, New Venture Creation
Essers & Benschop (2007)	E Qual	Multiple Identities, Gender, Ethnicity	Processes of identity construction of female ethnic minority entrepreneurs	Entrepreneurship, Organisation Studies
Johansson (2004)	C	Entrepreneurial Identity, Narratives, Methodology	Superior utility of narrative approach as a method for understanding the construction entrepreneurial identities	Entrepreneurship
Down & Reveley (2004)	E Qual	Generations, Identity, Entrepreneurs	How entrepreneurial identity is shaped by generational encounters within a small organisation context	Organisational Studies
Cohen & Musson (2000)	E Qual	Culture, Discourse, Enterprise, Sense-making	How individuals construct and reconstruct material practices and psychological identities through the articulation enterprise discourse	Organisation Studies

** E = Empirical; C = Conceptual*

Table 11: Summary of Studies in the Identity-Entrepreneurship Nexus

A second limitation in entrepreneurship calls for further empirical studies to assist in theory development. Specifically, the need to better gauge the applicability of existing theories of identity to the multitude of settings encompassed by entrepreneurship such as CE, which is of particular interest to this thesis (Krueger, 2007; 2003; 2000). Much like the EI literature (Chapter 3), identity-entrepreneurship studies focus on 'pure' and unfettered entrepreneurship where the archetypal entrepreneur operates in the wider society rather, than individuals acting entrepreneurially within the confines of an established organisation. This limitation is further compounded by the persistence of the CE 'black box' that can be attributed to the anthropomorphisation of the organisation (Dess et al., 2003; Sheppard & Krueger, 2002). As such, a pre-occupation with the organisational level of analysis renders the 'individual in CE,' who they are, how they think and how they act, a markedly under researched level of analysis (Chapter 2). This is reflective of a burgeoning knowledge space that is revitalising the field. I contend that identity is one lens through which the growing interest in the 'individual in CE' can be enriched.

As per the literature presented above, identity can provide a contextualised view of the self. It links the individual to the social context represented by their organisation which, encapsulates the relationships, networks, organisational functions, products, services, strategic decisions, cultures and preferred outcomes that can typically constitute identity Navis & Glynn (2007). This is particularly relevant in professionalised healthcare organisations such as the NHS, as its member's behaviour seems to be indelibly influenced by the dominance exerted by the organisation and 'traditional' healthcare professions. Thus, in the context of both established and professionalised organisations, existing identities become paramount.

Further, organisational members' identity (past, current and future) can offer a fine-grained appreciation of what Krueger (2007; 2000) calls the organisation's underlying cognitive infrastructure or structures. Krueger (2000) asserts cognitive infrastructure is a critical antecedent of EI formation, primarily because it captures organisational members' values and beliefs towards aspects of CE that can hinder or facilitate CEI formation via negative, positive or neutral evaluations

of CE desirability and CE feasibility. Although some scholars have connected identity to general intentions (Fielding, Terry, Masser & Hogg, 2008; Terry, Hogg & White, 1999), the systematic review of the EI literature in Chapter 3 demonstrates researchers have yet to link identity specifically to EI or CEI. Thus, I propose identity can provide both a differential and augmented perspective on CE behaviour that can reduce parsimony and improve CEI's predictive ability.

Moreover, as discussed above, the frequency with which organisation scholars are addressing identity from a multitude of perspectives including organisational and professional is increasing. Thus, the true value of identity's fine-grained approach to CE and factors from the organisational context that can influence CEI formation is reflected in the multiple identities that inevitably constitute the social self. As each identity is constituted of and regulated by of its own set of beliefs, values and behaviours, each identity may prompt differing and/or reinforcing evaluations of CE desirability and CE feasibility. As such, my study will consider the implications of multiple co-existing corporate entrepreneurial attitude evaluations for CEI formation. In this sense, integrating identity with CEI could potentially be a fruitful avenue toward a more consistent treatment of the individual level of analysis in the CE literature.

A final and significant limitation is the propensity of the extant entrepreneurship literature to concentrate on an entrepreneurial identity once it has been fully established. That is, when an individual has already become an entrepreneur (Fauchart & Gruber, 2011; Cardon, Wincent, Singh & Drnovsek, 2009; Navis & Glynn, 2007). A noteworthy exception is the contribution Hoang & Gimeno (2010) make by using IT to shed light on how individuals construct a founder identity as they make career transitions. Similarly, Farmer et al. (2011) contribute by looking at the role of prior entrepreneurial experience in becoming an entrepreneur. My study contributes to this emerging line of inquiry as it proposes a view of organisational members' choice to participate in CE activity as being is grounded in identity construction that involves becoming a corporate entrepreneur by creating a corporate entrepreneurial identity.

From the preceding literature review one can glean that the process of 'becoming' or transitioning into new careers or by extension participating in new behaviours such as CE is complex and multifaceted. As such, it is important to disaggregate and examine which aspects of identity facilitate or hinder this transition in addition to how CE choice may be a product of identity work. This perspective provides this study with the opportunity to also contribute to the identity literature in several ways.

First, the evolutionary processes by which individuals adjust or adapt an existing identity to construct some new version of their social self are not yet fully understood. I empirically explore how CE is entered into as part of an identity work process whereby, in response to identity tension, an individual deploys efforts to achieve a consistent sense of self. In this thesis this process pertains to the tasks of (1) organisational members separating themselves from an existing in-group(s) (organisational or professional) and (2) organisational members re-working their identity to become a member of the distinctive out-group with a propensity to act as a corporate entrepreneur, which McGrath & MacMillan (1992) propose is necessary for CEI formation in Section 3.8.

Transitioning in to CE activity represents a rich and unique setting in which to understand identity work given the equivocality surrounding CE activity. First, there are restrictions that come from working within the confines of an established organisation that can act as a hostile environment to the new (discussed in Chapter 2). Such an effect is only amplified in a professionalised public sector organisation like the NHS (Section 4.4.2.1, a more in depth this context is forthcoming in Chapter 5). Second, Doolin (2002) states that identity is central to understanding the basis of clinician's reactions to attempts to change behaviour, for example, participating CE activity. One must consider the risk individuals face where they may no longer be seen as a legitimate group member for deviating from the prescribed behavioural script of their social groups. Third, career transitions can represent a disruptive force that prompts identity work to resolve identity tension and stabilise the self (Dutton et al., 2010). Here, a parallel can be draw with the precipitating events (Chapter 3) that displace the normal course of events, which are required by the SEE framework to prompt evaluations

of CE desirability and CE feasibility. Navis & Glynn (2007) state that identity defines and gives meaning to an entity. As such, identity operates as a critical organisational resource under the conditions of uncertainty or ambiguity created by precipitating events and disruptions. Identity therefore, is important in CE propagation, as early on as, the decision to choose an entrepreneurial course of action and the preliminary stages when CV and SE endeavors are little more than abstract concepts or inspiration, crafted by non-entrepreneurs transitioning to nascent entrepreneurs attempting to seize novel market opportunities.

Second, considerable research has documented the nature of career transition and the resulting identity tension experienced by doctors as they incorporate competing organisational initiatives into their professional values (Pratt et al. 2006; Doolin 2002). A by-product of this practice is minimal engagement with less dominant professions such as, nurses, AHPs and healthcare scientists. This limited approach is problematic when one considers that Ireland et al.'s (2009) CE model, Figure 2, proposes that the successful propagation of CE activity is the responsibility of every organisational member. Within this thesis I aim to redress this focus and consider the transitions of other professions after a precipitating event. This is in keeping with this thesis' bottom up approach to CE and the emerging trend in some CE models to use multiple levels of analysis to better understand CE propagation across the organisation (Ireland et al., 2009; Hornsby et al., 1993; Burgelman, 1983). Further, this will serve to enrich and extend my understanding of career transition and the identity issues that potentially bear on identity work as organisational members adapt their professional identity accordingly.

To enhance my understanding of the identity work performed by these organisational members in transition, I employ the concept of sensemaking. Sensemaking as identity work provides an opportunity to better understand the cognitive abilities of corporate entrepreneurs. Within the confines of this study the sensemaking process is viewed as being grounded in the discovery of who organisational members believe themselves to be, what they think of themselves and others and how they act (Weick et al., 2005; Weick, 1995). In turn, organisational members adapt or construct some new identity that includes CE

behaviours such as opportunity recognition or exploitation. This aligns with Jeliek & Litterer's (1995) proposition that to understand entrepreneurship at the organisational level, a paradigm that focuses on the individual sensemaking process of its members is required. Furthermore, as discussed in Chapter 3, CE activity can be theorised as a planned behaviour or a sequence of tasks stimulated by precipitating events. To participate in this planned behaviour organisational members may have to or be expected to overcome the prescriptiveness and biases of their current multiple social identities. Thus, organisational members must interpret these events and create and evaluate the multiplicity of new meanings associated with some corporate entrepreneurial version of their future self.

Finally, my study also presents a setting to gain further insight into the presumed stability and durability of identity by concentrating on resistance processes as a form of identity work. First, I intend to extend the existing research that pursues a more contextualised view of resistance. Thomas & Davies' (2005) study on identity construction and resistance suggests that the nature and form of resistance is determined by the on-going communication and discourse that occurs within a specific context. In turn, the form and emphasis of resistance will vary by social group. Where their study focuses on managerial identities, other scholars lament that resistance research has neglected certain groups of individuals (Thomas & Linstead, 2002; Willmott, 1997; Alvesson & Willmott, 1996). To remedy this, I consider the multiple social groups organisational members may belong to. By capturing reflections of their multiple social identities, I will examine how individuals as part of a social group counter the paradox associated with identity tension to regain a secure sense of self via resistance. Further, I will consider whether resistance processes vary from one identity to the next. This challenges the underlying assumption in the literature that the vulnerability and ambiguity associated with identity tension will inevitably trigger identity transformation (Croft et al., 2015).

4.8 Conclusion

From the above literature review it can be seen that identity has long been promoted as a novel interpretive frame to understand how organisational

members navigate issues surrounding the self in a workplace context. In this sense integrating identity with CE and CEI is a potentially fruitful avenue towards a more consistent treatment of the individual level of analysis to illuminate the persistent CE 'black box.' Yet, though the body of knowledge on identity is extensive, some gaps still exist that require continued conceptual and empirical consideration by scholars. Specifically, questions that surround the stable or malleable nature of identity, the identity tension created by events that thwart the normal progression of identity and finally the identity work processes by which these tensions are minimised or resolved. It is only in illustrating organisational members understandings of their multiple social identities that a deeper understanding of how CE propagation can be hindered or facilitated can be gained.

CHAPTER 5: NEW PUBLIC MANAGEMENT: ENTREPRENEURIAL PERSPECTIVES FROM THE NATIONAL HEALTH SERVICE

5.1 Introduction

This chapter aims to give an overview of the context in which this study will be conducted: the National Health Service (NHS). In doing so, I bring much needed depth and dimensionality to the Large East Midlands Trust (LEMT) by grounding the state of the case in the history, politics and policies of the wider NHS organisational context. This is necessary to define the NHS as a special contextual variant, which is largely missing in the CE (Phan et al., 2009) and EI (Sheppard & Krueger, 2002) literatures. The NHS is the largest and arguably most important public sector organisation in the UK, which exhibits its own range of complex behaviours, management hierarchies, structures, strategies and processes. To demonstrate this I will present a synopsis of the modernisation of the NHS via the New Public Management (NPM) reforms over the past 35 years. NPM represents governmentally driven attempts to devolve central control and create an enterprise culture through the application of private sector management techniques to the provision of public services. The tensions this has created for organisational members will be presented, followed by the intersection of CE and NPM.

5.2 The Inception of the NHS & the Introduction of Managerialism

The NHS was established on July 5th 1948. It was equipped with administrative structures to provide universal healthcare for all British citizens based on three founding principles (1) that the NHS meets the needs of everyone (2) that the NHS be free at the point of delivery and (3) that the NHS be based on clinical need and not the ability to pay (NHS, 2013; Klein, 2001). The NHS began as a monolithic centralised hierarchy where service provision units were run by a administrative team usually consisting of a Medical Chairman, Matron and Administrator (Edwards, 1995). Since its inception however, the NHS has

undergone several drastic overhauls in response to evolving public need and opinion and economic inefficiency.

The post-war era of the 1950s found the UK public service user had markedly changed. They were now more affluent and had growing expectations of their public services and the NHS was no exception (Ferlie & Fitzgerald, 2002; Klein, 2001). With the demanding nature of patients increasing, it seemed inevitable that it would be accompanied by a growing feeling of discontent with the traditional NHS public administration structure. This dissatisfaction with the NHS was largely attributable to the bureaucracy, resulting inefficiency and central control exerted and perpetuated by Government handing down policy edicts developed in isolation and without the impetus of critical stakeholders. This created the impression that public officials were generally acting in their own interest, rather than that of patients, as a result they were often seen as inefficient and incapable of achieving service change (Pollitt, 1993). Consequently, this generated an anti-bureaucratic public sentiment condemning the system as slow, inefficient and unresponsive to public need (Hughes, 2003; Lane, 2002; Dawson & Dargie, 2002; Hood, 1974). Politicians however, viewed supporting the changing demographic of NHS service users within the existing service configuration as inevitably unsustainable. This was evidenced by the increasing expenditure trends that were largely driven by clinicians, mainly doctors, whose primary concern is determining the patient's course of treatment and care pathway and not the cost of these (Doolin, 2002). As such, the growing consensus in government was that some strategy or means was needed to exert control over clinicians.

These problematisations of the NHS were articulated in the NHS Management Inquiry Report (Griffiths, 1983). This report cited several issues that reflected poorly on the administrative structure of the NHS. These include a lack of service evaluation, central guidance, performance, economic efficiency and leadership from NHS administrators. The growing urgency to mitigate these issues was met with a rather progressive proposition that required a fundamental shift from the dominant NHS logic. Specifically, the report called for the redesign of the system so it was free from central control with the goal of fostering the devolution of authority, responsibility and accountability to the service provision units in the

system. This signalled the start of what is arguably the biggest cultural shift in the NHS since its inception from administration to *managerialism*.

Managerialism assumes that private sector culture and practices are innately superior to those utilised in the public sector. As such, its advocates the adoption of private sector techniques, culture, reducing professional control, establishing competition and prioritising efficiency to facilitate effective service provision in the NHS (Ferlie, Ashburner, Fitzgerald, Pettigrew, 1996). Uptake of this new logic would be dependent on both the introduction of general managers (a professional group previously discussed in Section 4.4.2.2 and the transfer of authority over and responsibility for service provision from clinicians to these managers (Flynn, 2004; Rivett, 1998). Unlike the regulation enforcement duties of administrators, managers would act as change agents that sought to maximise efficiency and responsively allocate resources as needed (Keeling, 1972).

5.3 New Public Management in the NHS

The UK government's utilisation of private sector general management practices share similar ideologies to reforms seen globally. For instance, the United States of America's (USA) 'Reinventing Government' movement advocates competition, market mechanisms, an empowered citizenry, promoting consumer choice, decentralising authority and measuring outcomes (Osborne & Gaebler, 1992; DH, 1989). Though the priorities and processes for achieving bureaucracy reform may vary from country to country, a shared need to improve responsiveness to public need and reduce economic unproductivity still exists. As such, it was Hood (1991) who proposed deploying the heuristic label 'New Public Management' (NPM) to collectively capture the common, overlapping and interchangeable ideological concepts and practical interventions, which underlie these modernisation reforms. The central features encompassed by NPM have been summarised in Table 12 below.

NPM Tenets	Meaning
Professional Management	Clear, visible control and accountability, no diffusion of power
Performance Measures and Standards	Defined, quantifiable goals and outcomes which helps measure accountability
Emphasis on Output	Resources and budgets are linked to performance outcomes, results are more important than process
Decentralisation	Breaking down large units, decentralising public sector budgets, separating provision and production
Competition	Contracts and competitive tendering to decrease costs and increase standards
Private Sector Management Practice	Hiring and recruiting from the private sector, using 'proven' management techniques
Resource Budgeting	Cutting costs, achieving better outcomes with less resources

Table 12: Tenets of New Public Management (Hood, 1991)

From Table 12 it can be seen that NPM modernisation strategies do not align with the attributes of a traditional public service. Instead NPM is reliant on the premise that when the appropriate management techniques are applied, social service objectives can be fulfilled at a significantly reduced cost while increasing efficiency and effectiveness (Ferlie & Steane, 2002). Some authors consider these interventions to be a form of 'entrepreneurial governance' tailored towards this public sector context (du Gay, 2004, 2000; Osborne & Gaebler, 1992). Therefore, almost all of the NPM reforms deployed by consecutive Conservative and Labour Governments in the UK throughout the 1980s and 1990s have been intent on altering the institutional context of the NHS in favour of an enterprise culture.

Propagating a culture of enterprise in the NHS started in the late 1980s when the Conservative government sought to both alter the form of the NHS while fostering specific entrepreneurial characteristics that would define the organisation's conduct and govern its relationships. Essentially, the monolithic bureaucracy of the NHS was fragmented so that service providers were separated from their purchasers (DH, 1989). This created multiple smaller business units that would ultimately go on to constitute a new internal market within the NHS and stimulate competition amongst them. The current Coalition government sets out the most recent configuration of this contractual relationship between NHS

organisations in Equity and Excellence: Liberating the NHS (DH, 2010). Clinical Commissioning Groups (CCGs) have been formed with the function of purchasing services from acute Trusts (which are the setting for this this study). Equity and Excellence expounds the virtues and utility of an enterprise culture and entrepreneurship for navigating the increasingly hostile economic conditions post the 2008 economic crisis stating,

> *We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises.* (Equity & Excellence: Liberating the NHS, DH, 2010, p.5)

Foundation Trusts (FTs) were introduced by the previous Labour government as a commitment to the decentralisation and devolution of public services (DH, 2005). FT status was touted as a goal that NHS Trust's should aspire to. As an organisational form it afforded greater internal governance and financial autonomy (such as generating alternative revenue streams via borrowing from private institutions or developing tertiary services) in a manner that more closely mirrored the private sector. In turn this would enable FTs to be proactive in meeting the needs of the local markets being served in a patient-led NHS. It should be noted that in retaining the FT concept the Coalition Government has made FT status adoption mandatory for all existing Trusts. Possibly the most salient point in the Equity and Excellence is that financial under performance would be grounds for decommissioning a service provider.

This policy is indicative of the corporatisation of NHS organisations via NPM through the use of performance indicators. The performance indicators used to set out clear and assessable service objectives and outcomes were based on the Business Excellence Model, widely used by leading companies in the private sector (Ahmad & Broussine, 2003; Blair, 1999; Boyne, 1998). In turn, organisational effectiveness was closely monitored and enforced within an economic rationality and statistical and quantifiable outcomes framework (Hughes, 2003; Lane, 2002). Further, the redefinition of the contractual

arrangements between organisations via marketisation and competition suggests that responsibility and accountability for the performance of these smaller business units are attributed to some collective or individual in the organisation. In doing so, du Gay (2004) argues the control exerted by NPM tenets subverts the orientation and ethics of the collective or individual so they become complicit in adopting an identity that can be characterised as entrepreneurial in nature. Descriptively, the beliefs, values and behaviours attributed to such an identity include being less risk-averse, innovative, responsive and creative (Osborne & Gaebler, 1992).

5.3.1 New Public Management: Transferability & Effectiveness

As might be expected, questions of transferability indelibly plague this amalgamation of private sector practices with universal healthcare provision. These questions arise primarily because NPM is reliant on the premise that the generalist management techniques from the commercial sector are superior to those of public administration (Doolin, 2002). Blair (1999) loans credence to this assumption in Modernising Government where NHS managers are advised and actively encouraged to build their credibility by adopting private sector management styles and values. Despite these claims however, it cannot be denied that these techniques and values have ultimately been developed in a commercial context that is not always comparable to the non-commercial sector.

Thus, scholars often debate whether private sector theories and models of management are an appropriate tool to satisfactorily support a responsive patient care system (Pollock, 2005; Hunter, 1996; Wilkinson, 1995). Especially, as measures of health or quality are often subjective and not always clearly defined by policy makers making them difficult to quantify (Dawson & Dargie, 2002). As such, questions of direct transferability to a tightly centralised, professionalised public sector context that is constantly revised to address the newest public priority and governmental policy, still pervade (Currie, Boyett & Suhomlinova, 2005). This complexity is further enhanced by the emotional dimensions and service values, which uniquely define the public sector (Hoggett, 2006; Lane, 2002).

It follows that with questions of transferability come questions regarding the effectiveness of NPM in resolving the aforementioned bureaucracy and professional control problematisations of the NHS. First, NPM implementation was essentially driven from the top-down by the government and DH to propagate change and enforce policies. As such, some scholars recognise a paradoxical effect where mandates to shed bureaucracy are enforced by the same hierarchical centralised control structures (Hoggett, 1996). The fragmentation of departments and the devolution of accountability to numerous business units has bred additional bureaucratic management hierarchies that operate in silos, which are difficult to coordinate, sometimes duplicate functions and are expensive to run (Dunleavy, Margetts, Bastow & Tinkler, 2006). Further, these smaller businesses units do not instil the same sense of stability, continuity and coordination, which are positive characteristics of quintessential public sector institutions like the NHS (Dunleavy & Hood, 1994). For instance, consider the decommissioning of the Primary Care Trusts (PCTs) that were responsible for service purchasing prior to the CCGs implemented by the Coalition government. Weber (1947) argues that though bureaucracies are often criticised for rigidly following rules, which leads to inefficiency, in reality they represent one of the most rational and effective organisational structures in existence. This makes them fundamental to the efficient coordination and control of the public sector resources. Thus, some scholars suggest that despite the tenets of NPM, bureaucracy can and will endure in complex organisations (Olsen, 2006; Meier & Hill, 2005).

Additionally, attempts to reduce bureaucracy in accordance with NPM principles require the transfer of authority and accountability to the senior politicians and managers who generate and enforce government policy (Hood, 2005). This place clinicians under managerial control, forcing them to conform to standardisation and measureable outcomes (Broadbent & Laughlin, 2002; Rivett, 1998). Broadbent & Laughlin (2002) highlight that healthcare professionals often resist the use of NPM performance indicators, for several reasons. Performance indicators require healthcare professionals to view patients as markets, which is at odds with their professional values. Further, focusing on the observable and quantifiable aspects of treatment creates more bureaucracy and procedural paperwork that reduces the time that can be devoted to service provision

(Harrison, 2004; Hoggett, 1996). Finally, benchmarking and accountability perpetuates a system of continual monitoring though audits and inspections that signals that it values outcomes more than the service process. Cumulatively, these issues have served to undermine professional autonomy, reduce job satisfaction and morale over time (Broadbent & Laughlin, 2002; Hoggett, 1996).

However, this shift in authority and accountability under NPM became even more problematic as governmental policies now had to be enacted by the same healthcare professionals that were now at the bottom of the formal hierarchy (Meier & Hill, 2005; Dawson & Dargie, 2002). This granted healthcare professionals the opportunity to wield the considerable informal authority they had garnered at local levels and regulate the nature and pace of reform (McNulty, 2003). This can incite conflict between managers and professionals as each group seeks to establish or maintain their authority. Further, as covered Section 4.4.2.2 the dominance of the medical profession is indicative of the clear professional hierarchy that exists in the NHS. This hierarchy furnishes doctors with rather more influence than other healthcare professionals. Whilst other professions, (nurses for instance, see Section 4.4.2.2) are particularly susceptible to the control and influence of general managers, doctors do have a role in setting targets associated with reform for their organisation. This can prove to be disruptive as it upholds the public administration status quo where doctors may see some managers as ineffective and circumvent their authority (Currie & Suhomlinova, 2006; Klein, 2001). Though the emergence of managerial-professional hybrids (Section 4.4.2.1) such as, Clinical Directors in the NHS, has partially mitigated this problem, these hybrids exert even more influence other healthcare professionals than managers. Ferlie & Geraghty (2005) attribute this to a hybrid's penchant for blending their professional values and ethics with the achievement of management initiatives. As opposed to the resistance that can manifest when healthcare professionals are unable to balance both their accountability to patients and the public's best interest as well as being accountable for implementing government policy they deem to be misguided (Hoque, Davis & Humphreys, 2004).

As previously discussed, autonomous professional managers who are 'free to manage,' innovate and be agents of change locally, are critical to the success of managerialism in the public sector. However, the continuity of central control restricts managerial autonomy by demanding conformity to governmentally determined performance outcomes. However, it is managers not politicians, who are held personally accountable for achieving these performance outcomes and under performance is often rewarded with termination (Hughes, 2003). Therefore accountability (the process by which citizens can hold public servants and managers legally accountable for their actions and service performance thereby preventing corruption) seems to be a two edged sword (Aucoin & Heintzman, 2000). Managers find themselves caught in a culture of blame that ultimately discourages managerial autonomy and hinders NPM. Moreover, though managers have been charged with acting innovatively they are rarely included in the decisions that are made by politicians. This creates the impression that professional managers are relatively insignificant as they are merely passive participants who are subjected to organisational forces beyond their control, dependent on a politically created culture and not the purveyors of innovation and change touted by NPM (Currie et al., 2008; Currie & Lockett, 2007).

5.4 Post New Public Management

From the above it can be seen that the desired effect of NPM implementation was not always achieved. Thus, as a strategy for NHS reform, its effectiveness is contestable. Yet there is the growing sense that after decades of reform, NPM has been remarkably successful in one regard. NPM has become so embedded in the UK's public sector and in the NHS in particular, that its removal maybe virtually impossible (du Gay, 2006; McNulty & Ferlie, 2004; Ferlie, Hartley & Martin, 2003; Ferlie & Fitzgerald, 2002). This notion has been reflected since the late 1990s where post-NPM models began surfacing in the NHS under the New Labour government. Post-NPM strategies are novel solutions that favour lateral versus vertical modes of organising with the aim of rectifying and challenging NPM policies while still utilising NPM's existing esoteric language, structures and techniques (du Gay, 2006; Dunleavy et al., 2006; McNulty & Ferlie, 2004; Ferlie, Hartley & Martin, 2003; Ferlie & Fitzgerald, 2002).

Within the NHS a range of interrelated post NPM strategies have emerged including, the need for networks of organisations (Ferlie, Fitzgerald, McGirven, Dopson & Bennett, 2013), partnership working between organisations (Sullivan & Skelcher, 2002) and process redesign such as business process reengineering (McNulty & Ferlie, 2004). Of particular interest to this study however, are the post NPM policies that focus on the individual level of analysis, specifically those that emphasise the importance of involving clinicians in organisational decisions. Thus, there has been a shift from the importance of managers to the importance of leaders as being key to the delivery of an effective, efficient and innovative health service. Such policies aim to to enable clinicians so they may reclaim some of their professional autonomy (NHS, 2014; DH, 2009; Darzi, 2008). The type of leadership that has been encouraged in the NHS by its governments has been characterised as dynamic, inclusive of transformational aspects (vision and charisma) and entrepreneurial aspects that utilise the EO construct discussed in Chapter 2 (innovation, risk-taking and proactiveness) (Currie et al., 2008; Darzi, 2008; Currie et al., 2005). More recently, the Five Year Forward Plan (NHS, 2014) announced a continued commitment to leadership by investing in research, training and development of NHS staff via the NHS Leadership Academy and NHS Improving Quality.

Yet, Borins (2000) found that public sector leaders are still unable to effectively lead as the organisational confines continue to be hostile. Mainly because, the barrier of tight central control and accountability discussed previously remains. Leaders in the formal structural hierarchy are still accountable to achieve performance targets set by politicians. This ensures that distributed leadership is limited in favour of individualistic leadership. Several studies have shown that this approach does not propagate innovation or risk-taking. Rather it is counter-intuitive to the distributed, transformational, collective leadership advocated in current policies (Currie, Lockett & Suhomlinova, 2009; Bolden, Wood & Gosling 2006; Currie et al., 2005). Similarly, professional leaders are hindered from taking innovative risks due to the aforementioned blame culture and negative influence of and resistance to performance indicators (Javidan & Waldman, 2003). Ultimately, leaders are not attempting to act in a transformational manner

by initiating change (setting an entrepreneurial strategic vision for instance), instead they only implement and enforce the regulations and rules of policy makers. As such, the extent to which NHS managers and professionals are able to successfully enact leadership also continues to be unclear (Currie & Lockett, 2007).

5.5 Corporate Entrepreneurship & New Public Management

The previous sections have sought to explore the attempts of consecutive UK governments over the past three decades to institute the virtues of enterprise in to the nation's public sector organisation, specifically the NHS. The literature provides a conception of enterprise/entrepreneurship, as it exists in a large established non-commercial organisation. As such, NPM can be viewed as a bespoke form of organisational entrepreneurship similar to CE. Amidst the on-going debates about the limited success of NPM and post-NPM strategies, it is clear that much consideration has been devoted to understanding how NPM has impacted clinical and non-clinical professionals in NHS organisations. A significant work that has successfully captured the relationship between NHS professions and NPM discourse is that of Cohen & Musson (2000) during a significant period of NPM reform in the 1990s. In their study, the authors investigate how enterprise discourse can constitute an individual's identity as it influences the construction or reconstruction of the prescriptive and proscriptive beliefs, values and behaviours of general practitioners.

This thesis however, has been conceptualised from the literature on organisation level entrepreneurship in the commercial sector, CE. Comparatively, from the literature review presented in Chapter 2, the concepts and models that constitute CE concepts are very different from those that inform the descriptive and prescriptive research on NPM in the management and public administration literatures. Granted my use of CE perspectives in this study could come under fire for the same criticisms of NPM as CE models and concepts have also been developed in the private sector. However, I argue the value of the CE-NPM intersection is fivefold.

First, CE does not represent a drastic philosophical shift as it has long been recognised by CE scholars as a moderate form of entrepreneurship. Mainly because CE is continuously curtailed by the hostility of the organisational confines towards the 'new' as well as the organisational growth paradox (Section 2.3.1.2). Second, the public and private sectors can often no longer be clearly distinguished. Conditions of modernity, such as the market driven reforms of NPM and the realities of financial constraints after the 2008 economic crisis, are now active in eroding this boundary. As such, public service values, such as equality, representation and citizenship are being marginalised in the quest for efficiency, profit and competition (Dawson & Dargie, 2002; Haque, 2001; Stewart & Walsh, 1992). Third, Chapter 2 indicates that the CE domain suffers from contextual homogeneity, which generally limits theory development and application (Zahra, 2007). Fourth, where NPM espouses the need for managers and now clinical leaders to be agents of change and champions of innovation, the nature or type of the changes/innovations that manifest as organisational phenomena remains vague. CE however, provides a specific typology of CE phenomena (Section 2.2.2) that are based on different types of innovations (radical, incremental, process, product or service) that are the basis of CV or SE as a strategic option. Finally, unlike NPM research, which has extensively probed organisational members, CE lacks a comprehensive understanding of its organisational members. Therefore, by studying CE in the NHS context, the NPM literature can augment the CE literature by lending granularity to the individual level of analysis as it suggests critical factors and that should be taken into account when considering the 'individual in CE.'

An NPM perspective on organisational members however, appears somewhat nihilistic, especially as the success of NPM can be viewed as limited and contestable. From the above discussion it can be seen many studies capture the negative effect of NPM on the organisational architecture and members. Conversely, CE has been firmly associated with improved organisational performance (Antonicic & Hisrich, 2001; Lumpkin & Dess 1996; Zahra, 1995). Thus, CE can be viewed as a potentially valuable alternative perspective on organisational entrepreneurship than NPM. As such, CE research has a more

positive outlook where much of the domain is focused on how to propagate CE and has emerging lines of inquiry into understanding organisational member's role in CE via entrepreneurial choice. It is this divergence in perspective where to me, the most striking difference between CE and NPM crystallises.

The introduction of NPM and the propagation of enterprise culture has been an attempt to merge private sector discipline with governmental control (du Gay, 2004; Kanter, 1990). A recurring theme in this nexus is how governmental control has systematically stripped NHS organisational members of their autonomy, professionally or managerially. Arguably, large established commercial organisations exert control as well through risk management to maintain their strategic and competitive positioning. However, Burgleman's (1983) pivotal work states it is the 'autonomous strategic initiatives' of individual organisational members that are a critical bottom-up process for the emergence of CE. More recently, Lumpkin et al. (2009) indicate that autonomy is a necessary antecedent of entrepreneurial activity. Similarly, Goodale, Kuratko, Hornsby & Covin (2011) state critical entrepreneurial behaviours such as opportunity identification are usually best recognised by organisational members who have discretion over their work.

I submit that this incongruity goes directly to the crux of this thesis, which uses a bottom-up approach to understand how CE can be developed in the NHS and what are the barriers and facilitators to its enactment. Especially, when the loss of organisational member's autonomy, increased bureaucracy and continued central control can be traced back to and top-down initiatives like NPM. Further, the literature's understanding of the extent to which current bottom-up post NPM strategies, like leadership development, are having the desired effect is still limited at best.

5.6 Conclusion

Arguably, of all the public services in the UK, the NHS has undergone the most drastic organisational reconfiguration in the last three and a half decades. The entire NHS it seems has been influenced by NPM reforms including competitive markets, measurable performance outcomes and managerial control. In addition to the corporatisation of the NHS through the introduction of language and culture used in the private sector. However, many tensions still exist and remain unresolved, which have been created by the intersection of the traditional organisational architecture and values of the NHS with contemporary commercial management models. For instance, the complex and diverse nature of the NHS organisations will be inevitably reliant on some form of bureaucracy and hierarchical control to deliver quality services nationally with a high degree of consistency or uniformity, which can contradict perspectives or ideas typically seen in CE. Additionally, the pervasiveness of excessively tight political control has proved problematic for clinical professionals and managers attempting to maintain and exert autonomy. This remains a problem even with the deployment of mitigating post-NPM strategies that advocate a shift from management to leadership. Despite this, it cannot be denied that there is a return to the significance of clinical professionals as they are encouraged to work with managers to deliver services in an entrepreneurial manner (NHS, 2014; DH, 2010). The extent to which these reforms have filtered down to and are successfully reflected in the managerial and clinical organisational members in service provision units like LEMT will be explored in the remainder of this thesis.

CHAPTER 6: METHODOLOGY

6.1 Introduction

This thesis aims to address the research question:

> *How can corporate entrepreneurship be implemented in the National Health Service and what are the barriers and facilitators to its enactment?*

To this end, in the previous chapters I have discussed models of corporate entrepreneurship (CE) in Chapter 2 and entrepreneurial intentions (EI) formation models in Chapter 3, to outline a theoretical framework to guide my examination of CE propagation at the individual level of analysis. Based on the research question and the gaps found in the literature, this research is guided by three objectives:

1. To understand how the individual chooses to engage with CE in a large mature organisation.
2. To apply EI formation models to the organisational context as a possible framework to draw out understanding of how individual organisational members make the entrepreneurial choice.
3. To identify and examine the contextual factors from the LEMT case study that can hinder or facilitate EI formation in the organisational context, or what might be thought of as 'corporate entrepreneurial intention' (CEI) formation.

This chapter discusses the research methods that are most appropriate to achieve these objectives in addition to the theory behind these methods, which Walliman (2001) states is the essence of methodology. This chapter has six sections. I start by outlining my motivation for investigating the NHS context, via its service provision unit, Large East Midlands Trust (LEMT), using the *interpretivist* research philosophy, in Section 6.2. This is followed by a discussion of the *qualitative* methodological approach used to empirically probe the case and extend theory, in Section 6.3. In Section 6.4 I present my research strategy,

namely a *single case study with embedded units* probed over two phases of data collection. Section 6.5 addresses quality assurance considerations in qualitative research followed by the data analysis considerations and methods that best serve my research questions and contribute to theory in Section 6.6. Last, the chapter concludes with a brief summary in Section 6.7.

6.2 An Interpretivist Approach to Corporate Entrepreneurship & Corporate Entrepreneurial Intention Formation Research

Research philosophy relates to both the development of knowledge and the nature of knowledge (Saunders, Lewis & Thornhill, 2007). It embodies assumptions that underpin how a researcher sees the world, their research strategy as well as the methods they then employ to interrogate their subject matter. Researchers present their research philosophy in terms of ontology and epistemology, which they subsequently link to their research methodology. In the remainder of this section I will set out the research approach I have taken for my study by outlining the tenets of *interpretivism* and how it relates to my enquiry. Next I will present the qualitative methodological approach with which interpretivism is usually used to understand the 'individual in CE' and CEI formation.

Morgan & Smircich (1980) state that all approaches to social sciences are based on interrelated assumptions about ontology and epistemology. The reviews of the CE and EI literature reveal a widespread use of positivist epistemology that use quantitative methods where theoretical propositions are manipulated using formal logic and hypothetico-deductive logic (Lee, 1991). This indicates that, ontologically, these researchers view knowledge as fixed and 'out there,' being independent of an observer's understanding. Counter to this perspective, my research takes the ontological stance that knowledge consists of social properties that are phenomenological outcomes of the interactions and experiences between people (Gill & Johnson, 2002). The implication of such an ontological view is that epistemologically, knowledge is attained from the individual participant in action and the 'products' that document them (Tadajewski, 2004). Interpretivism is one such epistemological paradigm that subsumes the ontological perspective just described. The thesis will be completed in this tradition of for two reasons:

(1) the chosen individual-level of analysis; and (2) the unique context in which these individuals are engaged.

First, the main strength of interpretivism is that it suggests knowledge is created and understood from the point of view of the individual. This allows the observer to understand the actual production of the meanings and concepts used by social actors in real settings. This aligns with my study's governing theoretical framework, which focuses on understanding how individual organisational members in a universal healthcare context chose or not to enact CE phenomena by forming CEI. As such, an interpretivist approach supports this effort as it can facilitate the intimate proximity to organisational members required to understand what factors have a role in their entrepreneurial decision-making process. Ultimately, this will provide a deeper understanding of CE enactment than the extant CE or EI literature provides. This offsets the critique of organisational research of neglecting the individual in favour of overarching reductionist explanations (Morgan & Smircich, 1980).

Further, because interpretivism seeks individual perspectives rather than overarching reductionist explanations, it is able to accommodate the notion that a diverse range of meanings can exist in a given context. As such, interpretive research describes how different meanings held by different persons or groups produce and sustain a sense of truth, particularly in the face of competing definitions of reality. This is particularly useful as the LEMT organisational members participating in this study are NHS civil servants and not the private sector managers who are usually sampled in CE research or individuals who are not bound to an organisation in the EI literature. Arguably their choice to work for an organisation much less a public sector organisation and not themselves suggests they attach their own meanings to entrepreneurship or have differing motivations. This array of meanings will in turn influence how people understand and respond to their social and historical context and ultimately their perceptions of CE desirability and CE feasibility. This is evidence of Astley's (1985) argument that any knowledge generated during the course of interpretivist research is not objective but a social artefact unique to that particular context.

Second, an interpretivist approach is equipped to disentangle not only the richness and significance of the individual actor but also the context that surrounds them. This is particularly useful when the NHS context, to which this study is inextricably linked, is considered. As discussed previously, the CE and EI literatures are based on traditional and homogenous contexts: CE in large mature private sector organisations and EI on the individual in the wider society who may want start a new venture. However as a taxation-funded institution with a social mission, the NHS represents a context that embodies its own bespoke external and internal characteristics that may prove challenging to CE enactment and CEI formation. Therefore the NHS context presents a potentially fruitful outlier context that can propagate *'socially robust knowledge'* (Starkey, 2002) by producing a range of new factors that can influence CEI formation. Furthermore, context poses a very specific challenge to the positivist approaches that dominate both the CE and EI literatures. Thus, this research aligns with the growing consensus that process versus variable conception of CE activities can revitalise the field (Corbett et al., 2013; Russell, 1999; Burgleman, 1983). This suggests that epistemological approaches such as the interpretivist-qualitative methodology used in my study may have a greater role to play in the future of CE research.

The nature of the NHS context in conjunction with the different meanings held by organisational members relates to the relativism aspect of the interpretivist paradigm. Relativism proposes that an actor's experience is a localised inter-subjective product of both the subjective and objective meanings of their environment (Gephart, 2004). As such, the perspectives held by LEMT organisational members still collide with the realities of their organisational environment. For instance a senior academic once described the NHS to me as *'nothing short of a national religion.'* Despite its highly-revered status, when this study was commissioned by LEMT, the NHS was and continues to be the target of much criticism and is embroiled in an unrelenting national-level discourse. This discourse is made more poignant as resources continue to diminish in the aftermath of the global economic crisis of 2008. Therefore, despite their beliefs about being in the NHS's employ, LEMT employees are faced with the reality of a changing and increasingly hostile healthcare industry landscape, which has implications for their organisational context. Klein & Myer (1999) assert that an

interpretivist paradigm is fit for studying a *'moving target'* or an organisation in flux such as LEMT. Interpretivists argue that organisations are not static and that the relationships between people, organisations and the external environment are not fixed but constantly evolving. This requires the researcher to treat phenomena as a unique historical occurrence, which is context and time dependent (Krauss, 2005). Therefore, interpretivism can bring a more dynamic and contextualised view of CE propagation, which is lacking in some of the models reviewed in Chapter 2.

Despite its utility there is one debate researchers usually foreground within the interpretivist paradigm. That is, an *a priori* framework, like the framework proposed in Figure 7 of Section 3.9, violates the emergent nature of interpretive research. However, within this thesis I have embraced a middle position. While I agree that interpretive research does not subscribe to the idea that easily isolatable variables can be manipulated in a mechanistic way, I do not concur that there should be no bounding constructs that demarcate the study. Eisenhardt (1989) asserts that *a priori* construct specification can assist in shaping the design of theory-building research. As such, I submit that while this project is largely consistent with interpretivism, I assert that it is better to have some governing principles than none at all, especially as the absence of any criteria may result in poor reception of this work by CE and entrepreneurial cognitions scholars given the presence of a substantial body of variable-driven work in these areas. Finally, it also stabilises and prevents 'slippage' by providing some bounding parameters, which a caveat associated with the case study design I will discuss in Section 6.4 (Yin, 2009).

As introduced above, the ontological and epistemological standpoint taken by a researcher is intimately related to the methodology they then adopt (Anderson, 1986; Burrell & Morgan, 1979; Krauss, 2005). The interpretivist paradigm is often linked to the broad qualitative methodology that accommodates the deeper and broader understanding of the research subject using a multi-method focus involving an integrative approach to its subject matter (Denizin & Lincoln, 1994; Krauss, 2005). I address the qualitative methodology used in this study in the next section.

6.3 A Qualitative Approach

John Van Maanen in 1979 observed,

> *A quiet reconstruction going on in the social sciences…It's hardly revolutionary, but a renewed interest in and felt need for qualitative research has slowly been emerging.* (p. 522)

More than twenty years later, Bluhm, Harman, Lee & Mitchell (2010) asserted that the field of management is growing ever closer to a tipping point, noting that,

> *…more qualitative work has been published in top American management journals in the past ten years than in the previous twenty* (p.2),

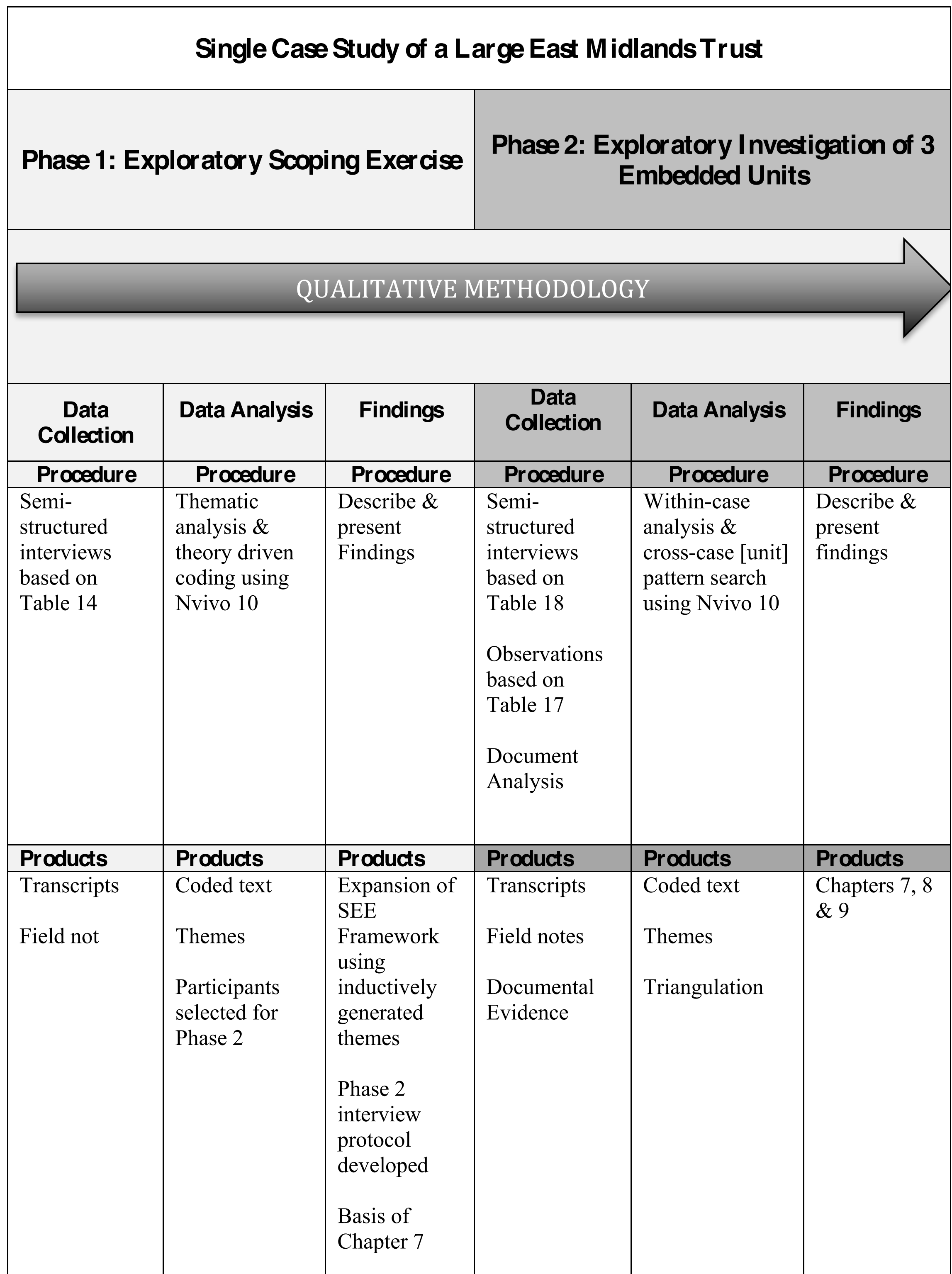
which dominate much of entrepreneurship research. It would seem the growing popularity of qualitative methods and analysis stems from (1) the value of the unique insights and richness of the knowledge generated through these methods and (2) the improved validity of the methodologies themselves are starting to surpass the need to meet the positivistic standards which relegate qualitative research to quantitative research's less attractive sister.

As previously emphasised in Sections 6.2 and 6.3, philosophical-methodological consistency is required to successfully tell the research story. This becomes particularly relevant as I attempt to apply an untraditional philosophical perspective to CE and even EI research where positivist-quantitative approaches dominate. To accommodate the epistemological and ontological positions of interpretivism, it follows that qualitative methods of inquiry would be more suited to this type of organisational research. Qualitative methods have an inherently literary and humanistic focus, unlike quantitative methods, which are grounded in mathematical and statistical explanations. Furthermore, qualitative methods concentrate on the contextual significance of events and can therefore explore the way in which the respondent perceives and constructs such as CE, CE desirability

and CE feasibility. Taking the preceding into consideration, it can be seen that an interpretivist-qualitative partnership tends to be a means of theory generation with the purpose of providing in-depth appreciation of human behaviour and the reasons that govern them (Morgan, 1980). This lends itself to a qualitative approach.

Qualitative research consists of a number of interpretive methods, which are situated in the real world and focuses on the aforementioned rich descriptions of social phenomenon. Contextual variables are also taken into consideration, making it more conducive to theory building than quantitative research (Parry, 1998, Goodwin & Horowitz, 2002, Denzin & Lincoln, 2003). Four types of qualitative research designs are presented by Bryman, Stephens & Campo (1996) including (1) single case studies, (2) multiple case studies, (3) large amounts of semi-structured interviews, or (4) inviting people to describe specific practices.

When the exploratory nature of the research question and objectives are considered with both literature review chapters and the framework in Figure 7 of Section 3.9, it appears a flexible research design capable of capturing various aspects of CE choice is needed. First it must capture participant's own constructions of entrepreneurship as per the organisation context; second it should assess the way in which CE is enacted; and finally it should capture what aspects of the organisational context EI can motivate or hinder entrepreneurial behaviour. Therefore, the most appropriate approach would appear to be to use one of Bryman et al.'s (1996) suggested designs in a way that is sensitive to context—the single case study design, shown in Table 13. However, this case shall be approached in two phases: (1) Phase 1 uses in-depth interviews with organisation members branded as entrepreneurial in LEMT; and (2) Phase 2 will focus on multiple embedded units within the single case (Yin, 2009) using a combination of in-depth interviews, participant observation and document and archive analysis. Details on Phase 1 and Phase 2 will be provided in Sections 6.4.1 and 6.4.2 respectively.



Single Case Study of a Large East Midlands Trust					
Phase 1: Exploratory Scoping Exercise			**Phase 2: Exploratory Investigation of 3 Embedded Units**		
QUALITATIVE METHODOLOGY					
Data Collection	**Data Analysis**	**Findings**	**Data Collection**	**Data Analysis**	**Findings**
Procedure	**Procedure**	**Procedure**	**Procedure**	**Procedure**	**Procedure**
Semi-structured interviews based on Table 14	Thematic analysis & theory driven coding using Nvivo 10	Describe & present Findings	Semi-structured interviews based on Table 18 Observations based on Table 17 Document Analysis	Within-case analysis & cross-case [unit] pattern search using Nvivo 10	Describe & present findings
Products	**Products**	**Products**	**Products**	**Products**	**Products**
Transcripts Field not	Coded text Themes Participants selected for Phase 2	Expansion of SEE Framework using inductively generated themes Phase 2 interview protocol developed Basis of Chapter 7	Transcripts Field notes Documental Evidence	Coded text Themes Triangulation	Chapters 7, 8 & 9

Table 13: Visual Research Design Summary

6.4 Research Design: A Single Case Study with Embedded Units

The *case study* has been characterised by leading methodological scholars such as Eisenhardt (1989) and Yin (2009) as a *research strategy* that focuses on understanding the dynamics present within contemporary events. An example of this strategy in CE research is Stopford & Baden-Fuller's (1994) paper that used longitudinal case studies with multiple levels of analysis to understand how a hostile business environment can act as a triggering event for the firm to adopt policies that foster entrepreneurship. What is obvious from this example and extends its utility to this thesis, is that a case study design is capable of accommodating (1) 'live' exploratory research, (2) multiple levels of analysis and (3) multiple methods of data collection. I will elaborate on these three benefits below.

As my research question suggests, this thesis has been developed with the purpose of developing theory. Eisenhardt (1989) refers to several pieces of the process of building theory from case study research that have appeared in the literature. Eisenhardt (1989) goes further to state that building case studies around exploratory research questions, can lead to the attainment of focused and robust data, which has been previously mentioned in Section 6.2. Additionally, case study design lends itself to inductive theory development as relationships and patterns among concepts within cases emerge, or more specifically to this thesis, within the embedded units in the single case (Eisenhardt & Graebner 2007).

This theory building approach in turn has sampling implications in that it allows for a purposeful, theoretical approach to sampling for the purpose of developing constructs (Eisenhardt & Graebner 2007) (subject selection will be discussed in more detail in Sections 6.4.1.4 and 6.4.2.2). This approach to sampling will enable me to focus on specific CE activities, events or programmes which provide a unique conceptual insight into my theoretical framework at multiple levels (Siggelkow, 2007, Yin, 2009, Curtis, Gesler, Smith & Washburn, 2000) versus attempting to select statistically representative samples. Further, interviewing

participants across the three embedded units at different hierarchical levels and organisational positions will provide different perspectives on the phenomenon, an essential element of single case research (Eisenhardt & Graebner, 2007, Gobo, 2007).

As per the second point above (benefit of multiple levels), case study research can involve a multi-level approach to enable an in-depth understanding and development of existing theory. Cases can be used to magnify a social phenomenon or even the organisational, group or individual level, by allowing researchers to examine real life events in a rich context (Yin, 2009). Specific to this 'individual in CE' thesis, I anticipate this approach allows for both the individual being the main level of analysis while simultaneously maintaining the connection to the larger organisational level so the case does not develop in an overly abstract manner (Yin, 2009). Thirdly, using a mixture of data collection methods, to expand and develop novel theories, best supports the prior two aspects of case study research. I will be utilising three complementary methods, (1) semi-structured interviews, (2) (participant) observations and (3) archival analysis, as a good case study should use as many sources of evidence as possible to achieve *triangulation* (Yin, 2009). I will discuss triangulation through multiple sources of data in subsequent sections in tandem with details of the research phases and the methods used.

Thus far, I have extolled the utility and benefits of a case study design. However as with every choice there are associated caveats to consider and mitigate to protect the integrity of my research. Due to the sampling approach outlined, it will only be possible to make analytical generalisations but not statistical ones (Curtis et al., 2000). However, fully exploiting the applicability of these generalisations requires the previously-mentioned multiple sources of evidence to generate robust examples of pattern matching and theoretical logic (Yin 2009). Observations and in-depth interviews are the most widely acknowledged as central to case study research as these methods embody the contemporary facets of this methodological tradition.

When all of the preceding issues are considered, I draw on aspects of Yin's (2009) recommendation that a case study protocol can enhance rigour and validity when conducting case study research. These protocol aspects which are directed at the sole data point, in this case LEMT, are clearly set out in the data collection phases documented Sections 6.4.1 and 6.4.2 to allow transparency and to improve the replication of this study. Further, Section 6.5 sets out a framework from Lincoln & Guba (1985), which will guide the production of 'valid' and 'reliable' qualitative research. Their framework facilitates the transparency and rigour of data collection, analysis and how it relates back to theory (Spencer et al., 2003), which critics cite as often lacking in case study and qualitative research.

Before I proceed with the details of this study's design, I will focus on defining LEMT as a useful and unique case to answer this study's research questions born of the CE and EI literatures. EI research has been conceptualised and operationalised to focus on the individual in wider society's choice to start a new venture or embark on an entrepreneurial career path (Bird, 1988; Krueger, 1993). As such, applying SEE models to the LEMT case presents an opportunity to understand whether the organisational context has any significant impact on EI formation when that target is CE activities like CV and SE. This makes the NHS organisational context particularly relevant when one considers that it is one where little to no CE or EI research has been developed. Consequently there has been a call from researchers to understand the emergence of entrepreneurial activities in established organisations that are not commercially driven such as the NHS (Narayanan et al., 2009). Pettigrew (2002) suggests that the historical maturation of public services have entrenched barriers in the structure, strategies and processes of these organisations that can delay entrepreneurial activity. Thus, CE scholars advocate the need to account for these contextual contingencies by exploring unconventional settings (Bamberger & Pratt, 2010). For example as the largest public sector organisation in the UK, the NHS exhibits a monolithic structure characterised by strong central control and bureaucracy (Blair, 1999; Frederickson, 1996; Meier & Hill, 2005). As covered in Chapter 2, such a structure is an anathema to scholarly consensus that entrepreneurial organisations are (or should be) configured to be organic and boundary-less (Dess et al., 1999). Further the NHS is a not-for-profit organisation driven by a social mission versus

wealth creation, which is still seen as the main objective of entrepreneurship and why private organisations employ entrepreneurial strategies (Wennberg, Wiklund, DeTienne, & Cardon, 2010). Also, the NHS's dependence on government funding and its monopolistic nature (despite some private provision) create a risk-averse culture that renders the pursuit of opportunity, which is essential to CE, as 'persona non grata.' Lastly, employment law and the heavily professionalised and institutionalised context of healthcare provision present another differential trait of the NHS. A career in the NHS involves a high level of task specialisation, adherence to formal rules and procedures as well as an expectation of a lifetime career. Combined, these issues can foster an aversion to the risk-taking and proactiveness processes suggested by Lumpkin & Dess (1996) as individuals may be inclined to place more value on the job security associated with public sector employment than risk entrepreneurial activity (Currie et al., 2010; Bellante & Link, 1981).

Taking the above into account, the research design detailed in Sections 6.4.1 and 6.4.2 has been purposefully selected to extract the insights this novel context can provide for CE enactment through EI cognitive precursors. Further, this case study design can also accommodate the emergence of new concepts and constructs that are a product of fulfilling my research objectives, especially as these emergent constructs will direct the way forward and further define the nature of the case, which Yin (2009) states is crucial to the rigour of case study research.

6.4.1 Phase 1 Scoping Exercise: Exploratory Research

During a period of informal familiarisation in the first year of this project, it became clear that people attached different truths, perceptions, meanings and expectations on what entrepreneurship and CE is and what it entails. This divergence of opinion also extended to entrepreneurship's role in the NHS, LEMT and their work, its outcomes and what hindered or encouraged them to act entrepreneurially. As such, it became imperative that I develop a formal exploratory inquiry phase to cover these issues and 'problematise' CE enactment in LEMT. Additionally, this exploration had a descriptive element in that it (1)

established context appropriate language and (2) signalled the inclusion of a variety of inductive constructs into the overarching SEE framework. However, prior to proceeding into the field, some ethical issues were first considered, especially in light of the NHS context.

6.4.1.1 Ethical Considerations

Regardless of the relationship established between LEMT and myself, it was clear very early on that any research conducted within the NHS had to follow rigid ethical guidelines to protect staff and patients. The initial scoping exercise was categorised as service evaluation by the R&D Department allowing this phase of the project to move forward quite smoothly; although the respondents did have the same rights (which are discussed subsequently) as in the second phase of the project, which did seek full ethical approval and sponsorship.

However, Governance Arrangements for Research Ethics Committees (GAfREC) issued by the UK Health Departments in May 2011 came into effect from September 1st 2011 as the scoping exercise commenced. This regulation stated that NHS-based research that did not involve patients would not require National Research Ethics Committee (NRES) authorisation but only R&D approval from the Trust for the specific site of the study (NRES, 2011). While this did provide some leeway, I still sought approval from the Ethics Committee at the Nottingham University Business School (NUBS) and focused on the five areas identified by the NRES as integral to conducting ethical research in the NHS (NRES, 2011).

6.4.1.1-1 Informed consent

NUBS made arrangements for training courses from certification providers on Informed Consent and Good Clinical Practice (www.gcptraining.org.uk), which I completed online. GCP defines informed consent as the agreement to participate in a study after risks and alternatives have been offered to an individual. To ensure informed consent in this study, I developed a Participant Information Sheet (see Appendix 12), which was sent out with invitations to participate in interviews and meeting agendas for participant observations. This allowed

participants time to consider the research and make an informed, unpressured decision. My contact details were also been included on this sheet to make to myself available to any questions potential participants may have. After this period of familiarisation, a Consent Form (see Appendix 13) was provided for signing and dating if and before the participant entered the study. Contact details were also left with participants at the end of the interview or observation in the event of any questions or concerns arising.

6.4.1.1-2 Confidentiality

A key consideration for NHS Trust members is confidentiality. Due to tense and tumultuous conditions that LEMT is currently experiencing, characterised by budget cuts, pressures to reduce spending and redundancies, confidentiality and anonymity are essential to increase the number of participants as well as ensure honesty is reflected in responses. Several measures were taken to enforce these. Firstly I was the only person with access to the recorded interview sessions or transcripts. Secondly participants were assured that their information would be kept from their employer until completely anonymised for dissemination by utilising code numbers. Lastly, the Director of Strategy negotiated a clear guideline that other senior members of staff will not be able to access interview or observational data nor will the details of specific respondents be revealed or discussed.

6.4.1.1-3 Data Protection

Study participant's rights to privacy will be by protected throughout, in adherence to the Data Protection Act, 1998. As such I collected the minimum required information for the purposes of this study. Coded interview transcripts and participant information continue to be stored on password-protected computers accessible only to myself. Additionally, source documents shall be stored at NUBS in locked drawers and will be destroyed after 7 years in accordance with university guidelines.

6.4.1.1-4 Right to Withdraw

Participants were able to withdraw from the study at their own request without having to provide a reason as participation as their completely voluntary. As part

of this, participants were made aware that withdrawal would not affect their future role or employment within LEMT. However, via the information sheet and consent form, participants were made aware that should they withdraw the data collected to that date cannot be erased and may still be used in the final analysis.

6.4.1.1-5 Potential Benefits and Harms

Due to the non-invasive, theoretical nature of the study there were no anticipated risks, adverse effects or discomfort associated with taking part in this study. Though participants will be giving up their time to participate, as such I was flexible in accommodating participant by frequent visits across all three LEMT sites as well as issuing prior reminders.

The benefits of this project are two-fold and were conveyed to the participants. The first benefit directly impacts the respondents, as the interview process allowed them the opportunity to reflect on and make sense of their roles, the conditions in LEMT and where they fit into the organisation's new direction. The second benefit is an indirect one as the overall aim of the project was too improve strategy implementation within LEMT as it aspires to be entrepreneurial.

6.4.1.2 Phase 1 Data Collection Methods: Semi-structured Interviews

Dingwall (1997) suggests three broad ways of qualitatively gathering social phenomena data: asking questions, 'hanging out' and reading text. While all three are relevant to case study research overall, the first, interviews, was the main method used during the Phase 1 scoping exercise. I conducted these interviews over 6 weeks from September 2011 to October 2011.

Asking questions about CE activity in LEMT seemed to be the most appropriate approach due to its apparent advantages of ease, efficiency and flexibility. Also, as this exercise was concerned with '*find[ing] out what's happening [and] to seek new insights*,' which is the essence of exploratory semi-structured interviewing, it is an ideal approach (Robson, 2002 cited in (Saunders, Lewis & Thornhill, 2003, p.248). Semi-structured interviews have made some headway in CE research though mainly through mixed-method research (Cresswell & Plano-Clark, 2007).

An example of this is Birkinshaw's (1997) study of CE in multinational corporations and the characteristics of the subsidiary initiatives developed through the parent company's corporate venturing activities. The authors use semi-structured interviews as an exploratory initial phase upon which a survey was based for the second part of their study.

Conversely, studies, which wholly use interviews to gather data, have illuminated a number of areas that quantitative studies could not. For instance, interviewing seems to be the method of choice for many researchers particularly in the public sector. Currie et al. (2008) conduct semi-structured interviews to elicit narratives of public-sector managers from the NHS and secondary and further education institutions. The authors cited that their approach was greatly influenced by the evident lack of qualitative work in leadership behaviour, entrepreneurial or otherwise. They justify the use of the narrative method as a means of individual sense making (Ricoeur, 1984; Brunner, 1991). Moreover, the nature of the data they were trying to elicit, in addition to the public sector context, required a deeper understanding of the social construction of entrepreneurial leadership. The use of interviews for Phase 1 of this project elicited voluminous data on complex systems of social interaction, diverse political discourse and varying historical accounts about the NHS, LEMT and participant experience as part of both these entities; factors which can be described as resistant to straightforward theoretical reduction and not easily isolatable from their context.

It should be noted however that despite its utility it is important to recognise and address some general limitations associated with interview techniques. Firstly, there is an assumption that respondents perceive the meaning of questions in the same way as the interviewer. If this is not the case and the respondent perceives the social world from an unexpected standpoint, it becomes probable that they are not answering the questions posed (Mason, 2002). Secondly, assumptions are also made about the nature of participant's responses in terms of whether respondent's accounts are a 'realistic' expression of their situation and subjective experience. Thus, it is not always clear whether the respondents are describing an accurate report of events, a report of what they think happened, or merely stating what they want others to believe (Goodwin & Horowitz 2002). Further, this effect can be

potentially amplified as the presence of the interviewer can change participant responses to what they belief the interview may want to hear. Finally, what questions should be asked to access the sense-making of individuals through their interview accounts relies on the researcher to correctly identify and ask questions the inclusive and specific to the relevant loci (Waldman et al., 1998). As such, without the right questions the relevant data cannot be elicited

Taking into consideration the limits and benefits of interviews when investigating the proposed framework, overall, the use of semi-structured interviews is mutually supportive of the research intent and for probing this embedded single case study and efforts have been made to acknowledge and mitigate methodological concerns. Interviews will be audio taped and transcribed. Further details of the actual interview process will be given in Section 6.4.1.3 below.

6.4.1.3 Interview Protocol for Phase 1 Scoping Exercise

A semi-structured interview protocol derived from the literature reviewed was developed; apart from an introductory question that addressed what role respondents held in LEMT. The interviews were approximately 30-60 minutes in length and as is the nature of semi-structured interviews, it was anticipated that the direction of each interview would vary from one respondent to another. This highlighted the need for me to be adaptable and flexible to accommodate and respond to the themes emerging from the conversation. Appendix 14 contains the full interview protocol for Phase 1.

Question 1A was posed because as an academic community, entrepreneurship scholars and further CE scholars acknowledge the multifaceted nature of these domains and the numerous definitions available. Moreover, I started with a general definition of individual entrepreneurship, as I did not expect the average respondent to be able to distinguish between individual-level or organisational-level entrepreneurship. As such, Question 1's sub-questions were developed to 'ease' the respondent into linking entrepreneurship to two familiar areas: the first area being their entrepreneurial experience in healthcare in general; the second

area was the entrepreneurial experiences in they had in the LEMT organisation, which is of interest within the scope of this project.

Questions 2A-2E were aimed at cementing the entrepreneurship-organisation link by utilising the EO construct, which characterises the entrepreneurial organisation as per Ireland et al.'s (2009) model CE strategy. Additionally, both Questions 1 and 2 required the respondents to provide examples of entrepreneurship or entrepreneurial individuals, which had a four-fold purpose. Firstly, it required the interviewees to recall and focus on examples of entrepreneurial projects or persons they have encountered during their time in the healthcare industry. Secondly, as each EO dimension was introduced, the examples proffered became richer with increasing layers of detail. Thirdly, these examples described their involvement in entrepreneurship and the contextual factors that facilitated or impeded their actions. Lastly these examples would be considered collectively to establish possible embedded units for further investigation in Phase 2.

Having focused the interviewees on CE in their context, what CE entails and the CE examples that surround them (or not), Questions 3 and 4 sought to increase proximity to the individual and probe their evaluative process. Specifically these questions sought to ascertain their personal affinity for entrepreneurship and their perceptions of CE desirability and CE feasibility. Question 5 required respondents to state if CE supported the organisation objectives. However this question was designed to capture further detail on the aspects of the LEMT context that respondent's thought hindered or supported CE action by organisational members in LEMT. Lastly, Question 6 was aimed at understanding whether participants associated CE with positive and/or negative outcomes. This links to the discussion in Chapter 2, in which it was found that there is an underlying assumption that CE is a positive thing for an organisation to engage in and that employees will act as such.

6.4.1.4 Phase 1 Subject Selection

Eisenhardt (1989) suggests a purposeful sample rather than a random sample is useful in qualitative case study research. Following this advice my respondents

for the Phase 1 scoping exercise, who are tabulated in Table 14 below, were selected for two main reasons which are critical to defining the case and procuring answers relevant to my research question. First as this study seeks to understand the 'individual in CE,' I had to identify organisational members who were involved in CE. As such, the participants selected were regarded as LEMT's entrepreneurs and problem solvers; described as persons who '*do things in-spite of the Trust*.' Maintaining such broad selection criteria allows for varied and diverse perspectives, which is important within exploratory research (Niemi et al., 2009; Yin, 2009). These candidates were sourced in consultation with three senior managers in the organisation. Second this first sample was selected to give me an overall view of and familiarise me with LEMT. As such, I sought a selection of managers and clinicians who hold varying roles to best give a cross-section of LEMT at the corporate, clinical business unit and service levels. Therefore, these respondents routinely gather and adapt information on LEMT's service provision and business processes from different vantage points in the organisation.

Interviewees	Management	Academic	Clinical
1	✔	✔	✔
2	✔	✔	✔
3	✔	✔	✔
4	✔	X	✔
5	✔	X	✔
6	✔	✔	✔
7	X	X	✔
8	✔	X	✔
9	✔	X	X
10	✔	✔	✔
11	✔	X	✔
12	✔	✔	✔
13	✔	X	✔
14	X	✔	✔
15	✔	✔	✔

Table 14: Distribution of Persons Interviewed in Phase 1 by Job Role

✔Job Role Held; **X**: No Role Held

6.4.2 Phase 2: Embedded Case Study Design for Further Exploration

The flexibility of single case study research is one of its greatest strengths though simultaneously it can be a source of criticism. Yin (2009) refers to the unwitting 'slippage' of the project's focus, mentioned previously in Section 6.2, due to the emergent and live nature of case study research. As such, a case is at risk of slowly digressing from its purpose as new data emerges, rendering the original research design unfit. Therein lies the primary reason for including embedded units within the case: Embedded units mitigate this risk through the use of multiple subunits of analysis to focus the inquiry (Yin, 2009). Analysis of the Phase 1 interviews revealed logical sub-units for exploration (see Table 15). In response to Question 1B, the interviewees stated that entrepreneurship was '*patchy.*' As such to conduct an in-depth exploration of CE and EI formation, Phase 2 was geared towards exploring these 'CE patches.' I extracted 3 subunits, which have been described in Table 16, for additional exploration based on two criteria. The first criterion was these units should be strategically placed at different levels in the LEMT's structure so a diverse range of organisational members could proffer their perspectives. The second criterion was specific CE phenomena could be identified (1) innovation in Units 1 and 2 and (2) joint CV in Unit 2.

LEMT Single Case

Embedded Units	
Unit 1: *Corporate Level*	Research & Development Committee
Unit 2: *Clinical Business Unit Level*	Pathology Joint Venture
Unit 3: *Service Level*	PulmonaryRehabilitation Service

LEMT Single Case

Table 15: Embedded Units within the Single LEMT Case Adapted from Yin (2009)

Embedded Units	Description
Unit 1: Corporate Level	***Research & Development Committee (R&D)***
	R&D is a major strand of LEMT's strategy. The R&D committee consists of number academics, clinicians, directors and members of the public. The committee monitors the R&D Department who works in collaboration with various academic and industry partners. LEMT undertakes a wide portfolio of patient-centred research, which includes almost every aspect of specialist medicine and surgery. The committee also accommodates in-house ideas and proposals for service improvement initiatives.
Unit 2: Clinical Business Unit Level	***Pathology Joint Venture (PJV)***
	PJV is a joint venture between two of the largest Pathology services in England. PJV seeks to be a commercially driven venture by establishing a new operational service model while taking advantage of economies of scale to maximise efficiency and reduce costs. PJV also aims to be recognised as a Centre of Excellence for advice, training and research as it concentrates the technical, scientific and medical expertise of both partners.
Unit 3: Service Level	***Pulmonary Rehabilitation Service (PRS)***
	The Pulmonary Rehabilitation Service provides a programme of exercise and education to improve the health and wellbeing of patients with chronic respiratory and cardiac conditions. By improving long-term health outcomes and potentially reducing hospital admissions, rehabilitation can help to reduce the huge social and economic burden of these long-term conditions to the NHS. The PRS is also a Research that has an international reputation for its work on developing novel rehabilitation treatments and self-management strategies that can be put into clinical practice in both primary and secondary care settings. At present they are currently involved in 8 research and implementation studies.

Table 16: Descriptions of the Three Embedded Units with in the LEMT Case for further Investigation in Phase 2

6.4.2.1 Phase 2 Data Collection Methods: Semi-structured Interviews, Participant Observation & Document Gathering

Where the use of a single data collection method was suitable for the purpose of the exploratory scoping exercise, it is not considered to be best practice for fully developing case study research. Yin (2009) strongly recommends the use of *'converging lines of inquiry'* or triangulation to strengthening the integrity of any case study being developed. Triangulation aims to collate and corroborate sources of evidence by focusing on the symbiosis created as (1) methods compensate for each other's weaknesses, (2) the multiple methods compel the researcher to access a variety of data sources and (3) contemporary evidence placed centre-stage (Yin, 2009).

Therefore, in addition to the semi-structured interview method described and deployed in Phase 1, Phase 2 employed two additional research methods. These methods include Yin (2009) and Dingwall's (1997) recommendations of: participant observation and document analysis, described in Sections 6.4.2.1-2 and 6.4.2.1-3 respectively. I conducted Phase 2 over 5 months from August 2012 to December 2012. Last, it should be noted at this point that as I am the sole investigator in the field, this alleviates the risk of improper use of any of the methods employed.

<u>6.4.2.1-1 Semi-structured Interviews and Interview Protocol for Investigation of Embedded Units in Phase 2</u>

Questions 1 through 6 from Phase 1 were retained for Phase 2 with the exception of questions 2C and 2E. Primarily because these questions seemed to elicit very robust and detailed descriptions of the organisational context as well as how respondents' perceptions of these contextual factors influenced their perceptions of CE desirability and CE feasibility. However 2C and 2E were usually perceived as irrelevant by respondents and did not yield voluminous detailed responses and were thus removed from the interview schedule. Phase 2 interviews were generally longer than those conducted in Phase 1, lasting approximately 30-90 minutes. This was due to the semi-structured interview protocol generated for this second phase being adjusted to accommodate my preliminary findings from analysing the 15 transcripts produced from Phase 1. Appendix 15 contains the full

interview protocol for Phase 2. In the remainder of this section I will present the revised protocol in tandem with some the potential drawbacks to the new line of questioning and techniques used to manage these.

My preliminary findings from Phase 1 included detailed descriptions of organisational-level factors that appeared to influence case informants' CEI formation process. However in my findings respondents also revealed descriptions of themselves and other organisational members. These individual-level factors are of particular interest as they operate at this study's chosen level of analysis. As such the questions I added to the Phase 2 protocol where designed supplement the personal analysis section of the Phase 1 interview protocol to gain more in-depth insights into these individual-level characteristics. Gerson & Horowitz (2002) states that these types of individual interviews allow insight into how individual actors experience large scale self-transformations and are affected by their interactions within the social and cultural context.

Individual focused interviews however are not without drawbacks. For instance, Alvesson, Ashcraft & Thomas (2008) suggest that interviewers should beware that the overt act of asking a question like 'what do you do' can stimulate self-transformation processes, which may not give a true reflection of the individual. Alvesson et al. (2008) also suggest that, responses about one's self in an interview can take many forms that do not reveal the 'truth.' The authors suggest respondents could be pre-occupied with impression or image management, some political agenda or following some given script. These are particularly relevant in the LEMT context when one considers the current political debates surrounding the NHS mentioned in Section 6.2 and detailed in Chapter 5.

Taking these issues into account, my questions were developed in a manner adapted from Goldman, Hunt, Allen, Hauser, Eammons, Maeda & Sorensen (2003). These authors advocate the use of life history interviews for capturing past and present contextual influences on perceptions and behaviours. As such Questions 7-16 were geared towards two goals. First I wanted to elicit a career history interview that spanned respondent's education and training to their current position in LEMT. Second some of these questions were developed to encourage

respondents to focus more intently on themselves by reflecting on significant events or turning points in their careers. Similarly Questions 17-21 were developed to refine the defining entrepreneurship section of the Phase 1 interview protocol. As such in addition to gaining entrepreneurial definitions these questions were tasked with cementing the link between the individual and the CE activity in their area, which corresponds with the embedded units of analysis. Further respondents were asked to assess themselves based on the EO dimensions of innovativeness, proactiveness and risk-taking by providing examples of when they participated in any of these processes. More generally they were also encouraged to offer the characteristics and behaviours they believed were necessary to be a corporate entrepreneur and assess if they displayed any of these.

6.4.2.1-2 (Participant) Observation

The constructs I have employed in this project's overarching framework are theorised as being situated in organisational practice. This poses the notion that interviews, or 'talk about the organisation,' does necessarily or sufficiently reflect an understanding of CE enactment (or not) in organisations. As such, participant observations can enable access beyond what people say to what people do (Barley & Kunda, 2001). Additonally, participant observation in this study can reduce the problem of interview variation. Participant observations provide a multi-layered and living view of context, which can demonstrate, how individuals, groups, organisations and socio-historical influences interconnect at snapshots in time (Fairhurst, 2009, Dingwall, 1997). Used frequently in anthropological studies, participant observations affords the researcher the opportunity to develop some understanding of the context they are studying and observe and interpret interactions between actors (Delamont 2007, Marshall & Rossman, 1999). This method incorporates the researcher as they simultaneously interact and observe the actor, to generate detailed field notes (Delamont 2007, Bryman 1988). However as LEMT commissioned this work and the relationship I developed with the Strategy Team, I have been afforded greater access to observe a range of strategic and operational meetings and other activities that may not have been available under other circumstances. The caveat inherent in this 'insider' status is the potential biases that may result. Seale & Silverman (1997) offer reflexivity

(see Section 6.5.4) as one of the most important aspects of the fieldwork process for researchers to lessen this risk.

Additionally, the inability to directly observe 'CE in action,' presented a considerable challenge. As such, I spent 65 hours in the field attending a series of formal meetings, tabulated in Table 17, to contextualise the information generated from interviews. To this end, I followed participant observation guidance from Delamont (2007) and produced detailed field notes to develop a rich contextual and theoretical understanding of the development approaches. Field notes will be kept and discerned between observed events and observer inference as well as produce observational vignettes as supporting evidence (Gibbs, 2007; Yin 2009).

<table>
<tr><th>Focus of Observation</th><th>Name of Meetings</th><th>Number of Meetings Attended</th><th>Number of Observation Hours</th></tr>
<tr><td>Unit 1: R&D</td><td>Research & Development Committee</td><td>3</td><td>7</td></tr>
<tr><td rowspan="3">Unit 2: PJV</td><td>Project Executive</td><td>2</td><td rowspan="3">17</td></tr>
<tr><td>Board Meeting</td><td>4</td></tr>
<tr><td>Staff Forum</td><td>3</td></tr>
<tr><td rowspan="6">Unit 3: PRS</td><td>Journal Club</td><td>8</td><td rowspan="6">26</td></tr>
<tr><td>Information Technology Solutions</td><td>3</td></tr>
<tr><td>Clinical</td><td>3</td></tr>
<tr><td>Research</td><td>3</td></tr>
<tr><td>Implementation</td><td>2</td></tr>
<tr><td>Product Launch</td><td>1</td></tr>
<tr><td rowspan="2">LEMT</td><td>Cost Improvement Programme</td><td>3</td><td rowspan="2">15</td></tr>
<tr><td>LEMT Executive Board Meeting</td><td>2</td></tr>
<tr><td>Total</td><td></td><td>37</td><td>65</td></tr>
</table>

Table 17: Meetings Observed as a Data Generation Technique

6.4.2.1-3 Document Gathering

As the name suggests, documentation gathering is a straightforward process involving the accumulation of documents as a source of evidence (Yin, 2009). Documents are increasingly available through the Internet and the Freedom of Information Act (2000) and take the form of memoranda, meeting minutes, agendas, project management records, annual reports and print media, to name a

few. As a data collection method, documentation's main strength is in its ability to corroborate and augment other sources of data. Yin (2009) cautions however when information found in documents is contradictory to other sources of data the researcher must investigate further. I have collected 80 documents about LEMT and the three embedded units in the case. As such I have adhered to Miles & Huberman (1994) recommendation to create a document summary database to record documents as well as indicate its significance in the context of the case. This record allowed for easy coding during analysis.

6.4.2.2 Phase 2 Subject Selection

Similar to Phase 1, the subjects selected for Phase 2 will also be a purposeful rather than random sample Eisenhardt (1989). As such Phase 2 respondents, who are tabulated in Table 18 below, were distributed across the 3 embedded units with in the case that were involved in CE activity. I used two additional criteria, which are critical to fully developing the case and gathering the data relevant to my research question. First, this thesis is interested in bottom approaches to CE by investigating the individual level of analysis. Therefore I was sure to select a range of junior to senior organisational members as entrepreneurial processes and behaviours can emerge from anywhere in the organisation (Floyd & Wooldridge, 1999; Ireland et al., 2009). Fulfilling this first criterion was aided by 3 tactics, (1) I used departmental structure charts where available, (2) snowball sampling and (3) approaching persons I had observed in various meetings. Second, each of the embedded units had varying service provision functions in LEMT summarised in Table 16. As such, the 5 major professions commonly found in the NHS Agenda for Change policy (Department of Heath, 2008) were exhibited across the 3 units. Therefore I also strove to interview, observe and collect documentation on each of these professions, see Table 18.

Embedded Units	Persons Interviewed					
	Nurses	Doctors	Allied Health Professionals	Healthcare Scientists	Managers	Total
Unit 1: R&D	1	5	1	X	3	**10**
Unit 2: PJV	X	1	X	2	9	**12**
Unit 3: PRS	8	3	11	X	1	**23**
Total	**9**	**9**	**12**	**2**	**13**	**45**

Table 18: Distribution of Persons Interviewed in Phase 2 by Job Role and Embedded Unit

6.5 Rigour in Qualitative Research

Although the terms *qualitative* and *case study* are often used interchangeably, case study research can involve qualitative data only, quantitative data only, or both (Eisenhardt, 1989). Despite this often-misguided synonymy, case study research is vulnerable to the automatic application of quantitative standards. Yin (2009) refers to tests for validity and reliability to establish the quality of any empirical social research, which are cornerstones in the quantitative tradition. As such, the recommended standards for achieving high quality case study research designs, solely utilising qualitative methods, are plagued by a lack of clarity. It is fitting then to start at the basics and acknowledge what makes for 'high quality' qualitative research. I will start with the debate surrounding rigour.

As previously stated in Section 6.2, despite its growing popularity, qualitative research is considered a second-class citizen when compared to the use of quantitative-reductionist approaches. This is mainly because qualitative methodologies are often criticised for not producing rigorous, valid or generalisable results (Torrance, 2008). However strides have been made to improve the rigour of qualitative methodologies with a range of appropriate and significant factors, which go beyond validity and reliability criteria (Seale, 1999). Some scholars such as (Rolfe, 2006) assert that the path to rigour emerges from the outright rejection of preconceived positivist standards of reliability and

validity and the notion of universal 'truths.' Whereas others like Porter (2007), to which I subscribe, state that what is 'valid' is dependent on the methodology employed by the researcher. As such, the methodology used should truly reflect the multitude of perspectives on phenomena in complex social circumstances whilst accepting the limitations of any of these perspectives.

To aid in achieving this, I have employed the framework proposed by Lincoln & Guba (1985) in their classical work on attaining quality qualitative research. This framework has formed forms the basis for contemporary applications in the work of authors such as, Barker's (2003) five key points to assessing quality, Seale's (2007) four quality factors and Easterby-Smith et al.'s (2008) 'intent-of-quality-making' view. Lincoln & Guba's (1985) original framework uses three criteria, *credibility*, *transferability* and *dependability* to facilitate a more acceptable and accessible assessment of the quality of qualitative research. This will be useful in establishing my study's rigour in a predominately quantitative field such as CE. The following sections will detail Lincoln & Guba's (1985) framework in more detail as well as suggestions on how this research addresses its concerns. Further, I will address reflexivity as an additional supporting factor in developing good quality qualitative research.

6.5.1 Credibility

Lincoln & Guba (1985) refer to *credibility*, the truth of the data and its interpretation and suggest it as the overriding goal for qualitative inquiry. They propose several key techniques to establish confidence in the qualitative findings. The authors suggest researchers should adopt activities that increase the prospect that credible findings will be produced, through: (1) triangulation and (2) an extended and tenacious engagement in the field. I have used both of these techniques in this study. Yin (2009) states triangulation is a crucial and valuable data collection principle and contributes to building high quality and rigourous of case studies. I have illustrated the indispensability of triangulation to this study through the use of multiple sources of evidence: semi-structured interviews, participant observations and document gathering, in Section 6.4.2.1. Furthermore, Lincoln & Guba (1985) promote triangulation through participants where

multiple viewpoints can be obtained via a single-case mode of inquiry. Additionally, the dual phase design and exploratory-qualitative nature of this research has encouraged me to engage extensively with respondents in the field. I have completed 60 interviews, 60 observation hours and collected 80 documents over two phases of data collection.

In addition to responding to Lincoln & Guba (1985) and Yin (2009) suggestions on credibility, it is my position that the research itself presents a further point. The case informants engaged over 2 phases of data collection have extensive NHS backgrounds through their education, training and work experience. As these interviewees were sufficiently qualified to provide rich details and practical reflections that would enhance the quality of this research while clarifying and deepening the understanding of the inquiry.

6.5.2 Transferability

Transferability refers to the generalisability or the extent to which findings can be transferred or are applicable to other groups beyond the current case study (Lincoln & Guba, 1985, Cresswell, 2009; Yin, 2009). Lincoln & Guba (1985) suggest that achieving transferability entails the provision of *sufficient descriptive data* so readers can appraise the applicability of the findings to other contexts. Combined the methods used over both phases of data collection have produced voluminous transcripts, field notes and a slew of useful documents that have met and surpassed this descriptive data requirement. Additionally, the lack of statistical generalisability has been framed as a shortcoming of case study research. However, Yin (2009) suggests that analytical generalisability should be the goal of case study research. As such, researchers should strive to link findings to the broader theories and phenomena such as EI and CE framework used in this study.

6.5.3 Dependability

Dependability aims to minimise errors and biases within a case study and increase the stability of the data through establishing consistent, replicable procedures. In short, dependability addresses the question, 'would the findings of a case study

inquiry be repeated if it were replicated with the same (or similar) participants in the same (or similar) context?' (Yin, 2009; Cresswell & Plano-Clark, 2007; Lincoln and Guba, 1985). Lincoln and Guba (1985) propose that credibility and dependability are tightly linked in that if credibility is successfully achieved it lays the foundation for attaining dependability. To address this concern more directly, I have drawn on aspects of Yin's (2009) suggested case study protocol by carefully detailing the data collection procedures followed throughout both phases of data collection in Sections 6.4.1 and 6.4.2.

6.5.4 Reflexivity

Lincoln & Guba's (1985) framework forms a robust platform for building rigour. Yet, it does not account for the presence of the qualitative researcher who is keenly engaged with in the processes of data generation, organisation and interpretation. Thus, it is now becoming more commonplace and almost imperative for critical self-reflection to be conducted by the researcher. Therefore, I have included a fourth criterion for assessing the rigour of qualitative research, which Altheide & Johnson (2003) in Denzin & Lincoln, (2003) and Alvesson (1996) refer to *validity-as-reflexivity*.

My choice is in keeping with scholarly calls for research design to cultivate and exhibit closer philosophical, methodological and reflexivity linkages (Finlay, 2002). Reflexivity takes into account the inter-subjectivity of the interpretivist paradigm used in this study, by accounting for the researcher's interpretation of events shaped by their own experience, culture, ideology, gender or language (Denzin & Lincoln, 2003). For instance, I have previously worked in the NHS. Admittedly, this allows me to relate to the respondents and their context; however, I acknowledge there is also a risk of biases stemming from the preconceptions and positiveness of my work experience. This issue of researcher reflexivity has been discussed as one of the primary issues for qualitative researchers (Ahern, 1999). As such, critical reflection and identification must be an on-going process to mitigate this threat. I draw on Ahern (1999) who identifies a technique known as *bracketing* to identify and put aside these personal feelings in a reflexive and iterative fashion. Additionally, the input of academic

supervisors also assisted in guiding research analysis and preventing (or at least reducing) the risk of biased analysis.

Reflexivity however, has evolved beyond 'introspective reflexivity' where I as the researcher would contemplate the manner in which I could explicitly or implicitly influence the research process and findings based on my experiences, background, beliefs, values, behaviour or position in the social world (Finlay, 2002). Instead, contemporary perspectives on reflexivity indicate that it should be viewed as a typology, as being reflexive in one's research can apply to a variety of elements in the research process (Bryman & Bell, 2011; Johnson & Duberly; 2003; Lynch, 2000). Drawing on the work of Ashmore (1989) and Woolgar (1988), Lynch compiled what he calls an inventory of reflexivities (Table 19). I will explain the types of reflexivity from this list that I have found to be relevant and useful in my study.

Mechanical Reflexivity	Substantive Reflexivity	Methodological Reflexivity	Meta-theoretical Reflexivity	Interpretive Reflexivity	Ethno-methodological Reflexivity
Knee-jerk Reflexivity	Systemic Reflexivity	Philosophical self-reflection	Reflexive Objectification	Hermeneutic Reflexivity	A combination of theoretical, substantive & methodological reflexivities
Cybernetic Reflexivity	Reflexive Social Construction	Methodological self-consciousness	Standpoint Reflexivity	Radical referential Reflexivity	
Reflections ad infintium		Methodological self-criticism	Breaking frame		
		Methodological self-congratulation			

Table 19: Inventory of Reflexivities (Lynch, 2000)

6.5.4.1 Methodological Reflexivity

Methodological reflexivity is tasked with understanding how the various methods used to gather, organise and interpret data may impact on a study's findings. The above inventory indicates there are several variations of methodological reflexivity. The selection and use of any one type however, is largely dependent on the nature of the research being conducted. Based on the exploratory nature of my study I have selected methodological self-consciousness.

First, methodological self-consciousness addresses the many issues that may arise in relation to access to the object, or in this instance, subjects that constitute the LEMT case. It requires me as the researcher to reflect on (1) how I gained entry in to LEMT (2) any biases that influence or distort or stem from this access (3) how this may in turn influence my findings (Lynch, 2000; Hammersley & Atkinson, 1983). This was particularly pertinent to my study primarily because the Director of Strategy who sits on the LEMT Board of Directors had commissioned my research. As such, my initial socialisation, introduction and familiarisation into LEMT was at the executive level by spending time and shadowing the Strategy Director and members of the Strategy Team. This included an induction day with the Chief Executive Officer (CEO), attending public board meetings and Cost Improvement Programme meetings and 'meet and greets' with Division Heads, general managers and other Directors. Further, joint supervisory meetings were held with the academic team (students and supervisors) and the Strategy Team to pitch ideas for my study's direction and receive input from the Strategy Team.

While this proved useful for access one matter became critical. It was clear I was on a 'public relations' mission not just about promoting my research but also promoting the Strategy Team as an innovative group developing it's own management research portfolio. In this regard, it became increasingly important to maintain the academic integrity of the project and not succumb to every suggestion from the Strategy Team and those I was encouraged to meet, regarding what data I collected or from whom it should be collected. As such, it was pivotal that the research question and research design had a strong foundation in the extant CE and EI and eventually identity literatures.

At face value this level of access seemed extremely valuable. I was even commended for the impressive access I had been granted at my 2nd year annual review at the Nottingham University Business School, which monitors the progress of my research. However, since this research was commissioned but the Strategy Director, it was to the team's benefit that the quality of data I had access

to would make for stronger study findings that could be utilised by the Strategy team in the LEMT Integrated Business Plan (IBP). In this sense, the Strategy Director was useful in that a request from her office to grant me interview time was generally well accepted. As such, I had an impressive 75 percent response rate from individuals expressing willingness to participate in Phase 1 of data collection.

Yet, this came with one main caveat that I had to carefully manage once I started data collection and eventually during analysis: my close association with management. This prompted me to consider some of the hierarchical issues, (informal versus formal structure and clinicians versus non-clinicians) alluded to in Chapters 4 and 5. More specifically, the tenuous influence holders of managerial titles held over clinicians. When the NHS-NPM intersection is considered it demonstrates managers may have limited stock with clinicians as they do not possess the same clinical skills or knowledge, a patient focus or wield little influence and decision making authority.

Thus, I had to ensure the data I collected was not coloured by my relationship with the Strategy Director. I had to consider the possibility that despite the seniority of the respondents in Phase 1, they may have felt obligated to not refuse a Director. Or perhaps they would view the interview as an opportunity to directly convey their dissatisfaction to a Board member perhaps. This prompted me to spend a considerable amount of time in interviews explaining the data collection and ethics processes with a particular focus on data protection. This ensured that respondent's understood that their data would not be attributable. Further, I used a positive organisational psychology approach to build my own rapport with case informants regarding the new ways of working or changes they were instituting in their area and the value of my research. This aided me in minimising the perception that I had been 'sent by management.'

My access considerations became more complex as I entered Phase 2 of data collection. I was again able to leverage my relationship with the Strategy Director to introduce the second phase of data collection to 5 potential Clinical Business Unit, Service Heads and Chair of the R&D Committee selected from Phase 1

interviewees. Whilst this provided me with access to the person in charge, this access did not automatically translate to their team. Thus, Phase 2 interviews with the leads of the 3 embedded units taken forward (Table 16) were critical to not only collecting data but also locating and cultivating further access points. These included, key team members, meetings, pertinent policy papers and internal documents to assist in fully developing the embedded units within the LEMT case.

Methodological self-consciousness also has a role when the researcher deploys (participant) observation as part of data collection strategy, as I did in this study's second phase. This requires I take into account the relationships I cultivated during the research process and then leveraged for further access. Furthermore, it calls for me to be mindful of my own, even if inadvertent, biases, prejudices or assumptions in addition to, those I may unintentionally accept from case informants. Thus while employing participant observation at the meetings I learned of allowed me to meet and observe team members as well as offer them an opportunity to participate in the study, I had to be aware of the risk of no longer being seen as an observer.

For instance, I was asked to participate in one of the research group meetings, Journal Club (Table 17), as a presenter on the Foundations of Qualitative Research. I will say I was apprehensive about presenting on qualitative research to a team whose discipline was grounded in quantitative methods. Especially as I understood that my presentation invited evaluations and criticism that could influence how they perceived me as a credible researcher and the robustness of qualitative research. However, I also knew that it was an opportunity to provide the PRS team with insight into the value of management research and its practical contributions to organisational life. I was also aware that being seen as contributing to the PRS team could help shift perceptions enough to encourage more willing participants to give up time for interviews, which would otherwise be devoted to their clinical and research remits.

As it was several PRS team members volunteered to participate after my presentation. This was valuable in that it allowed me to (1) speak to individuals in

a wider variety of professions, for example, different types of AHPs and (2) a more in depth probe of the PRS team as an embedded unit within the single LEMT case. This was particularly useful as the team was on the frontline where healthcare professionals are expected to institute change to best serve the local market. Overall, it was a valuable opportunity to immerse myself in the group and shift myself away from my association with management in the eyes of the Head of the PRS. Further, I could move closer to frontline staff who had less knowledge of my relationship with the Strategy Director. Especially as this study seeks to explore individuals at all levels in the organisation.

6.5.4.2 Interpretive Reflexivity

Reflexivity and interpretation go hand in hand because the researcher has to contemplate or think to they make sense of an object, subject or text. Foremost, interpretive reflexivity advocates the researcher utilise an interpretive style where non-obvious, alternative modes of thinking and acting are sought. I use radical referential reflexivity to achieve this as it promotes a sceptical treatment of representation (Lynch, 2000). That is, as a researcher I a have fiduciary duty to go beyond the truth claims of study participants and question how as a researcher I construct meaning. As such, analysis should deconstruct or at least problematise subject claims about the social world or their local context. Furthermore, by acting as a radically reflexive researcher I acknowledge my role as an intersubjective inventor of reality, not its representative. As such, radical reflexivity demands I turn the act on myself to deconstruct my own view of reality and the nature of meanings. This is critical as my construction of accounts in this thesis is open to varying interpretations from future readers.

Wearing this ‘sceptic’s hat,’ I considered the data collected in conjunction with the bodies of literature upon which this thesis is predicated. For instance, I had to challenge some of the underlying assumptions in the extant research. As a CE researcher I accept the consensus in the literature that CE is firmly associated with improved firm performance making it an activity an organisation and its members should strive towards. However, as LEMT respondents gave accounts of their negative perceptions of entrepreneurship in wider society and then within

their organisational context, I had to consider these in parallel to my own positive views of CE. Case informants also drew delineations between the NHS and 'business-like' private sector organisations, despite the attempts of NPM reforms to transform the health service. This also often linked to the strong political views that respondents held about how the NHS has evolved and has been managed. As such, I had to take into account the strong feelings and convictions respondents expressed and how these views could distort depictions of reality.

Nonetheless, even as they wholly rejected CE and challenged its applicability to the NHS, questions regarding EO as an alternative conceptualisation, revealed that there were aspects of entrepreneurship they found useful. At its core my research seeks to understand how one set of beliefs, values and behaviours can be substituted with these more CE/EO behaviours, activities and processes. That is, how organisational members can move from not acting in an entrepreneurial manner to doing so on their organisation's behalf. This prompted me to reflect on the characterisations of public sector employees as risk-averse agents of bureaucracy and purveyors of rules and regulations in the literature. I considered this in conjunction with the idealised image of their selves that respondents proffered, first as a NHS employees and second their job within LEMT as a factor that prevented them from being entrepreneurial for LEMT. Further, as barriers to CE, these self-descriptions did not fit comfortably with the factors (organisation size, external environmental condition for example) known to the CE literature. Yet, the embedded units selected for Phase 2 were involved in some sort of CE related activity. This prompted me to question respondent's firm adherence to this idealised image and probe deeper to seek out how the individuals in these units accomplished a CE related mode of thinking and acting. It is within this exploration with respondents that accounts of transformations of who they were emerged.

6.6 Data Analysis for Qualitative Case Study Research

To re-iterate, this research is wholly qualitative for theory development on how organisational members choose to act entrepreneurially via CEI formation rather than test a specific hypothesis or formula. Thus, it is concerned with identifying

themes *from* the data, rather than identifying to what extent theories and constructs identified in the literature occur in practice. Thus, full transcripts and field notes were generated from each interview to successfully facilitate analysis as well as reduce the threat of losing context and misquoting. However, Eisenhardt (1989) states qualitative data analysis for the aforementioned purpose can be somewhat difficult when the following three issues are considered. First, as described previously, context remains a key concern (Seale et al., 2007). Second, the lived reality of social phenomena and therefore its emergent and dynamic nature requires the researcher to frame it as a situational circumstance or temporal change. Third, the phenomena's beginning or ending cannot be easily distinguished (Holstein & Gubrium 2007).

These issues raise analytical concerns on two levels: (1) the overarching integrity of the case and (2) the actual analysis of data and its transformation into findings. To address the first concern, Yin (2009) encourages the adoption of an overarching analytic strategy that the researcher should adhere to throughout the analysis process. This will continuously enhance rigour and optimise the quality of case study development. For this project, the selected analytic strategy employed relies on adhering to the research objectives that reflect theories of EI formation and CE phenomena, to ensure I focus on pertinent data.

Pertaining to the second issue, Eisenhardt (1989) asserts,

> *Analysing data is the heart of building theory from case studies, but it is both the most difficult and the least codified part of the process.* (p. 539)

As such Eisenhardt (1989) identifies several key techniques commonly used in the management literature to minimise the chasm that often separates data from conclusions, which can degrade the rigour of case findings (Yin, 2009; Miles & Huberman, 1994; Glasser & Strauss, 1967). The main analytic techniques I will employ are *within-case analysis* and *cross-case patterns* (Eisenhardt, 1989) both of which are suitable for the single embedded cases. Within-case analysis involves the development of a descriptive framework for organising the case study. This strategy generates insight, emphasises context description and

captures contemporary phenomena to build the transferability and credibility of case findings (Gersick, 1988; Pettigrew, 1988). Cross-case patterns strategies are used to improve rigour by forcing the researcher to go beyond initial impressions and use diverse lenses on or re-organise the data. This technique is usually employed when a study has a multiple case study design. However, I have adapted this technique and have used it as a *cross-unit patterns* strategy. This has enabled me to draw comparisons and highlight differences between the 3 embedded units with my single case.

Both these techniques aided me in identifying key themes and patterns to create categories to link the data with theoretical explanations and concepts from the CE and EI theoretical constructs and the research questions (Coffey & Atkinson 1996). Further, the themes produced from the interview data were be merged with field notes and documental evidence to boost accuracy and link interview responses with the organisational context (Silverman, 2003). To aid the coding process I used the software program NVivo 10, which some researchers advocate produces a more rigorous and transparent approach to data analysis (Bringer, Johnston & Brackenrisge, 2004). Although the Nvivo 10 software suite can be advantageous for coding and data management it does not analyse data per se. Actual data analysis lies solely with the researcher who must interpret, conceptualise, examine relationships and develop theory as well as prevent data from becoming de-contextualised or quantified (Bligh, Kohles & Meindl, 2004; Bringer et al., 2004).

As such, to establish high quality qualitative data analysis procedures I adapted the process suggested by Cresswell (2009) and Tesch (1990) to guide my use of Nvivo. First, I selected a transcript and considered its underlying meaning without thinking about the content. I repeated this for all the participants, to create a master list of first order codes, which consisted of common statements regarding respondents' perspectives (Locke, 2001). Next, in an iterative fashion, I travelled back and forth between the literature the first order codes to begin grouping and reducing the number of first order topics and categories (Miles & Huberman, 1994). This created second order codes by considering what fit with my theoretical framework and whether new codes or categories had emerged. As data

analysis proceeded I was able to draw further links between some of the second order codes and group these into third order codes. Collectively, second and third order codes represent descriptions or themes represented in the data. This allowed me to take a broad interpretation of the data via personal interpretations and meanings derived from the literature or theories (Cresswell, 2009). Creswell (2009) also recommends that all first, second and third order codes represented in the data must be documented through tables, figures or visuals. I have chosen to present my findings in a series of tables and summary figures. I will present these tables in the subsequent sections with a detailed account of how these codes were derived. These tables will also be presented in tandem with empirical Chapters 7, 8 and 9 of which they are the basis along with figures that summarise my findings.

6.6.1 Data Coding for Chapter 7

Corporate Entrepreneurship Desirability: As set out in my theoretical framework in Chapter 3 CEI are a function of organisational member's entrepreneurial attitudes. The first entrepreneurial attitude is CE desirability, which I defined in Chapter 3 as the degree to which organisational members find the prospect of strategic entrepreneurship, corporate venturing and entrepreneurial orientation to be attractive. With this definition in mind I probed the case data (transcripts, field notes and documents) in line with the analysis procedures set out in above to find contextual factors that influenced respondent's affect towards CE. This process yielded four main organisational contextual factors that influence CE desirability: *language, external environmental conditions* and *NHS identity* and *professional identity*. NHS identity and professional identity were later linked to produce the third order code *social identity*. I have captured these factors in Table 20 and will present how I distilled these contextual factors that influence CE desirability next.

Language: As I stated previously in Section 6.4.1.3**,** CE is not a term common to the layperson. Therefore introducing the CE concept to respondents to glean their perceptions of CE desirability was an incremental process. This involved first asking respondents to define entrepreneurship in general and then make

connections to the organisational context, LEMT and NHS. Forming these links was facilitated by posing questions about the dimensions of the *entrepreneurial orientation* EO construct discussed in Chapter 2, which is routinely used in CE research. From the case data, I considered the difficulties respondents had as they attempted to define entrepreneurship, CE and EO (*definitional uncertainty,* Table 20). However, it became clear that these terms elicited very specific opinions, associations and connotations that spoke to the core of CE desirability. These included some unflattering descriptions and opinions of *entrepreneurial individuals* and respondent's *perceptions of entrepreneurship in the NHS*, (Table 20). This links to the growing research agenda on socially situated cognitions in entrepreneurship (Clarke & Cornelissen, 2011). Hill & Levenhagen (1995) state that *language* has formative effects on cognitive processes, in this case respondent's perceptions of CE desirability. Consequently, the authors argue that language should be integrated and theorised in the context of entrepreneurial action (or inaction). This signals to the emergence of language as a second order code, Table 20.

External Environmental Conditions: I considered respondent's perspectives on several policy changes at the governmental level from the DH to cope in these challenging conditions (*political agenda,* Table 20). Some of these policies advocate that NHS Trusts like LEMT adopt a more business-like approach and signalled to what some respondent's deemed 'the new NHS.' This suggests that at the governmental level, CE is a desirable strategic option. Yet, my analysis also revealed that most respondents on the frontline questioned the validity of the new policies and generally found them wanting (*applying entrepreneurship in the NHS*, Table 20). This suggests that CE was not necessarily as attractive to organisational members as it was to policy makers. As such, I adopted *external environmental conditions*, which are purported as a trigger for an organisation to adopt policies that foster entrepreneurship (Ireland et al., 2009; Stopford & Baden-Fuller, 1994) as a second order code that influenced perceptions of CE desirability, Table 20.

Social Identity: Creswell (2009) suggests that researchers should analyse their data for codes they would expect to find from common sense. As such, it was not

surprising that first order codes that summarised and described *what the NHS* is emerged (Table 20). All study participants invariably cited the beliefs and values that govern the NHS's social mission and how it was funded. Their descriptions created the impression that the NHS was a dominant entity characterised as both a monopoly and employer monopsony. Correspondingly, the NHS's dominance was reflected in respondent's descriptions of their selves or *who I am as an NHS employee* (Table 20). Respondents with a clinical remit customarily referred to the major role the NHS played in their education and training in addition to their motivations for joining the organisation. Similarly, the use of the cross-unit pattern search technique encouraged me to select participants who belonged to various professional groups: nurse, doctor, AHP, healthcare scientist and manager. Throughout each of their interviews all respondents frequently described the very specific work of their chosen profession, which elicited the first order code, *what I do as a professional* (Table 21). A second first order code emerged, *who we work for*. All respondents, clinical and non-clinical, constantly discussed patients who they put first and foremost and were inextricably linked to the work they did and how they did that work.

In keeping with the iterative nature of qualitative research I returned to the literature as these four first order codes did not naturally constitute part of the CE or EI domains, as per the literature reviews in Chapters 2 and 3. By taking cues from the first order codes, which reflected how study participants defined themselves in the LEMT organisational context I attempted to locate a suitable theoretical base. Several literatures emerged (socialisation, for example). However, I found an extensive body of work existed that addressed both self-concept and professions in the identity literature. This prompted the full literature review on identity completed in Chapter 4. In doing so, I was able to focus on social identities that stem from membership to and the knowledge gained from a social group as well as, the value and emotional significance the individual then attaches to that membership (Tajfel, 1978). Additionally, this provided insight into how individuals behave when they are part of a social group, which describes, prescribes and proscribes, the individual's beliefs, attitudes, feelings and behaviours (Hogg, Terry & White, 1995).

Using this theoretical base, I interpreted the NHS and profession codes as representing two discrete social groups to which respondents belonged in the NHS-LEMT organisational context to create the second order codes, (Table 20): (1) NHS identity and (2) professional identity. As both the NHS and professional identities are predicated on group membership, I linked them to create the third order code social identity, (Table 20). Returning to the data I was able to further extract and refine the first order code *legitimacy*, which captured the importance of complying with the recognised rules, standards, traditions and behaviours of their chosen profession (Tajfel, 1978). Respondent's need to maintain legitimacy speaks to CE desirability. CE becomes less desirable as case informants are equally motivated to maintain their in-group status by adhering to the beliefs, values, attitudes and behaviours stipulated by the group and avoiding those that are not (Hogg et al., 1995). Based on their descriptions, it was clear that CE behaviours are not an inherent part of respondent's NHS or professional identity and as such should be avoided. This motivation to avoid CE behaviour was only compounded by the profit maximisation and privatisation outcomes they believe to be associated with introducing CE policies into the NHS.

<table>
<tr><th>First Order Codes
Statements about:</th><th>Second Order Codes SEE Influencing Factors from the Organisational Context</th><th>Third Order Code SEE Influencing Factors from the Organisational Context</th><th>Entrepreneurial Attitude Influenced by Organisational Factors</th><th>Evaluation of CE Desirability (Negative/Neutral/Positive)</th><th>Findings Derived From</th></tr>
<tr><td>“Definitional uncertainty ” e.g.
• What it entails: financial gain, innovation, competition
• It is a private sector practice</td><td rowspan="3">Language</td><td rowspan="5"></td><td rowspan="5">Corporate Entrepreneurship Desirability</td><td rowspan="3">Negative & Positive</td><td rowspan="5">Across the LEMT Case</td></tr>
<tr><td>“Entrepreneurial individuals” e.g.
• Organisation founders
• Personality, characteristics, traits & behaviours of the entrepreneur</td></tr>
<tr><td>“Perceptions of entrepreneurship in the NHS” e.g.
• Negative connotations: untrustworthy, suspicious
• Focus on profit generation
• Uncomfortable topic</td></tr>
<tr><td>“Political Agendas” e.g.
• Governmental policy
• Financial constraints</td><td rowspan="2">External Environmental Conditions</td><td rowspan="2">Negative</td></tr>
<tr><td>“Applying entrepreneurship to the NHS” e.g.
• Historical maturation/NHS traditions
• Privatisation/Business-like approach
• The ‘new’ NHS</td></tr>
</table>

Table 20: Data Analysis Table Showing Influencing Factors from the LEMT Context that Impact Perceptions of Desirability in Corporate Entrepreneurial Intention Formation

<table>
<tr><th>First Order Codes
Statements about:</th><th>Second Order Codes SEE Influencing Factors from the Organisational Context</th><th>Third Order Code SEE Influencing Factors from the Organisational Context</th><th>Entrepreneurial Attitude Influenced by Organisational Factors</th><th>Evaluation of CE Desirability (Negative/Neutral/Positive)</th><th>Findings Derived From</th></tr>
<tr><td>“What the NHS is” e.g.
• Publicly funded
• NHS beliefs & values
• Monopsony: main employer
• Monopoly</td><td rowspan="2">NHS Identity</td><td rowspan="5">Social Identity</td><td rowspan="5">Corporate Entrepreneurship Desirability</td><td rowspan="5">Negative</td><td rowspan="5">Across the LEMT Case</td></tr>
<tr><td>“Who I am as an NHS employee” e.g.
• Education & training
• Socialisation processes
• Motivation: Why we joined the NHS</td></tr>
<tr><td>“Who we work for” e.g.
• Two masters: LEMT & patient
• Patient-clinician relationship</td><td rowspan="3">Professional Identity</td></tr>
<tr><td>“What I do as a professional” e.g.
• Caring, diagnosis, rehabilitation, therapy, managing, diagnostic testing
• I am here for the patients</td></tr>
<tr><td>“Legitimacy” e.g.
• What behaviours are or are not valued by a professional group</td></tr>
<tr><td colspan="6">Emergent Theory: (1) Social Identity Approach</td></tr>
</table>

Professional Identity Types present in LEMT Case	In vivo examples ***Statements about:*** ***What I do as a Professional***	First Order Codes: Professional Identity Work Content	CE Desirability Influencer	Evaluation of CE Desirability
Nurse Identity	*Nurses feel the need to hold on, get a bit too touchy feely… the fluffy side of caring that's where nurses are…I was a CCU [Coronary Care Unit] nurse. And I do look back on those days very fondly; because we had a small 8-bedded unit and the most you looked after was 3 patients, and that was not very often. It was usually 1 or 2. You were able to give complete and utter care and time to that patient. It was great!* ***(Nurse 3, Phase 2)***	'Caring'	**Professional Identity Influences Corporate Entrepreneurship Desirability**	Negative
Doctor Identity	*So if you went to another discipline like surgery where a lot of it is down to the skill of the surgeon or the anaesthetist for example. It's a bit less the case for us where people like myself [physician] who provide more overall strategy and leadership than care of patients. So sometimes it feels like you don't do anything, when actually what you're doing is directing the rest of the team, providing a broader context. In a way that's what Doctor 4 and I do in the rehab group [Pulmonary Rehabilitation Service].* ***(Doctor 2, Phase 2)***	'Discipline-based Diagnosis Treatment'		
AHP Identity	*Initially when you very first qualify, your first couple of years it was all about just getting hands on experience, so really nailing down and perfecting your skills, sort of hands on skills, your manual skills and your clinical reasoning and decision making processes for diagnosing and treating these patients…* ***(AHP 5, Phase 2)***	'Rehabilitation & Therapy'		

Table 21: Data Analysis Table Extracted from Table 20 showing Professional Identity Work Content

Professional Identity Types present in LEMT Case	In vivo examples *Statements about:* *What I do as a Professional*	First Order Codes: Professional Identity Work Content	CE Desirability Influencer	Evaluation of CE Desirability
Healthcare Scientist Identity	*The backroom boys who don't really you know…there was an element of being a bit like the mad scientists. There is a door there, nobody really comes through there, you know, largely. It is so different to a ward environment or an office environment and most people if they don't work in pathology have no idea and don't want to know what happens, because it's rather well… oh it's bits of bodies! Blood and urine and faeces and chemicals- so I think it [pathology] is a bit of a rarefied environment.* ***(Healthcare Scientist 2, Phase 2)***	'Diagnostic Testing: Exploratory and/or Confirmatory'	**Professional Identity Influences Corporate Entrepreneurship Desirability**	Negative
Manager Identity (Non-clinical)	*…it was about a lot of forward thinking, strategy planning, capital investment, capital development, working with commissioners, doing a lot of the external networking stuff. You know… it was a whole multiplicity of, combination of skills and expertise. You have to have energy enthusiasm, commitment, thinking out of the box, not being frightened to come up with a new idea. Respecting people's values and views, active listening, being in a position to respond, there's responsiveness, I think flexibility, effective communication at all levels. It's about giving and receiving feedback, very much about being a 'do-er' and somebody who delivers. It's also about offering those core leadership qualities. It's about values and behaviours,* ***(Manager 7, Phase 2)***	'Managing & Administration'		

Corporate Entrepreneurship Feasibility: In Chapter 3 I defined the second entrepreneurial attitude CE feasibility as the degree to which an individual believes they are personally capable of behaving like a corporate entrepreneur or participating in CE activity. This definition guided my analysis of the case data to find factors that respondents perceived influenced their ability to act entrepreneurially in LEMT. I was able to extract three organisational contextual factors that influence CE feasibility. These factors include: *organisation size and structure, strategic vision* and *professional identity* (summarised in Table 22).

Organisation Structure and Size: Despite respondent's expressed willingness to be proactive, innovative or take risks, they conveyed that, in its current configuration, LEMT was unable to facilitate such behaviours. Guided by this interpretation as well as the a priori constructs, 'conditions that engender CE' discussed in Chapter 2, I extracted 2 first order codes that spoke to LEMT's organisational design: *changes to LEMT's configuration* and feeling *disconnected from LEMT*. Changes to LEMT's configuration spoke to the mandatory structural reconfiguration of LEMT induced by NHS England. This resulted in LEMT's current state as one of the largest Trusts in England. Respondent's disconnectedness from LEMT however, stemmed from their views that these changes impede communication, increase bureaucracy and centralise decision-making and ultimately hinder their ability to act entrepreneurially in LEMT. Referring to the CE literature I subsumed both first order codes into the second order code: organisation size and structure.

Strategic Vision: From a top-down perspective the CE literature widely promotes that an organisation's strategic vision can foster CE as it reflects the belief and values of the top management team (Ireland et al., 2009). However, this thesis aims to understand CE from the bottom-up. Thus, by focusing on the transcript data from respondents on the frontline, I was able to extract 2 first order codes: *credibility* and *no supporting infrastructure*, that spoke to the perspectives of frontline staff on LEMT's strategic vision. The *no supporting infrastructure* first order code, spoke to the practicalities of realising LEMT's vision. Respondents considered that while research was part of what LEMT did as a teaching hospital, it certainly did not have the expertise or capability to support innovation.

Credibility summarised respondent's lack of support for and inclination to question the foundations upon which LEMT's strategic vision is built.

Professional Identity: Case informants belonged to a variety of professional groups, each of which had its own specific work content (Table 21). In conveying the type of work they performed, respondents simultaneously signalled to the *nature of work* (Table 22). They referred to the time consuming nature of the professional routine they performed each day that was expected as a part of LEMT's service provision (shifts and ward rounds, for example). Further, they underscored the importance of performing that work in the manner prescribed by their education and training as well as the rules and regulations of a profession's governing body (Royal College of Nursing, for example). While prescriptiveness was a part of work in this context, in some cases it created the impression among some respondents that participating in new behaviours like CE was *not a part of their job* (Table 22). I linked both first order codes to the established second order code professional identity.

First Order Codes *Statements about:*	Second Order Codes SEE Influencing Factors from the Organisational Context	Entrepreneurial Attitude Influenced by Organisational Factors	Evaluation of CE Feasibility (Negative/Neutral/Positive)	Findings Derived From
"Disconnected from LEMT" e.g. • Directed by discipline not formal structures • Where we work	Organisation Size & Structure	Corporate Entrepreneurship Feasibility	Negative	Across the LEMT Case
"Changes to LEMT's configuration" e.g. • Historical factors: Merger to form LEMT • Extensive and complex management hierarchy • Blocked communication • Bureaucracy and centralised decision-making				
"No supporting infrastructure" e.g. • No commercialisation expertise in LEMT • 'R but no D': Strong research background but no development	Strategic Vision		Negative	
"Credibility of," e.g. • Political policies commercial agenda • LEMT strategies				
"Space for entrepreneurship" e.g. • Re-active culture, constant fire-fighting • Time consuming nature of work	Professional Identity		Negative	
"Nature of work " e.g. • Routinised • Prescriptive • Time consuming, don't have space for CE • Fire fighting, reactive				
"Entrepreneurship is not my job" e.g. • Not part of my professional identity • Entrepreneurship is not a valued behaviour				
Emergent Theory: (1) Social Identity Approach				

Table 22: Data Analysis Table Showing Influencing Factors from the LEMT Context that Impact Perceptions of Feasibility in Corporate Entrepreneurial Intention Formation

6.6.2 Data Coding for Chapter 8

Precipitating Events

I revisited the SEE framework presented in Chapter 3 and utilised the a priori construct: *precipitating events*. Shapero & Sokol (1982) proposed that precipitating events aid EI formation by interacting with an individual's pre-existing positive evaluations of desirability and feasibility so EI maybe formed. These events displace the inertia that guides the normal course of individual behaviour, so entrepreneurial action can ensue. In an iterative fashion I returned to the transcript data. I considered all 60 transcripts and not just those from the entrepreneurial units investigated in the second phase of data collection. This was because Phase 1 study participants were labelled as entrepreneurial as per the selection criteria. I searched for any precipitating events that respondents described as disruptions to the normal course of their beliefs, values and behaviours associated with their NHS or professional identities. This process yielded the four first order codes presented in Table 23.

These four first order codes summarise the stories and experiences proffered by respondents of various precipitating events that punctuated their career paths. Each first order code was also indicative of some change in their circumstances that prompted case informants to reconsider the normative thinking and prescriptive behaviours of their NHS and professional identities. As analysis progressed, these first order codes naturally disaggregated into categories that targeted respondents' NHS identity: *policy change* or professional identity: *policy change, adopting new roles* and *exposure to others*. NHS identity policy changes were those policies that usually stimulated national level debates as they inevitably held implications for the NHS founding principles such as commercial agenda of Equity and Excellence policy discussed previously.

Professional identity policy changes were policies that had implications for a how a particular professional group would provide services. For instance, the Carter Report (DH, 2006) sought to introduce competition into pathology services provision, which had implications for how doctors, healthcare scientists and managers would work. As respondent's careers progressed, they usually adopted

new roles that changed their prototypical work content (such as doctor who no longer saw patients and was now solely research based). Exposure to others was inevitable as all respondents joined various teams and organisations as their careers progressed. Finally, I integrated these first order codes to empirically derive one theoretical second order code: precipitating events that disrupt social identity, Table 23.

Multiple Social Identities	First Order Codes *Statements about:*	Second Order Codes	Findings Derived From
NHS Identity	'Policy Changes' e.g. • The 'new NHS' • Commercial agendas • Financial constraints	**Precipitating Events that Disrupt Social Identity**	**Across the LEMT Case**
Professional Identity	'Policy Changes' e.g. • New service delivery pathways • Meeting targets rather than outcomes		
	'Adopting new roles' e.g. • Leadership roles • Management roles • Research roles		
	'Exposure to others' e.g. • Joining a new team • Working with other professions • Encountering significant others e.g. role models, entrepreneurs etc.		

Table 23: Data Analysis Table Showing Precipitating events That Disrupt the Normal Progression of Social Identity

Identity Tension: Inauthenticity, Credibility & Self-Efficacy: First, respondents described the disruptions to their multiple social identities as being pulled in two separate directions by two sets of identity demands. I summarised all of these accounts with the first order code bi-directional pressure (Table 24). The first of these demands that case informants described was the pull of an existing social identity. Whereas, the second set of demands originates from the new circumstances created by precipitating events in the LEMT context. These new circumstances advocate that respondents should ultimately adopt some new set of beliefs, values and behaviours that differ from those originally held by the social group. Returning to the identity literature, I was able to link the bi-directional pressure first order code to the existing *identity tension* construct as a second order code, Table 24.

In conveying the bi-directional dichotomy presented by identity tension, respondents generally conveyed great uncertainty when considering or attempting to adopt the new beliefs, values and behaviours suggested by precipitating events. These difficulties primarily stemmed from respondents contemplating what it meant to move away from their existing NHS and professional identities and towards some newly constructed or re-constructed version of their self as directed by precipitating events. This reaction is in keeping with portrayals of identity tension in the literature, which indicate that shifting identities can be experienced as contradictory or incompatible. As such identity tension is often characterised by ambiguity and paradox (Kreiner et al., 2006; Knights & Willmott, 1999). Following this premise, I returned to the transcript data and probed for issues related to identity tension (conflict, contradictions, paradox) as suggested by Gotsi, Andriopoulos, Lewis & Ingram (2010) for the NHS identity and professional identity. I also searched for the emotional and cognitive arousal cues which also signal to identity tension (Kreiner, et al., 2006; Alvesson & Willmott, 2002).

This process produced seven first order codes that spoke to the nature of identity tension: two for the NHS identity and five for professional identity. Analysis revealed that the possibility of shifting from their NHS identity to some new version of their NHS self, raised concerns about *incompatibility* of the old and

new. For instance, having a commercial mind-set in in publically funded institution. They also considered the possibility of a *NHS identity cost*. That is, the future version of their NHS identity would require they compromise or give up the NHS founding principles upon which their NHS identity is predicated. Similarly, respondents were concerned about a *professional identity cost* where their new professional self may take them away from the frontlines of practice. Case informants also refer to the perceived *incompatibility* new work content with their existing work content. I linked the two NHS identity first order codes and two professional identity first order codes to the *inauthenticity* construct.

Data analysis revealed three additional first order codes (later mapped onto 2 second order codes) that characterised professional identity tension. The possibility of a shifting professional identity raised issues surrounding an individual's competency in the eyes of others. I summarised these issues in the two first order codes *other's perception* and *in-group relationships* and linked them to the second order code *credibility* from the identity literature. The final first order code, *adopting new work content*, emerged as respondents conveyed concerns about their own competency. This aligned with self-efficacy concept discussed in the EI literature review in Chapter 3.

	Multiple Social Identities	First Order Codes *Statements about:*	Second Order Codes	Depictions of Identity Tension *Statements about:*	Second Order Codes	Findings Derived From
Precipitating Events Interrupt Multiple Social Identities	**NHS Identity**	'Bi-directional pressure': being pulled in two directions • Pull of prototypical social identity • Pull towards a re-constructed version of the self	**Identity Tension**	'Incompatibility' e.g. • Business mentality versus NHS founding principles • Private versus public sector • Profit generation versus taxation funding	**Inauthenticity**	**Across the LEMT Case**
				'NHS Identity cost' e.g. • Threat of losing NHS founding principles		
	Professional Identity			'Incompatibility' e.g. • Changing professional expectations • Less time for practice	**Inauthenticity**	
				'Professional Identity cost' e.g. • No longer on the frontlines • Forced to change work content		
				'Others perception' e.g. • Is 'X' competent? • Working with other professions	**Credibility**	
				'In-group relationship' • People challenge my new work content		
				'Adopting new work content' e.g. • Am I capable? • Do I have the right skill sets? • What I do know versus what I do not know • Learning	**Self-efficacy**	

Table 24: Data Analysis Table Showing the Impact of Precipitating Events that Interrupt the Normal Progression of Social Identity

6.6.3 Supplementary Data Analysis Procedures and Coding for Chapter 9

The within-case and cross-unit pattern analysis techniques as well as my coding procedures have proven useful in accommodating the emergent identity concepts and theories. However, handling some of identity's emergent constructs appropriately required me to employ more specialised techniques. The succeeding sections will detail these more specialised data analysis techniques and how they were used in conjunction with the established analysis and coding procedures.

Identity Work: Individuals ultimately seek a stable or routinised life situation where the narrative of self- identity, including their multiple social identities, runs fairly smoothly (Krueger, 2007; Alvesson & Willmot, 2002). Following this premise, I continued to analyse the qualitative data (transcripts from in-depth semi-structured interviews, documents gathered and [participant] observation vignettes) in an iterative manner as per the single case study design and within-case analysis technique. This took me back to the identity literature to understand how this consistency can be achieved. I focused on the theoretical and empirical literature that suggests ambiguity and uncertainty can trigger processes that initiate its own resolution or minimisation. These processes involve the interpretive activities where identity construction takes place in social contexts known as *identity work* an appropriate response to identity tension (Beech et al., 2012; Sveningsson & Alvesson, 2003; Dickie, 2003; Ibarra, 1999; Van Maanen, 1997). It is important to note that participants did not use the term 'identity work' rather; the term was wholly a theoretically informed interpretation of recounted experiences.

In the initial stages of data analysis I used the within-case and cross-unit pattern techniques aided by Nvivo 10, to search for indicators of self-concept and group membership like *who I am* and *what I do*. My interest in the transformative nature of identity work prompted me to look for instances of more transitional versions of these codes such as, *who I am becoming*, *who I am now* and *what I do now*. However, to augment these generalist techniques, I integrated the within-case and cross-unit pattern analysis techniques with techniques more commonly used in

identity research. I used recommendations from identity researchers to search the case for content issues common in identity work to guide coding at this stage. Specifically, I used three content indicators (1) personal pronouns, (2) emotion and (3) cognition which I elaborate on below (Lutgen-Sandvik, 2008; Kreiner, et al., 2006; Alvesson & Willmott, 2002; Stets & Burke, 2000).

First, I focused closer attention on singular and plural personal pronouns (e.g. I, I'm, my, mine, etc. and we, we're, us, our, etc.) to point towards the individual as a member of the NHS as well as a professional group (Lutgen-Sandvik, 2008). For example, *'I don't see myself as'* or *'us as a team are.'* Additionally, the literature states social identity is equally determined by the accentuation of perceived differences between the self and the out-group as well as similarities between the self and the in-group (Stets & Burke, 2000). Therefore, I also searched for singular and plural third person pronouns (e.g. he, she and they, them, others) to point towards whether the out-groups respondents were comparing themselves against varied or remained the same. For instance,

> *'I've been involved in senior management roles… but the clinical leads for the clinical business units [CBUs] are first and foremost, still doctors and that's what they still want to do.'* ***(Doctor 6, Phase)***

This suggests that a manager identity is more representative of Doctor 6's current in-group membership than a doctor identity.

Second, emotions were also important for initial coding because they signalled to identity work in response to identity tension (Kreiner, et al., 2006; Alvesson & Willmott, 2002). Ashforth & Humphrey (1993) state that in addition to being a sign of the 'I,' emotions symbolise strong cues that identity construction was occurring or had occurred, such as, *'I was happy.'* Additionally, Ibarra (1999) states negative emotions are also particularly useful as they stem from an inability to convey 'an image that is consistent with a salient self-conception' (p. 780). For example, *'we were forced'* and *'it doesn't feel right.'*

Third, Stets & Burke (2000) state cognitions are key to understanding identity construction as they underpin the beliefs, values and behaviours of social structures. Similarly, the changing circumstances instigated by precipitating events require an information processing view to assist in the interpretation of the respondents changing social contexts in LEMT so they could act accordingly. As such, I searched for instances of cognitive processing such as, 'I think,' 'I probably' or 'I guess.' Further, within the larger scope of this project, cognition aids in explaining attitudes (Azjen, 2001), which underpin CEI formation.

Once the identity work content was acknowledged for respondent's NHS and professional identities, I returned to the traditional within case analysis and cross unit techniques, aided by Nvivo 10. This allowed me to search for unique patterns and themes within the identity content to complete the coding process. I noticed two general themes: (1) resistance to changing circumstances in the NHS and professional identity content and (2) willingness to change as circumstances did in the professional identity content only. Both of which fit with my interest in what can hinder or facilitate CE. Guided by these two themes, which I generally thought of as the basis of 2 distinct identity work processes, I continued the data analysis process to fully understand their defining features, described below.

Re-affirmation Identity Work: I first noticed elements of resistance during observations and interviews. Respondent's appeared steadfast to the NHS and professional identity prototypes described in Table 21, amidst the changing circumstances created by precipitating events in Table 24. Even as respondent's existing NHS and professional identities were being challenged, they chose to actively resist changes to the beliefs, values and behaviours that governed their NHS identity (NHS founding principles) and professional identity (work content). This suggests that some level of reconciliation was occurring via identity work to resolve or minimise identity tension in favour of their existing NHS and professional identities. I extracted three first order codes that spoke to resistance for the NHS identity: *maintaining specific aspects of the NHS identity, actively rejecting incongruous messages* and *maintaining a sense of altruism*. For professional identity there were two first order codes, which spoke to resistance: *strengthening and re-iterating a preferred identity* and *convincing others to treat*

one according to a preferred and valued identity. The five resistance first order codes across the NHS and professional identities were grouped to create a second order code that was wholly derived from the data, which I called: *re-affirmation*, Table 25.

Sensemaking Identity Work: Conversely, I found instances where individuals had embraced change. This was usually reflected in observable behaviour during meetings and narratives around how they had or were somehow changing so that they had incorporated new beliefs, values and behaviours, some of which were pro-CE. However, data analysis revealed this change was only evident in the professional identity content. This suggests some respondents had employed an identity work strategy to counter professional identity tension in a manner that allowed them to successfully adapt or start adapting their professional identity. This tendency by some case informants to accommodate the new direction precipitating events were pushing them towards was not surprising, as I had sought out CE pockets in LEMT as per my research design.

It should be noted however, that the data I will present in Section 9.5 about this willingness to change was largely found in Unit 2: Pathology Joint Venture (PJV) and Unit 3: Pulmonary Rehabilitation Service (PRS) (indicated in Table 25 and 26). This varies from the rest of the study, where data was pulled from across the entire case. This was because the PJV and PRS study participants were actively involved in CE at the time of this study. Whereas in Unit 1: R&D Committee, while these individuals were considered to be entrepreneurial by their peers, as a committee my case data indicated they considered the committee to be largely R&D governance. Therefore, while the data yielded from Unit 1 was useful in a contextual (Chapter 7) and effect of disruptions to social identity sense (Chapter 8), it was less useful in understanding identity re-construction that facilitated CE activity.

I extracted first five order codes that spoke to willingness to change, largely directed at respondent's attempts to understand or give structure to the new circumstances created by a precipitating events. Imposing order on the new circumstances seemed to be achieved in three ways. First, respondents tried to

identify some alternative course of action amidst the flux where they felt competent by re-interpreting and re-organising their work content. Second, based on their new work content, study participants sought an adapted version of their professional self (wholly new or reconstructed) that was positive cognitively and affectively. Third, as one would expect with issues of the self, respondents sought to see their new sense of self reflected in their peers. This three-pronged approach to re-organising work content to establish a consistent sense of self seems to align with the extant literature on *sensemaking* (Weick et al., 2005).

I initially designated sensemaking as a second order code. However, after further engagement with the sensemaking literature, I reassigned sensemaking to a third order code having extracted three central sensemaking features that the five willingness to change first order codes seemed to link to, Table 26. These three sub-processes that appeared to ultimately reduce the salience of respondents' professional identity group membership include: *noticing and bracketing*, *labelling* and *communication* were then designated as second order codes.

Noticing and Bracketing: Professional identity is predicated on the more practical aspect of 'what I do as a professional' or work content (Pratt et al. 2006). Therefore, if professional identity is re-constructed in some way by identity work, this suggests work content must have been altered in some way as well. This is evidenced by the atypical pursuit of CE based activities by the PJV and PRS units within the LEMT case. This begs the question, what new work content does the re-constructed professional identity encompass? Undoubtedly some of the precipitating events tabulated in Table 23, assign new work content indicative of management, leadership and research behaviours. However, in the transcript data respondents would spend time explaining what used to be their prototypical work content (see Table 21). This would then be followed by a description of what their work content now looked like. As such, I extracted the first order codes, (Table 26): *delineating prototypical behaviours and new behaviours in new circumstances* and *re-building work content based on new circumstances*. Taken together, the delineating and rebuilding actions were indicative of study participants evolving work content and points to the first sub-process in sensemaking identity work: *noticing and bracketing* (Table 26).

Labelling: As discussed in Section 4.6.1.3-1, noticing and bracketing is only a preliminary step in sensemaking identity work. Even as respondents engaged in noticing and bracketing, their new work content, perspectives and reconstructed professional self remained basically unnamed. As such, during interviews respondents spent time identifying who they perceived themselves to be now. This appears to overlap with the categorisation process in SIA and enabled them to impose order on the social environment and new flows of activities in the wake of precipitating events. The first order codes that summarised these categorisation attempts include: (1) *reducing the incongruence and dissonance created by the 'new'* and (2) *accommodating new self-meanings & expectations* and aligned with the *labelling* aspect of sensemaking (Table 26).

Communication: As one would expect with issues of the self, respondents sought to see their new sense of self reflected in their peers. This links to the discussion I presented in Section 4.6.1.2, where a social identity is only confirmed from the conduct of others. During interviews case informants would relay patterns of two-way and group exchanges that provided opportunities to influence how others saw them and ultimately *gaining credibility with others*, as shown in Table 26. These exchanges seemed to aid the identity work process as study participants were able to articulate and make explicit who they were after the normal course of their social identity was disrupted as well as their new and corresponding work content. This is especially pertinent in the LEMT context where one professional group, is constantly encountering an out-group. Thus, as communication proceeded respondents were able to interpret changing circumstances. I found that my observational fieldnotes from various meetings were very useful to observe these exchanges in action and how the individual and others forged professional identity reconstruction.

Multiple Social Identities	First Order Codes Statements about:	Second Order Codes Identity Work	Identity Work Effect on Multiple Social Identities	Findings Derived From
NHS Identity	Maintaining specific aspects of identity e.g. • Beliefs and values encompassed by the NHS founding principles • Highlighting the incongruence of entrepreneurship Actively rejecting incongruous messages e.g. • DH white papers setting out the 'new NHS' • Suspicion of political agendas Maintaining a sense of altruism e.g. • Higher calling and purpose • We are 'safe' because of what we stand for	Re-affirmation *(Self-enhancement focus)*	**No Change in NHS Identity**	**Across LEMT Case**
Professional Identity	Strengthening, re-iterating preferred identity e.g. • I am a healthcare professional • I have always wanted to be a particular profession • I can't see myself doing anything else • Work content that defines a particular profession or 'what I do as a professional' Convincing others to treat one according to a preferred and valued identity e.g. • Working with others professions • Divergent professional philosophies	Re-affirmation *(Categorisation focus)*	**No Change in Professional Identity**	**Unit 3: Pulmonary Rehabilitation Service**

Table 25: Data Analysis Table Showing Re-affirmation Identity Work Processes Employed & Impact on Social Identities

Multiple Social Identities	First Order Codes Statements about:	Second Order Codes Identity Work	Third Order Codes Identity Work	Identity Work Effect on Professional Identity	Findings Derived From
Professional Identity	Delineating prototypical behaviours and new behaviours in new circumstances e.g. • Are professional meanings changing? • Recognising there maybe more to my work • Orienting myself to when new behaviours are required e.g. product development	Noticing & Bracketing	Sensemaking *(Depersonalisation focus)*	**Professional Identity Re-constructed**	**Unit 3: Pulmonary Rehabilitation Service**
	Re-build work content based on new circumstances e.g. • Exposure to new perspectives, norms, philosophies, beliefs and values • What is my new work content? • Compiling a new repertoire of behaviours e.g. Market research, product development				
	Reducing the incongruence and dissonance created by the 'new' e.g. • Re-interpreting and re-defining professional routines • Justifying why new behaviours • Alternative conceptualisations of entrepreneurship e.g. EO behaviours	Labelling			**Unit 2: Pathology Joint Venture** **Unit 3: Pulmonary Rehabilitation Service**
	Accommodating new self meanings & expectations e.g. • Who I am now • What I do now				
	Gaining credibility with others • Letting others know who I am now • Expressing a willingness to reform their self • Taking cues from others on purpose in new circumstances • Reducing dissonance/conflict surrounding who I/we are now in new circumstances	Communicating			**Unit 2: Pathology Joint Venture** **Unit 3: Pulmonary Rehabilitation Service**
Emerging Theory: Sensemaking					

Table 26: Data Analysis Table Showing Sensemaking Identity Work Processes Employed & Impact on Professional Identity

6.6.4 Levels of Analysis

Levels of analysis need to be clearly defined and articulated in any rigorous research study. Klein, Dansereau & Hall (1994) outline a framework of three alternative assumptions that underscore the conditions of levels in organisational theory: (1) lower subunits are homogenous within higher-level units, (2) they are independent from higher units or (3) they are heterogeneous. CE research has predominantly viewed the individual-level as homogenous with the organisation-level, subsuming organisational members as creators and proliferators of organisation structure, strategy and process. However, as I propose throughout the preceding chapters, this is not necessarily the case. Thus the individual as an enactor of CE will be the main level of analysis for this project.

With regard to the investigation of the embedded subunits however, this individual level approach may become somewhat problematic. As documented in the literature, the individual is vital in the enactment of CE at all levels in the organisation (Floyd & Lane, 2000; Ireland et al., 2009). However, as the CE activity progresses past initial conceptualisation it becomes more of a team effort, thus introducing a group-level of analysis. Klein et al. (1994) takes the view that, individual members of a group are assumed to be sufficiently similar with respect to the construct and the group can therefore be conceptualised as a whole entity. Within the scope of this project however, I diverge from this conceptualisation of the group as homogenous based on Fitzsimmons & Douglas' (2010) typology as it suggests individual have varying EI levels. Therefore, it is possible that not everyone clustered in a group facilitating a CE initiative has the same high or sufficient EI level for driving the activity.

6.7 Conclusion

Within this chapter I have outlined the methodological approach selected to govern this project while considering some of the key anticipated challenges. An interpretivist epistemology has been selected, to focus on a single case study with embedded sub-units of analysis that enhance the probative nature of exploring how CE is enacted in the NHS. Using a combination of semi-structured

interviews, participant observation and document analysis, complex detailed and in-depth data sets will be produced. Qualitative analysis will be completed according to the guidelines suggested by Yin (2009), Eisenhardt (1989) and Cresswell (2009) to organise the data and facilitate coding. Rigour and validity are the main aim in building this case study, as such the research process will be as transparent as possible, drawing on Yin's (2009) case study protocol recommendation and using a theoretical rationale for coding choices. Reflexivity has also been incorporated as a vital aspect of the study to enhance validity. Theoretical analysis will take place at the individual-level to generate knowledge on bottom-up approaches to CE. The findings produced will offer insights into individual level CE enactment in the NHS, via the emergent contextual factors and process that can influence organisational members EI formation.

CHAPTER 7: FACTORS THAT INFLUENCE CORPORATE ENTREPRENEURSHIP DESIRABILITY & CORPORATE ENTREPRENEURSHIP FEASIBILITY

7.1 Introduction

This chapter discusses the barriers and facilitators to CEI formation in LEMT (Large East Midlands Trust) through organisational members' perceptions of CE desirability and CE feasibility. The historical maturation and social mission of the NHS universal healthcare system has resulted in the NHS developing a complex organisational architecture that can challenge CE propagation. This complexity extends to the NHS's service provision units like LEMT, which make for an unconventional setting for CE and EI research (Bamberger & Pratt, 2010; Gartner, 2008; Steyaert, 2007). This chapter makes explicit the novel contextual contingencies that exist in LEMT that may play a role in organisational members CEI formation process. In doing so, I also offer an in-depth description of the LEMT case and its organisational members (Eisenhardt, 1989). Section 7.2 provides the general 'state of CE activity' in LEMT. Section 7.3 identifies and examines the LEMT contextual factors that influence CE desirability (language, external environmental conditions and social identity). Section 7.4 continues to discuss contextual factors by presenting the factors that influence CE feasibility (organisational size and structure, strategic vision and professional identity). This will be followed by a discussion of the findings and implications for the CE and EI literatures in Section 7.5. I conclude this chapter in Section 7.6.

7.2 The State of Corporate Entrepreneurship in the Large East Midlands Trust: Organisational Context Considerations for Corporate Entrepreneurial Intention Formation via Perceptions of Corporate Entrepreneurship Desirability and Feasibility

It was apparent across the LEMT case that study participants did not consider LEMT to be a wholly entrepreneurial organisation; rather, they portrayed CE

activity in LEMT to be *'patchy.'* I present a selection of quotes from three transcripts that support this interpretation,

> *So for example if I think about, if I think, I've probably seen 3 real grass roots, maybe I'm being unfair, but I can remember 3 real grass roots examples of individuals who have sort of stuck their head above the parapet and said, you know, 'I've got a great idea.'* ***(Non-Executive Director 1, Phase 2)***

> *I think it's [entrepreneurship] pretty vital, particularly in terms of services and being a service provider. I think traditionally perhaps LEMT has waited and reacted to things rather than been proactive. I think there are areas of service where there has been very proactive engagement with primary care. But I think again that's patchy and it's certainly not across the board.* ***(Doctor 9, Phase 1)***

> *There are some trailblazing individuals, but I don't think it's a culture in the organisation.* ***(Doctor 8, Phase 1)***

Collectively, the above quotes are indicative of two things. First, organisational members do not perceive LEMT as wholly entrepreneurial. Doctor 9 and Doctor 8 indicate that CE does not occur *'across the board'* or is *'not a culture in the organisation.'* This supports my documentary analysis, which suggests that CE propagation is not only the formal/top-down process conceptualised by some CE scholars (Zahra et al., 1999; Covin & Slevin, 1991; Guth & Ginsberg, 1990). As such, CE in not driven by LEMT's top management team, strategic vision or some underlying organisational strategy that wholly infuses the organisation according to some CE perspectives (Covin & Miles, 1999).

Second, these quotes also suggest that any CE activity in LEMT may be largely attributed to the *'grassroots'* and informal efforts of individual organisational members in their particular work silo. For instance, Doctor 8 and Non-executive Director 1 use euphemisms such as *'trailblazing'* and *'I've got a great idea'* to describe the autonomous initiatives of individuals they believed to be the specific

locus of CE activity in LEMT (Burgelman, 1983). This supports the underlying premise of my thesis to advance CE research by disentangling individual corporate entrepreneurial choice to benefit their organisation from the bottom-up. Crediting CE to the individual and not to the organisation is indicative of not only *'patchiness'* but also the CE behavioural dichotomy that exists for LEMT organisational members. On one end of the spectrum there were CE behaviours occurring with some success within LEMT. The opposite end of the spectrum demonstrates a wider and more pervasive lack of CE of activity in LEMT. This CE-to-no-CE dichotomy has specific implications when considered within the SEE framework I have chosen to employ throughout my study.

As established in Chapter 3, CEI are the best predictor of CE behaviour. Therefore based on the CE- to- no CE behavioural dichotomy discussed above it can be deduced that a corresponding CEI- to- no CEI formed continuum may also exist (Fitzsimmons & Douglas, 2010). Three CEI formation scenarios emerged from the data for consideration. The low incidence of CE activity in LEMT accounted for two of these three scenarios. First, the low incidence of CE activity in LEMT suggests that the majority of organisational members had not formed CEI. Second, the sporadic incidents of CE activity described by respondents and subsequently probed in the course of my research indicate that at some point a few organisational members had formed CEI. Last, in a few instances respondents had not even considered the pertinence of CE activity in the NHS or LEMT, also suggesting CEI were not formed.

Whether CEI are formed or not, is a function of the negative, neutral or positive evaluative judgments of the corporate entrepreneurial attitudes: *CE desirability* and *CE feasibility* towards specific the CE activities covered in Chapter 2 (strategic entrepreneurship, corporate venturing or EO). CEI formation via the SEE framework proposes that CEI formation is facilitated by positive evaluations of CE desirability and CE feasibility. Correspondingly, if CEI are not formed CE desirability and CE feasibility were evaluated negatively. Hence, when I considered the low incidence of CE in LEMT I concluded that respondents evaluative judgments of CE desirability and CE feasibility, varied so they were positive, neutral or negative.

The remainder of this chapter will explicate the LEMT contextual factors that elicit the positive, neutral or negative evaluations of CE desirability and CE feasibility. These influencing factors appear to be attributable to (1) a collection of individual behaviours and cognitions and (2) internal and external organisational conditions. I have summarised these factors in data analysis tables presented in Section 6.6 in Chapter 6. However I will again present these tables in tandem with the data in Sections 7.3 and 7.4 respectively. I begin by presenting the factors that influence CE desirability- *language, external environmental conditions* and *social identity* in Section 7.3. This will be followed by factors that influence CE feasibility- *organisational size and structure, strategic vision* and *social identity* Section 7.4. The descriptions of these influencing factors have also emerged as useful for the secondary purpose this empirical chapter's content and format. While Chapter 7 is primarily probative, it also serves as a detailed case description of the LEMT organisation and the professions of LEMT employees. This provides extensive portrayals of what and how structures, processes and strategies have evolved in the LEMT case in relation to the history, politics and policies of the NHS context presented in Chapter 5. I will culminate with a discussion of the influencing factors I have discovered and how they bear on CEI formation and implications for the wider CE and EI literatures. This will be followed with my choice to focus on the emergent identity literature as a novel perspective on CEI formation in the organisational context.

7.3 Corporate Entrepreneurship Desirability Influencing Factors from the LEMT Organisational Context: Language, External Environmental Conditions & Social Identity

Throughout this section I focus on CE desirability, defined as the degree to which organisational members find the prospect of strategic entrepreneurship, corporate venturing and entrepreneurial orientation to be attractive. Essentially, it reflects one's affect towards CE. I introduced above that respondents cited three organisational contextual factors that appear to influence CE desirability only: *language, external environmental conditions* and *social identity*, Table 27, which I discuss in the remainder of this section. First, language appeared to an

ambiguous influencer as it elicited both negative and positive evaluations of desirability. External environmental conditions produced negative evaluations of desirability. Last, social identity prompted negative evaluations of desirability. Overall it can be concluded that LEMT contextual factors largely influence desirability negatively so that CEI are formed.

First Order Codes *Statements about:*	Second Order Codes SEE Influencing Factors from the Organisational Context	Third Order Code SEE Influencing Factors from the Organisational Context	Entrepreneurial Attitude Influenced by Organisational Factors	Evaluation of CE Desirability (Negative/Neutral/Positive)	Findings Derived From
"Definitional uncertainty " e.g. • What it entails: financial gain, innovation, competition • It is a private sector practice	Language		**Corporate Entrepreneurship Desirability**	Negative & Positive	Across the LEMT Case
"Entrepreneurial individuals" e.g. • Organisation founders • Personality, characteristics, traits & behaviours of the entrepreneur					
"Perceptions of entrepreneurship in the NHS" e.g. • Negative connotations: untrustworthy, suspicious • Focus on profit generation • Uncomfortable topic					
"Political Agendas" e.g. • Governmental policy • Financial constraints	External Environmental Conditions			Negative	
"Applying entrepreneurship to the NHS" e.g. • Historical maturation/NHS traditions • Privatisation/Business-like approach • The 'new' NHS					

Table 27: Data Analysis Table Showing Influencing Factors from the LEMT Context that Impact Perceptions of Desirability in Corporate Entrepreneurial Intention Formation

First Order Codes ***Statements about:***	**Second Order Codes SEE Influencing Factors from the Organisational Context**	**Third Order Code SEE Influencing Factors from the Organisational Context**	**Entrepreneurial Attitude Influenced by Organisational Factors**	**Evaluation of CE Desirability (Negative/Neutral/Positive)**	**Findings Derived From**
"What the NHS is" e.g. • Publicly funded • NHS beliefs & values • Monopsony: main employer • Monopoly	NHS Identity	Social Identity	**Corporate Entrepreneurship Desirability**	Negative	**Across the LEMT Case**
"Who I am as an NHS employee" e.g. • Education & training • Socialisation processes • Motivation: Why we joined the NHS					
"Who we work for" e.g. • Two masters: LEMT & patient • Patient-clinician relationship	Professional Identity				
"What I do as a professional" e.g. • Caring, diagnosis, rehabilitation, therapy, managing, diagnostic testing • I am here for the patients					
"Legitimacy" e.g. • What behaviours are or are not valued by a professional group					

Emergent Theory: (1) Social Identity Approach

7.3.1 Language Influences Corporate Entrepreneurship Desirability

First, language's negative impact on CE desirability emerged when I first asked respondents to define entrepreneurship. In their attempts to provide a definition, case informants habitually and intuitively portrayed impressions of the entrepreneurial actor or entrepreneur in their responses like Doctor 8 and Non-executive Director 1 above. For instance, even as some respondents used well-known commercial organisations that would be characterised as entrepreneurial; they still focused on the organisation founder as the entrepreneur and driving force of the company, for instance Richard Branson and Virgin. However, where Richard Branson inspired a positive impression, one doctor who was a Head of Service synonymised the entrepreneur with a television character with a deeply negative connotation,

> *The image that comes to mind is Arthur Daley selling cars. I don't know a definition of it…* ***(Doctor 2, Phase 1)***

This comparison may appear innocuous however; the Arthur Daley character in the television series is a professional criminal and disreputable used car salesman with unethical business practices. Doctor 2's quote reflects his perspective that an entrepreneur can be unprincipled, dishonest and should be viewed with suspicion. Thus, as a civil servant in a taxation funded system like the NHS which is accountable to the public, to be categorised as an entrepreneur could potentially associate them with similar unprincipled practices. Similarly, another consultant physician conveyed his perspectives on CE's undesirability,

> *Well an entrepreneur is presumably someone who sees opportunities and maximises their opportunities and to some extent yes I've always done that…but not with official agreement.* ***(Doctor 4, Phase 2)***

In his definition Doctor 4 also choses to focus on the individual entrepreneurial actor. Though unlike Doctor 2, who stated he *'didn't know a definition,'* Doctor 4 defines the concept quite accurately. He bases his definition it on opportunity identification and exploitation. Of particular interest however, is that even though

he admits to his involvement in these entrepreneurial activities, he protests being categorised as an entrepreneur. As such, the term entrepreneur and associated entrepreneurial behaviours appear to impact the desirability of CE negatively.

The negative impact of CE related language on CE desirability continued to gain traction as I continued to analyse the data. Respondent's perception that entrepreneurial actors were unprincipled appeared to be inextricably linked to one aspect they believed to be an inevitability of CE and entrepreneurship - financial gain. For instance, while Doctor 3 states that he did not know an official definition, he believed one aspect to be inextricably linked to CE and entrepreneurship - financial gain,

> *I associate with that [entrepreneurship and CE] making money. My immediate reaction, if that's what you want, is very much a sort of a business thing... I get very twitchy about anything to do with making profit. I don't mind it as long as it goes back into the organisation [NHS/LEMT], but to me I just associate entrepreneurship with personal profit. I don't deny I get rewarded well for what I do so there's maybe some hypocrisy in there but I do feel uncomfortable about individuals profiting financially from our [NHS] system. Very uncomfortable with that.* ***(Doctor 2, Phase 1)***

Doctor 2 describes the NHS as *'our system'* to indicate he is part of a larger group in which he is very much invested and feels strongly protective of. He also conveys his uneasiness with anyone personally profiting from the NHS system. Similarly, another Head of Service, AHP 1, conveyed her concerns about the monetary gain focus of CE and entrepreneurship and proffered what she believed to be useful advice to aid my data collection,

> *Most times people assume a financial reward with being entrepreneurial in a way that there may not be with being innovative. I would suggest that the Trust (LEMT) not use the term 'entrepreneurial.'* ***(AHP 1, Phase 1)***

AHP 1's quote makes two notable points that signal to language's ability to both influence CE desirability negatively and positively. I will address the negative influence first. Like Doctor 2, AHP 1's casts both a powerful and damning aspersion on entrepreneurship and CE when she suggests that in the course of my study on behalf of LEMT I *'not use the term entrepreneurial.'* Ultimately, she agrees with Doctor 2 that the term invariably evokes images of financial gain and unscrupulous profiteers pillaging the NHS, which supports my proposition, that language can lower the desirability of CE. Further, respondent's apprehension regarding profit generation stemmed from their belief that a fundamental incongruence existed between financial gain and the tenets upon which the NHS and by proxy LEMT is built. One Non-executive Director commented,

> *You can't really look at entrepreneurship, because there is the inherent, for me, the inherent conflict between entrepreneurship and the patient… because with the patient, with the best will in the world, irrespective of money or resources or anything else like that, if it's going to cost £15 million to sort out an individual, then that's what we should be doing. That's what the NHS is about. That's what most of the people signed up to, their careers.* ***(Non-executive Director 2, Phase 2)***

From Non-executive Director 2's quote any notion of profit maximisation would ultimately endanger the NHS's primary goal to provide good quality healthcare that should be available to all UK citizenry, regardless of their individual financial circumstances. This suggests that in the LEMT context CE desirability is more nuanced than I previously proposed. That is it goes beyond organisational members affect for CE. Instead it begs the question is CE even desirable for my organisation?

Further, associating financial gain with CE further diminished the desirability as respondents connected CE to their scepticism on the implementation of yet another NHS reform from the Department of Health (DH). The reform policy paper titled, Equity and Excellence: Liberating the NHS (DH, 2010), sets out of current Coalition government's plan, to combat the financial challenges facing the NHS, which continues to be hotly debated in the media,

> *I think that what's encouraged in the 'new NHS' is financial entrepreneurship… In terms of setting up a business to make money out of the health service I would profoundly oppose that route because I still believe that the NHS should be a publically provided service.* ***(Doctor 4, Phase 2)***

Doctor 4's reference to the *'new NHS'* appeared to be a locally generated term used by respondents to convey the changing direction and future state of the NHS post policy reform. However, his commentary indicts this policy reform signalling to what some case informants collectively believed to the initial stages of the governmental attempts to *'privatise the NHS.'* Chiefly, as one of the major policies in Equity and Excellence is aimed at creating competition in the healthcare provision market. The policy allows private sector organisations to directly compete and provide services traditionally provided by NHS organisations. Thus Doctor 4 like Doctor 2 conveys very strong views on this new direction stating he *'would profoundly oppose that route.'* He went on to convey his negative view of these competitors, which leads on from the point made earlier that these commercially oriented organisations are potentially ruthless,

> *They changed the law to marketwise the health service… The private sector will no doubt come and 'clean up' on the bits that they can do and care will be fragmented.* ***(Doctor 4, Phase 2)***

Returning to AHP 1's quote above I will make my second point regarding the positive impact language also appears to have on study participants' evaluation of desirability. In AHP 1's quote above, without prompting from myself, she extricates innovation from entrepreneurship. Innovation is a core concept in CE and sits at the heart of it strategic entrepreneurship component as discussed in Chapter 2. AHP 1 suggests that unlike entrepreneurship being described as innovative does not have the same negative connotation as entrepreneurship where one would be driven by financial gain. This indicates that even as the interviewees mulled over the profound conflict of interest entrepreneurship presented, they still believed there maybe some elements of CE that could be

disentangled, adapted and applied to the NHS at large and LEMT in particular. This was especially relevant because even though some case informants did not agree with the DH policy reform they were still acutely aware of increasingly constrained financial position of the NHS and the even more precarious position of LEMT post the 2008 economic crisis. One consultant doctor who was also a Director commented,

> *We haven't traditionally embraced that [entrepreneurship] in the healthcare setting, but it's an interesting concept that we can probably adapt slightly…* ***(Doctor 8, Phase 1)***

Doctor 8's comment suggests that CE is a potential strategy to stabilise and sustain LEMT in the face of economic downturn. It also raises the question as to what these adaptable elements could possibly be? As I previously outlined above and in Chapter 6, to elicit respondents understanding of CE they were encouraged to make links between entrepreneurship and the healthcare organisational context (NHS in general and LEMT in particular). This was aided by the EO construct introduced in Chapter 2. As alternative conceptualisation of CE, EO focuses on the practices and processes of an organisation and its members and not on outcomes such as financial gain that seemed to make the respondents uncomfortable and render negative evaluations of desirability. Initially, I introduced all five dimensions EO, *innovativeness, proactiveness, risk-taking, competitive aggressiveness* and *autonomy* in the Phase 1 interview schedule. However, the EO construct seemed to split into two categories (1) EO terminology that elicited negative to neutral evaluations of CE desirability: competitive aggressiveness and autonomy and (2) EO terminology that elicited positive evaluations of CE desirability: innovativeness, proactiveness and risk-taking. I will discuss these two categories next.

First, the competitive aggressiveness dimension (the intensity of a firm's efforts to directly and intensely challenge competitors, outperform industry rivals and improve the organisations position in marketplace, (Lumpkin & Dess, 1996)) prompted neutral desirability evaluations as it was viewed as somewhat irrelevant due to the monopolistic hold the NHS exerted on healthcare provision. Thus,

where some respondents like Doctor 4 opposed this marketisation approach others held the perception that LEMT was protected from competition as it is not only one of the largest Trusts in the UK but the only acute service provider serving this section of the East Midlands. However, this dimension's negative influence emerged when one Divisional Director expressed a rather vehement view,

> *I think it's completely distasteful to think of being competitive and what was the other?* ***(Doctor 3, Phase 1)***
>
> *Aggressive.* ***(Interviewer)***
>
> *And aggressive. Completely! I think one should phrase it differently and say 'it's important to outperform the opposition.' That's a term that I actually used for many years as the directorate leader. Quiet level of competitiveness. Slightly understated, but relentlessly aggressive without saying it. I think that there's always an ambition to do as well as you can, there should always be an ambition and I have that. It mustn't overtake the way you do business.* ***(Doctor 3, Phase 1)***
>
> *I don't see it as being central to our ethos. I think that would be regrettable if there's any way we could differentiate was by being more aggressive than the next trust.* ***(Manager 1, Phase 1)***

The above excerpt from Doctor 3 raises the question whether being competitive or aggressive are appropriate approaches to business for the NHS or LEMT. This links to the point I made earlier regarding whether organisational members find CE to be desirable in a public sector organisation like LEMT. More so it also demonstrates how language can negatively impact the desirability of CE in this context. This is explicit where Doctor 3, like AHP 1, suggests a euphemism should be substituted when he states, '*one should phrase it differently.*'

The autonomy dimension (organisational members ability to disengage from organisational constraints, operate outside the organisation's existing norms and strategies to think and act more independently) also elicited neutral CE

desirability evaluations. Autonomy was viewed as lip service as the bureaucracy and accountability that went hand in hand with taxation funding limited their decision-making power,

> *We try and we say glibly things like autonomous divisions and autonomous business units. But there's no such thing within the hospital system because we are a system, we're interrelated* ***(Doctor 4, Phase1)***

Second, clearly positive evaluations of CE desirability were noticeable in interviewee's responses as they talked their way through the innovativeness, proactiveness and risk-taking dimensions,

> *In parts. I'm normally very proactive. I look for different opportunities, I like to do something different, I don't follow traditional pathway* ***(Nurse 8, Phase 2)***

> *I'll call on them [innovation, proactiveness and risk-taking] depending on the role* ***(Manager 9, Phase 2)***

> *... when it comes to patient care I'm incredibly risk-averse. When it comes to research then I think yeah, you have to be prepared to take more risks.* ***(Doctor 7, Phase 2)***

> *We [my team] perceive that we are innovative, I'm not sure we [my team] are entrepreneurial.* ***(AHP 1, Phase 1)***

Collectively, these quotes demonstrate two things. First, like AHP 1 above they show an apparent positive connotation can be attributed to innovativeness (the successful implementation of creative ideas that result in bringing something into new use) and proactiveness (an organisation's internally motivated and forward-looking perspective to take initiative to seize opportunities versus being passive). Risk-taking however, required me to clearly frame it in non-clinical terms to limit respondents from resorting to the default position of clinic risk in this setting. For instance Doctor 7 draws a very clear distinction regarding risk being required for

his research undertakings only. Once this non-clinical frame was set participants described the NHS as risk-averse and the need for LEMT to start looking toward taking calculated risk especially in the current economic climate.

The above connects to the point Doctor 8 made above regarding what parts of CE could be adapted to the health service and make CE desirable. It can be seen that even though participants were identified by their peers as entrepreneurial or participating in entrepreneurial projects, they had trouble identifying themselves as wholly entrepreneurial like Doctor 3 or AHP 1. However, via the EO construct respondents were able to extract and connect to what they perceived to be the positive and appropriate aspects of CE for the LEMT organisation. For instance, after walking Doctor 2 through the EO dimensions I asked if he thought of himself as entrepreneurial having been selected by his peers for interview,

> *As we've gone through and I'm starting to think of it slightly more broadly I guess I probably am entrepreneurial, yes, although I don't feel comfortable with the phrase. I don't like it, which is interesting... but, yeah. I see all of those [EO dimensions] in me personally.* ***(Doctor 3, Phase 1)***

In summary CE language appears to have both a hindering and facilitating effect on CEI formation. The multiplicity of language's impact on CEI formation appears to operate via respondents CE desirability. First, CE language and its derivatives such as entrepreneur and financial entrepreneurship, prompt negative evaluations of desirability. Primarily because respondents do not want to be associated with any of the negative connotations they believed to be related to being described as wholly entrepreneurial. In turn CEI formation in the SEE framework is hindered. However, where respondents were uncomfortable with these entrepreneurial descriptors, they were able to extricate particular facets of EO that they believed to be acceptable entrepreneurial behaviours including innovativeness, proactiveness and risk-taking. This exemplifies that some CE terminology has a role in prompting positive evaluations of CE desirability, which within the SEE framework can facilitate CEI formation.

7.3.2 External Environmental Conditions Influence Corporate Entrepreneurship Desirability

The 2008 global economic crisis represented a significant triggering event. The resulting financial constraint of the financial crisis has held dire and severe consequences for the private and public sectors alike,

> *...over these next five years, for the majority of which we're going to see a reduction in real terms in funds available to the NHS if not throughout all those five years.* ***(Manager 1, Phase 1)***

> *...changes in the NHS commissioning environment, restructuring activity, greater competition amongst Trusts. That's inevitably going to be due to a lack of funding, public funding. It is going to drive efficiencies and innovation for its [NHS's] survival. The commercial awareness element and the need to expedite becoming proactive, innovative and entrepreneurial is a requirement for survival.* ***(Non-executive Director 3, Phase 2)***

In response the Coalition government through the DH has instituted the Equity and Excellence policy (DH, 2010). As presented in Chapter 5, this white paper stipulates an action plan for navigating increasingly hostile economic conditions and ensuring the provision of services fit for purpose in the future,

> *We aim to create the largest social enterprise sector in the world by increasing the freedoms of Foundation Trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises.* ***(Equity & Excellence: Liberating the NHS, 2010)***

So what did these policy changes mean at the organisational level? First. LEMT's executive management teams' express interest in CE follows on the heels of these DH directives. As such, when I commenced this study, the LEMT Strategy Team was in the process of pursuing Foundation Trust (FT) status and developing the 5-year Integrated Business Plan (IBP) required by all FTs, instead of the prior

system of standard budget requests. The IBP sought to showcase how the organisation would operate with a commercial mind-set by seeking revenues sources other than taxation funding. For example, consider LEMT's intent from the extract of the strategy section in the IBP presented below,

> *The financial freedom and local accountability afforded to Foundation Trusts represents a key stage of our journey from being a good hospital to being a great hospital. The Trust [LEMT] will take advantage of the financial freedoms afforded to Foundation Trusts, such as commercial borrowing and the reinvestment of surpluses. These features will be critical factors contributing to organisational innovation and improvement and better quality patient care. As a Foundation Trust, we will be able to pursue joint ventures and partnerships with private and other public organisations more freely and therefore enhance existing service development plans.* ***(Strategy Chapter, LEMT IBP, 2012, p.11)***

From this excerpt it can be seen external environmental conditions can prompt positive evaluations of CE desirability at the governmental level. This is ultimately reflected in the policies that have been developed at a national level. These policies aim to manipulate NHS structures, strategies and processes in favour of a commercial mode of operation. Potentially, the LEMT executive team holds the same positive evaluation of CE desirability. They have effectively translated these DH policies into LEMT's guiding strategies for the future to navigate a hostile economy by pursuing FT status, which the LEMT executive team believes is critical to fostering innovation, which is central to CE.

Arguably, the CE desirability mirrored in strategic response of the LEMT executive could be attributed to DH policies being compulsory. However, scrutiny of my interview transcripts with the LEMT executives did not reveal any dissonance at this level. Rather, it was the frontline staff, (who are of special interest to this thesis' study of bottom-up CE), who formed a significant portion of my sample group, who acted as catalysts for dissent against the positive connotations imbued in the entrepreneurial political agenda. For instance one senior consultant physician commented frontline staff's perceptions of these

policies changes,

> *I think there's a difference in the political culture and what's actually happening on the ground. Fundamentally, things don't change very much but there is a desire for a more business-like approach. Particularly a competitive approach which I think many people and me included, feel is not likely to gain that much traction amongst people on the front line. That's a political issue really.* ***(Doctor 3, Phase 2)***

Doctor 3's comment shows that he is aware that the DH policies that call for a more *'business-like approach'* are being driven by a political agenda. Further, he implies a marked distinction between frontline staff that are responsible for actual provision of care and interface with patients versus the executive team who are not. He is explicit in his view that these commercial policies will not gain traction with the frontline staff. This indicates that on the frontline external environmental conditions do not prompt the same positive evaluations of CE desirability.

> *Yeah I think so because as I said earlier you know, if the people at the top are just doing it and nobody underneath is doing it, you're not going to be able to get the service development that you're after and improve the service. So I think everybody needs to do it in a sense really to make sure that you know, development filters down and the patients get the best benefit at the end of the day.* ***(AHP 3, Phase 2)***

This CE undesirability is only compounded by and unsurprisingly so, frontline respondents feeling that this commercial agenda has been forced up them up them,

> *Some of it [the commercial agenda] has been sort of thrust upon us rather than of our choice.* ***(Doctor 8, Phase1)***

> *Well, it's the increasing pretence that they [Trusts] are private companies, you know, that moving to a Foundation Trust status increases their [a Trusts] financial freedoms. But it's all in a very artificial matrix, which isn't*

what patient orientated health service clinicians are about. They've changed the law to 'marketise' the health service. They were not up front about that before they were elected and yet they've done that and to my mind turned the health service upside down. ***(Doctor 4, Phase 2)***

The *'pretence'* that Doctor 4 refers to is that if Trusts were really private companies they would be able to shed the less profitable parts of the business. One such example would be decommissioning the Accident and Emergency (A&E) service, which is traditionally one of the most expensive Clinical Business Units (CBUs) in LEMT. However, A&E is an essential and compulsory service for a large acute Trust and LEMT would not be allowed to decommission this service. Another consultant doctor concurred,

Emergency care is a lost lead really you can't make a lot of money out of it you have to just do it. Again it just shows the futility of the business-like approach. ***(Doctor 5, Phase 2****)*

The above represents a dynamic where policy does not match practice. First, it can be seen that an external environment characterised by hostility, dynamism and diminishing resources can force a large mature public sector organisation to renew their ability to compete in a harsh global economy. However, this project is interested in the individual-level of analysis. From the data presented above it can be seen that these external environmental conditions are not guaranteed to influence organisational members perceptions of CE desirability. Rather, respondents in their disagreement with the resulting commercial policies, find CE undesirable.

7.3.3 Social Identity: NHS Identity and Professional Identity Influence Corporate Entrepreneurship Desirability

A third and final contextual factor emerged from the data, Table 27, as an influencer of CE desirability in the LEMT context, *social identity*. Case informants reported the presence of two discrete social identities, (1) *NHS identity* Section 7.3.3.1 and (2) *professional identity* Section 7.3.3.2 (*nurse, doctor, allied health professional, healthcare scientist* and *manager*).

In defining these various social groups respondents provided each group's (1) belief and value system and (2) descriptions of how these groups behaved in LEMT. By providing both of these, study participants were actually specifying what cognitions govern their social group. In turn these cognitions ultimately determine how the social group would subsequently behave. What was clear in their descriptions of how these social groups thought and behaved, respondents made no mention of CE. This suggests that CE activity do not inherently form part of their social group's activity. Further, if one considers that CEI is the best predictor of CE behaviour, it can be inferred that CEI had not been formed. From the data, I found social identity hindered CEI formation by prompting negative and neutral evaluations of desirability. In the subsequent sections I will present the detail of these social identities.

7.3.3.1 NHS Identity Influences Corporate Entrepreneurship Desirability

The first social group that all respondents identified they belonged to was the NHS organisational employee group, designated *NHS identity*. Respondents revealed several defining characteristics of this group, which prompted them to negatively evaluate CE desirability. I will present these factors below.

First, it became clear that discussing the NHS and what it meant to be a civil servant in its ranks evoked an emotive response from study participants. Respondents used expressive language, comparable to that used in Section 7.3.1 above, to convey their exceedingly positive and strong feelings about the NHS. For instance, a senior nurse expressed how she felt when started working for the NHS 30 years ago,

> *...immensely proud and felt I was achieving and felt that I was doing something good for my patients... I defend the NHS quite rigorously. They say that it's all going to rack and ruin and what have you, but I feel very precious about it [NHS] and defend it [NHS] because although there are always things that I know should do better, or we could do better. I've worked many years for it [NHS] to and feel very loyal to the NHS.* ***(Nurse 8, Phase 2)***

Nurse 8's quote is representative of person who is heavily invested in and committed to her to NHS group. She expresses how valuable she finds the NHS describing it as precious. The high worth she places on the organisation inspires great loyalty, which breeds a willingness to *'defend the NHS quite rigorously.'* Further, she hints to the one on the most basic underlying beliefs and values of the NHS identity, when she refers to wanting to do better. She went on to elaborate,

> *At the end of the day, its public service monies and it [the NHS] is something that is free to everyone. And I'd hate it not to be. I wouldn't want anyone to think that they couldn't go and seek help for something, because they were frightened of how much it would cost or anything like that.* ***(Senior Nurse 8, Phase 2)***

From its inception, the NHS mission has been governed by three founding principles presented in Chapter 5. Nurse 8 demonstrates how being a part of the NHS social group is inextricably linked to this intangible ethos, that the NHS *'is something that is free to everyone.'* The NHS principles are reflected in first four of LEMT's five values on their website. Respondents derive a source of pride at being affiliated but with these principles and have adopted these as deeply held values,

> *It's taken for granted that when we talk to the patient there is no financial incentive in any way, so the patient can have absolute trust the opinion we're giving is genuine, what's in the best interest of the patient and you won't get that in any other health system. You certainly won't get it in*

America. 'You must have this operation,' they know you're doing it because you get paid for this operation. So that fundamental is often taken for granted but it's terribly important. ***(Doctor 4, Phase 2)***

Doctor 4's excerpt makes reference to there being *'no financial incentive in any way'* when it comes to the provision of NHS services. This provides the patient with absolute security and trust that the patient-clinician relationship is not corrupted in any way. Taken together, Nurse 8 and Doctor 4's comments provide insight into the points made by respondents in Section 7.3.1. Specifically, why CE language prompted NHS employees to so vigorously oppose the role of financial gain as a CE outcome in the NHS and ultimately find CE undesirable. That is, the beliefs and values or NHS founding principles upon which their NHS identities were predicated would not allow for a profit maximisation focus. As such, NHS identity appears to hinder CEI formation. One non-executive director who had spent his career in the private sector as a venture capitalist commented on the devotion to the NHS he observed in its employees since joining the LEMT board. Thereby proposing a theory of why of CEI formation and thus CE behaviour was a rare occurrence in LEMT or any NHS organisation,

> *I think in the commercial sector, my experience was, the values were pretty well embedded right throughout the organisation but I was suspicious shall we say, of sometimes the leadership sneaking off piste. Whereas I think from what I've seen in the NHS actually, I'm far more a believer in the leadership being value driven…Within the NHS actually very few people are really motivated by making money. Therefore, instinctively, you actually would expect to have a much lower entrepreneurial population within NHS than you would within technology.* ***(Non-Executive Director 1, Phase 2)***

This negative impact of NHS identity on CE desirability was further reinforced on a more personal level as most respondents shared that their motivation to join the NHS was linked to the NHS ethos, values and beliefs,

I had a family that came from the NHS background and has a deep respect for individuals and wanting to actually help people at their time of need. ***(Nurse 8, Phase 2)***

I don't particularly believe in private medicine, I've always been somebody who's been a supporter of the NHS. ***(AHP 8, Phase 2)***

I wanted to be a doctor because of the NHS; because it's very... sort of has a socialist political view I suppose. Yeah the fact that it's free, free for everybody at the moment, it doesn't discriminate. I actually thought I was going to go to a third world country when I was 18. Yeah, that's where I thought I was going to go [laughs]. Then I realised that I didn't have to do that to be able to, provide something for people. Yeah, I've always been very proud to work for the NHS. ***(Doctor 3, Phase 2)***

Collectively, the quotes presented above demonstrate that respondents NHS identity began forming when they were members of the general public, long before they officially joined the NHS. This is indicative of an extended socialisation period that started long before and subsequently intensified during their formal healthcare professional (HCP) education and training. As such, from very early on HCPs were subjected to prolonged exposure to a non-commercially driven environment. This protracted engagement with the NHS served to both ingrain the NHS values and also establish the impression that the NHS is a singular overarching monopsony for new HCP graduates,

Well in the UK if you train as a doctor you inevitably work at the NHS. ***(Doctor 4, Phase 2)***

Well it was the only employer at the time. For those with medical degree it was the only one place to go. ***(Doctor 5, Phase 2)***

Well I always wanted to work in health care and I always assumed that I would work for the NHS, ***(AHP 4, Phase 2)***

The inevitability of a singular employer signalled to a level of expectation of and resignation to employment rather than individuals considering employment in a commercial environment. As such, some respondents conveyed that they never had to consider behaviours beyond their clinical work far less the CE behaviours rendering a neutral evaluation of desirability.

The above demonstrates the existence of a social identity: NHS identity. The NHS identity represents a group of individuals who are governed by the time-honoured NHS principles. It is their underlying belief in these principles that prompt respondents to evaluate CE negatively. Primarily because the financial motives that they associate with CE do not align with the NHS principles. Further, the development of the NHS identity can also be attributed to the various socialisation processes respondents are subjected to. These processes reveal case informants motivations for joining the NHS, where they are exposed to an environment characterised by monopoly and monopsony. As such, a commercial agenda driven by CE activity is not something they had to consider as an NHS employee. This prompted neutral evaluations of CE desirability which also hinder CEI formation. More interestingly is the lack of LEMT identity as a form of organisational identity. NHS identity is the dominant (only) form of organisational identity.

7.3.3.2 Professional Identity Influences Corporate Entrepreneurship Desirability

Professional identity also prompted respondents to negatively evaluate CE desirability. However, professional identity appears to elicit this negative evaluation of CE desirability via a different interaction than NHS identity. From Section 7.3.3.1, it can be seen the NHS identity appears to operate as a more abstract influencer reliant on the meanings and significance study participants attached to their values and beliefs about the NHS. It is these values and beliefs that guided individuals to find CE undesirable. Conversely, professional identity has more tangible nature. All respondents gave detailed accounts of the beliefs values and most notably the work content that defined and legitimised their professional identity, as highlighted in Tables 27 and 28. It is only in respondent's possession of, routine participation in and performance of their specific work and tasks that they are considered members of their respective professional groups.

This is indicative of the prescriptiveness of professional identity the prompts negative evaluations of CE desirability.

Professional Identity Types present in LEMT Case	**In vivo examples** ***Statements about: What I do as a Professional***	**First Order Codes: Professional Identity Work Content**	**CE Desirability Influencer**	**Evaluation of CE Desirability**
Nurse Identity	*Nurses feel the need to hold on, get a bit too touchy feely… the fluffy side of caring that's where nurses are…I was a CCU [Coronary Care Unit] nurse. And I do look back on those days very fondly; because we had a small 8-bedded unit and the most you looked after was 3 patients, and that was not very often. It was usually 1 or 2. You were able to give complete and utter care and time to that patient. It was great!* ***(Nurse 3, Phase 2)***	'Caring'	**Professional Identity Influences Corporate Entrepreneurship Desirability**	Negative
Doctor Identity	*So if you went to another discipline like surgery where a lot of it is down to the skill of the surgeon or the anaesthetist for example. It's a bit less the case for us where people like myself [physician] who provide more overall strategy and leadership than care of patients. So sometimes it feels like you don't do anything, when actually what you're doing is directing the rest of the team, providing a broader context. In a way that's what Doctor 4 and I do in the rehab group [Pulmonary Rehabilitation Service].* ***(Doctor 2, Phase 2)***	'Discipline-based Diagnosis Treatment'		
AHP Identity	*Initially when you very first qualify, your first couple of years it was all about just getting hands on experience, so really nailing down and perfecting your skills, sort of hands on skills, your manual skills and your clinical reasoning and decision making processes for diagnosing and treating these patients…* ***(AHP 5, Phase 2)***	'Rehabilitation & Therapy'		

Table 28: Data Analysis Table Extracted from Table 27 Showing Professional Identity Work Content

Professional Identity Types present in LEMT Case	**In vivo examples** ***Statements about: What I do as a Professional***	**First Order Codes: Professional Identity Work Content**	**CE Desirability Influencer**	**Evaluation of CE Desirability**
Healthcare Scientist Identity	*The backroom boys who don't really you know…there was an element of being a bit like the mad scientists. There is a door there, nobody really comes through there, you know, largely. It is so different to a ward environment or an office environment and most people if they don't work in pathology have no idea and don't want to know what happens, because it's rather well… oh it's bits of bodies! Blood and urine and faeces and chemicals- so I think it [pathology] is a bit of a rarefied environment.* ***(Healthcare Scientist 2, Phase 2)***	'Diagnostic Testing: Exploratory and/or Confirmatory'	**Professional Identity Influences Corporate Entrepreneurship Desirability**	Negative
Manager Identity (Non-clinical)	*…it was about a lot of forward thinking, strategy planning, capital investment, capital development, working with commissioners, doing a lot of the external networking stuff. You know… it was a whole multiplicity of, combination of skills and expertise. You have to have energy enthusiasm, commitment, thinking out of the box, not being frightened to come up with a new idea. Respecting people's values and views, active listening, being in a position to respond, there's responsiveness, I think flexibility, effective communication at all levels. It's about giving and receiving feedback, very much about being a 'do-er' and somebody who delivers. It's also about offering those core leadership qualities. It's about values and behaviours,* ***(Manager 7, Phase 2)***	'Managing & Administration'		

Professional identity prescriptiveness was further compounded by professional identity proscriptivensess where respondents seemed equally motivated to avoid non-professionally based behaviours. This suggests that despite conditions of modernity and career transitions, any introduction of new behaviours, such as those encompassed by CE phenomena for example, were unfavourably viewed as a threat to the legitimacy of an individual's professional identity. For instance,

> *...you were knackered, but for the right reasons. Not because you sat at the end of a telephone in an office with no windows and feeling that that's not the job of a nurse. I don't feel personally that it's my progression to sit on the end of phones. It doesn't feel right.* ***(Nurse 4, Phase 2)***

The above quote suggests that Nurse 4 had moved from a primarily ward based caring role to one that requires more managerial aspects. More so, when she states *'that's not the job of a nurse'* and *'it doesn't feel right'* she is indicating her displeasure at being taken away from caring for and focusing on what she could do for her patients. Consequently, it appeared nurses had little tolerance for any work they perceived as taking them away from caring for patients. For instance, even the highest-ranking nurse within LEMT's formal organisation structure described her attempts to avoid the negative feelings described by Nurse 4 by maintaining contact with traditional nursing behaviour,

> *...even now, I still do clinical shifts. So the other night I was in A&E and I was moving patients from A&E onto the wards. It's about actually having that connection with the patient and asking how it had been and how they feel and a great sense of wanting to keep my ear to the ground in what happens. I don't want to be in an ivory tower. I visit every ward in this Trust once a month. So, what 92 wards and I personally walk every ward every month.* ***(Nurse 8, Phase 2)***

Nurse 8's commentary demonstrates both the prescriptive and proscriptive nature of professional identity I introduced earlier. Nurse 8 like Nurse 4 also demonstrates an intolerance for non-nursing work via her compulsion to adhere to the nurse professional identity despite the *'ivory tower,'* which symbolises her

high-ranking non-clinical management role off the ward. As such, she makes efforts to escape the ivory tower by doing clinical shifts and visiting every ward in LEMT on a monthly basis. In doing so she demonstrates that she still embodies the core characteristics associated with the nurse professional identity. By exhibiting this intolerance Nurse 8 signals she is still a legitimate and positively regarded member of her nurse professional group. Further, Nurse 8 also maintains legitimacy by avoiding negative opinions from other nurses. For instance, one nurse who had transitioned from a ward-based nursing role to an office based role commented,

> *If it's friends from a clinical background they'll say, 'oh you've gone onto a desk job and away from 'real' nursing.* ***(Nurse 7, Phase 2)***

Nurse 7's commentary signals to how professional identity proscriptiveness can diminish one's legitimacy with their fellow colleagues. It also provides additional insight into why Nurse 8 still did clinical work despite her senior management remit. Nurse 7 articulates how his clinical colleagues perceive his *'desk job'* as moving away from the *''real' nursing'* described in Table 28. As such, his comments convey connotations of disparagement and derision that his clinical colleagues hold for his *'desk job.'* Primarily because a desk job is tantamount to no longer being in touch with what it meant to be a nurse.

Like Nurse 8 above who had ascended to a very high level management role in LEMT, some of the doctors I interviewed had also taken on management and administrative roles such as Medical Director or Head of a Service. It is in assuming these roles that the proscriptivensess of the doctor professional identity emerged. For instance, within these management roles doctors understood they had a role in securing LEMT's future, especially in the financially constrained conditions the organisation faced. Doctor 2 went on to elaborate,

> *…clinicians have a responsibility to talk to managers and explain what they're doing and also have some responsibility about the financial health of the Trust… managers are responsible for that and in the current climate, that's a difficult job so we have* to have some responsibility for

that. So I think there is some potential conflict there, a bit of tension. ***(Doctor 2, Phase 2)***

Do you think there would be further tensions around this idea that the Trust wants to start employing more entrepreneurial strategies in how they go about doing business? ***(Interviewer)***

No, I would encourage that. It's a never ending frustration that we have services and I run a specialist X service, which never reached its business potential for making money because we never had an entrepreneurial or business-like approach to seeking more business really, outside the area. This is a tertiary service but, ensuring we get paid properly and an appropriate tariff for what we do, there's no one that sorted it out and it's not in my interest or my job to do that.... But they [LEMT] could offset that by proper investment and streamlining and a more entrepreneurial approach to other specialist areas where there's more potential for making money. So I suppose that's a disappointment but at the end of the day, my responsibilities don't extend as far as a balance sheet for the whole Trust. ***(Doctor 2, Phase 2)***

Doctor 2's excerpt represents a contradiction I often found in the data and signals to one of the most salient points about how maintaining the legitimacy of a professional identity appears to hinder CEI formation. First, Doctor 2 states he would support LEMT employing CE strategies. This would suggest that he finds CE desirable at the organisational level or at least the remit of managers. Nonetheless he admits that as a clinician he has a supporting role in safeguarding the *'financial health'* of the organisation. This responsibility should be magnified as he runs one of the tertiary services, which are usually considered to be an unexploited profit generation centre in most NHS Trusts. Yet, in running his tertiary service he concedes that he and his team do not take an *'entrepreneurial or business-like approach'* attributing this to there being no one to negotiate appropriate tariffs. Arguably, from a CE perspective as the service founder and Head, financial issues would fall under his purview. However, Doctor 2 admits being entrepreneurial or having a business-like approach is not a part of his job as

a doctor, which is first and foremost. This signals to the prescriptiveness of professional work, which is necessary for professional legitimacy. This suggests that on an individual level, which is the focus of this project, professional identity prompts a negative evaluation of CE desirability.

AHP professional legitimacy went beyond general rehabilitation and therapeutic work. Rather, the AHPs interviewed sought legitimacy in defining the specific rehabilitative disciplines they chose to specialise in. AHPs spent a lot of time in our interviews, distinguishing between the various rehabilitative disciplines. For instance, AHP respondents represented only three types of AHPs: physiotherapist, occupational therapist and health psychologist. So they spent time and psychic energy managing the in-group and out-group perceptions,

> *We're [health psychologist] classed as allied health professionals… **to be a health psychologist** in this department I need to stay true to the psychology side and not just try and be a 'physio[therapist].' So you have to be very strong on what your role is and you have to allow those boundaries to be blurred, obviously but you then, you have to stay very core to what your expertise is or else you're going to lose it. I think.* ***(AHP 10, Phase 2)***

> *I'm not a physio[therapist] by profession... **I'm an occupational therapist** that is my profession... making sure that they're independent so very sort of hands on physical job. Assessing whether they're able to get up stairs, giving them the equipment that they need… So I'm the only OT in a team of physios and nurses.* ***(AHP 2, Phase 2)***

Taken together, the above quotes build the impression that the all-encompassing term 'AHP' is problematic as it was an overarching generic term for a group of professionals who provide adjunct services on behalf of other clinicians. As such, the AHP term did not communicate the highly specialised nature of their work or knowledge bases that underpin their profession. As such, adhering to one's work content was critical while accommodating multidisciplinary working. Consequently, some AHP informants, proffered extensive descriptions of the

academically intensive and evidence-based nature of their undergraduate and postgraduate degree courses or professional bodies, to which they belonged,

> *So throughout your training there's a big sort of emphasis on being evidence based, looking to the evidence for doing your treatments. And that sort of runs throughout it. So I think from early on in your career, you're quite mindful of being a bit more academic rather than doing something because that's the way it's always been done. I think you're quite mindful to stay on top of the literature. I think if you've got that interest and you're looking at literature regularly and assessing the evidence I think you're a bit more likely to want to go down a more academic route. And I think, I mean to get onto the course in the first place, you know, it's not an easy course to get onto. You need good A-level results; you need to show that you've done work experience and things.* ***(AHP 4, Phase 2)***

> *I was a member of my professional body anyway; the British Psychological Society became aware of this new area of health psychology, which was growing. So I went and did my Masters in Health Psychology.* ***(AHP 10, Phase 2)***

> *I'm still registered as an OT and I've got some research funding actually from the College of OT a few years ago. So I still see myself as an OT.* ***(AHP 2, Phase 2)***

Healthcare scientists however, presented as somewhat exceptional group. Three major markers separated them from other healthcare professions (1) their lack of direct contact with patients (2) they worked in laboratories and (3) laboratories are governed by financial efficiency.

> *First of all, pathology is a non-patient place in the business so you can manage your time more easily. And secondly, I think because pathology, the way it was run, certainly in my day, involved running a budget to run*

*the laboratory you got into a financial way of thinking, perhaps more so than some other part of medicine… **(Doctor 5, Phase 2)***

The point Doctor 5 makes about how working in laboratories promotes a more commercial mind-set in healthcare scientists when compared to other healthcare professional groups working on wards is a major differentiating feature. This seems to align with Doctor 2 above who works in a traditional ward setting who states commercial approaches are not in his interest or part of his job. The commercial mind-set of healthcare scientists became more prominent during data collection as a response to the increasingly hostile external environment described in Section 7.3.2. LEMT has launched numerous cost improvement programmes and laboratories were one of the centres where savings and efficiencies goals could actually be realised. Mainly because laboratory operations can be solely addressed in the commercial terms to which LEMT aspires in its 5 year IBP. This commercial mind-set was even more pronounced as the Carter Report (2008) and the current conservative government policies have injected further elements of competition amongst Pathology service in the NHS. This prompted the establishment of the Pathology Joint Venture (PJV), the second embedded unit within the LEMT case.

These professional markers suggest that healthcare scientists do not have the same clinician-patient relationship as other professional groups with a clinical remit. Thus, unlike the nurses, doctors and AHPs above, healthcare scientists seem to have a greater tolerance for what these other HCP groups would consider proscriptive behaviours and perspectives. Taken together, this commercial mind-set and lack of direct patient involvement would appear to facilitate CEI formation by circumventing the normal prescription and proscription seen in other clinical professions. Yet, despite these exceptions healthcare scientists still found that,

I think, by the very nature of our job, we are quite prescriptive. So, what we actually train people to do is to follow the rules and because that's absolutely necessary. That's the training we have, this is the way to do it, you document that that's the way, so the mind-set is, is not to change

things or to change things slowly. We are not into big bangs...The NHS is not efficient we have real problems for example, in getting our patients out of acute beds into the community hospitals, or the interface with social services. ***(Healthcare Scientist 2, Phase 2)***

... PJV and all the systems like it are inherently a good thing and bring advantages to staff, patients, etc. And so really it is to get that message over as well that, it's not just about money, although money is a lot, but it's also about giving better quality and doing something that is sort of new and exciting as well and so hopefully you can bring staff along to participate in that. ***(Senior Healthcare Scientist 1)***

Though healthcare scientists seems to be an exceptional group of clinicians, Healthcare Scientist 2 still speaks to the prescriptiveness of her work content in particular and the NHS by extension. Further, Healthcare Scientist 1's indicates that for the commercial mind-set to prevail, it still needs to be balanced against non-financially driven motives. From Sections 7.3.1 and 7.3.2 I reveal how respondents are largely suspicious and opposed to financial motivations. As such, healthcare scientists search for some legitimacy in the eyes of other HCP groups. When these points are considered collectively, it can be seen that the prescription and proscription of the healthcare scientist identity can still prompt negative evaluations CE desirability.

While this study encountered clinically based healthcare professionals (HCPs) intersections with management were inevitable as per the NPM literature reviewed in Chapter 5. Further, it was necessary to understand the CE perspectives of the top management team whose remit it would be to develop and implement DH policies and adopt CE strategic options where necessary. LEMT has an extensive formal management structure, with a mixture of (1) HCPs that held management roles and (2) non-clinical managers. I will focus on the latter and manager will be used to refer to these non-clinical individuals hereafter.

Despite manager's descriptions of their work content, Table 28, their management style was a matter of personal choice; dependent on their strategic or operational

remit in LEMT. However, as suggested by the NPM reforms, management work was prescriptive in *how* it was done in two ways. First, there were extensive accountability measures associated with managing a publically funded organisation,

> *Because of the nature of restrictive public finances, the executive team, we have to deliver as much as we can, a high quality safe service. If you have been 'gung ho' entrepreneurial within the organisation to the detriment of the consistent quality grass roots care, then obviously you're obviously getting the balance wrong aren't you...* [there are] *boundaries, which would not necessarily, be good governance within the private sector of course where there are more freedoms. But within the public sector there is a, a framework which has got to be respected. Now you could say, well because there is that framework how would you tackle entrepreneurship?* ***(Non-executive Director 3, Phase 2)***

Combined, the bureaucracy that seemed inherent in management work and public accountability prompted management respondents to find CE undesirable. Though it should be noted unlike Doctor 2 who stated CE is not a part of his job, managers did not find actual CE action undesirable, rather their negative evaluations of CE stemmed from the proscriptivensess of going against the public sector-NHS management norm.

Second, a fundamental divide exists between clinicians and managers. Managers do not have the same knowledge as clinical professional groups academically or tacitly. As a result managers seem to be underfoot due to the precedence that the clinician-patient relationship takes in every organisational decision. While they agreed this is rightfully so, they walked a line where decisions about the financial well being of the Trust were also critical. As such, whilst managers perceived much of their work was supporting and facilitating the work of clinicians, some of their work included convincing clinicians, admittedly to varying degrees, that decisions were based on fundamental clinical principles. One senior finance manager who transitioned from the private sector conveyed how this affected his work,

You can never leave the patient behind; you can never lose sight of the quality and of the outcomes. But you've got to get the clinicians into position where they recognise that these three things all need to be considered in every investment, in every change that we do. I think if you lead with efficiency, you are in danger of losing the attention and the emotional engagement with the clinicians in the organisation and if you do that, you're sunk. ***(Manager 1, Phase 1)***

Manager 1 deems this patient focus necessary to convince clinicians that their management and administrative decisions prioritised the clinician-patient relationship. This aligns with my observational evidence from Board and R&D Committee meetings where patient advocacy representatives were present. Otherwise change is unlikely in the LEMT without the attention and emotional engagement of clinicians.

7.4 Corporate Entrepreneurship Feasibility Influencing Factors from the LEMT Organisational Context: Organisation Size and Structure, Strategic Vision and Professional Identity

This section will be devoted to discussing factors from the LEMT context that influence CE feasibility. CE feasibility is defined as the degree to which an individual believes they are personally capable of behaving like a corporate entrepreneur or participating in CE activity. This definition guided my analysis of the case data to find factors that respondents perceived influenced their ability to act entrepreneurially in LEMT. I was able to extract three organisational contextual factors that influence CE feasibility. These factors include: *organisation size and structure*, *strategic vision* and *professional identity*, summarised in Table 29 below. CE feasibility influencing factors were homogenous in that they only prompted negative evaluations of CE feasibility so that CEI formation is largely hindered. I will present this data to the subsequent sections.

First Order Codes *Statements about:*	Second Order Codes SEE Influencing Factors from the Organisational Context	Entrepreneurial Attitude Influenced by Organisational Factors	Evaluation of CE Feasibility (Negative/Neutral/Positive)	Findings Derived From
"Disconnected from LEMT" e.g. • Directed by discipline not formal structures • Where we work	Organisation Size & Structure	Corporate Entrepreneurship Feasibility	Negative	Across the LEMT Case
"Changes to LEMT's configuration" e.g. • Historical factors: Merger to form LEMT • Extensive and complex management hierarchy • Blocked communication • Bureaucracy and centralised decision-making				
"No supporting infrastructure" e.g. • No commercialisation expertise in LEMT • 'R but no D': Strong research background but no development	Strategic Vision		Negative	
"Credibility of," e.g. • Political policies commercial agenda • LEMT strategies				
"Space for entrepreneurship" e.g. • Re-active culture, constant fire-fighting • Time consuming nature of work	Professional Identity		Negative	
"Nature of work " e.g. • Routinised • Prescriptive • Time consuming, don't have space for CE • Fire fighting, reactive				
"Entrepreneurship is not my job" e.g. • Not part of my professional identity • Entrepreneurship is not a valued behaviour				
Emergent Theory: (1) Social Identity Approach				

Table 29: Data Analysis Table Showing Influencing Factors from the LEMT Context that Impact Perceptions of Feasibility in Corporate Entrepreneurial Intention Formation

7.4.1 Organisation Structure and Size Influence Corporate Entrepreneurship Feasibility

LEMT's current size and structure is an artefact of a DH and NHS England mandated merger to take advantage of economies of scale. Three East Midlands Trusts merged to become LEMT. As a result, LEMT is now one of the largest NHS Trusts in England with a considerable workforce and extensive organisational structure. There are now 12 000 employees spread across three sites physically and four Divisions, fourteen CBUs and sixty-two specialties structurally. The magnitude of LEMT's size and structure were not lost on respondents,

> *DH [Department of Health] is always pushing the thing to change but it's like changing direction of an oil tanker. It's a huge, monolithic organisation and changing anything of that scale is going to be difficult. There's this inherent inertia within the health system. Just because it's so big and everything is dependent on everything else, chaos theory kind of thing, it's inherently difficult because of what it is.* ***(Doctor 2, Phase 1)***

> *I think the problem with the LEMT I guess to some extent is that it's very large and unwieldy. And I think that doesn't help, because you end up with an overarching structure and an overarching culture… Acute Division for example, it's almost bigger than some medium sized general hospitals.* ***(Doctor 12, Phase 2)***

> *I think probably the biggest change in the first place is that everybody was fairly comfortable with the way* [this hospital site] *was running before it became a much larger Trust.* ***(Doctor 8, Phase 2)***

Collectively, Doctor 2, Doctor 12 and Doctor 8's comments indicate their perceptions on the LEMT's size. Doctor 2 describes the NHS as a monolithic organisation and highlights the inherent inertia and resistance to change that develops when an organisation reaches a certain size. Similarly, Doctor 12 indicates that in it current state LEMT has also become too unwieldy. Doctor 8

supports Doctor 12's observation by indicating that the smaller hospitals that existed before the merger were more manageable. More interestingly, the above quotes were commonly proffered as explanations as to why they perceived CE was not feasible in LEMT. Further analysis revealed two reasons why LEMT's size and structure negatively influenced their belief that they were personally able to participate in CE activity in LEMT.

First, respondents indicated they were largely disconnected from LEMT as an organisation. From Section 7.3.3.1 respondents gave impassioned and emotive accounts of the NHS and its values. In doing so, they proffered their motivations for joining to this publically funded institution and poignant meanings they attached to being in the NHS's employ. However, these strong feelings did not appear to instinctively transfer to the LEMT organisation. Rather, their accounts of LEMT itself were far less zealous and far more pragmatic than those proffered about the NHS. This created the impression that they simply viewed LEMT as an organisation *where* they worked. Thus, LEMT was merely a means of 'living' the aforementioned NHS founding principles and practicing their various professions. This view effectively relinquishes the LEMT entity to a minor concern along with their placement in the formal organisational structure. One senior physician conveyed his perception that the LEMT organisational structure was largely irrelevant to his work,

> *It's only two years ago that they changed it [LEMT structure] to Divisions. I mean we have very little to do with any other or the Acute Division, apart from cardiology who of course who we work closely with. So it's a very academic collection. To some extent what goes on in LEMT goes over our heads and where our focus, by and large as doctors, is. What we do day to day and what we do within our specialty. I've calculated that I have had 8 chief executives in my time. They come and they go. They come and make a change, they swap everything around and then they go away again. Usually having failed.* ***(Doctor 4, Phase 2)***

Doctor 4's comments demonstrate an apparent disconnect between himself as a clinician and the organisation he works in when he states, *'we have very little to*

do with any other or the Acute Division' and *'what goes on in LEMT goes over our heads.'* Therefore, the continuous waves of organisational restructuring coinciding with changes to leadership were viewed as largely *'academic'* and nothing to do with the clinical aspects of his doctor identity. This detachment signals to organisational members that do not have to concern themselves with larger organisational issues such as the financial issues LEMT is currently experiencing. This links to Doctor 2's comments where he has limited responsibilities to LEMT.

Second, respondents cited the extensive management hierarchy that inevitably developed after the LEMT merger only strengthened their negative evaluations of CE feasibility. This was primarily because these management layers hindered communication. Consequently, this gave respondents the impression that they had to cut through these layers to achieve any change. For instance, Doctor 12 related his personal experience of trying to move his service from one site to integrate it with the specialist testing facilities at another site,

> *The problem is within the organisation; because it's so large, very few people are empowered to make decisions, or even don't understand that when you're being paid £50,000 a year as a middle manager, you should be making decisions. For example, we had a meeting and the lady who came along was the manager of outpatients at* [one of the hospital sites]*. I said to her, 'Who's using that space, it looks empty to me?' 'It is empty,' she said, 'but we can't use it.' I said, 'But you're the manager, why can't we use it?' 'We just can't, because there's a lot happening.' 'What's happening?' So they're never really questioned directly about what's going on. Clearly it was very uncomfortable, because she didn't see being accountable as part of her role. I asked, 'You're the manager, who's above you?' She reports to the Director but the Director doesn't want to be dealing.* ***(Doctor 12, Phase 2)***

Doctor 12's account provides insight into how organisation size and structure exacerbates the disconnectedness Doctor 4 introduces above to prompt negative evaluations of CE feasibility. He relates how the multitude of management layers

delays and complicates decision-making processes in LEMT. His commentary also indicates that decision-making is centralised which is also a by-product of bureaucracy that develops in large organisations especially public sector organisations. Consequently, accessing decision makers to facilitate his project such as the Director he mentions become difficult.

7.4.2 Strategic Vision Influences Corporate Entrepreneurship Feasibility

As introduced in Section 7.3.2, LEMT is operating in an increasingly hostile and competitive environment. To combat these conditions LEMT's executive team has adopted the plan set out in the DH's Equity and Excellence White Paper to develop strategies and direct the Trust's way forward. This new direction is summarised in LEMT's strategic vision,

> *Our vision over the next five years is to become a successful, patient centred, Foundation Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience.* ***(LEMT Website, 2013)***

Having reviewed LEMT's strategic plan as part of my document analysis, it is clear the strategic vision is derived from the policies set forth in Equity and Excellence. However, Section 7.3.2, illustrates that frontline staff do not wholly trust Equity and Excellence's commercial orientation as the policy opens the NHS up to privatisation. The lack of infrastructure combined with lack of support from staff created the impression amongst respondents that it was unlikely that LEMT would realise its vision. In turn, this prompted negative evaluations of CE feasibility from respondents, which I will elaborate on in the remainder of this section.

From the excerpt above it can be seen that a central aspect of LEMT's vision is the organisation's pursuit of FT status, previously mentioned in Section 7.3.2,

since 2010. However, to achieve FT status, LEMT must remedy its precarious financial position and reduce its £800 million budget by 7% each year for 3 years as part of its IBP. This particular task has made LEMT's quest for FT status a daunting one and to date LEMT has still has not achieved this government mandate. One consultant drew on his previous experience working at a Double Excellence FT to convey,

> *They [staff] have to understand it [Foundation Trust status]; they've got to see the opportunities. That's why I didn't think at this time we [LEMT] deserve to be a Foundation Trust, because I'm not convinced that people get that. I've heard lots and lots of consultants in a meeting describe this as being some wet dream of the management. If that's the case, if people think that, you've got a real problem, haven't you?* **(Doctor 8, Phase 1)**

Doctor 8's quote demonstrates that LEMT's vision does not ring true and lacks credibility with its organisational members. Doctor 8 states that some of his colleagues, similar to Doctor 2 in Section 7.3.3, believe that achieving this vision was a concern for management and not themselves as clinicians. This statement also infers that FT is an unattainable fantasy especially when the financial targets presented above are concerned. As a result Doctor 8 suggests that LEMT does not deserve FT status.

Further, Doctor 8 indicates LEMT's organisational members do not appreciate the opportunities offered by becoming a FT. Mainly because do not exhibit the opportunity seeking, far less opportunity exploiting behaviours that would necessary to compete in the *'new NHS.'* For example, interviews and documentary analysis revealed that LEMT has a strong research tradition. LEMT has been awarded national Biomedical Research Units with £19 million in funding and the one of the hospital sites has an excellent world-class reputation. However, despite these sources of innovation LEMT does not look for opportunities to exploit them and generate revenue to offset their debt. One Head of Service observed,

> *Well, I think the Trust is missing a trick with consultancy because the program we run has a national and international reputation. So people are always coming and saying, 'Can we come and visit?' and they [LEMT] are saying 'Yes,' but there is a cost to the organisation because I'm not doing my day job walking these people around and essentially giving them 20 years worth of experience so they don't make mistakes. Well, I think the Trust should charge for that because every time somebody comes and visits the Trust for an expert opinion there is a cost associated with that.* ***(AHP 1, Phase 1)***

AHP 1's excerpt relates her experiences building and managing a research team funded by an external funding group. In relating her experience she elaborated further on why CE was not generally viewed as feasible by organisation members by focusing on a second aspect of LEMT's strategic vision: innovation,

> *I mean innovation doesn't comfortably sit with R&D. The R&D Department do not see that [innovation] as their core activity. And that's probably right because the bureaucracy associated with research, that's overwhelming and hugely time-consuming. I would imagine that they are two distinct functions [Research and Development] and I'm not aware that the Trust has access to or has employed anybody that can essentially do development. I would have thought there would be some merit in either joining with the university or commissioning the universities to provide their expertise in developing spinout companies to encourage innovation and entrepreneurs. That's the brave new world in terms of Foundation Trust Status. If we're meant to be generating income then clearly that is one way of doing that.* ***(AHP 1, Phase 1)***

AHP 1 suggests that research and development are two separate organisational capabilities. She concludes that in her experience LEMT appears to only be able to facilitate research but not development, which is key to converting innovation into viable revenue streams that could potentially offset their budgetary constraints. This introduces as second point, regarding the practicality of implementing LEMT's vision. Specifically, that LEMT does not have personnel

with the skills and expertise needed to drive a FT's commercial agenda forward. A procurement manager who came to LEMT after spending the majority of his career in the private sector commented,

> *It [LEMT] doesn't have a Commercial Director who will drive it [commercial agenda] forward. So if you're serious about it you put someone in position. So, we're serious about clinical, quite rightly, we have a Medical Director, a number of Medical Directors. We're serious about finance; we've got a Finance Director. We've got a CEO, but there isn't a Commercial Director. Any commercial sector company, you ought to have a Commercial Director and I think either you call it that or sales and marketing, or something like that. Whatever you call it – we don't have it.* ***(Manager 3, Phase 2)***

Manager 3 makes a very salient point. He indicates that senior managers oversee all of LEMT core business functions, such as a Medical Director to direct clinical functions. Such senior appointments signal to organisational members that LEMT is committed to that function. In Section 7.3.3 I demonstrated the importance of appearing committed to one's work in this context. As such, Manager 3 suggests that by not hiring someone with a commercial remit such as a Commercial Director, LEMT is effectively signalling to its organisational members that it is not serious about achieving its vision. Mainly because LEMT is not providing them with the human resource or processes required to facilitate commercialisation. In turn this fuels respondent's perception that LEMT's strategic vision is not credible and prompts them to evaluate CE feasibility negatively.

Finally, without commercialisation processes or personnel in place, respondents found LEMT did not have the ability to absorb new ideas that breed innovation,

> *We don't know who to go to with an idea. When you do have an idea and you bounce it off senior people they don't seem be able to convert into anything, there's no real constructive help.* ***(Manager 1, Phase 2)***

Manager 1's comments indicate that the existing senior managers do not have the expertise of capacity to develop or implement new ideas, which is also central to LEMTs vision. This impression only served to enhance respondent's negative evaluation of CE feasibility as they construed this as yet another organisation barrier they had to surmount. Further, Non-executive Director 1 suggests that even if respondents found LEMT's strategic vision to be credible and positively evaluated CE feasibility, innovative ideas may not survive these barriers over an extended period of time,

> *There are individuals who sort of stuck their head above the parapet and said, you know, 'I've got a great idea.' And almost every example that I have seen the approach of the organisation almost grinds them down to a point where they say, this is too hard, you know.* ***(Non-executive Director 1, Phase 2)***

7.4.3 Professional Identity Influences Corporate Entrepreneurship Feasibility

Professional identity emerged a second time in data, as a negative influencer of CE feasibility. Though how professional identity negatively influenced CE feasibility was different from how it influenced CE desirability. In Section 7.3.3, professional identity influenced CE desirability via the professional legitimacy created by respondents adhering to and avoiding specific beliefs values and behaviours. However, professional identity's negative effect on CE feasibility had more to do with the consequences of the work respondents' performed summarised in Table 29 above. Specifically, respondents cited both the time-consuming and heavily regulated nature of their daily work were responsible for their perception that they were not capable of participating in CE activity. I discuss both of these in the remainder of this section.

As established in Section 7.3.3 respondents had specific work related to their various professions. These professional behaviours were learned very early on in their careers, particularly for respondents who were clinically based and consequently established a clear career path that they generally did not deviate from,

Initially when you very first qualify, your first couple of years it was all about just getting hands on experience, so really nailing down and perfecting your skills, sort of hands on skills, your manual skills and your clinical reasoning and decision making processes for diagnosing and treating these patients. That's kind of what it was all about for the first couple of years. ***(AHP 5, Phase 2)***

I think I get frustrated, that sometimes, the personal skill sets that you have are constrained. I don't know if that's just in the NHS. I'm sure there are many people at work that have a certain role to provide and you want to do more. At the same time in the NHS, certainly as a doctor, you've got a natural career progression. There's a lot of routine work, I suppose that gets a bit frustrating. ***(Doctor 3, Phase 2)***

Both AHP 5 and Doctor 3's perspectives demonstrate that their training places a natural behavioural limitation on what they do. For instance AHP 5 indicates her early years were focused on perfecting her clinical skills only whereas Doctor 3 refers to the expected career path a doctor should follow. Doctor 3 also refers to the routinised nature of work, which determined how she spent her time and what she did in that time. Some respondents went on to elaborate on the consequences adhering to this routine had for their perceptions of CE feasibility,

It's not encouraged [entrepreneurship]. I think in the main, because we [NHS professionals] don't have the space for entrepreneurship. Partly because we don't have the space and part, because we're always fighting financial issues, lack of staff, you know. We are always managing on a day-to-day basis, rather than having the time and the space to think about other things and also I think, by the very nature of our job, we are quite prescriptive. So, what we actually train people to do is to follow the rules and because that's absolutely necessary. ***(Healthcare Scientist 2, Phase 2)***

That's one of the big cultural challenges isn't it? How do you get people on the front line to think about innovation and if they had and how do you even give them time to think about innovation and then how do you give them, how do you empower them to take those ideas forward in a situation where a lot of it is fire fighting, you know, just basically keeping the plates spinning. It's not a culture that lends itself easily to thinking outside the box ***(Doctor 5, Phase 2)***

Healthcare Scientist 2 and Doctor 5's comments indicate that the routine associated with their professional identity was time consuming and ultimately determined what they perceived they had time for. As such, both respondents indicate to not having space to consider new behaviours much less CE related one like innovation. This raises an interesting point from Section 7.3.1 where respondents find innovation desirable yet as described above it may not be feasible. This tension, Doctor 5 observes, is one of the major cultural challenges facing the NHS. Furthermore, their comments indicate this time-consuming characterisation is further compounded by a second issue that contributes to their negative evaluation of CE feasibility. Specifically, Doctor 5 and Healthcare Scientist 2 depict their work in LEMT as largely reactive, which is an anathema to the proactiveness required for successful CE. Thus, they refer to *'fire fighting'* a multitude of operational and strategic issues, which was a common grievance amongst respondents. More so they suggest that a reactive stance is not conducive for promoting or facilitating *'thinking outside the box.'*

Finally, Healthcare Scientist 2 states that as professionals they were trained to *'follow the rules.'* This suggests that the prescriptive nature of professional identity introduced in Section 7.3.3.2 extends beyond being a legitimate member of a particular profession to include the formal rules and regulations that governed professions and negatively influenced respondent's perception that they could act entrepreneurially in the organisational context. Doctor 5 went on to elaborate,

...in the health service context there are things called standard operating procedures which are there to make sure people don't make mistakes. Now that's the antithesis of innovation... And I think another thing you

ought to add to this debate is the fact that there is, it's not actually in peoples gift to deviate very far from the rule book anymore because, in the context of healthcare, practice is so strictly governed now and the governance around research innovation is so, some people would say, over burdensome, but it is actually, it takes an awful lot to take an idea forward so even if you want to, even if you want to test a new device you know it could be anything, slightly different heart valve or something, you can't just go and do it, you know you've really got to put it through a whole series of governance procedures, which is good because obviously otherwise it becomes unsafe but at the same time it puts a lot of people off actually bothering to step outside the routine practice, Absolutely, even all of the paperwork. ***(Doctor 5, Phase 2)***

Doctor 5 provides insight into how the following profession related rules negatively influence perceptions of CE feasibility. He suggests that following the rules is *'the antithesis of innovation.'* Further, he states the rules that govern professions exist for clinical safety reasons nonetheless these rules have become so convoluted and restrictive that they stifle innovation in several ways. First, the nascent idea generation phase of innovation is handicapped as organisational members do not have the space to think of solutions to the plethora of operational, clinical or strategic problems in LEMT. Second, Doctor 5 indicates that even if someone did have a viable idea outside routine professional practice, gaining approval to take that idea forward was an exercise in bureaucracy with burdensome governance procedures.

7.5 Discussion: Contextual Factors that Influence CEI Formation

The findings presented thus far provide insight into CEI formation by deploying the SEE framework within the LEMT organisational context. To help connect the various concepts in the data presented above, I have constructed Figure 8, which both captures and summarises my main findings:

- There are 5 main factors in the LEMT context that act as barriers to CEI formation.

- The LEMT contextual factors operate through organisational members negative perceptions of:
    - CE desirability only (language, external environmental conditions and NHS identity).
    - CE feasibility only (organisation size and structure, strategic vision).
    - CE desirability and CE feasibility (professional identity).

In the remainder of this section I discuss the implication of these findings for bottom-up CE propagation and the utility of SEE in the organisational confines in understanding CEI formation.

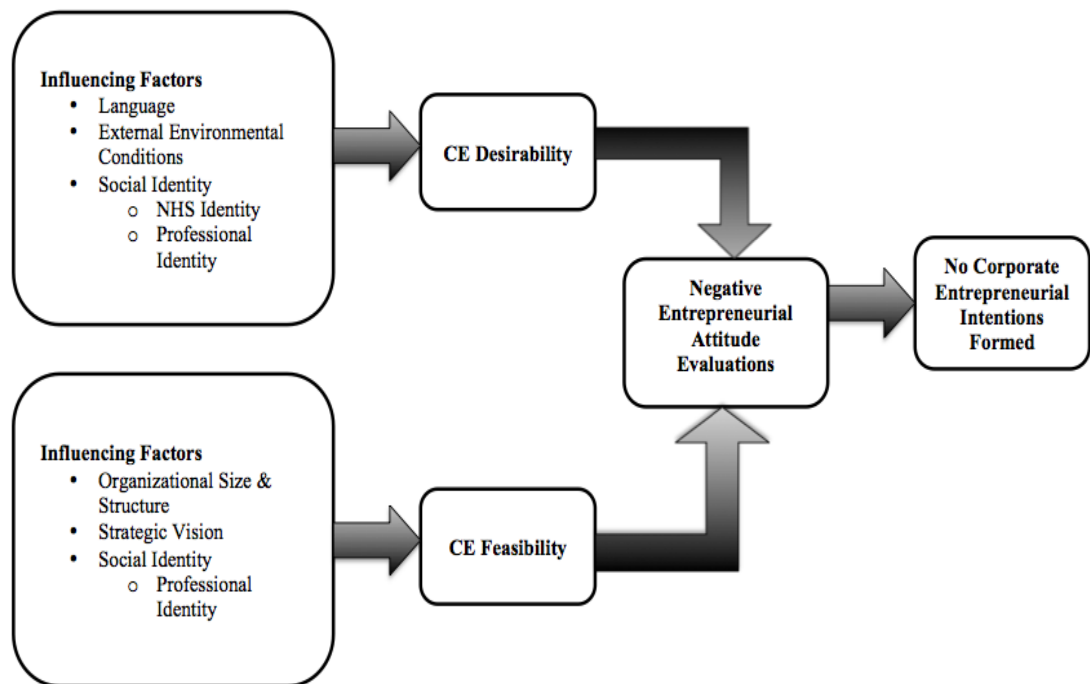


***Figure 8:** Diagram Showing the Expansion of Shapero's Entrepreneurial Event to include Organisational Contextual Factors that Act as Barriers to Corporate Entrepreneurial Intentions Formation in LEMT*

Early conceptualisations of CE advocated that the term should only be deployed when the entire organisation exhibited an entrepreneurial philosophy rather than just parts of or individuals in the organisation (Covin & Miles, 1999). Yet, respondents conveyed their impression of CE in the LEMT case as *'patchy'*

occurring with low frequency and in isolation in various parts of the organisation led by individual organisational members. When this finding is considered, I submit that while Covin & Miles (1999) is undoubtedly a seminal work in CE, their conceptualisation is somewhat restrictive in two ways. First, it proliferates the dominance of the organisational level of analysis in CE. Second, it perpetuates a binary view of CE where CE phenomena are either present or absent/present in its entirety or not at all. Rather, my finding is more reminiscent of emerging contemporary perspectives from Wales et al., (2011) who challenge the notion that that CE-related phenomena such as EO are manifested homogenously throughout the organisation vertically (hierarchically), horizontally (across business units) and temporally (time-wise). Such a view allows for a more granular treatment of CE, particularly where the source of its propagation are individual organisational members, who are the focus of this bottom-up study of CE.

Yet, the irregularity and infrequency of CE activity in LEMT suggests, that the majority of its organisational members had not formed CEI. Therefore similar to EI researchers I sought to understand what factors from the organisational context acted as barriers to CEI formation by negatively influencing CE desirability and CE feasibility. Identifying these factors also serve to mitigate the parsimony often associated with EI models like SEE (Krueger, 2000). Several organisational contextual factors emerged from the data as influencers for each of the corporate entrepreneurial attitudes. CE desirability was influenced by: *language, external environmental conditions* and *NHS identity* and *professional identity* discussed in Section 7.3. CE feasibility was influenced by: *organisational size and structure, strategic vision* and *professional identity* Section 7.4. While the use of some EO language (innovation and proactiveness) appeared to have an positive influence on CE desirability, it is evident from my findings that there is a preponderance of the identified organisational factors hindering CEI formation via negative perceptions of CE desirability and CE feasibility, Figure 8. This has theoretical implications for both CE and CEI research.

First, the data corroborates the assertion in the CE literature that the organisation environment itself can be a hostile environment to CE activity (Burgelman, 1983;

Sharma & Chrisman, 1999). It achieves this by following a nascent trend in CE research to scrutinise the interplay of the organisation's features on individual organisational members cognitive processes (Hoskisson et al., 2011; Corbett & Hmieleski, 2007; Baron, 2004; Gaglio and Katz, 2001; Busenitz & Barney, 1997). Particularly within my study, the data produced five factors born of the organisational context that negatively influence organisational members perceptions of CE desirability and CE feasibility to prevent CEI formation. This interaction appears dependent on whether organisational members believed LEMT truly valued CE and would facilitate their CE endeavours. This represents a departure from the application of SEE in individual entrepreneurship where influencers of desirability and feasibility focus on the individual's assessment of himself or herself and their choice to start a new venture.

This contradicts two underlying assumptions in CE research. The first being that organisational members view CE activity as inherently good for the organisation as it has been shown to improve firm performance (Antoncic & Hisrich, 2001; Zahra & Covin, 1995). Rather, the data reflects that respondents have their reservations about what CE entails, the role it may play in and its applicability to a public sector institution like the NHS and its service provision units like LEMT. As such, regardless of whether organisational members can objectively view CE or facets of CE as beneficial, the nature of a publically funded healthcare organisation remains a predominant barrier to CEI formation. More so, SEE in individual entrepreneurship proposes that EI formation only requires individual's positive perceptions of desirability and feasibility to be above some threshold level to interact with a precipitating event (Krueger, 1993). However, it is clear that in a public sector healthcare organisational context, largely negative perceptions of CE desirability and CE feasibility exist. This suggests that from a CE perspective, organisational member's CE desirability and CE feasibility perceptions may start at a threshold lower than that of individual entrepreneurs in society or a private sector organisation. This lower CE desirability and CE feasibility threshold suggests that the precipitating event interaction proposed by SEE may not be applicable in CEI formation. I will examine this proposition in further detail in Chapter 8.

The second assumption in the CE literature is that if the organisation re-configures its internal environment or the external environmental in which the organisation operates change to favour CE, organisational members will automatically engage a CE strategic option. Instead, the data indicates that respondents were so preoccupied with the status quo, represented by the five influencing factors; they questioned the credibility of any pro-CE changes made by their organisation like LEMT's strategic vision. In turn case informants could only continue to evaluate CE desirability and CE feasibility negatively. Krueger (2007; 2000) reminds us that realistically organisations do not participate in CE; rather, its manifestation is contingent on the presence of corporate entrepreneurs whose cognitive structures enable them to recognise their organisation's need for renewal or new venture creation. This suggests that the hearts and minds of organisational members are the first 'locus of alignment' for successful CE implementation. This signals to the direction of the remainder of my study and how I intend to contribute to the CE literature. Specifically, I aim to address the lack of clarity surrounding how organisational members start to think entrepreneurially and choose to adopt CE, a process that is often implied but is rarely fully explicated in the CE literature. This will be addressed extensively in Chapters 8 and 9 subsequently.

Third, CE research is customarily based on data collected from traditional commercial sector corporations and firms with successful CE records (Phan et al., 2009; Stopford & Baden-Fuller, 1994). My data reveals constructs that are consistent with the current CE knowledge pool such as external environmental conditions, organisation size and structure and strategic vision (Ireland et al., 2009) as CEI influencers. More interestingly, my data also illuminates some individual-level contextual contingencies that define public sector healthcare organisations, hinder CEI formation and thus CE activity. For instance, entrepreneurship research has generally focused on how entrepreneurs use language to gain and sustain support for new ventures or represent their ventures as compatible with more widely established sets of activities (Hoskisson et al., 2011; Cornelissen & Clarke, 2010). However, in the NHS-LEMT context it would appear that the use of CE and entrepreneurship related language has a distinctly opposite effect and generally elicits anti-CE sentiments. This in turn

reduces a CE initiative's legitimacy so that largely negative evaluations of CE desirability are rendered. However, I submit that the task of overcoming language's negative influence on CE desirability is not insurmountable. It can certainly be remedied by using terminology more positively viewed by respondents such as innovation and proactiveness.

Social identity however, as a barrier to CEI formation, presents more of a challenge to alter primarily because of how it is constituted. Krueger (2007; 2002) states the behind entrepreneurial attitudes, lie cognitive infrastructures which represent a collection of beliefs and values that an individual holds to govern their decisions and ultimately their behaviour. Respondent's multiple social identities (NHS and professional identities) are manifestations of two cognitive structures that are made up of two sets of deeply held beliefs, values and behaviours that have been ingrained through lengthy education and training periods. Relevant to this study is that neither of these collections of beliefs values and behaviours traditionally promotes nor favours CE. Study participant's public sector background (except the 5 respondents who were had worked or are working in the private sector) further compounds this as they appear to have a limited and/or even distorted mental model of what being an entrepreneur far less a corporate entrepreneur entails in terms of beliefs, values and behaviors. It follows, that potential corporate entrepreneurs may be deterred from CE based on mental prototyping which is a cognitive phenomenon akin to categorisation and central to SIT and labeling in sensemaking (Tsoukas & Chia, 2002; Hogg et al., 1995; Jelinek & Litterer, 1995).

Therefore, I propose that in LEMT, triangulating social identity with corporate entrepreneurial attitudes and CEI formation can be fruitful. It will allow me to provide some insight into how changes to deep cognitive structures like social identity come about and how this change can influence CEI formation and ultimately, organisational member's choice to participate in CE activity. The inception and progress of this change will be the focus of the two remaining empirical chapters, Chapter 8 and 9.

7.6 Conclusion

I started this chapter by outlining the extremely limited and inconsistent pattern of CE-activity in LEMT using the SEE-CEI framework. The empirical data confirms several contextual factors that ultimately hinder CEI formation in this organisational setting. In summary, desirability is influenced by language, external environmental conditions and social identity whereas CE feasibility is influenced by organisational size-structure, strategic vision and social identity. Consequently, CEI formation has been largely hindered by these factors.

However, my study also seeks to investigate the few pockets of CE activity that have been found in LEMT by understanding the how organisational members choose to participate in CE. In my methodology (see Chapter 6) I have focused on 3 units where entrepreneurial individuals can be found. This suggests that there was some change in the negative evaluations of CE desirability and CE feasibility by organisational members discussed in Sections 7.3 and 7.4 to positive or neutral. Consequently, sufficiently high CEI levels were reached resulting in individual organisational members participating in CE. From an individual level perspective this suggests the possibility that homogenous in-group behaviour directed by a particular social identity was disrupted in some way to prompt a re-evaluation of entrepreneurial attitudes, so CEI were formed. As such, Chapter 8 will consider how these disruptions to social identity may have emerged to facilitate CEI formation.

CHAPTER 8: SOCIAL IDENTITY DISRUPTIONS AS A FACILITATOR AND BARRIER OF CORPORATE ENTREPRENEURIAL INTENTION

8.1 Introduction

In this chapter I continue to explore the nascent 'individual in CE' line of enquiry by concentrating on the emergent *social identity* construct. This chapter begins explicating how changes in a social identity may emerge. achieve this, I will present the disruptive events that appear to interrupt and destabilise the normal progression of social identity using the *a priori* construct precipitating events in Section 8.2. Next, I discuss in detail the impact of these precipitating events on LEMT respondent's NHS and professional identities. Specifically, I address how precipitating events create identity tension in respondents' multiple social identities and the associated consequences of inauthenticity, credibility and self-efficacy they experienced in Section 8.3. In section 8.4 I discuss the implications of a precipitating events-social identity interaction within the SEE framework and finally present my propositions in Section 8.5.

8.2 Precipitating Events Disrupt the Normal Progression of Social Identity

My thesis seeks to understand the *facilitators* of CEI formation and not just the *barriers* to CE enactment, which were in abundance in Chapter 7. As I proposed previously in Section 7.6 organisational members social identity may have been *altered* in some way that could facilitate CEI formation. This altered social identity would then enable organisational members to re-evaluate CE desirability and CE feasibility so that CEI were eventually formed. In turn, this altered social identity may explain the few pockets of CE activity found in LEMT. More explicitly, an altered social identity suggests that the normal progression of respondents' NHS or professional identities was interrupted in some way. The remainder of this section will discuss the nature of precipitating events and how

they disrupt the normal progression of respondent's NHS and professional identities and the implications for CEI formation and CE propagation.

Multiple Social Identities	First Order Codes *Statements about:*	Second Order Codes	Findings Derived From
NHS Identity	'Policy Changes' e.g. • The 'new NHS' • Commercial agendas • Financial constraints	**Precipitating Events that Disrupt Social Identity**	**Across the LEMT Case**
Professional Identity	'Policy Changes' e.g. • New service delivery pathways • Meeting targets rather than outcomes		
	'Adopting new roles' e.g. • Leadership roles • Management roles • Research roles		
	'Exposure to others' e.g. • Joining a new team • Working with other professions • Encountering significant others e.g. role models, entrepreneurs etc.		

Table 30: Data Analysis Table Showing Precipitating events That Disrupt the Normal Progression of Social Identity

The disruptive function of precipitating events was particularly evident in the data as I considered the narratives proffered by all study participants within the three embedded units within the single LEMT case. For example, one doctor based in the Pathology Clinical Business Unit (CBU) described when the normal progression of his professional identity (akin to behavioural inertia, Section, 3.6.2.2) was interrupted by a major change in his work content,

> *Solving the puzzles and making the diagnosis… that did well for me for the first 5 to 10 years when I was a consultant until about the mid 90s.* ***(Doctor 2, Phase 2)***
>
> *So what happened in the 90s?* ***(Interviewer)***
>
> *I started to do management work. So I started off as being the lead for Cytopathology, which is one small bit of Pathology. No one else wanted to do it. So I ended up doing it at a very young age here. And it was just me.*

So basically I had control over a small area myself. I could control myself. I could do what I want and do it well. So that gave me a taste of actual power. ***(Doctor 2, Phase 2)***

Doctor 2's representation of precipitating events appears to be quite a linear cause and effect relationship aligning with its representation in the EI literature. Doctor 2 first conveys the prototypical work content performed by a doctor, diagnosis and puzzle solving (Table 28). However, it is clear that there is a significant difference between a doctor's work content and a manager's administrative and managing functions. As such, career transition such as adopting a managerial role was a significant enough event to prompt Doctor 2 to consciously decided to review his work content and by extension his professional identity. More so, the above account reflects a view of a possible professional self, where he is a doctor with more control and discretion over his work.

When Doctor 2's account is considered in the LEMT organisational context however, precipitating events appear to operate differently from Shapero & Sokol's (1982) depiction in the SEE framework, Figure 9. As previously, covered in Chapter 3 precipitating events interact with an individual's pre-existing positive evaluations of desirability and feasibility.

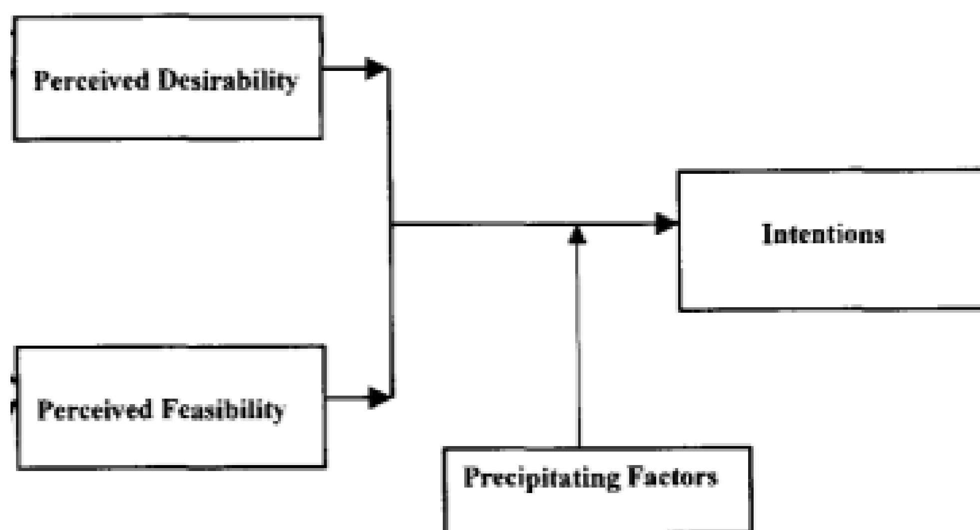


Figure 9: ***Where Precipitating Events Operate in Shapero's*** **Entrepreneurial Event**

The findings presented in Chapter 7 however, indicate that in LEMT respondents had negative-to-neutral evaluations of CE desirability and CE feasibility. As such, if a precipitating event did interact with these negative-to-neutral evaluations no CEI would form and no CE activity would ensue. Thus, Doctor 2's account materialises as particularly informative as precipitating events appear to operate in a manner more in keeping with Hornsby et al.'s (1993) description in their *Interactive Model of Corporate Entrepreneuring*, presented in Chapter 2, Figure 10.

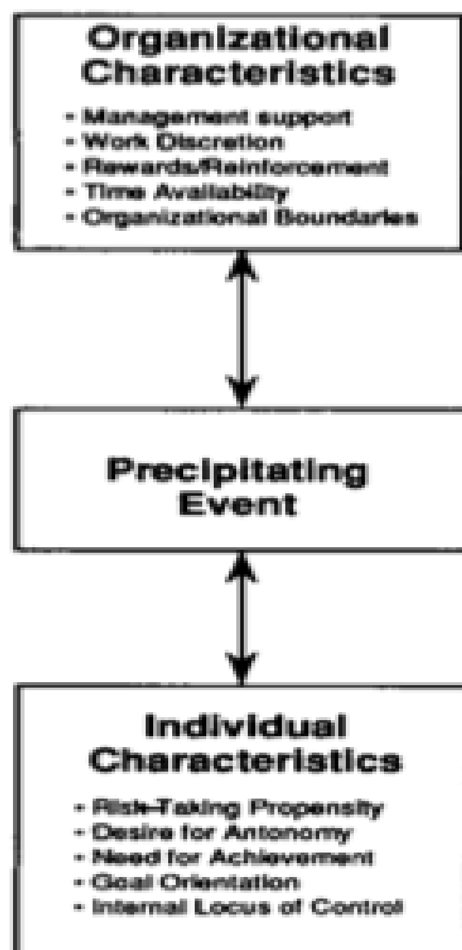


Figure 10: ***Where Precipitating Events Operate in Hornsby et al.'s (1993) Interactive Model of Corporate Entrepreneuring***

In their model Hornsby et al. (1993) postulate an individual's decision to participate in CE can be attributed in part to an interaction between precipitating events and the individual's characteristics. The authors compile a list, which they

state is not exhaustive, of commonly cited traits and characteristics from the entrepreneurship literature including, risk-taking propensity, desire for autonomy, need for achievement, goal orientation and internal locus of control. Similarly, in the LEMT context, precipitating events appear to interact with social identity, which like Hornsby et al. (1993), I have conceptualised as an individual-level factor that can influence CEI.

Further, when the interactions that precipitating events have with a NHS identity or professional identity are considered, these events emerge as more nuanced and complex as they are able to prompt an individual to call a social identity in to question. Comparably, Greenberger & Sexton (1988) state that a *'salience of events'* needs to exist for the individual to engage with their changing circumstances. That is, while many events occur; few are actually salient enough so that the individual consciously processes them. Therefore, when the myriad of precipitating events flagged by respondents as being salient enough to have the aforementioned interruptive impact (in Table 30) are considered, some important observations can be drawn. The first and most apparent characteristic of precipitating events is their variety. Overall, four main categories of precipitating events emerged from respondents accounts, two of which had further sub-categories. This variety is indicative of a second feature, where precipitating events are social identity specific. First, for the NHS identity, precipitating events include *policy change* only. Professional identity however, had a greater variety of precipitating events that encompassed (1) *policy change* in addition to (2) *adopting new roles* such as management, leadership and research roles and (3) *exposure to others* including significant others like role models, working in new teams and with other professions.

Another aspect of precipitating events not covered in the literature is that these events are not necessarily singular or isolated incidents. Rather, the inception of one precipitating event may subsequently trigger a variety precipitating events in close succession. For instance, AHP 9 relates a story where several precipitating events targeted at her professional identity occurred earlier in her career,

Initially I saw the research job with the PRS [Pulmonary Rehabilitation Service] but it was something I hadn't heard anything about throughout my training. And I think all the way through my training I felt I was much better at the clinical side of things than I was the academic side of things. But after about a year, a year and a half here [with PRS] I was so sucked into the research side of things. I really enjoy it and actually now I can't imagine going back and having a purely clinical job. I just think when you're doing research and have this ownership over a project you're so much more, I don't know, I could say you invest more. But I think it sort of feels like yours if you like, feels like your baby. But yeah, I think it challenges you in different ways definitely. And you get opportunities to go to conferences and met people from different countries and things like that. Yeah I really really enjoy it.

Plus, the more I've started to think of AHP 1. As well as having her all her clinical expertise, she has research expertise and she's a businesswoman as well. And I just sort of think there are so many skills that you need to have to reach that kind of level in your career. ***(AHP 9, Phase 2)***

AHP 9's narrative reflects a cluster of precipitating events directed at her professional identity: a new research role, joining a new team and encountering a role model. First, taking on a research role was a departure from the therapeutic and rehabilitative work she was trained for at university. More so, joining the PRS team exposed her to work in a research-intensive environment focused on developing and conducting rigorous in-house research to improve the clinical services the team also provided. In working closely with a multidisciplinary team of researchers including doctors, physiologists, psychologists, nurses and other AHPs, she encountered a new role model, AHP 1, an established and renowned academic and practitioner. AHP 9 draws the conclusion that while clinical expertise is necessary for a successful career, it may not be sufficient. She considers that other skills such as AHP 1's research and business expertise maybe necessary. She relates her quest to acquire research skills particularly, by overseeing a research study as part of a Doctor of Philosophy Degree, with AHP 1 as one of her academic supervisors.

Collectively, these three events challenged her professional identity. Each event appears to re-enforce the other and amplify the disruptive effect and simultaneously create opportunities for study participants to construct a new or re-construct an existing social identity. This can be seen as AHP 9 begins to question what it means to be an AHP and how she should then behave. As such, when she says she could not imagine resuming a purely clinical role this suggests a genuine transformation or re-construction of her professional identity had occurred.

Conversely, narratives of precipitating events targeted at respondents' NHS identity did not appear to cluster like those targeted at professional identity. Rather, these precipitating events seemed to be separated by long periods of time, coinciding with government elections or some healthcare centred public crisis. For example, two years separate the publication of two major governmental reforms. The first is High Quality Care for All (2008) from the previous Labour Government. The second report is the Equity and Excellence (2010) from the current Coalition Government. This gives the impression that these precipitating events are far less frequent than those targeted at professional identity.

Further, these policy changes targeted at the NHS identity appeared to cascade rather than cluster. That is when these changes start at the governmental level in the Department of Health (DH); they then have to filter down through multiple regional and local organisational strata before finally reaching the individuals within the organisation. As such, the time lag between policy changes appears even more exaggerated. This cascading effect can also be attributed to the time it takes for policy changes to filter into LEMT, for the top management team to implement the changes and then organisational members to eventually act accordingly. For instance, the commercial and entrepreneurial agenda of the Equity and Excellence paper mandate all NHS Trusts, including LEMT, must obtain Foundation Trust (FT) status, discussed in Chapter 7. While the pursuit of Foundation Trust status is reflected in LEMT's 5-year integrated business plan (IBP), the organisation has still not obtained this status four years on according to their website,

We remain committed to becoming a Foundation Trust. In April 2012 our Trust Board approved our 2012/13 Annual Plan. We have recently completed a market assessment (looking at population, prevalence and activity trends and what this could means for the services we currently provide), which will help us to refresh our strategy and ensure we are meeting the needs of our patients. We will be developing our five-year Integrated Business Plan (which we need to have for a successful FT application) over the coming months. This Integrated Business Plan will describe how over the next five years, we make our strategy happen. ***(LEMT Website, 2013)***

From the above an inference can be drawn about NHS identity targeted precipitating events. That is presumably the time lag, created between when (1) the event occurs, (2) the implications of the policy change are implemented and (3) the corresponding changes to NHS beliefs, values and behaviours are seen in organisational members, represents a major temporal separation. As such, the point of impact and implications of policy change can seem far removed and distant from the individual's context as an NHS employee. Therefore, it appears the interruptive effect of a government level policy change is essentially dissipated as conveyed by some respondents,

I've heard lots and lots of consultants in a meeting describe this [pursuit of Foundation Trust status] as being some wet dream of the management. If that's the case, if people think that, you've got a real problem, haven't you? ***(Doctor 8, Phase 1)***

No I don't get to hear a great deal about that side of things [pursuit of Foundation Trust status] and I think that's true for a lot of people that work here. It's not necessarily just for LEMT – I assume probably other Trusts are like that, but again it's all about communication. Staff will think far more of the managerial side of things if they're kept informed about what's happening and feel involved and that definitely doesn't

happen enough. Like we've not had a proper permanent Chief Executive for a while. ***(Nurse 6, Phase 2)***

Both the NHS and professional identities have policy change in common. Nonetheless policy change directed at professional identity much like the other professional identity- precipitating events described by AHP 9 above seem to have to have a closer impact proximity to the individual. Particularly as these events have a more direct impact on how the individual will consequently work and what that work would now entail. For instance a consultant doctor who sat on the R&D Committee conveyed his thoughts on the policies regarding how services were commissioned,

> *We've been forced to develop because within each of these sorts of service delivery situations you now have a position where you have to come up with business cases. It's absolutely obligational if you're developing a new service. To give an example, if you're wanting to have a specialist service commissioned then what you're forced to do then is actually provide a business case that is commercially viable. So actually having a service that might improve patient care on its own is insufficient. Although it is a major part of the business case, on its own it's insufficient. So it's absolutely forced.* ***(Doctor 7, Phase 2)***

Doctor 7 describes a policy change with a far more localised proximity to the professional identity than has been observed for the NHS identity depicted above. Doctors are generally involved in developing and providing services. Therefore when Doctor 7 uses the words *forced* and *obligation,* he is also expressing the view that new behaviours, like building business cases and proving commercial viability, have been adopted as a direct result of operational directives rather than in the normal course of his profession. Thus, unlike policy changes targeted at the NHS identity, those targeted at the professional identity appear to have a more significant interruptive effect, as they are determinants how everyday work will be conducted in the future.

Collectively, the above data also offers a final and particularly useful insight into the salience of precipitating events and their disruptive effect beyond frequency and proximity. Precipitating events in relation to social identity show how individuals in the organisational context may use precipitating events in a favourable but also unfavourable manner. Organisational members appropriate precipitating events as contextually and socially relevant resources to create, negotiate and evaluate changing circumstances, future selves and courses of action, based on their position or circumstances in the organisation. AHP 9 for instance, drew on the socially significant relationships she had with AHP 1 as a role model and social interactions that aided her in learning new research skills in her new multidisciplinary team. Similarly, Doctor 2, recognises the local relevance of his peers not wanting to run the Cytopathology Service creates a management opportunity that could facilitate him becoming a more autonomous professional.

Conversely, some respondents drew on precipitating events in an unfavourable manner. For example, some NHS policy changes may not be of interest to some professional groups. Doctor 8's quote highlights the well established, on going clinician versus manager conundrum. In doing so, he indicates that while impending policies may prompt new circumstances for managers, it did not for the doctors he spoke of. Thus, it appears organisational members inclination to incorporate, modify or reject the new circumstances created by precipitating events may have a role in influencing how they experience any resulting demands these disruptions may generate for their multiple social identities and their subsequent actions.

Most importantly however, is that the disruptions created by precipitating events prompted LEMT case informants to consciously consider the beliefs, values and behaviours encompassed by their NHS identity and professional identity. The conscious consideration of the self as a precursor to behavioural change was not without personal consequence. Included in these accounts of precipitating events were also details about how respondents felt, what they questioned about the event it self and how it related to their self-concept. In Section 8.3 below I will give details on the specific effects precipitating events have on a social identity.

8.3 Impact of Precipitating Events on Multiple Social Identities: Identity Tension & Associated Consequences of Inauthenticity, Credibility & Self-Efficacy

All respondent's current or retrospective orations of past, impending or on-going precipitating events or series of events, conveyed their disruptive impact on both their NHS and professional identities. First, I explore the manifestation of these disruptions as a form of identity tension where organisational members experience bi-directional pressure from two main identity demands: the dichotomy between an existing social identity and some altered or new future self. Second, I explicate how the nature and complexity of identity tension for each of the multiple social identities that respondents proffered as central and salient in this context can and do differ. NHS identity tension is characterised by inauthenticity (Section 8.3.1) whereas professional identity tension is characterised by inauthenticity, reduced credibility and reduced self-efficacy (Section 8.3.2). These findings are summarised in Table 31 below.

<table>
<tr><th></th><th>Multiple Social Identities</th><th>First Order Codes
Statements about:</th><th>Second Order Codes</th><th>Depictions of Identity Tension
Statements about:</th><th>Second Order Codes</th><th>Findings Derived From</th></tr>
<tr><td rowspan="8">Precipitating Events Interrupt Multiple Social Identities</td><td rowspan="2">NHS Identity</td><td rowspan="8">‘Bi-directional pressure’: being pulled in two directions
• Pull of prototypical social identity
• Pull towards a re-constructed version of the self</td><td rowspan="8">Identity Tension</td><td>‘Incompatibility’ e.g.
• Business mentality versus NHS founding principles
• Private versus public sector
• Profit generation versus taxation funding</td><td rowspan="2">Inauthenticity</td><td rowspan="8">Across the LEMT Case</td></tr>
<tr><td>‘NHS Identity cost’ e.g.
• Threat of losing NHS founding principles</td></tr>
<tr><td rowspan="6">Professional Identity</td><td>‘Incompatibility’ e.g.
• Changing professional expectations
• Less time for practice</td><td rowspan="2">Inauthenticity</td></tr>
<tr><td>‘Professional Identity cost’ e.g.
• No longer on the frontlines
• Forced to change work content</td></tr>
<tr><td>‘Others perception’ e.g.
• Is ‘X’ competent?
• Working with other professions</td><td rowspan="2">Credibility</td></tr>
<tr><td>‘In-group relationship’
• People challenge my new work content</td></tr>
<tr><td>‘Adopting new work content’ e.g.
• Am I capable?
• Do I have the right skill sets?
• What I do know versus what I do not know
• Learning</td><td>Self-efficacy</td></tr>
</table>

Table 31: Data Analysis Table Showing the Impact of Precipitating Events that Interrupt the Normal Progression of Social Identity

8.3.1 NHS Identity Tension: Inauthenticity

The bi-directional pressure of NHS identity tension manifested when precipitating events required respondents to move away from the founding principles of the NHS. As detailed in Chapter 7 the NHS identity is predicated on the three NHS founding principles that respondents had been familiar with even prior to their employment with the organisation. However, when case informants considered governmental policy changes such as the commercial mandate of the Equity and Excellence (2010) white paper, they were pulled towards a more commercial and entrepreneurial ethos. One consultant doctor described the bi-directional pull he experienced in the excerpt below,

> *I think the public's perception of entrepreneurship is that you come up with an idea, you exploit the idea to make it into a product and then you generate a company or a business after that. Now, in health, entrepreneurship is slightly more difficult to define, because the National Health Service has always had this view that people shouldn't view healthcare in the context of value or money and therefore, you don't put a price on anything and you can't make money out of it. I do think there's an issue in the NHS of discouraging that kind of culture. Whilst I would never want to see the NHS converted into a business per se, I think having some of the business mentality in the NHS and the business discipline in the NHS that comes from the culture that develops entrepreneurs, then would be very valuable.* ***(Doctor 11, Phase 1)***

Doctor 11’s quote exemplifies the dichotomous nature of identity tension introduced above. He first indicates his in-group status as a NHS employee based on the organisation’s non-profit founding principles. He concurrently describes the second directional pull represented by a possible re-constructed NHS identity that encompasses new beliefs, values and behaviours about profit generation and commercial agendas, he believes to be associated with entrepreneurial policy change.

Additionally, Doctor 11 indicates this re-constructed identity based on entrepreneurial or commercially driven beliefs and values has been historically discouraged in the organisation and is largely viewed by some as incongruent to the NHS principles. However, some respondents, like Doctor 11, stated while there maybe some value in adopting a '*business mentality*,' they ultimately questioned whether a privatised or profit driven NHS would allow them to act in accordance with the governing beliefs of their true NHS self. This suggests study participants perceived the new possible versions of their NHS selves to be inauthentic.

One Divisional Head who is also a consultant doctor conveyed a further instance that illustrates identity tension as well as introduces another aspect of inauthenticity,

> *There is a distrust of private enterprise and with good reason sometimes... I wouldn't trust them either! The NHS is quite precious about people working for the NHS and you can see that there's a huge tribal love for it, if you work for the NHS. It's a great edifice. People who start chipping away bits of that edifice are looked on with huge suspicion. "You're dismantling the whole health system of the country," is the argument. It gets very political.* ***(Doctor 5, Phase 1)***

Doctor 5 uses two institutional representations, a publicly funded NHS versus commercially driven private enterprises, as proxies to represent the bi-directional tension of her existing NHS identity and her possible future NHS self. She expresses strong personal views about what she perceives as the incompatibility of the philosophies that govern the public and private sector. She uses emotive language approaching hyperbole such as '*tribal love'* and *'precious'* to describe the NHS indicating her affinity to the NHS in-group. Simultaneously she also expresses '*suspicion'* and '*distrust'* of the private sector, which would be an example of what the NHS and she, by proxy, would become if NHS Trusts like LEMT complied with policy reform.

However in conveying the dichotomy and incompatibility of these two points of view, Doctor 5 describes what is tantamount to an attack on the values on which her NHS identity is predicated, stating the NHS identity is at risk of being '*chipped away*,' '*dismantled'* and eventually lost. This suggests some case participants may believe it necessary to betray a particular social identity for the sake of some other version of their self, specifically the NHS identity for the commercially driven NHS identity. AHP 1 taps into this view suggesting her fellow NHS employees may also perceive a new commercially driven or entrepreneurial NHS identity as inauthentic as it required the loss of or detraction from the existing internally held NHS principles and ultimately who they was as NHS employees,

> *I think people that have been in the NHS for a while, are very uncomfortable talking about money or making profits. It's not a language that we use commonly. I guess a lot of it is that you enjoy working with patients. As soon as you step out of that environment, you lose sight of what the issues are [NHS principles, patient centred care], in a way.* ***(AHP 1, Head of Service, Phase 1)***

AHP1 like Doctor 5 suggests, there is a 'NHS identity cost' linked to moving away from the traditional NHS identity prototype. NHS employees may consider themselves to be potentially at risk of forgetting or abandoning the patient-centred and non-commercial rudiments of the NHS founding principles. Understandably, one would expect that this loss of NHS beliefs and values would decrease incongruence and thus perceptions of inauthenticity. Rather, perceptions of inauthenticity only increased as the new commercially and entrepreneurially driven version of themselves was met with more suspicion and distrust, as it required the destruction of who they were ultimately.

8.3.2 Professional Identity Tension: Inauthenticity, Credibility and Self-Efficacy

As established in Section 7.3.3.2 professional identity is predicated on the more tangible practicalities of work content (Table 28) and the time consuming nature of that work, Section 7.4.3. As such, professional identity tension materialised as respondents were faced with altering their professional work content and adopting the largely foreign work content and responsibilities dictated by precipitating events. For example, one doctor who had taken on several management and academic roles that have led to his current senior post conveyed,

> *I've been involved in senior management roles, which have taken me away from the front line of practice…but the clinical leads for the clinical business units [CBUs] are first and foremost, still doctors and that's what they still want to do. So they don't, even if they were given the opportunity, they wouldn't want to spend, all of their time managing. And yet, they're in positions of incredible responsibly in terms of the amount of money and staff, so that is an intrinsic and unanswered tension I think in the system.* ***(Doctor 6, Non Executive Director, Phase 2)***

Doctor 6 expresses the same bi-directional pressure is also experienced in professional identity tension. He defines the struggle between the central and salient nature of a traditional professional identity with managerial demands that he and his colleagues experience. Doctor 6 like AHP 1 above indicates there is also a 'professional identity cost' associated with this change. Specifically, he is no longer on the frontlines to directly provide treatment to patients, which is key to a doctor's professional identity. This suggests a level of inauthenticity exists not only in marked differences in work content for a manager or doctor but also the loss of a major component of his prototypical identity. Hence, he suggests that despite changes in work content to include management responsibilities his colleagues would ultimately resist these changes as they consider themselves to be doctors first and foremost.

It should be noted however, that the interviews conducted in Phase 1 and 2 were targeted, at individuals and then units where the staff had been identified as entrepreneurial. As such, the range of participants found were not necessarily typical representations of a professional prototype. Therefore, while Doctor 6 speaks on behalf of his colleagues regarding evolving work content, it can be seen Doctor 6 no longer views himself as an interchangeable doctor prototype. This suggests he has successfully embraced management work and altered his professional identity so that he no longer views himself as a typical representation of a doctor.

Yet, within these atypical units respondents were able to recall the difficulties they experienced in the midst of professional identity tension when the started to adopt new work content. Unlike Doctor 6 and more like the colleagues he speaks on behalf of, case informants revealed they perceived their new work content to be inauthentic in relation to their professional identity. Nurse respondents for instance recounted several policy changes undergone by their profession. One nurse related her experience of these changes as she is pulled from what she perceives as a traditional nurse identity to her present state,

> *I was trained as a hands-on nurse. I was trained as a state enrolled nurse. I started off as a ward clerk, so my progress through is very different from people who have come in at a degree level. I was always happy to be a hands-on nurse. I didn't want to do any more; that was my passion. Then we were forced into the next step – if you wanted to stay [in the profession]... You were knackered, but for the right reasons, not because you sat at the end of a telephone in an office with no windows and feeling that that's not the job of a nurse. I don't feel personally that it's my progression to sit on the end of phones. It doesn't feel right.* ***(Nurse 4, Phase 2)***

Nurse 4 maybe viewed as an extreme exemplar of someone experiencing the pull of professional identity, as she wants to maintain the traditional vocational origins of nursing described in Section 7.3.3.2. Consequently, she perceives the mandated career progression towards a re-constructed nurse identity with new work content

as *'forced'* and a violation of her traditional nursing professional identity. Nurse 4, similar to AHP1 and Doctor 5 in Section 8.3.1 above, expresses the incongruence between what she believes it means to be a nurse and the now expected external expression of nursing she perceives as inauthentic, saying her new work content *'doesn't feel right'* and *'not the job of a nurse.'*

Accounts of NHS and professional identity tension imply difficulties like inauthenticity are primarily an internal issue based on the individual's perceptions of their group membership. However, the heterogeneity of the five professional groups (doctors, nurses, AHPs, healthcare scientists and managers) delineated in Section 7.3.3.2 and Table 28, appear to add a layer of complexity to professional identity tension that does not emerge in NHS identity tension. The NHS identity is largely homogenous because as NHS employees they do not routinely come into contact with the private sector out-group. Conversely, highly specialised and diverse professions are expected to co-exist of in a single organisation like LEMT. Therefore, as people encounter members of many different professional groups as their work content evolves, they must consider how altering their professional identity may influence others' perceptions of their competence. This introduces the credibility issue previously mentioned, which I will discuss next.

The importance of others perceptions in the identity construction process can be seen as Doctor 6 continued his interview. In his account he proffers his perspective on a continual debate rampant in the NHS surrounding the credibility of clinicians taking on management roles. In his pre-amble he refers to whether there should be a traditional separation in duty, where managers manage and clinicians treat patients. While respondents like Doctor 6 generally intimate this appears to be the simplest solution, it is lacks the utility to solve what is a nuanced and complex problem. Hence, as reflected in Chapter 5 the post NPM era calls for clinicians at the heart of the management and leadership process. One Executive Director who had a private sector career and no clinical background expressed this viewpoint stating,

> *Changes will only be delivered, I would say, if they are clinically driven and clinically supported. More than clinically supported, they're actually*

based on fundamental clinical principles. If they're not, they will certainly flounder on the political maelstrom into which they will sail. Then you are at risk of loosing the clinicians altogether ***(Manager 1, Phase 1)***

However, as Doctor 6 highlights an underlying conflict regarding clinicians in managerial roles that links to credibility,

The problem is how do you make sure that the clinicians are competent managers? Traditionally, medics don't get taught management. I mean in my day there was absolutely zero training in it, either as an undergraduate or postgraduate. Nowadays there is more and those who have that sort of inclination can go on some quite high level courses and so on, but at the end of the day, you know, they are sort of amateurs aren't they in a sense? When compared with people who have done the management courses right the way through, or have been trained to be management right from the very beginning. ***(Doctor 6, Non Executive Director, Phase 2)***

Where management decisions require or gain credibility via the involvement of clinicians, clinicians as managers do not necessarily gain the same credibility from their peers. A PRS nurse gives further insight into this issue as she recalls transitioning into a management role within a team she had been a member of for about 10years,

It has been very difficult for some and very easy with others. A majority of the team, it was ok, it was fine and they were happy to have a manager that they knew instead of an outsider [non-nurse] coming in. But it does change, you try not to let it change, but the fact is that you are actually managing that person whereas before you were an equal. It is difficult to actually get that balance right especially within a small team…

> *But it has been difficult for me too, changing roles and actually becoming, instead of a colleague, the boss. But at the same time you want to be a colleague so you try to take a little step back, but try to keep in touch with what's going on. Joint decisions, is a lot of what we do, whereas people would say 'we're doing this and that's it' sort of thing. But as you get higher people say 'this is the way it's going to be done' you know; they're not interested in what your feelings or views are. I try to be more democratic where we decide between the team 'let's try this.'* ***(Nurse 2, Phase 2)***

Comparable to Doctor 6 above Nurse 2 indicates a re-construction of her nurse identity to some hybridised version of her professional self. This change in work content raises two central issues. First, when she states that she was once an '*equal'* or interchangeable nurse prototype she maintained her credibility with some team members as someone who knew what it meant to be a nurse. Yet, as an equal the individuals she now manages have the same esoteric nurse knowledge afforded to the professional group. As such, these individuals know the limits of her skill-set, which do not include management skills traditionally. Therefore, when Nurse 2 presents herself as a manager, this can be viewed as lacking credibility in the eyes of her peers. Thus, she is more likely to experience negative consequences for her relationships with professional group members.

Second, Nurse 2 also conveys a high degree of difficulty as she attempts to straddle the chasm of being a nurse-manager hybrid. She states that she finds herself trying to *'take a little step back'* but also *'trying to keep in touch with what's going on'* and keeping team members at the centre of the decision making process like Manager 1. This suggests she is learning and developing new competencies to best meet the expectations of her management role. As professional identity is largely delineated by a profession's specific work content, data analysis revealed some respondents questioned whether they could perform the work content required in the new circumstances created by precipitating events, which links to perceptions of *self-efficacy*.

In the LEMT context respondents often referred to whether the current state of their professional identity allowed them to successfully transition into their new work circumstances after a precipitating event. For instance, one consultant based in the Accident & Emergency (A&E) CBU, described the professional identity tension he experienced due his clinical and managerial responsibilities. He questioned his own efficacy in his new role by highlighting the personal difficulties he experienced in adapting to the vast responsibility of overseeing an essential service in LEMT with approximately 400 staff members,

> *Which fool would let a £28 million CBU be run by a guy who's got no management experience? Hello, it's me! [with no management experience] .*
>
> *My emergency CBU is tiny [in comparison to other CBUs in LEMT] but has got a budget as big as some or whole divisions in other hospitals. I have to ask why the hell are we allowing a tiny, much smaller numbered staff, who are nowhere near as experienced, to run the same amount of money in a CBU here?* ***(Doctor 8, Phase 1)***
>
> *Do you think there's a sort of assumption that because you guys are pretty clever, you're consultants after all, that you can figure out how to manage?* ***(Interviewer)***
>
> *There's obviously some of that but it's a very careful balance you have to strike in doing that.* ***(Doctor 8, Phase 1)***

Doctor 8's account is in keeping with one aspect of self-efficacy covered in Chapter 3, self-efficacy is domain specific. Therefore, while Doctor 8 has reached the level of consultant in his professional domain as a doctor, indicating attainment of high-level esoteric skills and knowledge, it is not unexpected that he finds himself unsure in his management role. However, in practical terms it can be seen that his competency is expected to be transferrable. As such, his account takes on a jocular inflection as he expresses some disbelief at how unprepared he feels even after 15 months since starting the role when I conducted this interview.

Similarly, AHP 1 in her role as Head of Service related a chronological account of evolving policy changes that have had profound effects on how healthcare professionals (HCPs) provided respiratory services throughout the UK. In response to some of these changes AHP 1's team have carried out various clinical trials and implemented many of their findings to improve service provision in accordance with new policies. Some of the team's findings have taken the form of products, which have been subsequently sold to various clients including one of the Clinical Commissioning Groups (CCGs) for the East Midlands. However AHP 1 recounts that while she has clinical, academic, management and research skills that enabled her and the PRS team to develop the content for these products, certain aspects of product development sat far outside her abilities,

> *We developed several things. There is a self-metric for patients with COPD that we've sold...we just sort of plucked a number out of the air and thought, 'Right, they've written the cheque out.' We had no idea on how to cost it, so I just stick a finger in the wind and if people go, 'Oh my God,' or if they say, 'I think you should have charged more,' I say, 'Perhaps we can negotiate,' There's no framework for these income streams.*
>
> *That's been going on for about four years in total. We've had to sort out all the web hosting agreements, because there are no department guideline around that, for the Trust [LEMT]. The Trust, took 12 months, just to get an IT policy sorted. We found a legal champion, who is great, but it's not his remit. He's lovely but it's not his job. So we've sorted that out with an external legal company.* ***(AHP1, Phase 2)***

AHP 1's account is of particular interest as the precipitating events that have occurred have directly led to a specific sequence of behaviours that can be viewed as entrepreneurial. AHP 1 and her team developed a novel income generating solution in response to policy changes, which is far removed from the modus operandi of AHP 1's counterparts throughout LEMT. It can be seen AHP 1 and her team have integrated behaviours not typically described by respondents. She and her team operate in the manner described by classical entrepreneurship

theorists where they are not only innovative and fill gaps in the market but also harness the legal and information technology skills of others while managing market and pricing uncertainties. However, despite leading these activities AHP 1 views herself as a novice. Like Doctor 8 above, AHP 1 uses an amused and self-effacing tone when asked if she viewed herself as entrepreneurial,

> *I don't see myself as entrepreneurial. I'd probably say I'm quite innovative, but not entrepreneurial.... maybe stupid, I think, is probably…[laughs]*
>
> *I don't think there's much that would prevent us as a team from being innovative. I think as a team, we're quite good at that.*
>
> *I think what stops us from being entrepreneurial is that we're healthcare professionals and a bit soft about money, is the honest answer.*
>
> *I personally don't have a problem with it, on an individual level. If I could be brave enough, I probably would have left the health service years ago. In some ways… I think the proper entrepreneurs have left the service years ago, to be honest….* ***(AHP 1, Phase 1)***

Two important points can be taken from the data presented throughout this section. First precipitating events seem to create tension, in respondents' NHS and professional identity. That is a bi-directional tension is created where two sets of demands pull the individual in two directions specifically (1) the pull of their current social identities and (2) some future version of themselves reflective of the new circumstances created by precipitating events. Second, respondent's accounts of identity tension were focused on scrutinising the implications of becoming some future version of themselves. This examination process raised specific issues for each of their multiple social identities. For NHS identity tension, case informants cited perceptions of inauthenticity of their possible future self as their main concern. Whereas their professional identity tension concerns included, perceptions of inauthenticity, lower levels of credibility and lower levels of self-efficacy of their possible future self.

8.4 Discussion: Precipitating Events & Identity Tension Implications for CEI Formation

This section aims to help make sense of the various concepts and their relationships in the data by both summarising and generalising the main findings presented thus far in Figure 11. I will focus on the precipitating event- social identity interaction identified in Sections 8.2 and 8.3 and the resulting tensions experienced in respondent's NHS and professional identities. In doing so, I will explore how identity tension can act as both a facilitator and barrier to CEI formation.

Study participants were embedded in entrepreneurial units within the LEMT case. This suggests that at some point these individuals had formed positive evaluations of CE desirability and CE feasibility so CEI were formed and CE activity ensued. The data I present above begins to explicate the initial stages of how these positive re-evaluations of CE desirability and CE feasibility came about. I have identified that in the LEMT context the entrepreneurial attitudes-precipitating event interaction proposed in the SEE framework (Figure 8.1 above) does not lead to CEI formation. This can be attributed to the pre-existing negative evaluations of CE desirability and CE feasibility brought about by social identity discussed in Chapter 7. Instead, I propose that in the LEMT context, a precipitating event-social identity interaction (Figure 8.2 above) may have greater utility in facilitating CEI formation. Primarily because precipitating events seem to displace the normal progression of respondents NHS and professional identities. This is supported by the data in Section 8.2 where I explicated 4 types of precipitating events with varying frequency and proximity that case informants cited as significant enough to prompt them to consciously deliberate whether they should act in a manner that was foreign to their prototypical social identities.

Generally, precipitating events do not receive much attention in the EI literature. The phenomenon's acknowledgement tends to be limited to its disruptive ability in the SEE framework (Krueger, 1993; Shapero, 1982). As such, representations of precipitating events can appear somewhat simplistic and linear. However, when precipitating events interact with a social identity they are revealed to more

nuanced in their functionality for prompting behavioural change. In part, identity is forged through interaction (Cerulo, 1997). The data shows a social identity's interaction with precipitating events in the organisational context can bear on identity transition to participate in CE. Respondents appear to receive and interpret precipitating events as a resource for contemplating who they are and determining who they should, could or may (not) become. For instance, precipitating events may be used as an occupational utility maximising resource, consider Doctor 2 and AHP 9 in Section 8.2; or may not like Nurse 4 in Section 8.3. As Douglas & Sheppard (1999) write in their economic perspective on EI formation, that what determines a beneficial decision to purse a course of action may not always appear rational to the outside observer. Rather, it is individual specific and in this case appears to be grounded in the individual's self-concept. This enhances Greenberger & Sexton (1988) view, in Hornsby et al.'s CE model, that the salience of precipitating events is critical to changing and individual from a non-initiator to venture initiator.

As per the data, a precipitating event-social identity interaction is not without effect. This interaction appears to disrupt the normal progression of respondents NHS and professional identities so they experienced identity tension (Beech et al., 2012; Beech 2010; Michlewski, 2008). Identity tension was characterised by respondents as a bi-directional pressure where they were pulled toward some new set of values, beliefs or behaviours stipulated by precipitating events that differed from their prototypical social identities. Specifically, NHS identity tension manifested when precipitating events required respondents to move away from the founding principles of the NHS. Professional identity tension materialised as respondents were faced with altering their professional work content and adopting the largely foreign work content and responsibilities dictated by precipitating events.

Furthermore, it appears organisational members can experience numerous sources of tension stemming from their multiple social identities. This suggests identity tension can be multi-layered, which may amplify its destabilisation effect in existing multiple social identities. In considering these multiple social identities it can be seen the nature and complexity of identity tension can vary from one social

identity to the next. Consider respondent's NHS identity tension characterised by inauthenticity where they perceived their existing social identity as incongruent with their possible identity. Professional identity tension however, proved more complex as multiple professions exist in the LEMT context. Thus, in addition to inauthenticity, two additional issues emerged, (1) the credibility of the new identity in the eyes of others and (2) respondents perceived self- efficacy to fully behave in accordance with the new identity.

Identity tension is indicative of a destabilised social identity where respondents were compelled to consider both sides of the identity tension coin. This destabilised state is evidenced by the issues of inauthenticity, reduced credibility and reduced self-efficacy described by case informants. Identity tension places respondents in an ambiguous state where they are unsure of themselves and who they should be in their new circumstances. This reaction is in keeping with portrayals of identity tension in the literature, which characterises it as contradictory or incompatible (Gotsi, Andriopoulos, Lewis & Ingram, 2010) and ambiguous or paradoxical (Kreiner et al., 2006; Knights & Willmott, 1999) promtping emotional and cognitive arousal (Kreiner, et al., 2006; Alvesson & Willmott, 2002). This state of identity tension can hinder CEI formation and CE activity. Primarily because the identity questions of 'who I am?' and 'what I do?' are misaligned. This destabilised state is wrought with identity questions such 'who am I/who should I be,' 'what I do/what should I do' as respondents seek a consistent self-concept. It follows, that if individuals are unsure of who they are in a given context, they are also unsure about how they should act, which increases the likelihood of delayed action.

Yet, it is only in this destabilised state that respondents were compelled to contemplate the foundations upon which their membership to a particular social group is predicated. In doing so, they first assess the compatibility of their current social group's beliefs, values and behaviours with the new circumstances suggested by precipitating events. Second, they consider whether they would want to assimilate new beliefs, values and behaviours. Third, if so, they can use and/or reject these new beliefs values and behaviours based on appropriateness in the organisational context. Thus, constructing a new or re-constructing their

existing social identity inclusive of new behaviours like CE, in a manner that allows them to remain credible, legitimate and efficacious to themselves as well as the in-group and corresponding out-groups. As such, the destabilising effect of identity tension may also facilitate CEI formation as it creates an opportunity for some alternative version of the self, which views CE activity as desirable and feasible to be consciously considered.

Taken together, this suggests that with respect to CEI formation, the influence of identity tension can be twofold. Identity tension paradoxically functions as both a facilitator of and barrier to CEI formation in the organisational context. More interestingly, is the implication that in its role as a CEI formation facilitator, identity tension may be conceptualised as a positive state where opportunities for CE related behavioural change might be realised. Hence, in the context of established organisations, a better understanding of positive identity tension and how it can be created may be a beneficial perspective on individual organisational members choice to participate in CE as well as the bottom processes by which CE may be propagated.

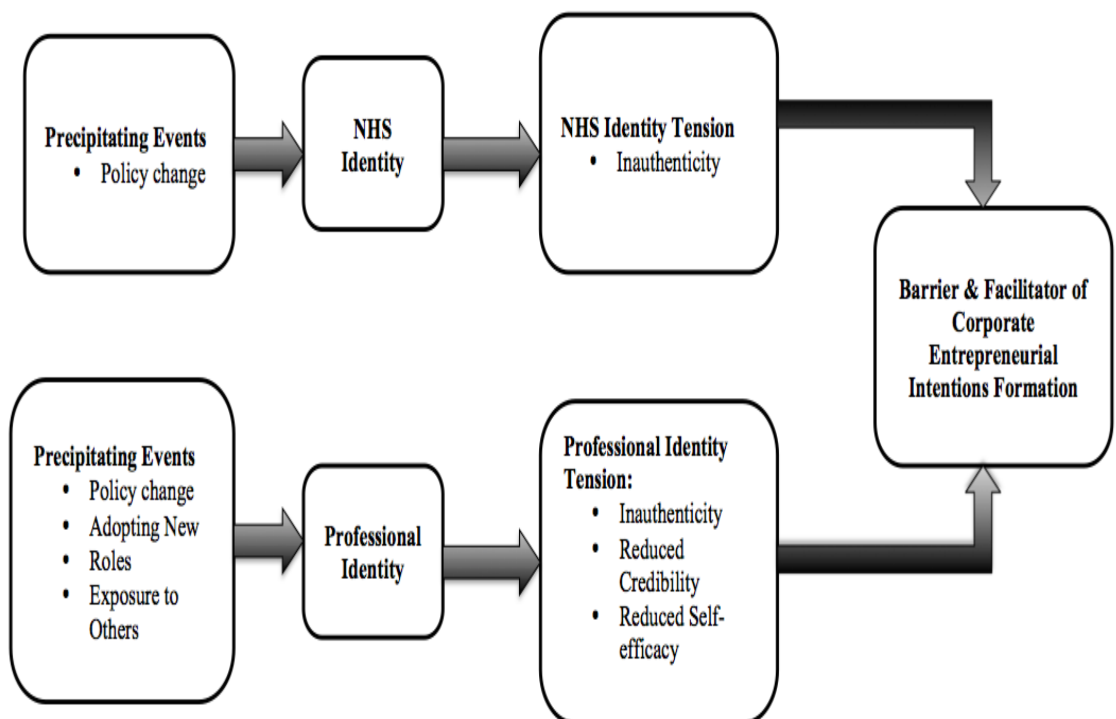


Figure 11: Summary of Proposed Precipitating Events-Social Identity Interaction in LEMT Context

8.5 Conclusion

Chapter 8 serves to not only extend EI formation theory by understanding how it operates in CE but also strengthen the link between the individual and CE research. As re-iterated throughout this study the individual-level of analysis in the extant CE literature is rarely addressed or explicated. As such, my research contributes to understanding how individuals decide to undertake entrepreneurial activity within the organisational confines by using the EI formation model SEE. However the data revealed applying the SEE framework in the LEMT context is not with several challenges. This suggests corporate entrepreneurial intentions (CEI) formation requires further attention. As such, I submit the following propositions:

- A precipitating event-social identity interaction may increase the likelihood of corporate entrepreneurial intention formation in the organisational context;
  Precipitating event are contextually and socially relevant resources that can be brought to bear on identity transition;
- The identity tension created by a precipitating event-social identity interaction can act as both a facilitator of and barrier to CEI formation; and
- Identity tension can be a positive state that facilitates CEI formation.

CHAPTER 9: IDENTITY WORK AS A FACILITATOR AND BARRIER OF CORPORATE ENTREPRENEURIAL INTENTION FORMATION

9.1 Introduction

This third and final empirical chapter will be devoted to extensively discussing the specific strategies employed by respondents to regain a consistent self-concept. To achieve this I will draw on the identity work process. This study is based on entrepreneurial units in LEMT. This suggests that at some point CEI were formed due to a possible shift or change in respondents NHS or professional identities. Furthermore, the emergence of identity tension is indicative of a social identity's ability to shift and be constructed and reconstructed. It follows that to best understand the role of social identity in CEI formation; its ability to be formed and reformed via identity work merits closer analysis. I have disentangled two specific strands of identity work from the data for each of the multiple social identities. Re-affirmation identity work was used to resolve NHS and professional identity tension, Section 9.2 and 9.3 respectively. Whereas sensemaking identity work was employed in the professional identity only, Section 9.4. Last, in Section 9.5 the role of re-affirmation and sensemaking identity work will be discussed as facilitators or barriers to CEI formation in SEE.

9.2 Re-affirmation Identity Work in NHS Identity

All respondents maintained a great affinity for their original NHS identity. This suggests that even as their existing NHS identity was being challenged, some level of reconciliation was occurring to resolve or identity tension in favour of their existing NHS identity. I present *re-affirmation* identity work (Table 32) as a form of resistance to combat NHS identity tension.

Multiple Social Identities	First Order Codes Statements about:	Second Order Codes Identity Work	Identity Work Effect on Multiple Social Identities	Findings Derived From
NHS Identity	Maintaining specific aspects of identity e.g. • Beliefs and values encompassed by the NHS founding principles • Highlighting the incongruence of entrepreneurship Actively rejecting incongruous messages e.g. • DH white papers setting out the 'new NHS' • Suspicion of political agendas Maintaining a sense of altruism e.g. • Higher calling and purpose • We are 'safe' because of what we stand for	Re-affirmation *(Self-enhancement focus)*	**No Change in NHS Identity**	**Across LEMT Case**
Professional Identity	Strengthening, re-iterating preferred identity e.g. • I am a healthcare professional • I have always wanted to be a particular profession • I can't see myself doing anything else • Work content that defines a particular profession or 'what I do as a professional' Convincing others to treat one according to a preferred and valued identity e.g. • Working with others professions • Divergent professional philosophies	Re-affirmation *(Categorisation focus)*	**No Change in Professional Identity**	**Unit 3: Pulmonary Rehabilitation Service**

Table 32: Data Analysis Table Showing Re-affirmation Identity Work Processes Employed & Impact on Social Identities

In Chapter 6, I refer to a colleague equating the NHS to a *'national religion.'* Universal healthcare represents a core national value, evoking pride and patriotism in the UK people. This was reflected in the NHS tribute during the opening ceremony of the 2012 Olympics in London. The significance of the NHS is only multiplied exponentially in NHS employees who constitute the fifth largest workforce in the world (BBC News, 2012). Hence, case informants resisted their new possible selves by maintaining specific aspects of their NHS identity, specifically, the NHS founding principles and non-profit ideology. For instance, a senior AHP in the PRS team related a very personal perspective,

> *I've never felt very comfortable about charging people for treatment I have done the odd bit of private work myself in the past. I used to do acupuncture and bought some equipment years ago with the idea that I might do some private work. But I never really felt very comfortable when it actually got to the point of saying, 'right that's £25 quid' or whatever, I just didn't really like it, I mean it's just not really for me.*
>
> *Most of our [PRS] patients come from a fairly low socioeconomic group, you know a lot of them are sort of ex-miners and you know they are not people who are paying. It's not a glamorous area of medicine; you wouldn't go into respiratory if you wanted to make private money. It sounds a bit cheesy really but it's kind of wanting to help people and make them better.*
>
> *So for me that's never sat that easily with me charging people, I guess it's partly political as well, I don't particularly believe in private medicine. I've always been somebody who's been a supporter of the NHS. You know I've had a lot of treatment myself. I've had X-illness 3 years ago and I've had extensive treatment, I was out of work for nearly a year, so I've been personally treated, you know.*
>
> *If I was American, I would have been bankrupted by what I had and I feel hugely lucky to have the NHS and I guess that's why I still work in it after all these years. I mean it drives me crazy all the politics and the changes*

and things but I think still, there's enough of the ethos of why a lot of people go into it that makes it still a good place to work really. I hope that isn't changed by making it too much of a business and competition... ***(AHP 8, Phase 2)***

AHP 8 provides a perspective that supports my earlier statements in Section 7.3.3.1 where I characterised NHS identity as having a 'softer,' emotive and intangible quality due to its philosophical focus. Especially when compared to the more tangible nature of work content in professional identity. From an identity work perspective, it can be seen AHP 8's description is constructed to convey an emotively driven preference for her NHS self which goes beyond merely being in the organisation's employ. She simultaneously taps into loftier ideals of patriotism and the core values of universal healthcare as both an employee and a service user. AHP 8 draws comparisons to the United States of America (USA) where private health insurance is the norm and how that would have been financially detrimental had she been treated there. Furthermore, she explains her time in the NHS was about helping people and not *'glamour'* or making *'private money.'* This is consistent with her choice not to do private practice and her discomfort with charging for services. Ultimately, she appears to take a *self-enhancement focus*, one of the processes described in the social identity approach (SIA) in Section 4.3. Self-enhancement motivates and binds an individual to a social group through the generation of positive group expectations, stereotypes and behaviours. Consequently, she accentuates the difference between the NHS in-group and two out-groups, the private sector and USA, by promoting a positive depiction of the NHS even as it is threatened by waves of politically driven change.

In considering these political agendas, AHP 8's commentary links to a second aspect of re-affirmation where respondents actively reject messages they believe to be incongruous with the NHS identity they are trying to maintain. This was reflected in an interview with one doctor who referred to an opinion article that he had written and had been published in *The Guardian* newspaper on the day I conducted his interview. Showing me the article he went on to explain,

I mean there are some private views obviously about the health service reforms. Such as the legal changes, were totally necessary to achieve the government aims. But that isn't a patient orientated health service with clinicians in charge and aiming at the targets rather than outcomes. There's an existing domain structure and they did not need to change the law to do that. They changed the law to 'marketise' the health service. No! They were not up front about that before they were elected and yet they've done that and to my mind turned the health service upside down. Because we no longer know, since most of what we do is with chronic disease, we're no longer sure that the integrated pathways that we had spent so long trying to develop will still be retained after April when commissioners, groups of GP's, are free to purchase bits here, bits there. The private sector will no doubt come and clean up on the bits that they can do and care will be fragmented. ***(Doctor 4, Phase 2)***

Doctor 4 admits he has suspicions about whether the Coalition government was truly committed to maintaining the universal accessibility of a fully integrated patient-centred NHS. He questions whether the legal reforms stipulated by the Health and Social Care Act passed in 2012 were necessary, proffering his opinion that the current government had been less than forthcoming about their intentions. He also, like AHP 8 above, chooses to render the private sector in a negative light, where they could *'clean up'* by choosing to provide the more lucrative services only. Combined, his suspicions and again negative view of the private sector aid him in actively rebuffing claims that directly contradict a long established and deeply held set of beliefs and values that define who he is as an NHS employee. He went on to comment directly on whether there was any truth in the governmental claims that these policies were meant to create the *'largest social enterprise sector in the world'* (DH, 2010),

Well I think it's [entrepreneurship] encouraged in the 'new NHS' but I think that what's encouraged in the 'new NHS' is financial entrepreneurship. That has never been my driving force. My driving force has been to improve health care for people with respiratory disease and that includes improving the service in whatever way I can. In terms of

setting up a business to make money out of the health service I would profoundly oppose that route because I still believe that the NHS should be a publically provided service. ***(Doctor 4, Phase 2)***

Doctor 4, like other respondents (for example Doctor 5 in Section 8.3.2), seems to use the NHS organisation interchangeably as a representation of his own NHS identity. Thus, when he refers to the profit driven 'new NHS' he establishes a possible future self. Doctor 4 chooses to distance himself and thus his NHS identity from this new financially driven version of the NHS. Essentially he re-affirms his choice for the traditional publically provided service while he vehemently rejects what he perceives as messages motivated by financial entrepreneurship.

From the above it can be seen that maintaining specific aspects of the NHS identity appears to work in tandem with actively rejecting incongruous messages. However, it seemed case informants completed both these aspects during re-affirmation so they could complete the third aspect of this type of identity work- maintaining the sense of altruism that accompanies being a NHS employee. Arguably, it can be said people undertake healthcare related professions because they are driven by a need to help others like AHP 8 or Doctor 4. Or alternatively, in the UK, they are driven by the monopoly and employer monopsony of the NHS addressed in Section 7.3.3.1. However, most respondents indicated their sense of altruism stemmed from the nobility of seeking employment in the NHS which was tantamount to answering the higher ideological calling set out by the NHS founding principles. For example, Doctor 3 below conveys the NHS as social group embodied specific aspects of who she wanted to be and who she finally is as she finishes her residency,

I wanted to be a doctor because of the NHS; because it's very… sort of has a socialist political view I suppose. Yeah the fact that it's free, free for everybody at the moment, it doesn't discriminate. I actually thought I was going to go to a third world country when I was 18. Yeah, that's where I thought I was going to go [laughs]. Then I realised that I didn't have to do

that to be able to, provide something for people. Yeah, I've always been very proud to work for the NHS. ***(Doctor 3, Phase 2)***

It can be seen Doctor 3's NHS identity began forming when she was a member of the general public, long before she officially joined the organisation. Additionally, as her NHS identity symbolises a long-desired version of herself, it can be deduced that such an established facet of her identity would present a high level of resistance to change. She elaborates on how her NHS identity has remained focal and salient over the last 15 years of her career,

It [entrepreneurship] is not something that drives me, but I'm probably a bit naïve. I probably don't think enough about how the NHS is actually going to survive. I don't think there have been any major changes [in myself]. I was only ever patient focused and completely blind to the rest of it and disinterested.

I like working for the NHS. I like providing care, not based on a financial incentive. It would upset me if that changed. I understand that it has to change in some way, but I hope that the philosophy of the NHS doesn't change. If it became private healthcare, completely, I would move somewhere, but where it wasn't [private healthcare]. I feel that strongly I would never do private healthcare. ***(Doctor 3, Phase 2)***

It can be seen Doctor 3 is an extreme exemplar of wanting to maintain this sense of altruism, as it seems to be absolutely critical to who she is. Even though she is aware that some change is on the horizon in terms of the on-going NHS policies, it can be seen she actively resisting this change as she claims *'disinterest,'* being *'a bit naive'* and *'being blind'* about anything that would detract from her being patient focused. Further, she cites the risk of loosing this aspect of her NHS identity evokes a very strong emotional response. She gives an extreme example of resistance stating that were the NHS philosophies ever compromised she would not only be upset but also actually consider working outside the UK.

This sense of altruism however, seemed to be a double-edged sword even though it is traditionally perceived as a noble quality. Some interviewees suggested a level of complacency may emerge as a by-product of altruism and can further amplify the resistance effect of re-affirmation. Some study participants had the impression that despite a rapidly changing healthcare provision landscape characterised by diminishing resources and commercial interests, some of their colleagues resisted change by maintaining the belief these changes would not directly affect them. As one consultant physician stated,

> *We are very lucky in many ways, in the public sector. We're very lucky but if I'm honest with you, I do think part of it is the fact that the people feel 'safe.' I think that's a fallacious view that patients will always come because there's nowhere else around us that are going to want our patients. There are hospitals around and there are potentially private organisations that might want to poach some of our patients. But there is a general feeling that we are OK because there isn't anywhere else in* county *that's going to take our patients. There are three hospitals [in LEMT], we all work together and they're going to come here because where else would they go.* ***(Doctor 7, Phase 1)***

This feeling of safety seemed to partly emanate from the status the NHS holds in the wider society. More so, in the LEMT context it seemed case informants perceived they were afforded another level of protection, in light of the Foundation Trust (FT) mandate in Equity and Excellence (2010). This mandate states that Trusts that are no longer financially viable were at risk of being decommissioned or subsumed by another Trust. However, LEMT is one of the largest Trusts in the UK as well as the only acute service provider for the local health economy in this section of the East Midlands. For respondents this coalesced into the impression that the organisation could not be allowed to fail. This looks to be supported by the precipitating event example I presented in Section 8.2, where more than three years after the introduction of the compulsory FT policy, LEMT has still not achieved this status and has not been subjected to any sanctions.

Overall the data presented above suggests NHS identity re-affirmation is defined by three elements (1) maintaining specific aspects of the NHS identity (2) actively rejecting incongruous messages and (3) maintaining a sense of altruism. Taken together, NHS re-affirmation identity work appears to function as a form of resistance where respondents make a positive re-assertion in favour of the existing NHS identity to resolve or minimise identity tension so they behaviourally and perceptually favour the NHS in-group. As such, I propose that the NHS identity remains fundamentally unchanged. The implication of an unchanged NHS identity will be discussed in the overarching SEE-CEI framework in Section 9.5.

9.3 Re-affirmation Identity Work in the Professional Identity

Professional identity tension appeared to be resolved or minimised, as some respondents seemed to also actively resist impending change similar to NHS identity re-affirmation above in Section 9.2. However, the manner in which resistance was achieved in the professional identity differed from the NHS identity. This stems from a point I previously discussed in Section 8.3.2 regarding the varying nature of NHS identity tension versus professional identity tension where the perceptions of others plays a large role. Professional identity tension manifested as more complex and particularly challenging for respondents for two reasons. First, an individual's standing within their in-group, (seniority, for example), influences how their professional identity is perceived personally and by others. Second, the standing of one professional in-group in relation to other professional out-groups within the larger social structure (society in general and the NHS professional hierarchy) influences how a professional identity is perceived personally and by others.

This hierarchical complexity did not emerge for respondent's NHS identity, as they do not routinely encounter the private sector out-group. Granted some of the study participants I interviewed had had private sector experience (5 respondents), they were engaged with LEMT on a part-time basis as Non-executive directors or small business owners hired on as consultants. Conversely, it is an everyday occurrence for one professional identity to encounter another in

the LEMT context. Consequently, while inauthenticity was an issue associated with professional identity tension, the issue of credibility emerged as far more striking. Hence, where NHS identity re-affirmation appeared to be focused on resistance by positively viewing the in-group; professional identity re-affirmation was a resistance strategy targeted at managing the perceptions an associated out-group has of the in-group (Table 32).

However, before I present the details of professional identity re-affirmation, I will re-iterate one point about sample selection. The interviews conducted in Phase 1 and 2 were targeted, as per the methodology outlined in Chapter 6, at individuals and units perceived as being involved in CE activity within LEMT. Hence, the majority of participants included in the study were not necessarily typical representations of professional prototypes. Yet, within this atypical group by LEMT standards, there were a few study participants who were very much typical professional prototypes and accordingly were more representative of LEMT at large. So while data from more typical respondents was limited, I was still able to elicit the 2 very closely linked facets of professional identity re-affirmation from the data, which I will present in the remainder of this section.

The first aspect of professional identity re-affirmation became clear when I reconsidered Nurse 4's account of her career thus far from an identity work perspective,

> *I was trained as a hands-on nurse. I was trained as a state enrolled nurse. I started off as a ward clerk, so my progress through is very different from people who have come in at a degree level. I was always happy to be a hands-on nurse. I didn't want to do any more; that was my passion. Then we were forced into the next step – if you wanted to stay [in the profession]… You were knackered, but for the right reasons, not because you sat at the end of a telephone in an office with no windows and feeling that that's not the job of a nurse. I don't feel personally that it's my progression to sit on the end of phones. It doesn't feel right.* ***(Nurse 4, Phase 2)***

While describing professional identity tension she concurrently re-iterates and strengthens a preferred and valued professional identity in the face of policy change**.** Nurse 4 places great emphasis on and establishes her preferred nurse identity. She speaks about having once been a *'hands-on'* nurse when she first started her career, referring to her '*passion,'* having been '*happy'* and not wanting *'to do more.'* This notion of being a hands-on nurse had resurfaced for Nurse 4 as she continued to relate yet another policy change six months prior to our interview. This policy change resulted in a major adjustment for her Respiratory Team (RT) that is solely made up of other nurses. A much larger multi-disciplinary team, the PRS, subsumed the RT. As such, the RT nurses were now working in a new team in close proximity to a range of professions, the majority of whom were a variety of AHPs, doctors and other nurses. Nurse 4 went on to give her impressions of RTs new circumstances as she and her colleagues were confronted with a new way of working and thinking directed by PRS,

> *Within our job, we were very much face-to-face contact, seeing patients at home. So seeing the environment they lived in and how that implicated on their disease process, how they would manage their disease and whether within that environment we could change things. Now you see a patient in a pair of pyjamas at the side of a bed and you may be able to discuss, 'do you manage at home?' But it's not giving you the true picture of that individual as they were in their life. You used to walk in the house and be able to see their past, or what was important to them.*
>
> *Now it feels like we've been focusing on the COPD. I understand that we see more patients and we reach more patients, but on a personal level I miss that personal involvement with the patient. If I'm honest it feels like I'm ticking boxes now, but I understand the reasons why. On a personal level it doesn't have the right feel that it had before.*
>
> *There's this big team [PRS], then there's just this little pea size at the end, which is us [RT]. I can't ever see us being within that team because they're so established and we're so… a lot of what they talk about feels over my head and it's all very pulmonary rehab*[ilitation] *based – it's not*

> *nursing based – and it's not what we [nurses] would talk about as a team. So it does feel very much like we're on the edge.* **(Nurse 4, Phase 2)**

Nurse 4's quote exemplifies two points. First, the RT is now working in close quarters with a new out-group: the multi-disciplinary team of professionals in the PRS. Having been branded as entrepreneurial in LEMT, the PRS is perceived as having very different philosophies, behaviours, beliefs and values. Consequently, Nurse 4's need to re-iterate and strengthen her nurse identity becomes more urgent to separate and define herself within the localised PRS context. This seems to have a *categorisation* focus (Section 4.3), which allows individuals to impose order and structure on the social environment by defining themselves and others according to social stereotypes and expected group behaviours. To aid in this process Nurse 4 first conveys the similarities amongst herself and members of the nursing in-group. She accentuates properties of the nursing in-group including, attitudes, beliefs, values, affective reactions, behavioural norms and speech style by highlighting the *'face to face'* and *'personal involvement'* aspects of nursing. Simultaneously, she stresses the differences between the multidisciplinary out-groups and her conventional nursing in-group. In doing this she points out all she perceives to be wrong with her new circumstances, which detract from her nurse identity, stating that she just feels like she is *'ticking boxes'* and her new work *'doesn't have the right feel,'* ultimately characterising PRS work as *'not nursing based.'*

The second point that Nurse 4 makes, which is discussed further in subsequent sections, is that work content is an everyday occurrence. That is even though she wants to adhere to the traditional nurse prototype (Table 28), she and the other RT nurses have to perform their job everyday in a manner that is in keeping with the stipulated policy change and expected by AHP 1 as Head of PRS. Yet, what is also noticeable from the observational and interview data is that while Nurse 4 and her colleagues are performing their new work there was clearly no true buy-in. Instead, efforts to dis-identify from a work-imposed identity in favour of their 'authentic' nurse-self were found.

Hence, the resistance created by re-iterating and strengthening a preferred identity is obvious to AHP 1 and the two clinical leads, Nurse 3 and AHP 2, who oversee the RT. They commented,

> *You'll find, the RT nurses, they'll say 'that [PRS work] is way out of our comfort zone' because it's not in nursing and it's a real shame.* ***(Nurse 3, Phase 2)***

> *So, it's difficult for the team leader there... We [PRS] haven't been very popular. So we've had to take our values within this team [PRS] and I suppose...we've sort of imposed or more shoe horned them into another team [*RT*] and we've never done that before. So it's been a bit of a learning curve really.* ***(AHP 2, Phase 2)***

> *It's a big push and a drag really [integrating the* RT *team], but I think it's a problem if people [*RT*] haven't been managed properly for ten years. If you don't have that culture within your team, you're not going to change anything are you? No one's questioned what they do or why they do it so they've done exactly the same.* ***(AHP 1, Phase 2)***

Collectively, the above excerpts reflect the resistance of the RT nurses to their new work circumstances even though were doing their new jobs. For instance, AHP 1 described that integrating the RT has been a *'big push and a drag,'* attributing this to the RT's existing culture. This links to the second aspect of professional identity re-affirmation where respondents attempt to convince others to treat them according to a preferred and valued identity. For example, AHP 2 refers to how difficult it has been to get the RT nurses to assimilate the PRS team values. One of the PRS values is identifying themselves as a, 'research driven multi-disciplinary team' separate to other rehabilitation services in LEMT. To help confirm this social identity and propagate cohesion amongst the many professions within the PRS team, AHP 1 stated that she created a specific PRS uniform. Two of the PRS AHPs commented on the importance of this uniform,

We all bring different qualities to the team and I think everybody values everybody else's skill. So that's probably why there isn't any professional ownership over what you wear because I think everybody's sort of valued in an equal respectful kind of way I think. ***(AHP 11, Phase 2)***

Whether you are a nurse or a medic or a physio[therapist], though you can still sometimes see those little professional conflicts, we wear a rehab uniform. We have nurses and an OT [occupational therapist] in our team who wear that uniform, I myself as a psychologist. Most health psychologists wouldn't be in this uniform. ***(AHP 10, Phase 2)***

During data collection my observations revealed the RT nurses had not conformed to this 'de-professionalisation' and had opted not to wear the PRS team uniform. During interviews with 4 of the nurses from the RT they related that prior to joining the PRS, their team was community based so they completed home visits in civilian clothes. Though once the policy changes were instituted they were expected to return to hospital-based work. However, instead of wearing the PRS uniform the RT nurses opted to wear the standard issue dark blue nurse uniform reflective of their profession and seniority and sit together during meetings. Both AHP 11 and AHP 10 went on to comment on this deceivingly minor act of re-affirmation,

Well actually I think in this team most of the pulmonary rehab team are just in the white tops that say Pulmonary Rehab[ilitation] *on them. Then there are the nurses that are in the blue uniforms and they're the RT. They have undergone a difficult transition from an old role into a new role and I think that there would be an expectation of integration over a period of time. But I think the reason that the nurses are still in their uniforms is because they're not ready to lose their old identity just yet because I think it's been an extremely stressful transformation for them. Yeah, I think AHP 2 who manages them knows that they are having real difficulty adapting from the old role to the new role. So to ask them to come out of their uniform is a bit too much for them to cope with. Yeah, I think they desperately want to try and keep their own identity* ***(AHP 11, Phase 2)***

> *I remember noticing when we [RT nurses and PRS team] first started being integrated they were still obviously in their plain clothes and I suddenly noticed one time in a meeting they were all in [nurse] uniform. Yes, that was weird because the RT nurses aren't doing traditional nursing duties when they're on the ward. But then I don't know, if someone was to say to them you're going to wear a rehab uniform, would that make them unhappy or would they be resistant to that. I wonder if they have the same job satisfaction as they did when they were working one to one with the patients in their own home... I suppose it's a way of, them keeping that [nurse] uniform, a way of keeping themselves separate. Yes they are part of our team technically but I certainly still feel like they are a separate team, they are still the RT nurses.* ***(AHP 10, Phase 2)***

Uniforms are particularly significant professional markers of work content and status for healthcare professionals and patients alike. This provides support to my position that professional identity re-affirmation is partly about maintaining credibility with others. For instance, both AHP 10 and AHP 11 acknowledge some level of identity tension was in play for the RT nurses by indicating the difficulties that merging the teams had created. Particularly, they point out that changes in work content have been challenging for the RT nurses. AHP 10 and AHP 11 highlight the RT nurses were no longer doing traditional nursing work and had new roles, which suggests a misalignment between profession and work content. AHP 10 acknowledges this by speculating about whether the RT nurses have the same level of job satisfaction post precipitating event.

Further, re-affirmation identity work appears to minimise identity (or arguably delay the inevitable) for the RT nurses because despite changing work content they have managed to convince other PRS team members like AHP 10 and AHP 11 of their nurse identity. Both AHPs seems to be acutely aware of this tactic as they draw the same conclusion that a uniform change would be tantamount to stripping the last vestiges of the RT nurses nurse identity. Of her own accord, AHP 11 specifically mentions the identity construct stating she believes they '*desperately want to try and keep their own [nurse] identity.*' Similarly AHP 10 is

sympathetic to the RT nurses stating that having them change their uniforms could quite possibly elicit negative emotions of unhappiness and would be something they would resist.

In summary professional identity re-affirmation appears to have two goals, (1) strengthening and re-iterating a preferred social identity and (2) convincing others to treat one according to that preferred and valued social identity. Therefore, it appears professional identity re-affirmation also functions as a form of resistance though with a different focus than NHS identity re-affirmation. Where NHS identity re-affirmation seems to have a self-enhancement focus, professional identity re-affirmation appears to focus on categorisation. As such, respondents not only stress differences between the in-group and out-group, but also the similarities among in-group member's normative behaviours to resolve or minimise identity tension. Therefore, I propose that professional identity is also resistant to change despite the identity tension induced by precipitating events, thereby remaining fundamentally unchanged. The implication of an unchanged professional identity will be discussed in the overarching SEE-CEI framework in Section 9.4.

9.4 Sensemaking Identity Work in the Professional Identity via Notice & Bracketing, Labelling & Communication Processes

The case data revealed the respondents in the Pathology Joint Venture (PJV) and PRS units countered identity tension in a manner that allowed them to construct or re-construct their professional identity and accommodate the new direction precipitating events were pushing them towards. Yet, I was able to extract respondent's stories that conveyed changes in their prototypical selves facilitated by identity work. However, as Table 33 as well as the data presented thus far in Sections 9.2 and 9.3 indicate, changes to social identity were only detected in respondents' professional identity. This suggests that keeping the prototypical professional identity narrative going proved more challenging for some individuals when compared to the unchanged NHS identity. This is evidenced by the entrepreneurial nature of the embedded units within the case. This maybe attributed to two points made earlier.

First, in Section 8.2 the nature of precipitating events that led to respondent's professional identity tension differed from those targeted at their NHS identity. Professional identity precipitating events occurred with more frequency, broader variety and within closer proximity to informants when compared to those targeted at the NHS identity. This suggests that there maybe a higher likelihood of professional identity tension developing. Thus, precipitating events may have greater utility for eliciting change in an individual's professional identity than in their NHS identity. Second, in Section 9.3 I stated carrying out one's work content is an everyday occurrence, which aids in confirming that professional identity. It follows, that even if there are professional identity-work content discrepancies, individuals may ultimately have to adjust how they work to continue performing their jobs. The RT nurses in Section 9.3 who are no longer doing traditional nursing work demonstrated this. Again this suggests professional identity presents increased opportunities for identity change to eventually occur.

As documented in Section 6.6.3, sensemaking identity work was not a monolithic process. Rather, it occurred through 3 sub-processes: noticing and bracketing, labelling and communications, which I will present in Sections 9.4.1-3 below.

<table>
<tr><th>Multiple Social Identities</th><th>First Order Codes
Statements about:</th><th>Second Order Codes
Identity Work</th><th>Third Order Codes
Identity Work</th><th>Identity Work Effect on Professional Identity</th><th>Findings Derived From</th></tr>
<tr><td rowspan="5">Professional Identity</td><td>Delineating prototypical behaviours and new behaviours in new circumstances e.g.
• Are professional meanings changing?
• Recognising there maybe more to my work
• Orienting myself to when new behaviours are required e.g. product development</td><td rowspan="2"><u>Noticing & Bracketing</u></td><td rowspan="5"><u>Sensemaking</u>
(Depersonalisation focus)</td><td rowspan="5">Professional Identity Re-constructed</td><td rowspan="2">Unit 3: Pulmonary Rehabilitation Service</td></tr>
<tr><td>Re-build work content based on new circumstances e.g.
• Exposure to new perspectives, norms, philosophies, beliefs and values
• What is my new work content?
• Compiling a new repertoire of behaviours e.g. Market research, product development</td></tr>
<tr><td>Reducing the incongruence and dissonance created by the ‘new’ e.g.
• Re-interpreting and re-defining professional routines
• Justifying why new behaviours
• Alternative conceptualisations of entrepreneurship e.g. EO behaviours</td><td rowspan="2"><u>Labelling</u></td><td rowspan="2">Unit 2: Pathology Joint Venture

Unit 3: Pulmonary Rehabilitation Service</td></tr>
<tr><td>Accommodating new self meanings & expectations e.g.
• Who I am now
• What I do now</td></tr>
<tr><td>Gaining credibility with others
• Letting others know who I am now
• Expressing a willingness to reform their self
• Taking cues from others on purpose in new circumstances
• Reducing dissonance/conflict surrounding who I/we are now in new circumstances</td><td><u>Communicating</u></td><td>Unit 2: Pathology Joint Venture

Unit 3: Pulmonary Rehabilitation Service</td></tr>
<tr><td colspan="6">Emerging Theory: Sensemaking</td></tr>
</table>

Table 33: Data Analysis Table Showing Sensemaking Identity Work Processes Employed & Impact on Professional Identity

9.4.1 Noticing and Bracketing Process in Sensemaking Identity Work in Professional Identity

Noticing and bracketing appears to be the first step of re-constructing professional identity, respondents sought to understand 'what I should do now?' It should be noted that the data revealed respondents tended to wholly adhere to the shared values, ideals and principles surrounding the sanctity and primacy of the patient-professional relationship. However, from the stories recounted by study participants, there seemed to be a fundamental transformation to what they believed it meant to be a member of a particular profession and what their work content to be. For example, I reconsidered a portion of AHP 9's quote from Section 8.2, where she indicates there maybe more to being an AHP than clinical expertise,

> *... after about a year, a year and a half here [with PRS] I was so sucked into the research side of things. I really enjoy it and actually now I can't imagine going back and having a purely clinical job… Plus the more I've started to think of AHP 1. As well as having her all her clinical expertise, she has research expertise and she's a businesswoman as well. And I just sort of think there are so many skills that you need to have to reach that kind of level in your career.* ***(AHP 9, Phase 2)***

AHP 9's quote illustrates that she has been engaged in a process of re-interpreting what it may mean to be an AHP by reviewing the work content of a role model. This highlights one of the aspects of noticing and bracketing. Respondents reduce identity tension by searching for an alternative course of action by first delineating prototypical work content from the work content created by new circumstances. AHP 9 first indicates the prototypical AHP identity is grounded in clinical expertise only as covered in Table 28. As she orients to the change in her circumstances after the cluster of precipitating events described in Section 8.2 (joining a new team, meeting a new role model and doing research work), she begins to search for what the new work content for her new AHP identity could entail. Ultimately, she takes cues from AHP 1 about what work content she could adopt to maximise her contribution to the PRS. Subsequently, she discovers that a

more expansive work content repertoire including business and research skills maybe required. AHP 9 indicates that she now cannot see herself returning to a purely clinical purview. This suggests a fundamental change to her AHP-self and increased levels of self-efficacy, represented by the Doctor of Philosophy degree she currently pursuing.

Similarly, one nurse described how his work content changed when he transferred from the cardiac rehabilitation team and assumed a new non-clinical nurse role of in the PRS team,

> *Yeah I was completely out of my comfort zone! So before as a nurse you look within your own department and your service and that's it. Now I have to look over the wider scene and commissioners. It's things that nurses don't really get involved with and you don't because there's no need to be involved and know what the commissioners are doing. But now you should know what they're doing [commissioners] and what the GP's [general practitioners] are doing, who you're marketing to and that's hard. So I've been sort of learning as I go along.* ***(Nurse 7, Phase 2)***

Nurse 7 like AHP 9 also delineates between the prototypical and re-constructed professional identity by first establishing a baseline for what he believes to be normal nurse perspectives. He directly addresses the inherent behavioural limitations the nurse in-group imposes on itself referring to *'things nurses don't really get involved with,'* which is consistent with the prescriptive nature of social identity. However, despite the rigidity of his nurse group membership, Nurse 7 forcibly extracts new meanings and behaviours as he re-constructs his nurse identity. This occurs with notable personal difficulty due to low levels of self-efficacy as he began to learn his new work content. However, it is also difficult as some of the new behaviours required to fulfil his new role maybe considered proscriptive by and lack legitimacy with his professional in-group. Nurse 7 elaborated on how his new work was perceived by other nursing colleagues,

> *If it's friends from a clinical background they'll say, 'oh you've gone onto a desk job and away from 'real' nursing.'* ***(Nurse 7, Phase 2)***

Nurse 7 uses this notion of *'real nursing'* as a cue, to recognise that his new implementation role requires alternative perspectives and behaviours to that of the prototypical nurse. In response to this deviation from the normative professional identity, Nurse 7 orients himself to his new role so he notices and brackets signs, cues and moments he interprets as requiring new actions such as, marketing and market analysis. This suggests that the noticing and bracketing process in sensemaking identity work affords participants the opportunity to recognise the rigidity of their professional identity. Consequently, case informants were then able to begin reducing the salience and centrality (Section 4.4.3) of their professional identity by experimenting with provisional or possible versions of their professional selves that integrate these new behaviours. Further, as noticing and bracketing seems to be an experimental period, Nurse 7 does not necessarily classify these new behaviours as entrepreneurial. Rather, these behaviours remain largely unnamed occurrences in a transitional period of work life.

Collectively reflected and specifically exemplified by Nurse 7 and AHP 9's accounts, as respondents notice and bracket, they are continuously drawing delineations between classic and new behaviours. It is in these delineations that the second aspect of noticing and bracketing emerged. Respondents began re-building their work content with new behaviours based on new circumstances to re-construct and eventually stabilise their professional identity. For example, being part of the PRS involved attending a scheduled series of informational meetings each week. One such meeting is the weekly Journal Club. AHP 4, who joined the PRS from a private physiotherapy practice and oversees one of the PRS clinical trials as part of a Doctor of Philosophy degree, compiles a list of skills developed as a result of this specific meeting,

> *Being able to critique journal articles, analysing evidence. Things like being able to do a systematic review. Things like that, that I've learnt here [PRS] I think you forget when you've been working here a little while how unusual it is in the NHS to have a weekly journal club say. Whereas I think say ward staff, nurses, perhaps don't have that time dedicated to learning.* ***(AHP 4, Phase 2)***

Similarly, I observed one Nurse manager during the weekly Information Technology Solutions meeting, who was key in leading the development of a rehabilitation self management website under the purview of the PRS department. She also highlighted the new skill sets she learned during her PRS tenure,

> *We're still learning, years down the line, about contracts and other aspects, you know? Service-level agreements and all of that around how we manage it [rehabilitation self-management website] properly and all the safety aspects of web design and security, that was all new, you know? That wasn't something we were experts in, but we had to learn.* ***(Nurse 3, Phase 2)***

By their own admission the above descriptions of work content proffered by Nurse 3 and AHP 4 clearly differ from the traditional caring work content for a nurse, or the rehabilitation and therapy work of AHPs. This links the noticing and bracketing process in sensemaking identity work to the reduced self-efficacy issue discussed in Section 8.3.2 by introducing two themes: time and learning. Time is required for case informants to detect what competencies are needed. They then learn these new skills to best execute new work. In turn, this leads to increased individual perceptions of self-efficacy in new circumstances. Nurse 3 suggests she believes herself to be a novice as she is still learning about the new areas she is venturing into, referring to the 10 years it took to develop the rehabilitation self-management website. While she has the clinical knowledge to compile the website content she still had to learn about website development, security, contracts and service level agreements. However, attempts to make sense of her new work are detected. Her lack of knowledge indicates that the learning process requires far more focus and involvement from herself to develop a realistic view of what launching the website entailed.

The preceding examples demonstrate the noticing and bracketing process in sensemaking identity work to facilitate changes in work content. However, as I continued to analyse Nurse 3's story it became evident that as she re-built her work content with the new behaviours and perspectives accumulated over a

period of time, she experienced a fundamental re-construction of her professional identity. Consequently, Nurse 3 began to actively challenge her in-group's status quo,

> *I loved coronary care it was great! There we had a professor of nursing leading us who questioned us, who asked us to explain, where's our evidence based? Can we do this differently? Sometimes you can have one or two people who can just spark something in you and just keep you interested and keep you thinking differently. And there's not a lot of professors of nursing are there? And I think it's a real shame.* ***(Nurse 3, Phase 2)***

> *What about when you saw a lot of physios in PRS team having or working towards PhDs?* ***(Interviewer)***

> *Yeah well that's where the threat is you see [for nurses]. Where you'll find the Respiratory Team nurses saying, that is way out of our comfort zone, because it's not in nursing and it's a real shame… That's why I'm becoming an honorary physio…* ***(Nurse 3, Phase 2)***

Similar to Nurse 7, Nurse 3 also reported a shift in her thinking after what appears to be the cumulative effect of two precipitating events in her career history: meeting a professor of nursing role model and second joining the PRS team. Nurse 3 refers to a '*spark'* akin to taking cues from her changing circumstances indicating the adoption of new behaviours and perspectives. This segues into her expressly signalling to a more drastic re-construction of her prototypical nurse identity. This re-construction takes the form of a aspirational provisional self. As such, when she says *'I'm becoming an honorary physio'* she is indicating a future aspirational self where she no longer perceives herself as an interchangeable typical representation of the nurse profession. This points to a reduction in the nurse in-group's social influence and an increase in that of the AHP out-group she now aligns herself with. Further, this alignment with AHPs also suggests a change in out-group, which symbolises a true re-construction of professional identity.

Thus, Nurse 3 now accentuates differences between herself and other nurses and similarities between herself and AHPs.

It should be noted however, that the physiotherapists to whom Nurse 3 is referring are a part of the AHPs in PRS team led by AHP 1. AHP 1 is known for having and encouraging a more entrepreneurial approach to her role as Head of Service when compared to the AHPs that work in the LEMT Physiotherapy Department (LEMT-PD). Admittedly atypical in their current professional-characterisations, the PRS AHPs represent a re-constructed AHP identity that includes new work content such as research and service development skills like those AHP 9, Nurse 7 and Nurse 3 refer to. For instance, AHP 5 gave her impressions of her re-constructed AHP identity and work content by drawing distinctions between her experiences working in the LEMT-PD prior to the PRS with its extensive research portfolio of approximately 8 on-going clinical trials,

> *So I know a lot of the staff there [LEMT-PD], sort of from my previous life if you like… It's going to sound mean but I'd say no [LEMT-PD is not entrepreneurial]. But I think it's perhaps to do with the way that they are organised and the role that they have and perhaps the opportunities don't come along or they perhaps don't see the opportunities quite so much. So I think they certainly have the potential to be but in my experience not so much.*
>
> *Whereas certainly in this department you accept that entrepreneurship is, well kind of what I think my definition of it [entrepreneurship], is built into the department and our goals and our role and what we're looking to strive to improve and achieve… and then that also comes from the top of this department. It's kind of a given really.* ***(AHP 5, Phase 2)***

AHP 5's account of taking on a senior physiotherapist role in the PRS team again exemplifies the transformation in work content conveyed by respondents. In this case AHP 5 like Nurse 3, reports a marked metamorphosis in her professional life referring to her days in the LEMT-PD as a *'previous life.'* AHP 5 uses an existing mental model acquired during her time in LEMT-PD to guide noticing and

bracketing to augment her ability to notice what is new in her changed circumstances and what is now expected of her. AHP 5 draws distinctions between the prevailing conventional logic of LEMT-PD versus the perceived unorthodox logic of the PRS team. She takes cues from the local organisational structures, roles in the wider LEMT organisation, varying opportunity identification competencies and locus of entrepreneurship as criteria to guide and simplify expected behaviours in the PRS team.

Additionally, AHP 5's account makes two things evident about the reformation of professional identity. First, there is a change in out-group where the PRS-AHPs seem to consider themselves as the in-group whereas other prototypical AHPs are now a part of the out-group. This leads to the second point where PRS-AHPs are no longer interchangeable AHP prototypes. Instead, they seem to be a unique version of an AHP identity that is amenable to CE. This suggests that the depersonalisation process at work in the SIA has been mitigated in some way so that the original in-group social influence is reduced and unique versions of the professional self can re-emerge.

From the above it can be seen that respondents used noticing and bracketing as part of the sensemaking identity work strategy to resolve or minimise professional identity tension. In using this strategy, study participants became aware of and registered moments from their changing circumstances in mind so they can determine an alternative course of action. This was achieved by respondents delineating new behaviours from prototypical behaviours and subsequently re-building their work content based on these new behaviours. This facilitated a re-construction of their professional identity to best navigate new circumstances. Ultimately, noticing and bracketing signals the inception of professional identity re-construction where an individual is no longer an interchangeable professional prototype due to their new work content. This suggests noticing and bracketing starts attenuating the depersonalisation process so that respondents could begin becoming more unique versions of their professional selves.

9.4.2 Labelling Process in Sensemaking Identity Work in Professional Identity

Respondents usually articulated the labelling process in sensemaking identity work with personal pronouns (I am, we are or they are etc.) followed by a some label indicative of who they were or what work they did. For example, I reconsidered AHP 5's excerpt in Section 9.4.1 above and found that while she is noticing and bracketing differences between PRS and LEMT-PD she is concurrently labelling what happens in PRS as entrepreneurial versus LEMT-PD as not entrepreneurial. This entrepreneurial label minimises professional identity tension as it suggests the work content of professionals in the PRS department should encompass specific behaviours such as opportunity recognition, which is a key aspect of CE. However, labels such as: entrepreneurship, CE, entrepreneur, entrepreneurial and aspects of entrepreneurial orientation (EO) (innovativeness, proactiveness, risk-taking, competitive aggressiveness and autonomy) were introduced by myself as I sought to understand the emergence of CE activity. As such, AHP 5's quote also demonstrates the retrospective nature of sensemaking identity work as this 'entrepreneurial' label is only deployed as AHP 5 reflects on past experience. Further, where AHP 5 seems to be comfortable with using the term entrepreneurship as a professional identity label, one pharmacist who sits on the R&D Committee, proffered an alternative perspective. She suggests that entrepreneurial labels may instead have a disorganising effect in the LEMT-NHS context,

> *It's not that I don't think it [entrepreneurship] happens in the NHS, I just think there's probably some perceptions about what it looks like, or what are or should be the proper elements.* ***(Pharmacist 1, Phase 2)***

When Pharmacist 1 refers to *'what it looks like'* or *'the proper elements'* this suggests a specific behavioural typology is associated with the entrepreneurship label. Yet simultaneously, she expresses a level of uncertainty regarding what this typology should include in the NHS-LEMT context. A major point of contention that elicited ambivalent opinions from respondents was that entrepreneurial labels suggest profit driven motives like those of the private sector discussed in Section

7.3.3.2. However, due to the taxation funding provided to the NHS and LEMT, profiteering is not considered a priority or even an appropriate outcome. Like Doctor 4 or AHP 8 previously in Section 7.3.3.2, respondents conveyed they joined their professions to help patients. Thus, categorising their new work as entrepreneurial proved problematic as these outcomes appeared at odds with each other. Hence, in the NHS-LEMT organisational context, when entrepreneurship-related labels were deployed they needed to be constructed or re-constructed so that monetary gains were not the primary focus. I will discuss the latter in more depth subsequently.

The labelling process in sensemaking identity work was not only retrospective like AHP 5 and Pharmacist 1. Rather labelling also seemed to cluster in the wake of precipitating events as respondents sought to best organise and interpret their new work content and circumstances. Labels were locally (relevant with in a particular unit or group of individuals) or personally derived to imply entrepreneurial action had been taken even if respondents were unable to specifically articulate this at the time. For instance, I considered Doctor 2's quote presented below as he explained why he was in his current role as in Pathology Clinical Business Unit (CBU),

> *I think it goes back to taking control of my own destiny. The reason why I am where I am today is because I got fed up of being stopped from doing things or not being allowed to do things or being imposed on and that desire to become a little bit more autonomous, more in control. So that, I wouldn't get annoyed by people sending me yet another form to fill in. So in order to try and circumvent that and try and do a good job I have to try and do something a bit different... So I started off as being the lead for Cytology that is one small bit of Pathology. No one else wanted to do it; no one understood it very well. So I ended up doing it at a very young age here. And it was just me. So basically I had control over a small area myself. So I could control myself. I could do what I want and do it well. So that gave me a taste of actual power.* ***(Doctor 2, Phase 2)***

When Doctor 2 uses the label *'control my own destiny'* it suggests some sort of action geared towards exerting control over his future professional self. He describes his strategic decision to quickly ascend in the NHS and professional hierarchy by doing a role with minimal competition from his fellow pathologists. Additionally, his attempts to increase his power and control while minimising his interactions with organisational bureaucracy can be likened to the proactiveness dimension in the EO construct. When Doctor 2 chooses to do *'something a bit different'* and deviate from the normal career path of a pathologist, he re-defines a unique version of his professional self. This aligns with my previous proposal that overall, sensemaking identity work attenuates the depersonalisation process so that case informants drift further away from their prototypical professional identity. Additionally, the above quote demonstrates that the labelling process in this context maybe be characterised as being as much an immediate and concurrent process as it is retrospective as previously discussed in Section 4.6.1.3-2.

Typically organisations deploy agreed upon labels to establish stable entities to describe its employees and their functions (e.g. doctor or nurse. However, as I established throughout this chapter professional identity maybe subject to change. Further, CE phenomena are rare occurrences in the LEMT organisation and are generally viewed with scepticism by organisational members. Hence, CE labels tend to lack any formal organisational endorsement and meaning. Therefore, the immediate and concurrent nature of the labelling process in sensemaking identity work appeared to aid in resolving or minimising respondent's identity tension by reducing the incongruence and dissonance created by the 'new' so the disorganising effect mentioned by Pharmacist 1 could be avoided. Instead, a myriad of labels that pointed to CE or being entrepreneurial were deployed based on colloquialisms like Doctor 2 referring to *'controlling his own destiny'* or AHP 11 referring to the PRS as a *'multi-disciplinary team'* These locally and personally constructed labels appeared to allow respondents to first, maintain credibility with others as these labels afforded them some protection from the stigma of being branded as entrepreneurial in a publicly funded organisation. Second, these labels reflect that respondents perceived being described as wholly entrepreneurial was largely inauthentic (such as AHP 1's preference for being

identified as innovative rather than entrepreneurial in Section 8.3.2). Finally, the labels used indicate some respondents had not ever considered CE or entrepreneurship at all prior to our interview.

For instance, while Pharmacist 1 delineates the negative connotations associated with entrepreneurship, she also proffered a range of desirable behaviours portrayed by entrepreneurial individuals. Descriptors of entrepreneurial actors included being creative, forward-thinking, innovative, coming up with new ways of doing things and then having the drive and the commitment to make those ideas happen. However, study participants deployed the professionally based labels of academic or researcher in lieu of the traditional entrepreneur label to encompass these activities within LEMT,

> *Most definitely academics, I remember seeing, in my role as clinical lead for cancer, a Professor of Haematology was developing a website which allowed patients to hold their own data. So, that is relatively new. It's going out on his own. It's something he created himself and was driving forward. Some of the renal units I am aware that they did some things that are again ground breaking for sure.* ***(Doctor 2, Phase 2)***

> *To me you should be, every time you're in clinic, every time you're seeing patients you should be thinking about how I should do better. And I think how you can do better is by research. I cannot see how I could be a good clinician without doing research.* ***(Doctor 7, Phase 2)***

From the above quotes being an academic or researcher in the LEMT context appeared to carry implications for the actions described by Pharmacist 1. More importantly however, these labels do not imply that academics or researchers in the NHS-LEMT context are driven by commercial motives. As such, Doctor 2 and Doctor 7 are able to label themselves or someone else as a more unique professional identity yet minimise incongruence by re-interpreting and re-defining professional identities to justify new behaviours. However, despite the pejorative connotations attached to the profit-generation aspect of entrepreneurship, some respondents deployed labels which seemed to negate this. In these occurrences

labels that marked the individual as having some business ability (like AHP 9 stating AHP 1 was also a 'businesswoman' in Section 8.2, for example) were used in conjunction with a professional identity label (e.g. clinician). Consider, Healthcare Scientist 1 who works closely with Doctor 2 on the PJV,

> *Doctor 2's got a very good business head as well. He's a clinician with a lot of knowledge about that [business]. You don't always get clinicians with a lot of knowledge about that but Doctor 2 does have...* ***(Healthcare Scientist 1, Phase 2)***

Informal labels like having *'a head for business'* places the bearer in a category that far removes them from the professional prototypes that have been discussed throughout these empirical chapters. Simultaneously, these labels suggest some sort of balance exists between being a professional and someone who also has some level of efficacy for business and displays entrepreneurial behaviour, without having to directly label the individual as entrepreneurial. However, Manager 5 who had been with the PJV from its inception like Healthcare Scientist 1, reflected on Doctor 2's performance during our discussion of CE, entrepreneurship and EO and came to the following conclusion,

> *I would say Doctor 2 is extremely so [entrepreneurial] for a clinical leader* ***(Manager 5, Phase 2)***

Manager 5's determination leads to the second aspect of the labelling process in sensemaking identity work, which allowed respondents to accommodate new meanings and expectations from their self and others. The phrasing of Manager 5's statement *'[entrepreneurial] for a clinical leader'* suggests that based on his experience, entrepreneurial prowess is anomalous for a clinician. As such, Manager 5 adjusted his expectations of Doctor 2 as a clinician indicating that this entrepreneurial identity was highly credible. Similarly, when Nurse 3 in Section 9.4.1 uses the label *'I am becoming physio'* to refer to herself she is clearly conveying an on going and concurrent re-construction of her prototypical nurse self. This allowed her to better accommodate new meanings and expectations

associated with being a researcher with critical thinking and analytical skills aimed at improving service output levels.

Further, I considered the wider PRS team who consistently deployed locally relevant labels that were indicative of a re-constructed professional identity. One of these labels was *'this [PRS] department,'* which was deceptively innocuous. However, this label seemed to accommodate changing professional meanings and expectations while eliciting identity questions of 'who I am now' and 'what I do now.' This label appeared to reduce professional identity tension as it firmly redirected study participants towards a new set of professional behaviours deemed appropriate within this group. For instance, AHP 2 explained what it the label 'PRS department' entailed,

> *So I'm an OT [occupational therapist], the only OT in a team of physios*[therapists] *and nurses, but my job is very different to what a regular OT would be doing... Given the choice, I would have the quiet life, to be honest. But you don't really get the quiet life here [PRS]. There is certainly an ethos within this department, that new ideas are recognised and we don't stand still; change is what it's all about. And that's uncomfortable for quite a few members of the team but it's the way, it won't change, that's the way we'll always be. It's the way that it's been for about 20 years, I suppose.*
>
> *In this service, in terms of research ideas, there is a culture of we don't do anything unless we've got the evidence to back it up. So it will start with a research idea, funding the research project and then implementing the results of that. We identify the problems and do something about it. And we identify the problem because we've got somebody else asking us the questions. Or we know someone will ask us the questions. So we can have the answers ready. (**AHP 2, Phase 2)***

AHP 2, like several other team members, had completed a Doctor of Philosophy Degree under AHP 1's supervision and now worked as 1 of 4 deputies under AHP 1 overseeing the clinical aspects of the service. She highlights that she has been

trained as an OT (a type of AHP) but being labelled as a member of the PRS team has drastically altered her work content. AHP 2 goes on to elaborate that in addition to her new work content, the PRS department label suggests a particular ethos and culture, which separates them from other departments in LEMT. The PRS ethos and culture is founded on valuing ideas, a strong evidence base, problem solving and the inevitability of change akin to innovativeness in EO. She expressed that even while she longs for the *'quiet life'* she is aware that that is not an option within the departmental context. Her own professional identity re-construction is only made more convincing as she indicates that some teams members have yet to fully embrace what it meant to be in the PRS team expressly denoting that she has.

From the above it can be seen that labelling as part of sensemaking identity work was employed by case informants as a strategy to resolve or minimise professional identity tension as labels imply a course of action. Labelling enabled respondents to (1) reduce the incongruence and dissonance created by the 'new' and (2) accommodate new meanings and expectations of the self or others. Further, labelling appeared to be on going as both retrospectively and immediately deployed labels allowed respondents to categorise the parts of their new professional work content (compiled via the noticing and bracketing process) as entrepreneurial. Thus, like noticing and bracketing, labelling has a depersonalisation focus so that respondents were no longer interchangeable professional prototypes due to their new work content.

9.4.3 Communication Process in Sensemaking Identity Work in Professional Identity

The communication process in sensemaking identity work becomes a necessary strategy as study participants made attempts to convey to others 'who they are now' and 'what they do now' in the wake of precipitating events. For example, I considered Doctor 2 who was labelled as *'a clinician with a head for business'* by his colleagues, Healthcare Scientist 1 and Manager 5, who have worked closely with Doctor 2 over an extended period of time. Doctor 2 related his narrative surrounding how he became involved in the PJV, which demonstrates the

usefulness of the communication process in sensemaking identity work. Doctor 2's story began with him highlighting a precipitating event in the form of a national level policy change in pathology service provision called the Carter Report (DH, 2006; 2008). The new policies set out in the report were aimed at propagating competition amongst NHS pathology service providers across the UK. As he notices and brackets changes to his own work in terms of how he would have to manage the LEMT Pathology CBU in these new circumstances, this coalesced into the impression conveyed below,

> *I had always thought that Pathology would have to change eventually but the timing of it, I wasn't too sure… I subscribed to the view that there would be consolidation in the future but I didn't know how I could influence it or make it happen…* ***(Doctor 2, Phase 2)***

The above quote illustrates the disruption created by precipitating events as Doctor 2 conveys *'he wasn't sure'* of what course of action should be taken in these new circumstances. What is also clear is that by his own admission Doctor 2's individual attempts to make sense of the disruption had little influence on whether he could effect the change and re-organisation of Pathology service provision at the organisational level in LEMT. However, Doctor 2, in Section 9.4.2, has identified himself as wanting to *'control his own destiny'* or be proactive. Thus, as he continued telling his story, the communication process he engaged in as part of his sensemaking identity work was targeted at having his proactive self externally approved as credible by important others in LEMT, specifically the CEO of LEMT,

> *I had a couple of conversations with the CEO who had experience in a previous job in London with bringing together two pathology services. He had the same impression that I had, that there would be major change within pathology. We had this conversation when he first arrived and nothing happened for 12 to 18 months. Though it wasn't high on my agenda because I was too busy running the business [Pathology CBU].*

> *Then there was another conversation. It was me trying to figure out how I could 'float off' [create an external corporate venture]. So I was looking into not-for-profit organisations. How else could we run pathology to benefit both the Trust [LEMT] and the pathology CBU? And that then went into another conversation and then the CEO also, suggested initially 'floating off' by ourselves as a semi-autonomous organisation. Then shortly after that he introduced a NHS partner into the mix as well. And I think that was a catalyst.* ***(Doctor 2, Phase 2)***

The above excerpt demonstrates Doctor 2's professional identity tension. That is despite his proactiveness in predicting and wanting to manage impending change, he is pulled towards the time consuming nature of running the Pathology CBU, which I concluded in Chapter 7 hinders a positive evaluation of CE feasibility. In response, Doctor 2 determines a potential course of action, creating a corporate venture, which he labels as *'floating off'* or *'semi-autonomous organisation'* reflective of his preferred proactive self. In turn, the CEO with his own understanding of pathology services re-configuration from a strategic and operational perspective represents a significant and knowledgeable other. As such, he would be capable of truly validating Doctor 2's solution and by proxy his unique professional self as an entrepreneurial clinician. The CEO then confirms Doctor 2's credibility with further overt signifiers. These signifiers include ratifying Doctor 2's corporate venture plan by approving its alignment with LEMT's strategic vision via a new organisational structure, board of directors, forging a partnership and eventually a business plan for the PJV.

The above illustrates the communication process as: (1) focused on an individual and (2) an informal. Doctor 2 and the CEO's exchange uses words to assemble an explicit description of Doctor 2 as a viable person to lead the PJV. However, where Doctor 2 has gained credibility, this credibility did not necessarily extend to the PJV as a semi-autonomous organisation. In an interview with Manager 4, a consultant hired by the PJV, she commented on the executive board's bi-directional identity demands,

They've [Doctor 2, Healthcare Scientist 1, Manager 5 etc.] never actually been trained to be a commercial entity. I think the PJV is still figuring out what it is. You've got a wholly NHS service, which is now operating as a 'quasi-commercial' entity and obviously it's still in the NHS and still publicly funded. ***(Manager 4, Phase 2)***

Manager 4's insight prompted me to pay closer attention to my observational data collected from attending the monthly PJV board meetings. On the surface these meetings appeared to be typical informational discussions between relevant parties concerning finances, operations and business development. However, the subtext of these meetings were geared toward addressing Manager 4's view that '*PJV is still figuring out what it is,'* that is, commercial versus publically funded entity. This suggests the communication process could be distributed across a group of individuals and be facilitated by more formal interactional structures. I considered an excerpt from an observational vignette based on the second PJV board meeting I attended,

Today is a transitional meeting and as such was divided into 2 parts. The first hour was carded as the PJV Project Executive Meeting where the project managers assigned by the parent Trusts [LEMT and NHS partner] gave final impetus and officially handed over the PJV project to the PJV Executive Board. One of the project managers commented, 'bring in the new board members without any of our [LEMT, NHS partner, NHS] baggage.'

The second hour represents the start of the first PJV Executive Board Meeting. The project managers and Manager 4 exit the room leaving the PJV executive board members only. Doctor 2, who will be straddling both a Managing Director and Medical Director role in the short term, changes his seating location. He moves to sit the left of the newly appointed PJV Board Chairman. The Chairman takes a few minutes to express his belief in the venture and PJV's obligation under the terms of reference. He states, 'I am passionate about the Trust [LEMT] seeing us as a credible separate organisation. This is like absolute freedom, so let's

get on with it!' The Chairman invites Doctor 2, to speak, 'we have spent 2 years planning for this moment. Now the trick is to convince people we know what we are doing.'

Doctor 2's comment ignites a discussion surrounding how they were going to keep building this credibility. The general consensus was this is a delicate balance. Manager 5 states, 'well we don't want to demand too much autonomy too early from the 'parents,' rather we have to earn it and have them see we are growing up or have grown up.' However, the conversation then segues into minimising risk for the parent Trusts and keeping the risk register 'live.' It is at this point Manager 7, who is the Commercial Director, intervenes saying, 'yes minimising risk and protecting the Trusts are important, but we are a Pathology business, risk is part of it.' Manager 6 supports Manager 7's view stating, 'we have to remember it is not business as usual; we can't operate in a bureaucratic manner. We have to make it happen and make some money.' ***(Observation 2 Project Executive Meeting & Executive Board Meeting, PJV, Phase 2)***

The above excerpt is particularly enlightening as it demonstrates the communication process in respondent's sensemaking identity work occurring through interactive exchanges and symbolic representations of their new circumstances. For instance, the project manager's comment about the board moving on *'without any of our baggage'* suggests the PJV is an entity in its own right, free of the bureaucracy and restrictions of a typical NHS organisation. The Chairman confirms that as a group they have been afforded a rare opportunity for *'absolute freedom'* by NHS standards.

Though it can be seen that fully and consistently embracing this newfound freedom proved challenging for some board members. Mainly because they were pulled toward the familiar caution and risk-averse nature of work. This caution prompts Manager 7 to re-direct the group's attention. Manager 7 has been hired on as the Commercial Director for the PJV. He had led a private sector career as a management consultant specialising in healthcare. Additionally, he has what can be classified as an entrepreneurial identity having also been Managing Director of

his own boutique healthcare-consulting firm, which he subsequently sold to a large service organisation. In my one-to-one interview with Manager 7 he stated that he was very comfortable with and understood the way the NHS and clinicians worked. As such, the challenge for him in his role has been removing some of the mystique surrounding what he calls *'commercial stuff'* while improving perceptions of efficacy for some of the board members who only had NHS work backgrounds,

> *It's more about confidence really, I don't think that the guys on the team [Doctor 2, Healthcare Scientist 1, Manager 5] are lacking in commercial nouns. I just think they probably don't have the confidence because they don't feel they have the experience or exposure really…* ***(Manager 7, Phase 2)***

It can be seen that Manager 7, like the CEO above, is a significant other who can provide external approval. He has a key role in the observational vignette as forcing and pushing sensemaking identity work and professional identity re-construction forward via communication. Essentially, Manager 7 is able to prompt his colleagues to continue constructing a new identity or re-constructing their professional identity so that stable and consistent identities appropriate to and necessary for the success of the venture are focal. For instance, in the case of Doctor 2 who has begun constructing a corporate entrepreneurial identity, Manager 7 encourages him to adhere to this corporate entrepreneurial identity so it is more salient and central in the identity hierarchy. This is especially important as Doctor 2 is concurrently holding two posts, which require both his prototypical professional identity as Medical Director as well as his corporate entrepreneurial identity as Managing Director to be salient and focal. As such, when Manager 7 declared, *'we are a pathology business'* there was what I can only describe as a 'mental reset' as the NHS based board members remembered why the PJV was set up. This can be seen in Manager 6 who was a strategy based manager at the PJV NHS partner who states, *'we have to remember it is not business as usual.'* This links back to the initial comment made by the project manager at the beginning of the excerpt about shedding baggage and who the PJV now was. Ultimately, Manager 6 is able to then articulate his willingness to reform his

professional identity in these new circumstances. In my one-to-one interview with Manager 6 he reiterated the importance of Manager 7's role in the building the credibility of the venture as well as the individual board members who led it,

> *From the very beginning with the PJV there has been a viewpoint expressed that in order for the PJV to fulfil its potential it actually needed to be a private-public partnership. So we would need at whatever the point in time, to partner with a proper big commercial outfit to be able to bring that entrepreneurial spirit and that private sector sort of profit motive drive into pathology. Because otherwise you know, us lily livered kind of public sector types we just do what we've always done and we won't bring the innovation and the progressiveness into the piece. There was scepticism that we could deliver it within the NHS. But we've kind of resisted that and a big part of that has been bringing in Manager 7 for example, who has a private sector background, who clearly understands the commercial world. But my personal view is that it's a very important role that he [Manager 7] plays because we do need that commercially originated skill set because it doesn't exist as a routine in the NHS. It's not what people come into the NHS to do particularly for the most part.* ***(Manager 6, Phase 2)***
>
> *So is that difficult in terms of you all keeping that [entrepreneurial/ commercial] mode of thinking but then also getting staff on side with that sort of thinking?* ***(Interviewer)***
>
> *It has been difficult yeah because people, again particularly the public sector ethos is that profit is a bit of a dirty word. The connotation of making profit from human misadventure or mishap is not particularly attractive. So people are naturally uncomfortable with it.* ***(Manager 6, Phase 2)***

From the above it can be seen the communication process as part of sensemaking identity work was employed by case informants as a strategy to resolve or minimise their professional identity tension. Specifically, communication facilitated respondent's attempts to re-work their professional identity. This was

achieved as respondents sought credibility in the eyes of important others who are integral to confirming and validating the new version of their professional self being constructed. Like the noticing and bracketing process, communication also seemed to be an on-going process as it presented as both immediate and prospective. The immediacy of communication enabled study participants to place emphasis on who they were becoming in the moment. Whereas, the prospective communication allowed some respondents define who they ultimately wanted to become. Finally, communication like labelling and noticing and bracketing has a mitigating effect on depersonalisation. As such, respondents were again defining themselves as different from their archetypal professional identity.

Collectively, the noticing and bracketing, labelling and communication processes as part of sensemaking identity work allows respondents to interpret and organise changing circumstances. As such, study participants were able to answer 'who I am now' and 'what I do now.' In answering these questions case informants engaged in forming or re-forming their professional identity so they were no longer interchangeable prototypes of the professional in-group. Therefore, I propose these re-constructed professional identities have implications for the overarching SEE -CEI framework. I will address these implications in Section 9.5 below.

9.5 Discussion: Identity Work Implications for Corporate Entrepreneurial Intention Formation in Shapero's Entrepreneurial Event

Thus far, I have set out the findings from my empirical study, which aimed to explore the experience of LEMT organisational members transitioning in to CE activity. I will focus on the identity work mechanisms identified in Sections 9.2, 9.3 and 9.4 that appear to facilitate or hinder CEI formation by resolving the identity tension created by precipitating events interacting with social identity.

In the extant literature, when tensions are acknowledged the view is that identity work, when successful leads to resolution (e.g. Alvesson & Robertson, 2006; Bain et al., 2005). The findings presented above corroborate this proposition and illustrates two identity work processes: reaffirmation and sensemaking were performed to resolve (or at least minimise) identity tension in respondent's multiple social identities: NHS identity and professional identity. Though the means by which resolution was achieved by each of these processes were very different.

The first identity work process, re-affirmation used to resolve or minimise identity tension in both NHS and professional identities was a resistance based strategy. Respondents reported they resolved identity tension in a manner that left their prototypical NHS and professional identities largely unchanged. These unchanged NHS and professional identities are indicative of the on going debate surrounding the resistant versus malleable nature of identity. The NHS identity is reflective of all the enduring beliefs and values respondents perceive as worth preserving about their organisation (Albert & Whetten, 1985). Specifically, respondents referred to the ethos of the NHS predicated on the NHS founding principles.

Where professional identity is concerned, re-affirmation involves resisting and opposing changes to one's work content. Consider the four RT nurses who had joined the PRS. For instance, the RT nurses choice to wear their nurse uniforms instead of the PRS uniform and maintain their team's name are clear attempts to present their preferred nurse identity as well as convince their new team members to treat them in accordance with this preferred nurse identity. Arguably, this resistance may be viewed, as being only in principle as the performance of work content is an everyday occurrence. Having been subsumed by the PRS team with its innovative multidisciplinary ethos, the RT nurses may inevitably have to alter their work content but without fully accepting the changes these new circumstances impose on who they are as nurses. This is reflective of Beech' (2011) work on identity re-construction where an individual can experience partial or incomplete identity changes where they are caught between an existing and impending identity. Thus, regardless of (Pratt et al., 2006) proposition that

changing work content is indicative of professional identity adaptation, my findings reflect that even in being *'in between'* resistance persists in the sense that the RT nurses beliefs and values about their nurse identity remain unchanged.

While identity tension resolution was being achieved through re-affirmation both illustrations of this identity work process challenge the underlying assumption in the literature that identity tension will inevitably trigger identity transition (Croft et al., 2015; Beech et al. 2012; Beech, 2011). Rather, the findings indicate that re-affirmation allowed respondents to maintain their enduring group memberships by bolstering the effect of the self-enhancement and categorisation processes (Hogg & Terry, 2001; Tajfel & Turner, 1979). NHS identity re-affirmation appears to have a self-enhancement focus where respondents sought to behaviourally and perceptually favour the NHS in-group by vilifying the private sector out-group. Comparably, professional identity re-affirmation also maintains group membership via a categorisation focus. RT nurse respondents not only stress differences between the in-group and out-group, but also the similarities among in-group member's normative behaviours (similar to Nurse 4 distinguishing between the RT nurses and PRS team). In doing so, they make known their desire to distance themselves from the various professionals in the PRS team who had adapted their professional identities to participate in their CE related activities. More so, the RT nurses signal they wanted to be viewed and treated as nurses. This is an important facet in re-affirmation identity work as an identity is only fully formed when acknowledged and validated by others in similar social positions (Pratt et al., 2006; Ibarra, 1999).

These findings align with the identity perspectives on resistance, which suggest resistance is more nuanced than the workers versus management dialectic (Thomas & Davies, 2005). Rather, the findings illustrate that in the face of conditions of modernity represented by precipitating events, respondents consider the multiplicity of meanings that new circumstances hold for who they are and who they may become, which has implications for CEI formation, though this will be discussed subsequently. This nuance is only further complicated where these meanings coexist and have to be considered for both their NHS and professional identities which are closely linked in the NHS-LEMT context. Yet,

this enables the separation of nature, form and emphasis of resistance for each of the social groups the individual belongs to: self-enhancement focus for NHS identity re-affirmation and a categorisation focus in professional identity re-affirmation.

In contrast to the RT nurses, the doctors, other nurses, AHPs and healthcare scientists interviewed and observed as part of the PRS and PJV units appeared to not only successfully resolve their professional identity tension but also achieve identity transition into their new CE related remits indicating that their identity adaptation had been successful. This is not unsurprising for the doctors who are a part of this study, as their ability to adapt their professional identity and transition is well documented in the extant literature (Croft et al. 2015; McGirven et al., 2015). Yet, it gives some insight into the ability of professions such as, AHPs and healthcare scientists that are rarely the subject of studies such as mine, to adapt and re-construct their professional identities. Both AHPs and healthcare scientists appear able to successfully alter their work content. However, from discussions in Section 4.4.2.2 and reported professional descriptions in Section 7.3.3.2, these groups are somewhat exceptional. AHPs for example have a propensity for interdisciplinary working, possibly facilitated by the fluidity of the AHP term which is used to denote thirteen different disciplines in the NHS (Baxter & Brumfitt 2008, Nancarrow, 2004; Booth & Hewison 2002). Similarly, many healthcare scientists have also trained as doctors who we know are able to adapt. This is compounded by the rarefied laboratory environment where healthcare scientists work, which has a commercial efficiency mind-set that is not coloured by frontline contact with patients.

More interesting, are the PRS nurses who transitioned and displayed a willingness to adapt to and contribute to the PRS CE based ethos. These nurses started to identify with the AHP professional group as an aspirational identity based on the high educational attainment levels and research evidence based tenets they perceived were part of the AHP profession. More so, these skills are required to thrive and succeed in the PRS department. This suggests with the right precipitating event as a contextually and socially relevant resource to draw on, nurses can successfully transition and balance both identity demands. More

importantly, the CE related practices of the PRS openly encourages and values this willingness and ability to adapt through practices such as Journal Club, Research Meetings and Implementation Meetings.

Resolution of professional identity tension where identity transition was successful was achieved via sensemaking identity work. Sensemaking identity work appears to have a mitigating effect on the depersonalisation process (Turner et al., 1987). Therefore, unlike those respondents who re-affirmed their prototypical professional identity, some respondents over time drifted further away from the shared social norms and behaviours of their professional groups. The PRS nurses who saw an aspirational self in the AHPs they perceived as more entrepreneurial exemplify this. This suggests that relative to a particular professional in-group, some respondents develop greater individuality as they moved away from their respective group prototype and towards a more unique version of their professional selves. Thus, sensemaking identity work resolves or minimises identity tension in a manner where the professional identity is adapted or a new identity is constructed so group members exhibit increasing levels individuality that can successfully and comfortably accommodate CE related beliefs, values and work content.

Taken together, both re-affirmation and sensemaking identity work contribute to existing work on how individuals manage identity tension (Beech et al. 2012). However sensemaking identity work in particular, brings some clarity to literature on how individuals are then able to move towards new identities as they manage these tensions, which is not always clearly explicated (Croft et al. 2015; McGirven et al., 2015; Beech et al. 2012). Primarily because the sensemaking identity work process was not monolithic. Rather, it was achieved via three sub-processes, noticing and bracketing, labelling and communication. During, noticing and bracketing PRS respondents reported throughout the adaptation of their various professional identities how they deduced what their new work content would be. Undoubtedly the precipitating events (Table 30) that prompted identity tension were indicative of new work content such as management, leadership or research behaviours. However, they reported they had to re-interpret their professional identity in a manner that allowed them to work within the PRS

team. Case informants used new and tacit knowledge gathered from changes circumstance and their existing mental models to select a course of action. In doing so, they were able to compile and organise a new behavioural repertoire to re-build their work content. That is, what they do now as an adapted professional and ultimately who they were now as CE participants.

The labelling process aided the sensemaking identity work process by providing study participants with a set of locally generated terms that cognitively and behaviourally described what they now did and who they were. For instance, respondents across the PJV and PRS units deployed labels that linked themselves with a business, commerce, innovation, new product development or business development. In doing so, they are identifying, routinising and normalising this new CE inclined self. Finally, during observations and interviews where there frequently referenced meetings, study participants both described and acted as who they now were or would like to be and their corresponding new work content. This provided opportunities to have their re-constructed professional identity and ultimately who they were now as CE participants recognised by others as the success of these newly adapted identities are dependent on the validation of others (Pratt et al. 2006; Ibarra 1999) such as those who are also involved in the CE process.

Finally, though helpful in resolving identity tension, identity work can still prove problematic. Consider that re-affirmation identity work maintains the NHS identity so that CE desirability was negatively evaluated and sensemaking identity work that enabled professional identity to adapt and transition so CE desirability and CE feasibility were positively evaluated. The co-existence of this outcomes paradox (CE is undesirable versus CE is both desirable and feasible) within individual organisational members suggests that even when identity work leads to successful resolution it is also indicative of a moment when the very identity work completed because of tension can perpetuate it. This provides a perspective on understanding how contextual situations may remain unresolved such as, an organisational member who thinks CE does not have a place in for the NHS but who simultaneously wants to act as an entrepreneurial professional on behalf of their organisation.

Taken together, these identity work strands provide insight into how social identity as a CEI influencer is maintained or altered. This has implications for my project's overarching CEI formation framework, SEE, which is concerned with factors that facilitate or hinder the emergence of CE activity. Further, the systematic review of the EI formation literature in Chapter 3 reveals limited findings on the notion of CEI formation. I return to this literature and discuss how social identity maintenance or its re-construction may extend theory in the EI literature

Ireland and Webb (2007) noted that entrepreneurship can be akin to a process of identity construction where entrepreneurs launch enterprises based on and motivated by self-identities. This process is exemplified by the sensemaking identity work that facilitated the successful adaption of respondent's professional identities. Two distinct perspectives proposed in numerous studies about who an entrepreneur is are: (1) entrepreneurs have a strong sense of self (Morris, Miyasaki, Watters, & Coombes, 2006; Hemingway, 2005; Hytti, 2005; Verheul, Uhlaner, & Thurik, 2005; Kets de Vries, 1996) and (2) entrepreneurs tend to see themselves as an out-group distinctive from non-entrepreneurs (McGrath & MacMillan, 1992).

As discussed in Chapter 3, the SEE EI formation model is predicated on this out-group status and individuality (Krueger et al., 2000; Shapero & Sokol 1982). However, the SIA employed in this study indicates that in the LEMT context, the emergence of this out-group and individual status is largely thwarted at two junctures. The first instance was discussed in Section 8. 2 where CEI formation is dependent on the precipitating event-social identity interaction to disrupt the normal progression of social identity. The resulting identity tension creates an opportunity for a new CE oriented identity to possibly thrive. However, identity tension represents an ambiguous state, which hinders behaviour, as individuals are unsure about who they are and what they should do. The second instance has been the main subject of this chapter thus far, identity work. Specifically, CEI formation also appears to be dependent on identity work processes, where organisational members may or may not move towards a corporate entrepreneur

identity or become active in contributing towards some CE goal. The remainder of this section will examine the implications of both these identity work strategies in the SEE framework and CEI formation.

First, as explored in Chapter 7, social identity dictates uniformed behaviour as group members try to maintain a positive in-group perception. As such, re-affirmation allows respondents to resume normal activity and keep a particular narrative going for both NHS and professional identities. This effectively mitigates the emergence of individualistic behaviour, which is the underlying premise of SEE. Thus, negative evaluations of CE desirability are maintained from the NHS identity and negative-to-neutral evaluations for CE desirability and CE feasibility by a professional identity.

Second and conversely, sensemaking identity work appears to destabilise professional identity as it attenuates the depersonalisation process that binds an individual to the in-groups' prototype by facilitating the uptake of shared norms, values and collective action. This involves substantive shifts as individuals make sense of their professional identity to fit within an altered set of work circumstances and eventually resume a substitute course of action. However, as reflected in the noticing and bracketing sub-process described in Section 9.4.1, this should not suggest that the new values, beliefs and behaviours were automatically entrepreneurial. Rather, respondents were afforded the opportunity via the bi-directional pull of identity tension to choose to open themselves to these new behaviours, some of which were then labelled as entrepreneurial. Subsequently, it appears a more unique professional identity is able to prompt a re-evaluation of the original negative evaluations of CE desirability and CE feasibility toward entrepreneurial action. Consequently, as the entrepreneurial nature of the embedded units suggests CE desirability and CE feasibility were given positive evaluations.

Though it should be noted that despite these unique professional identity re-constructions now being focal in the social identity hierarchy, the new positive evaluations of CE desirability and CE feasibility elicited do not necessarily replace the original negative evaluations of CE that existed prior to sensemaking

identity work. As discussed in Chapter 3 attitudes are viewed as a dynamic element of human behaviour that maybe subject to change through the accrual of life experience (Ireland et al., 2009). Ajzen (2001) however, states that while there is some scope for malleability, an existing attitude evaluation it elicits can be quite resistant to change. Similar to the prototypical NHS and professional identities proved to be resistant via re-affirmation identity work.

Thus, much like tensions for each social identity may co-exist, so do attitudes. As such the negative evaluation from the NHS identity co-exists with that of any new positive evaluations elicited by the new or adapted professional identity. This is representative of the attitudinal ambivalence research, which addresses the co-existence of multiple conflicting attitudes towards an object or concept such as CE (Ajzen, 2001; Maio, Fincham & Lycett 2000; McGregor, Newby-Clark, Zanna, 1999; Eagly & Chaiken, 1993). Attitudinal ambivalence has been found to be a better predictor of intentions than non-ambivalent attitudes, as ambivalence provokes more systematic information processing (Jonas, Diehl & Bromer, 1997; Bell & Esses 1997; Maio, Bell & Esses, 1996). This raises two points for consideration.

First, attitudinal ambivalence has been found to increase as a function of the number of conflicting attitudes held by the individual (Priester & Petty, 1996). Thus, I propose to extend this to the co-existence of multiple identities (NHS identity, professional identity, adapted professional identity) in the identity hierarchy. Mainly because the multiple social identities in the identity hierarchy may elicit multiple entrepreneurial attitude evaluations. It follows that respondent's ambivalence is further amplified as positive CE evaluations emerge, as professional identity is adapted via sensemaking identity work. Second, ambivalence provides some insight into the type of identity work employed in professional identity re-construction. Specifically, attitudinal ambivalence prompts more systematic information processing. Similarly, sensemaking identity work is a strategy that can facilitate systematic information processing as it acts as a primary site for interpreting and organising to inform work content. Thus, as respondents notice and bracket, label and communicate, they are trying to engage

with evolving circumstances in a complex organisation, systematically process information as it unfolds and consider what they should do next.

9.6 Conclusion

Despite increasing interest in identifying the factors that can influence CE propagation in organisations, the individual level of analysis and entrepreneurial cognitions in CE continues to be under-researched. I have sought to extend and enrich theory in these areas by exploring the ability of individual organisational member's multiple social identities to be maintained or adapted via identity work as a facilitator or barrier to CE activity. I argue that participant's identity work have implications for CEI formation as respondents engaged in a two of identity work mechanisms. While re-affirmation identity work maintained NHS and professional identities, sensemaking identity work facilitated professional identity adaptation. This adapted professional identity enables positive re-evaluations of CE desirability and CE feasibility so sufficiently high CEI are attained. As such I submit the following propositions:

- Identity work may minimise the uniformity of social identity and increase individualistic behaviour to facilitate CEI formation in SEE;
- Some social identities maybe more susceptible to change via identity work which increases the likelihood of CEI formation; and
- The existence of multiple conflicting evaluations of corporate entrepreneurial attitudes (CE desirability and CE feasibility) from multiple social identities increases entrepreneurial attitude ambivalence and the likelihood of corporate entrepreneurial intention formation.

CHAPTER 10: CONCLUSION

10.1 Introduction

Management researchers and practitioners have touted CE as a valuable strategic option for an organisation that is seeking to improve its competitive capability and reposition itself in the marketplace (Ireland et al. 2009; Antoncic & Hisrich, 2001; Zahra & Covin, 1995). As a result the primary focus of CE research has been to create a comprehensive body of knowledge on how CE can be propagated within an organisation. This line of inquiry is evidenced by the copious amounts of studies that investigate the organisational antecedents of CE (Hornsby et al. 2013; Green, Covin, & Slevin, 2008) the organisational outcomes of CE (Monsen & Boss, 2009; Zahra & Covin, 1995) and their relationship. These studies have been consistently conceptualised at the organisational-level of analysis. They traditionally utilise organisational-level variables such as organisational architecture or environmental conditions discussed in the review of CE models in Chapter 2. Consequently, CE propagation appears to be a top-down, induced phenomenon. However, the dominance of the organisational-level/top-down approach has been criticised by scholars for anthropomorphising the organisation (Shepherd & Krueger, 2002). That is, while the organisation can be configured to create conditions that encourage and engender CE it is not the organisation that acts entrepreneurially per se. Rather, CE can only be propagated if the organisational members recognise their organisation's need for renewal and choose to instigate that renewal. Top-down approaches have focused on investigating the role of top-level managers who induce CE through organisational-level factors such as structure and strategy. However, this still overlooks the critical observation made by Burgelman (1983) in his seminal work that CE activity can also emerge due to the autonomous strategic efforts of *any* organisational member and not just those with managerial remits.

Taking the above into account, I submit that in its current state the extant CE literature does not comprehensively address how entrepreneurial activities can be propagated within an organisation. Therefore, I have chosen to position my research within a budding movement in the CE field that calls for an in-depth

exploration of bottom-up approaches to CE that places *all* organisational members at the heart of the CE process (Corbett et al., 2013; Wales et al., 2011; Monsen et al., 2009).

This final chapter consists of four sections. Section 10.2 draws together the main findings presented and discussed in Chapters 7, 8 and 9 and the contributions this thesis makes to CE knowledge (Section 10.1.1), CEI formation theory (Section 10.1.2) and identity (Section 10.1.3). Section 10.3 focuses on stakeholder implications. Section 10.4 discusses my study's limitations and maps directions for future research. Finally, Section 10.5 concludes this thesis.

10.2 Key Contributions to Knowledge

My study contributes to the under-researched individual level of analysis in the CE domain by exploring how and why individual organisational members arrive at decisions to act entrepreneurially on behalf of their organisation. To conceptually and empirically explore the corporate entrepreneurial choice of individual organisational members I blended the CE literature with the relatively mature EI literature using the EI formation model, SEE. In doing so, I have extracted various LEMT organisational contextual factors that can potentially influence organisational members' CE decision-making. One contextual factor: identity was taken forward for further investigation into its role in organisational members entrepreneurial choice. The contributions my research process has allowed me to make to these domains are presented next in Sections 10.2.1-3.

10.2.1 Contributions to Corporate Entrepreneurship

Overall my findings corroborate the general consensus among scholars that CE phenomena are difficult to propagate (Morris et al., 2011; Burgers et al., 2009; Hill & Birkinshaw, 2005; Burgelman & Valikangas, 2005; Dess et al., 2003). The historical maturation of the NHS and the control it exerts over LEMT has produced a variety of top-down/induced contextual factors that play a role in hindering CE is propagation in in this organisational context. From my findings,

these factors include external environmental conditions, organisational size and structure and strategic vision.

From the top-down/induced perspective that dominates the CE literature, external environmental conditions can prompt an organisation to adopt CE as a strategic option. As discussed in Chapters 5 and 7, the Equity and Excellence policy (DH, 2010) developed by the Coalition government seeks to implement yet another wave of reorganisations of the NHS and its Trusts like LEMT (mandatory adoption of Foundation Trust (FT) status, for example). This is an effort to combat environmental hostility by making the NHS a more cost-effective and competitive social enterprise sector. In response to this policy the LEMT executive team was induced to develop a strategic vision that favoured CE to direct the Trust. However, my research findings demonstrate that regardless of these pro-CE conditions, CE activity was still rare across LEMT. This suggests two things. First, top-level manager's recognition of the need for CE adoption may not be sufficient to propagate CE. Second, for individual organisational members who were not at the executive level, hostile external environmental conditions, a strategic vision favourable to CE and impending FT status do not necessarily trigger CE related responses as proposed by some CE models (Antoncic & Hisrich, 2001; Covin & Slevin, 1991; Guth & Ginsberg, 1990).

This finding challenges the inherent determinism in the majority of the CE literature and CE models that if the organisation is reconfigured to reap the improved organisational performance benefits of CE, its members will automatically begin acting entrepreneurially (Antoncic & Hisrich, 2001; Covin & Miles, 1999; Dess et al., 1999; Guth & Ginburg, 1990). Instead, based on the findings yielded from my bottom-up re-examination, I contend that CE propagation is also difficult due to a failure to fully understand the 'individual in CE'. This answers the significant call for more research to explore CE from the bottom-up (Corbett et al., 2013; Wales et al., 2013; Monsen, 2005). As such, my study contributes a conceptualisation of how and even why individual organisational members may or may not be moved from CE inaction to CE action.

I achieve this understanding of the 'individual in CE' by triangulating the emergent individual level social identity construct with the qualitative exploration of organisational members entrepreneurial attitudes (CE desirability and CE feasibility) and subsequent CEI formation. In doing so, I explore CE in terms of individual organisational members cognition as being shaped by their social identity to better understand their choices to act entrepreneurially or not. This offers a valuable perspective on CE propagation as Krueger (2007) states an understanding of individual cognition is largely lacking in CE research. As such, my approach redresses the limited in-roads entrepreneurial cognitions have made into CE research (Hoskisson et al., 2011; Sheppard & Krueger, 2002) through empirical exploration within the parameters of Ireland et al.'s (2009) Model of CE Strategy (which has governed this study). In doing so, I make a two-fold contribution to the CE domain.

First, I extend Ireland et al.'s (2009) model by theorising a more evolutionary view of how pro-CE cognitions come to exist. This challenges the predisposition of contemporary CE models and CE-performance studies to effectively view CE as binary: either being present or absent, present in its entirety or not at all. This is particularly relevant to the LEMT case where respondents characterised CE activity as 'patchy'. This characterisation is congruent with Wales et al., (2011) who reject the assumption that CE is vertically (hierarchically), horizontally (across business units) and temporally (time-wise) homogenous throughout the organisation. Thus, by understanding organisational members journey from anti-CE cognitions to pro-CE cognitions, I contribute a richer, progressive, grey-scale, interpretation of CE by understanding how organisational members form CEI and choose to act.

As such, where Ireland et al.'s (2009) model starts with generic pro-CE attitudes, I have integrated a specific view of entrepreneurial attitudes via CE desirability and CE feasibility. Both of which are components of the entrepreneurial cognition CEI, the best predictor of CE behaviour (Fini, et al., 2010; Krueger et al. 2000; Krueger, 1993). This casts individual organisational members choice to participate in CE as an internally generated evaluative process where they can assess top-down inducements and determine how these factors negatively or

positively influence their decision to act entrepreneurially on behalf of their organisation. However as my findings indicate, within the LEMT context organisational members did not have pro-CE cognitions. Rather, they were overtly anti-CE reflected in their negative perceptions of CE desirability and CE feasibility, which is indicative of my second contribution below.

I extend Ireland et al.'s (2009) model by paying greater attention to the organisation's cognitive infrastructure, which is reflective of individual organisational members deeply held beliefs and values that precede entrepreneurial attitudes, (Figure 3) (Kuratko et al., 2005; Sheppard & Krueger, 2002; Volberda et al., 2001; Brazeal & Herbert, 1999; Hornsby et al., 1993). To achieve this I focus on where organisational members acquire their beliefs and values. Specifically, I concentrate on the emergent manifestation of deep beliefs and values represented by organisational members multiple social identities. Despite positing identity's significance in propagating CE, Krueger (2007; 2000) observes when identity related constructs have been studied in entrepreneurs it has only occurred at a cursory level. Further, this approach has been dominated by the use of role identity as a representation of the beliefs and values that govern how an individual socially constructs his or her self as an entrepreneur by organising information and knowledge content from certain situations as entrepreneurial (Murnieks et al., 2012; Hoang & Gimeno, 2010; Krueger, 2007). My study however, diverges from this trend as the findings reveal the dominant cognitive infrastructure in LEMT is determined by social identity (the prescriptive and proscriptive beliefs and values that govern organisational members behaviour as members of a social group). Though, social identity perspectives have been considered in CE, Wales et al., (2011) acknowledge that its application only benefits the dominant top-down paradigm in CE by studying groups of managers at various levels in the organisational hierarchy. This only continues to neglect the bottom-up perspective where CE is dependent on the autonomous entrepreneurial activity of all organisational members at all levels (Wales et al., 2011; Ireland et al., 2009; Hornsby et al., 1993).

Instead, by integrating social identity as a dominant cognitive structure I bring a fine-grained approach to Ireland et al.'s (2009) CE model by enhancing the

model's multiple levels of analysis structure (see Appendix 11). Social identity disaggregates further levels within the organisational members level of analysis. It reveals the complexity of organisational members via the multiple social groups they belong to while traversing managerial hierarchy. For instance, in the LEMT context, organisational members have two social identities: (1) NHS identity, governed by the NHS founding principles and (2) professional identity, governed by work content. The deeply held governing beliefs and values of these multiple social identities did not favour CE behaviours as maintaining a positive in-group status by avoiding CE behaviours was paramount. As such, a social identity perspective is potentially more useful for both revealing where and why CE-averse cognitive structures persist in an organisation than the literature's current reliance role identity.

Furthermore, by using social identity as a deep cognitive infrastructure I provide a starting point for my evolutionary view pro-CE cognition emergence. The extant research focuses on how individuals move from novice to expert entrepreneur (Krueger, 2007; Peterman & Kennedy, 2003; Gaglio & Katz, 2001). Yet, within the LEMT case a social identity perspective suggests organisational members start out as non-entrepreneurs (reflected in their negative evaluations of CE desirability and CE feasibility). As such, my study takes a further step back to understand how organisational members move from non-entrepreneur to novice entrepreneur. Thus, my evolutionary view of pro-CE cognitions explores the emergence of novice corporate entrepreneurs through significant changes in their deep cognitive structures. Specifically, I look the changes in organisational members social identity, punctuated by critical developmental experiences such as precipitating events. In doing so, I contribute to existing work that views entrepreneurship as a process of identity construction. Though this line of enquiry is nascent, it is primarily focused on individual entrepreneurship where entrepreneurs launch enterprises based on and motivated by role identities (Farmer et al., 2011; Hoang & Gimeno, 2010; Ireland & Webb, 2007; Krueger, 2007). I extend this view to CE and propose the emergence of pro-CE beliefs, values and attitudes that facilitate an individual's choice to act entrepreneurially on behalf of the organisation is also dependent on the identity construction process, identity work.

My findings identify two identity work processes that were employed by respondents after a precipitating event: (1) re-affirmation and (2) sensemaking. Ultimately, these identity work mechanisms played a role in the SEE framework and CEI formation process. Re-affirmation identity work did not bring about the necessary change in social identity as it manifested as a form of resistance where case informants maintained their existing NHS and professional identities after a precipitating event. This contributes a bottom-up perspective on why CE is difficult to propagate as organisational members may actively resist changes to the beliefs and values that constitute their multiple social identities. Conversely, sensemaking identity work allowed respondents alter their beliefs and values through the adaption their professional identity. This provided an opportunity to escape the behavioural homogeneity dictated by their professional identity and the opportunity to incorporate new pro-CE beliefs, values and behaviours. This facilitates the emergence of the out-group status required to break free of the in-group and participate in CE (Krueger et al., 2000; McGrath & MacMillan, 1992). Sensemaking identity work was achieved via three sub-processes: (1) noticing and bracketing (2) labelling and (3) communication. These sub-processes enabled organisational members to regain a consistent sense of self and organise their altered circumstances after a precipitating event and choose a new course of action that favoured CE. In turn, respondents evaluated CE desirability and CE feasibility positively so CEI were formed. The contributions made by exploring this of this process of becoming (or not becoming) a corporate entrepreneur will be presented in Section 10.1.3 below.

10.2.2 Contributions to CEI Formation

In regard to the CEI formation remit, the application of the SEE framework in the organisational context contributes to an on-going debate in the wider entrepreneurship field. This debate considers whether entrepreneurial cognitions are an innate ability of entrepreneurs or whether entrepreneurial cognitions are engaged because of the context or the demands of an entrepreneurial role (Hoskinsson et al., 2011; Corbett & Hmieleski, 2007; Baron, 2004; Gaglio & Katz, 2001; Busenitz & Barney, 1997). My findings support the former proposing

that for persons acting as corporate entrepreneurs or participating in some CE activity, the formation or non-formation of their CEI is largely dependent on the organisational context in which they operate. For instance, organisational member's NHS and professional identities, which were barriers to CEI formation, are inextricably linked the LEMT context.

The influencing effect of social identity on CEI formation signals to a second contribution to the EI literature, where the application of EI formation theory to the organisational context has remained largely conceptual (Sheppard & Krueger, 2002; Krueger, 2000; Krueger & Brazeal, 1994). This thesis offers theoretical and empirical insights that enrich conceptualisations of the conditions under which organisational members form CEI. Krueger (1993) proposes that in the SEE framework an individual's positive perceptions of the entrepreneurial attitudes, desirability and feasibility must be above a certain threshold to interact with a precipitating event so EI are formed. However, as social identity prompts negative evaluations of organisational members perceptions of CE desirability and CE feasibility, the pre-existing positive entrepreneurial attitude pre-requisite does not exist. This suggests researchers must consider that in the organisation, contextual factors may exist that influence organisational members perceptions of CE desirability and CE feasibility so they are well below the necessary threshold required by SEE. Consequently, when some precipitating event occurs no CEI are formed.

This leads to my third contribution to CEI formation, a modification of where precipitating events operate in the SEE framework when applied to the organisational context. My findings indicate that in the organisational context the precipitating event-individual characteristics interaction proposed by Hornsby et al. (1993) may have more utility for prompting CEI formation than the precipitating event-positive entrepreneurial attitudes interaction proposed by SEE. This social identity-precipitating event interaction extends Greenberger & Sexton's (1988) work, in Hornsby et al.'s CE model. Greenberger & Sexton (1988) state the salience of precipitating events is critical to changing an individual from a non-initiator to venture initiator. I propose that the displacement

effect of a precipitating event is the result of the relative importance of that event to a particular social identity.

Finally, the identity work processes active in identity construction suggests group identity can be dynamic, requiring active involvement from the individual. This greatly separates social identity from the list of personal and situational EI influencing factors compiled from the 36 papers reviewed in Chapter 3 such as, education (Peterman & Kennedy, 2003) and family experience (Carr & Sequira, 2007). Specifically because, scholars have primarily represented influencing factors as static snap shots. Kautonen et al.'s (2010) study however, is exceptional in that it attempts to address a gap in the EI literature by viewing work history as a dynamic socialisation process influencing EI over time. Similarly, my findings contribute to existing knowledge on work as an influencer of CEI formation using identity perspectives. I also present a more dynamic and evolutionary view of work experience by mapping how CEI formation relates to identity transitions from a prototypical professional identity to a reconstructed CE active identity via identity tension and identity work.

10.2.3 Contributions to Identity

While this study primarily set out to make the contributions to bottom-up approaches to CE, the emergence of identity and its related theories and concepts as an influencer of CEI formation has allowed me to make important contributions to the identity literature as well.

My findings corroborate the extant research suggesting that identity tension manifests as the pressure exerted on individuals when identity demands pull them in two or more directions (McGirven et al., 2015; Beech, Gilmore, Cochrane & Greig, 2012; Beech, 2011; Ellis & Ybema, 2010). In this case it was the bi-directional pressure organisational members experienced from the demands of their existing identity (NHS or professional) and the new circumstances created by precipitating events. These new circumstances usually require organisational members to adopt some new set of beliefs, values and behaviours that differed from those originally held by their social group, such as CE. In this case, CE

related beliefs, values and behaviours differ quite markedly from those of the NHS and professional identities held by many of the individuals in this study.

I extend perspective on identity tension through the use of multiple social identities, which are salient and central within a particular context. First, the manifestation of identity tension for each identity may be different and of varying degrees of complexity; inauthenticity in the NHS identity and inauthenticity, reduced credibility and reduced self-efficacy for professional identity. Thus, identity tension can be multi-layered and amplified where an individual's multiple social identities are concerned. More interestingly, is the scenario in my findings where the outcomes of the identity work performed in multiple social identities are contradictory: (NHS identity is unchanged so CEI are formed, professional identity is adapted to CEI are formed). As such, I contribute a multiple social identity perspective on Beech et al.'s (2012) self-perpetuating tension-identity-work cycle, where tension persists when the identity work performed creates more tension. In this case the tension between being an anti-CE NHS organisational member versus being an entrepreneurial professional with in the NHS. This split has positive implications for the CEI formation and CE propagation as it creates and perpetuates attitudinal ambivalence towards CE where individuals are in a state of flux here cognitive load is increased and systematic information processing is proceeding which increases the potential for a CE course of action to be selected.

Identity work can be heightened in response to identity tensions (Beech, 2011; Ellis & Ybema, 2010). I, however, challenge the implicit assumption that because individuals seek a secure sense of self by reducing or eliminating identity tension, that identity tension is an inherently negative state. Generally, the emotional arousal and cognitive load of managing identity tension characterised, in this case, by inauthenticity, reduced credibility and reduced self-efficacy, can be viewed as quite detrimental to self-concept (Costas & Fleming, 2009; Pratt, 2000; Baumeister, 1999). Yet, it is only in this disrupted and transitional state where the individual is seeking to regain their sense of self that they are consciously considering 'who I am' and 'what I do' as well as 'who could/should I be' and 'what could/should I do,' that the propagation of CE activity is able to make any

in roads. I propose identity tension creates a fissure in an individual's identity, which represents a valuable opportunity for the adaptation of an existing identity to start becoming a corporate entrepreneur or participating in CE. Thus, my findings suggest identity tension can be viewed as a positive outcome. This indicates a more binary conceptualisation of identity tension may be more valuable when the self is challenged to adapt and evolve. Such a proposition seems natural when one considers that identity tension represents part of Beech's (2011) work on transitional states such as liminality, which have been categorised as positive, negative (Croft et al., 2015), or perverse (Fischer, 2012). Further, this notion of positive identity tension, as a form of identity tension, aligns with Beech et al. (2012) who have started to compile a typology of identity tensions that can trigger identity work.

This positive perspective on tension, however, appears to be contingently dependent on the individual's evaluation of the resources they are drawing on that create multiple identity demands. Specifically, within this study one can consider the nature of identity tension inciting precipitating events, which represent a multitude of contextually and socially relevant resources that can influence identity tension. For instance, individuals can and will draw on or may exhibit an affinity to preferred resources such as, significant relationships and social interactions in the LEMT case when considering multiple identity demands. Thus, moving into a leadership role prompts the individual to start to view and question him or herself as 'other' such as, 'do I want to be a leader?,' 'what does it mean to be leader?' or 'what do leaders do?' This perspective gives further credence and wider applicability of Watson's (2009) findings that identity work (in this case triggered by identity tension) is not just dependent on notions of policy-instituted enterprise culture to define who a person is and what they do but also contextually-pertinent resources. Similarly, Doolin (2000) found that the success of policies that promote enterprise culture is not inevitable; rather it is predicated on individual action.

Further, my study has extended the application of identity work in CE by not only focusing on the nature of identity tension that can exist for the NHS and professional identities but also by inquiring into and illustrating the processes of

responsive identity work prompted by this identity tension. First, my finding that organisational members use re-affirmation identity work to resist change challenges the underlying assumption in the literature that identity tension will inevitably trigger identity transition (Croft et al., 2015; Beech et al. 2012; Beech, 2011). Via re-affirmation identity work all respondents did not appear to adapt their NHS identity in favour of some corporate entrepreneurial reconstruction. Similarly, a few respondents, **4** nurses, chose to resolve their professional identity tension via re-affirmation identity work. The latter corroborates findings by, Croft et al. (2015), Noordegraaf & Van Der Meulen (2008) and Jarl, Fredriksson & Persson (2012) that nurses can remain committed to their professional identity and do not construct a new professional cadre as they moved into management.

Re-affirmation identity work seems to align with Thomas & Davies (2005) re-conceptualisation of resistance at the level of identity. This proposes a multidirectional view where individuals seek to maintain a consistent sense of self amidst conditions of modernity via identity work. I also bring a multidirectional view of resistance that is born of the bi-directional pressure of identity tension where organisational members consider a contest of meanings and subjectivities regarding who they are and who they may become that in turn influence CEI formation and ultimately participating in CE. However, I propose this multidirectional view can be extended to the meanings and subjectivities that are generated for *each* of the multiple social identities that organisational members are managing in their identity hierarchy specifically, their NHS and professional identities (Thomas & Davies (2005) only consider the professional identity of public sector managers).

This offers a more nuanced perspective on resistance and the motivations of individuals to resist. It allows for the disaggregation of the nature and form of resistance produced within a specific organisational context and the recognition that resistance may have different emphases for each social group an individual belongs to. Consider NHS identity re-affirmation identity work, which had a self-enhancement focus. Respondents remained committed to their NHS social group by adhering to the NHS founding principles, a sense of altruism and rejecting the incongruity of NPM reforms. Whereas professional identity re-affirmation

identity work had a categorisation focus, respondents strengthened and re-iterated their preferred professional identity (in this case an idealised nurse archetype) while convincing others to treat them in accordance with this preferred and valued professional identity. This supports Thomas & Davies (2005) call for a shift from a meta-theory of resistance to a more generative theorisation that avoids overly deterministic perspectives.

Where re-affirmation was found to resolve professional identity tension of the 4 Respiratory Team nurses in the Pulmonary Rehabilitation Service (PRS), all other respondents in PRS and the (Pathology Joint Venture) PJV embedded units utilised a second strand of identity work in response to identity tension in their professional identity: sensemaking. Based on my findings sensemaking appears to function as a valuable identity work tool that allows organisational members to re-form their professional identity so that it may incorporate new CE behaviours, beliefs and values with who the individual believes themselves to be, the organisational context (the NHS) and others (other professional groups). This indicates that in keeping with the extant literature, doctors appeared to successfully adapt their identities and achieve identity transition (Croft et al, 2015). Members of understudied professional groups such as, AHPs and healthcare scientists were also able to successfully do the same, which may have been aided by their education, training and workplace. Finally, four PRS nurses were able to adapt their nurse identities and transition. My findings align with Croft et al., (2015) who argue this transition can reduce the influence of the PRS nurses amongst the professional group as they were no longer seen by their clinical peers as 'proper' nurses, which could in in turn have wider organisational implications. However, I submit that Croft et al.'s, (2015) findings do not account for the PRS nurses growing influence within their local context that promotes, instigates and values these adapted nurse identities that show a clear willingness to participate and contribute to the CE based ethos of the PRS.

The emergence of sensemaking identity work brings some clarity to not only work on how individuals are able to manage potential identity tension but also how they move towards new identities which is often under explicated in the literature (Croft et al., 2015). My findings bring some clarity through the

incremental sub processes of sensemaking that emerged: noticing and bracketing, labelling and communication. Noticing and bracketing allowed study participants to delineate new behaviours, beliefs and values from the old to rebuild their work content. Labelling in turn reduced the dissonance of new circumstances by creating new meanings for new behaviours locally. Taken together, noticing & bracketing and labelling facilitated professional identity reconstruction by aiding study participants in interpreting events in a manner that that called for a new behavioural repertoire that did not fit with established, normal patterns of behaviours. In turn, this enabled them to break existing behavioural patterns and the associated meanings of their professional status quo. Communication aided professional identity reconstruction as it involved building and gaining credibility with others. This effort goes to not only getting others to accept but also allowing the individual to validate this newly reconstructed professional identity.

Overall, this application of sensemaking identity work in CE provides insight in to the call for further understanding of processes of identity adaptation where career transitions in organisational context are concerned (Croft et al, 2015; McGirven et al. 2014; Pratt et al., 2006). Through sensemaking identity work organisational members seem to experience an escalating commitment to some new corporate entrepreneurial identity through systematically processing and organising events to construct a plausible account of how and why they adapted cognitively and behaviourally to participate in CE.

10.3 Implications for Stakeholders

The findings in this study are relevant to policymakers and managers in several ways. First, UK governments via DH policies have a long established tradition of reorganising the hardware component of the NHS's organisational architecture as a strategic option for inducing NHS Trusts like LEMT to conduct service provision in particular manner. The rhetoric of the current Coalition government in Equity and Excellence (DH, 2010) depicts the transformation of the NHS into the largest social enterprise sector in the world. This has been publicised in national level discourse as a necessary movement away from the inefficiencies of bureaucracy to ensure the NHS's survival. The DH has continued to introduce

systems reminiscent of NPM with more entrepreneurial governance that promotes decentralised decision-making, competition through the amendment of the Health & Social Care Act (2012), generating alternative revenue streams and cost effectiveness. Significantly, my findings demonstrate that these top-down structural and strategic manipulations may all be for naught. Primarily because, the effect of these top-down inducements are largely restricted to the executive management level and do not wholly pervade the organisation.

Instead, my thesis demonstrates that for the entrepreneurial imperative to succeed the entirety of the *people* component within the NHS organisational architecture must be considered for two reasons. First, my findings indicate that CE activity in LEMT is born of the grassroots efforts of organisational members on the frontline. Second, DH policies such as Equity and Excellence (DH, 2010) that favour a more commercial mind-set are perceived as incongruent to the NHS founding principles. This goes the core of organisational members NHS identity, which my findings indicate will invariably direct them to actively resist such policies. Therefore, any chance of these policies truly transforming the organisation is thwarted. This demands that DH policy makers develop complimentary bottom-up strategies, which present the entrepreneurial imperative in a balanced manner that meets the NHS's financial needs without alienating its organisational members who are wholly committed to protecting its social mission. One possible strategy would be to appeal to its member's professional identities. My findings indicate that while professional identity can be resistant, in certain circumstances (after a precipitating event), it can also be amenable to accommodating a commercial mindset more so than organisational members NHS identity.

Arguably, the people component of organisational architecture falls more naturally within the remit of the actual Trusts in the NHS system like LEMT. As such, the development of these bottom-up CE strategies should be a priority of LEMT's top-management team. My findings provide some guidelines for or issues that organisations seeking to develop bottom-up strategies should consider. First, my thesis conceptualises CE propagation as an evaluative decision-making process that is influenced by context for organisational members. This

automatically de-mystifies the entrepreneurial myth that entrepreneurial individuals are 'special,' have special entrepreneurial cognitions or can only be found in management positions. In turn, this exponentially expands the pool of potential corporate entrepreneurs in the organisation from a select few to all organisational members. Second, since corporate entrepreneurs can be found anywhere in the organisation, the responsibility of locating and nurturing these individuals should be divested to all managers and unit leaders throughout the organisation. Especially as, the CE activities observed in LEMT are grassroots frontline efforts that may not attract the attention of top-management who are balancing the entrepreneurial imperative with everyday business operations.

Third, the above re-iterates the importance of fully understanding what factors influence organisational members CEI formation process to best establish a pro-CE cognitive infrastructure. My findings indicate that organisational members are complex and multi-faceted individuals whose behaviour is governed by their various deeply held beliefs and values. This is reflected in the NHS and professional identities found in the data. The prototypical state of these multiple social identities make it difficult to get people in a large organisation like LEMT to think entrepreneurially. This is because organisational members have already self-selected themselves out of the role of a corporate entrepreneur as their NHS and professional identities negatively influence their perceptions of CE desirability and CE feasibility. However, my detailed individual level approach indicates that CE propagation strategies or policies should be directed at organisational members professional identity. Mainly because the precipitating events that provide the impetus for them to act entrepreneurially seem to have the greatest potency for disrupting professional identity. Furthermore, the salience of these professional identity-precipitating event interactions provides management with key points at which they can strategically intervene and nurture the emergence of CEI. For example, when an organisational member adopts a new role.

Last, the occurrence of precipitating events again re-emphasises the importance of all managers and leaders at all levels in the organisation playing a role in locating and nurturing organisational members. Chiefly because, these managers or unit

leaders are closest to organisational members after a precipitating event. Thus, they are in a position to capitalise on changing circumstances and guide the organisational members in their charge towards a mindset that favours CE with appropriate interventions. For instance, if a doctor adopts a managerial role he or she can be directed to business and commercialisation education and training opportunities to (1) pre-emptively to minimise feelings of inauthenticity and reduced self-efficacy and credibility that accompanies changing circumstances and (2) increase their openness to a commercial principles. In having some skills to rely on, organisational members identity tension may not be quite so daunting. Additionally, they have a commercially related mental model that can potentially lead to more individuals engaging in sensemaking identity work that can favour CEI formation.

10.4 Study Limitations & Avenues for Future Research

While this research has been valuable in systematically developing propositions that can be taken forward in the literature and contributions to knowledge surrounding the 'individual in CE,' CEI formation and social identity, four main limitations merit discussion. The findings and contributions presented so far are tempered by these limitations and are discussed here along with specific suggestions and avenues for future research.

As addressed in Chapter 6, I have used a qualitative methodology in this study. As is typically the case with this type of methodology, my sample is a limited one. Limited samples present a unique challenge to attempts to build and elaborate theory. Primarily because, the researcher must be careful in considering the transferability of their findings to other organisations. This is particularly relevant as my study is based in a NHS organisation and not the commercial context that dominates the CE tradition. Nevertheless, the bureaucracy and structure-context issues witnessed in this study do bear broader relevance, as do ideas of the self and social identity. Theoretically then, there is no reason to believe that the findings contained in this study may be fruitful for understanding the broader landscape of individuals in CE. Moreover, LEMT is but a single acute service provision organisation in the NHS, which has hospitals that are likely to

have matured differently to LEMT and thus have different organisational contextual factors that could influence CEI formation. For instance, in a smaller hospital with a less complicated structure that has competitors in their local health economy, it may be easier to institute CE strategies from the top-down. Still, it is perhaps worth considering that the case of LEMT-NHS as an 'extreme' one where legacies, structural complexity, context and the existence of multiple social identities within individual actors exists in ways perhaps far beyond other organisations. This makes it a valuable area in which to study such issues and understand new themes of relevance to CE more broadly. The study could be augmented by cross case analysis techniques where additional acute provider cases as well as primary care provision units are explored.

Even as a public sector organisation, the NHS is still different to other public sector organisations due to the esoteric and specialised knowledge of its employees. Further, although as a qualitative study my research lacks statistical generalisability, this does not exclude 'naturalistic generalisation' whereby the researcher recognises similarities based on experiences with similar studies without any statistical inference (Stake, 1995). For example, healthcare based professions are well documented in the identity (Goodrick & Raey, 2010; Pratt et al., 2006) and sociology of professions literatures (Abbott, 1988). As such, it is possible to draw parallels with these studies that also look at a profession's resistance to change or re-construction. However, as covered in Chapter 6, my study seeks analytical generalisability by extending theories rather than detailing frequency (Yin, 2009).

Furthermore, because this study sought to understand how CE emerged in LEMT, it followed that I had to seek out parts of the organisation and individuals who were described as entrepreneurial. Thus, the interview protocols developed for data collection required me to introduce the actual term entrepreneurship and CE, unlike the social identity related questions, which were more indirect. This may have introduced some form of bias as respondents may 'play' to the entrepreneurial label. Thus, researchers repeating this study in additional NHS Trust cases will need to adhere to the methodology set out in Chapter 6 and use multiple sources of supporting data to ensure additional credibility (Lincoln &

Guba, 1985). Researchers could also consider improving credibility via a more extended or immersive engagement in the field using a longitudinal or ethnographic approach.

The inductive nature of this research has yielded a considerable and voluminous data set. Though, as a single researcher I could only pursue a limited amount of the emergent concepts and theories. As such, there are several avenues available for pursuit by researchers. For instance, there is a growing body of work on socially situated cognition in entrepreneurship where researchers highlight the role of language and communication in this agenda (Clarke & Cornelissen, 2010). This body of work claims it is crucial to understand and recognise language's formative role in conceptualising opportunities and influencing stakeholders about the feasibility of a venture. The emergence of language and communication from the data signals to the dynamic and active interrelation between language and thought, known as sensemaking, which was also emerged from the data as a form of identity work. I expect a more diligent exploration of language's disorganising effect in the LEMT context and its subsequent use in communication to organise changing circumstances is a fruitful avenue for CE research. Researchers can explore how these devices influence the cognitions of both novice corporate entrepreneurs and others, including, top-management and corporate venturing partners. This could provide insight into how corporate entrepreneurs acquire resources, management support for or align their autonomous CE initiatives to the organisation's current strategic portfolio. All of which are considered to be key barriers to CE propagation in large mature organisations (Morris et al., 2011; Burgers et al., 2009; Hill & Birkinshaw, 2005; Burgelman & Valikangas, 2005; Dess et al. 2003).

Answering the question of how CE is propagated in the LEMT context has required me to adopt methodological approaches that are not commonly used in CE research. That is, while I appreciate the value of surveying top management as a valid source of understanding CE propagation, other methods like those used in this study that use organisational members at all levels, may provide new insights into CE propagation (Lumpkin et al., 2009; Lumpkin & Dess, 2001; Covin & Slevin, 1990). Stratifying organisational members by their multiple social

identities has successfully transcended the dominant top-management approach to include all organisational members via their NHS and professional identities. However, professional identity was largely conceptualised as a homogenous construct, even though 5 different professional groups participated in the study. As such, more fine-grained approaches to the emergence of the corporate entrepreneurial identity from the perspective of each profession may prove more beneficial. This might help to identify the pockets in the organisation's cognitive infrastructure that typically resist or manifest CE behaviours. Especially in light of the resistance to behavioural change observed in some of the nurse participants versus healthcare scientists or AHPs who seemed more amendable to change.

10.5 Conclusion

Research in CE has begun to move beyond descriptive studies and antecedent-outcome relationships toward deeper and richer studies into 'how' CE is propagated or enacted, utilising strong theoretical bases to explain findings. This line of inquiry is especially useful for advancing the field as CE scholars generally conclude that CE phenomena are difficult to propagate. I contend that these difficulties are a direct function of the failure to understand the 'individual in CE.' As such, my study adopts an exploratory view to pry open the 'CE black box' and offer a deeper appreciation of these difficulties from the perspective of individual organisational members. This thesis adds to this growing body of literature by understanding how individual organisational members chose to act entrepreneurially in their organisational context via their CEI formation process. This has led to a number of propositions about CEI formation and the contextual factors that may hinder or facilitate the process. This presents an opportunity for an in-depth appreciation of the complex nature of corporate entrepreneurial choice. I believe that I have highlighted a vital gap in the literature and through the qualitative methodology provided some insights that will encourage other CE researchers to use various perspectives to advance the 'individual in CE' research agenda. I firmly believe this will lead to an important series of insights that have the potential to inform the body of knowledge on CE and guide managers in better understanding the 'individual in CE.'

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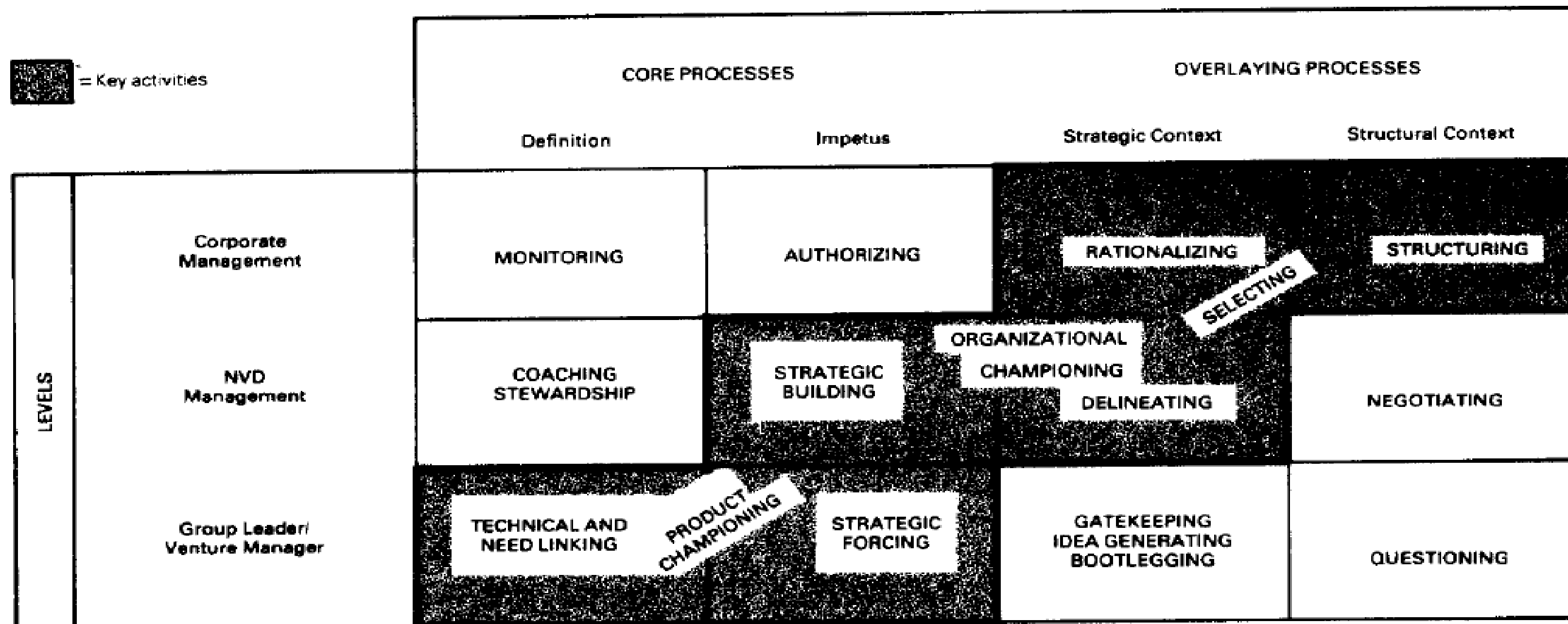
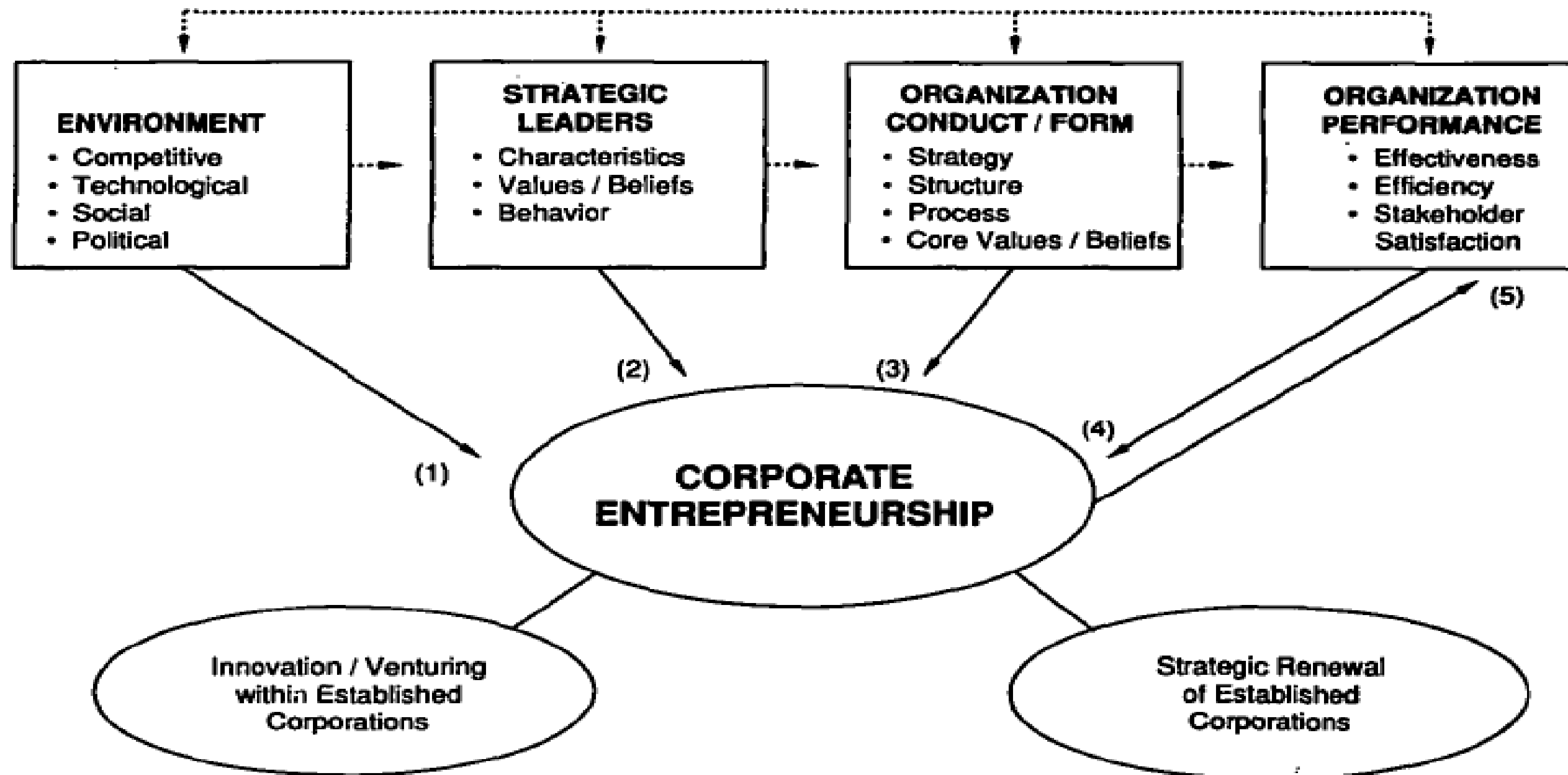
APPENDICES

Appendix 1: A Process Model of Internal Corporate Venturing



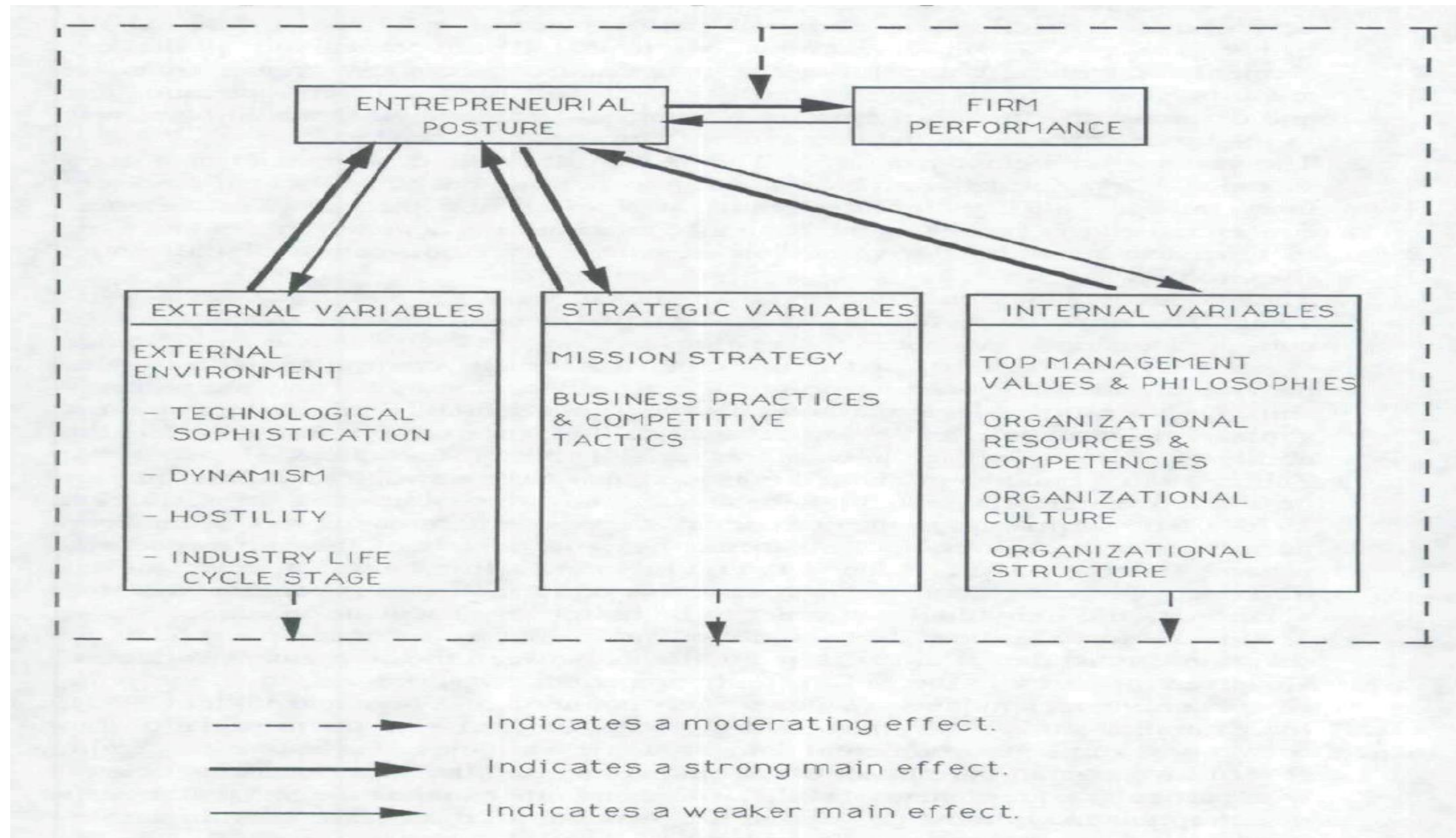
A Process Model of Internal Corporate Venturing in a Major Diversified Firm (Burgelman, 1983)

Appendix 2: Fitting Corporate Entrepreneurship into Strategic Management



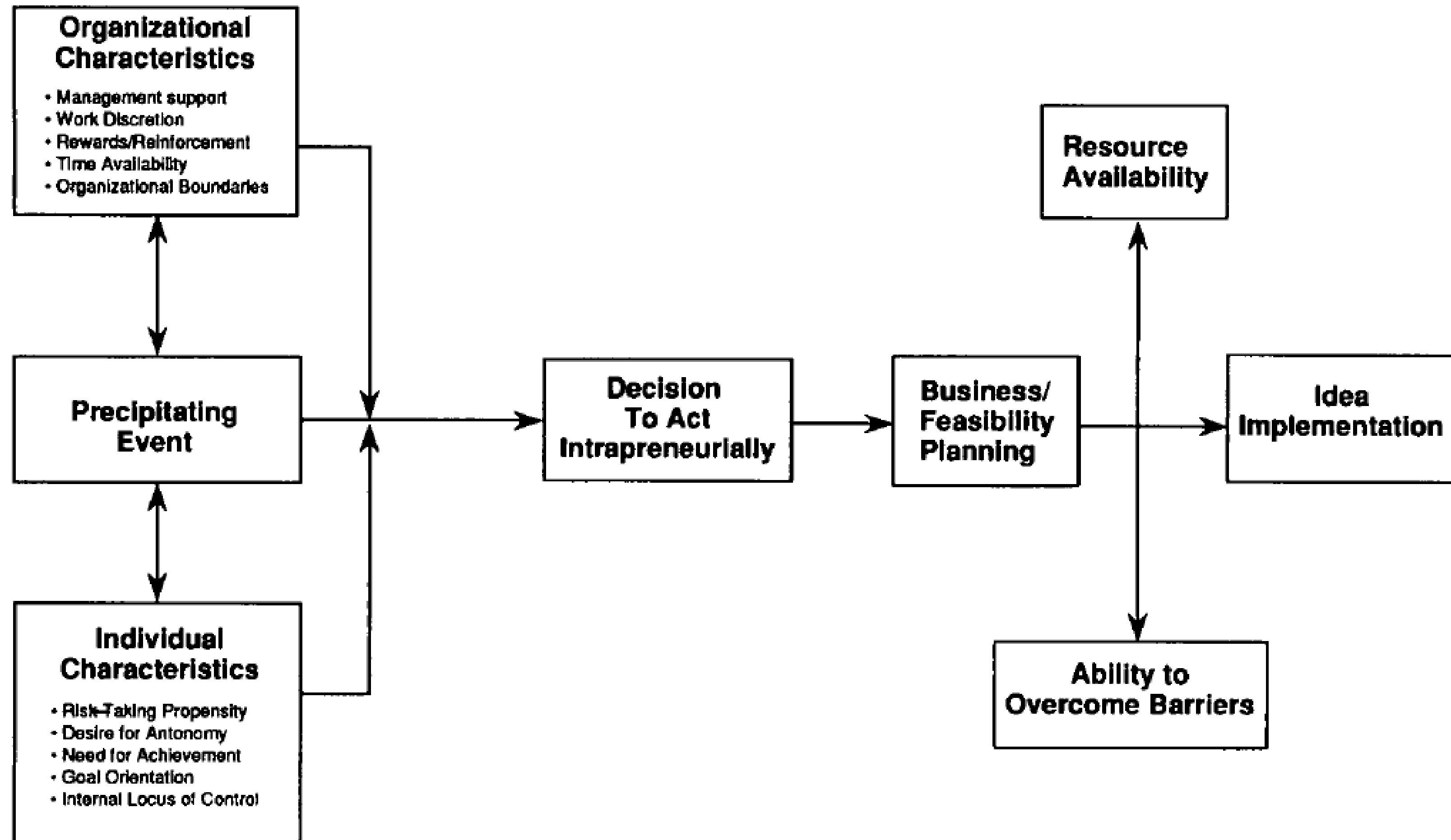
Fitting Corporate Entrepreneurship into Strategic Management (Guth & Ginsberg, 1990)

Appendix 3: A Conceptual Model of Entrepreneurship as Firm Behaviour



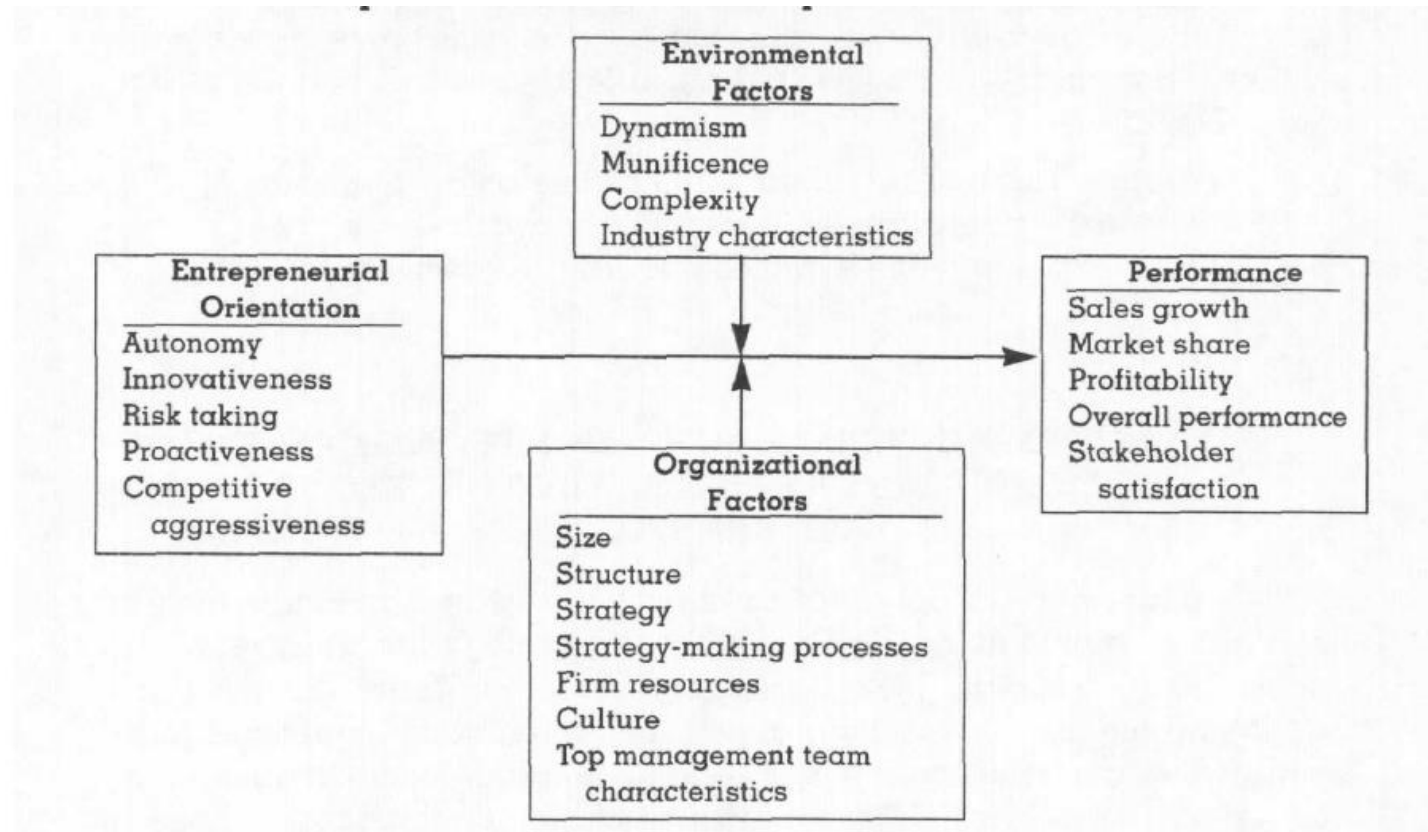
A Conceptual Model of Entrepreneurship as Firm Behaviour (Covin & Slevin, 1991)

Appendix 4: An Interactive Model of Corporate Entrepreneuring



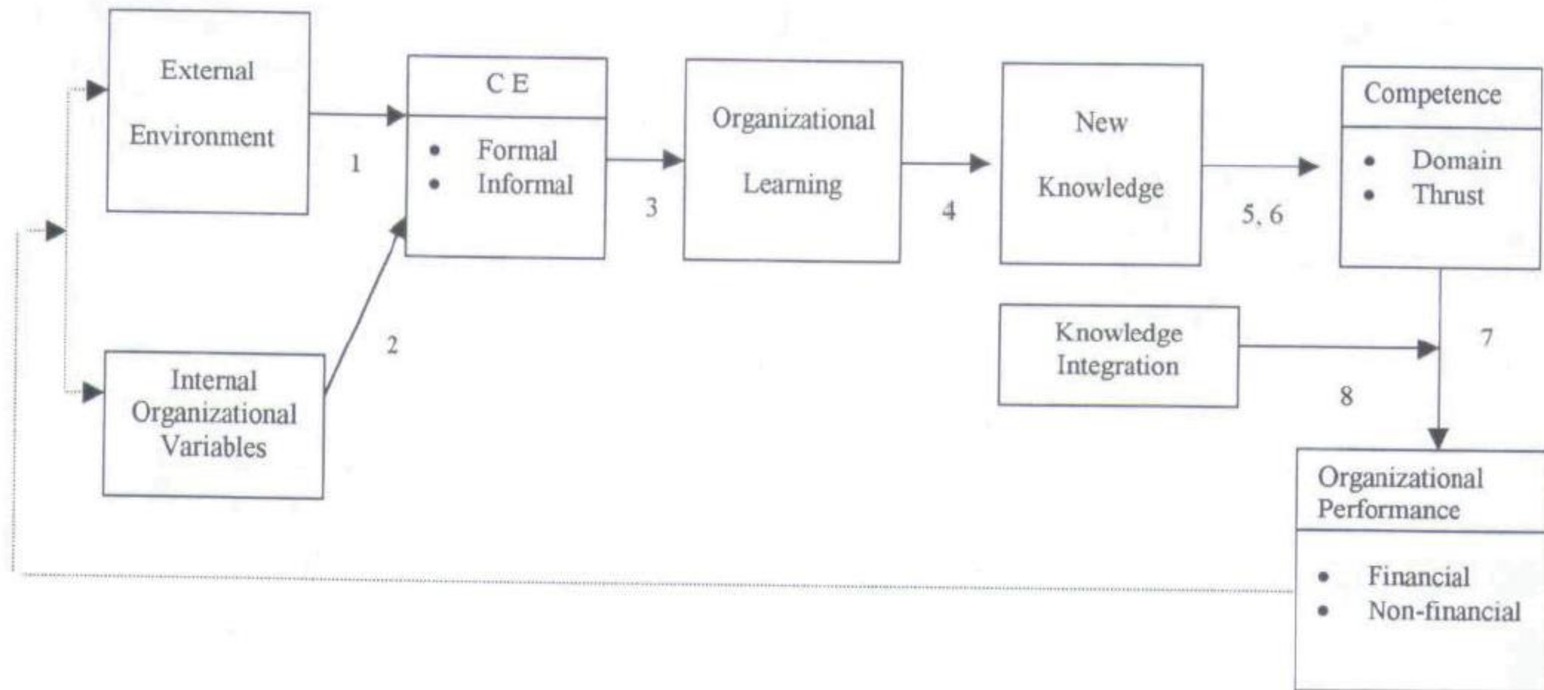
An Interactive Model of Corporate Entrepreneuring (Hornsby, Naffziger, Kuratko & Montagno, 1993)

Appendix 5: Conceptual Framework of Entrepreneurial Orientation



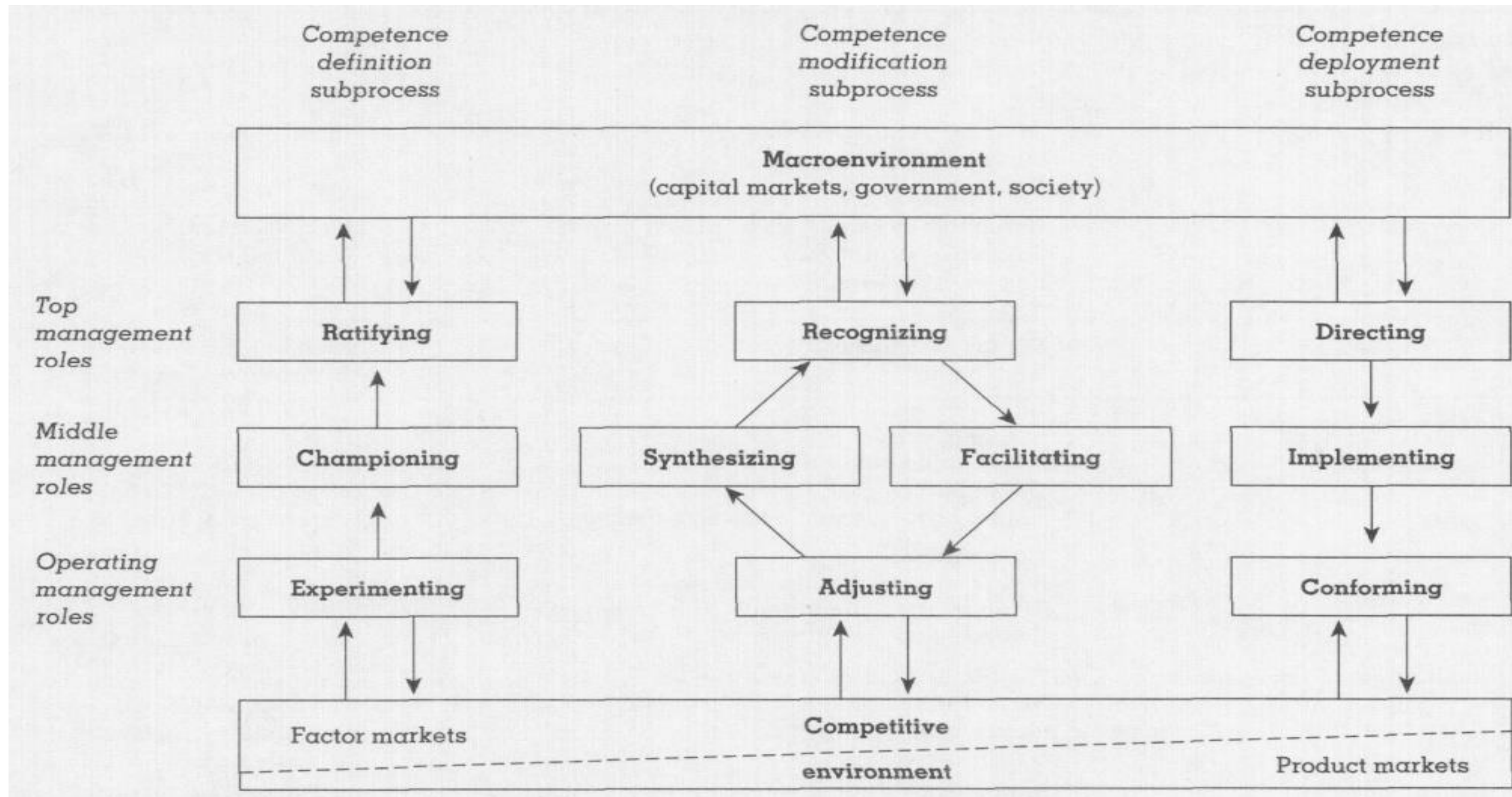
Conceptual Framework of Entrepreneurial Orientation (Lumpkin & Dess, 1996)

Appendix 6: Corporate Entrepreneurship, Knowledge and Organisational Competence Development



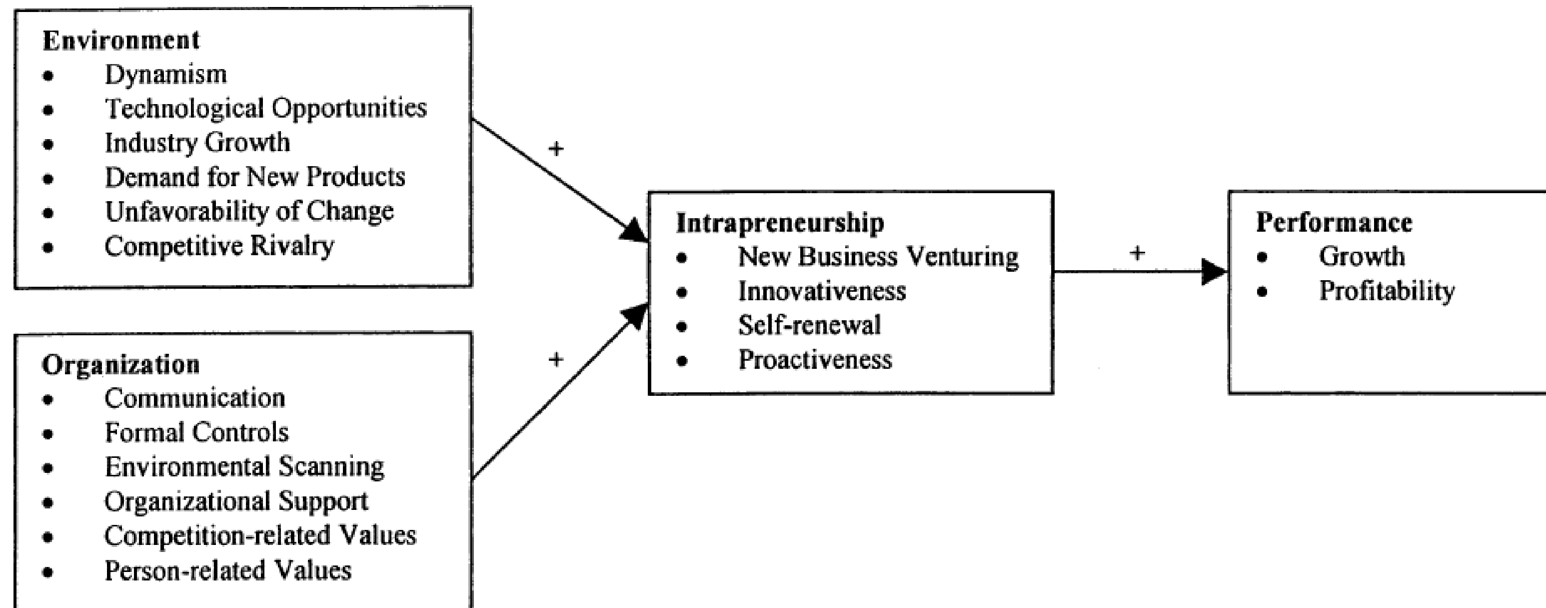
Model of Corporate Entrepreneurship, Knowledge and Organisational Competence Development (Zahra, Nielsen & Bogner, 1999)

Appendix 7: Managerial Roles, Information Exchanges and the Strategic Renewal Sub-Processes



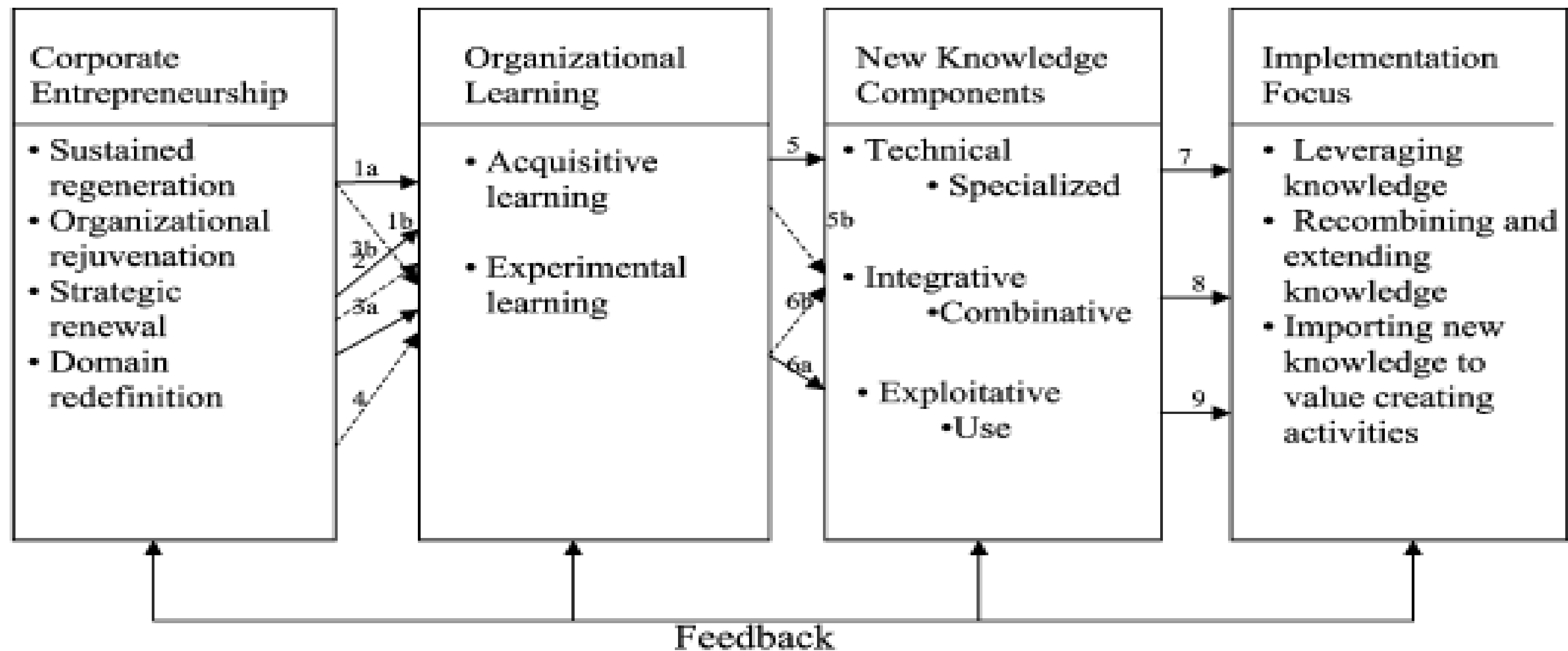
Managerial Roles, Information Exchanges and the Strategic Renewal Sub-Processes (Floyd & Lane, 2000)

Appendix 8: The Intrapreneurship Model and its Direct Effects



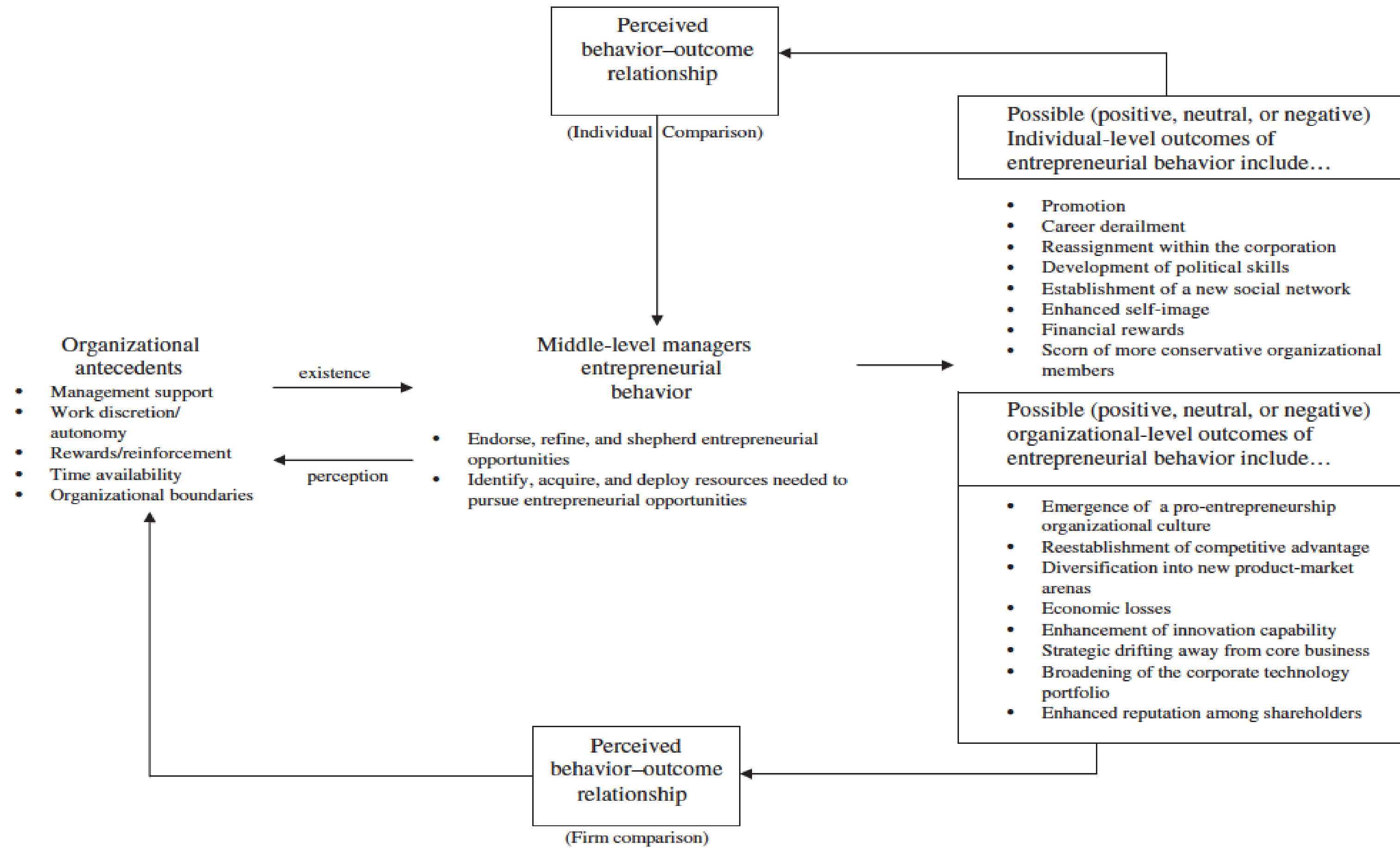
The Intrapreneurship Model and its Direct Effects (Antoncic & Hisrich 2001)

Appendix 9: Corporate Entrepreneurship Strategy, Organisational Learning, Knowledge and Implementation



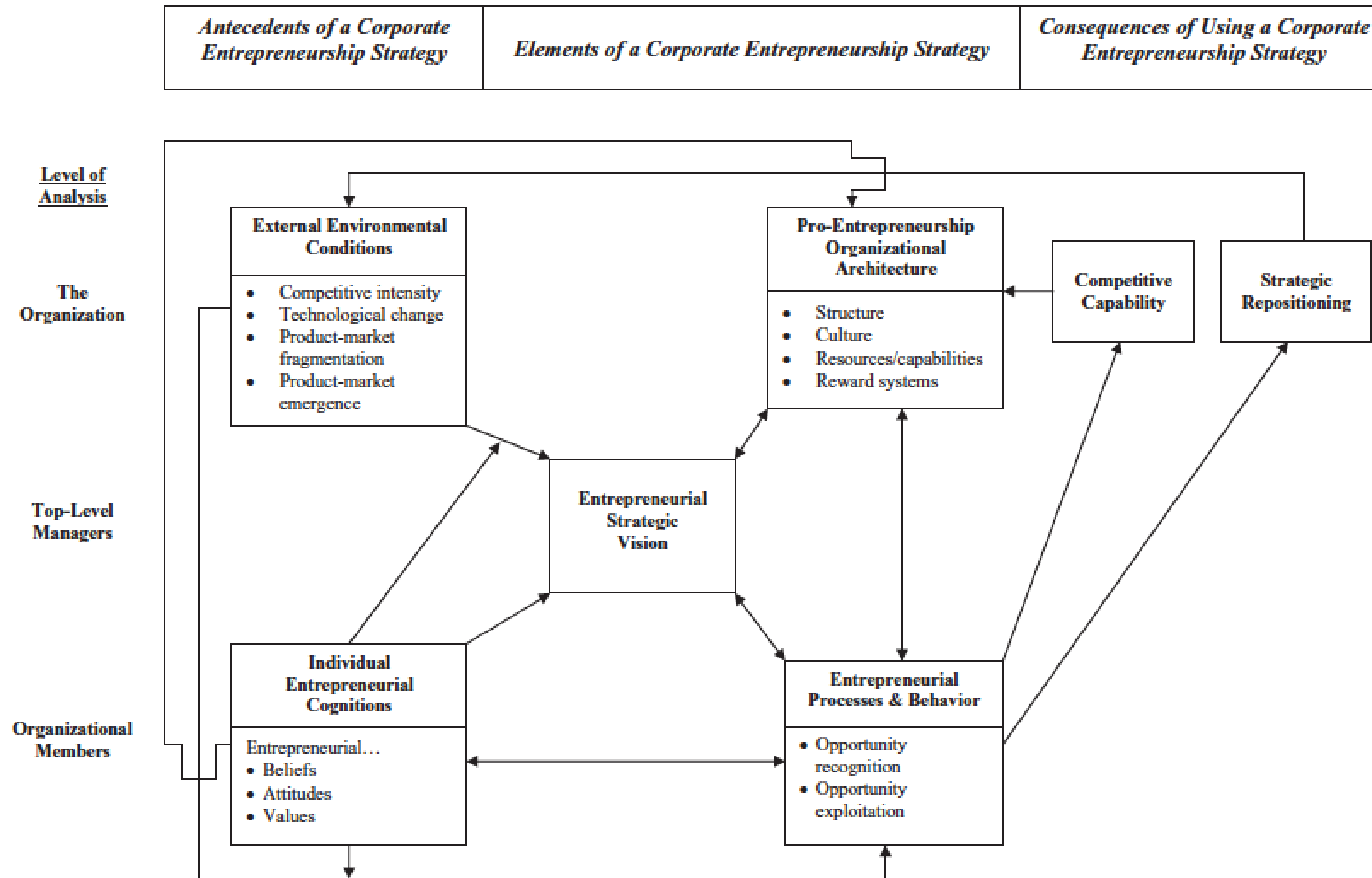
Relationships among Corporate Entrepreneurship Strategy, Organisational Learning, Knowledge and Implementation (Dess, Ireland, Zahra, Floyd, Janney & Lane 2003)

Appendix 10: A Model of Middle Managers Entrepreneurial Behaviour



A Model of Middle Managers Entrepreneurial Behaviour (Kuratko, Ireland, Covin & Hornsby, 2005)

Appendix 11: An Integrative Model of Corporate Entrepreneurship Strategy



An Integrative Model of Corporate Entrepreneurship Strategy (Ireland, Covin & Kuratko 2009)

Appendix 12: Participant Information Sheet

Participant Information Sheet

(Final version 1.0: 21st February 2012)

Study Title: Developing Corporate Entrepreneurship Strategy in the National Health Service: A Study of a Large East Midlands Trust

Researcher(s): Associate Professor Mathew Hughes, Dyneshia Johnson

We the research team would like to extend an invitation to you to part-take in our research study. However before you make a decision, we would like to take this opportunity to assist you in understanding why the research is being conducted and what your involvement will mean. As such one of the research team will go through this information sheet with you to answer any questions you have.

What is the purpose of the study?

The very definition of entrepreneurship can be viewed as being in direct opposition to what occurs in the public sector with it inherent social mission and bureaucracy. This study seeks to understand how strategy implementation processes, specifically corporate entrepreneurship strategy, can be improved in a large and complex universal healthcare organisation. To accomplish this, the research project is specifically focused on identifying what influences people's attitudes as they form intentions to act entrepreneurially within the Large East Midlands Trust (LEMT).

As such our aim is not to assess how effective LEMT is at planning or the competency of staff involved in the study. Instead we want to reveal more about what is involved in entrepreneurial strategy implementation within LEMT and what motivates staff to pursue opportunities. We are particularly interested in what organisation factors facilitate or hinder an entrepreneurial intention to create and sustain entrepreneurship in LEMT.

This study will focus on entrepreneurial "pockets" within LEMT focusing on four cases where entrepreneurial activity has been identified by an initial scoping exercise conducted in October 2011.

Why have I been invited?

The research team has chosen to invite you to take part because of your experience within this entrepreneurial endeavour the knowledge and insights you may be able to offer. The research team has invited 50 participants total across the four cases to take part.

Do I have to take part?

The decision to participate is entirely up to you. If you do accept our invitation you will receive:

- This information sheet to keep and
- A consent form for you to sign

Please note, should you decide to participate and then change you decision you are still free to withdraw at any time, without having to give a reason. This would not affect your legal or employment rights.

What will happen to me if I take part?

An appointment for an interview will be set up with the researcher, Miss Dyneshia Johnson at a mutually convenient time and location where your privacy and confidentiality can be assured.
The interview will be a discussion of your understanding of entrepreneurship, experience in your remit, attitudes and factors that influence your attitudes in choosing to pursue entrepreneurial activity with LEMT. The interview will take place during work hours as such you will need to seek permission if necessary for a minimum of 30 and maximum of 60 minutes.

Additionally, Dyneshia would like to record interviews to ensure she captures all of your responses accurately. If you are not comfortable with your interview being recorded, feel free to let Dyneshia know so she can adjust her data collection strategy accordingly. Please note Dyneshia may approach you at a later date for a second shorter interview, approximately 30 minutes, to clarify our understanding of what you have said.

Also the research team will be observing meetings related to the four entrepreneurial projects. These include:

- Board meetings
- R&D meetings,
- Division meetings
- Clinical business unit meetings
- Other meetings suggested, which encompass the remit of the four entrepreneurial activity cases

These will not be recorded; instead, Dyneshia will be making notes. These notes will be treated in the same way as the interview data- confidentially. Dyneshia will not observe any meetings or activities that you (or those involved) do not give her permission to observe.

Expenses and payments
Participants will not be paid to participate in the study and travel expenses are not anticipated.

What are the possible disadvantages and risks of taking part?
There are no anticipated risks or discomfort associated with taking part in this study.

What are the possible benefits of taking part?
While we cannot promise that the research findings will directly impact your area of work, we expect our findings may help improve strategy implementation within LEMT in the future.

What if there is a problem?
The researchers' contact details are given at the end of this information sheet. Feel free to convey any concerns regarding this study and the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?
We will adhere to University of Nottingham and NHS ethical guidelines. All information about you will be handled in confidence.

If you accept our invitation to join the study, some sections of the data collected via interviews and field notes, will be looked at by authorised persons from the University of

Nottingham research team to ensure this study is being carried out correctly. All authorised persons will have a duty of confidentiality to you as a research participant.

Most importantly you can be rest assured all information, which is collected, about you during the course of the research will be kept **strictly confidential**. To aid in this all hard copy information will be stored in a secure and locked office and all electronic information on a password protected database. Any information about you, which leaves the hospital, will be anonymised using a unique code.

Any work contact details (email address, telephone number) collected during the course of this study will not be kept for more than 3 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All research data will be kept securely for 7 years after which your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

We will not breach confidentiality **unless** you tell us about unsafe or illegal activity which we feel we must act upon.

What will happen if I don't want to carry on with the study?
Please keep in mind your participation in this study is completely voluntary. As such you are free to withdraw at any time, without giving any reason and without your legal rights being affected. However please note if you withdraw as a participant, the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?
The data gathered from this research project will be analysed for patterns in each of the four cases as well as across the four cases. Findings will be written into

- Reports for the hospital
- Dyneshia's Ph.D. thesis
- Journal articles.

Be assured participant anonymity will be maintained during this dissemination phase. Copies of these reports will be available in the hospitals library.

Who is organising and funding the research?
This research project has been organised and funded by the University of Nottingham in collaboration with LEMT and the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham (Business School) Research Ethics Committee.

Further information and contact details

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Appendix 13: Consent Form

CONSENT FORM
(Final version 1.0: 21/02/2012)

Title of Study: Developing Corporate Entrepreneurship in the National Health Service: A Study of a Large East Midlands Trust

REC ref: ***(to be added after approval given)***

Name of Researcher: Dyneshia Johnson

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number …………dated..................................... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my employment or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports.

5. I agree to take part in the above study.

________________________ _______________ ______________________
1 Name of Participant Date Signature

__________________________ _______________ ______________________

Name of Person taking consent Date Signature
2 copies: 1 for participant and 1 for the project notes

Appendix 14: Interview Schedule Phase 1

Dyneshia Johnson
Doctoral Research Candidate
Large East Midlands Trust
Nottingham University Business School
Email: lqxdj2@nottingham.ac.uk

PHASE 1 Scoping Exercise: Interview Schedule

PART A: Defining Entrepreneurship

1. What do you understand by the term entrepreneurship?

    a. How does entrepreneurship manifest itself in the healthcare domain and more specifically in LEMT?

    b. Do you think LEMT is an entrepreneurial organisation or has potential to be?

    c. Can you think of any examples of entrepreneurship and / or entrepreneurial individuals/CBUs/divisions in LEMT?

2. I'd now like to talk through with you some of the features commonly associated with entrepreneurial organisations.

    a. What is your understanding of **INNOVATION**? How important do you think being innovative is for LEMT? Do you see LEMT as an innovative organisation? Can you think of any examples of innovation in LEMT or in healthcare?

    b. What is your understanding of **PROACTIVENESS**? How important do you think being proactive is for LEMT? Do you see LEMT as a proactive organisation? Can you think of any examples of proactiveness in LEMT or in healthcare?

    c. What is your understanding of **COMPETITIVE AGRESSIVENESS**? How important do you think being competively aggressive is for LEMT? Do you see LEMT as an competively aggressive organisation? Can you think of any examples of competitive aggressiveness in LEMT or in healthcare?

    d. **RISK-TAKING:**
        i. How do you define risk?

ii. What does risk in your organisation involve? E.g. personal, patient safety, resources,

e. What is your understanding of **AUTONOMY?** How important is autonomy for LEMT as an organisation? Do you see autonomy as an important factor encouraging entrepreneurship at an individual level?

PART B: Personal Analysis

3. Do you see yourself as entrepreneurial? If so, why? If not, what stops you from being entrepreneurial?

4. Do you see being entrepreneurial as relevant and useful in your work? If yes/no how and why?

PART C: The Effects of Entrepreneurship

5. Do you see entrepreneurship as relevant and useful to supporting the priorities of the NHS/ LEMT/ your CBU? If yes/no how and why? Facilitators and barriers

6. What do you think are the positive and negative effects of entrepreneurship in a) healthcare and b) LEMT?

Appendix 15: Interview Schedule Phase 2

Dyneshia Johnson
Doctoral Research Candidate
Large East Midlands Trust
Nottingham University Business School
Email: lqxdj@nottingham.ac.uk

Phase 2 Embedded Unit: Interview Schedule

PART A: Defining Entrepreneurship

1. What do you understand by the term entrepreneurship?

    a. How does entrepreneurship manifest itself in the healthcare domain and more specifically in LEMT? **Pathology Joint Venture Partner/Pathology Joint Venture?**

    b. Do you think LEMT/**Pathology Joint Venture Partner /Pathology Joint Venture** is an entrepreneurial organisation or has potential to be?

2. I'd now like to talk through with you some of the features commonly associated with entrepreneurial organisations.

    a. What is your understanding of **INNOVATION**? How important do you think being innovative is for **PATHOLOGY JOINT VENTURE/ Pathology Joint Venture Partner /**LEMT? Do you see **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**LEMT as an innovative organisation? Can you think of any examples of innovation in **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER**/LEMT or in healthcare?

    b. What is your understanding of **PROACTIVENESS**? How important do you think being proactive is for **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**LEMT? Do you see **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**LEMT as a proactive organisation? Can you think of any examples of proactiveness in **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**LEMT or in healthcare?

    c. **RISK-TAKING:**

        i. How do you define risk?

ii. What does risk in your organisation involve? E.g. personal, patient safety, resources,

iii. **PART B: Personal Analysis**

3. Do you see yourself as entrepreneurial? If so, why? If not, what stops you from being entrepreneurial?

4. Do you see being entrepreneurial as relevant and useful in your work? If yes/no how and why?

PART C: The Effects of Entrepreneurship

5. Do you see entrepreneurship as relevant and useful to supporting the priorities of the **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**NHS/ LEMT/ your CBU? If yes/no how and why? Facilitators and barriers

6. What do you think are the positive and negative effects of entrepreneurship in a) healthcare and b) **PATHOLOGY JOINT VENTURE/PATHOLOGY JOINT VENTURE PARTNER/**LEMT?

PART D: Career History

7. Can you tell me about your career history both before (if applicable) and after joining the NHS/ **PATHOLOGY JOINT VENTURE PARTNER/**LEMT **JV?**

8. What motivated you to join the NHS / **PATHOLOGY JOINT VENTURE PARTNER/** LEMT **JV?**

9. How did you feel when you started working in the NHS / **PATHOLOGY JOINT VENTURE PARTNER/**LEMT **JV?**

10. How would you describe yourself in relation to your work? Has this changed over time?

11. How do your family and friends view your career?

12. How would you describe the organisational identity/culture within the NHS and is LEMT **/PATHOLOGY JOINT VENTURE PARTNER/PATHOLOGY JOINT VENTURE** different in any way?

13. To what extent do you feel you are able to express yourself/ values/ personality at work and is this different to any previous work / role? (why/ why not?, what has changed? why?)

14. Do you think you will ever move out of NHS? Why?
15. What is your current role?

16. What characteristics (e.g. adjectives) are needed to successfully carry out this role?

PART E: Service Delivery

17. Can you tell me about the on going service improvement projects in your area?

18. To what extent did you initiate these changes?

19. Can you tell me about your role within the scope of these changes?

20. Can you tell me about the role of others/team working on these changes? Internal and external partners (Important meetings associated)

21. Do you see any of the following as abilities needed to support these changes in your unit and LEMT and how do you fit into the equation (e.g. initiator; supporter etc…)
    a. Innovation
    b. Pro-activeness
    c. Risk-taking (business)

Explain further