What Is Mutual About Public Service Mutuals?

A critical realist study of mutualism within healthcare organisations in England.

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For Lisa

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Abstract

Former Cabinet Office Minister Francis Maude once made the ambitious claim that one million public sector workers would own and run the services they provide by 2015. It never happened, but there are still approximately 110 Public Service Mutuals (PSMs) in England. Yet whilst mutuality permeates the discourse of this policy, mutualism in PSMs, as both ethos and practice, is under-theorised and under-researched. This thesis addresses these gaps using a critical realist approach.

Drawing on a review of literature on mutuality and co-operation, mutualism in PSMs is conceptualised as interrelated cultural and structural emergent properties, comprising mutual ideas, relations and practices. These are applied in an empirical research project to explore the mutual in PSMs. A large N survey of healthcare providers was followed by in-depth comparative case studies of an NHS Foundation Trust and two PSMs. Using a critical realist framework, mutual structures and generative mechanisms, together with agent (employee) interaction with them, were investigated.

The findings revealed that organisational mutual practices of ownership, shared benefit, voice and transparency can cause the emergence of the mutual relations of trust, co-operation and reciprocity when allied to a common purpose. In turn, the causal powers of these mutual relations strengthen organisational mutual practices. However, this does not occur quickly or automatically and the corporate agency of managers and staff, coalescing around joint projects, is necessary for the mutual in Public Service Mutuals to emerge and thrive.

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Chapter 1 Introduction and Theoretical Approach

1.1 Introduction

The promise of mutualism in public services once aimed for "…as many as 1 million workers who would be co-owners in some form of the public service entity that they're part of…" by 2015 (Maude, 2011). Whilst this did not happen, approximately 110 Public Service Mutuals, or PSMs, now operate in England (CIPFA, 2017, p. 8) compared to 9 in 2010 (Cabinet Office, 2014a). PSM policy, initially the responsibility of the Cabinet Office, is now promoted by the Department for Digital Culture Media and Sport (DCMS Mutuals Team, 2017). PSMs operate in a range of public service delivery sectors, including health, social care, education, probation, housing and culture and media (CIPFA, 2017, p. 11).

PSMs have been consistently referred to as 'mutuals', a term that has permeated the policy discourse (Maude, 2010). The concepts of mutualism, mutuality and mutual have a long and varied history in the United Kingdom (Yeo, 2001, p. 226). Use of the term so extensively, therefore, engenders expectations of increased mutuality within public service delivery and a commitment by policy makers to mutualism.

Yet the role of mutuality in PSMs is under-researched (Yeoman, 2017, p. 481), despite PSM policy being lauded a success by ministers (Cabinet Office, 2014a). Both the idea of mutualism and the practice of mutuality, as well as their respective roles in PSMs, have not been theorised or researched sufficiently. This thesis aims to complete some of the gaps that exist through a series of research questions developed from the literature discussed in Chapter 2. What distinguishes PSMs and what is mutual about them, forms the basis of what follows.

1.1.1 Public Service Mutuals: the Policy

A PSM, according to the DCMS Mutuals Team (2017), is:

> "An organisation that has left the public sector (also known as 'spinning out'); which continues to deliver public services, and has staff control embedded within the running of the organisation."

Policy to encourage new PSMs has been promoted extensively since 2010, using pathfinder projects and mentors from the employee ownership, co-operative and mutuals sector. A Mutual Support Programme was introduced, providing ten million pounds of funding to assist the transfer of public service delivery teams into newly formed PSMs (Cabinet Office, 2011). Through the 'Right-to-Request' and 'Right-to-Provide' policies introduced into the health and social care sectors (Hazenberg and Hall, 2016, p. 442), at least 38 PSMs since 2010 were health or social care providers. Those in other sectors, including leisure, education and local government, took advantage of similar policies promoted by other government departments (Birchall, 2012, p. 153). This was despite limited evidence or empirical research available to inform the policy.

To address this, the Cabinet Office commissioned the Mutuals Taskforce to examine PSMs and the supporting case for their use, which published a literature review of the evidence base (Le Grand, 2011) and a subsequent report of recommendations to grow and develop PSMs (Le Grand, 2012). Both reports focused on the definition of PSMs referred to above, limited to organisations that had employee control and the evidence cited mainly considered employee ownership and engagement.

The policy focus was on employee involvement, therefore, not mutualism as understood by co-operative and mutual writers (Birchall, 2012, p. 147). The PSMs included on an interactive map published by the DCMS Mutuals Team (2017), moreover, reflect this, being made up of a majority of employee owned or controlled organisations, whilst continuing to refer to PSMs as mutuals. This has resulted in an unhelpful blurring of terminology, concepts and theory. The case for PSMs is largely derived from accounts by researchers focused on employee owned businesses delivering private sector services in a for-profit environment and makes the case for ownership by employees (Birchall, 2012, p. 154) rather than mutual organisations

delivering public services. The evidence base cited does not distinguish mutualism, as a concept, from mutual organisations, where mutualism is practised.

The conflation between mutuality and its operationalisation assumes public sector organisations can be transformed into mutual ones through the presence of employee ownership and control mechanisms alone (Cabinet Office, 2014a). It is assumed these new organisations will, in turn, generate beneficial outcomes, including improved service delivery, when there is limited evidence that this is the case (Hazenberg and Hall, 2016, p. 443). As Yeoman (2017, p. 481) says, the legal form of mutuality does not automatically equate to its practice.

Without conceptualisations of mutuality and mutual practices that apply to PSMs, and explanation of how these two related, but separate, concepts interact, the literature on mutualism cited in support of the PSM policy is under-theorised as well as under-researched. To address this, a framework to conceptualise mutuality is required that can then be applied when researching the mutual in PSMs.

1.1.2 Researching the mutual in Public Service Mutuals

The deficiencies in the theory and research of mutuality in PSMs are addressed here by examining the relationship between organisational practices associated with mutuality and the process through which mutuality emerges. A critical realist approach is used to analyse the literature on mutualism, conceptualise mutuality and mutual practices and then conduct a research project investigating these, within health provider organisations in NW England.

A mixed methods approach informed the collection and analysis of data from a range of organisations in order to identify, classify and explain the mutual in PSMs. A large N survey of healthcare providers identified these mutual practices and compared them between different types of organisation. In-depth comparative case studies then explored in greater detail how these arrangements operated. Critical realism informed the explanation of how, and to what degree, mutualism emerges from the operation of mutual practices in PSMs.

The research is narrowly drawn as far as mutualism is concerned. It focuses solely on mutualism within organisations delivering public services, and limits itself to the UK Government's definition of PSMs (DCMS Mutuals Team, 2017). As a significant proportion of PSMs operate in the health sector (CIPFA, 2017, p. 11), and all were in

England (Cabinet Office, 2014a), the research focused on healthcare providers in England.

This necessarily restricts investigation to staff and employee owned or controlled entities, rather than multi stakeholder or other models of mutual organisation (Turnball, 2001; Yeoman, 2017, p. 481). For similar reasons, there is no attempt to address mutualism in its wider form, insofar as it applies to private sector goods and services, friendly societies, co-operatives and other community mutuals. This is not an endorsement of employee ownership and rejection of other types of mutualism, but merely a reflection of the limitations that PSM policy has thus far imposed.

Given the paucity of existing research, and the early stages of the policy, the research is necessarily exploratory. An approach is required, therefore, that can explore mutualism from its initial conceptualisation and also provide a framework to address the process through which mutuality operates and develops. Critical realism provides such a framework, both to address the theoretical conceptualisations required and to explore mutualism in practice.

Applying critical realism to researching mutuality within PSMs is a distinctive perspective, one that cannot be located in the literature on PSMs. As critical realist concepts and terminology underpin the approach, time is taken in the remainder of Chapter 1 to set these out. This provides the framework applied throughout the remainder of this thesis, including review of the literature and development of research questions in Chapter 2 and the research design in Chapter 3, as well as the data collection and analysis discussed in the succeeding chapters.

1.1.3 Researching mutuality and PSMs: a critical realist approach

Mutualism operates at multiple levels. It is a philosophy and an idea, a set of relations between people and a cluster of practices (Birchall, 2001b, p. 245; Davies and Yeoman, 2013, p. 2). Investigating what it is and what its processes are, therefore, is to ask about social structures that both affect, and are in turn affected by, the actions of agents at these various levels. How structures and agents interact, and the processes that may change existing configurations or cause them to endure, is appropriately explored through critical realism (Archer, 2003, p. 7).

To illustrate critical realism in the following sections, a hypothetical recurring organisation is used, called Example Health. As the research is focused on healthcare organisations, this reflects the context of the research field, incorporating similar traits to the case studies discussed later. Example Health is assumed to be a corporate body with an independent legal identity to its owners, staff and service users. It employs staff under employment contracts, delivers healthcare services to patients and utilises resources such as premises, IT systems and medical equipment. This type of organisational form and arrangement is broadly typical of healthcare organisations (Allen et al, 2011, p. 81).

1.2 The Critical Realist Approach

Critical realism is not a testable theory, but a meta-theoretical position (O'Mahoney and Vincent, 2014, p. 12). It is premised on the principle that what exists is not simply what is observed or observable (Sayer, 1992, p. 4). Instead, it acknowledges deep underlying structures and generative mechanisms that influence actions through their interaction with the surrounding context (Pawson and Tilly, 1997, pp. 77). The results of these interactions produce empirical (and so observable) phenomena that can be investigated, to posit explanations of what underlying features generate the observable phenomena. Generative mechanisms, therefore, are the aspects of these deep underlying structures that can be said to cause phenomena to occur.

This framework of underlying structures and generative mechanisms makes explicit a stratified ontology, distinguishing between experiences (the empirical domain of observable entities), events (the actual domain of what may or may not be capable of happening) and generative mechanisms and structures (the real domain where events are created, whether they occur or not) (Collier, 1994, p. 42). The distinction between the various domains means that there are deeper levels to research and investigate beyond mere observation to reveal potential generative mechanisms and structures.

Critical realism recognises the world as an open system, comprising entities that interact in complex, non-linear ways, unlike the closed system created in a laboratory (Sayer, 1992, p. 83), which means events cannot be predicted or determined with any certainty (O'Mahoney and Vincent, 2014, p. 6). Within open systems entities have effects in their own right, causal properties that are themselves distinct and not

merely sums of their component parts. This recognises the importance of emergence. The creation of an emergent causal power occurs through a fundamental modification of the existing powers of a group of entities (Sayer, 1992, p. 80). How individual agents engage with, affect, and are affected by, the various social structures they inhabit, and have previously inhabited, is key (Delbridge and Edwards, 2013, p.16) and a focus of this research.

Critical realism adopts terminology that has specific meanings. Table 1.1 sets out some key definitions that will be used in this chapter, and the remainder of the thesis, along with some examples of their use in the context of an employment structure.

Table 1.1 Critical realist terminology

Terminology	**Definition**	**Example**
Social structure	A social structure or structure, is a set of relations between entities that are each necessary to the other for the other to exist in that position.	An employment structure comprises relations between an agent in the role of employee and another agent in the role of employer. For the structure to subsist each must be a necessary condition of the other. The practice of employer needs an employee and vice versa. Otherwise neither of the positions or practices associated with employment can subsist on their own.
Generative mechanism	The aspects of deep underlying social structures that can cause phenomena to occur if they are activated.	In an employment structure generative mechanisms include wages, which agents must engage with in return for work, and wage labour, the process through which employees produce work for employers in return for wages.
Positioned-practice	Occurs when agents inhabit a role identified with a set of relations and at the same time engage in practices related to that position. These practices are separate from the individual identity of the agent.	Agents engaging in the positioned-practice of employee interact with generative mechanisms for receiving wages, producing work, following instructions and working at specific times. They do not do these things in other positioned-practices outside of work, such as parent or friend.
Causal configuration	A causal configuration is a group of components comprised of social	An employment causal configuration is a set of necessary relations between an employer and employees, governed by

Terminology	Definition	Example
	structures, generative mechanisms, position-practices, causal powers and rules that have the tendency to act in a particular way.	employment contracts, workplace rules and employment legislation, all of which creates a social structure. Agents engage in positioned-practices of employer or employee and in those positions become involved with generative mechanisms such as wages and wage labour. The employment configuration has the tendency to cause work to happen as well as associated causal powers such as hierarchy and control.
Rules	These are formal and informal regulations, norms and practices that govern relations and positioned-practices. They help create social structures through compliance with rules.	These are the employment contract, employment legislation, staff handbooks and other workplace regulations and norms that regulate day-to-day events and activities.
Tendency	A tendency of a causal configuration is the usual way it acts when agents, adopting relevant positioned-practices, engage with associated generative mechanisms.	The tendency for an employment configuration would be for agents, in the positioned-practice of employee, to produce work and for other agents, in the positioned-practice of employer, to pay wages in return for that work.
Causal Powers	A causal configuration has the power or capacity to do certain things but not the power to do other things.	In employment, the causal power is to produce paid work and generate associated behaviours of employees. Employment does not have the power to produce rainfall.

Source: Sayer (1992); Fleetwood (2004)

1.2.1 Intransitive and Transitive Knowledge

The foundational critical realist claim is that the world is independent from our knowledge or thoughts of it (Sayer, 1992, p. 4). This ontological claim accords with a distinction between the two dimensions of knowledge: intransitive and transitive. The intransitive dimension concerns the object(s) being studied, whereas the transitive dimension relates to theories and knowledge that explain such objects

(acknowledging that theories and knowledge can themselves be objects of study) (Sayer, 2000, p.10).

The distinction can be illustrated using Example Health, and human resource management. The intransitive dimension, or object under study, is employees and their management in an organisational context. The transitive dimension comprises human resource management, knowledge and theories about how employees can be managed within organisations. Whilst theories of human resource management (transitive) might change over time, the employment relationship (intransitive) generally does not. So in Example Health, ideas to improve employee performance do not substantially affect the basic employment relationship. Employees continue to produce work in return for wages. This distinction between transitive and intransitive knowledge will be utilised in the conceptualisation of mutuality in Chapter 2, to distinguish between the idea and the practice of mutuality.

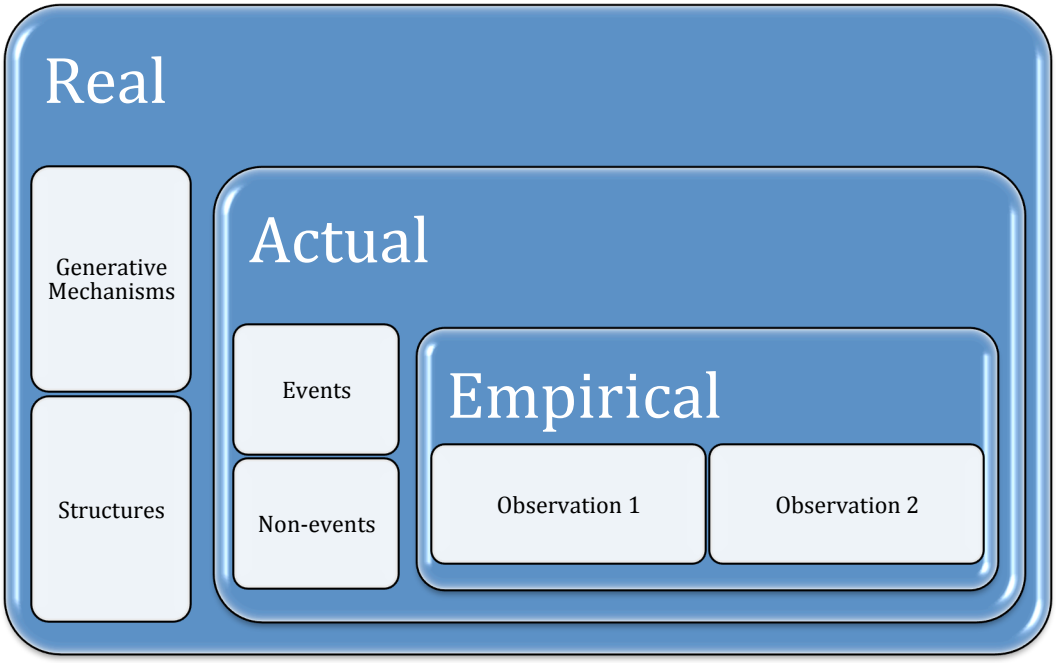
1.2.2 Stratified reality

Critical realism embraces a stratified ontology, incorporating Bhaskar's (1978, p. 56) three domains of reality: the empirical, the actual and the real. These stratified domains are linked, but separate, and are key to critical realist thought (Collier, 1994, p. 42; Sayer, 1992, p. 4). Figure 1.1 shows a simplified version of these domains.

At the real domain, structures and generative mechanisms exist, which are actualised or not. In the actual domain there are generated not only events, but also non-events, from the structures and generative mechanisms existing in the real domain. At the empirical domain, observed events occur (Observations 1 and 2) where the operation of actualised mechanisms generating events can be seen.

However, any non-events, for example a set of rules that exist at the real domain as a structure but which have not been actualised to produce observable events, would not be seen. An observer may not witness this happening, or rather not happening, purely by observation. In a stratified reality an account of what is happening and what is not happening is required.

Figure 1.1 Domains of the real, actual and empirical within Example Health



Source: Adapted from Collier (1994, p. 42)

1.2.3 Structure, Agency and the Morphogenetic Approach

Agents interact with structures at the real domain by actualising (or not actualising) their associated generative mechanisms (Figure 1.1). Structure enables and constrains the actions of agents, and in turn, agents affect those structures by reproducing or altering them through their engagement with generative mechanisms (Archer, 2003, pp. 5-9). This interaction between structure and agency is key to critical realist thought, using methodology that is based on Archer's (1995, p. 15) conception of analytical dualism.

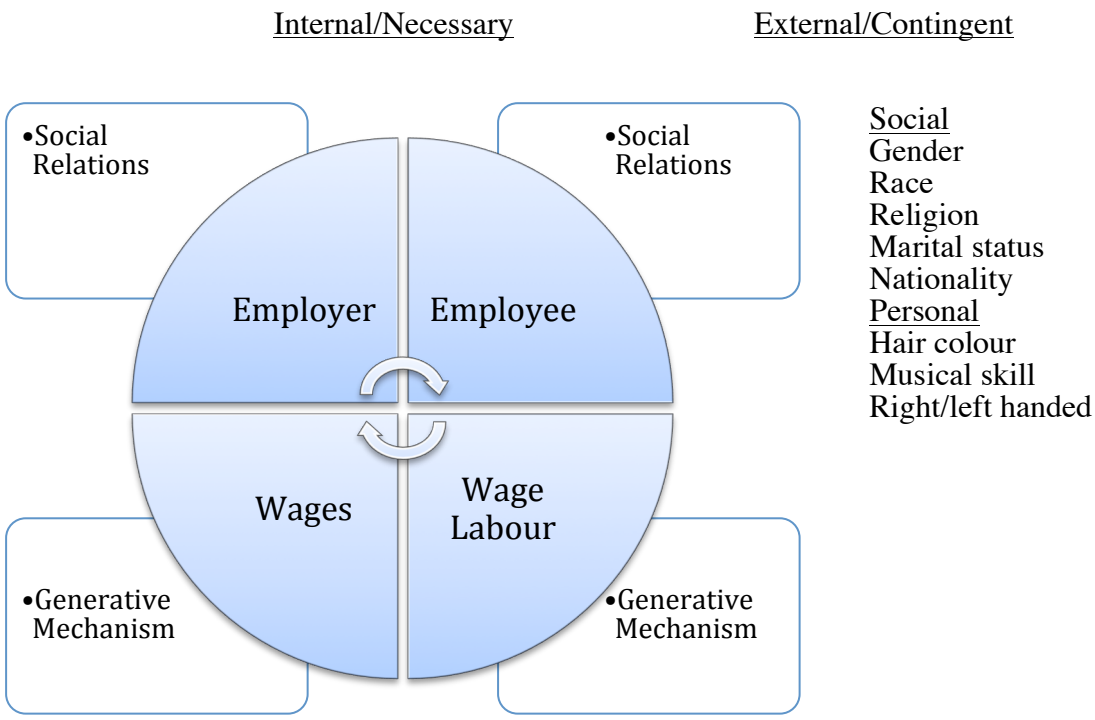
Analytical dualism advocates the separation, and keeping separate, of structure and agency, with each having properties and powers irreducible to the other. As structure must precede any action that has the effect to transform it, then structure must, by implication, exist temporally prior to agency (Archer, 1995, p. 157). Temporal precedence of structure before agency is a contested concept, and alternative viewpoints are discussed at Section 1.3.2, but before then the critical realist approach is outlined.

1.2.3.1 Structure

Social structures are a "… a nexus of connections among [agents] causally affecting their actions and in turn causally affected by them…" (Porpora, 1989, p. 200). Focus is on relations, and the agents who enter into them. Sayer (1992, p. 60) identifies structural relations as those that are internal, not external.

Figure 1.2 illustrates employment relations in Example Health, re-described as internal and external relations. Both employer and employee are examples of internal (structural) relations, whilst wages and wage labour are each generative mechanisms. Internal relations are those that cannot exist without each other. Employer and employee are both necessary to the other.

Figure 1.2 Structural relations of employment in Example Health



Source: Adapted from Sayer (1992, p. 60)

External relations, whilst capable of having an effect, do not generate the same dependency. Internal employment relations can be re-described as structural, with associated generative mechanisms that have tendencies for individuals to act in a particular way. In this sense employment has causal powers that have the tendency to

generate work at specified times, for agents to attend a particular place of work, comply with workplace rules and so on.

Applying Sayer (1992, p. 60), an employment structure comprises relations between an entity (or entities) in the role of employee and another entity acting in the role of employer (shown in Figure 1.2 as internal social relations). Neither can stand alone without the other. An employee without an employer is an individual and an employer without employees is a shell organisation. Wages paid by employer to employee are also necessary to this structure, as is the employee producing wage labour for the employer's benefit. Wage labour produced by a human being without paid wages could be a volunteer or slave structure, but not an employee. Money paid to human beings without work in return is a gift, welfare benefit or charity, but not wages. The minimum necessary relations required for an employment structure, therefore, are between employer, employee, wages and wage labour.

To briefly draw out the distinction between internal and external relations, the person inhabiting the role of employee may also possess other traits, as shown under External/Contingent in Figure 1.2. These may include social aspects (gender, race, marital status, religion and nationality), as well as individual traits (right or left handed, ability to play the piano and hair colour). Whilst some or all of these traits, social or personal, may be exhibited in the individuals who inhabit the role of employee, none are necessary to employment structures.

Whether someone is male or female may influence the type of employment they engage in, or may affect how they are treated in that role, but their gender does not generally alter the basic employment structure. Whilst the amount of wages may differ, with women paid less, for example, at the basic employment structure of employer and employee, the structure remains the same. Similarly, whether someone can play the piano is not relevant to their role as employee (assuming piano playing is not the job), and is therefore external to employment relations. Only production of wage labour for another entity, the employer, in return for wages paid, are necessary to the basic employment structure.

This concept of necessary, internal relations is an important aspect of the analysis discussed in Chapters 5, 6 and 7. To understand the various mutual type structures within PSMs, the necessary relations they comprise were abstracted from the data and analysed to identify the nexus of relations. Once abstracted, structures can be

examined to establish how agents interact with them and the outcome of that elaboration (Archer, 1995, p. 168).

1.2.3.2 Agency

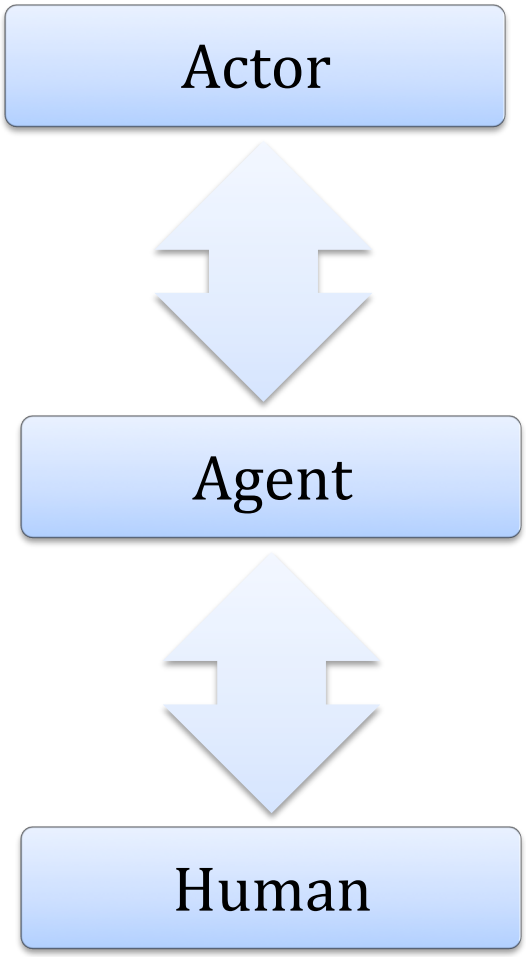
Agency in critical realism also reflects a stratified approach to reality, with Archer (1995, p. 256) distinguishing between human beings (or persons), agency and actors. Agency acts as an intermediate tier of stratification, with actors above and human beings below, as in Figure 1.3, and is the linking element between individual humans and social actors. In this function, the concept of agency aids understanding of who occupies what role and why they act in the way that they do (Archer, 1995, p. 257).

This turns attention to the key differences between human beings and social actors, as illustrated in the external/contingent traits in Figure 1.2. Every human being embodies and possesses a personal identity (e.g. sense of self, personal traits), whereas social actors also incorporate social identities in addition to those personal identities (e.g. gender, religion, class). Agency mediates between these two stratified conceptions of people, the personal and the social, in any structure-agency dynamic.

Returning to the employee example, each incumbent of the positioned-practice of employee is a separate individual, with different personal identity whilst also encompassing social identities. At the same time they each inhabit the position-practice of employee as agent. As an employee, a social actor produces wage labour and receives wages, in accordance with a matrix of rules, regardless of their personal traits, such as hair colour or social traits, such as religion.

The positioned-practice of employee pre-exists whomever the occupant of the position is, with many different occupants subsisting as employee at any particular time, all with different personal and social traits. Current, past and future incumbents mediate the role through the agency of being an employee, with any change or reproduction of the employment structure happening through that mediation. The role of employee creates a positioned-practice (Archer, 1995, p. 153), whereby actors both inhabit the position of employee and engage in its associated practices, irrespective of their individual identity.

Figure 1.3. Genealogy of Humans – Agent - Actor



(Based on Archer, 1995, p, 256)

The role of agency is central to understanding how change and stability occur in social settings. To analyse the relationship between structure and agency, a model of interaction is required, through which data collected from the research cases can be analysed. Archer (1995) has developed the concept of morphogenesis to do this, building on the critical realist concepts discussed so far.

1.2.3.3 Morphogenesis

Two sets of powers subsist in Archer's (1995, p. 15) concept of analytical dualism to explain how structure and agency interact. First, both cultural and structural emergent powers have the capacity to affect agents. Second, agential emergent powers respond to the impact of those cultural and structural powers. Whilst

structure and agency are ontologically separate, operating at different strata of reality, each has the capability to affect the other, through their interrelation.

Change depends on enablers and barriers impacting on generative mechanisms and agential interaction with them. These constraints and enablers do not exist as entities themselves, but "…are the potential *causal powers* of structural emergent properties such as distributions, roles, organisations, or institutions, and of cultural emergent properties, such as propositions, theories or doctrines." (Archer, 2003, p. 5, italics in original). Enablers and constraints are contingent on whether they are activated and actualised, containing no inner ability to act in the abstract.

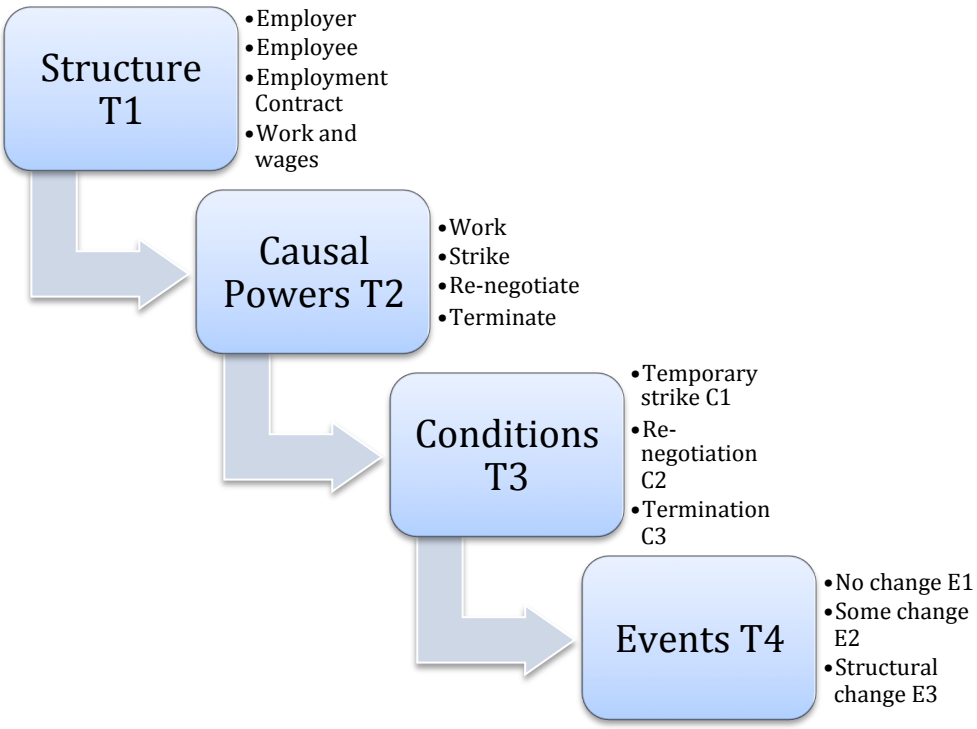
Morphogenesis can be illustrated using employment relations in Example Health again. The necessary relations combine and interact to create the employment structure, which has tendencies to act in a particular way, such as inducing individuals to produce work outputs (treat patients), to attend a designated location (office/clinic) and so on. Actions employees feel compelled to perform within work that they would not feel compelled to do so outside of work, such as attend a clinic, are the result of causal powers inherently possessed by that employment structure. Whilst not physically coerced, each employee performs certain work activities as part of their own individual interaction with the employment structure. Causal powers are not deterministic, but merely tendencies. Under specific conditions, different events may occur, dependant on the nature of those conditions and the collective action of employees when faced with them.

To illustrate this further, the example can be expanded into different contexts, such as industrial action, as shown in Figure 1.4, where Archer's (1995, p. 76) morphogenetic cycle is repeated. Employment structures prior to industrial action occur at T1. T2 – T3 is the time period when the various conditions, such as temporary strike (C1), renegotiation (C2) and employment termination (C3) are elaborated. Interaction of agents (employers and employees) and actualisation of generative mechanisms (right to strike, the ability to re-negotiate and terminate employment), give rise to causal powers to influence whether change, at T4, occurs.

At the occurrence of E1, employees have engaged the mechanism of striking, but not so as to effect structural change, resulting in morphostasis (Archer, 1995, p. 157). When E2 occurs, the employer has engaged the mechanism of re-negotiation, employees have responded with agreement and the strike ends with some structural

changes made to employment relations. A form of morphogenesis thus occurs (Archer, 1995, p. 157). At E3, the employer engages the mechanism of termination, causing the whole structure to change. Employment relations are altered fundamentally and the internal relations broken. Significant change occurs, and again this is morphogenesis.

Figure 1.4. Morphogenesis in employment relations



Source: Adapted from Archer (1995, p. 76)

The example demonstrates structures are not deterministic, nor is agential action freely applied. Social structures impinge on what agents do, and agents respond by either complying with, or altering, structure through elaboration. Either morphostasis, reproduction of existing structure, or morphogenesis, altered or

changed structures, occurs (Archer, 1995, p. 157). The morphogenetic approach will be applied to PSMs in later chapters. The transfer of existing public services into new independent employee controlled entities, as discussed in Section 1.1, produce different contexts or conditions, as in Figure 1.4. Examining this process, and agential reaction to it, provides a lens to investigate PSMs.

For powers of constraint or enablement to affect a particular project or personal aims of an agent or group of agents (Archer, 2003, p. 5), those powers must be positioned in relation to the relevant projects. Taking the industrial action example, if the rationale for striking meets the needs of the individual projects of the agents (employees) who strike, and this outweighs the negative consequences caused by striking (lost wages), then agents will pursue the strike and change will be enabled. However, this is only if the projects of the employer (represented by management) are to prioritise an end to the strike.

Archer's (1995, pp. 258 -265) concepts of corporate agency and primary agency are helpful here. Through the possession of the means to influence and shape structural and cultural formation, corporate agents organise and promote their goals and aims, thus affecting the context within which primary agents operate. In the industrial action example, if employees' individual projects are met by one or other outcome, such as the industrial action resulting in changed conditions (E2 in Figure 1.4), then they are likely to promote their goals through prolonged industrial action and morphogenesis may occur. The collective industrial action is an act of corporate agency, as employees organise and specify their aims in order to pursue their goals, around which their aims have coalesced.

In contrast, primary agents do not have the same influence over organisations, nor do they express their goals, or organise, in the same way as corporate agents. They react and respond to the context within which they operate, but as an aggregation of lone voices, rather than in a co-ordinated exercise of organised reaction to the structural and cultural properties they inhabit. Agency is not fixed, however, with actors adopting multiple agencies, being both corporate and primary simultaneously, in relation to different structures (Archer, 1995, pp. 259-265). An agent at any one time can be engaging in both primary agency and corporate agency. This reflects an inherently complex and multi-stratified open system, another key concept in critical realist thought.

1.2.4 Open systems, emergence and causal configurations.

A critical realist account of reality, based on stratification, implies two key facets. Systems are open, not closed, and open systems comprise emergent phenomena (O'Mahoney and Vincent, 2014, p. 6). Both are influential in the conceptualisation of entities, such as mutuality, and in researching entities to provide explanations, such as how mutuality emerges in PSMs. To develop these ideas necessitates an understanding of what comprises an entity in critical realist thinking.

1.2.4.1 Open systems and real entities

The world is an open system, possessed of inherent complexity, with unpredictable interactions and relations (O'Mahoney and Vincent, 2014, p. 6), without any of the artificial closure that exists in, for example, a laboratory. Entities within open systems are not predictable in how they form, nor are they an aggregate of their constituent parts. They emerge as new entities, indistinguishable from those that generated them.

A real entity "…has an effect or makes a difference." (Fleetwood, 2004, p. 29). This conception of reality is not limited to the material, such as a weather system, or even the artefactual, such as a computer. Both of these entities can have an effect through their operation, but so can ideas and social relations. This is key in the chapters that follow. Mutualism and mutual practices will be conceptualised as real entities that can make a difference, comprising both ideas and social relations. An illustration of such an entity would be the concept of a team within Example Health, as in Table 1.2.

This exercise does not reduce the team to the various parts that combine and interact to make up the team, however. The team exists as an independent entity with its own causal powers, not reducible to the causal powers of the entities it is made up of. To provide an explanatory account of the actions of the team, it is not enough to examine team members as materially real individuals (human beings) or socially real agents acting as a group, nor the ideas of teamwork as an ideally real entity (Fleetwood, 2004, p. 32). None of these alone will give a full picture. When material, artefactual, ideal and socially real entities combine as a team, what comes into being is a new and separate entity with its own causal powers irreducible to those of its constituent parts.

Table 1.2 Reality as comprised in teamwork

Type of Reality	**How comprised**	**Occurs within team at Example Health**
Materially Real	Comes into existence and remains regardless of human thought and actions.	Human beings, oxygen in the workplace.
Artefactually Real	Entities that have been created by human activity.	Premises, computers, office furniture, telephones, stationary
Ideally Real	Concepts that depend on human activity such as ideas, theories and discourses.	Human resource management, theories of team working, performance targets, managerialism.
Socially Real	Social practices that depend on human activity.	Employment relations, team structure, hierarchy, collaboration.

Source: Adapted from Fleetwood, (2004, p. 32)

This is an important concept when considering mutualism and mutual traits in Chapter 2. Mutualism is both ideally and socially real. It emerges from a theory of how individuals should interact and behave with each other and from a set of social relations between individuals (Yeoman, 2017, p. 481). A new entity emerges from the operation of both of these real entities, possessing its own causal powers. The idea and social relations of mutualism, as well as mutual practices, cannot be reduced to each other, but together generate a new, emergent entity.

1.2.4.2 Emergence

Emergence is the generation of an entity with causal powers not equivalent to the combination of its constituent parts (Eldar Vass, 2010, pp. 13-39). Emergence operates within the stratified ontology discussed in Section 1.2.2, occurring when, at any particular stratum, properties interact with each other to create new properties that exist at a different stratum (Thursfield and Hamblett, 2004, p. 120).

Using the team example again, a set of individual employees operating as a designated team acts as individuals within a specific artefactual, ideal and social entity (Fleetwood, 2004, p. 32). Through use of artefactual equipment, the ideas of teamwork and the social structure of a team, the emergent properties and causal

powers of teamwork can deliver outcomes that individuals cannot produce alone, or as an aggregation of individuals. Such an outcome could be treatment of a patient.

Treatment is the result of an emergent process from the team. If neither the idea nor the social structure of the team existed, the patient would experience one person treating them, who may not have all the requisite skills, or experience a disaggregated group of individuals acting separately. Instead, the real entity of the team possesses an emergent property with a tendency to produce treatment and causal powers to generate an outcome, such as improved patient health.

The concept of emergence, along with the other aspects of critical realism discussed so far, will be applied to mutualism and PSMs. To do this, and to analyse how the requisite causal powers can be activated through emergence in such context, requires a framework to abstract entities and then re-describe them to assist explanation (Thursfield and Hamblett, 2004, p. 120). This thesis uses the framework of causal configurations to do this.

1.2.4.3 Causal configurations

The aim of critical realist research is to provide explanation. An explanatory account of what enables and constrains emergent phenomena (whether treatment, mutualism or other) involves a re-description of such phenomena and its various relations in terms of the concepts previously discussed. A useful framework to examine entities is to see them as clusters of different entities that have causal powers. Fleetwood, (2004, p. 46) calls these causal configurations, or just configurations.

Examining configurations of equally important and related causal powers enables a researcher to separate those concepts that are acting together at the domain of the real and the actual, and provide a lens to examine each one. Causal configurations can further refine real entities into phenomena such as social structures, generative mechanisms, rules, tendencies, positioned-practices and causal powers. These have been defined earlier in Table 1.1. Added to these, for the purpose of this research, are resources. In an organisational setting, agents adopting positioned-practices engage with and use resources as part of the social structure that is in effect. An example from an employment context would be money as part of the generative mechanism of wages.

This is not an exhaustive or closed list, but reflects an appropriate degree of abstraction for an organisational setting. Viewing these collectively as a configuration is a heuristic device for analysis purposes, enabling re-description of structures and generative mechanisms into their separate related entities. The way a causal configuration is developed from analysis of data is by using a step-wise approach. The first step is to identify the internal relations that make up any particular structure from relevant data. Then, to provide a more refined framework, these internal relations are sorted into the various entities that make up the relevant causal configuration.

Causal configurations will form a key analytical schema to investigate mutualism within PSMs. By treating mutualism as an emergent entity, which is generated within an organisational social structure at a different stratum to those entities from which it emerges, provides a framework within which the data collected from research case studies can be analysed. However, before setting out how this framework will be applied, it is appropriate to address some of the criticisms of the critical realist approach.

1.3 Some criticisms of critical realism

Criticisms of the critical realist approach can be grouped into two broad categories. The first concerns the insistence of critical realists on the necessity of an ontological meta-theoretical approach. The three domains of reality (Collier, 1994, p. 42), conceptions of structure (Sayer, 1992, p. 61), agency (Archer, 2003, p.118) emergent properties (Eldar-Vass, 2010, p.13) and the interaction of structure and agency (Archer, 1995, p.76) plus accounts of generative mechanisms and causal configurations (Fleetwood, 2004, p. 46) have all been developed to provide a definition of social reality as a precursor to social research (Cruickshank, 2010, p. 580). A diverse group of objections to the requirement of such a meta-theory have been made, including from Marxist, social constructionist and post-positivist positions.

A second broad category of critique concerns the critical realist approach to the issue of structure and agency. In particular, the analytical dualism of the morphogenetic approach (Archer, 1995), which in turn builds on Bhaskar's (1978) transformational model of social action, or TMSA, has been challenged. The objections here, again

whilst wide-ranging, focus on alternatives to the approach to structure and agency adopted by critical realists. Each of these broad objections is considered in turn.

1.3.1 Ontological meta-theory

There are a number of objections made to the requirement for *a priori* definitions of social reality of the type adopted by critical realism. Cruickshank (2010, p. 580) summarises a number of these authors and their varied philosophical backgrounds, making the point that their overarching critique rests on the too general nature of any group of abstractions posited as part of a meta-theory. This develops into a criticism of the flexibility necessarily inherent in the range of definitions and the meta-theoretical concepts developed (e.g. structure, agency, generative mechanism, emergent properties). The critique is that these concepts are too wide-ranging to be of use in empirical research. In essence, so the argument goes, any data can be applied to, and interpreted from, these concepts.

To answer this criticism requires a two-part response. The first is to acknowledge a degree of validity in the arguments made, but to argue that this is as much a benefit as it is a burden. The second is to recognise that with the acknowledged flexibility comes a greater responsibility to abstract research entities appropriately, so as to ensure that the meta-theoretical descriptions do not become meaningless. Each of these responses is expanded on below.

1.3.1.1 A valid critique, but benefit not burden

There is considerable flexibility within the concepts and definitions developed in the critical realist tradition, and this flexibility has the potential to be all things to all researchers. This is evident amongst critical realist authors, who interchange terminology frequently. An example includes basic concepts such as social structure and generative mechanisms. What is described as a generative mechanism can also be described as a structure and vice versa, just as a generative mechanism can be interchanged with causal powers (Fleetwood, 2004, p. 45; Kempster and Parry, 2014, p. 106). This suggests the charge of meaningless abstractions, raised by a number of authors and summarised by Cruickshank (2010, p. 580), is a valid critique.

This criticism is acknowledged, but is not considered fatal. Flexibility is both a necessity of any meta-theoretical approach (critical realism is an approach to action

not a complete theory) and a benefit when it comes to applied research. An account of causal powers is not limited to generative mechanisms alone, nor is it limited to social structures. As Pawson and Tilly (1997, p. 77) have elaborated, context plays a part, as do structural and cultural emergent powers (Archer, 1995, p.265) as well as Fleetwood's (2004, p. 45) causal configurations.

The very essence of the critical realist assertion of open systems and emergence implies complexity and non-linear causality. Whilst the criticism of flexibility is valid, the virtue is that such flexible concepts provide the researcher room to explore complex interactions without prior theoretical constraints. However, with that flexibility comes a responsibility on the part of the researcher to apply critical realist concepts with precision.

1.3.1.2 Appropriate levels of abstraction

The level of abstraction, or level of the strata, of society being examined, is critical to providing a justifiable account of the object of research. A high level of abstraction brings with it limits as to the explanatory potential of many of the critical realist concepts, such as structures and generative mechanisms. The reason for this lies in open rather than closed systems. The wider the abstracted object of research, such as the economy, the more difficult it is to isolate and examine causal configurations. In contrast, the narrower the abstraction of the choice of research subject, an organisation rather than a sector for example, the more useful is applied critical realist research.

This is why critical realism is wholly appropriate for research into PSMs, being organisations that exist at lower level strata than, for example, the health sector. Organisations have legal boundaries to their organisational form, enabling identifiable structures and mechanisms and other causal configurations to be isolated and identified. Whilst operating within external contexts and open systems, organisations such as PSMs provide a greater degree of closure (whilst not being closed) for research purposes, than wider abstractions such as political institutions or sectors of economies.

Examining causal configurations within an organisational context provides a more complete explanatory account of mutualism by harnessing the flexibility of *a priori* definitions comprised within critical realist meta-theory. These definitions can be

applied with greater certainty and specificity than in more abstract research contexts, without losing their flexible approach or by having to revert to fixed theoretical concepts. At the same time, different theories can be applied to critical realist analysis, through retroduction (Crinson, 2007, p. 39), to find the best fit (see Section 3.5.3).

1.3.2 Structure-agency

There have been a number of critiques of the structure-agency position of critical realism. Baert (1996, p. 520) has argued that critical realist accounts of transformation are best equipped to explain stasis. This would suggest that critical realist approaches do not adequately explain social change, but rather why social structures remain the same. Whilst there is some validity in this view as regards Bhaskar's (1978) TMSA, with its focus on agential interactions with entities as a way of reproducing such structures, Archer's morphogenetic approach, which develops the TMSA, addresses Baert's objection (Mingers, 2006, p. 30). Archer's (1995) morphogenetic model, through its use of the concept of agency to delineate society from individual actors, enables both reproduction and transformation to take place through the mutual interaction of structure and agency.

Hay (2002, p. 89) makes a second critique of critical realist views of structure-agency, and morphogenesis in particular, with his strategic relational approach. Here, the temporal separation of structure and agency that underpins the morphogenetic approach is criticised. Instead, Hay (2002, p. 127) argues, "…structure and agency are mutually constituted…" with neither existing without the other. This stands in contrast to Archer (1995, p.15) who argues for analytical dualism between structure and agency, based on the temporal pre-existence of structure and rooted in an ontological separation of the two.

There are some important implications of Hay's (2002, p. 127) approach, not least that a 'mutually constituted' conception of structure and agency removes causal power from both structure and agency acting independently. As Marsh (2010, p. 218) points out, this negates any dialectical relationship between structure and agency. By implication, agency becomes privileged over structure, with focus on agential choice. Agents decide whether to acknowledge, and be influenced by, structures.

This agent-centric view can be challenged from a morphogenetic perspective, not least because it does not acknowledge the role of structures that agents are not conscious of. By positioning agential choice within a strategic context shaped through discourse (Marsh, 2010, p. 219), there is no recognition of deep structures that may influence action of which the agent is not consciously aware.

By adopting an approach based on ontological, rather than solely analytical, distinctions between structure and agency, the causal powers of each are recognised. The relationship between them is brought to the fore and, through morphogenesis, the dialectical relationship highlights how agential action is enabled and constrained by social structures (Marsh, 2010, p. 219). This includes deep structures that agents may not be consciously aware of, thus providing a more complete explanatory framework to examine social transformation, or indeed, stasis.

1.4 A critical realist framework

Taking these criticisms into account, and building on the critical realist principles outlined in Section 1.2, this research adopts an approach congruent with critical realism and appropriate to providing an explanatory account of mutualism within PSMs. Practically, this means conceptualising entities possessing causal powers to generate mutualism from the literature on mutuality. These in turn inform the collection of data from a large N survey and in-depth organisational case studies. By re-describing these entities as causal configurations, a framework to examine mutualism emerges.

This framework can then be applied to examine cultural, structural and agential emergent properties present within the respective organisations. Using Archer's (1995) morphogenetic approach, the outcomes that occur in different organisational contexts, under differing conditions, can be investigated and compared as they were in Figure 1.4. In this way an explanatory account of the emergence of mutualism within PSMs can be developed using critical realist meta-theory as the overarching framework.

Critical realism is an appropriate meta-theory to study PSMs because it avoids reduction of structure to action, or downwards conflation, which ignores agents' ability to act. It also avoids reduction of action to structure, or upwards conflation,

which does not account for the enabling and constraining powers of structures (Archer, 1995, pp. 81-86). By holding separate structure and agency, critical realist meta-theory avoids both conflations, providing an appropriate perspective to explain change. New social structures and agential interaction with them can be examined to give a full explanatory account.

This can be contrasted with alternative meta-theories, such as institutionalism. Institutional approaches, whilst prevalent within organisational theory, assert that institutions determine agents' actions. However, if "…actors cannot escape institutional embeddedness…" (Leca and Naccache, 2006, p. 628), then a paradox occurs when explaining institutional change. Actors are denied autonomy if their actions are pre-determined by institutional structures, raising the question of how actors effect change. This paradox is avoided by the non-conflationary approach of critical realism, which enables both structural and agential influences to be examined equally. It is thus preferred as a meta-theory for studying PSMs, where employees are a central feature and whose engagement with organisational structures determines whether change occurs.

1.5 Outline of remainder of the thesis

Having introduced the policy of PSMs and set out the overarching approach, the remainder of the thesis is as follows. Chapter 2 examines the literature on mutualism and PSMs. After concluding that it is under-developed, under-researched and under-theorised, a conceptual model for mutualism is constructed, and applied throughout the rest of the research. This conceptualisation provides a working definition of mutualism as the emergence of reciprocity, co-operation and trust in pursuance of common purpose over time. The extent to which these mutual relations emerge in PSMs through the practices of employee participation in ownership, shared benefits from the organisation, voice and informational transparency forms the central focus of the research. Acknowledging that these practices challenge subsisting theories of power and leadership in organisations, Chapter 2 also reflects on possible theoretical approaches that may fit a mutual conception of power and leadership. Research questions, derived from gaps in the literature, are then developed to explore mutualism and mutual practices.

Chapter 3 then outlines the methodological approach adopted, consistent with critical realist methodological pluralism. Without a pre-determined methodological template, critical realism advocates a best-fit approach to research design and analysis. Congruent with the exploratory nature of the research, a mix of methods is employed in a two-stage sequence, leaving space for interaction and flexibility as results emerge. This involves first exploring the field, here healthcare providers in NW England, using a survey to collect data, then applying the results to inform in-depth case studies.

Analysis of the survey data is discussed in Chapter 4. Using a mixture of descriptive statistics, frequency analysis and cluster analysis, causal configurations derived from the literature were identified and classified amongst the cases. From this analysis three organisations for in-depth comparative case study were identified. These are Acute Health, an NHS Foundation Trust, Community Health, a recently formed employee owned PSM and Psychological Health, also an employee owned PSM that is over five years old. Each has been re-named here for anonymity. The cases are introduced at the end of Chapter 4, with the PSMs positioned within the healthcare market, before data collected from them is discussed in detail in Chapters 5, 6 and 7. Anonymous quotations from the participants in each case are included in these chapters to reflect the themes that are discussed. They are edited to preserve anonymity and to maintain continuity. A schedule of the codes and job roles of each participant is included in Appendix A.

Chapter 5 examines ownership, one of the causal configurations identified from the literature on mutualism, which is mapped and compared between cases. A contrast is then drawn between employees at the two PSMs, and how they have engaged with their ownership structure, and Acute Health, were no employee ownership exists. There is evidence that ownership has been embraced by the PSMs, albeit more fully in the more mature Psychological Health, increasing levels of trust, co-operation and sense of responsibility, and so reciprocity, amongst employees.

The causal configuration shared benefit, representing how employees share in the benefits produced by the organisation, is analysed in Chapter 6. Whilst the data revealed limitations concerning traditional means of sharing benefits, such as distributing profits from surpluses gained, this did not prevent a causal configuration emerging within the PSMs from re-invested surpluses. There was a strong egalitarian attitude amongst staff at both PSMs, with surpluses going towards achieving their

social mission and delivering on their collective aims. This extended to include training and career development for staff, particularly in Psychological Health, where there was evidence of a virtuous circle between reinvestment in training, improved staff skills, subsequent improved service delivery and so on.

The final two configurations, voice and transparency, are discussed together in Chapter 7. This is because participants in each of the cases regularly merged the two. What subsequently emerged from the data is that these two configurations are very closely linked, and that an active staff voice is contingent on full access to information concerning the decisions being made. What also became apparent was that the employee voice configurations in Acute Health were ineffective, despite a membership structure having been in place for over seven years, compared to those voice configurations in the two PSMs. This suggested that for staff voice and transparency mechanisms to be effective, they had to embrace all aspects of the organisation's decision-making at the macro (rule setting), meso (strategic decision-making) and micro (day-to-day) levels.

Chapter 8 discusses the results of the data analysis and answers the five research questions developed in Chapter 2. In doing so, an explanatory framework that explains how mutualism emerges within PSMs is outlined as the first step for future research into PSMs. Some suggestions for future research are made that address some of the limitations in this research. The chapter concludes with some reflections on the contribution this thesis makes to PSMs and on the future of the policy.

Chapter 2 Public Service Mutuals: A Literature Review

2.1 Introduction

The Coalition Government's promise in 2010 to encourage the transfer of public services from state control into new organisations (Great Britain. Coalition Agreement, 2010, p. 30) was partially effected through a policy promoting Public Service Mutuals or PSMs (DCMS Mutuals Team, 2017). This policy encouraged public sector workers to form new independent organisations to deliver public services (Maude 2010) and by 2014 there were over 100 PSMs, responsible for delivering £1.5 billion of public services per annum according to UK Government accounts (Cabinet Office, 2014a).

Despite having mutual in the name the literature drawn on in support of PSMs does not adequately engage with mutualism as a concept within public service delivery. If PSMs are claimed to be mutual, then it follows that mutualism is a key element of the rationale for their use and implementation. Instead, the evidence cited for the policy is based primarily on employee owned businesses and employee engagement (Le Grand, 2011) rather than on mutualism and mutual organisations as recognised in the wider literature on mutuality.

By not engaging with mutualism, as either an idea, a set of social relations or cluster of practices, there has been a failure to fully address the mutual in PSMs. This chapter will address this critique by reviewing the literature on mutualism to provide a foundation to investigate mutuality in PSMs. The chapter is organised as follows. First, there is literature on early mutualism, representing the ideas of utopian and mutuality writers, mainly from the 19th and early 20th Century. Second, the closely related subject of co-operation is discussed, representing the first successful and sustainable operationalised form of mutual practices. Third is a review of the

literature on New Mutualism, arising from a renewed interest in mutualism in the mid 1990s and 2000s. Fourth is a review of some of the employee ownership literature, which has been cited in support of PSMs.

This review is followed by a conceptualisation of mutualism and its practices for use in the context of PSMs and to enable research into these types of organisation to be carried out. With this conceptualisation to hand, PSMs themselves are reviewed, along with recent research on them. Such an approach addresses the enquiry at the heart of this research: what is mutualism in the context of PSMs and what causes it to emerge? As PSMs are reviewed, research questions are developed to address gaps in current knowledge of PSMs.

An initial exploratory review of PSMs revealed that a systematic review would have provided insufficient literature to consider. A direct evidence base for PSMs is only slowly emerging, and whilst some relevant research has been carried out, they are small in number. The literature that does exist consists of a limited number of peer-reviewed papers and book chapters, with the remainder comprising non-peer reviewed research, reports and commentary from academic institutions, think-tanks and member associations active in the employee ownership, social enterprise, co-operative and mutuals field. As such, some of these are open to charges of bias and promoting their own agendas, either explicitly or implicitly.

This lack of directly relevant peer-reviewed material necessitated a more flexible and iterative approach as the most appropriate strategy. A narrative review was therefore conducted, embracing the literature relating to mutuality and mutuals, as well as the related topics of co-operatives and employee ownership insofar as they were relevant to PSMs as defined by the UK Government, (DCMS Mutuals Team, 2017). In this way, insights, theories and concepts from the wider literature on mutualism, co-operation and, to a lesser degree, employee ownership that may assist research into PSMs could be considered.

The search comprised a series of key words relating to PSMs, mutualism, co-operation and employee ownership combined with public services, selected from initial reviews of texts relating to PSMs. The review was developed iteratively, as analysis of results of searches and references were followed-up. Websites of relevant Government departments were examined, including the DCMS Mutuals Team and the Cabinet Office. ASSIA and Web of Science databases were used, as well as Google Scholar. Searches were made using online catalogues at each of University of

Manchester and University of Nottingham libraries. References from any reviewed literature with relevant references were followed up. With limited peer-reviewed literature available, non-peer-reviewed literature was, by necessity, included.

The narrative methodology means the review is subjective, but with research on PSMs at an early stage, the review provided an appropriate framework for exploratory research, and to develop concepts for further investigation. This was done by indexing key terms and phrases found in the literature and then grouping them thematically to generate a set of common recurring themes that were consistently representative of the ideas, relations and practices of mutualism throughout the literature. These themes then formed the basis of the conceptualisation that takes place in Section 2.3.

Without a comprehensive unified theory, or set of theories, for mutualism in the literature, when conceptualising mutualism and its practices it was necessary to consider multi-disciplinary theoretical approaches. Critical realism has informed the development of all of the concepts in this chapter. Where appropriate, literature from other disciplines, particularly organisational and management theory, as well as game theory, has been applied to assist the development of the concepts in Section 2.3.

2.2 Mutualism prior to Public Service Mutuals

The literature on mutualism is somewhat disparate and incomplete, reflecting historical trends where the prominence of mutualism and mutual organisations has fluctuated over time. As such, there is no definitive text on mutualism, leading Birchall (2001a, p. 5) to advocate for "…a new multi-disciplinary field of study, that we might label 'mutuality studies'". Unfortunately, this has not occurred in any comprehensive way and so a review of mutuality requires the weaving together of concepts from different historical stages.

Four strands of thought were identified from the literature related to mutualism when seeking to identify appropriate concepts for PSMs. For the purposes of this research project these have been categorised, in historical order, as Early Mutualism, Co-operation and the Co-operative Movement, New Mutualism and Employee Ownership.

2.2.1 Early Mutualism

The exact first use of the term mutualism as a concept to guide societal organisation is unclear, but appears to have emerged initially in France as "mutuelisme" by Charles Fourier in 1822, was subsequently adopted by Pierre-Joseph Proudhon as "mutualite", before being taken up by English and American writers in the mid 19th Century (Bestor, 1948, p. 272). The works of Fourier and Proudhon, along with other non-English writers such as Kropotkin (1904) and Swartz (1927) who came later, are therefore the primary works relating to mutualism (as opposed to the co-operative movement discussed below) from this time.

Both Fourier and Proudhon argued for the inherent nature of justice present within humans, which could be liberated through alternative models of society (Prichard, 2007, p. 628). If repressed, this leads in Fourier's view to excess individualism and from Proudhon's perspective, overt despotic control. As their respective outcomes differ, so did their proposed solutions to liberating this inherent natural justice.

Fourier laid out a complex system of utopian type societies that included the supply of goods to consumers using co-operative shops, whilst not prohibiting private ownership or interfering with the means of producing goods and services (Hoyloake, 1875, p. 50; Dayson, 2002, p. 16). This approach presented a mixture of democracy, in how the co-operative shops were organised, and a form of collectivism in how goods and services were supplied, whilst preserving private ownership and wealth. Fourier advocated utopian societies with co-operation as a means of maintaining and improving social order, where wealth was retained but the wealthy co-operated with the less wealthy to ensure a just society. It was utopian, as it assumed wealthy individuals would co-operate for a common good.

Such a mixed system was only a partial attempt at what would be considered mutualism by Proudhon (Prichard, 2007, p. 641). He laid out a more comprehensive system of mutuality that sought to preserve individual liberty, ensured reciprocity in how the benefits of capital were enjoyed, established democracy, organised education on professional (not religious) grounds and enshrined oversight to prevent despotism (Prichard, 2007, p. 641). This prescription for a mutual society comprised a federation of social institutions and organisations, with rules and norms emanating upwards rather than top down. In contrast to Fourier's utopian, but limited, version of co-operation amongst different levels of society, Proudhon envisaged a sweeping

reform to ensure individual liberty as well as reciprocity and democracy through the operation of autonomous social units.

Fourier and Proudhon essentially foreshadow, albeit unwittingly, the story of mutualism and co-operation in the decades and centuries that followed. Fourier's pragmatic accommodation of co-operation with private property and wealth, anticipates the development of the co-operative movement in the United Kingdom, which has not sought to usurp capitalism and market systems of allocating property, but instead has tried to work within and alongside it. In contrast, Proudhon's mutualism is a more comprehensive system, seeking to replace private ownership of property, and the means of production, with a more reciprocal system of allocating the proceeds of capital, as well as introducing democracy and respect for individual liberty within self-governing autonomous social groups.

An implication of this is that co-operation is a sub-set of a wider conception of mutualism. Fourier was limited to co-operation and restricted collective aims, operationalised through the generative mechanisms of democracy to ensure supply of goods and services and so alleviate poverty and hunger. This limited ideal maintains private wealth and aristocracy, relying on co-operation and collective aims to achieve its ambitions.

Proudhon goes further. His social units embrace co-operation and reciprocity expansively, so that all share in the benefits of economic wealth, not merely ensuring they have sufficient goods and services to survive. The generative mechanism of democracy is utilised but so is a reciprocal sharing of benefits produced and equality of allocation. Proudhon's version encompasses a more equal distribution of the economic benefits amongst everyone, going beyond basic co-operation and limited collectivism to embrace also reciprocity and common purpose, such as individual liberty, self-governance, autonomy and re-distribution of economic wealth.

The ideal of autonomous social units and ideas of individual freedom and equality were also central to Kropotkin's Mutual Aid (1904) which relied on evolutionary analysis of nature and primitive societies to situate mutuality within human social groups as a natural state of being, if allowed to subsist. Kropotkin (1904, p. 272) promotes mutual aid as one set of human relations that counter individualism. In suggesting mutual aid as a naturally inherited feature of social relations, mutualism is expressed to be *a priori,* and so is a natural state for humans, in similar fashion to both Fourier and Proudhon.

Individualism necessarily seeks to break the bonds of community and so mutual aid is a counterweight to that. Kropotkin promotes the benefit of co-operation and reciprocity between social groups as competing ideals to competition amongst individuals. In this sense, he is more aligned with the form of mutualism articulated by Proudhon, centred on autonomous communities, albeit recognising that these autonomous social units sit within a hierarchy of sovereign control.

There are two closely related ideas from Kropotkin that can be seen later in New Mutualist writings. First is the role of the state and how it restricts individual liberty. Kropotkin considered medieval cities and guilds the epitome of mutual practice (Kropotkin, 1904, pp. 263-264). These fortified villages, towns and cities evolved as a response and defence against medieval control by myriad rulers, and within their confines mutual aid thrived as societal co-operative action, culminating in the guild system. This represented a degree of communal self-determination rather than disaggregated individualism. Feudal control subsisted, but with laws administered by community representatives and not wholly by a local ruler. This autonomy and self-determinism, free from an overbearing state, is echoed by New Mutualists such as Kellner (1998, p. 2) discussed below.

The second idea related to this is mutualism as a potential mediator between individualism and the ruling state. Kropotkin's account of guilds and their mutual aid did not replace any higher sovereign authority, but sought to operate at level below it whilst still above individuals and their respective competing interests (Kropotkin, 1904, pp. 181-183). They operated collectively, with the workers and merchants combining co-operatively and reciprocally, setting their own rules and norms concerning purchase, manufacture and sale of goods. This system mitigated individual competition, and the adverse excesses that Kropotkin considered arise from it, without resorting to higher order control from a sovereign body that would impinge on individual liberty. Again there are elements of this self-organising system without the requirement of excessive laws in Kellner's (1998, p. 2) mutual principles.

Swartz (1927, p. 1) set out a comprehensive definition of mutualism using similar ideas to Fourier, Proudhon and Kropotkin, invoking equality of freedom and reciprocity, self-determination, as well as co-operation and voluntary association. What is key to this idea of mutualism, as with Fourier, is acknowledgement of privately held property (in contrast to common ownership) alongside individual freedom. At the same time, there is recognition of the interaction between individual

action and co-operation, reflecting the theme of each of these being different aspects of social relations between humans.

After these early accounts, mutualism fell out of fashion as a theory and set of principles during a large part of the 20th Century in the United Kingdom, as state socialism promoted by the Labour Party prevailed as the dominant non-capitalist alternative (Yeo, 2001, p. 231). Emphasis shifted to a narrow, operationalised account of mutuality, used to describe a particular form of organisation operating mainly in the financial and insurance sectors and known as mutuals, friendly societies or building societies (Drake and Llewellyn, 2001, p. 14). These were types of firm rather than a way of organising society and offer limited concepts applicable to PSMs. Instead, the co-operative movement represents the most developed of the operationalised movements during this time with relevance to PSMs.

2.2.2 Co-operation and the Co-operative Movement

The philosophy of co-operation, and its practical embodiment through the co-operative movement, occurs alongside the emergence of mutualism as a separate, but closely related, terminology and set of principles. The philosophical precursors to co-operation are found in utopian writings and ideas. Examples in England included Thomas More's utopian vision, founded on religious beliefs, and describing an early utopian community and John Bellers' "College of Industry", a comprehensive scheme for a co-operative industrial society that could produce everything required by its members without the need for trade or money (Hoyloake, 1875, pp. 28-36). These were theoretical writings, not implemented schemes, which outlined an ideal social unit based on principles of equality, achieved through communal ownership of property and means of production. They are idealistic in that they obviate requirements for private property and means of exchange (money). As ideals they provided a basis for the subsequent practical experiments carried out by the earliest co-operators.

Early co-operative societies based on specific enterprises emerged in the latter part of the 18th century, with the first acknowledged to be in the dockyards of Woolwich and Chatham (Cole, 1944, p. 14). Here, flourmills and baking were organised on co-operative principles to provide alternatives to local monopolies, and spread elsewhere in response to other such monopolies (Birchall, 2001c, p. 73). Whilst these provide examples of *ad hoc*, reactive developments of co-operative practices, the

earliest formalised and comprehensive co-operative ideas, developed to build a society on co-operative principles, were those expressed through the work and writings of Robert Owen (Hoyloake, 1875, p. 56).

Owen is seen as a figurehead of the co-operative movement, with the practices embodied at his mill at New Lanark in Scotland and farther afield, creating "Villages of Co-operation" (Cole, 1944, p. 36). As thinker, creator and practitioner, he acts as a bridge between the idealistic utopian theories and vision of the likes of More and Bellers, and the later pioneers of the co-operative movement who established sustainable, but more limited, enterprises. He conceived and put into practice communities where equality and commonality were fostered, with democratic ideals supporting a fairer foundation for people to base their lives and livelihoods on in a co-operative way. In this sense, Owen was closer to the Early Mutualists, such as Proudhon.

The Owenite communities, which echoed some of the ideas of Proudhon, were relatively short-lived. It was not until the formation of a co-operative retail enterprise in Rochdale in 1844 that co-operation as both an ideal and a practical application took hold in the United Kingdom in a sustainable way (Birchall, 2001c, p. 74). This venture was successful in two regards. First, it demonstrated the viability of member (in particular consumer) owned enterprises operating in competition with traditional private organisations. Second, it introduced a set of ideas for the enterprise that, in variant form, exist today as ideals of the co-operative movement.

As the co-operative movement thrived in the latter part of the 19th century and the early part of the 20th, the principles established by those Rochdale Pioneers, as they were known, became a core component of co-operative enterprises. Birchall, (1997, p.7) summarises these original principles as set out in Table 2.1. Some of these principles addressed concerns at the time faced by working class societies, and so have not survived advances in consumer legislation that addressed such issues as quality of goods on sale.

The majority of these founding principles, though, have survived in one form or another into the most recent iteration published by the International Co-operative Alliance (2017), which are also in Table 2.1 for comparison purposes.

Table 2.1 Comparison between co-operative principles

Rochdale Pioneers (Birchall, 1997, p. 7)	**International Co-operative Alliance principles (Birchall, 1997, p. 221)**
Democratic control	Democratic member control
Open membership	Voluntary and open membership
Fixed and limited interest on capital AND Distribution of the surplus as dividend on purchases	Member economic participation
Political and religious neutrality	Autonomy and independence
Education	Education, training
Pure and unadulterated goods,	Co-operation among co-ops
Cash trading	Concern for community

Source: Birchall (1997) adapted to highlight similarities

Commonalities between the two sets of principles include commitments to democracy, open membership, member economic participation, education and autonomy and independence. These demonstrate core principles of co-operation that have subsisted for over 150 years, reflecting ideas from Early Mutualists of democracy, self-determination, autonomy and equality of participation in benefits. These themes thus carry forward as key principles of mutualism and co-operation when seeking to conceptualise mutuality and its practices.

The co-operative movement declined in the period after the1950s (Birchall, 2001c, p. 77) and the practical application of mutualism through building societies started to retrench with de-mutualisation (Drake and Llewellyn, 2001, p. 14). Mutualism, practised through organisational forms such as consumer co-operatives or financial mutuals, started to recede from fashion in the United Kingdom. It seemed that mutualism would slowly fade into small pockets of activity, when resurgence occurred in the mid 1990s with the advent of New Mutualism.

2.2.3 New Mutualism

New Mutualism emerged from the Third Way discussions in the mid 1990s, with the advent of New Labour in United Kingdom politics (Birchall, 2001, p. 1a). Seeking an idea that would fill the gap between public and private approaches, more pluralist ownership models were sought, based on alternative ideas to traditional forms of socialism or capitalism. One such idea was termed "New Mutualism" by Kellner (1998, p. 4), a concept he claimed did not carry historic overtones in the way that socialism did, and so represented a new terminology for middle ground ideas between public and private provision. Despite the history of mutual type organisations within the 19th and 20th Century, particularly co-operatives and building societies, mutualism or mutuality was not a commonly used term in the 1990s (Yeo, 2001, p. 226). Kellner's (1998) "New Mutualism" sought to re-introduce and re-invigorate its terminology and principles. In this sense, mutualism was a refreshed idea that would form a new doctrine. Birchall (2001a, p. 5) also acknowledged mutuality as a new subject around this time.

Kellner's (1998) exposition of mutualism was published under the banner of the Co-operative Party, which was representative of the prevailing terminology and influence in this sphere at the time. There was not a Mutualist party or mutualism movement. Nonetheless, Kellner sought to go beyond traditional co-operative ideas to set out a doctrine that would influence all of society, not simply certain aspects such as retailers, financial institutions and suppliers of services (Kellner, 1998, p. 1).

Kellner's (1998) pamphlet was the introduced by Tony Blair, the Prime Minister at the time. This is indicative of the discussions happening within the New Labour Government, as they sought to expand the ideas of what had become known as third way thinking (Birchall, 2001, p. 1a) and links New Mutualism directly to UK Government policy. In response, Kellner claimed that what he called New Mutualism, to distinguish it from 19th Century antecedents, forms a non-ideological basis for third way policies, based on co-existence of both freedom and mutual responsibility (Kellner, 1998, p. 6). There are echoes of Kropotkin (1904) and Swartz (1927) here, with aims of individual liberty, mutual aid and social systems based on fairness.

Kellner's (1998, p. 6) version of mutuality emphasises mutual responsibility as key to achieving what he calls the primary principles of liberty, equality and fraternity.

His justification for mutualism is founded on both an ethical dimension of what is good, and an anthropological basis that draws on evolutionary biology and a form of genetic determinism. Citing the work of evolutionary biologist Richard Dawkins (2016) and game theorist Robert Axelrod (1984), Kellner (1998, p. 7) makes the case for mutualism as "…a moral, genetic and practical imperative".

Each of the authors cited employs the operation of reciprocity, trust and co-operation in their respective fields. Dawkins' (2016, p. 202) "reciprocal altruism" also cites Axelrod's work on the game theory exercise of prisoner's dilemma, which outlines a very simple form of reciprocity and co-operation, expressed in a repeated game over time between participants. Trust strategies maximise the outcome for participants of the game, which Axelrod (1984, p.184) simulated using computer programmes to demonstrate that over time trust and co-operation were the optimum strategies.

With that foundation, and following the pattern of the co-operative movement, Kellner (1998, p. 2) set out seven pillars of mutualism that can be summarised as:

1. Mutual responsibility aids development of individual liberty.
2. Mutualism should be encouraged not enforced.
3. Oversight and dispersal of power is important, not its source (as long as legitimate).
4. Market gains come with rights and obligations.
5. Government is the mediator of markets and not a competitor to other participants.
6. All should have equal access to participate in society.
7. Government is responsible for basic equality of access, but not delivery.

Whilst much is made of Kellner's re-invigoration of mutualism (Birchall, 2001a, p. 1) these seven pillars are rather general and uninspiring when compared to earlier versions of mutual thought. They are expressed at a high level of abstraction and as such appear vague, with little that can be disagreed with. For example, both free market libertarians and socialists would agree that all should have access to participate in society and that there are both rights and obligations attached to anyone who seeks to gain from the operation of markets. They would each differ, however,

in how to ensure such access and what those rights and obligations are. Kellner does not add any detail to how these pillars will work, and merely sets them out as guiding principles.

Subsequent authors adopted New Mutualism and developed it as an idea to advocate mutuality and mutual organisations in the United Kingdom. Leadbetter and Christie (1999, p. 11) based their argument for mutuality on ideological and ethical grounds, endorsing the role of mutualism as an intermediary between state power and individualism, echoing the Early Mutualists above. They base this on the idea of mutualism as collaborative and collective, representing key co-operative values from Table 2.1. Emphasising democracy, they maintain that mutuality grows and fosters trust between organisations and members, which can include employee owned entities (Leadbetter and Christie, 1999, p. 16).

Whilst not addressing the theory of mutualism in detail, Leadbetter and Christie (1999, p. 16-17) do make a distinction between strong and weak mutuality within organisations. They classify those mutual organisations owned and under control of members, such as employees, as being strong mutuals whilst weak mutuals are those that promote a mutual culture whilst not being member owned and controlled. There is a question arising here as to the extent that a mutual culture can be fostered without the generative mechanisms of ownership. The research carried out by Allen et al (2012), discussed below, demonstrates the failings in member influence that can occur when ownership vests elsewhere.

Not focusing on the theoretical nature of mutualism is a trend amongst New Mutualism authors. They do not adequately engage with the theoretical foundations of mutualism, choosing instead to focus on its operationalisation. An example of this occurs in Birchall (2001a, p. 3) when, in setting out the meaning of mutuality, three levels are described, with the top level representing an articulation of values that would represent the philosophy of mutualism. Whilst referencing Kellner's (1998, p. 9) mediating role for mutualism, as discussed above, Birchall expressly leaves the idea and philosophy of mutualism unexplored and states that the rest of his book addresses mutuality at lower levels where mutual practices occur.

This approach is repeated by Zamagni, (2013, p. 238), who also gives mutualism three levels of meaning, with the highest level representing a doctrine through which collective action achieves the optimum outcome for both individual and common benefit. Again, mutualism is seen as a mediator between liberty and equality,

counteracting unrestrained action of human activity, to ensure that egalitarian outcomes are achieved. Whilst referring back to Proudhon and Swartz, however, which would provide a foundation for an up-to-date analysis of what comprises mutualism at this level, there is no development of these ideas into a coherent account of what mutualism comprises as a philosophy for current times.

Rogers (1999, p.12), in a pamphlet again published by the Co-operative Party, applied Kellner's ethical and socio-biological rationale for mutualism to housing, arguing through a series of case studies from secondary sources for policies that promoted egalitarian and co-operative solutions. He advocates that occupiers of social housing in the co-operative ownership model, to promote co-operation and reciprocity through their respective mutual obligations, would do this.

At the centre of what Rogers is arguing is a move from transactional to relational interactions by altering the structure of the traditional landlord and tenant relationship. The implication of such a shift is that occupiers adopt new positioned-practices, and so different roles. As long-term members, they move beyond a contractual exchange relationship to a mutual one, and their long-term motivations change. Yeoman (2017) has conducted primary research on this type of model and is discussed below.

New Mutualism permeated some of the policy initiatives by successive New Labour governments between 2001 and 2010, with the introduction of NHS Foundation Trusts into healthcare delivery the most significant (Allen et al, 2012, p. 240). The model selected for NHS Foundation Trusts, introduced in 2004, was the Public Benefit Corporation, which sought to replicate a mutual organisational model, albeit remaining fully owned by the state (Allen et al, 2012, p. 241). Multi-stakeholder participation was introduced, along with elected governance boards (Allen et al, 2012, p. 242). A membership that includes patients, community and staff, elects the majority of a governance board (Day and Klein, 2005, P. 11), and whilst not owned by its members, claims to be a mutual organisation through its membership structure.

Comparative case study research was conducted between four NHS Foundation Trusts to investigate the role of membership and whether it improved public participation in decision-making and governance (Allen et al, 2012). Their findings showed there was limited ability for new membership and associated governance structures to hold executive managers to account. In addition, Allen et al (2012, p. 253) did not consider these organisations to be mutual ones. This was due to a non-

mutual ownership arrangement, with ownership remaining with the state, no ability to distribute surpluses and minimal evidence of staff involvement in governance structures. They concluded that mutuality as an ethos, therefore, was not in evidence.

The introduction of NHS Foundation Trusts highlighted the partial and varied approach to mutualism during the first decade of the 21st Century. Whilst claims were made for the formation of mutual organisations, as Allen et al (2012, p. 253) demonstrated, this was at times more form than substance. Whilst mutualism and mutual organisational forms continued to play a part within the public service reform agenda up to the general election in 2010, it formed part of a wider discourse about alternative delivery models for public services (Simmons, 2008, p. 279). PSMs as a distinct policy agenda only moved on apace following the election of the UK Coalition Government in 2010 (Conroy, 2012, p. 44; Cabinet Office, 2014a). When it did, it was employee ownership not traditional mutual organisations that influenced the policy agenda.

2.2.4 Employee ownership

Whilst not part of the mutualism literature, the PSM policy has relied on employee ownership literature to justify the use of PSMs (Le Grand, 2011). Employee ownership, as the title suggests, comprises forms of legal ownership of organisations where property rights are vested in employees, either wholly or in part. Drawing on research within both United Kingdom and USA private sectors, the benefits that can be derived from an engaged workforce realised through employee ownership mechanisms forms the basis of Le Grand's (2011) case for PSMs.

One such piece of evidence, cited by Le Grand, comprised a review by Matrix Evidence (2008), a private sector research organisation, which included a wide range of organisational types in its classification of employee owned businesses, including co-operatives and mutuals. Whilst not based on primary research, or on public service providers, their review of literature found that worker commitment and employee satisfaction were greater in employee-owned organisations (Matrix Evidence, 2008, p. 5).

The main benefits they assert as accruing to employees from ownership emanate from the ability to influence management decisions (Matrix Evidence, 2008, p. 12). However, ownership on its own is not as significant as ownership that has meaning

and influence. In critical realist terms, this is about the actualisation of generative mechanisms that are part of an employee ownership structure. Where the ability to influence decisions is real, and employees feel their voice and influence is heard, then employee ownership is considered meaningful. Without such an actualisation of the relevant mechanism, then employee ownership is not seen as a perceived benefit for employees.

This would suggest there is no actual benefit from ownership *per se*, but that benefits arise as a consequence of what ownership brings. The Matrix Evidence (2008) review, therefore, in suggesting that ownership makes employees financially better off as well as having increased job satisfaction, is advocating active rather than passive employee ownership. What engages employees is participation in ownership mechanisms that provide the benefits of employee ownership, such as influence and shared financial rewards.

Lampel, Bhalla and Jha (2010), also cited by Le Grand (2011), using comparative analysis of survey data from employee owned and non-employee owned businesses, found links between employee ownership and efficiency and profitability. Their findings indicated that smaller employee owned businesses of less than 75 employees were more profitable, but other than it being easier to involve staff in decision-making and innovation in smaller organisations, they did not provide any significant reasons as to why this would be the case. In addition, their focus was on the material benefits derived from employee owned businesses, such as profitability and well-being, rather than how these were attained and the different organisational models of employee ownership that could be used. As will be discussed later, the ability for employees to share in financial rewards of organisations providing public services is limited and so the applicability of this conclusion to PSMs is questionable.

Turnball (2001), writing from a New Mutualism perspective and not cited by Le Grand (2011), promotes a different version of employee ownership, termed multi-stakeholder. This approach does not limit organisational ownership simply to employees, but involves additional cohorts of stakeholder such as suppliers and customers in the ownership configuration, alongside employees. This model is embraced by the mutualism literature, having been endorsed by Birchall (2001a, p. 11) as a form of mutual organisation. It is termed by Turnball (2001, p. 186) a "stakeholder mutual firm" and offers an alternative to the models cited by Le Grand (2011).

The version of employee ownership put forward by Turnball (2001, pp. 186 – 195) disperses power away from the traditional investor ownership cohort. He identifies a number of features that are required for employee owned entities, including employees participating in the making of decisions, sharing in economic benefits and sharing in management level information (Turnball, 2001, p. 188). These structures ensure employee participation in key resources of the organisation, such as decisions, finances and information. They enable power to be divided amongst a wider group and mirror some of the principles that are representative of the co-operative movement.

2.3 Conceptualising mutualism: re-describing mutualism using a stratified ontology

From the literature reviewed, a conceptualisation of mutualism and its practices can be constructed. Davies and Yoeman (2013, p. 2) articulate a separation of the principles and practices of mutualism, as does Howieson (2016, p. 668), who advises separating mutuality, the idea, from the mutual legal form. The approach taken here, however, goes further, using ontological depth to separate not only the conceptualisation of mutualism and its practices, but also the cultural and structural entities that make up mutualism.

Using a critical realist framework to conceptualise mutualism provides a systematic approach that has been lacking thus far in the literature reviewed. For example, whilst recognising that mutualism operates at three levels (Birchall, 2001a, p. 3; Zamagni, 2013, p. 238) as discussed in Section 2.2.3, neither author goes on to explore the first level of mutualism as an idea or philosophy, instead concentrating on lower order levels where mutualism is operationalised. By adopting a stratified ontology, as outlined in Section 1.2.2, these gaps in the recent literature on mutualism can be addressed, by separating the strata at which both mutuality and its practices occur (Eldar-Vass, 2010, p. 49). The task is to identify the respective causal configurations at each level, by drawing on the literature discussed above to identify entities that make up both mutualism and its practices. It is expected that there will be a number of interrelated causal configurations in each. Before discussing the respective configurations, however, the concept of mutualism in principle requires further analysis.

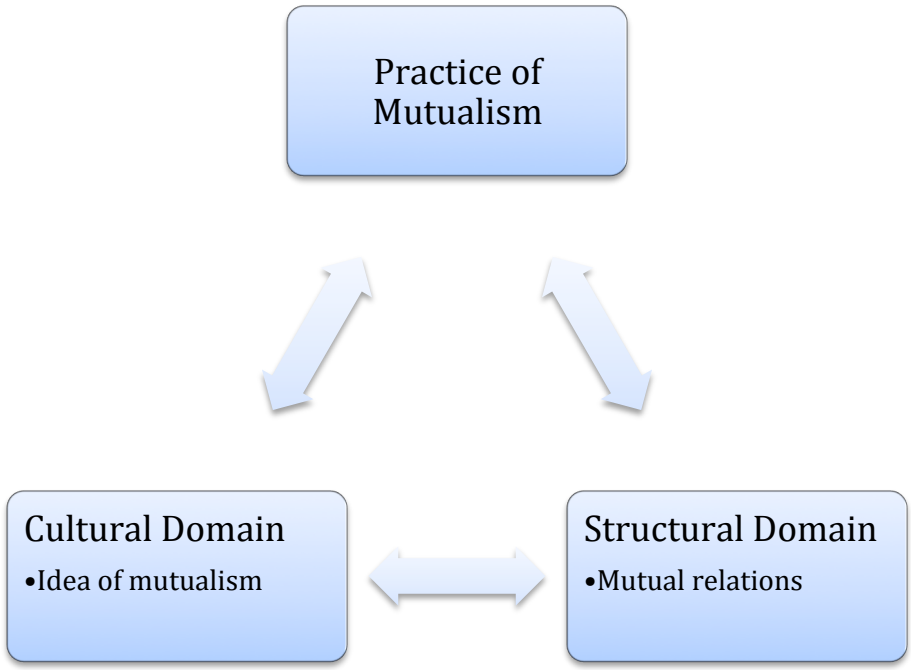
2.3.1 Mutualism in principle

The concept of mutualism has variously been discussed in the literature as a "doctrine" (Kellner, 1998, p. 7), "a set of principles…" (Birchall, 2001b, p. 245) and a "philosophy" (Davies and Yeoman, 2013, p. 2). All agree that there is an idea of mutualism that is capable of having an effect as an idea, as well as in practice. In critical realist terms the idea of mutuality is an ideally real entity (Fleetwood, 2004, p. 43) with cultural emergent properties. The idea of mutualism is capable of having an effect.

It is not sufficient, however, to conceptualise mutualism simply as an idea *qua* idea. It must be an idea about something, and stand in relation to socially real entities. Otherwise, the idea has no effect as a cultural emergent property, and a conflation occurs between the idea of mutualism and the relations that it embodies. For this research project, to provide a more complete explanation of mutualism in practice, it is appropriate to ask of the idea of mutualism: what is it an idea of?

Building on the approach of Davies and Yeoman (2013, p. 2) and Howieson, (2016, p. 668) who kept the idea of mutualism separate from its practice, the idea is also kept separate from the individual relations it governs. This enables the effect of the idea of mutualism on individual relations to be investigated in a research context. Yeoman (2017, p. 481) acknowledges that mutualism is relational and a critical realist stratified approach provides a framework to show this.

Figure 2.1. The interaction of the ideas, relations and practices of mutualism



Source: Author's own

Figure 2.1 illustrates the relationship between the idea (mutualism) and the object of the idea (mutual relations between individuals) both operating at a similar strata (cultural and structural domains respectively). Mutual relations reflect, and at the same time are conceptually mediated by, the idea of mutualism, shaping, but not determining, how agents within those mutual relations act (Archer, 2003. p. 6). In turn, they each reflect, and are conceptually mediated by, the practice of mutualism operating at a separate, real domain, comprising different structures and generative mechanisms. The various two-way arrows indicate this multi-way interaction.

Turning to the idea of mutualism, without an agreed definition in the literature discussed earlier, it is left to construct one from first principles that is appropriate for organisations such as PSMs. One starting point to understand the idea of mutualism is its definition in the Oxford English Dictionary:

> "The action or practice of a group of people in co-operating towards a common goal and for the common good" (OED Online, 2017).

This definition is incomplete (Howieson, 2016, p. 667), but provides helpful beginnings that the idea of mutualism relates to a group co-operating towards a common goal for common good. The literature on mutuality often implies the operation of a set of co-operative social relations in pursuit of a common aim as a basic idea of what mutualism is intended to comprise (Kellner, 1998, p.7). This is not the finished concept, but acts as a guide for the search through the literature for appropriate concepts that would meet this idea.

2.3.2 Mutual Relations

Four entities can be identified from the literature reviewed in Section 2.2 as being consistently recurring in mutualist and co-operative thought and which can be re-described as comprising mutual relations. These are trust, reciprocity, co-operation and common purpose.

2.3.2.1 Trust

Trust relations emerged from the literature as significant in generating and operationalising mutualism. Kellner (1998, p. 27) highlighted mutualism as constituting social relations based on high levels of trust, as does Leadbetter & Christie (1999, p. 8). Trust recurs as an essential relation in Axelrod's (1984, p. 184) experiments. An essential element of mutualism, it is one of the significant emergent entities that both generates, and in turn is generated by, the various mechanisms associated with mutual practices.

A critical realist perspective of trust centres on the social structures that comprise trust relations within an organisational context, alongside the generative mechanisms and the tendencies that trust possesses when it is exercised as a causal power. These are together situated alongside multiple other interacting structures and mechanisms, and so trust operates in the context of other social structures that enable and constrain its emergence. Mutualism is not trust in this analysis, but trust is an important configuration within mutual relations.

Whilst not specifically considering mutualism, Reed (2001) has applied a critical realist approach to the analysis of trust in the context of re-organised health service delivery. His approach is useful in conceptualising trust as "a particular form of

social relations …in which social actors engage in reciprocal interactions based on mutual rights and obligations" (Reed, 2001, p. 217). What Reed is setting out is the concept that trust operates as a series of positioned-practices that agents adopt.

This can be seen in Kellner's (1998, p. 7) idea of trust in modern business relationships, where trust relationships go beyond formal contracts and subsist through repeated interactions within firms. Re-describing trust as a social relation within this context involves different trust relations of agents with other agents being considered in whatever positioned-practice the relators adopt. The trust relations between manager and employee may be different than between shareholder and manager. In each case, though, where there is no immediate and finite exchange, trust between the respective agents involves looking to the future and expecting long-term benefits.

2.3.2.2 Reciprocity

As well as trust, Birchall (2001a, p. 3) suggests a combination of rights and responsibilities, as means of achieving balance between individual and collective needs, a form of reciprocity similar to Kellner's (1998, p. 7) "mutual dependence". The foregoing of individual claims for collective benefit features here, through communal, or societal, habitual reciprocity. Like trust, all of these recognise going beyond one-off exchange transactions. By repeating over time, reciprocity is developed as an on-going social relation, with reproduction through agent interaction creating its own structure.

The New Mutualist authors draw on the advances in game theory to justify their assessment of both reciprocity and (see below) co-operation as significant features of mutualism. Axelrod (1984, p. 13) carried out a series of simulations that showed that co-operation requires on-going interaction between agents. This approach and premise is suitable for an organisational context, such as PSMs, where staff are interacting on a regular basis over an indefinite time frame within a bounded organisational setting.

Whilst not discussing mutualism or mutual organisations *per se* Sanders and Scyns (2006, p. 514) asserted reciprocity as a significant entity in the emergence of trust and co-operative relations within organisations. This enables the idea of reciprocity, expressed by mutualist writers, to be applied in an organisational context. By re-

describing reciprocity in critical realist terms as a social structure with its own associated generative mechanisms and causal powers, a conceptualisation of reciprocity that fits with the idea of mutuality within an organisational context emerges.

Reciprocity involves a set of social relations, with at least two actors involved in a mutual exchange of resources in a habitual manner, over time. It can be a direct, repetitive exchange, such as producing work for wages, or more indirect, such as providing favourable working conditions that result in a generally higher degree of work effort. Staff behave and act in a particular way, in response to those conditions and the benefits generated by their collective actions enable the organisation to achieve its goals. This happens if there is a common purpose between the goals of the organisation and the staff, so that staff satisfaction is gained from successful outcomes achieved by the organisation.

The reciprocity described by Axelrod (1984, p. 113), classified as a "nice" strategy, creates a social structure that endures through reproduction by agents when applying a critical realist perspective (Archer, 1995, p. 157). There is interplay with trust, as reciprocity constitutes a structure that enables habits to form. Reciprocal behaviour implies the operation of trust, as each actor may not receive an immediate exchange in return for his or her actions. As the group works collectively towards a common purpose over time, following the idea of mutualism conceptualised above, those repetitive actions enable reproduction of trust through reciprocity and co-operation.

2.3.2.3 Co-operation

A third set of relations that comprise mutualism revolves around co-operation. Rogers (1999, p. 32) rooted his conceptualisation of New Mutualism within the co-operative tradition, incorporating values of "self-help, self-responsibility, democracy, equality, equity, and solidarity… the ethical values of honesty, openness, social responsibility". In the context of a bounded organisational form, co-operation combines aspects of each of these core ideas and echoes Early Mutualist ideas already discussed.

A critical realist conception of co-operation focuses on relations necessary for co-operation to occur. Co-operation, like reciprocity and trust, goes beyond one-off

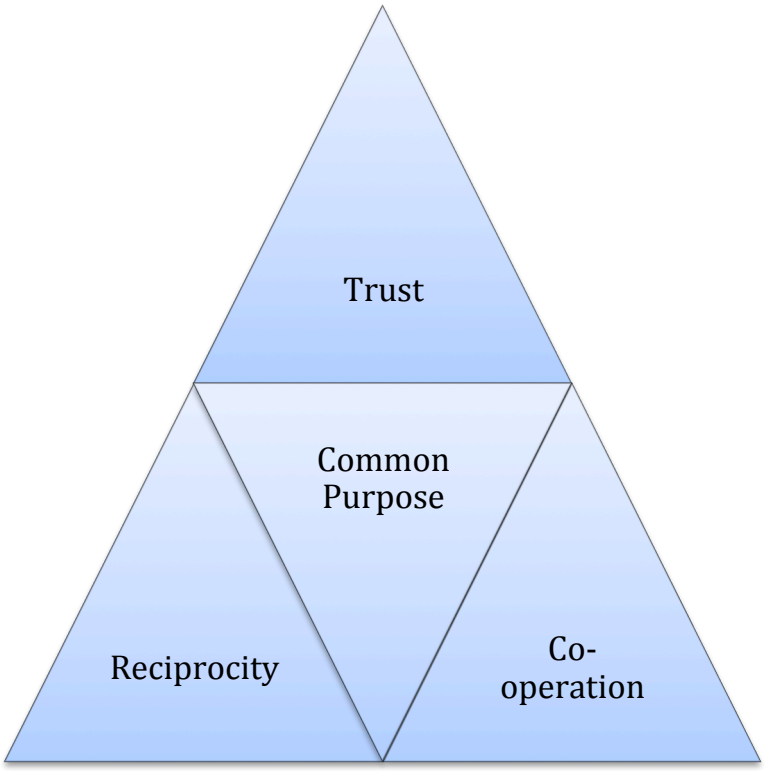
exchange transactions. There is expectation of gaining future benefit involved in co-operation (Axelrod, 1984, p. 15). This fits with the concepts of trust and reciprocity already discussed, which are implicitly part of co-operative relations through their respective iterative interactions. Re-described in social structure terms, co-operation comprises necessary relations between individuals working together towards a common end or purpose. In turn this structure operates and interacts with structures of trust and reciprocity, working towards a joint aim.

2.3.2.4 Common purpose

Whilst each of the social structures trust, co-operation and reciprocity combine to form a mutual set of causal configurations, those configurations will not subsist without a common purpose (Howie, 2016, p. 668). They all require an aim that is common to the group of agents who are engaging in those structural relations. Without it, disparate aims or goals, or what Howieson (2016, p, 668) calls the "privileging of teleological action", undermine, and ultimately destroy, mutualism. An example is the de-mutualisation of building societies in the 1980s and 1990s, when members privileged individual financial pay-out to themselves, over the previous shared purpose of accessible low risk financial products, leading building societies to cease their mutual form (Birchall, 2001a, p. 2).

A fourth dimension of mutualism, therefore, is common purpose, which interacts which each of trust, reciprocity and co-operation to provide a set of interrelated causal configurations. Figure 2.2 illustrates a simplified version of a mutual structure, with common purpose the central feature to bind the causal configurations of trust, reciprocity and co-operation together into a new, emergent, entity called mutualism.

Figure 2.2. A simplified model of mutualism



Source: Authors own

The pyramid format of Figure 2.2 is intended to show that no set of relations is primary, and so any can be at the apex at any time. The relationship between these elements is dynamic and iterative, whilst common purpose remains constant. By combining these four dimensions of mutualism into interrelated causal configurations, a critical realist conceptualisation of mutualism begins to emerge. The dynamism of the interactions between these four components indicates that time is essential to mutualism.

A temporal dimension is critical to any conceptualisation of trust, reciprocity and co-operation (Axelrod, 1984, p. 113; Dayson, 2002, p. 33). All of the ideas from the literature that go to conceptualise these aspects recognise an indefinite timeframe as being significant. Over time, repeated actions of agents working co-operatively and reciprocally towards a common purpose builds trust. Trust between agents in turn enables co-operation and reciprocity. All presume a common purpose to aim for. The critical realist rationale for this temporal dimension is to enable co-operation, trust

and reciprocity to develop, through the formation and reproduction of social structures, in keeping with Archer's (1995, p. 157) morphogenetic approach.

To summarise, mutualism is conceptualised as *the interrelated causal configurations of reciprocity, co-operation and trust in pursuit of a common purpose over time*. This meets the idea of mutualism as a set of co-operative social relations in pursuit of a common aim. It acknowledges the history of mutualism and includes its key tenets, whilst recognising the contested nature of mutualism definitions. It acts as the starting point for research into its operationalisation through organisational form, whilst keeping the idea of mutualism analytically separate.

This conceptualisation embraces mutualism as both ideally real and socially real, so that both can have effect in an organisation. The next step is to develop the practice of mutualism, and how it is operationalised.

2.3.3 Mutual Practices

Mutual practices are the causal configurations within an organisation that both generate the emergence of mutualism and are in turn influenced by the ideas and relations of mutualism. A critical realist approach provides the basis for investigation of causal configurations that operationalise the cultural and social structures of mutualism into mutual practices. From the literature reviewed above, these practices are employee ownership, the sharing of the benefits generated by organisations, employee voice and informational transparency.

2.3.3.1 Employee ownership

Kellner (1998, p. 27) highlighted plurality of ownership generally, not just one class such as employees, and multi-stakeholder ownership is a feature of a number of authors (Turnball, 2001, p. 171; Yeoman, 2017, p. 481). Birchall, (2012, p. 147), in particular, has been a strong proponent of member ownership as a significant differentiator of mutual organisations.

The case for PSMs, alternatively, has relied substantially on employees only. The evidence cited in Le Grand (2011) drew on the employee ownership literature to argue for employee control contributing to enhanced levels of employee engagement as discussed above. One of the main drivers in the employee ownership argument is the breaking down of hierarchies between employees and the managers of the

organisation (Turnball, 2001, p. 174). By embedding employee ownership into structural arrangements of organisations, employees take on an enhanced role, able to participate in rule and agenda setting, and so disperse power.

As PSMs focus on employees, it is their participation in ownership that is investigated here as a mutual practice. Employees comprise all workers employed, including director and manager as well as staff without managerial responsibility. This distinction between employees and staff/managers/directors will be maintained in the remainder of this thesis. Employee ownership can be re-described as a causal configuration, with necessary relations between the owners (in this case all employees) and the entity owned (the PSM). Generative mechanisms are actualised within ownership configurations, namely private property rights (for ownership to occur). In a corporate legal entity, ownership vests in shareholders (a positioned-practice adopted by employees) and is evidenced by ownership of shares (a resource within this configuration). A set of rules and norms govern the structural arrangements of shareholders, such as Articles of Association (the legal constitution of the organisation) and are supported by legislation relating to companies.

This employee ownership configuration operates to create structures with which agents (staff and managers/directors) engage with in their respective positioned-practices. Through this interaction the structure is elaborated in the same way as shown in Figure 1.4, with either change or stability occurring. These are different configurations from the antecedent parent body, in that ownership now vests in a set of agents with associated positioned-practices of owner and shareholder, not the UK Government or a public body.

2.3.3.2 Shared benefit

Prevailing ideas embraced by mutual and co-operative practices include those that reflect equity and fairness (Birchall, 1997, p. 221; Davies and Yeoman, 2013, p. 2) and egalitarianism (Rogers, 1999, p. 32). These are actualised through equal or fair sharing of benefits generated by an organisation. In PSMs this would be the employees participating in ownership (Birchall, 2001b, p. 246). Howieson's (2016, p. 668) conceptualisation of mutuality privileges shared benefit of the outcomes of mutual action, where collective endeavours in pursuit of a common purpose are prioritised over individual gain.

Re-casting shared benefit as a causal configuration involves structural relations between the beneficiaries (employees) and the organisation, with generative mechanisms that support the sharing of benefits. These include equality and egalitarian ideals, drawn from the literature discussed above, as well as generative mechanisms whereby agents participate in the benefits generated. Sharing benefits can take many forms, such as profit shares and bonuses, indirect benefits from retention of financial surpluses to fund enhanced training or provide job security or sharing in success of the organisation's social mission. Resources, therefore, can take the form of cash, employment benefits, benefits in kind or more intangible benefits such as the satisfaction of participating in a social good.

2.3.3.3 Employee voice

Increased employee involvement in organisational governance through democratic mechanisms and equal participation (Rogers 1999, p. 32; Davies and Yeoman, 2013, p. 2), is considered a mutual practice in employee owned organisations (Matrix Evidence, 2008, p. 12). Whether through staff boards, staff directors, workplace democracy or by agenda and rule setting through the generative mechanisms of employee ownership, each increase staff participation in decision-making. These are grouped together under the collective description employee voice as a label for a causal configuration that increases staff participation in governance.

An employee voice configuration comprises relations between staff, in their capacity as both employees and owners (where ownership is vested in employees), and managers/directors in the organisation (who could also be owners). The decisions, whether at a macro-level, such as constitutional rule setting, meso-level such as board decisions or micro-levels such as day-to-day decisions, are resources of the organisation.

The generative mechanisms are usually democracy and participation, (Rogers, 1999, p.32; Birchall and Simmons, 2001, p. 203; Davies and Yeoman, 2013, p. 2), with decisions being made collectively through direct or indirect democratic means (Yeoman, 2017, p. 483). Staff adopt different positioned-practices, such as shareholder, board or staff council member, alongside their role of employee and a set of rules and norms will govern those decision-making forums, such as the Articles of Association.

Employee voice through staff participation in governance and decision-making, like ownership, creates a causal configuration through which agents interact. It is likely that, due to the participative nature of PSMs and their differences to prior public sector bodies, the antecedent structures and configurations will differ. Whether this has an effect as to generate the emergence of mutuality will be determined by how those agents are impinged on by the voice configuration, and in turn how they engage with it.

2.3.3.4 Transparency

There is a tangible link between flow of information and effective participation in governance and decision-making (Turnball, 2001, p. 188). For active decision-making to occur, participants need to both know and understand the relevant information relating to the decision and its context. Increased transparency and openness amongst staff, through dispersal of information and the means to understand it, increases employee participation in decision-making. Information in hierarchical organisations is often privileged to managers and strictly controlled (Turnball, 2001, p. 175) notwithstanding that it is a significant resource of the organisation. This enables those in control of information to possess power to make decisions and enact policies that privilege their interests at the expense of others, such as employees.

Research carried out by Davies and Yeoman, (2013, p. 19) on PSMs highlighted the importance of openness and transparency in developing mutuality within organisational context, particular when the mutual practices were newly introduced. Keeping everyone fully informed was part of the process of developing a trust environment. In a multi-stakeholder mutual, openness was considered part of the culture that was being developed, which in turn fed into the governance principles that involved stakeholder participation (Yeoman, 2017, p. 484). This emphasises a link between transparency and voice.

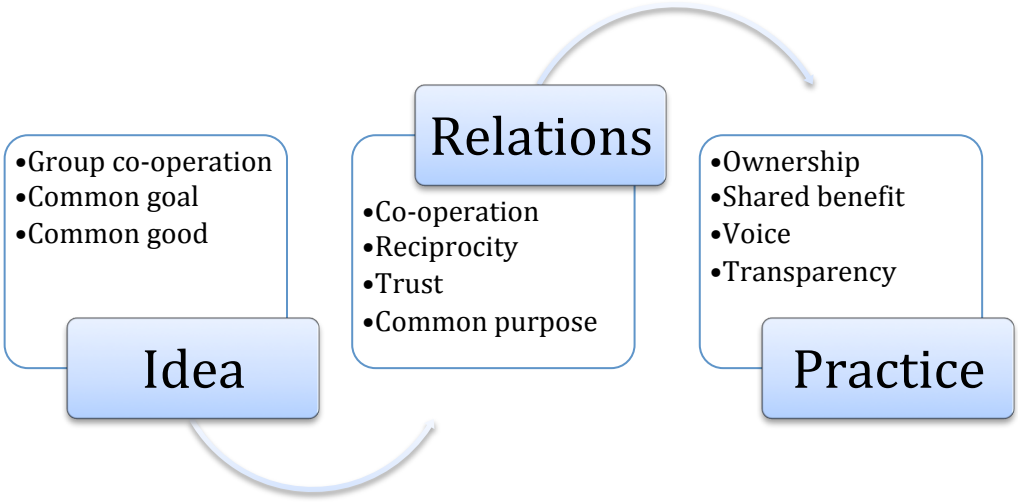
In a mutual organisational environment, therefore, openness and information sharing operate as a causal configuration of transparency. Information is the resource in this configuration and structural relations exist between staff and managers/directors, who share and receive information. Generative mechanisms involve openness and transparency, which are engaged by directors, managers and staff in their respective

positioned-practices. Agency has the effect, when the generative mechanisms are actualised, of generating causal powers that enable active participation in decision-making, as well as trust between staff and the organisation/management.

2.3.3.5 Mutualism as idea, relations and practices

The individual relations of trust, reciprocity, co-operation and common purpose operate in relation to the idea of mutualism, a set of co-operative social relations in pursuit of a common aim as described above. These two concepts interact at the strata of mutualism in principle, with both the idea and the relations having effect within an organisational setting. In turn they interrelate with the four employee participation configurations of ownership, shared benefit, voice and transparency, at the level of mutuality in practice, and vice versa, as in Figure 2.3.

Figure 2.3. A conceptualisation of mutualism as idea, relations and practice



Source: Authors own derived from literature on mutualism

Figure 2.3 shows a process of interaction between the three types of reality and can be read in conjunction with Figure 2.1, with multiple interactions between the three levels operating in multiple directions, each influencing and shaping the emergence

of the other. With this conceptualisation of mutualism and its practices, PSMs and research on them can be analysed to examine mutuality in that context. First, however, a brief reflection on how mutual practices interact with prevailing perspectives on organisational power and leadership is merited.

2.4 Reflections on power and leadership within PSMs

The conceptualisation of mutuality developed so far, centred on democracy and participation, moves away from organisational hierarchies. Concepts of power and leadership associated with such hierarchies, focused on a distinction between leader and follower (Ridley-Duff and Bull, 2011, p. 197), therefore require a critical re-evaluation, reflecting a context where that distinction becomes blurred.

Power is essentially a contested concept (Lukes, 2005, p. 61), with numerous competing versions in the literature. These include power as resources, outcomes and relations, as well as power considered in organisational or discursive terms, as zero-sum games, transitive or intransitive power, at the level of structure or agent and with different dimensions or faces (Arts and Tatenhove, 2004, pp. 347-348). Despite the variety of perspectives, however, one recurring theme is the lack of an adequate approach that acknowledges both structure and agency in the power debate (Arts and Tatenhove, 2004, p. 349).

Through the ontological irreducibility of structure and agency, a critical realist perspective analyses power relations in both these terms (Bates, 2010, p. 371). In so doing, the issues that arise with, for example, Lukes' (2005) third face of power perspective are avoided. Applying the third face analysis to an employment scenario, employee desires are manipulated by the employer's structural influences so that the employees' own objective interests are masked from them. This results in a blurring of interests, as employees adopt their employer's aims and desires as being for their own benefit.

However, in similar fashion to the critique of institutionalism in Section 1.4, this third face approach denies agents their freedom to act. Consequently, a PSM with enhanced participation and democracy requires a perspective that recognises structural power relations that enable and constrain agential action, and also agential ability to respond to, and alter, those structures. When managers and staff have equal participation in decision-making, the leader-follower approach and associated power

relations are disrupted. This requires alternative theories to explain leadership and power relations appropriate to the less hierarchical context of PSMs. Three distinct, but related, concepts that may assist such an explanation are employee voice, distributed leadership and communities of practice.

Employee voice, discussed as a mutual mechanism in Section 2.3.3.3, introduces democracy and staff participation into organisational relations, with staff adopting different positioned practices alongside their role as employee. The alternative practices of shareholder, board member and participation in day-to-day decision-making, challenge leadership models focussed on a distinction between leaders and followers (Ridley-Duff and Bull, 2011, p. 197).

Managers are traditionally considered leaders in organisations, exercising power over employees (Gohler, 2009, 28-29), whereas employee voice participative decision-making mechanisms transfer power away from managers to staff (Heery, p. 35). This dispersal of power requires an alternative approach to leadership. With more employee participation in decision-making, and less hierarchical command and control, the leader-follower model is disrupted. Distributed leadership theories (Bennett et al, 2003; Bolden, 2011) fit the changed relations between managers and staff, and corresponding power shift, effected by employee voice mechanisms.

Whilst comprising diverse terminology and concepts (Bolden, 2011, p. 252) distributed leadership's overarching theme is leadership as a collective social activity, not the actions of one person. Recognising the contested nature of distributed leadership, Bennett et al (2003, p. 7) identify three common ideas within this theme. First, leadership is emergent from the relations of a group of interacting agents. Second, leadership is open, not bounded. Third, different types of expertise are dispersed across the group, not retained in individuals or a small cohort. These three ideas disrupt the concept of leadership imposed on a group by individuals. Instead, leadership is a group activity operating through relations in those groups, not individual action.

To accommodate the dispersed nature of leadership, power and expertise in PSMs, Lave and Wenger's (1991) communities of practice may be helpful. Wenger, McDermott and Snyder (2002, p. 27) have refined communities of practice into domains that define groups of interests, where communities focused on that domain develop shared practices for use within it. These characteristics are useful in

highlighting differences between communities of practice and units or teams in organisations, where contrasting sets of leadership and power relations are reflected.

Communities of practice may reflect power relations that exist in an organisation (Roberts, J, 2006, p. 626) thus implying a greater range of voices in PSMs where power is distributed more widely through democratic participation. In contrast, where leadership, and thus power, is more centralised, such as hierarchical public sector organisations, communities of practice may reflect organised team structures, with reporting lines to hierarchical leaders.

This wider participation in communities of practice, which work better in organisations with high levels of trust (Roberts 2006, p. 627), suggests they may complement the democratic and participative structures and mechanisms of employee voice and distributed leadership. Communities of practice may assist development of mutuality, through a shared domain focused on mutual ideas and practices, as well as other common purposes. Additionally, as PSMs move away from antecedent public sector norms, domains may emerge that concentrate on new leadership practices and decision-making or shared resources and knowledge focused on quality service delivery in a new organisational structure.

To summarise, employee voice, distributed leadership and communities of practice may complement mutual practices within PSMs. Following Roberts (2006, p. 630), change occurs slowly within organisations where subsisting organisational structures maintain existing leadership and power relations. However, when antecedent hierarchical power and leadership structures are replaced by employee voice mechanisms, new structures emerge where leadership and power is dispersed, enabling new voices to be heard and distributed leadership practices to emerge. Communities of practice may help to embed those new practices within PSMs, through shared communities focused on mutuality, decision-making and service delivery.

2.5 PSMs in England since 2010

Whereas New Mutualism sought to introduce a new political philosophy, PSM policy sought to introduce a new type of organisation. Mutual practices, such as employee ownership and control, together with the concept of employee engagement, permeate the narrative emanating from the DCMS Mutuals Team

(2017). Much was made of John Lewis as an example of the benefits of employee ownership, with the Chairman being recruited by the Cabinet Office to mentor pilot PSMs (Cabinet Office, 2010).

Whilst drawing on organisations that had formed alternative delivery models having left the public sector (Cabinet Office, 2010), there was a lack of empirical evidence to support the case for PSMs in the early stages of the policy. An initial evidence base, in the form of a review of literature, was published by the Mutuals Taskforce in the name of Le Grand (2011, p. 6) and drew a number of conclusions that have influenced the development of the PSMs policy agenda.

An assertion was made of a materially relevant and reliable evidence base for mutualisation of public services. This is based on a selection of evidence on employee ownership and engagement. The Matrix Evidence (2008) review and Lampel, Bhalla and Jha (2010) were two of the papers cited, which considered employee ownership as a means of improving staff engagement and productivity, as discussed above. However, other works used as evidence, such as (Kuler et al, 2008, p.10) and Macleod and Clarke (2008, p. 9) focus on employee engagement alone (without ownership models). By focussing on employee engagement rather than employee ownership, the conclusion that there is a significant body of evidence supporting PSMs is undermined.

The main arguments made by Le Grand (2011, p. 10) are associated with intrinsic and extrinsic benefits. These are benefits that improve employee job satisfaction intrinsically through increased employee engagement that has a positive effect on staff. Through this enhanced employee engagement, service delivery is improved, because of the instrumental effect of the increased engagement. An improvement in service generates decreased cost of delivery and improved productivity.

There is little explanation of the links between intrinsic and extrinsic benefits made by Le Grand (2011). The intrinsic benefits are claimed to derive from organisations with ownership and strategy being vested in the professionals who deliver the service. This synergy leads to greater commitment and job satisfaction. Whilst linking this to an unspecified emotional experience by drawing on the employee engagement findings of Kuler et al, (2008, p.18) the relationship between the perceived intrinsic emotional experience and the outcomes of improved efficiency are not explained.

Partly this lack of explanation is due to Le Grand (2011, p. 9) conflating mutualism and mutual organisations. Whilst recognising "a rich tradition of principles and values" associated with mutualism, there is no effort made to explore these, nor any attempt to conceptualise mutualism as an idea or set of relations applicable to PSMs. Neither is there any attempt to situate PSMs within the history of mutualism. Instead, it seeks to define what a mutual is (the organisation not the concept) but then does not do so, defining a PSM instead. A PSM is a much narrower conception of a mutual organisation than those co-operatives and stakeholder mutuals discussed in Section 2.2, even to the extent of focusing on employee control rather than ownership.

Subsequent research into PSMs (discussed below) has already cast doubt on the simplified approach taken by the Le Grand (2011), with Davies and Yoeman (2013, p. 2) highlighting the absence of "…systematic understanding of how organisations apply the principles and practices of mutualism…" The distinction between principles and practices is critical if an explanatory account of the process of mutualisation of PSMs is to be developed for research purposes. Without this, the rationale for the mutual in PSMs is undermined. If there is no account of mutualism in PSMs and the benefits that accrue from it, then they should be called something else and mutualism abandoned as nomenclature for the policy. Which leads on to an issue with the definition itself.

The definition of PSMs used by the Mutuals Taskforce, and subsequently adopted by the DCMS Mutuals Team (see Section 1.1), also causes concern as a basis for PSM policy. No explanation is provided as to why focus is on employee control, rather than employee ownership or co-operative and mutual forms. There is a lack of precision that is not helped by the inter-changeability of the term "mutual" and "public service mutual", which further emphasises the lack of detailed theoretical analysis around the concept of mutualism in the context of public services and the conflation of mutuality and mutual organisations.

The definition of PSMs is vague in that it refers to organisations "in which employee control plays a significant role in their operation" (Le Grand, 2012 p. 9). There is no indication of what counts as significant. An example of this is MyCSP, a joint venture providing management services to the civil service pension scheme, owned by the UK Government (35%), a private sector company (40%) and employees (25%) (National Audit Office, 2013, p. 5). Whilst considered a PSM by the DCMS

Mutuals Team (2017), and formed with their support, employee ownership of 25% is not employee control, and arguably is not significant either.

This can be contrasted with alternative definitions in the literature on mutualism, such as Leadbetter and Christie (1999, p. 15) and Birchall (2012, p. 147), which distinguish mutual organisations by virtue of them existing to benefit members of the organisation only. Membership is not limited to employees in these alternative definitions, and can encompass service users as well (Yeoman, 2017, p. 481). Whilst no agreed definition of a mutual organisation existed prior to the Coalition Government's PSM policy, the consensus from the co-operative and New Mutualism literature reviewed above is that a mutual organisation is owned or controlled exclusively by its members, who could be a range of stakeholders (Birchall, 2012, p.148). This contrasts with the definition applied to PSMs, with focus on employee or staff control (not ownership).

There has been a small body of research and analysis on PSMs, independent to the work of the Mutuals Taskforce, since the PSM policy was launched. These can be divided into two types. The first comprise commentary and analysis of the policy itself, situating it within existing theory relating to public service reform (Myers and Maddocks, 2016) or PSMs' relationship to mutualism (Birchall, 2012). The second consists of empirical research conducted on the process of transferring from public sector into PSMs (Hazenberg and Hall, 2016), the differences between PSM and in-house provision of public services (Alexander et al, n.d.), the process of change involved in becoming a PSM (Davies and Yeoman, 2013; Yeoman, 2017) and the type, motivation and benefits of PSMs (CIPFA, 2017). Of these, the empirical research is most relevant here, representing empirical evidence from PSMs.

Alexander et al (n.d., p. 1) used both qualitative and quantitative analysis of data gathered from two PSMs, identified by the Cabinet Office. Data collection was divided into two parts, with interviews and focus groups held with managers and senior staff and an online survey of other staff members. Whilst the survey increased the range of staff members from whom data was collected, there was no opportunity to explore qualitative data of staff experiences of employee ownership and control in a PSM, as there were with senior managers, a deficiency the research in this thesis intends to address.

Notwithstanding this, Alexander et al (n.d., p. 11) revealed useful data from their two case studies that are helpful in developing conceptualisations of mutualism and its

operation. High degrees of employee control, brought about by employee ownership, with a sense of responsibility and involvement, were considered to exist in the PSMs. Shareholding itself created a sense of co-ownership with an influence on the organisation's culture and decision-making. Both of these can inform conceptualisation of mutual practices.

Hazenberg and Hall (2016) focused on the process of transfer itself, again through data gathered from interviews with senior managers and Local Authority leaders. They considered four PSMs that had transferred from local authorities, highlighting the drivers of the process as funding cuts to the public sector. They did not consider mutualism in operation following the transfer into PSMs, and so the study is limited to the process itself. In part this was due to the aims of the research, which were focused on the process of transition. At the time the research was conducted none of the four potential PSMs had actually left the host Local Authority, and therefore any mutual causal configurations were not yet actualised. This meant that none of the data was gathered from participants actually operating a PSM, with findings focused on triggers for the transition.

These included financial restrictions at the host body, the PSM policy context (including support from the Mutuals Support Programme), change of political control at the host authority and senior leaders who promoted change. Whilst these do not offer insight into the operation of PSMs, it is notable that none of the triggers involve employees, suggesting a top down transition process. For entities that are focused on creating employee owned businesses, it is surprising that the triggers are not employee focussed.

The process of change was also addressed by Davies and Yeoman (2013) and Yeoman (2017), but from a different perspective. These two pieces of research focused on mutualism and its operations and recognised that part of the change process involved the development of mutual practices, as well as the idea of mutualism, amongst the participants. Davies and Yeoman (2013, p. 2) was notable for not conflating the idea of mutualism with its practice and operation, as has been prevalent in a number of works in the literature on mutualism.

Yeoman (2017), consisting of a case study of a multi-stakeholder owned PSM in the housing sector, considered the process of embedding mutuality through the process of change, as well as the importance of co-ownership. Data was collected at all levels of the organisation, including staff and tenants, to provide a richer explanatory

account. A key finding relevant to research into mutualism in PSMs related to the transition from old organisational identity to a new one, and recognition of the complexity this entails. In critical realist terms this highlights conflict between competing positioned-practices, such as co-owner and employee, when new positions and practices sit uncomfortably with old ones. This conflict could inhibit the emergence of mutualism in a newly formed organisation that retains some of the antecedent positioned-practices.

Finally, the most recent empirical work was commissioned by the DCMS Mutuals Team, (CIPFA, 2017) and represents the first time those promoting the PSM policy have commissioned empirical research since the Mutuals Taskforce in 2011. This study aimed to generate increased understanding of the characteristics, benefits, challenges, performance and contribution to success of PSMs, using a mixture of online survey and telephone interviews.

The sample comprised the list of PSMs held by DCMS Mutuals Team, with a response rate of 55%. There are useful outputs, especially relating to employee ownership. It was reported that the majority of PSMs who responded were employee owned, either in whole or part, with 50% wholly employee owned (CIPFA, 2017, p. 23). This is helpful in the conceptualisation of how PSMs operationalise mutualism, and reflects the member owned philosophy prevalent in the literature on mutualism, albeit with a member cohort restricted to employees (Birchall, 2012, p. 147).

The research also asserts that it takes several years to embed staff engagement practices within PSMs so that they can be effective, and requires considerable time and effort from managers (CIPFA, 2107, p. 23). The temporal dimension of mutualism was considered above, and forms part of the discussion in Chapter 8, re-enforcing observations made about time and the efforts required for mutualism to emerge.

2.6 Conclusion and Research Questions

A conflation between the idea, the relations and the practice of mutualism has occurred in the literature on PSMs, resulting in unsatisfactory explanations of the role of mutualism within these organisations. This is particularly important as PSMs are not formed without antecedents, and a lack of understanding of how mutualism occurs risks new PSMs inheriting their parent public body's cultural and structural

emergent properties, thus negating any perceived benefits of the mutual organisational form.

Keeping separate the idea, relations and practice of mutualism provides a framework for research into mutualism within PSMs. Causal configurations, such as employee ownership, employee voice, informational transparency and employee shared benefit, have been identified as mutual practices that would be expected to be operationalised in an organisation that is claimed to be mutual. By examining these practices within PSMs, their relationship with mutuality and its emergence can be examined.

The aim in the remainder of this thesis will be to provide an explanatory account of how mutualism emerges within PSMs, adopting a critical realist approach. The outcome will be a conceptual framework that explains how mutualism is operationalised within PSMs. This raises a number of research questions that will need to be answered to achieve this, highlighted in bold in the following paragraphs.

There is a lack of consensus in the wider mutualism literature about what comprises a mutual organisation, and what are suggested conflicts with the PSM and employee ownership literature. The first research question, given this conflict, is to ask: **what distinguishes PSMs from other organisations delivering healthcare public services?** In answering this question, any mutual traits, re-described as causal configurations, can be identified as a first step in determining how mutualism emerges.

A second question concerns the generative mechanisms that form part of these configurations, and asks: **what generative mechanisms operate within PSMs compared to public sector organisations delivering healthcare?** PSMs have been presented in the literature as being different from the host bodies from which they emerged. By focusing on the mechanisms that make up the mutual traits, and comparing them to public sector organisations they are intended differ from, a picture will emerge about PSMs and their perceived differentiation.

A key element of the critical realist approach concerns how agents interact with structure, and in particular whether they actualise generative mechanisms or not. The third question addresses this by asking: **how agents interact with these generative mechanisms in PSMs in comparison to public sector organisations delivering healthcare?** Again, the comparison with public sector organisations should highlight

the contrast between PSMs and the organisations they have left, to address what has not been covered in literature on PSMs thus far.

The penultimate question concerns whether the actualisation of generative mechanisms occurs, and what influences this. This involves asking: **what enables and/or constrains the operation of these generative mechanisms within PSMs?** The conditions required for any mutual practices to have effect within PSMs, so that mutualism emerges, can be explored in this question.

The final question aims to bring together the outcomes from the research and deliver the intended aims. Building on the previous four questions, the analysis is concluded by asking: **how can mutuality be conceptualised within PSMs?**

The following chapters set out the answers to these research questions through the adoption of a critical realist approach, which will seek to explain how mutualism emerges within the context of PSMs, culminating in conceptual framework that gives an account of the emergence or otherwise of mutualism within the context of PSMs.

Chapter 3 Research Design and Methods: a critical realist approach

3.1 Introduction

This research project aims to develop an understanding of how the principles and practices of mutualism operate within Public Service Mutuals, or PSMs, using a critical realist framework. One of the conclusions from a review of the literature in Chapter 2 is that PSM policy lacks a foundational body of empirical research and theory to build on. By implication, research into PSMs at this juncture is restricted to an exploratory project, aimed at developing conceptualisations of mutualism within PSMs and understanding how mutualism works within them. The research questions developed in Chapter 2 reflect these exploratory aims, as does the methodology employed to answer these questions. Whilst informing the research, the critical realist framework does not determine choice of methods or how research data is analysed (Sayer, 1992, p. 164).

This chapter discusses the research methodology employed by providing an outline of the critical realist framework, focused on how it influences research methodology and design. An overview of the research design is set out in Section 3.3 before a detailed account of the iterative combination of extensive and intensive research methods selected (Sayer 1992, p.163). Sections 3.4 (Extensive) and 3.5 (Intensive), each respectively detail the sampling, data collection and analytical methods employed. A discussion on research integrity completes the chapter, including corroboration of research findings and research ethics issues.

3.2 A critical realist framework for research

3.2.1 Critical realist approach to methodology

Critical realism, as discussed previously, adopts two simultaneous positions that influence methodological choices for empirical research, summarised as objective and subjective. The objective view says the world is independent from our knowledge or thoughts of it (Sayer, 1992, p. 3). The subjective recognises there is also individual interpretation, or reflexivity, which affects how that external world is perceived (Archer, 2003, p. 36; O'Mahoney and Vincent, 2014, p. 2). This dual objective/subjective approach contrasts with wholly objective positions (such as positivist and empiricist paradigms) and wholly subjective positions (such as social constructionism, with its emphasis on interpretation through human perception), and is reflected in methodology employed for research.

Part of a critical realist research paradigm is methodological pluralism, albeit within the constraints of the ontological position adopted. The distinctiveness of this approach is best shown when compared to ideal type wholly positivist and wholly constructivist positions. It is recognised that wholly positivist and wholly interpretive paradigms are infrequent, with researchers often adopting mixed methodologies that do not accept rigid divisions in ontology (Bryman, 2012, pp. 628-631). However, whilst acknowledging that there are many variations in-between these antithetical positions, comparing critical realism to them helps to highlight the contrast.

Critical realism's commitment to ontological depth, recognising the causal nature of social structures, but eschewing positivist claims that all such social structures and relations are fully observable, distinguishes critical realism from positivism on fundamental grounds (Sayer, 1992, p. 73). The existence of deep structures and mechanisms imply some accounts of their operation based wholly on observation will not present a true picture: observation alone cannot fully examine and test hypotheses of how social relations operate. The teamwork examples in Chapter 1 illustrated this.

In another variance to positivist thought the world is an open system, with limited ability to extract and isolate any aspect of the world from its environment or context. This has manifest implications for research methodology in social sciences. Unlike the natural sciences, there are limited opportunities to replicate 'laboratory' type

conditions under which social experiments can be examined, with variables isolated to minimise or remove their assumed impact. With limited ability to isolate variables, quantitative analysis, through inferential statistical processes, is considered able to assist in describing patterns of events (Sayer, 1992, p. 164), but not to explain causation based on correlations of events. This places limitations on how quantitative methods can be used in critical realist informed research.

The ability to predict or generalise is confounded by the numerous interactions and feedbacks that influence social systems. Prediction and generalisability, as advocated by a positivist approach, are impractical aims within a critical realist framework, and so are not prioritised as an outcome. Instead, developing an understanding of the operation of structures and generative mechanisms, along with their interaction with agents, is the focus of research. Once this understanding has been achieved, it is applied to different contexts to develop the understanding further.

Contrasting critical realism with a wholly interpretative worldview presents a different set of objections. Social constructionism, for example, does not acknowledge an external reality, and rejects the idea of objectively developed knowledge of any such reality. Knowledge is claimed to be discursive and constantly capable of re-formulation and change due to its inherent lack of stability (O'Mahoney and Vincent, 2014, p. 5). Whilst there is overlap with critical realists who are equally sceptical of universal claims to "truth", there is a divergence. Critical realists do not accept that all reality is equivalent to that which each individual claims it to be. Otherwise, knowledge provides no basis for societal understanding. Without an underlying appreciation of aspects of the social, there is limited foundation for emancipatory critique, which is an essential part of any explanatory project (Collier, 1994, p. 172).

Ontological commitment to a partly unobservable external reality, with recognition of interpretive reflexive action, has implicit epistemological implications. To explain how deep unobservable social structures operate in any particular context means arguing for the position that provides the best explanation that can be inferred from the circumstances under investigation (Hollis and Smith, 1991, p. 207). At the same time, this approach recognises that outcomes of the operation of social relations are affected by interpretation of them, notwithstanding the independence of those social relations from any such interpretation (Furlong and Marsh, 2010, p. 205). Social structures do not determine agential behaviour, but they do enable or constrain it.

Simultaneously, agents acting reflexively have the ability to interpret structures and, in doing so, may change or reproduce them (Archer, 2003, p.6).

A second epistemological implication of the critical realist approach is the fallibility of knowledge of the world that exists independently of that knowledge, and its 'theory-laden' nature (Sayer, 1992, p. 4). To provide accounts of inter-relations between social objects, it is necessary to do two things. First, establish what the external reality of the aspect of the social world under investigation is and develop an understanding of it. Second, conduct a similar exercise to identify and understand how that particular reality is socially constructed (Furlong and Marsh, 2010, p. 205).

Social research and methodology are thus guided by commitments to ontological depth and an open system that rejects purely positivist approaches, and associated methodology such as inferential statistical analysis. However, acknowledgement of interpretative and reflexive action equally rejects methodology solely aimed at individual interpretation. The methodology selected for research seeks to move between these antithetical positions as appropriate for the relevant research context.

3.2.2 Background to research design

Ontological privileging places emphasis on the identification of concepts to understand any data collected (Ackroyd and Karlsson, 2014, p. 21). This is why the conceptualisation of mutuality and mutual practices was such an important part of the literature review conducted in Chapter 2. Without appropriate and applicable concepts, it is not possible to explore fully the causal configurations that exist within PSMs. Addressing these concepts through data collected from applicable organisational contexts, results in an explanatory account of the social processes that occur as mutuality emerges within organisational form.

A consequence of prioritising ontology over epistemology, and the privileging of concepts to understand data collected, rather than primary focus on the data itself, is that selection of research methods is a flexible process. Methods are selected for their suitability to the project (Ackroyd and Karlsson, 2014, p. 22), in contrast to researchers following alternative approaches where method, to some degree, is pre-determined by the ontological and/or epistemological position adopted (Bryman, 2012, p. 629). Whereas large-scale surveys with quantitative statistical analysis are predominately the preferred method of positivist inspired researchers, in-depth

interviews and ethnographic methods are employed by constructionists to better understand meaning that individuals associate with what is happening.

Critical realists, on the other hand, use whichever method(s) are appropriate to generate an explanation from the concepts and context, mixing techniques across different research projects and different stages of the same project. Method follows whatever information the researcher is seeking to access. Whilst this is also the approach taken by many mixed methods researchers, the difference for critical realists is that method and data collection techniques are subservient to the ontological questions the research is seeking to answer. This often contrasts with the various approaches prevalent amongst mixed method researchers that do not expressly privilege ontology (Bryman, 2012, p. 649).

Critical realists are often looking at different data and information at different stages of the project, sifting through to find the best-fit explanations for the concepts they are exploring. It is this aspect of the critical realist approach that lends itself well to an exploratory research project, such as mutuality within PSMs. With limited research to build on, any pre-determined methodological approach, such as solely survey or ethnographic case study, may not achieve the research aims. Flexible combination of methods, with different data collection techniques at different levels of abstraction, provides variety and alternatives. If one approach does not work, another can be tried and so on. Combining quantitative and qualitative methods, surveys and case studies, across case and within case comparison, exploratory interviews, document analysis and in-depth interviews all provide different access points to the concepts being explored.

Creativity and flexibility are important when there is no set way of carrying out critical realist research. The research is designed to be iterative, with the expectation that not everything will work as planned. With that in mind, the research design developed for an exploratory investigation of mutualism within PSMs was explicit in maintaining a flexible approach.

3.3 Research Design

When adopting methodological pluralism, two related questions arise from a research design perspective, before finalising the methods of data collection themselves. First, what is the sequencing of the different methods? Second, which method, if any, shall

have priority in the research process? From a critical realist perspective there are no fixed answers to these questions, and the ultimate conclusion is driven by the aims of the research being carried out (exploratory, evaluation, corroboration) and the nature of the research questions themselves (Sayer, 1992, p. 162).

A number of suggested approaches to strategies for the sequencing and priority of combining research methods and analysis have been suggested (Tashakkori and Teddlie, 1998; Mingers, 2001; Creswell, 2014). Whilst there are variations in terminology and approach, each outlines an ideal type, offering different sequencing (sequential versus simultaneous) and priority (prioritise quantitative over qualitative, vice versa or equivalent status). Whilst these ideal types are useful, real life research does not usually fall into these neat categorisations and processes (Zachariadis, Scott and Barrett, 2010, p. 9).

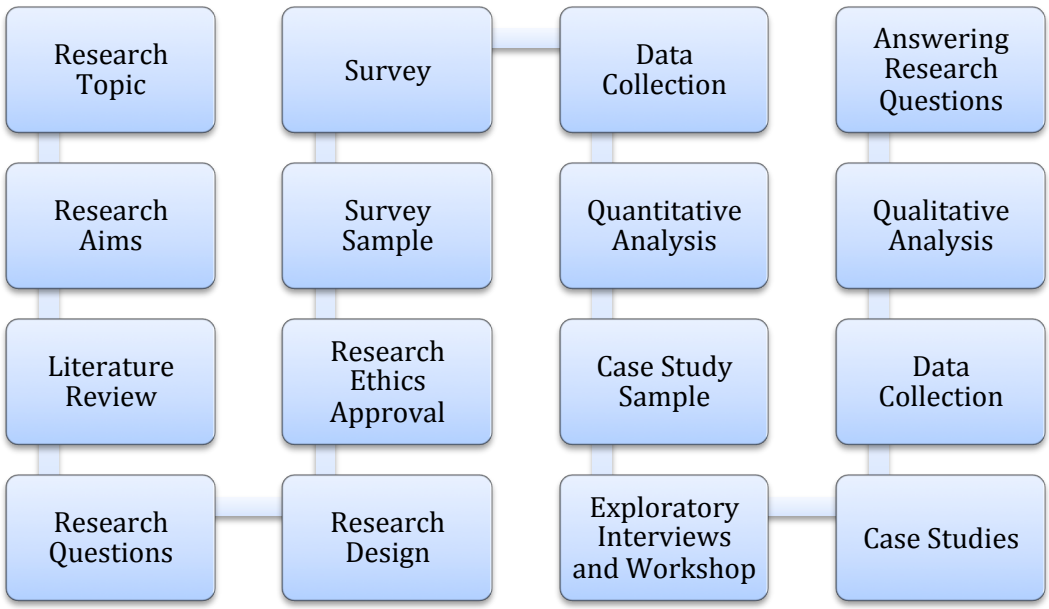
With that caveat, however, such strategies do provide a systematic process for research design, so that if (when) actual research activity does not adhere to the design and plan for any reason, the researcher has an overarching approach to refer to when adapting alternatives. This provides coherence with the aims and research questions, ensuring that by following the general framework, the integrity of the initial aims will be maintained.

Figure 3.1 sets out an overview of the sequence followed and the various stages of the research that were conducted, to illustrate how having such a framework can provide a guide. Mingers' (2001, p. 252) critical realist approach to research design was followed as it conforms to the ontological framework adopted. This led to a research design that is sequential, with different methods each leading into, and helping develop, the next, as shown in Figure 3.1. The sequencing was not wholly fixed from the outset. As each stage was completed, a review of the next steps was undertaken based on what had emerged from the previous stage.

Quantitative and qualitative approaches were adopted, with neither methodology considered dominant or having priority. The aim was to adopt a holistic view once research was complete. This approach had the advantage of aiding triangulation of research outputs, by enabling multiple access points to the research topic. By not definitively fixing the stages from the beginning, both flexibility and space for creativity were designed into the research process. This proved beneficial in the survey stage when initial analysis proved inconclusive. The flexibility of the design enabled a further statistical tool to be introduced, cluster analysis, which improved

the quality of the analysis and provided additional triangulation to the initial set of results.

Figure 3.1 Research design flowchart



Source: Author's own

This iterative, sequential, linked approach is an appropriate research path for exploratory investigation. Without a comprehensive body of existing research and theoretical underpinning to build on, investigation of PSMs is limited to first identifying, and then examining in greater depth, concepts relevant to mutualism. The research design comprised two main methodological phases to do this, each of which consists of complementary, but temporally sequential, methods, in accordance with Sayer's (1992, p. 163) extensive and intensive classifications.

Extensive research comprises methods collecting data across a large sample to provide relationships that can be analysed quantitatively. The purpose is not to infer causal connections from the quantitative data, but rather to look for, and identify, any

regularities, trends and descriptions for further investigation. This further investigation is the intensive phase of research, with more in-depth investigation of a smaller number of cases, aiming to investigate and provide explanations for occurrences within specific contexts, and thus attempt to explain causal relations.

Table 3.1: Extensive and intensive research methods used to investigate PSMs

	Extensive	**Intensive**
Research Questions	How is mutualism conceptualised in PSMs? What organisational mechanisms are engaged to operationalise mutualism?	How do generative mechanisms operate within PSMs in comparison with other organisations? How do agents affect how mutualism emerges within organisations? What enables and/or constrains the operation of these generative mechanisms?
Relations	'Formal relations of similarity'.	'Substantial relations of connection'.
Types of Group	Taxonomic groups with similar attributes but without necessary formal connections.	Causal groups, either similar or different, who 'relate to each other either structurally or causally'.
Types of Account	Descriptive accounts of patterns and regularities (not explanatory).	Causal explanations of process (but not necessarily representative).
Methods Used	Large N survey of representative sample, formal questionnaire and statistical analysis (frequency analysis and cluster analysis).	Comparative case studies, documentary analysis, semi -structured interviews and qualitative analysis (Re-description, analytical resolution, abduction, retroduction and re-contextualisation).
Limitations	Unrepresentative patterns and contingent relations. Non-generalisable.	Representative of a population but not necessarily generalisable to other populations.
Tests	Corroboration.	Replication.

Adapted from Sayer (1992, p.163)

The extensive phase comprised a survey and quantitative analysis and came first (Figure 3.1). This phase had three aims. First, to describe various mutual configurations and distinguish them in different types of organisations (formal relations of similarity). Second, to classify organisations into a typology, based on

whether they possess mutual configurations (taxonomic groups). Third, to identify organisations for the intensive case study phase.

The intensive phase followed, and comprised case studies and qualitative analysis (Figure 3.1), to explore the mutual configurations identified from the extensive phase in greater depth, in the specific context of cases selected from the identified taxonomic groups. By examining these configurations within each case, thus investigating how agents perceive them and their operations, alongside examining how agents, structures and mechanisms interact, the second phase aims to develop an explanation of how mutualism operates within PSMs and the relationship between mutualism and mutual practices.

All of the methods outlined in this chapter were carried out, following the sequence and design set out in Figure 3.1. Data was collected between February 2014 and May 2014 (survey data) and February 2015 and February 2016 (case study data).

3.4 Extensive phase

Within the research framework, methods of sampling, data collection and analysis were selected for their fit to the aims and research questions, and the identified phases of the research design.

3.4.1 Sampling and access

Obtaining accurate data of the number of operational PSMs is problematic, as no comprehensive independently compiled database exists. An interactive map of names and locations of 100 PSMs (not a full list of organisations) was published by the Cabinet Office, as part of a press release announcing the success of the policy (Cabinet Office, 2014a). This interactive map, which has subsequently been updated, is the only publicly available data on the number and identity of PSMs that could be found. Whilst helpful, it is purposive and not comprehensive, and includes organisations that do not recognise themselves as mutual organisations, as revealed by the survey data in Chapter 4. To overcome these issues, criteria for a new sample frame was generated by cross-referencing the data from the interactive map with other published data. The aim was to select a representative sector within which PSMs were operating from the interactive map and then use verifiable data from that

sector to establish a sample frame of organisations, both PSM and non-PSM, to generate a sample for comparative purposes.

A first step involved analysis of the interactive map data to establish a representative sector. Of 100 PSMs on the initial interactive map (Cabinet Office, 2014a), 28 (28%) were health providers and so one of the largest proportions by sector (CIPFA, 2017). Health provider organisations, therefore, were representative of the PSMs' policy. The health sector also comprises a mix of public, private and third sector organisations for comparative purposes. Care Quality Commission (CQC) regulates all healthcare providers in England, who in turn are required to be registered with the CQC (Health and Social Care Act, 2008). Monthly updated databases of all registered organisations, filtered by region, are published. In any geographical region in England, the database for that region should be accurate about the healthcare organisations operating in that location at that time.

As the PSMs publicised by the Cabinet Office (Cabinet Office, 2014a) are relatively evenly spread across all regions of the UK, the northwest (NW) region of England was selected as an appropriate sample frame. This region has a tradition of mutuality, being the home region of the Co-operative Movement, and had its own alternative PSM transitional support structure (LocalGov, 2012). Therefore, NW England had sufficient support in place to suggest PSMs would be capable of operating in a positive environment, with the space to develop and grow mutual practices, and have a reasonable opportunity of developing mutual characteristics in a supportive context.

Analysis of the CQC database revealed the whole population of healthcare providers in NW England comprised 202 organisations, which were adopted as the sample frame for the survey questionnaire. CQC's database provided address and contact details for key individuals at each organisation which were then cross-referenced with website data and other publicly available information. This enabled each of the 202 organisations to be surveyed by a combination of e-mail or post (depending on the nature of contact details held), and so the survey comprised a census of all NW healthcare providers. This ensured any healthcare PSMs would be surveyed, irrespective of their inclusion on the interactive map, and would also provide comparative data across all organisational types delivering healthcare in NW England. Response rates, and analysis of non-responses, are discussed in Chapter 4 as part of the analysis of the survey data.

3.4.2 Survey Questionnaire

To investigate situations that would reveal similarities and patterns required a research method that enabled a large number of organisations to be investigated within a short period of time. The greater number of relevant organisations that could be investigated, the more likely patterns of causal configurations may emerge. A survey questionnaire (copy at Appendix B) was prepared to achieve this aim, asking a series of questions relating to the organisational features of the respondent organisations.

The topics for the questionnaire were developed from the conceptualisation of mutualism that was discussed in Chapter 2, and reflected the focus on participation practices as possible causal configurations within PSMs. To provide contextual information for each case, additional data about the organisations was also sought, reflecting type, size and situational context for any of these participation mechanisms (questions 2, 3, 4 and 9).

The survey questions were closed, and provided mainly categorical data sets, along with nominal data derived from demographic questions. The reason for this is that this first stage of data collection analysis sought to establish both the presence and patterns of the causal configurations identified in Chapter 2. To establish such patterns within the sample of organisations surveyed required questions reflecting these configurations, or proxies for them, to identify whether or not they were present in the relevant organisations. No attempt was made to explore meanings or interpretations of these mechanisms as this stage, and so closed questions were sufficient for this purpose.

The survey questionnaire was designed to collect data from each organisation in three categories. First, questions collected demographic data relating to the type of organisation, finances and staff (Questions 2, 4 and 9). Second, questions 3, 12, 13 and 15-17 (inclusive) collected data on organisational configuration such as legal form, ownership, membership and governance. Third, data on participation in governance, decision-making, finances and information was sought in questions 7, 10, 14 and 18.

3.4.3 Quantitative analysis

The quantitative survey data was analysed using a statistical software programme (SPSS). Data from each of the surveys was inputted into the SPSS programme as each completed survey was returned. Once inputted, a comprehensive cross-reference of all the completed questionnaires and inputted data was made to check for input errors, followed by two further checks using random sampling. This was to achieve quality assurance of the data. One of these random sampling checks compared completed questionnaires against inputs, whilst the other reversed this comparison. All input errors were corrected.

Once the data had been entered into the SPSS software programme, it was analysed using descriptive statistics to summarise frequency of the occurrence of data. Frequency analysis (Bryman, 2012, pp. 361-363) was used to identify the mutual configurations present within the sample of organisations. Further statistical analysis was applied to sort the organisations by reference to the presence or otherwise of these configurations. This analysis was carried out using cluster analysis.

Cluster analysis is a multivariate method to classify individual cases into different sets, so that cases that are similar end up in the same group and so that differences between groups are maximised, and is considered a useful starting point in critical realist research of a large number of cases (Mingers, 2002, p. 301). This is achieved by sorting the cases based on specified variables.

Cluster analysis is an iterative process and therefore a number of cluster analysis methods were applied to the data, in sequence, in order to develop appropriate clusters. Variables were generated by two initial methods, hierarchical Ward analysis and K-means analysis. Hierarchical clusters produced models with cluster groups ranging from 1 cluster incorporating all cases to n clusters where each case comprises a cluster. Large data sets were grouped using K-means clustering.

Repeated cluster analysis using these two methods indicated that the cases formed 4 clusters, which were consistent across each method, both Ward and K-means. This provided an initial, indicative set of results, suggesting potential groups of variables for a further stage of iterative cluster analysis, using a third method. This further stage involved taking these initial variables, and then further analysis using a 2-step cluster method. This refined data into three clusters, and a smaller group of cases that could not be sorted into any of the three clusters.

The categorical variables were selected as proxies associated with the mutual configurations, representing the type of organisation, its legal form, the different cohorts involved in governance and board membership, who owned the organisation and its primary purpose, including whether it was for profit or not. Whilst not a direct relational or causal link, the proxies and associated questions revealed patterns and regularities within healthcare organisations that could be analysed further. The aim of using these proxy variables in this way through cluster analysis was to distinguish the types of organisation delivering healthcare in NW England and so identify those organisations that may incorporate a number of the mutual configurations. An extract from the SPSS output analysis is included at Appendix C. This shows the process through which the various phases of cluster analysis were conducted and the changes in output achieved.

The three clusters were then used to conduct between and within case analysis to identify further regularities and patterns of the distribution of mutual configurations within different categories of organisation. These within and between case analyses further assisted the answering of the research questions that sought to conceptualise mutualism within PSMs and identify what organisational configurations are engaged in mutual practices.

In addition, cluster analysis provided a more refined sample frame of organisations from which to select cases for the comparative in-depth case studies. By grouping the cases into three organisational types, Private Profit Oriented, Public Service Trading and Social Trading (as discussed in Chapter 4), the purposive sampling of cases for further investigation was given more specificity and enabled case selection to be focused on a smaller number of organisations with greater similarity and relevant difference.

3.5 Intensive phase

The second phase examined a selection of organisations drawn from the survey sample frame in greater depth, building on the regularities revealed by the extensive phase to develop an explanatory account of mutualism and mutual practices in PSMs.

3.5.1 Sampling

Analysis of the survey data directed focus for in-depth case study research on Public Service Trading and Social Trading organisations, using those organisations from the survey sample frame that fell within these two classifications as a refined sample frame for case study participant selection. Additional sampling criteria were then applied based on previous attempts at mutualisation in healthcare.

The case study organisations were also selected purposively both for difference and similarity. The cases selected for difference give the best opportunity to identify contrasts between cases relating to different mechanisms operating in different contexts. In addition, cases were selected for similarity in relation to some of the organisational mechanisms concerned so as to best examine their operation within each case study, albeit within different contexts. The aim here was to provide bases for comparison between possible theories that could explain mutualism within PSMs, in relation to issues and themes arising from each case (Bergene, 2007, p. 24).

The first category of cases considered, were those in the Public Service Trading group. Within this group three organisations, each an existing NHS Foundation Trust, had taken part in the Mutuals In Health programme (Cabinet Office, 2014b). As this programme explored mutualism with staff and stakeholders, including considering alternative organisational forms, it was considered appropriate to prioritise these organisations from the sample frame as potential case studies. Representatives of all three organisations were invited to, and attended, a collective workshop to discuss mutualism within the context of their organisations.

Contact with these three organisations and their attendance at the workshop was achieved due to professional relationships with senior executives at each of the organisations. This workshop was used both to initially explore the various causal configurations that had been identified from the first stage of research and to develop criteria for the selection of one of the organisations for further, in-depth case study research. One of the NHS Foundation Trusts, Acute Health, emerged from this workshop as a viable and appropriate case for further research, and the Chief Executive agreed to provide access to staff and documents for research purposes into PSMs. The other two, whilst willing to participate in the workshop, did not consider further research appropriate whilst they were still engaged in the Mutuals in Health pathfinder.

In selecting two other organisations for in-depth case study research, the sample frame of Social Trading organisations was used as representing organisations with mutual causal configurations identified in the first phase of research. Again, selection of cases from the sample frame was purposive, identifying Social Trading organisations that incorporated the four causal configurations identified in Chapter 2. In addition, each of the organisations selected had undergone organisational change as a consequence of the aims to introduce mutualism into healthcare delivery.

Rather than solely relying on these mutual causal configurations to select the two cases, a cross-reference was also conducted with the Cabinet Office's published interactive map (Cabinet Office 2014a) and the list of organisations provided with financial support by the Mutuals Information Service (DCMS Mutuals Team, 2017). By cross-referencing these with the Social Trading sample frame, five organisations were identified as potential cases. All five were approached, and two, Community Health and Psychological Health, were willing to take part in the research project and provide access to managers and staff for semi-structured interviews, as well as organisational documentation. The remaining three, whilst initially indicating willingness to participate, failed to respond to the follow-up request.

Again, professional relationships with senior members of the relevant organisations and/or intermediaries enabled meetings to take place that helped assure the organisations of the bona fides of the research. These professional relationships assisted significantly in the obtaining of consent to participate in the research and illuminate one of the benefits of the professional doctorate when conducting practice-based research.

Private Profit Oriented organisations were excluded from the second phase of research. Analysis of the survey data revealed that they did not incorporate mutual causal configurations with any particular regularity. Therefore, it was considered that research of a Private Profit Oriented case would not add anything to the analysis that would help explain mutualism within PSMs.

3.5.2 Case studies

The exploratory workshops with NHS Foundation Trusts and exploratory interviews with Chief Executives and Directors from each of the three cases were used to obtain an overview of the organisations themselves, their organisational form and practices.

Roles within each organisation were identified, along with organisational features that provided context within which to situate the identified causal configurations. These exploratory workshops and interviews were also used to develop semi-structured interview topic guides to explore with participants mutualism and mutual configurations, their context, operation and interactions within each of the organisations. A sample of the interview topic guide is attached at Appendix D.

In order to obtain data from staff at different levels in each organisation (manager, clinician, administrative) a call for volunteers at every level of employment was made within each organisation. This addresses one of the deficiencies in some of the research into PSMs identified in the literature in Chapter 2, which have so far concentrated mainly on leaders and managers, rather than staff. In addition to four exploratory interviews, 29 additional volunteer participants were identified across all of the organisations, representing staff, senior managers and board members, all of whom consented to be interviewed and were subsequently interviewed. Details of participants and roles are set out in Appendix A.

The exploratory interviews also identified a number of documents and other media for investigation for each case. These included constitution documents, board reports, policy documents, websites and organisational structure charts. In addition, supplementary documentation was identified at publicly available online repositories including Companies House, the Community Interest Company Regulator (corporate regulator of each PSM) and Department of Health, as well the CQC database. These documents were made available by each case or were sourced from the relevant repositories and then analysed as part of the data analysis mentioned below.

The interviews were conducted using an explicitly critical realist inspired approach (Pawson and Tilley, 1997, pp. 164-69) supplemented and developed by Smith and Elger (2014, p. 116). This approach informs both participant selection and interview topics. By placing the theory being explored (in this case mutual configurations and mutualism) at the centre of the interview process, the theory is made the subject of the interview.

What this means for participant selection is that a first step is to identify the levels of expertise of the practitioners and subjects within each organisation as regards the causal configurations being investigated. Whilst the researcher is the expert on the theory being developed and tested (Pawson and Tilley, 1997, p. 164), the interviewee has an active and critical role in exploring how the relevant theory operates in that

participant's individual context. With focus on theories of mutual configurations, such as participation, and their potential effect on staff, it was considered important that participants were drawn from all levels of each organisation, including employees, not just senior managers and directors.

The concern here was that senior managers and directors would have an orthodox view, particularly where they had been influential in mutual configurations being incorporated into the organisation, whereas staff at different levels might have different views. All employees are intended to be the beneficiaries of the arrangements introduced, according to the PSM policy discussed in Chapter 2, and so how these configurations are actualised is relevant to their day-to-day activities.

The interviews, following the theory-driven approach, explicitly tested mutual configurations with participants. Potential casual powers were incorporated into the semi-structured interview topic guides as appropriate. The sample interview topic guide at Appendix D, therefore, include topics concerning ownership, voice, transparency and shared benefits as well as probes and prompts concerning trust, reciprocity, co-operation and common purpose.

Adopting this approach resulted in a theory-laden, explanatory framework to inform the conduct of the semi-structured interviews, which varied between cases and from participant to participant, dependant on the role of the interviewee within the organisation. Individual participants had multiple roles within the organisation, such as manager, director, staff representative or clinician as well as employee. As participants inhabited multiple roles and positioned-practices, the interviews examined these roles in the context of the mutual configurations to explore how the structures and generative mechanisms were mediated through the agency and positioned-practices of the various participants.

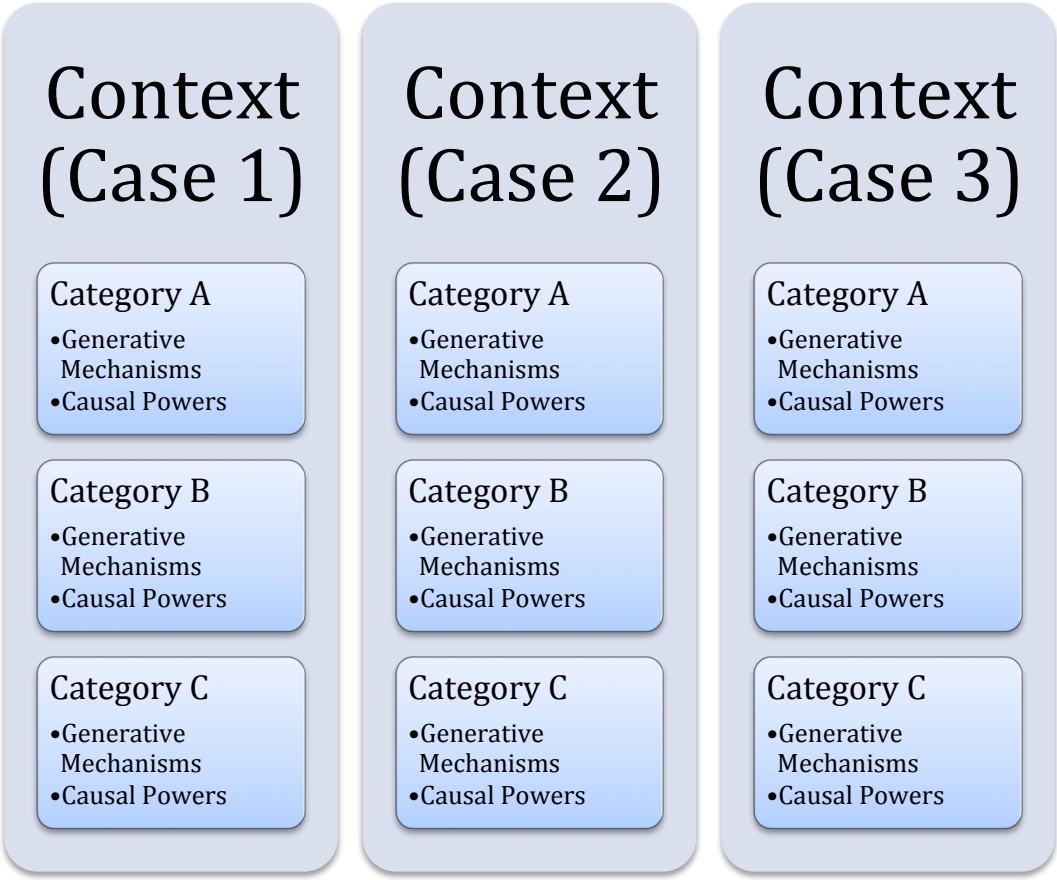
3.5.3 Qualitative analysis

Data collected from the case studies, including documents and interviews, were analysed qualitatively through a series of steps, which were then repeated a number of times until data saturation had occurred. These steps are outlined as follows, drawing on Danermark et al (2002), Crinson (2007, p. 39) and Bygstad and Munkvold, (2011, p. 5).

First re-description of concrete events through transcription of interviews was undertaken, with detailed hand written notes made of exploratory interviews and all semi-structured interviews audio recorded and then transcribed. Second, once transcribed, the transcriptions were reviewed, along with the audio recording of the interviews, as a cross check for accuracy of transcription. Further review of the transcriptions was conducted to identify themes and issues arising from the interviews relating to mutual configurations and other aspects of mutualism within the relevant organisations. These issues were indexed and collated, including any overlaps from different interviews. This resulted in a list of themes and issues from the transcriptions that related to the operation of previously identified mutual configurations within the context of each organisation.

Third, the compilation of indexed issues enabled the identification of key components or themes (i.e. analytical resolution) from the indexing. All issues and themes that had been indexed were reviewed, compared and contrasted to collate the themes into key groups. The fourth step involved abduction (i.e. theoretical re-description/re-contextualisation) by applying different theoretical explanations to the themes identified. Theoretical comparison occurs between the relevant theories as they relate to conceptual themes derived from each case (Bergene, 2007, p. 24). The various theories applied at this stage were those identified in Chapter 2, developed from the wider literature on mutualism.

Figure 3.2 Contrasting themes from the data



Source: Adapted from Kempster and Perry (2014, p. 106).

Fifth, retroduction was carried out to identify potential generative mechanisms to explain any phenomena generated. This involved analysing how the themes interacted and contrasted to reveal possible mechanisms that may explain any regularities observed from the quantitative data previously analysed. Figure 3.2 illustrates this process using Kempster and Perry's (2014, p. 106) framework to compare generative mechanisms and causal configurations in different contexts. Category A appears in a particular context with similar effect across cases. Category B is also present in a particular context, but generates a different set of events across cases. Category C is context specific to a case. At this stage the research is examined as whole, even though it had been carried out in sequential phases.

The sixth step was re-contextualisation, or applied explanation, to analyse selected mechanisms and outcomes to explain causally how mutualism operates (or not) within PSMs. This involved taking each potential explanation of how various

generative mechanisms and mutual configurations operate and applying them to the data that has been generated to test whether that particular explanation was an appropriate fit.

The above process was repeated, on a case-by-case basis and between cases, as often as was required to achieve satisfactory data saturation to produce coherent explanations. Through within case, and between cases, analyses, this approach generated answers to the relevant research questions as discussed in Chapter 8.

3.6 Research Integrity

Research integrity includes quality assurance of the research outputs and the ethics issues that were involved in conducting the research.

3.6.1 Quality assurance

Quality assurance through validity and reliability stem in the main from empiricist, and therefore broadly positivist, approaches to research, where internal and external validity are essential to the ideas of theory testing and measurement. When adopting a stratified ontology, an alternative understanding of quality assurance is required. In designing sequential research with multiple methods, the role of quantitative methods is limited to one of description, not inference. This is due to generalisations and correlations between variables on their own being considered incapable of identifying generative mechanisms. Further, they are also considered not to have any value in predicting occurrences in the future.

This alternative understanding builds on supplementing quantitative methods with qualitative ones, once regularities and patterns have been identified. Qualitative methods have the capability to describe phenomena, as well as build theoretical propositions. They have potential to identify structured interactions between generative mechanisms. Critical realism's methodological pluralism maintains connections between the overarching meta-theory and methods selected for research through its ontological and epistemological foundations.

Whilst this link between method and meta-theory justifies methodological pluralism, and provides for a basis for the use of analytical techniques as described above, the concepts of validity and reliability that are essential to a positivist inspired research

exercise are less relevant. This is because the use of analytical tools, such as retroduction, involves a back and forth between methods, as continuous, constant comparisons and contrasts are made (Mingers, 2002, p. 300).

Critical realist analytical processes involve interaction, comparison and contrast, carried out over and over again using different theoretical frameworks. Use of multiple methods, both quantitative and qualitative, aids this process, as analysis moves back and forth between re-contextualised narratives and descriptions to discover and identify generative mechanisms (Crinson, 2007, p. 41). The equivalents of traditional validity and reliability testing are, therefore, done differently.

This is not to say that reduction of inherent bias or requirement for corroboration are not essential to critical realist inspired research projects, as they are as equally relevant and important as research conducted under other paradigms. It is simply that the way to achieve reduction of any bias and to improve the integrity of research output requires a different approach, which for the critical realist approach taken here is by way of complementarity, completeness and compensation (Zachariadis, Scott and Barrett, 2013, p. 11).

Within critical realist ontology, complementary research methods are employed in the same project because alternative levels of abstraction are required in a stratified view of reality. One research tool gathering data from a particular source risks not representing reality at all levels of the various strata. By adopting a mix of methods, as here, this risk is reduced and the different methods used enable complementary perspectives to be obtained.

A mix of methods helps to achieve completeness of outcome through different approaches providing different access points to data. The survey gathered data at a level of abstraction that provided patterns and regularities. The case study data, on the other hand, provided a more in-depth perspective, exploring cases from the point of view of agents within them. Combined, these two approaches provide a more complete view than each can alone.

Finally, multiple methods help to offset weaknesses within different approaches. It has already been noted the limitations of purely quantitative techniques in generating explanatory accounts. The qualitative methods used in the case studies help to add explanation and so compensate for the missing perspective from the quantitative data.

In addition to a mix of methods, using analytical techniques of abduction and retroduction, with the back and forth between different data sources and methods, permits numerous theoretical perspectives to be considered within the same research. There is also an opportunity to analyse data in a more rounded and complete way, providing opportunities to unearth different interpretations of the same data. In this way, the integrity of the research and issues such as corroboration and crosschecking of data can be achieved through methodological and theoretical triangulation.

3.6.2 Ethical considerations

All research was conducted in accordance with Research Conduct Guidelines of University of Nottingham. Before any primary research was commenced, ethics scrutiny from the Research Ethics Committee of the School of Sociology and Social Policy, University of Nottingham was requested. Following review and consideration of the application, approval was granted. In considering all of the ethical approvals required, and given that primary research, both extensive and intensive, was conducted in the field of healthcare delivery, the requirement for additional NHS health sector and organisational approvals were also considered.

As all primary research involved organisational practices and structures and not patients, clinical procedures, clinical records, or any other clinical or patient activity, then in accordance with GAfREC (2012) no additional NHS or other research ethics committee approval was required for either stage of the research. Under the GAfREC (2012) requirements, the Research Ethics Committee of the School of Sociology and Social Policy at University of Nottingham approval was sufficient. Further, as all surveys and interviews of any staff were conducted with participants "…recruited by virtue of their professional role…" (GAfREC 2012, p. 13), NHS Research Ethics Committee approval was not required, nor for any attendance to conduct interviews with those staff at premises where healthcare was provided.

Some case study participants had been accessed using professional contacts of the researcher, and so a further review was conducted to evaluate whether any conflicts of interest arose between research participants and/or their organisations and the researchers own professional activities. As none of the cases were clients of, or had any other professional relationships with, the researcher or the researcher's employer, and were known to the researcher solely through professional networks, no such conflicts of interest where identified.

A risk assessment in accordance with University of Nottingham research guidelines was conducted before each stage of the research. This risk assessment did not identify any foreseeable risks to any organisation or individual participating in the research, nor any costs or inducements involved in taking part. All participants were over the age of 18 and no participant was considered vulnerable. All interviews were conducted in a private room at the premises of the relevant case study organisation with only the interviewer and participant present throughout.

All participants were provided with a participant information e-mail or letter (survey participants) or form (interview participants) describing the purpose of the research. Individual participants who were interviewed were provided with a consent form, in duplicate, which was signed before the research interview was conducted. Return of completed surveys comprised consent from survey questionnaire participants. Sample copies of participant e mail/letters and interview information forms, along with a sample interview consent form, are included at Appendix E.

The researcher retained copies of signed consent forms and completed questionnaires. Participation in the research project was entirely voluntary and any participant, whether organisation or individual, could withdraw from the research project at any stage, without having to give any reason and without any penalty or disadvantage to the participant in any way. No participants exercised their option to withdraw once consent had been given.

All data was collected and held on a secure server, accessed only by the researcher. All handwritten notes, copy documents relating to any organisation and all correspondence were held in a locked filing cabinet, again with access only available to the researcher. The information and data collected throughout the research was, and will be, used solely for the purposes of the research project and subsequent academic publication. All data was made anonymous, both at the organisational and individual level, with any identifying information removed or masked to avoid any organisation or individual being capable of identification.

3.7 Conclusion

The discussion in this chapter has set out the rationale, approach and methodology adopted for an exploratory research project into mutualism within PSMs. It is explicitly critical realist in the framework applied, which embraces a flexible, non-

deterministic methodology. A mixture of methods is employed, both quantitative and qualitative, including a large N survey, in-depth case studies, exploratory workshops and interviews, documentary analysis and semi-structured interviews. Together, they are analysed to first identify potential mutual configurations that may enable mutualism, and second to provide an explanatory account of how they do so within PSMs.

Chapter 4 Surveying the Field

4.1 Introduction

Researching mutuality is a search for the mutual configurations of ownership, voice, transparency and shared benefit in organisations. The presence or otherwise of these configurations should distinguish Public Service Mutuals, or PSMs, from other organisations. As the aim of critical realist investigation is to provide an explanation of these "'regularities'…[and]…'patterns'" (Pawson & Tilley, 1997, p.71), identifying them is a first step. This involves a search for the practices of mutual configurations within different organisational contexts, and a comparison of how they operate within those contexts (Pawson & Tilley, 1997, p. 68).

This chapter focuses on survey data collected from a sample of NW England healthcare providers and its subsequent quantitative analysis. As discussed in Chapter 3, the analysis of survey data was limited to providing a descriptive account of the patterns found in the sample of organisations surveyed. No attempt has been made to infer any account of causation from this data. The analysis in this chapter constitutes a first, exploratory stage, to survey the field.

This stage of research had three aims. First, to identify and describe the patterns of mutual configurations within organisations in the sample surveyed. Second, to classify organisations into a typology, based on the presence of mutual configurations. Third, to identify potential organisations for the case study phase, using the mutual configuration regularities identified and the typology that was developed.

The remainder of this chapter is organised as follows. Section 4.2 discusses the survey, the response rates and the initial descriptive and frequency analysis of the data. Whilst helpful in presenting initial patterns, limitations were identified that required further analysis to be carried out. This is set out in Section 4.3, which

employs cluster analysis to sort the regularities and patterns into a classificatory system to supplement the descriptive and frequency analysis.

Section 4.4 analyses the four mutual configurations for regular patterns. It is concluded that there are regularities of mutual configurations in PSMs, and partly so in some public sector healthcare organisations. They are not found regularly in private sector businesses. Section 4.5 presents three cases for further in-depth research to explore these mutual configurations. One is a NHS Foundation Trust, described in the literature as a mutual organisation, and the other two are PSMs, recognised as such by the DCMS Mutuals Team (2017). Each of these is introduced in advance of Chapters 5, 6 and 7, which analyse data from these cases.

4.2 The survey

A survey of 202 health provider organisations in NW England was conducted following the methodology outlined in Section 3.4. The survey obtained 65 responses (32%) and the first stage of analysis considered respondents and non-respondents, to verify the representative nature of the participants.

4.2.1 Survey response rates

Of the 137 cases that did not provide survey data, 14 responded to say they could not, or would not, provide a completed survey, whilst the remainder did not respond at all. Analysis of the 137 non-respondents was conducted using data taken from public sources (website, Companies House, Charities Commission) to ascertain the organisation's legal form. Organisational legal form provides a general classificatory tool, and is the only verifiable publicly available data for all organisations in the sample. Comparing participant legal form to the legal form of the sample provides a basis for assessing how representative the participants were.

Table 4.1 compares participants to the sample by legal form (abbreviated as a key for reference in the remainder of this chapter). Whilst there were discrepancies and slight variations between the percentages of legal forms in the two columns, the proportion of participants with each legal form was broadly in line with the relevant proportions of the sample as a whole. It was concluded that the participants were broadly representative of the sample.

Table 4.1 Comparison of participant and non-participant legal form

Legal Form (abbreviation)	**Sample by legal form (% of 202)**	**Participants by legal form (% of 65)**
Company Limited by Shares (CLS)	102 (50.49%)	27 (42%)
Limited Liability Partnership (LLP)	8 (3.96%)	5 (8%)
Company Limited by Guarantee (CLG)	39 (19.31%)	12 (18.5%)
Charitable Incorporated Organisation (CIO)	1 (0.5%)	1 (1.5%)
Community Interest Company (CIC)	8 (3.96%)	6 (9%)
Public Benefit Corporation (PBC)	28 (13.85%)	6 (9%)
Public Sector Body (Public Body)	14 (6.94%)	7 (11%)
Unincorporated	2 (1%)	1 (1.5%)
Totals	**202**	**65**

Source: Author's own derived from publicly available data (N = 202)

4.2.2 Survey Data

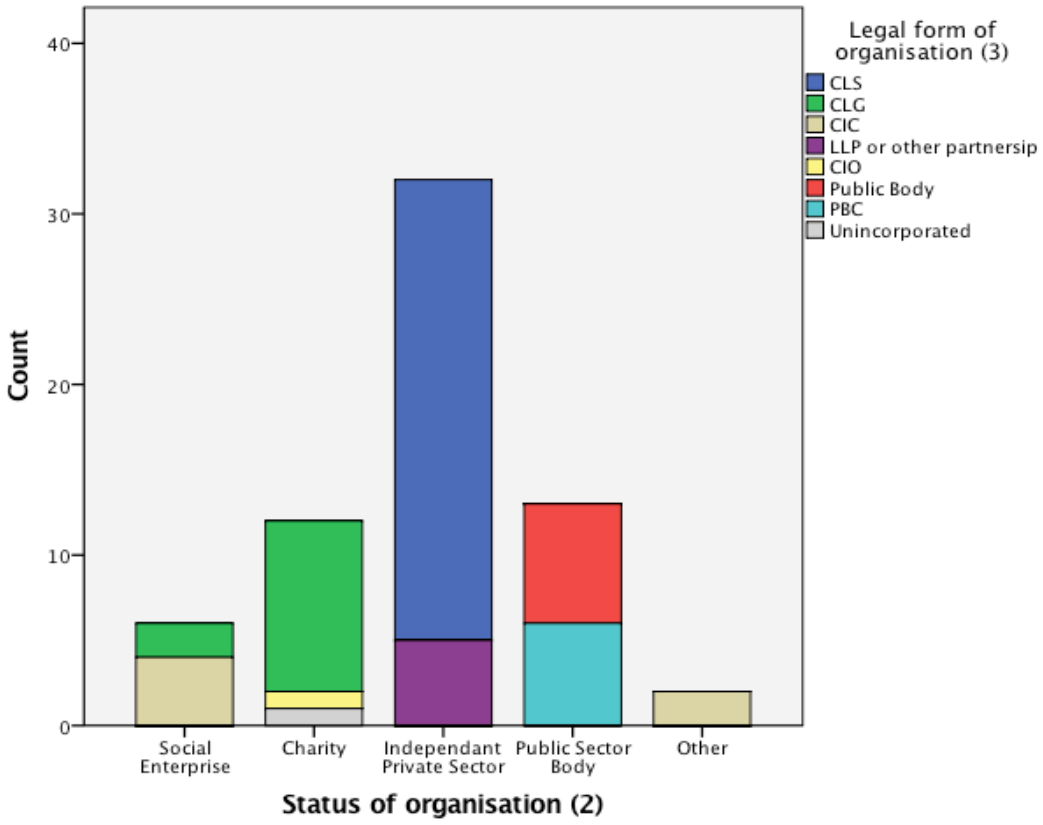
The survey participants provided a data set comprising each organisation's individual responses to questions relating to their self-identified status (i.e. do they identify as a public body, independent private, social enterprise, charity or other) and legal form of the organisation. Data was also collected about ownership structure, governance arrangements, and degrees of staff and user participation in the organisation and use of volunteers, together with demographic data such as staff numbers, annual income and sources of income. Questions about status and organisational legal form were to provide comparison data to differentiate the results.

Ridley-Duff and Bull, (2011, pp. 134 -149) identify some regularities and patterns between certain legal forms and different types of organisation. They consider Community Interest Companies, Industrial Provident Societies, Public Benefit Corporations and bona fides co-operatives to be legal forms adopted by social enterprises, whilst companies limited by shares and limited liability partnerships

were considered more regularly associated with independent private sector companies. Public sector bodies and Public Benefit Corporations were common for public sector organisations whereas charities are trusts, Charitable Incorporated Organisations, Unincorporated or Companies Limited By Guarantee. Similarly, certain descriptions of organisations are more likely to apply to PSMs, such as mutual and social enterprise. Other descriptions employed include charities, independent private sector and public body, all of which bring different connotations.

The first step in analysing the data was to consider the correlations between the status of the organisation and their legal form, to ascertain whether the descriptions in the literature provided a verifiable basis for distinguishing PSMs from other organisations. Figure 4.1 shows in bar chart status of organisation by legal form.

Figure 4.1 Status of Organisation by Legal Form



Source: Survey Data

All of the participants that classified themselves as private sector organisations indicated their legal form to be either Company Limited by Shares or Limited

Liability Partnerships or other partnership. This is in keeping with the suggestions from the literature, and in line with the fact that both of these forms of organisation are preferred for profit-making activities and ownership by entities who would expect to receive profits from the activities of the organisation. Both Companies Limited by Shares and Limited Liability Partnerships are legal forms that enable the distribution of profits to owners and investors (Ridley-Duff and Bull, 2011, p. 139).

Public sector bodies that responded were divided between public bodies and Public Benefit Corporations. As discussed in Chapter 2, a Public Benefit Corporation is a legal form introduced by statute that creates independent membership bodies for NHS Foundation Trusts. These two types of legal form are typical of the organisational forms used by healthcare public bodies and accord with expectations in the literature (Allen et al, 2011, pp. 81-82).

Those participants that were a charity had legal forms of Company Limited by Guarantee, Charitable Incorporated Organisation or Unincorporated (a trust arrangement). These responses accord with the literature once more, and the expectations of legal forms associated with charitable organisations. None of these legal forms generate or create value through their ownership structure, which is in keeping with the nature of charities, particularly given the regulatory constraints of those organisations (Ridley-Duff and Bull, 2011, pp. 141).

The remaining participants classified themselves as social enterprise or other. Those classed as ‘other’ were believed to have misunderstood the question, as when they were asked to specify what classification they considered themselves to be, they specified Community Interest Company (which is a legal form and one of the options in the following question). The Community Interest Company legal form was specifically introduced for social enterprise organisations, comprising a corporate legal form added onto the traditional CLS or CLG type of company. Statutory restrictions mean that its ability to distribute profits is limited to 35 per cent annually, its assets are locked and so have restrictions on the ability to sell them and it must have a defined community purpose (Office of Regulator of CIC, 2017).

The data has not been corrected to maintain integrity of participant responses but on their respective websites each participant that classified themselves as Community Interest Company specified that they were a social enterprise. Notwithstanding these discrepancies, those organisations that classified themselves as social enterprises utilised either Community Interest Company or Company Limited by Guarantee

legal forms. Again, this is in accord with the suggestions from the literature (Ridley-Duff and Bull, 2011, pp. 141).

Whilst the correlations between status and legal form accord with suggested orientations in the literature, the results are not helpful in distinguishing the features and characteristics of PSMs from other organisations. This is because, notwithstanding four participants were included on the interactive map of PSMs produced by the Cabinet Office, none classified themselves as a mutual in their response to the survey. Three self-identified as a social enterprise with the fourth self-identifying as 'Other', specifying its status as Community Interest Company, whilst classifying itself as a social enterprise on its website.

This is reflective of one of the issues when researching this area. Lack of definitional and conceptual certainty about what a mutual organisation is, and a PSM in particular, combined with the flexibility of terminology used by the DCMS Mutuals Team and the Mutuals Taskforce, has created a disconnect between the use of the term mutual and the organisations it is being applied to. What this means for analysis of survey data is that status and legal form are not helpful indicators of PSMs. If none of the respondents self-identify as a mutual, instead preferring to classify themselves as social enterprise or by their legal form, then subsequent identification of distinguishing features attributable to PSMs becomes problematic, without importing into the analysis data from outside of the survey, such as data from the Cabinet Office interactive map and the organisations' own websites.

Rather than mix data in that way, cluster analysis was used. This is an example of the flexibility incorporated into the research design, and referred to in Section 3.3, enabling changes to be made as issues arise. The revised approach re-analysed the data and grouped organisations with similar features and traits. In this way data collected to explore mutual configurations of ownership, voice, transparency and shared benefit could also be analysed to investigate whether certain configurations were distributed within particular groups of respondents. Using cluster analysis, as well as data on organisational status, enables survey results to be triangulated to aid quality assurance of the results and analysis.

4.3 Classifying Organisations

Cluster analysis is an iterative process and the methods used were discussed in Section 3.4.3. Categorical variables were selected as proxies associated with mutual configurations. Whilst not a direct relational or causal link, the proxies and associated questions had been selected to reveal patterns and presence of aspects of organisational form within healthcare organisations that were associated with mutual practices. Types of organisations delivering healthcare in NW England could be distinguished by the presence or otherwise of these proxy variables, identifying which groups of organisation incorporated a number of mutual configurations. By analysing the data using the status and legal form of the organisations that make up each cluster, patterns and regularities emerge.

57 of the 65 cases (88%) formed three clusters based on the mutual configuration proxies, with a non-attributable group comprising the remaining 8 cases. The distributions of cases in each cluster (and the unattributed ones) are shown in Table 4.2, which can be read together with Figure 4.2, which shows the distribution of clusters by status. Figure 4.2 illustrates the first cluster generated by the analysis as exclusively made up of public sector organisations.

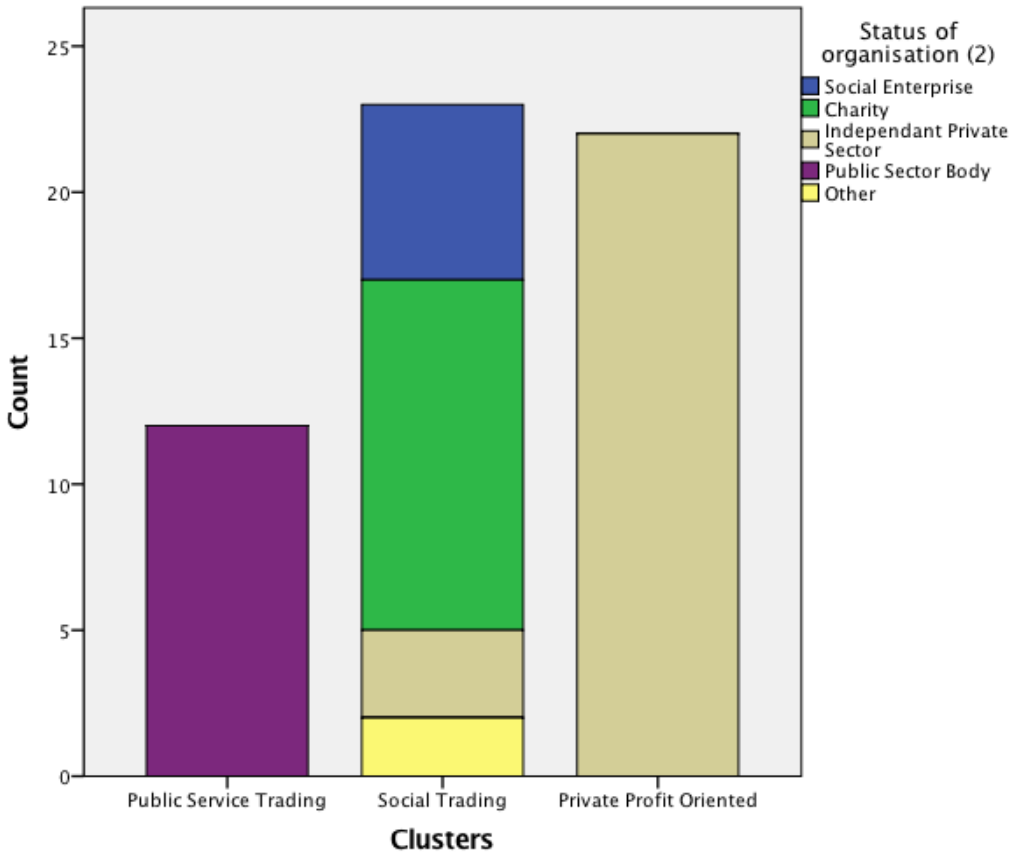
Table 4.2 Results of cluster analysis by typology

Cluster (Numbered as per SPSS output)	**Cases (N = 65)**	**Typology**
Cluster 1	12	Public Service Trading
Cluster 2	23	Social Trading
Cluster 3	22	Private Profit Oriented
Unattributed Cluster	8	N/a

Source: Survey data (N = 65)

These have been classified as Public Service Trading to reflect that, whilst they are publicly owned, in the healthcare sector they have a degree of autonomy and trade in a market place with non-public sector organisations. The third cluster is made up exclusively of private sector organisations, and again to reflect the competition between different types of trading organisation in healthcare in England, the classification is based on their profit-generating characteristics as revealed in the survey data. Accordingly, the third cluster was classified as Private Profit Oriented.

Figure 4.2. Clusters by Status



Source: Survey data

The second cluster comprised social enterprises (including the 'Other' category mentioned above that had been mis-labelled), charities and some private organisations. The two private organisations within this cluster, on further analysis of their legal form and data from CQC, comprised joint ventures between public and private entities. One was a private fee paying Limited Liability Partnership with NHS involvement and the other the private fee paying travel clinic of a university. Both of

these would be expected to have hybrid features in their organisation and practice. To reflect the diversity of this cluster it has been classified as Social Trading, as it is neither public nor private, nor is it made up of a homogenous group.

This combined analysis of clusters and status provides a typology of three types of organisation for further analysis of regularities of mutual practices, in line with Sayer's (1994, p. 163) aim of developing taxonomic groups with similar attributes but without any necessary formal connections.

4.4 Patterns of mutual configurations within clusters

Investigation of mutual configurations was carried out using the proxies associated with each configuration. These involved participation of employees in ownership (ownership), participation of employees in governance and board (voice), information sharing (transparency) and employee participation in the benefits of the organisation (shared benefit). Analysis of the survey data was conducted on a cluster basis, crosschecked with status, using the frequency of each case's employee involvement within each of these categories. The results were aggregated to ascertain patterns and regularities on a cluster-by-cluster basis, and to determine whether any trends could be established that would merit further in-depth investigation.

4.4.1 Ownership

Chapter 2 set out a critical realist account of an employee ownership configuration, as having tendencies to generate different behaviours than were evident when an organisation was in public sector ownership. To address this in the survey, questions were asked of organisations that concerned ownership of the organisation, particularly the classification of who the owners were (question 13). The aim was to explore patterns of employee ownership amongst the three types of organisation, to see if any regularity occurred as regards employees.

Table 4.3 show the frequency of the different ownership cohorts (members, staff, managers/directors and so on), with crosstabs to the cluster classification of each organisation. This analysis identifies the frequency by which different ownership cohorts feature as owners of the different classification of organisation. Results were

then analysed in the context of the literature on PSMs, mutualism and employee ownership to establish if any patterns are reflected.

Analysis was focused on staff and member ownership, in contrast to ownership by public bodies, external investors, communities, trusts, managers and directors. This follows the PSM focus on employees and the literature on mutualism with its consistent approach to membership as an ownership cohort of mutual organisations. Member and staff ownership was more prominent within the Social Trading cluster than in the other two, accounting for 12 (63.16%) of the total number of organisations that were member and staff owned. There is one instance of member and staff ownership within the Public Service Trading cluster, but this is an error in the response to the survey, as the organisation that responded in this way is an organisation with members (a Public Benefit Corporation) but remains wholly publicly owned. In the Private Profit Oriented cluster, the seven counts of member and staff ownership comprised 36.8%, lower than the Social Trading cluster even with broadly similar numbers of organisations in each cluster (see Table 4.2).

Table 4.3 Ownership by cluster

	Public Service Trading	**Social Trading**	**Private Profit Oriented**	**Total**
Owned by Members/ staff	1 (5.3%)	12 (63.16%)	7 (36.8%)	19
Owned by Managers/Dirs	0	3 (14.3%)	18 (85.7%)	21
Owned by Public Body	11 (91.7%)	0	1 (8.3%)	12
Owned by Investors	0	0	7 (100%)	7
Owned by Community	0	3 (100%)	0	3
Owned by Trust	0	3 (100%)	0	3
Owned by Others	0	3 (100%)	0	3

Source: survey data (n = 57 but multiple responses so total > 57)

There are indications that member and staff ownership features highly within the Social Trading healthcare cluster. Further analysis of this group of member and staff

owned Social Trading organisations by status, revealed that these 12 organisations are made up of four social enterprises, six charities and two private sector organisations.

Whilst not conclusive or predictive, there are indicators that where organisations are member or staff owned, they tend to be distributed amongst organisations that would be classified as Social Trading organisations. Further, within this cluster, a high proportion of member and staff owned organisations classify themselves as social enterprises (four out of six in total or 66.6%, six out of eight, or 75%, if the misattributed responses are taken into account). This indicates a regularity for social enterprises to be member or staff owned.

This regularity can be analysed further by cross-referencing those social enterprises or Community Interest Companies (CICs) that were also included in the interactive map of PSMs (Cabinet Office, 2014a). All of the social enterprises or CICs on that map responded that they were either member or staff owned, which further indicates a regularity attributable to ownership data of PSMs. This regularity around the ownership of social enterprises and CICs, especially those that are PSMs, merits further investigation by more in-depth case study research.

4.4.2 Voice

Employee involvement in decision-making and participation in the organisational forums where decisions are made, such as the organisation's governance board, provides a potential indicator of the operation of employee voice configurations. Where organisations demonstrate that they have employee governance and decision-making participation practices, then according to the literature discussed in Chapter 2, these practices may represent mutualism.

Analysis of survey data relating to voice configurations focused on the role of members and staff in the governance of the respective organisations. One feature of mutuality already discussed is plurality of stakeholder participation in decision-making within organisations. One way in which such participation can be achieved is for members or staff within the respective organisation to be able to participate in decisions that are ordinarily privileged to managers. There are a number of ways in which members and staff can participate in governance. These include acting as director, separate staff boards or councils and staff meetings where views are

meaningfully taken into account and influence decision-making within the organisation.

The last of these, meaningful staff meetings, was difficult to establish from the data collected from the survey. The reason for this is that whilst many participants indicated that there were regular team meetings, staff meetings and other such consultation and decision-making forums at which members and staff attended, it was not possible to differentiate the quality or meaningfulness of these between the various clusters. This was because the data from the survey only provided information as to what meetings took place, not what occurred in those meetings that would reflect meaningful staff participation. In addition, there was little distinction between the three clusters as regards holding team and other meetings for staff. This is an area that requires more in-depth exploration, to establish the extent and quality of the meetings that take place. This will be best undertaken during in-depth case studies, where staff and managers can be asked about the meetings in interviews, and discuss their role and benefit as a forum for staff voice.

It was a different position as regards staff governance, through staff councils and staff or member directors. Table 4.5 combines the frequency of staff representation within the three clusters. Some organisations in each cluster did not have any staff representation, whilst others had more than one so the totals in this table do not add up to 57. There were a high proportion of staff councils amongst Public Service Trading organisations (11 or 55% of the total) compared to Social Trading and Private Profit Oriented (5 or 25% and 4 or 20% respectively). It is suggested that the high proportion of staff councils in Public Service Trading cluster is attributed to the introduction of Public Benefit Corporations, a feature of which was elected staff representation on the governance council.

Of the other two clusters, there was nothing in the data that suggested any explanation why the Private Profit cluster would have staff councils amongst its cohort. However, the staff councils within the Social Trading cluster, when considered in the context of their status, show some correlation that may provide an indication of why. Two of the Social Trading organisations were Social Enterprises and also were on the interactive map of PSMs. This would suggest that staff councils might feature as a regularity amongst PSMs and therefore merit further investigation in more in-depth case studies.

Table 4.4 Clusters by Staff Council, Staff Governance and Staff Directors

	Public Service Trading	**Social Trading**	**Private Profit Oriented**	**Total**
Organisations with a Staff Council	11 (55%)	5 (25%)	4 (20%)	20
Staff are involved in Governance	5 (17.24%)	10 (34.48%)	14 (48.28%)	29
Staff are Directors	5 (19.23%)	7 (26.92%)	14 (53.85%)	26

Source: Survey data (n represents multiple responses)

Staff involvement in governance mechanisms other than staff councils was another feature examined in the data from the survey, including staff having a role as director. Staff involvement in governance and staff as directors in Private Profit Oriented organisations were a much higher proportion of the respective totals (48.28% and 53.85% respectively). For Social Trading organisations the number of organisations with staff involvement in governance increased substantially to ten (34.48% of the total) and staff directors increased to seven (26.92% of the total). This was to be expected as there is likely to be a convergence between staff involvement in governance and staff councils, and the same Social Trading organisations with staff councils also answered yes to staff involvement in governance, with another five that had staff involvement but no council. At the same time, this cluster showed a higher number of organisations with staff directors that included the same five again plus two others, one of which was also a social enterprise on the interactive map of PSMs.

A final stage of analysis relating to governance and staff voice, concerned voting rights within the respective organisations. How these are distributed, and so who has a vote and how they are conducted is a feature of the literature on mutualism discussed in Chapter 2. The distinction drawn here is whether voting rights were attributed to individuals on the basis of one member one vote, or OMOV, basis, or whether voting rights aligned with economic rights in the organisation. The former is a significant feature of co-operative and mutual governance, whilst the latter implies

the more an individual owns economic value in the organisation the more votes that individual has. The data relating to voting rights and their distribution is set out in Table 4.5.

Table 4.5 Clusters by Voting Rights: OMOV or economic

	Public Service Trading	**Social Trading**	**Private Profit Oriented**	**Total**
One Member One Vote	4 (16.67%)	17 (70.83%)	3 (12.5%)	24
Economic Rights	0	1 (12.5%)	7 (87.5%)	8

Source: Survey data (n=32)

Not all respondents answered this question and so whilst Table 4.5 shows the data analysed from the participants, it provides an incomplete picture. Nevertheless, there is a clear majority (17 or 70.83%) of Social Trading organisations with OMOV governance voting rights, which includes all of the social enterprises, as well as the three organisations on the interactive map of PSMs. This preponderance of democratic voting rights accords with the principles attributed to co-operative and mutual organisations, suggesting regularity associated with democracy within this cluster, and within PSMs themselves. Even with limited responses, all of the Public Service Trading organisations that provided an answer to this question (four or 100%) indicated that they, too, had OMOV governance voting rights in their organisation.

What can be assessed from this data concerning different methods of staff voice is that there appears to be some regularity amongst those Social Trading organisations that are PSMs within the participants, in that they all have amongst their governance structures staff involvement. These included staff directors, with two of them also including a staff council. Employee voice was suggested in Chapter 2 as a significant differentiator for PSMs and the regularities from the survey data would seem to indicate that this is the case.

The Public Service Trading cluster also had high numbers of staff councils, staff involvement in governance and OMOV governance. This level of regularity of staff

voice within public sector bodies is higher than Social Trading entities generally, but is at a similar level to PSMs when the Social Trading cluster is analysed further by cross referencing it to the data on PSMs (Cabinet Office, 2014a). Staff voice is an area, within both types of organisations, that merit further investigation in an in-depth case study to explore these regularities, and to compare the two types of voice mechanisms in both Public Service Trading and PSMs.

4.4.3 Transparency

In order for actors to participate fully in decision-making, they require informed knowledge of all relevant and material information relating to the decision to be made. Full transparency of information includes not only open sharing of all relevant material information, but also the means to understand information in the context of the particular organisation and the consequences of decisions and non-decisions. One factor that does count towards a transparent organisation would be ensuring that there is no privileging of information between agents (such as managers) in the organisation or between different hierarchical positions.

The survey contained a number of questions that were selected to ascertain how information was shared within the organisations. This included the various media and methods employed through which management informed the staff of what was happening within the organisation (question 10). As was discussed in Chapter 2, access to information within an organisation is a component of the ability for staff to engage voice mechanisms actively and meaningfully. In addition, wider dispersal of information, rather than being a privileged resource of managers, is an important component in the building of trust between the organisation and its staff.

Table 4.6 sets out the responses of each cluster to the various questions about information sharing media and forums. Public Service Trading entities have high levels of use of e-mail communication, staff noticeboards, newsletters and staff surveys with all of the respondents indicated they engage in these activities. This universality changes with intranet, staff handbook and staff suggestion schemes, but are still relatively highly used. A more mixed picture occurs with Social Trading entities, where e-mail, staff noticeboards and staff handbook are widely used whilst intranets, suggestion schemes and newsletters are less regular. Private Profit Oriented organisations do not provide any meaningful regularity with a mix of organisations using different media.

Again, as many organisations indicated multiple media and forums in the survey, whilst n = 57, the totals do not correspond to the number of participants.

Table 4.6 Clusters by Information Sharing

	Public Service Trading	**Social Trading**	**Private Profit Oriented**	**Total**
Surveys	12 (34.29%)	13 (37.14%)	10 (28.57%)	35
Newsletter	12 (40%	15 (50%)	3 (10%)	30
E-mail	12 (24.49%)	20 (40.82%)	17 (34.69%)	49
Staff Noticeboards	12 (28.57%)	20 (47.61%)	10 (23.81%)	42
Intranet	8 (25%)	12 (37.5%)	12 (37.5%)	32
Staff Handbook	8 (18.6%)	20 (46.51%)	15 (34.88%)	43
Staff Suggestion Scheme	9 (28.13%)	13 (40.63%)	10 (31.25%)	32

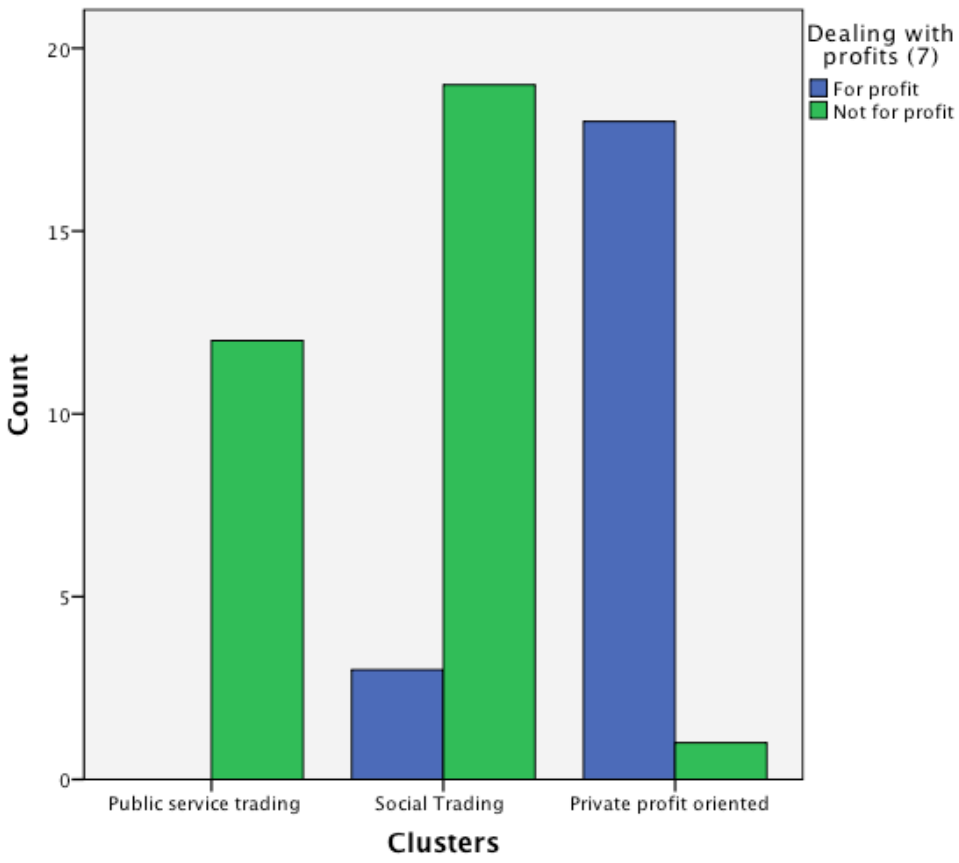
Source: Survey data (n=57)

4.4.4 Shared Benefit

The most obvious benefits to be distributed within any organisation are financial ones, with any surpluses generated by a mutual organisation being divided up in an egalitarian way (Howieson, 2016, p.668) so that the members of the organisation share in the benefits generated on an equal basis. There is a presumption of equal distribution of financial benefits to members in the literature on mutualism. Equal distribution may be dividends on shares, bonuses or enhanced salaries, which are not determined through economic rights of ownership or individual incentives, but on a fair and equitable basis. Sharing benefits within organisations in this way would be an indicator of mutual practices.

Questions in the survey questionnaire identified organisations with a mechanism to distribute surpluses to staff. The survey asked respondents a number of questions aimed at establishing regularities concerning this type of participation. The first was whether or not the organisation was for profit (question 7), and Figure 4.3 shows the responses. For profit and those not-for-profit are cross-tabulated by cluster. None of the Public Service Trading cluster is for profit, which is to be expected, and they do not have distributable profits to pay to staff. Similarly, Social Trading organisations are predominately not-for-profit. The organisations that are for profit in this cluster were the hybrid entities mentioned above.

Figure 4.3 Clusters by Dealing with Profits



Source: survey data

Apart from the hybrid organisations, neither of these clusters is in a position to distribute profits by way of shared benefit. Private Profit Oriented entities are the opposite, as the cluster name suggests, with almost all of the organisations in this cluster being able to distribute profits directly to staff should they wish.

Analysis of the data gathered on shared benefit is limited to the type of organisational aims (for profit/not-for-profit) and direct and indirect financial rewards and incentives. What is missing from a survey of this nature, and which is difficult to obtain from structured questionnaires in general, relates to indirect non-financial benefit. Public sector bodies and other non-profit making entities, such as charities and social enterprises, do not have financial rewards to distribute to staff in the same way that Private Profit Oriented organisations do. This can be seen from Table 4.8, where this latter group are mainly "for profit" entities, with a primary purpose to generate returns, with none of the former group having these characteristics.

Table 4.7 Clusters by Primary Purpose

	Public Service Trading	**Social Trading**	**Private Profit Oriented**
Member Benefits	0	2	1
Generate Returns	0	0	14
Social Purpose	11	20	6
Other	1	1	1
Total	12	23	22

Source: survey data (n=57)

However, shared benefit can take many forms, such as participating in a shared purpose to deliver a social mission or staff training and development, all made possible by retention and reinvestment of surpluses. These forms of shared benefit are best explored in semi-structured interviews within an in-depth case study research environment, to enable a deeper exploration of the meaning to staff of shared benefit and their own motives.

4.4.5 Limitations of the survey data

Regularities can be identified from this data, providing initial patterns across the three clusters. However, it is not a comprehensive account. This is due to limitations arising from closed questions to survey responses alone, one of the limitations of data of this nature. To establish meaningful explanatory accounts, it is necessary to build on this survey data with more in-depth research, which explores these four mutual causal configurations in greater detail.

The outcome of the analysis of the survey data provided some useful guidance about regularities of mutual configurations amongst the participants, which merited further investigation. In addition, the areas that could not be analysed also pointed to the need for further investigation in an interview environment, where the qualitative data gleaned could explore regularities in a way not open to quantitative analysis of survey data. This suggests that selecting organisational case studies for further investigation and comparison would be useful.

4.5 The Three Organisational Case Studies

What was apparent from the survey data and analysis of the three clusters is that two types of organisation provided appropriate context for case study research: PSMs themselves and NHS Foundation Trusts. PSMs were shown to possess a number of features that could be considered mutual configurations, particularly employee ownership and high staff representation in voice configurations. NHS Foundation Trusts, whilst not exhibiting mutual ownership configurations, did possess voice configurations.

As these two types of organisations provide similarities and differences in the regularities of mutual configurations in their organisational practices, comparing the two types should provide sufficient contrast to explore different generative mechanisms and causal powers in different contexts (Kempster and Parry, 2014, p. 106). In addition, as the survey data revealed that PSMs do contain more of the mutual configurations there is merit in carrying out comparison between two PSMs as well, to compare the operation of these practices. Taking this into account, three case studies would provide the contrasts required: one NHS Foundation Trust and two PSMs.

4.5.1 Organisational Case Study 1 – Acute Health

The first case study, Acute Health, comprises a hospital unit of an NHS Foundation Trust, and is a Public Service Trading organisation. There are a number of reasons for selecting Acute Health for intensive in-depth case study research into PSMs.

NHS Foundation Trusts are a relatively recent organisational innovation in public service healthcare delivery, introduced in 2003 as part of a series of reforms (Allen et al, 2012, p. 241). Their aim was to stimulate public participation by replicating mutual organisational models. As discussed in Chapter 2, their legal form, the Public Benefit Corporation, was an early experiment in mutualism in the delivery of public services, and in particular healthcare. This autonomous legal form, based on mutual ideals, provides further rationale for selection of an NHS Foundation Trust, along with the outcome of the survey data analysis.

Choice of which NHS Foundation Trust to investigate was made purposively, based on a recent mutual pathfinder for these types of organisations. Mutuals In Health (Cabinet Office, 2014b) was an exploratory initiative to explore and develop the feasibility of the mutualisation of all or part of NHS organisations, and was conducted between 2013/14.

Three of the NHS Foundation Trusts selected for the pathfinder operated in NW England, and formed part of the sample of healthcare providers selected for the survey questionnaire. With their Public Benefit Corporation legal form and participation in the Mutuals In Health pathfinder, these three NHS Foundation Trusts provided an opportunity to examine an organisation that incorporated some of the mutual configurations identified from the survey data and which, through the pathfinder, had knowledge of mutualism and its practices as part of PSM policy.

All three organisations were contacted and asked to attend a workshop conducted for the benefit of this research. This workshop, hosted at the researcher's offices, comprised exploratory discussions of each organisation's practices and experiences of the Mutuals In Health pilot and the existing mutual practices that occurred through their operation as Public Benefit Corporations. Chief Executives, Directors of Finance, Directors of Strategy, Human Resource Directors and Clinical Directors from each organisation took part, as well as representatives of one of the clinical professional bodies.

Handwritten notes of discussions were taken for the purpose of this research, following the obtaining of consent from all participants at the outset of the workshop. These notes were subsequently analysed to select a case study participant and to inform the interview topic guides used for participant interviews in the case study (see Appendix D), as well as being analysed for the purposes of the discussions in Chapters 5, 6 and 7.

Comparison was made of each organisation's experiences with the Mutuals In Health pathfinder and their own mutual organisational form, as well as their size and demographic information. Acute Health was found to be different from the other two. Whilst both the others were considering wholesale transfer of the entire organisation into a new body, comprising in excess of 2500 staff in each case, Acute Health was only considering one of its clinical functions for potential transfer, comprising between 90 and 100 staff.

In follow up conversations it was revealed that the two NHS Foundation Trusts that had considered wholesale transfer had endured difficulties that had led them to consider abandoning the project. Due to confidentiality the details of any issues were not revealed, although to date no transfer has taken place nor is planned. In contrast, the more restricted approach of Acute Health, limited to one clinical unit was developing into a potentially viable PSM that would also encompass related health professionals who worked for the local Council and GPs.

With the difficulties experienced by the other two NHS Foundation Trusts, compared to the more positive outcome from the pathfinder of Acute Health, it was decided that the latter would be most appropriate for in-depth case study research. A smaller unit would also provide data within a similar work environment that would be relevant to other data gathered from that unit, rather than across a large, diverse environment such as the whole organisation.

Acute Health had previously experienced performance difficulties and had been in special measures, a monitoring regime that was supervised by its regulator. It had recently been removed from special measures, following a number of actions, including replacement of senior managerial and clinical staff. A new Chief Executive, Director of Finance and Director of Strategy had all joined in the previous 18 months. The Mutuals In Health pilot was one of the actions that were undertaken to consider change in organisational structure as a consequence of the special measures regime.

The unit selected at Acute Health is responsible for delivering healthcare services to a geographic community of approximately 240,000. The unit comprises two in-patient wards (surgical and general), outpatient clinics and technical services, including diagnostics. There are approximately 100 full-time equivalent staff working within the unit, including consultants, junior doctors, nurses, managers, technical staff and administration. The unit is part of a larger organisational structure, comprising an NHS Foundation Trust.

4.5.2 Organisational Case Study 2 - Community Health

The second organisation selected for in-depth case research, Community Health was a newly formed PSM that had transferred from a Local Authority. Community Health provides healthcare services for adults with complex health needs in a defined geographical area in NW England. It has a budget of over £10m per annum and approximately 240 full time equivalent staff. The decision to spin out from its host authority followed a programme of savings that had been achieved over the previous three years of delivery of the services by the Local Authority. One of the rationales behind the decision to spin out was to enable a new, non-public sector organisation, to achieve further efficiencies and savings, alongside plans to develop new services that will generate further income.

The new organisation was set up in 2014 as a Community Interest Company in advance of staff and related resources being transferred into the new organisation in 2015. Community Health has been granted an initial five-year contract with the host authority for existing health services. In turn, the host authority currently holds provider contracts with the local NHS Care Commissioning Group, the local NHS Foundation Trust (not Acute Health) and other health commissioning bodies. Community Health delivers all these services on behalf of the Local Authority through the single contract. Community Health is recognised as a PSM by the Cabinet Office, its formation having been financed by the DCMS Mutuals Team.

As a newly formed PSM, and as an organisation that falls within the Social Trading cluster, Community Health provided an opportunity to examine a PSM that had undergone change, which reflected both antecedent structures from its host organisation and newly introduced structural arrangements and mechanisms as a result of its recent transformation. In addition, Community Health provides a contrast

to Acute Health with its alternative ownership model, whilst still retaining the same public sector employed staff that worked prior to its transformation.

One issue that did arise is the differential staff numbers in Community Health and Acute Health, also relevant to the third case study below. Whilst it would have been preferable to have three cases with similar numbers of employees, the limited number of PSMs in NW England, as with any other region, does not reflect any uniformity of size. Recent research by CIPFA (2017, p. 12) noted that numbers of full time employees at PSMs in England varied considerably from one to 6000. The average (mean) was 347, with a median of 75, full time equivalent employees. Whilst there are different sizes of case studies, they are representative of the diversity in the PSMs in England.

4.5.3 Organisational Case Study 3 - Psychological Health

Psychological Health is an organisation classified by the DCMS Mutuals Team as a PSM, providing community mental health services to a defined geographic community in NW England. It was established as a social enterprise, following the separation of provider services from commissioning services during the Transforming Community Services Programme (Department of Health, 2012).

This programme was not related to the PSM policy, according to PH6, Psychological Health's Chairman, but rather to the on-going aim of separating commissioners and providers in the NHS. Subsequently, as many of the health provider's under that programme that were transferred out of the NHS adopted social enterprise legal forms with employee ownership structures, they were retrospectively added to the interactive map of PSMs (Cabinet Office, 2014a). Psychological Health is one such organisation.

Psychological Health began trading as an independent service provider in 2011 with 11 staff, following its spin out from its host Primary Care Trust, the successor of which is now a Clinical Commissioning Group or CCG. The employees were transferred into a newly formed organisation, which had been set up as a Community Interest Company and intended to operate as a social enterprise.

Psychological Health currently employs approximately 45 full time equivalent staff and its annual turnover is over one and half million pounds per year. The majority of its income derives from a contract to provide community mental health services,

awarded by the local CCG. Other income streams have been developed to supplement the main contract, through business development opportunities, grants and research projects identified by the staff.

Psychological Health is an established organisation, and so provides a contrast to both Acute Health, through its ownership structure, and Community Health, through its longevity and opportunity to develop as a PSM over time. Similar reservations concerning differential numbers of employees as mentioned above are noted, but for the same reasons it is considered representative of the type of PSM that is prevalent in England.

4.5.4 Positioning the PSM case studies in the healthcare market

Both of the PSMs have contracts with their host authority that can be described as based on "block-grant" principles, with each PSM paid a fixed amount per annum and expected to manage demand for the services (Appleby et al. 2012, p.7). Adjustments are made to the following years payments based on actual demand. This form of contract can be contrasted with other types in the England and Wales health economy, such as payment by results (Appleby et al, 2012, p. 6).

Block-grant contracts provide certainty of income for each PSM over the years of the contract, and less competition in the market for their respective services. In awarding a contract for their respective markets, each PSM is given time for the transition to a PSM to be effective, without having to compete against competitors. This addresses a significant concern for newly formed PSMs, raised recently by Social Enterprise UK (2018, p. 15) that highlights the difficulties faced by PSMs from competing entities. The certainty of a block grant contract gives each PSM protection from such competition, and so enabling focus on developing mutual practices.

Chapter 5 Ownership

5.1 Introduction

In identifying mutuality, ownership practices are promoted as a key practice of mutual organisations. The literature reviewed in Chapter 2 discussed how both New Mutualism and the discourse around PSMs all agreed on the importance of ownership, with any divergence occurring in the identity of the owners. PSMs have focused primarily on employees, whilst other mutual writers promote multiple stakeholder ownership (Turnball, 2001, p. 171) and member ownership (Birchall, 2011, p. 5). Regardless, ownership is an appropriate line of enquiry to assess what differentiates PSMs from other organisations, and was suggested as such by analysis of the survey data in Chapter 4.

This Chapter considers ownership in the context of the three cases introduced previously: Acute Health, Community Health and Psychological Health. Data from each concerning ownership practices is analysed and compared across case, to build on the results from the survey data to explain how ownership configurations operate within the two PSMs, Community Health and Psychological Health and also compared to Acute Health.

To investigate ownership, the concept has been re-described in critical realist terms to provide a framework that takes account of the underlying structures and generative mechanisms that are in operation within ownership relations. Analysing these causal configurations provides a basis for comparison between cases, enabling different organisations to be compared and contrasted to identify the similarities and differences. Analysis and comparison between cases is conducted in Section 5.2 using a step-wise approach. First, the internal relations that make up an ownership structure for each case are identified from the data. Then, in order to provide a more nuanced framework for comparison, these internal relations are further refined into

the various entities that make up the relevant ownership causal configuration (Section 5.2.4).

This objective approach of examining causal configurations, however, provides a one-sided analysis, omitting agency and how social actors interact with the structures and mechanisms of ownership. Section 5.3, therefore, discusses how agents within each case engage with those configurations, including comparative analysis to discuss differences and similarities in how agential engagement with ownership configurations occurs within each. This will suggest that ownership configurations do create a mutual practice, but that time and agential engagement at all levels, not just senior management, determine to what extent.

5.2 Ownership as a causal configuration

There are common ownership characteristics within each of the three cases. Analysis of documentary evidence demonstrated they are all body corporates, each with their own legal personality and identity. This means they can legally act as if they were a human entity carrying out day-to-day activities, albeit through the actions of social actors.

One consequence of body corporate status is that a separate legal identity cannot stand-alone. Whilst human beings own themselves, and so do not stand in relation to any other entity, each body corporate must stand in relation to at least one other, whether human persons or other corporate bodies, that owns that organisation. This set of relations creates an ownership structure, operating as a causal configuration.

There are various entities that go to make up an ownership configuration for an ownership structure to exist, including social structures, generative mechanisms, rules, resources, tendencies and causal powers. They combine and interact possessing causal powers emanating from the ownership configuration. These tendencies could be multiple, ranging from the power to dissolve the corporate body and sell its assets, to changing how it operates by altering the rules, subject to external legal and other constraints.

5.2.1 Acute Health

Acute Health is a NHS Foundation Trust, with a legal organisational form known as a Public Benefit Corporation, which was created by legislation to manage NHS organisations (HMSO, 2003, p.1) as discussed in Chapter 2. The Public Benefit Corporation form introduced to Acute Health a degree of autonomy from the Secretary of State for Health (who exercises authority on behalf of the UK Government). Whilst the Secretary of State retains residual powers to cap budgets and deal with dissolved organisations, day-to-day management control is vested in the executive board of Acute Health, without direct Secretary of State intervention, except in limited circumstances. Creation of Acute Health transferred all the assets, staff, and operations of the previous NHS Trust to it. Acute Health, in keeping with all Public Benefit Corporations, became a membership organisation. Members are drawn from constituencies related to its geography and operations, as well as its staff and representation from partnership organisations, such as the local authority.

Acute Health is a membership organisation, but not owned by members. The previous NHS Trust transferred assets to Acute Health, but no transfer of ownership from UK Government occurred. Discussions with Chief Executives and Directors of Finance at the NHS Foundation Trust workshop (discussed in Section 4.5.1) confirmed this, as did analysis of documentary evidence and statutory provisions.

Table 5.1 sets out the results of analysis of ownership in social structure terms, using Sayer's (1992, p. 61) internal and external relations approach. The external relations are not exhaustive, as there are many such entities that could be listed, and so selection of the most relevant is included. This ownership structure comprises necessary relations between the Public Benefit Corporation, as the legal form of Acute Health, the UK Government (through the Secretary of State) in its agency of owner, legislation that specifies rules for the organisation, generative mechanisms relating to public sector ownership and the various assets and liabilities that comprise the resources of Acute Health.

Table 5.1 Internal and external relations of Acute Health's ownership structure

Internal/Necessary Relations	**External/Contingent Relations (Non-exhaustive)**
UK Government/Secretary of State	Members
Public Benefit Corporation	Employees
Legislation	Executive Board
Public Sector Ownership	Patients
Assets and Liabilities	Professional Bodies
	Regulators
	Council of Governors
	Local Authority
	Tax-payers

Source: Case study data

The external relations, whilst relevant in that they interact with the ownership structure, are not necessary to its existence and continuity. For example, Acute Health has members but whilst they interact with the organisation, if no members joined Acute Health, the ownership of the entity would not be affected. Members are not owners and ownership does not depend on there being members. Prior to Acute Health becoming a Public Benefit Corporation, it was a NHS Trust owned by the UK Government without members. Contrast this with the legislation that governs the operations of Acute Health and public sector ownership mechanisms. These two sets of rules and generative mechanisms are co-dependent, and without both, the ownership structure would dissipate, as there would be no statutory authority for Acute Health to exist in its current form and no public owner.

Other relations external to ownership structures are the patients and employees (both also members). Each of these agents is necessary to the structure of healthcare delivery but not to the ownership of the organisation that delivers healthcare. Likewise, the Executive Board and Council of Governors do not comprise any representatives of the owners and are external to the ownership structure, as are representatives of the local authority on the Council of Governors. Other examples of entities that interact with Acute Health, but are external to its ownership structure, are Professional Bodies (such as the Royal College of Nurses) and Regulators such as NHS Improvement (previously Monitor) and Care Quality Commission.

5.2.2 Community Health

Prior to 2015, the healthcare services provided by Community Health were delivered as part of a Local Authority service directorate. The Local Authority owned all assets and equipment and employed staff. There was no legal separation between assets, equipment, property and staff of the service directorate and the rest of the Local Authority. During 2015, to reduce costs, the Local Authority transferred all staff and assets into a separate independent legal entity called Community Health. The Mutuals Support Programme provided funding to assist this. CH6 noted the separation had been a significant act, with a clear break from Local Authority ownership:

> "Well obviously we've moved away from the Local Authority…I think it gives us a bit more independence…freedom and flexibility to create new services, to shape services around what people need, as opposed to within the Local Authority because of the cuts they needed to make, they were going and taking services off people" CH6, Level Two Support Worker, Community Health.

Community Health became a Community Interest Company, owned by shareholders, each of which evidence their ownership through shares in the organisation. The rules governing shareholders, directors and the operation of the company are set out in Articles of Association. The internal relations of the structure of ownership of any limited company presumes prior existence of private property rights (to vest ownership of one entity in another) as well as property to which those property rights attach. For Community Health, property comprises shares, a resource that both evidences and enables shareholders to exercise property rights. Ownership comprises a set of relations between shareholders and the body corporate itself.

By examining Community Health's corporate documents, the structural and non-structural relations set out in Table 5.2 can be isolated. Each permanent member of staff has a single share in the organisation, as prescribed in its constitution. Ownership, through legally enforceable rules of the Company, is collectively privileged to all permanent employees.

Table 5.2 Internal and external relations of Community Health's ownership structure

Internal/Necessary Relations	**External/Contingent Relations (Non-exhaustive)**
Community Interest Company	Executive Board
Shareholders	Staff Board
Shares	Service Users
Equal Private Property Rights	Managers
Employees	Professional Bodies
Articles of Association	Local Authority
Egalitarian ownership	Tax-payers

Source: Case study data

An important distinction emerges here between employees and shareholders. Using the critical realist concept of positioned-practices (Archer, 1995, p. 152), an employee is also a shareholder, but each of these positions are separate, comprising different associated practices, conducted by the same agent. As an employee, they have responsibilities under their employment contract to deliver work (treating patients). As a shareholder, they have a role in the ownership and macro-level governance of the organisation (voting at the AGM, electing directors). Both positions are governed by different rules (employment contract for employees, Articles of Association for shareholders) and the associated practices operate at different levels of the organisation.

Where this distinction becomes most acute is when considering which positioned-practices are necessary to ownership structures. Employees qua employees are ordinarily external to ownership structures, which subsist whether there are employees or not. An example would be all staff working temporarily under zero hours contracts. No employment relations exist; instead contractual ones do for one party to supply services to the other for payment. Yet the contracting entity is still owned by an owner.

Compare this to shareholders as part of an ownership structure with generative mechanisms. Regardless of the nature of staff relations (employee or zero hours contractor) shareholders are internal to ownership structures, as they are necessary to

that structure subsisting. Now consider Community Health. Employees, qua employees, are a necessary condition of shareholding. The same actors inhabit both positioned-practices and both are necessary to the ownership structures existing under the rules of Community Health.

Without data to the contrary, it would therefore be logical to exclude employees from the internal relations in Table 5.2, because in corporate bodies, ownership and employment are traditionally different structures. However, this would be an error for Community Health, where rules, internally related to ownership structure in themselves, mandate permanent employees to be shareholders, creating a necessary relation between ownership and employees. A shareholder cannot be any entity who is not a permanent employee. As a permanent employee in Community Health must also be a shareholder as a condition of employment, employees are necessary to ownership.

This is an example of differentiated contextual factors influencing the relevant social structures. In a non-employee owned organisation, such a nexus between ownership and employment does not exist and employment is an external relation to ownership. Mutual practices start to emerge here within PSMs that incorporate employee ownership, a difference that becomes apparent within a critical realist framework. The context specific environment, created by ownership rules, manifestly alters the ownership social structure.

Some of the relations external to the ownership structure are included in Table 5.2 as a non-exhaustive list. Theses are compared across cases in Section 5.2.4, but there is merit in considering the Local Authority here, as it provides a relevant example of how an entity can be significant to an organisation but not necessary to a structure. The Local Authority was both the prior owner of the services provided by Community Health, and so the legacy parent body, and continues to provide transitional support services. The Local Authority is also the current contractual commissioner of the majority of Community Health's services.

Notwithstanding the multiple links between the Local Authority and Community Health, historic and current, there are now no necessary relations as far as ownership structures are concerned. Whilst there would be significant impact on the operations of Community Health if the Local Authority were no longer to have any connections, there would be no effect on ownership. The necessary relation with ownership was

severed once Community Health left Local Authority control and became an independently owned entity.

The positioned-practice of Local Authority agency was once owner of the service and service provider, whereas now it is commissioner of services and supplier of resources. This change in positioned-practice reflects changes in ownership structure. Contextual differentiation has resulted in change in structure over time, suggesting morphogenesis. The extent and durability of this change will be examined in Section 5.3.2, but first Psychological Health's ownership structure will be considered.

5.2.3 Psychological Health

Psychological Health was also previously a service delivered through a public sector body. A NHS Primary Care Trust employed staff and owned the relevant assets required to provide community mental health services. All of the managers and staff who delivered the service, and were employed by that public sector body, now work for Psychological Health. Their employment contracts were transferred out of the public sector along with all assets required to deliver the service when the new organisation was formed. A number of new employees have also joined the organisation since the transfer.

There was a desire to create a different type of organisational structure and culture to the NHS when the transfer occurred. PH6 outlined options available:

> "Well, I mean, I suppose, when we were faced with the option of transfer into [Local NHS Trust], or going it alone, or possibly going into a community health trust, this was definitely the best option for us, 'cause it allowed us to remain autonomous. There was obviously an element of risk, in that, we were going as a standalone organisation, that's worked out very well…it's a Community Interest Company, you know, it's there, not to serve the shareholders, not to serve people looking to take dividends or make a profit, but really to be a successful company that is useful for the community. And also, there's some form of reinvestments in the community as well." PH6, Chairman, Psychological Health

Like Community Health, there are restrictions on the class of agents who are qualified to become shareholders in Psychological Health. In accordance with its

constitution, shareholding is limited to permanent employees and every qualifying member can hold only one share.

These rules create an ownership structure comprising only employees of Psychological Health. Private property rights required for share ownership are exercised in an egalitarian manner. Every such shareholder has one equal share. This creates a differentiated context through the interaction of the rules, mechanisms, resources, positioned-practices and relations. Whilst the relations between shareholders and the Community Interest Company create an ownership structure, not dissimilar to other corporate bodies, it is the rules mandating equal property rights and employee share ownership that distinguish Psychological Health's structure, as in Community Health, and from where mutual practices start to emerge.

Table 5.3 sets out the internal and external relations of this ownership structure, based on organisational form and shareholder restrictions. As with Community Health, employees are necessary to the ownership structure as shareholders but not in the positioned-practice solely as workers.

Table 5.3 Internal and external relations of Psychological Health's ownership structure

Internal/Necessary Relations	**External/Contingent Relations**
Community Interest Company	Executive Board
Shareholders	Service Users
Shares	Managers
Equal Private Property Rights	NHS Commissioners
Employees	Professional Bodies
Articles of Association	Tax-payers
Egalitarian Ownership	

Source: Case study data

As far as external relations are concerned, whilst there are differences in the identities that make up those that are contingent to ownership structure, they are broadly similar in function to Community Health. These are compared across case, along with the other ownership relations of each case in Section 5.2.4.

5.2.4 Ownership as Structure: Comparing cases

The ownership structures for each case study are made up of a set of internal relations that combine entities in such a way as to have the potential to influence how agents act in their respective roles within each organisation. These structures provide the context for agential action and so enable or constrain outcomes, depending on how agents mediate these structures. Table 5.4 compares the three cases.

Table 5.4 Comparison of ownership causal configurations

	Acute Health	**Community Health**	**Psychological Health**
Social Structure	UK Government Owned	Employee Owned	Employee Owned
Generative Mechanisms	Nationalisation NHS Secretary of State's Powers	Equal Private Property Rights Egalitarianism	Equal Private Property Rights Egalitarianism
Rules	Legislation	Legislation Articles of Association	Legislation Articles of Association
Positioned-Practices	Owner Secretary of State	Shareholder/Employee Owner	Shareholder/Employee Owner
Resources	Public Sector Funding Assets	Shares	Shares
External Relations	Members Employees Executive Board Patients Professional Bodies Regulators Council of Governors Local Authority Tax-payers	Executive Board Staff Board Service Users Managers Professional Bodies Local Authority Tax-payers	Executive Board Service Users Managers NHS Commissioners Professional Bodies Tax-payers

Source: Case study data

By separating out the internal relations that make up the structures into their respective parts, using a causal configuration framework, Table 5.4 re-describes ownership as a configuration of social structure, generative mechanisms, rules, positioned-practices, and resources. In so doing, the comparisons become more acute

and enable the cases to be compared and contrasted at a more detailed level. For completeness, and again to enable comparison between cases, the respective external relations are also included.

Comparison between cases highlights two different ownership structures. Acute Health is owned directly by the UK Government with no direct employee participation in its ownership structure. Whilst employees of Acute Health, as taxpayers, have an indirect relationship to NHS bodies through general taxation that provides the resources of public sector funding, this is not a direct ownership stake and they are external to the ownership structure.

The generative mechanisms that are engaged in this structure include nationalisation, enabling state ownership of NHS services and assets, and the NHS itself, which operates as its own causal configuration at a higher level of stratification, and also a mechanism at a different level to actualise nationalised health services. Other mechanisms include the Secretary of State's powers.

Legislative rules govern the ownership structure, including those enabling nationalisation of healthcare (which have become norms in the UK) and setting up NHS Foundation Trusts, as well as governing their operations as a public body. The UK Government acts through the agency of the Secretary of State, adopting a positioned-practice that mediates the structure, using public sector funding and assets as a key resource.

By comparison, Community Health and Psychological Health are each wholly owned directly by employees, with no UK Government ownership participation. Their rules differ from Acute Health as they are governed by Articles of Association bespoke to each organisation, as well as general legislation governing companies. Generative mechanisms within each configuration are egalitarian, representing equal property rights and staff adopt positioned-practices of shareholder, and so owner, as well as employees.

The ownership configurations of Community Health and Psychological Health, therefore, are similar and so would be expected to operate in similar ways. This is certainly the assumption made by the Mutuals Taskforce (Le Grand, 2012) and underpins the DCMS Mutual Team's approach to PSMs, discussed in Chapter 2. The structural relations concerning ownership investigated above, however, provide only

a partial examination of the influence of different ownership structures within each case.

Whilst ownership configurations include structural powers with the capability of "impinging on agents" (Archer, 2003, p. 19), exploring how they so "impinge" is insufficient on its own to provide a complete answer. This requires moving beyond the objective considerations of how structure affects agency or how a particular ownership configuration affects staff. By considering how agency affects structure, and so how staff respond to these structural arrangements and engage the generative mechanisms identified in Table 5.4, provides a more complete explanatory account.

5.3 Agential engagement with structure

How employees, as agents, respond to, and in turn engage with, the ownership configurations outlined in Section 5.2 determines the extent to which the causal powers inherent in those configurations are actualised.

5.3.1 Acute Health

Employees at Acute Health have no positioned-practice as owner and so their relations with ownership are external, as shown in Table 5.4. Employee engagement and interaction with ownership structures, therefore, are conducted through social actors operating through the various agencies of nurse, technician, consultant and manager. When investigating the effect of this ownership on those employees, the focus was necessarily limited to how they understood the current ownership structure to affect them in those roles and how they carried out their roles as agents within that ownership structure.

Inflexibility and resistance to change was a theme that recurred when nurses, technicians and consultants discussed the ownership structure of Acute Health. Employees expressed frustration at their inability to influence or effect change in the day-to-day proceedings. AH6 considered a strong resistance to change throughout the organisation, citing examples of this inflexibility both as a nurse working within the organisation and also as a patient, so in multiple positioned-practices. As a patient, she expressed frustration at being prevented from using services at Acute Health:

> "At the moment it's over dictated, I feel. The consultant says, 'This is what you need, this is where you're going,' for instance. I've got my GP at the moment telling me I can't come here to see my [Ear Nose and Throat] doctor, and instead I have to go to [Alternative hospital]. I don't have a choice. I know the [Ear Nose and Throat] surgeons here, but I can't come and see them, I have to go to [Alternative Hospital]. Seems nonsensical to me. Especially as I work here, it would be easier for my appointments but it doesn't seem to matter what the patient needed" AH6, Senior Sister, Acute Health

Inflexibility was recognised amongst senior nurses, but seen as necessary, with AH1, the Matron in charge, emphasising that inflexibility was a necessary feature of the organisation due to clinical governance issues and previous performance failings at Acute Health. As a consequence, ownership in the sense discussed above was not considered a relevant issue for the nurses. Instead, AH2 used ownership as a metaphor for responsibility, an idea she was keen to foster amongst the nurses:

> "Giving staff ownership of particular areas, and I just don't mean the qualified staff because that is what we tend to focus on, so now the healthcare [assistants]…there is someone who looks after mattress checks and someone else looks after nutrition and someone who looks after the pumps, so they all...nobody feels that one single person is singled out and I am not nagging one person to do this because we are all nagging each other and its all getting done... and taking ownership so it's things as simple as that..." AH2, Ward Manager, Acute Health

So whilst there was recognition amongst nurses of an inflexible culture, this was not necessarily equated to them being external to the ownership causal configuration. There were attempts to work within existing arrangements to try to generate autonomy at a local level within teams, but no desire to have an ownership stake in the organisation. Their efforts were generated within the team of nurses, not across the whole unit or organisation.

A contrast in attitude emerged within another team at Acute Health, the diagnostic technicians. Their team comprised 16 members of staff providing diagnostics, testing, monitoring and assessment services to patients. Whilst they interact with the rest of the clinical unit, and are under the direct control of the Consultants, they work as a team, with their own budget of approximately one million pounds per annum. As

such, they see themselves as having the potential to work autonomously, which is not wholly available to them as they are currently configured. The technicians' engagement with the organisation is through their clinical specialism and their role as employees, and they feel constricted by the organisation as a whole.

Procurement of equipment was an example provided of lack of autonomy:

> "If you go into the NHS, we don't know where the money is coming from, we have no idea how much we generate, we have no idea you know and when I have asked about it the answer is 'oh no we can't do that' ...we are told all the time you've got to save money, you've got to save money you've got to streamline, tell us if you have any ideas and then you hear ridiculous things like when we had to order pacemakers through the NHS contract that had been awarded to a large company and [procurement manager] could bring them in at about £1100 and the NHS contract wanted £1900 for the same thing and then someone will say tell me how the NHS can save money" AH5, Technician, Acute Health

This is an example of staff at Acute Health inhabiting positioned-practices of employee and clinician, without the capacity, or causal power, to make autonomous decisions, such as to purchase locally sourced equipment at lower cost than through NHS wide procurement. This can be contrasted with Community Health later, where employees, as owners, are empowered to make these kinds of decisions to save money.

Desire for localised ownership of issues and roles was a theme arising from teams at Acute Health, who were keen to mediate their own autonomy within bounded groups responsible for separate areas of clinical care, albeit to different degrees between the team of nurses and technicians. There was no evidence that this was happening across teams or organisation-wide but was evident through a desire to do so within teams.

AH3 expressed a view that as an autonomous independent unit the team could drive more efficiencies, attract additional funding, save costs and address the recruitment and training issues that were felt by the team. She envisioned a stand-alone unit, occupying space within Acute Health's premises, providing all of the services that are currently provided to Acute Health for a fee. In addition, the team would be able to generate new business and develop more efficient ways of working:

> "We know what the best decisions at ground level because it is a clinical decision...the guy sat behind the desk in the accounts department doesn't know that but we do, we know what is best for the patient if they need a pace maker what type they need and the best value" AH3, Manager, Technicians, Acute Health

She was supported in this view by two other technicians. They agreed the autonomy of independent ownership would bring benefits in terms of responsibility and efficiency. This echoes many of the claims made by the DCMS Mutuals Team (2017) when they promote the idea that public sector staff could be freed up to exercise more discretion in day-to-day operations when delivering services.

There were examples of staff members trying to introduce ideas similar to the concept of ownership and responsibility for day-to-day practices and issues (as opposed to ownership of the organisation itself) into the areas of work that they were responsible for. This was despite the perceived inflexibility they faced. Whilst the nursing cohort were content for this to happen within the confines of Acute Health ownership, the technicians were keen to operate as an autonomous independently owned unit.

This was not shared across the whole clinical unit, however, as resistance to the idea of independent ownership was expressed by consultants at Acute Health:

> "Now regarding the ownership of the staff and the public, I think it has to be done very carefully. Because if it goes wrong in John Lewis, nothing happens, no life is at stake…Over here in the NHS the problem is a bit different. If something goes wrong you can lose a life. So if the funds are compromised for some reason, so if the ownership goes to the staff and public, how do they run it? What are the priorities of the staff? Who is going to hold the finance? The most important thing in the NHS is the finance holding and distribution. If I'm doing a procedure, putting in some devices and I'm told, 'Oh, you can't put more than ten devices because we don't have the money' I think I will have very serious thoughts about it because it concerns the patient's life. In John Lewis you can say, 'Okay, you can have ten bags of this and not more.' And nobody is going to die if you haven't got ten bags." AH7, Consultant, Acute Health

Differing views were held at Acute Health between different cohorts of clinicians. There was recognition amongst technician staff at Acute Health of the potential autonomy and flexibility that an alternative, independent ownership structure would generate. They considered their organisation to be inflexible, without giving them autonomy in their roles as employees or clinicians. The nurses worked within their own teams to created localised autonomy and ownership in the sense of responsibility, without desiring actual ownership. Consultants made strong objections, however, and questioned whether autonomy of ownership and independence was worth the risk. The John Lewis Mutual rhetoric that has been prevalent within the PSM discourse was challenged as not appreciating the risks that are inherent in healthcare (Maude, 2010).

A hierarchical system with rigid rules pervades Acute Health, and any ideas that the staff may have to improve how their services are delivered are difficult to implement across the organisation. Whilst not in an organisation owned by employees, individual staff and managers did recognise the link between ownership and responsibility and its role in effecting change within the organisation. Within an employee ownership structure, as opposed to UK Government owned, some saw possibilities for different ways of working that reflected the rationale behind PSMs, although others saw risk.

As was seen with Psychological Health in Section 5.2.3, this decision was considered in exactly those terms, and the risks were considered outweighed by the benefits independent ownership brought. In contrast, at Acute Health ownership, and its perceived risks, was considered a significant barrier to change for AH7. This was not uniform, as nurses mentioned neither risk nor benefit, whilst the technicians did not believe the risks to be a barrier. There are thus differential attitudes to ownership, risk and autonomy within Acute Health amongst different cohorts of employees.

5.3.2 Community Health

Community Health employees inhabit various positioned-practices within the organisation as a result of their ownership structure. Whilst employees, clinicians, service providers and managers, they are also shareholders and, collectively, owners. These were new positioned-practices, only introduced within the year prior to participant interviews. Interviews explored how staff responded to these newly

introduced roles of being a shareholder and part owner, and the contrast with their previous roles in the Local Authority where these positions had been absent.

When Community Health was formed, each employee was allotted one share in the organisation in return for paying £1. It had been agreed that each employee should make the payment, notwithstanding that the amount was nominal. The act of paying £1 for their single share was important to the employees, carrying significance to their role as owner, as well as being a symbol (resource) of their ownership. Jokes were made about the payment:

> "We all paid a pound in to say that we're part. I think it's some sort of legal jargon, that side of it. But the funny side of it, I did actually say at the time was, I knew it had come to something when we started having to pay to come to work." CH1, Level Three Support Worker, Community Health.

The jokes highlighted awareness of the different practices expected of shareholders compared to employees, and the meaning of ownership to employees went beyond a share certificate. There was some knowledge of what ownership meant and how it changed how the organisation operated. This extended to express recognition that the organisation was in the ownership of the employees with clear independence from the Local Authority, employees being fully cognisant of the break from Local Authority ownership. As there was still money owed to the Local Authority as part of the arrangements to transfer the service to Community Health, the Local Authority were now seen in financial terms as an entity to deal with, not the owner of the service:

> "…it's like our own business. So whatever money we do actually make, they can actually bring it in and then pay off the Local Authority and then hopefully we train and spread the business even further" CH11, Nurse, Community Health

Responsibility for the way the organisation operated was evident, distinguishing from the previous position when the Local Authority owned the service. The distinction rested on autonomy: the organisation is self-deterministic and no longer controlled by a larger public sector body. Employees were starting to accept the organisation as their responsibility, with its success or failure not being remote from them, as it had been with the Local Authority. This manifested itself in staff considering cost-savings and income generation as part of their own individual

contribution to the organisation, with actions flowing from this sense of responsibility incorporated in day-to-day activities:

> "Yeah. If I walk past a room and there's nobody in and the light's on, I'll pop in and turn it off… You know, it keeps the electric bills, the hot water…just being more careful." CH8, Administrative Assistant, Community Health

CH4, working with patients with communications difficulties, referred to the responsibility as being equal across all of the employees:

> "For me, I thought it was having a shared responsibility for an organisation, and for us to be able to be part of the success of that organisation as well…I think before we went to the mutual that if you lost something or you broke something, someone's going to replace it. Now it's not…you've got a responsibility now to keep that equipment in good working order and looking after the equipment. So for me, that's part of that…it's more about the people rather than the industry. That's how I think about it." CH4, Lead Total Communication Co-ordinator, Community Health.

This highlights two aspects of the responsibility felt by employees at Community Health acting as owners. First, recognition that responsibility has transferred to them, along with ownership: the Local Authority will not step in to deal with things and self-help is expected instead. Second, that responsibility is both individual and, through equal shareholding as owners, shared amongst staff. Collective responsibility and self-help were themes highlighted in the mutuality literature discussed in Chapter 2.

A second theme concerned flexibility. The operations and procedures of the Local Authority were considered restrictive and burdensome. These have been reduced since the transfer of the service into an employee owned structure to what managers and staff consider more appropriate to the service they provide. CH12, the Managing Director of Community Health, commented that her weekly e-mails had reduced from over 1200 a week at the Local Authority, many of them Local Authority wide, to around 300 e-mails a week, all relevant to her and Community Health.

CH4, mentioned above, used the example of how restrictive the Local Authority had been about who was permitted to use the service. There was clear differentiation in approach between the two organisations, with a more restrictive mode of operation at the Local Authority compared to Community Health. This enabled her to offer

services to a wider range of patients. CH4 currently does work for the Local Authority as part of the transition agreement following the transfer, pending finding a replacement. The two approaches to how she works could be contrasted:

> "…the things we're asked to do at [Local Authority] have to go through a referral process that feeds into the health professionals, because me and my colleagues are clinically supervised by the health professionals and they have very strict criteria on what we can and can't do. From a [Community Health] point of view, if we have the skills to help someone, they are fine with it, no matter what discipline it comes from." CH4, Lead Total Communication Co-ordinator.

This flexible approach was repeated amongst other staff at the six different premises operated by Community Health, (referred to as centres). CH1, mentioned earlier, talked about making specialist equipment available to a wider group of potential users than would have been permitted by the Local Authority. CH3, Deputy Manager at one of the centres with residential capacity, spoke about opening up the facilities to users in the immediate location who had previously not had access to their services. CH2, Assistant Manager at a centre, spoke about inflexible application of health and safety laws previously:

> "From a manager's perspective, I feel that the staff are getting it that there's more ownership now, and that their views do count, and that they have got their own powers to do things. Whereas, under the Local Authority, we were more constricted to what you had to do, like adhere to all the procedures. It was for me, personally speaking, I felt like the health and safety was quite nailed down where you're kind of afraid to take risks because of the fear of consequences, because it was corporate. It was like, well, this happens, that happens. Whereas now, there is always going to be a risk, but we evaluate the risks and minimise them as much as we can." CH2, Assistant Manager, Community Health

Despite evidence of emerging ownership and responsibility, along with autonomy and flexibility, a wholesale change in culture had not yet occurred within Community Health. Staff still adhere to many Local Authority practices, and attitudes have been carried over in the transition. Some of these are formal, such as legacy contracts and working practices that are still in place and will be for a further year. Others are informal, reflecting habits that have persisted despite the change in ownership.

One example concerned three centres run by Community Health, previously operated as autonomous units by the Local Authority. Community Health had introduced more flexible staffing arrangements, combining these three centres due to their geographical proximity and similar services, with one manager for all three. However, staff were reluctant to work away from the centre they had previously been assigned to, and the manager found they still exhibited attachment to one or other centre, preventing the flexibility of resourcing that had been intended.

Whilst there is recognition of what ownership means, and acceptance of its responsibilities, there has not been complete integration of those responsibilities. Employees are doing certain things in their day-to-day activities and recognise what ownership means, but are not fully inhabiting the positioned-practice of owner. CH3 contrasted knowing what ownership and responsibility meant, with recognition it was not yet a lived experience:

> "Not quite yet. Because we're still quite new, there's still a lot of the structure and the stuff involved in what we do daily still Local Authority lead. We're still following a lot of the cultural stuff that we had with the Local Authority, the responsibility's not quite there yet, I don't think, not in my head. I understand it's there, but in reality I'm not sure I feel that it is." CH3, Deputy Manager, Community Health

Other managers recognised that changes that come with internalising the practices and thinking as an owner had registered with staff, but had not yet fully occurred:

> "I think the large majority of the workforce feel empowered by having that share, by being an owner and a passion to run with it and embrace it for everything that it is. But then you've got a small section of the workforce that aren't quite sure what it means, 'What does it mean that I've got this share, that I've paid this pound?' Again it's about educating the staff. It gives you the right to vote, you've obviously got the staff board and things. And this is on you." CH7, Service Manager, Community Health.

One suggestion as to why staff are unsure about the meaning of ownership could be that many staff had worked for the Local Authority for a long period of time:

> "They're mostly quite an older staff team and we don't have many young employees. So my responsibilities really are about changing or trying to change the mind-set of very established staff and to change the culture that's

> quite risk-averse and sometimes old school into freeing people up to be able to take risks, to be entrepreneurial, to think in a business way, to act like owners, to instead of having a can't-do culture changing it to a can-do culture, to have communication bottom-up instead of top-down" CH5, Director of Strategy, Community Health.

Staff at Community Health have started the process of engaging with the ownership structure and recognise the meaning of ownership, and the sense of responsibility that entails. However, this is slow progress, recognised by managers as needing learning and commitment. Contrary to claims made about the PSM policy (DCMS Mutuals Team, 2017), ownership and responsibility, as lived experiences, are not automatic from the introduction of a new structure but require staff to engage actively over time.

5.3.3 Psychological Health

Employees at Psychological Health are shareholders, and so equal owners of the organisation, albeit they did not pay anything for the shares, unlike Community Health, when the shares were issued. Payment for shares was not considered a significant act at Psychological health. Their engagement with ownership structures occurs as agents, through the agency of ownership and shareholder, and as incumbents of positioned-practices such as employee, clinician and manager. Analysis of data on ownership from Psychological Health reveals a number of themes that occur through agential interaction with ownership structures.

Clinical practitioners, without managerial responsibilities, reflected on their motivations and said ownership encouraged them to think more about their role and personal involvement, compared to a public sector owned organisation with no employee ownership. A distinction was drawn between being focused purely on carrying out a designated role as clinician, compared to responsibilities taken on as an owner:

> "I think it [ownership] is important, and I think it makes you think a little bit more, or it certainly does for me, a little bit more about what I'm doing and why I'm doing it, whereas I think, if you're in [different organisation], it sometimes feels that you just roll up, do your job and if you're not there

> someone else will be there." PH11, Psychological Wellbeing Practitioner, Psychological Health.

Comparing the role of ownership at Psychological Health with that of working as an employee only for a NHS organisation, opinions and views are valued equally in the employee ownership structure. There is a lack of hierarchy and privilege in how each person is treated. Again the positioned-practice of ownership mediates the experiences of staff, and ownership at Psychological Health was seen as part of an inclusive mechanism with extensive staff participation compared to the NHS:

> "I've never worked anywhere where I've felt I was involved in terms of everyone's opinion is, kind of, is valued as important as everyone else's in terms of what they can bring and there's lots of sort of forums and opportunities to speak about those things in. Comparing it to previously working where I did in [Previous NHS organisation], that there was very much sort of like, not sort of– It wasn't as if things were dictated but it was, kind of, like decisions had been made and this was what we could do, kind of thing…" PH10, Psychological Wellbeing Practitioner, Psychological Health.

PH1, with supervisory and clinical roles, also compared the sense of ownership and control at Psychological Health to the hierarchy prevalent within the NHS. This control was seen as being something staff were able to put into effect, a practice rather than being illusory. Staff suggestions were either implemented or considered reasons given as to why not. Control and autonomy introduced through staff ownership had been effective, with staff views not only heard, but also heard in equal measure. Implementation of their ideas and suggestions, and their voice taken into account, was something that did not happen in the NHS:

> "So that more kind of level of ownership really, and control, that is, I suppose, would be the main difference that I would remember from what it was like in the NHS; we have a lot more control about decisions being made, and our own direction and I suppose our own thoughts and ideas being something that we can really use, rather than just mull over." PH1, Clinical Manager, Psychological Health

The founders of Psychological Health, who are still employees, saw autonomy and independence as benefits of ownership. The autonomy generated as a new organisation, without the security provided by NHS ownership (referred to by the

Chairman in Section 5.2.3) was valued over lack of autonomy and less risk. The ability to have control over their own actions and the service they deliver, without being constrained by NHS hierarchies, practices and procedures was considered to be of greater importance than the security and certainty of being an NHS organisation. Compare this with consultants at Acute Health, where the reverse position was expressed.

PH3 gave examples including autonomy to change processes to improve the way the organisation dealt with issues that arose. A long-term issue concerned referrals direct from GPs, a high proportion of whom did not appear (DNA) at the designated appointment:

> "Our DNA rate was really high. So we're targeting surgeries at the moment that have got a 40% to 70% DNA rate, and we're doing the supported referrals where they go to see the GP. Instead of the GP filling out the slip, filling out the referral form, he hands the patient a slip, and then the patient will ring our admin team. Admin take all the details from them; they've got like a script to ask. So that takes out a lot, a chunk of work from the Psychological Wellbeing Practitioner to free them up to see more patients. So we're very much trying to improve all the time, and that's what staff want." PH3, Administrative Manager, Psychological Health

To support actions like these, Psychological Health changed recruitment practices, and increased the number of administrative staff it employs. This runs counter to NHS policies inherited by Psychological Health. PH3 mentioned that administrative assistants are being reduced in NHS organisations, whilst Psychological Health, in contrast, had tripled the number of administrative assistants employed since it became independent. This enabled the organisation to transfer tasks away from clinical practitioners, freeing time for them to devote to patients, whilst ensuring that efficiencies are made in the processes employed. One consequence is a reduction in DNAs. Autonomy to conduct operations as they best see fit to suit Psychological Health impacts many areas of their operations, including recruitment and resourcing policies.

Linking responsibility with ownership was another theme that was gathered from the data, in similar fashion to Community Health. However, here, responsibility was viewed less as being something to be concerned about, but rather a more internalised or adopted sense of responsibility as part of the process of doing the job:

> "Not as much [feeling responsible] now, I think when the change-over was happening, I think that responsibility, that pressure, was there because it was, like you say, 'Is it the right thing? Should we choose that?' but as we've settled down, and I suppose, things have developed for us, yes, the decision making's still there, but the pressure doesn't seem as intense as it did at the beginning, things just seem to have flowed better with it." PH1, Clinical Manager, Psychological Health.

During all of the interviews each participant expressed enthusiasm and a general sense of happiness and well-being with how the organisation operated and their role in it. The passage of time, combined with the operation of the ownership structure during the five years since Psychological Health was formed, had enabled mutual practices associated with ownership to develop into a positive experience for all interviewed, such that individual responsibility for the organisation had become a norm.

PH7, who was the service manager in the NHS and instrumental in the decision to leave NHS ownership, contrasted his NHS role, and its constraints and limitations, with his influence now. He had felt uncomfortably constrained within the NHS ownership structure, and was an individual who had tried to flex the boundaries of the positioned-practice he inhabited there:

> "As a Service Manager, you're highly constrained by the structure in the NHS. So I was at the – If you're maybe Director of Services, it may be you'd have some strategic latitude and influence, but as a basic Service Manager in the NHS, probably I pushed the boundaries of what you could do, but they…you had to be prepared to almost like go against the flow and fight the system. You had to use your own initiative to do that and there was a lot of disincentives in terms of possibly risks that you would expose yourself to and the disincentive of the time and energy, because often things would just get kind of put into the long grass, where most people would lose the will to live really. In the…here, I'm in a different strategic position, I am very…I've got more…I'm operating in a different strategic position where I can have more influence." PH7, Managing Director, Psychological Health.

The flexibility was not something that was only exercised and experienced by managers and clinicians. A trainee Psychological Wellbeing Practitioner also expressed the benefits of the organisation's ownership structure in terms of the

flexibility she experience, compared to previous experiences in the NHS. The organisation has freed staff from fixed employment roles and has introduced degrees of flexibility that staff engage with and value:

> "Yeah, but to me that's an attractive thing because I don't like the idea of having one fixed role, and not being able to shift from that. So the flexibility that working within [Psychological Health] offers versus the sort of static nature of your role in the NHS, that to me is much more attractive. And having worked here now, the idea of doing my job for an NHS Trust is much less appealing." PH8, Trainee Psychological Wellbeing Practitioner, Psychological Health.

When Psychological Health transferred out of the NHS to become an independent employee owned organisation, senior mangers and board members within the organisation promoted ideas of autonomy, independence and flexibility. Since its inception, the way staff and managers have engaged with ownership at Psychological Health has re-enforced these ideas, whilst leaving behind the bank of cultural ideas and structural resources of the NHS.

The hierarchy and inflexible command and control approach to management has been replaced with an inclusive, flexible approach where all staff interviewed say they have an equal role to play. There is not the same rigidity in the way services were planned and delivered. Flexibility and autonomy is present, valued by all the staff from trainees to managing director. As such, there is not the distinction between the goals of the managers and directors and those of the staff within Psychological Health. The positioned-practices of employee, owner and shareholder have mediated the interaction of the agency of ownership and employee and the structures associated with both.

5.3.4 Comparing cases

A comparison between the three cases focused on how employee agency engages with the relevant ownership structure prevalent within each organisation. Through the analytical framework of causal configurations, the positioned-practices of owner and shareholder were identified in both Community Health and Psychological Health, operating alongside the practice of employee (which exists in all three cases). It was these additional positioned-practices that led to a number of differences

between the cases. Table 5.5 compares the various aspects of the ownership configuration and respective agential interaction between cases.

Table 5.5 Comparing agential interactions between cases

Case	Positioned-Practice	Generative Mechanism	Agential Interaction	Causal Powers
Acute Health	Employee	Employment contract Hierarchy Managerialism	Employment relationship produces work for wages and benefits with limited control or autonomy	Transaction-exchange labour for wages; Hierarchy; Command/control
	Clinician	Professional Body Rules	Strong adherence to rules governing clinical work	Control
	Team Member	Team bonds (Limited) autonomy	Technicians create an insulated unit. Nurses operate as unit.	Bounded co-operation within team
Community Health	Shareholder	Paying £1-meaning in the share Responsibility Participation Egalitarianism	Meaning in being a shareholder –embrace having the share. Responsibility to participate in shareholder duties (active in AGM). Value equal shareholding	Co-operation Reciprocity Common purpose
	Employee	Egalitarianism Restrictive shareholding	Employees have equal share –equal owners Restrictive shareholding creates collective	Reciprocity Co-operation Common Purpose
	Owner	Responsibility Autonomy Flexibility	Staff taking responsibility for the organisation, cost saving	Co-operation Common purpose
	Clinician	Professional Body Rules	Strong adherence to rules governing clinical work	Control
Psychological Health	Shareholder	Equal Property Rights Participation	Active engagement with rule making structures Want equal shareholding	Co-operation. Reciprocity. Common Purpose
	Employee	Egalitarianism Restrictive shareholding	Employees have equal share – equal owners. Restrictive shareholding creates collective.	Reciprocity. Co-operation. Common Purpose.
	Owner	Ownership Responsibility Autonomy	Internalise ownership and responsibility. Prioritise autonomy	Co-operation Common Purpose
	Clinician	Professional Body Rules	Strong adherence to rules governing clinical work	Control

Source: Case study data

The usefulness of the causal configuration heuristic can be appreciated here, as the nuance of the relevant positioned-practices can be abstracted, and how agents inhabit these practices brought to the fore for comparison purposes. The relevant case studies are included in the left-hand column followed by associated positioned-practices. This is to enable the contrasting generative mechanisms, agent interactions and causal powers associated with each positioned-practice to be emphasised.

Without employee ownership structures, there is no positioned-practice of owner or shareholder for staff at Acute Health. Consequently, their engagement with the ownership structure is through the agency of employee and clinician, as well as team engagement in the case of the technicians and nurses, through their respective teams. This is reflected in limited sense of ownership and autonomy in the interactions with the organisation, which is seen as hierarchical and inflexible.

They are not able to engage on equal footing with the organisation, and so the managerial approach is seen as command and control, and authoritarian. The engagement is transactional between employees and managers/hierarchy through their employment relationship, thus leader-follower from Section 2.4.

The team of technicians did exhibit some positioned-practices that reflected ownership, but were not in fact attributable to an owner. As a small unit with many members of long-standing, they operated as much as possible as an autonomous unit. They would welcome the kinds of ownership structures that were available to Community Health and Psychological Health, giving them a degree of autonomy and responsibility they sought. Instead, they felt restricted in the existing UK Government owned structure, bound by hierarchies and inflexibility, unable to engage with any of the practices of ownership of the organisation at large.

This is contrasted with how staff at both Community Health and Psychological Health engaged with their ownership structures. Inhabiting multiple roles, they interact with ownership as part of its necessary relations, as well as employees. This means that they feel part of the organisation in a different way from Acute Health staff, more embedded into the organisational structure at different levels.

The sense of ownership and responsibility that was felt by staff at both PSM organisations stemmed from the shareholding that each had, which enabled them to engage not just on a contractual level as employees, but also on a relational level as part of the ownership structure. The similarity of ownership structure between

Community Health and Psychological Health, whilst resulting in some similarities in the way staff engage with that structure, is not all pervasive. Community Health does not exhibit the same degree of internalisation of ownership and responsibility that is prevalent throughout Psychological Health. There is a divide between managers at Community Health, who have led the service out of the Local Authority and so have embedded the sense of ownership and responsibility within their day-to-day activities, and some of the staff who have not achieved this level of internalisation. Whilst there is recognition of what ownership means, therefore, there is still a way to go before staff fully internalise and live the experience of ownership.

This can be contrasted with Psychological Health, where the manager/staff divide was not in evidence. From trainees through to the managing director there was a strong sense of ownership and responsibility, leading to feelings of autonomy, self-determination and control. This was highlighted through experiences in previous NHS organisations, where they were not owners, but engaged with the organisation through the role of employee and clinician only. As well as expressing strong preferences for their current arrangements, they drew parallels about the level of involvement they had, as well as the flexibility, autonomy and control, and the sense of equality and lack of hierarchy within Psychological Health.

A possible explanation is a new emergent leadership approach within Psychological Health. As employee ownership challenges antecedent hierarchical mechanisms in the public sector, both power and leadership become dispersed, as discussed in Section 2.4. This links closely with staff voice, particularly as discussed in Section 7.3.4, where wider participation in decision-making, made possible by employee ownership, results in both managers and staff being involved on equal terms.

Additionally, staff within Psychological Health, whilst they recognise and equate ownership with responsibility, focus more on responsibility as a wholly positive thing without negative connotations. This contrasts with Community Health, where responsibility still contains an element of apprehension and uncertainty. The differential temporal maturity between the two organisations may account for this, with the dissipation of apprehension within Psychological Health over time occurring as the organisation has thrived and been successful. This has been replaced with a different, more positive, type of responsibility that focuses on individual roles in pursuance of a common goal.

5.4 Conclusion

Ownership operates as a causal configuration with powers that have tendencies to influence agents' behaviour. Overall, ownership was a key recurring theme in PSM interviews conducted, expressed as a key differentiator from the Local Authority and/or the NHS, through the autonomy, flexibility and freedom it brought. However, there was also a sense of responsibility that equated with ownership, which indicated that ownership was not seen solely as a benefit, but also as potential burden. Within an ownership configuration, autonomy, flexibility and responsibility can be identified as generative mechanisms that employees and managers engage with as part of the process occurring in the transition to PSM. Consideration of agents' actions and interactions adds depth to the analysis, and avoids the over-simplification that introducing an ownership structure alone is sufficient to cause mutuality to occur.

Therefore, the ownership causal configuration operates to generate autonomy, flexibility and responsibility amongst staff members in both organisations, who in turn respond to these concepts. Over time different aspects of responsibility itself emerge, which can be classed as the burden of responsibility (incorporating apprehension) and the benefit of responsibility, which internalises a different, more positive approach to undertaking employee and ownership roles, placing individual staff members within a structure focused on achieving a wider common purpose. This interaction is discussed further in Chapter 8 through the causal powers that are engaged by an ownership configuration. When the generative mechanisms are actualised, as in Psychological Health, then causal powers of co-operation and reciprocity, along with trust and common purpose emerge, as indicated in Table 5.5. These emergent causal powers are the key to mutual relations between individuals in PSMs, as well as mutual practices that are embedded in the organisational structure. Operating at different levels, this is the interaction between mutual ideas, relations and practices when mutualism is successfully incorporated into an organisation.

Chapter 6 Shared Benefit

6.1 Introduction

The benefits (in the narrow sense of those that flow from finances) derived from an organisation are founded on an organisation's ability to generate a financial surplus. A financial surplus generated by a corporate body occurs when the overall costs of delivering the organisation's services (staff, property, supplies, energy and other operational costs) are less that the income received by the entity for delivering the service (payments by commissioners and/or service users). When costs are greater than income, a financial deficit occurs. What happens to any surplus generated is a key differentiator of different types of organisation.

For Private Profit Oriented entities, generating surplus (profit) is often the primary aim (see Table 4.7), and the surplus is distributed to the owners. Public Service Trading organisations that generate surpluses (not profit) return any monies to the UK Government, usually through the agency of a government department, or are entitled to retain and re-invest it. There are no surpluses paid to external investors. Between these two antithetical approaches, a mix of options is available to Social Trading businesses ranging from charities, where, by law, all surpluses must be applied to the charitable purpose, to social enterprises such as Community Interest Companies, where no more than 35% of profits can be paid to investors, with the remainder being applied to the enterprise's community purpose (Ridley-Duff and Bull, 2011, pp. 134-51).

This Chapter analyses data from the three case studies to explore how financial surpluses are ordinarily treated (if generated) in each and the causal configurations that influence what happens to such surpluses. Section 6.2 identifies and maps the necessary relations of each organisation. A comparison between the three cases investigates differences and similarities between their respective causal

configurations, to start to explain what constrains and enables the sharing of the financial benefits with staff.

Section 6.3 then investigates how the respective agents of each organisation interact with these structures, and what effect those interactions have on both the way any financial surpluses are treated and what that means for agents within the organisation. The conclusion drawn is that notwithstanding constraints on paying financial benefits directly to staff, the benefits of sharing in the reinvestment of any surpluses, either through achieving the organisation's social mission or through training and career development creates a complex interaction of individual and collective benefits for staff.

6.2 Shared Financial Benefit Structures

Analysis of data about whether and how financial benefits are shared derives primarily from the organisational rules governing how an entity functions and the environmental and contextual norms within which the relevant organisation is situated.

6.2.1 Acute Health

As a UK Government owned entity under independent regulatory supervision, albeit operating with significant autonomy, there are a complex set of exogenous and endogenous relations that influence how finances are treated within Acute Health. Before analysing these relations, however, it is important to acknowledge the current financial deficits affecting the NHS. At the time of the research and analysis of data the NHS generally was facing, and continues to face, significant funding shortfalls (NHS Improvement, 2017). Therefore, notwithstanding any structural relations that may enable or constrain the sharing of financial benefits, such distribution in the current financial context is unlikely.

Regardless whether Acute Health generates financial surpluses, the various relations that form the financial structure of the organisation make the distribution of surpluses outside of the UK Government impossible. Other than to agencies of the UK Government, no other payments generated by financial surpluses can be paid. In particular, members of Acute Health are not entitled to any such payments. Instead,

the necessary relations of the financial benefit structure include Acute Trust, UK Government, any surplus, and the various rules and norms relating to the finances of NHS organisations, but not members.

Whilst members of Acute Health relate to the organisation through their membership and representation by the Council of Governors, their relations with how financial benefits are distributed are contingent or external. Other external relations that are not necessary to this structure include the Board, which has overall responsibility for the finances of Acute Health and the Council of Governors (who approve the appointment of certain members of the Board). The sharing benefit structure exists whether or not Acute Health has members, elected governors or an executive board.

The outcome of this structure is that members, including staff, are not entitled to share in any financial surpluses that the organisation generates. Any benefits they receive are in their capacity as employees, such as salary, pension entitlements and paid time off for holidays and are a condition of their employment contract. In addition, whilst training is provided to enable them to deliver their clinical functions, it is not dependent on surpluses being generated by the organisation. Training is dependent on employment and the positioned-practice of the employee (doctor, nurse, technician). Structural interaction of rules and relations between entities governing Acute Health's operations privileges Department of Health (i.e. UK Government), not members of the organisation and its staff, as shown in Table 6.1.

Table 6.1 Internal and external relations of Acute Health's shared benefit structure

Internal/Necessary Relations	**External/Contingent Relations (Non-exhaustive)**
UK Government/Secretary of State	Members
Public Benefit Corporation	Employees
Legislation	Executive Board
Public Sector Funding	Patients
Surplus	Professional Bodies
	Regulators
	Council of Governors

Source: case study data

The internal relations and the external ones for shared benefit are similar to those in Table 5.1, relating to ownership for Acute Health. This is unsurprising, as ownership and shared benefit are inextricably linked in corporate body structures. The owner receiving the profit is a general principle of any corporation (Ridley-Duff and Ball, 2011, p. 135), and so it is logical that the two sets of internal relations would be similar. Likewise, as the same sets of relations subsist in Acute Health, the external relations are also similar.

6.2.2 Community Health

As a limited liability company with shareholders, ordinarily Community Health's financial benefit structure would permit the distribution of any surpluses made by that entity to those shareholders, in proportion to the economic value of the shares they own. This structural arrangement enables, but does not mandate, a separation between the beneficiary of any financial surpluses generated by the organisation and employees, managers and other stakeholders who do not hold shares. The rules of Community Health, however, preclude such a distribution of surpluses, combining to constrain both the amount that can be distributed and whether they can be distributed at all. This is the result of legislative constraint, which affects all Community Interest Companies, combined with rules bespoke to Community Health.

All Community Interest Companies are statutorily restricted from distribution of more than 35% of their profits to shareholders (Office of Regulator of CIC, 2017). This is to preserve any financial surpluses for the community benefit that the organisation has been set up to deliver. Regardless of its own rules, this constraint operates *ab initio* to restrict Community Health from distributing to its shareholders more than that specified percentage of profits each year.

Notwithstanding the legislative provisions, Community Health has elected to place its own, constitutional constraint on profit distribution. The Articles of Association of the organisation include the following provisions:

> "The Company is not established for private gain, any surplus or assets must be used principally for the benefit of the community" Articles of Association, Community Health.

Regardless of legislative provisions, any surpluses are to be applied primarily for the express purposes specified in the Articles of Association, which is for the benefit of the special health needs of the geographic area Community Health serves.

As shareholders, employees at Community Health are part of the structure created around shared benefit. The Articles of Association can be altered by majority shareholder vote in favour of a change. Within the constraints imposed by legislation, if employee shareholders wanted to, they could effect change to permit surpluses to be paid to them by way of dividend. As such, the employee shareholders are voluntarily foregoing any distribution of surpluses generated by the organisation in favour of the community their organisation serves.

Mapping the social structure created around shared benefit in Community Health, as in Table 6.2, the employees as shareholders and the organisation are necessary relations, as is any surplus generated. Additionally, the legislation governing Community Interest Companies and the rules of Community Health are necessary for the particular social structure that exists.

Table 6.2 Internal and external relations of Community Health's shared benefit structure

Internal/Necessary Relations	**External/Contingent Relations (Non-exhaustive)**
Community Interest Company	Executive Board
Shareholders	Staff Board
Shares	Service Users
CIC Legislation	Managers
Surplus	Professional Bodies
Employees	Local Authority
Articles of Association	Community
Commissioning Contract	

Source: Case study data

The community of service users, as beneficiaries of any reinvestment, can appear necessary to the structure, as they are an ultimate beneficiary of Community Health. However, their relations are still considered external. Without resources giving them a say in how benefits are shared (such as shares) they are not necessary to the shared

benefit structure, but are more a passive beneficiary. Their actions do not affect the structure.

Relations that are contingent to this structure include the board, who can direct how the surpluses are re-invested to benefit the community but who are not necessary to the structure, as they have no ability to change the underlying restrictions that the structure imposes. The Local Authority, who commission the majority of the services delivered by Community Health, are also contingent to the shared benefit structure. The commissioning contract itself (which acts as a generative mechanism to produce surplus) is internal, but whilst through that contract the Local Authority contributes a large proportion of the income received by Community Health, how any surpluses are distributed is not determined by any role they have in the structure. They are a contractual party to the arrangements, and could be exchanged for another entity or multiple entities carrying out the same contractual role. Whilst they are entitled to residual payments out of surpluses generated under the contract with Community Health, these payments are a prior cost of that contract rather than part of the surplus distribution structure of the organisation. If Community Health were to generate surpluses outside of this contract, the Local Authority would not be entitled to any proportion.

What is apparent from the shared benefit structure of Community Health is that whilst employees are not the direct recipients of any surpluses generated, they are still a necessary part of the structure. Their foregoing of shared profits is not imposed on them but was, and remains, a conscious choice. How employees, as agents at Community Health, interact with this structure will be discussed in Section 6.3.2.

6.2.3 Psychological Health

As a Community Interest Company, Psychological Health is also constrained through legislation as to what it can do with any financial surpluses that are generated. The legal requirements are also supplemented by constitutional constraints:

> "Shares are not entitled to dividends - the surplus of profits of the company are not to be distributed either directly or indirectly in any way whatsoever amongst members but shall be applied to provide prudent reserves [and] on expenditure to carry out the Company's Object. This provision may not be altered or rescinded" Articles of Association, Psychological Health.

These provisions, adopted by the initial shareholders of the organisation when it was formed, and not changed since, create an absolute prohibition on shareholders (members) receiving any profits from the activities of the organisation. This is regardless of what may be permitted under Communities Interest Company legislation. The Company's Object, to which surpluses must be applied (after reserves), is to carry on business to provide mental health services for its specified geographic community. This again creates a shared benefit structure where all surpluses are to be used for the social purpose of the organisation, not for the financial benefit of owners (and therefore employees).

Notwithstanding this, employees are necessary to the structure created, in the positioned-practice of shareholder, through which they ensure that the rules applying surpluses to the Company's Object are maintained. They are foregoing the opportunity to receive permitted distributions (under Community Interest Company's legislation) in maintaining this structure. Alongside employees (as shareholders), the organisation and the rules, the other parts of this configuration are any surpluses generated, both as a resource and as a generative mechanism of profit generation.

Table 6.3 Internal and external relations of Psychological Health's shared benefit structure

Internal/Necessary Relations	**External/Contingent Relations (Non-exhaustive)**
Community Interest Company	Executive Board
Shareholders	Service Users
Employees	Managers
CIC Legislation	Professional Bodies
Articles of Association	Clinical Commissioning Group
Commissioning Contract	Community
Surpluses	

Source: Case study data

A second generative mechanism in this structure is the contract arrangement through which the Company's Object is achieved. Psychological Health provides mental health services to a defined geographical community, paid for by the NHS through a commissioning contract. This contract acts as a generative mechanism by which any surpluses are produced from income. Delivering more, or better quality, mental health services through reinvestment, generated more funds and potential surplus and

so on. The additional mechanism through which this operates is the concept of the Company's Objects in the Articles of Association. These have a determinative effect on how surpluses are used.

Again, there are relations that are contingent, such as the community served by the Company's Objects. Whilst they receive benefits they have no say in how those benefits are shared, and so are passive beneficiaries to the structure created. The Clinical Commissioning Group is similar. There is nothing in Psychological Health's rules mandating that it should engage in the current contracts with the NHS. That it does is a choice made by the agents of the organisation (shareholders, employees and so on). If alternative contracts were entered into, shared benefit structures would prevail without NHS involvement.

The executive board, service users, managers and professional bodies are also external for similar reasons to Community Health. The shared benefit structures endure regardless of whether or not these entities have relations with Psychological Health.

6.2.4 Comparing causal configurations

Individual financial incentives, such as sharing profits or paying bonuses to staff from any available surpluses, were not permissible within the structure of any of the cases studied, albeit through different causal configurations. The configurations around each structure in the three case studies are set out in Table 6.4.

Whereas the genesis of the structures prohibiting sharing of benefits are exogenous to Acute Health, deriving from legislation and antecedent inherited structures that existed prior to the coming into being of Acute Health, this is not the case with both Community Health and Psychological Health. Each of these PSMs, whilst formed from staff, services and assets that were owned and operated by a public organisation, comprise a different type of structure to the hosts from which they emerged. The founding staff that set up each entity elected to incorporate structural rules that first limited, and then prohibited, the distribution of any surpluses to owners or investors in the respective organisations. As set out in Sections 6.2.2 and 6.2.3, each incorporated into their constitutional rules provisions that restrict application of surpluses to reinvestment in the organisation and their social mission.

Table 6.4 Comparing shared benefit configurations

	Acute Health	Community Health	Psychological Health
Social Structure	UK Government Public Benefit Corporation	Shareholders Employees CIC	Shareholders Employees CIC
External Relations	Members Employees Executive Board Patients Professional Bodies Regulator Council of Governors	Executive Board Staff Board Service Users Managers Professional Bodies Local Authority Community	Executive Board Service Users Managers Professional Bodies Clinical Commissioning Group Community
Rules	Legislation Regulations	Articles of Association Legislation	Articles of Association Legislation
Generative Mechanisms	Public Sector Funding regime	Egalitarianism Participation Reinvestment Commissioning Contract	Egalitarianism Participation Reinvestment Commissioning Contract
Resources	Surplus	Surplus Shareholder mechanisms Community Benefit/Social Mission	Surplus Shareholder mechanisms Company's Objects/Social Mission
Positioned Practices	Employee	Shareholder Employee	Shareholder Employee

Source: Case study data

This means that in choosing the form that each organisation would take, employees from the outset elected not to participate in the financial benefits generated by the organisations through sharing surpluses. An active choice was made. For example, whilst still adopting the Community Interest Company model, with the restriction on surplus distribution, they could have not added to the additional restrictions and so would be collectively entitled to receive 35% of any surplus. Instead, they actively elected to forego receipt of a financial share of surpluses generated, and have continued to do so.

This is different to Acute Health, where staff never had this choice to make. Acute Health, in its current form and in previous guise as an NHS Trust, has always been a UK Government owned entity without the ability to distribute surpluses to members, stakeholders or staff by way of profit shares. Staff in the positioned-practice of employee, have an employment relationship without any expectation of being able to

change the structural arrangements and rules that govern Acute Health. They inhabit that role and exercise their day-to-day activities accordingly.

In both Community Health and Psychological Health, employees were able to participate in a conscious choice concerning how the financial benefits of each organisation would be treated, and so were involved in rule setting that determines how the structure of the organisation was formulated. They did not solely adopt positioned-practices that were inherited from their prior employment relations, but sought to create additional positioned-practices alongside those of employee. Where NHS surpluses are returned to central funds of UK Government, both Community Health and Psychological Health have elected to retain such surpluses to reinvest directly in their own social mission.

This raises an interesting issue, as essentially the overarching social mission of all three entities is similar: treating patients free at the point of service. The ownership and shared benefit structures differ, but the overall purpose, or social mission, remains the same. Two different structural arrangements are aiming to achieve a similar outcome. Acute Health return any surpluses as part of the nationalised health agenda, whilst both Community Health and Psychological Health have elected to apply any surpluses locally within the community they serve and so under their own control.

6.3 Agential Interaction

The structural relations of shared benefits in each of the cases is complex, with an inter-relationship between internal and external rules governing how employees engage with those structures. In both the PSMs, where employees have a direct say in how these structures are operated, a conscious choice to forego participation in financial benefits has been made, by agents interacting with those structures to set their shared benefit configuration. Subsequent agential interaction, therefore, determines how these structures continue to operate, whilst also revealing employee motivations to make these choices.

6.3.1 Acute Health

Data on shared benefit from staff at Acute Health was limited, due to the restricted causal configurations around distribution of surpluses that were discussed in Section 6.2.1. Given this, employees were asked their views and opinions of sharing benefits within a mutual organisation where the existing restrictions of the NHS structure would not apply.

The desirability of financial incentives was accepted by interviewees at Acute Health, to motivate staff and to encourage innovation and best practice as part of a reward system over and above salaries. This manifested itself differently between different roles. There was a rejection of such payments being linked to targets or other incentives by staff other than senior clinicians. Employees in roles of nurse, focused on *ad hoc* payments by way of reward:

> "I think it would make them feel appreciated…I think if you pay, like for instance, if you had certain, not targets as such, but if you had someone achieving or coming forward with ideas or making a significant change to something, then they could get a bonus for that…You could use it for that kind of thing, like a reward system." AH6, Senior Sister, Acute Health

In contrast, senior clinicians went further on this issue, linking morale with financial reward and expressing the importance of incentives to staff well-being and engagement. AH8 considered morale strongly linked to finances:

> "I think for an organisation to work the morale of the staff is very important. Now finance, whether you like it or not, has a lot to do with morale. And I think the incentives, the John Lewis example as you say, the incentives are very important." AH8, Senior Consultant, Acute Health

Other than that, without direct shared benefit structure in place, it was difficult to obtain worthwhile data as to the motivations and effect of such sharing of benefits. Asking interviews for hypothetical projections as to what they might think it would be like proved inconclusive and vague. This was not the case in the two PSMs.

6.3.2 Community Health

Employees are owners and shareholders, as well as staff and managers in Community Health, and many had been part of the team that set up the organisation when it spun out of the Local Authority. This meant that when interviewing them, it was possible to ask about their views of how financial benefits were being dealt with, as they had actively engaged with the issue from the outset.

There was recognition that even within the constraints of the structure of the organisation, Community Health had further restrictions on what it could do with any surpluses generated. As part of the arrangements when the organisation was formed, the contract with the Local Authority provided that 82% of any surpluses generated from that contract would go to the Local Authority to repay initial funding provided to Community Health, rather than be retained by the organisation for its own purposes. Paying off these monies was seen as a priority, and was presented by some staff as a driver for expanding the business and generating surpluses, so that the Local Authority's obligations could be satisfied as soon as possible. Staff had the aim of being free from financial payments to the Local Authority so as to be able to apply surpluses solely for the benefit of the organisation.

Having acknowledged this further restriction, there was a general view amongst all employees that the structure of Community Health for dealing with surpluses was the right one. Applying surpluses towards their social mission was an appropriate approach for their organisation and the services they provided. If any money was generated by way of surplus, then it should be re-invested in the organisation to first keep existing services going and then expand on the services that Community Health could provide:

> "Nobody should get the profit, you know? It should be ploughed back in. Yeah. Keep us going. And giving the services...continue the services for... Like, the bit that I work on is dementia. So they can keep their services. Yeah. And plus their families might have ideas as well and they're able to come forward with ideas. So it's a collective thing right across." CH9, Level One Support Worker, Community Health.

There was a universal rejection by all staff interviewed of incentivised bonuses for staff based on performance. These were considered inappropriate for the organisation, the service it was providing and also in light of the fact that they had

left the public sector, and so should not be seen to be profiting individually. In addition, there was concern expressed that such incentives would lead to behaviours that were not appropriate to the organisation and that measuring performance targets on an individual basis would be both difficult and counter productive. On the other hand, universal employee pay increases were suggested as appropriate:

> "I don't think individual bonuses but I think it should be like the cost of living increases, like more or less you got 1%, 2%. I think that's what should be given if the money is there, to give them the cost of living, because I think it wouldn't be fair to say, 'No, you can't have a pay rise.' If they can see the business is growing and that with them being told they can't have pay rises it'll be, 'Well, why should we be doing all this work for them and we're not getting anything out of it? We're not getting appreciated.'" CH2, Assistant Manager, Community Health

Applying surpluses towards reinvestment was a theme embraced by staff, with a number of related sub-themes as to how this reinvestment could occur and the priorities they considered should be focused on. Several specific areas where surplus funds could be spent were suggested. One suggestion, offered by a staff board member, was to use any surpluses to re-open a centre that had been closed by the Local Authority due to lack of funds:

> "For instance, if there was spare money, personally myself, if there was spare money, I would look to maybe try and get some of [closed facility] back. You know, instead of people sat on a bus for an hour and a bit. Try and expand your business up there too. Look at different avenues." CH10, Level Two Support Worker and Staff Board Member, Community Health.

This desire to re-open facilities that had been closed due to austerity measures reflected a frustration in the previous running of the services that some staff now felt they could address through direct application of financial benefits from the organisation. Funding previously was part of internal budget procedures at the Local Authority. The independence of Community Health now meant that if staff are able to generate new business and/or reduce operating costs to generate a surplus, they might be able to direct that surplus to rectify deficiencies they see in the service. This is in contrast to the position previously, where any surplus would be absorbed back into the wider budget of the Local Authority. There was recognition of control over the finances that had not been available previously.

Another theme that was identified from the data concerned staff salaries, and the desire to ensure that staff wages and conditions were maintained at an appropriate level:

> "We've signed up to the Living Wage Charter. So we'll always look to pay the best salary that we can afford to people. We don't want to go down to minimum wage and pay in the way the private sector pays. It would be good to– I don't know whether it's realistic to think that we could always keep the terms and conditions that we've got now and survive another surplus, I don't know. But it would good to always do the best that we can for people." CH5, Director of Strategy, Community Health

This aim to ensure staff are paid appropriately was expressed as a sense of fairness. There had been an equalisation of pay on formation to address issues between historic NHS and Local Authority pay differentials that had not been corrected in the Local Authority. This had been welcomed, and the attitude of fairness to pay was considered a practical policy to retain staff, and also as a means of ensuring quality of service provision:

> "And I think that's where you get your quality from, because the better paid people, you get the good staff who want to come working for you, with the reputation you get as well. So the money…I think we need to invest some of the money towards more staffing, to develop stuff." CH3, Deputy Manager, Community Health.

Quality of service provision and expansion of services was a recurring sub-theme when discussing what should be done with any surpluses and what reinvestment meant to employees. Other areas that were discussed as ways of achieving this were enhanced training and staff development, using funds generated to improve the skills of staff and enable a better quality service to be provided. New equipment was suggested, as well as updating buildings to enhance the quality of service. Additional staff were considered a good use of available surplus funds too, again to improve quality of service:

> "Initially, I think that would be about perhaps employing more staff. If we had a surplus, that would mean that….But to have appropriate levels of staff would be great. I'm not saying we haven't got appropriate levels but we can certainly be better…But for the future, to be able to have the up to date

> equipment, that would be great. Just even ipads…I would love to be able to do something like that, but initially I need £5,000. But it's about getting that £5,000. But in the future, I think that £5,000 would be easily attainable, once we start ploughing the money back in." CH4, Lead Total Communication Co-ordinator, Community Health.

This approach manifests itself in a sense of purpose by staff towards the social mission of the organisation, and also a sense of collective aims and benefits over individual ones. This collective-over-individual approach manifested itself in the view that if, after reinvestment, any funds were available to pay to the staff by way of bonus or recognition, then these payments should be equal to all. This is a rejection of individualised incentive payments based on each member of staff's performance, and acceptance and embracing of an egalitarian approach with everyone getting the same benefit at the same time. If there were to be any individual awards then these would be small tokens to reward individual behaviour, by way of nominated individual performance:

> "I'm a big believer that your biggest investment in any company is your employees. People feeling valued and given the tools for their job. So I suppose yes, it would be nice to have a percentage at the end of the year but also there's training that people need to be able to do their job. Maybe a box of chocolates or every Christmas off might but...I say that jokingly and I think no amount of money can ever give you job satisfaction…And I think if we're going to give people money maybe something on an employee of the month. That sort of basis." CH1, Level 3 Support Worker, Community Health.

Staff responded to the structure of reinvesting surpluses in Community Health by embracing its ideals and by suggesting ways such reinvestment could improve services, and so contribute to their social mission. The generative mechanism of reinvestment was seen as a means of helping them deliver a better service, whether through training, enhanced services, re-opening previously closed facilities, new equipment, additional staff and retaining staff through decent pay and conditions. This combined with the egalitarian approach, with everyone receiving equal treatment. Individual gain was forfeited in return for the benefit of collective gain through achieving the social mission.

A collective, egalitarian approach reflects the principles of co-operation and reciprocity in pursuance of a common purpose. As staff work within Community Health, they want financial benefits applied towards their collective aim to deliver more and better quality services for their community. This is opposed to any desire to individually benefit from their efforts by way of financial rewards.

6.3.3 Psychological Health

As an organisation that has been operating independently for over five years, Psychological Health has had a sustained period where the structure when the organisation was formed could interact with actions of the staff. This enabled interviews with participants to reflect on these interactions, what they meant for their roles within the organisation, and how the shared benefit practices affected them.

The organisational form and structures relating to what happens to surpluses generated were designed and formulated by the original founders of Psychological Health, all of whom are still working at the organisation. In addition, twice as many new staff had been recruited since formation, and so had not been involved in the setting up. Representatives from both these groups were interviewed, and were able to talk about what was happening with surpluses generated in practice.

One aspect of the financial structure of Psychological Health that has been prioritised, is to make sure new staff are not disadvantaged by working there compared to working in the NHS. As staff have joined subsequently who were not originally in the NHS, this has extended to ensuring that all staff are on equal benefits, and that there is not a two-tier system. These commitments ensure that the financial benefits of the organisation focused on staff remuneration are competitive, although there are still issues:

> "In terms of the offer to the staff, my understanding is that we try to give them the same as what they would get if they were working in the NHS, so we've managed to retain superannuation grant, you know, contributions into the NHS pension, 'cause obviously, some staff would have been worried of whether we were moved across, that they would lose that benefit. We, as far as I understand, pay the going rates, we pay the same as what NHS provider companies for [mental health services] do. But we are under pressure, 'cause there's market forces and we've got external issues to consider, increase the

> members of staff going across to work for locum agencies or the bank. You know, that's a tension for us to consider, because we are losing staff to them and we're finding it difficult to recruit." PH6, Chairman, Psychological Health.

The challenge of competing salaries from agencies and locum providers means that Psychological Health has had to plan its remuneration and benefits carefully, within constrained budgets, to appeal to staff in an alternative way than higher direct salary payments. This is both a practical application of its financial management but also recognition of possibly different incentives applying for staff working at Psychological Health, which manifests itself in a sense of vocation in accordance with the social mission of the organisation. PH2 spoke of an overlap between the personal and the wider aims:

> "I do think we are all working towards improving individuals' mental health and quality of life. Hopefully as a result of that, that would feed into the wider community. So I suppose it would be a lot similar to our general mission…We may not know how that is impacting the wider community, but our hope is that it does trickle down, and impact everybody to feed into the mission." PH2, Psychological Wellbeing Practitioner, Psychological Health

With a social mission of improving mental health in the community, and how that is embedded in both the organisation and the aims of individual staff members, an incompatibility with earning profits for distribution to the owners of the organisation became apparent.

The organisation was considered not to be an entity where profit distribution to owners was either appropriate or welcome. This was prevalent across all employees, including directors, managers and staff, whether founding members or those who had joined subsequently. A tension was believed to exist between the service that was being provided and financial rewards being paid to staff for delivering that service. This tension manifested itself in an opinion expressed by employees concerning the effect of financial incentives as a motivating factor. This disconnect between the service that is being provided and financial incentives by way of bonus, was repeated often and reflected both a collective and individual perspective.

The collective perspective, summarised by PH5, the Director of Finance, concerned the nature of the service being provided and the social purpose of that service in the

community. He regarded this as a dual social mission, which was privileged over any desire to earn enhanced profits. Consequently, profit motive was absent from the positioned-practices exercised by staff in Psychological Health and in its place was not only a desire to deliver a quality service but also a community benefit.

The individual perspective centred on the nature of the mental health professional role, and its incompatibility with financial incentives and profit motives. A sense of public good and desire to help individuals with mental health issues were provided as motivation for the employees who entered the profession and who worked at Psychological Health. These were their primary motivators not financial reward. Whilst earning an appropriate salary was important, the prospect of being paid a share of any profits or bonuses linked to performance incentives was rejected as both an inappropriate and impractical practice.

PH8, new to both the practice and profession, summarised this in the following way:

> "I wouldn't feel right taking additional money in terms of bonuses given the work that we do because I don't think anybody comes into mental health for financial reward. People come here because they want to help people, and it would feel very obscure to me to do that on the premise that the more people you help, the better your wage packet at the end of the month. Like for me that would feel very counterproductive and quite wrong." PH8, Trainee Psychological Wellbeing Practitioner, Psychological Health

A tangential feature of the various roles carried out by employees at Psychological Health, which reflected the vocational element of the mental health professional, was that everyone interviewed (except for non-clinical administrative staff) retained a clinical role alongside any managerial responsibilities. This included the Managing Director and the Chairman. This means they all see patients regularly. This was seen as a significant benefit of the organisation for employees, enabling them to retain their vocation regardless of other roles, indicating that the vocational element of the job was strong throughout. This also reflects attitudes to individual financial rewards as being secondary motivation. Employees also differentiated their motivations from other jobs and professions through the types of rewards that they did covet. By preferring benefits in kind, such as training provided by Psychological Health that enhanced skills and career development, rather than cash bonuses, they were choosing to share benefits that the organisation generated in both a collective and individual way.

Employees sought improved skills that would not only enhance their own working lives, but would also have the power to enhance the quality of the services provided by the organisation. Whereas direct financial rewards such as bonuses and profit shares left the organisation entirely, to be spent or saved externally by staff, indirect rewards such as paid training remained within the organisation through the staff using their improved skills:

> "Yeah, I think so, 'cause the thing is, it's often, people think that we'll... I'll have extra pay or different bonuses, but I think, for us, and I think, part of it's the type of people we are and the type of job we do, the rewards don't always have to come in the financial way…obviously it is money, 'cause it goes back into training, but that gives you more of an opportunity that's linked to your role as well, so I think the funding going back in that way, gives us, probably more opportunities…than it would in an extra X amount in your monthly or weekly pay... There's a lot more opportunities that we get from putting it back in that way, for us and for the service as a whole as well." PH11, Psychological Wellbeing Practitioner, Psychological Health.

PH7 explained how considerable thought was put into how to best to use finances in the organisation, to benefit both Psychological Health and staff themselves. He used training as an example:

> "Okay, so with regards to the finances, we …think about what [staff value], so it may be rather necessarily a different pay grade, maybe somebody gets access to long term training that will benefit them and help them to establish a long term career, and where we get kind of buy-in and retention and that kind of knowledge brought in. So £4,000 for psychotherapy training a year, well if that was added to somebody's salary it wouldn't be a lot of money, but we'd have to give somebody £8,000 a year in terms of the tax and deductions, and then the hardship of actually letting go of that and paying for yourself is a hard one. The attraction of us paying was like as if they're directly able to get access to training for them on the cheap. Also an environment with this flexibility would enable them to pursue it, and then they sprinkle down the knowledge and they help to create an environment where ideas can germinate." PH7, Managing Director, Psychological Health

What is being described here is a form of recycling of monies generated, so that there are multiple shared benefits being derived at different levels of the organisation. At

the individual level, staff are incentivised to produce benefit to the organisation by being rewarded with training they value and consider beneficial to career development. The organisation, having obtained the benefit of the staff's incentivised efforts, is able to spend some of the benefits generated on staff training but in a way that is a more efficient use of funds than a cash payment to staff. Staff get full value from the training, whilst the organisation provides the lowest financial payment. Subsequently, both the organisation and staff get benefit from the training. The staff from enhanced career development and the organisation from better skilled staff contributing more. This becomes a virtuous cycle, as described by PH7, and, subject to diminishing returns, can continue in that cycle.

PH1, a Clinical Manager, provided a practical example of this. Since the organisation was formed she had studied for 3 separate Masters degrees in different aspects of mental health provision, all funded by Psychological Health and including time off for study. She believed that her career and skills had been enhanced considerably, including being able to provide new and different services to patients for the benefit of them and the organisation. This had generated additional income for Psychological Health, over and above the contract with the NHS, which had in turn benefitted the organisation's financial position. So the monies paid by Psychological Health for training, through the agency of the Clinical Manager, are eventually transformed into both better, and additional, services, earning more income for Psychological Health.

As with Community Health, the principles of co-operation between staff and reciprocity in how financial benefits are utilised, in pursuit of a common aim to deliver on the social mission, are evident from the shared benefit structures. With the passage of time since formation, these emergent entities have become stronger and the establishment of systems and resources around the shared benefit structure, such as training, have started to lead to a virtuous circle of collective and individual benefits. Money reinvested is being used to improve the range and quality of services and to enhance employee career development. A collective incentive is generating individual benefits and then collective ones, through co-operation and reciprocity in pursuit of a common purpose.

6.3.4 Comparing Cases

Comparisons with Acute Health, with its limited shared benefit structures, were not helpful in establishing how these structures may generate the emergence of mutualism. Comparison between Community Health and Psychological Health proved more fruitful, particularly with their contrasting periods of time in existence. Table 6.5 illustrates the contrasting interactions between the three cases, with tentative suggestions of causal powers each may possess.

Table 6.5 Comparing agential interactions with shared benefit causal configurations

Case	Positioned-Practice	Generative Mechanism	Agential Interaction	Causal Powers
Acute Health	Employee	Employment Contract	Interacting with employment relationship producing work for wages/ benefits	Transactional exchange of labour for wages
Community Health	Shareholder	One Member One Vote Democracy (AGM) Social mission	Voting for non-distribution of surplus to staff and for social mission	Reciprocity Co-operation Common purpose
	Employee	Egalitarianism Reinvestment Collective aim	All staff receiving same employment benefits/rewards Surpluses reinvested to achieve social mission	Reciprocity Co-operation Common purpose
Psychological Health	Shareholder	One Member One Vote Democracy (AGM) Collective aim Reinvestment	Voting for non-distribution of surplus to staff Voting for Company's Objects (social mission) Surpluses reinvested to achieve social mission	Reciprocity Co-operation Common Purpose
	Employee (and Clinician for training)	Training Reinvestment	Take shared benefit in training to improve own career development and quality of service provided	Reciprocity Co-operation Common Purpose

Source: Case study data

Whether or not any generative mechanism is actualised so as to engage the causal powers inherent in a configuration, depends on the activities of agents in their interaction with that mechanism and the surrounding structure. Agency is mediated through positioned-practices (employee, shareholder and so on). By focusing on this mediation and the resultant interaction, the extent to which mechanisms are

actualised, and the resultant powers activated, helps to explain whether mutual structures cause mutualism to emerge.

Activation by agents of the various mechanisms of reinvestment, democracy, collective purpose and egalitarianism all involve the employees at each organisation working co-operatively and reciprocally in pursuit of a common purpose. These causal powers, which are also mutual relations, are emergent powers actualised through the causal configurations of shared benefit. They are activated through agency, such as employee, as well as shareholder. As employees and clinicians, staff at Psychological Health, for example, prioritise their vocation over individual financial incentives. This can only happen through their agency, which acts in such a way as to engage and actualise the egalitarian mechanism and common purpose powers inherent in the shared purpose configuration. Communities of practice may operate here, as discussed in Section 2.4, focused on shared practice domains concerning vocation within Psychological Health. Through these domains, the group may share knowledge and prioritise vocation as a common purpose.

The mechanisms that exist as a consequence of the interrelated ownership structure and sharing benefits differ considerably from those in Acute Health. Employees at the two PSM cases, and particularly at Psychological Health, are able to interact with the shared benefit mechanisms to achieve their own individual motivations, or projects. This was not possible at Acute Health, because the relevant agency and structures were not present.

6.4 Conclusion

Shared benefit in PSMs is a complex interaction of individual and collective incentives, which were not enabled at Acute Health. Employees in the positioned-practice of staff only could not affect how surpluses were applied. Any personal projects were therefore not achieved.

In contrast, the two PSMs did have configurations that had been activated and the engagement with relevant mechanisms by employees in Psychological Health, in particular, enabled both collective (social mission) and individual (vocation) benefits to accrue. Here personal projects were achieved, and the expectation at Community Health was that this would occur there too. Congruence between individuals and the collective was achieved, and this may be through communities of practice.

Chapter 7 Voice and Transparency

7.1 Introduction

This chapter focuses on participation in decision-making and access to information, termed voice and transparency in Chapter 2. The extent to which staff are able to participate in decision-making, coupled with whether, and to what degree, they do so, provides an indicator of whether mutualism has the capacity to emerge within organisations. As discussed in Chapter 4, access to information and transparency are key components in effective decision-making structures. During interviews, participants combined discussion of voice with transparency of information so that they were hard to separate in the data: they were seen as two sides of the same coin. Given the interaction between them, they are discussed together in the following sections under the collective label of voice, incorporating participation in decision-making and governance as well as openness and transparency of information.

Staff voice structures within the respective case studies are analysed to investigate first how they are configured and second how they operate in practice. Each of the cases incorporates some form of staff participatory configuration through their membership constitutional arrangements. These enable staff to be represented in the decision-making process, albeit, as will be discussed below, to varying degree and effect.

Section 7.2 takes each case study in turn to map the causal configurations that make up staff voice structures. By separating out the various components of the configuration into the social structure, positioned-practices, rules, resources and generative mechanisms, a basis for comparison between the three is created, which is conducted in Section 7.2.4. To complete the analysis, external relations not necessary to the social structure are included so that these can also be compared between cases,

which help to assess whether a membership arrangement *per se* is sufficient to create a mutual practice.

Having mapped the configurations that possess the powers to enable or constrain staff voice, Section 7.3 investigates what is happening in practice through staff interaction with these configurations. By examining how agents in each case respond to, and engage with, these configurations, the extent to which the various generative mechanisms have been engaged and activated can be demonstrated. Section 7.3.4 compares the three cases to establish the extent to which employee voice is active in each organisation.

Section 7.4 concludes that Acute Health, whilst a member organisation with elected staff representation, in practice possesses limited structures for staff to effectively participate in decision-making. This is contrasted to both Community Health and Psychological Health, where there are effective and active voice configurations in place.

7.2 Staff voice as a causal configuration

A corporate body is a social structure and acts through the agency of the social actors who inhabit positioned-practices within the relevant organisation (directors, managers, clinicians, administrative, technicians, IT professionals and so on). An organisation does not send out e-mail, for example, people who work there do. Participation in decision-making by staff in corporate bodies is contingent on the extent to which they are able to adopt positioned-practices within formal and informal decision-making forums and their respective access to information. The positions inhabited by staff in those structures, what the rules of the organisation enable by way of participation and transparency, and how managers view staff participation, determine the degree and effectiveness of staff voice.

Each of the three cases is a membership body, with staff making up all or part of the membership. Focus is on these membership arrangements, to analyse their causal configurations, and how these membership structures interact with the decision-making processes in each organisation.

7.2.1 Acute Health

Acute Health's governance arrangements comprise two sets of causal configurations. The first is a Board of Directors, or Board, with appointed executive and non-executive directors. The second configuration comprises a Council of Governors, or Council, with elected and appointed governors. The configuration of the various Board and Council members is set out in Table 7.1.

Whilst non-executive directors have responsibility for liaising with the Council, and the Council appoints the non-executive members, no members of the Board are Governors and vice versa. The Board and the Council are interconnected in certain functions, as mentioned below, but from the perspective of who participates in each, they are mutually exclusive. The Board are responsible for day-to-day management of the organisation, and conduct of all statutory, regulatory, financial and contractual obligations of Acute Health.

Table 7.1 Governance forums for each case study

	Acute Health	**Community Health**	**Psychological Health**
Governance Forum	Board and Council of Governors	Board and Staff Board	Board
Unitary or Dual	Dual	Dual	Unitary
Elected/Appointed	7 Executive Directors Appointed by Board Committee 7 Non-executive directors appointed by Council of Governors 15 Governors elected by community, 7 elected by Employees, 6 appointed by Board	5 Executive Directors appointed by Non-executive directors 6 Non-executive directors elected at AGM Staff director elected by Staff Board 12 Staff Board members elected by staff	4 Executive directors appointed by non-executive directors 2 Non-executive directors elected at AGM 1 Staff director elected by staff
Staff representative on Board	No	Yes	Yes

Source: Case study data

The executive directors comprise the senior management team. The non-executive directors bring external oversight to actions and activities of executive directors, focused on strategy and governance. The Board appoints the executive directors, whilst the Council appoints the non-executive directors to fixed terms. The Board makes all operational decisions, which are in turn implemented through the various clinical and administrative units.

The Council represents Acute Health's members and comprises elected representatives of the community members and staff members. In addition, appointed governors represent various local partners, such as commissioners, health bodies, local authority and commercial partners. The Council focuses on relationships external to Acute Health, including developing the membership, collating the membership's views, and reporting to the Board on them. They also have a consultation role in internal discussions concerned with strategy development and improving services.

The Council appoints non-executive directors and represents the interests of members, but does not oversee the performance of the Executive Directors. This is the responsibility of non-executive directors. The Board is the primary forum for decisions, with day-to-day running of Acute Health delegated to the Executive Directors. The Chairman, a non-executive director and the Chief Executive, an executive director, are the liaison between the Board and the Council. As the Council's remit relates to matters outside of day-to-day operations, their influence is limited.

The Council's relations with the operational and day-to-day decision-making structures, therefore, are external because they are indirect. No governor is on the Board and other than in limited situations, such as a merger, there is no Council veto of Board decisions. This is in comparison to the Board, where the executive and non-executive directors are all internal to those decision-making structures. The decision-making structure would not exist without executive and non-executive directors, but would do so in the absence of the Council. This was the case prior to NHS Foundation Trust status when the Council did not exist.

In this structure, staff are not directly represented on the Board and there is no staff director. Seven elected staff governors represent them on the Council. As demonstrated in Table 7.1, staff representation is limited to the Council, which does not have a presence on the Board. Notwithstanding the seven elected staff governors

on the Council, staff are also external to the operational decision-making structures of Acute Health. Causal configurations relating to decisions exist whether there are staff representatives or not. It will be seen in Section 7.3.1 that the effect of this is to generate a degree of indifference to the role of staff governor amongst staff themselves, evidenced by low staff turnout in Council elections and limited engagement with staff governors.

As with decision-making, information is a key resource in the organisation and is essential to effective voice mechanisms. Informational openness redresses power imbalance between employees and managers and enables informed decision-making by staff. Acute Health's constitution, which governs Board conduct and how information is treated, places control of information in the hands of the Board:

> "The Board of Directors shall meet once per calendar month in private, having regard to the confidential nature of the business to be transacted, publicity on which could be prejudicial to the public interest, and the business interests of the Trust." Constitution, Acute Health

A presumption against openness and transparency exists by mandating privacy of board meetings ('shall' is used not 'may'). As staff in neither their role as governor, member or employee attend Board meetings as a matter of course, control of information remains with the Board at all times. A confidentiality policy restricts disclosure of information, enabling the Board to refrain from publishing information whenever they think appropriate.

Even the Council in their official capacity are limited in the information they receive, obtaining such information from the Board as is necessary having regard to their functions and responsibilities. Their role is consultative for designated aspects of Acute Health's operations, and so they receive such information as the Board decides. Further, the Council must "…maintain confidentiality with regard to information gained in accordance with the Trust's Confidentiality Policy." (Constitution, Acute Health).

Staff and their representatives on the Council are generally excluded from decision-making and information sharing structures. In this respect, their positioned-practice is staff only, not decision-maker or participant in information. The generative mechanisms that exist in this structure are confidentiality and managerialism, as well

as command and control. There are consultation mechanisms in the role of the Council, but these are limited in scope, defined by the constitution.

7.2.2 Community Health

Staff voice structures, comprising participation in decision-making and sharing of information, are embedded within Community Health. This reflects an employee owned business model (Birchall, 2011, p. 154) where staff adopt multiple positioned-practices, including owner and shareholder, as well employee, service provider, clinician and manager.

Articles of Association, or Articles, supplemented by legislation, regulate relationships between staff (as shareholders), directors and the organisation. How directors are appointed, the conduct of shareholders meetings, what matters are reserved to the board and what are reserved to the shareholders are determined by the interaction of the Articles and the appropriate legislation. The Articles set out how governance is configured and cannot be altered except by collective action of a majority of the shareholders, voting in a meeting. As staff are shareholders, they control the constitutional arrangements of Community Health, with collective power to change them. This creates internal relations between employees, as shareholders, and the organisation governed by the Articles and legislation.

The directors are authorised by Articles to make regulations to assist them in the day-to day operations of the organisation. However, these are only valid insofar as they are consistent with the Articles, which reflect the shareholders', and thus employee, requirements. The directors are an internal, necessary relation, with shareholders having ultimate control. Directors in Community Health are subordinate to the shareholders, and so, through staff ownership, to the staff, although in the structure of decision-making all are necessary to the other.

The Board, as shown in Table 7.1, comprises non-executive and executive directors, who make operational and strategic decisions. The Articles provide that at least one of the Directors must be an elected staff director. In turn, the staff director represents an elected staff board made up of 12 representatives, each corresponding to various units and teams within Community Health. The staff director, therefore, is a member of the Board and the Staff Board. At the level of operational decision-making staff are represented through generative mechanisms of participation, democracy and

representation through the staff director and staff board. Operational and strategic decisions, therefore, have staff participation.

The staff director and staff board provide a representative voice for the staff at the Board decision-making level, and so the two boards are not mutually exclusive but intersect and overlap. This provides multiple opportunities for staff voice to be engaged. These embedded structures create a set of internal relations made up of shareholders (employees), directors (executive, non-executive and staff director), staff board and staff (as electors) within the organisation.

Staff are therefore enabled to participate in the making of decisions at various levels. In order to be effective in those roles, information is shared openly across the organisation. This transparency goes further than mere openness and supply of information. The Articles ensure both transparency and understanding of information in context:

> "It is the responsibility of the board of directors… to ensure that… the issues to be decided are clearly explained, sufficient information in an accessible format is provided to… members to enable the rational discussions to take place, and where appropriate, experts in relevant fields are invited to address the meeting". Articles of Association, Community Health

These rules provide for meaningful dissemination of information that assists decision-making by staff. Information, as a resource, is not privileged to a small group, such as the Board, but is dispersed widely.

A causal configuration has been created around voice (see Table 7.2), with key resources of decision-making and information at its centre. Structural relations have been formed from the rules of the organisation between staff, in their positioned-practice of shareholder and as employee, that enable their participation in decision-making and access to information. The generative mechanisms of democracy, participation, representation, transparency, openness and learning (to assist understanding of the information shared) are present within this configuration.

This voice configuration enables active and meaningful participation in governance and decision-making within Community Health. Section 7.3 will analyse whether the powers inherent in this configuration have been actualised through staff interaction.

7.2.3 Psychological Health

As a staff owned entity, managers and employees own Psychological Health's shares, similar to Community Health. Embedded in staff shareholding are structural relations governed by rules regarding decisions and information, employing generative mechanisms to effect staff participation in decision-making. Staff voice has the capacity to operate at several levels in the organisation's decision-making practices, creating positioned-practices beyond traditional employee roles.

At the level of rule setting, in terms of how decisions are made and who can make them, Psychological Health's Articles operate as a framework, along with applicable legislation. The organisation, acting through its shareholders and directors, is legally obliged to carry out their actions within this framework. As shareholders, employees have the power to change the Articles, and thus the constitutional framework, by majority vote at general meetings. This gives staff, acting through a majority, ultimate control over these rules, and this extends to appointing directors. At the level of board decision-making, staff also have a say. As well as appointing directors, the conduct of directors and board meetings are set within the Articles, as voted on by the staff. Directors' actions are constrained accordingly.

The Articles include a number of provisions promoting staff voice, including information transparency. Including these in the constitutional rules of the organisation gives them privilege and priority. These rules provide for the shareholders (members) to be given a voice in the organisation, as well as being allowed access to information:

> "Membership provides members with access to information, a voice in the company, and the opportunity to be elected to a representative role in its governance" Articles of Association, Psychological Health.

Whilst the directors may formulate regulations to aid the efficient running of the business, any such regulations must be permitted by, and consistent with, the Articles. The constitutional rules are thus the ultimate control as regards decision-making in Psychological Health. As employees, in the positioned-practice of shareholder, collectively control these rules, they have ultimate control of governance and decision-making.

Additionally, the representative role for staff included in the Articles places staff in decision-making positions within the Board. This positions staff, through their representative, into internal relations with the Board and so a necessary part of the decision-making structure. This is illustrated in Table 7.1, which maps Board configuration of Psychological Health. Unlike Community Health and Acute Health, here there is a single (unitary) Board, reflective of the smaller size of the organisation compared to the others.

Staff, shareholders, directors, the Board, employees (in their respective positioned-practices) together with the organisation, combine to make a voice structure, which utilises resources such as information and decisions. By engaging generative mechanisms, including transparency, voice, democracy and participation, within the rules set out in the Articles and legislation, the configuration has the capacity for emergent powers to be generated. In this configuration, the service users and NHS commissioners are not necessary to the structure, remaining external, whilst employees in their position as shareholders and as staff, are necessary.

7.2.4 Comparison of Causal Configurations Between Cases

As membership bodies, all three cases have staff representation on the governance boards of their organisation, which should provide staff with an effective voice. However, analysis of configurations in each reveals this is not necessarily the case. The differences can be effectively highlighted by comparing each of the various components with the voice configuration side by side, as is done in Table 7.2.

By comparing the internal and external relations across each case, it becomes apparent that, whilst staff are part of structures concerning employee voice in both Community Health and Psychological Health, they are not a necessary component of voice structures in Acute Health. Staff members are excluded from influence in the setting and changing of the constitution of Acute Health, and whilst the Council provides staff representation, it is indirect through a long chain of agents and actors. The role of the Council is broadly consultative and not influential in day-to- activities of the organisation. The social structures and generative mechanisms identified in Acute Health are, therefore, not conducive to employee voice.

Table 7.2 Comparison between cases of voice configurations

	Acute Health	**Community Health**	**Psychological Health**
Social Structure	Board Executive Directors Non-executive Directors	Shareholders Board Executive directors Non-executive directors Staff Director Staff Board Staff Representatives Employees	Shareholders Board Executive directors Non-executive directors Staff director Employees
External Relations	Council of Governors Staff Governors Staff Members Staff GPs Patients Professional Bodies	Local Authority Service Users Community	NHS Commissioners Service Users Community
Rules	Foundation Trust Constitution Legislation Regulations	Articles of Association Legislation	Articles of Association Legislation
Generative Mechanisms	Confidentiality Hierarchy Command & control Managerialism	Transparency Voice Democracy (OMOV) Democracy (Representative)	Transparency Voice Democracy (OMOV) Democracy (Representative)
Resources	Information Decisions	Information Decisions	Information Decisions
Positioned Practices of Staff	Staff Consultee Member	Shareholder Staff Director Staff Representative on Staff Board	Shareholder Staff Director

Source: Case study data

In comparison to the other two cases, employee voice in Acute Health is a weak governance structure. The mechanisms that exist around decision-making and sharing of information point towards managerialism and command and control decision-making generative mechanisms, based on hierarchy, whilst confidentiality mechanisms govern information, placing control of knowledge about the organisation in the hands of the Board.

The positioned-practices adopted by staff in this configuration are equivalent to that of employee only, external to the voice structure. Employment roles and relationships are contractual relationships, based on rules that re-enforce an imbalance of power between employee and employer, using hierarchical and

command and control mechanisms. Membership structure in Acute Health does not affect existing employment relations for staff as far as voice is concerned.

In contrast, both Community Health and Psychological Health have staff voice strongly embedded in the social structures operating within each organisation. Staff are necessary relations along with the Board, Executive and Non Executive Directors in these structures. They adopt multiple positioned-practices and so operate on various levels. They possess voice in their role as shareholder, and voice through representatives who attend the board. As shareholders and staff, subject to any prior legal restraints such as data protection and privacy, they are entitled to full access to available information and the structures and mechanisms in place are there to ensure this occurs. These mechanisms include transparency, through the provisions in the constitutional rules and access to Board meetings by staff representatives. Further mechanisms that the configuration possesses include democracy.

Two forms of democracy are present in this configuration, reflecting the different levels at which staff voice operates. Direct democracy operates in connection with the Articles, which can only be changed by a majority of shareholders, and therefore employees, voting in favour of change at an AGM on a one-member-one-vote basis. There is also representative democracy, through staff representatives and staff directors. Elected through one-member-one-vote, their actions are conducted on behalf of staff. This is a practical necessity given that changing the articles happens infrequently, whilst Board meetings take place regularly and deal with many more issues.

There is a difference between the two structures, illustrating that different contexts can affect respective configurations. Community Health operates a separate representative body for staff, the Staff Board, which is not present in Psychological Health. One possible explanation for this is as a consequence of the differences in size and nature of each organisation. Community Health has approximately 240 employees operating across multiple centres delivering different services. Psychological Health has approximately 45 employees from one office offering a single service. Community Health has therefore adapted to its context and environment to maximise voice in the organisation by providing an additional layer of representation for each service and location.

The differences in causal configurations between the three case studies represent strong and weak voice configurations. Acute Health's is weak, with limited

employee voice mechanisms and structures. Community Health and Psychological Health, on the other hand, have strong employee voice configurations, appropriate to the size, scale and services of each. How employees, as agents, respond to these configurations and the extent to which generative mechanisms are actualised, will determine the extent to which employee voice causal powers are becoming operationalised.

7.3 Agential Interaction

The configurations outlined for each case study in Section 7.2 possess powers that have causal effect if they are both exercised and actualised. This section investigates how staff, employees and managers engage with the respective configurations. Section 7.3.4 assesses whether, and to what extent, the powers possessed by these configurations are emergent properties, not present in any of the configuration's individual components but generated by the interaction by agents and actors with the configurations.

7.3.1 Acute Health

The staff voice configurations at Acute Health indicated that the rules and norms of board and management control of information in the organisation tended towards limited information flows to staff, often in a manner that did not invite engagement from the recipients. There was limited understanding amongst staff of how the Council worked, and very minor engagement with its operations. Even though all staff were members, no staff interviewed could name their elected staff Governor, nor had any of them participated in voting, even though some elections had occurred weeks previously:

> "No idea. Don't know, I am not on the governance board. I don't know anything about it. I am not a decision-maker on that board. I am involved in [clinical] governance as part of the department. But I am not invited to give my opinion to the governance board or anything like that." AH5, Technician, Acute Health.

At the day-to-day level of operations, a strict hierarchical process operates between the head of the department and the various managers of the respective teams, at the

monthly business team meeting. AH1 spoke of this hierarchy, but considered it a necessary part of the organisation's history as a hospital with issues and now with a new management in place:

> "I do think there's building of trust and that in this as a new organisation and that and I think we are still working through that relationship and that structure and its still being established really and that, so I think from where it was and what an improvement journey we have been on to date its been necessary to have a hierarchical structure at times and to be focused on what improvement works need to be done and how that'd be driven. So I think in some ways it's absolutely appropriate and trust is still being built at the moment, to me, personally" AH1, Matron, Acute Health

This hierarchical system AH1 refers to has led to rigidity and limited space for discussion. AH3 explained how the monthly management meeting was run:

> "It's command and control, it's not even communication. This business meeting that we have every month there's an agenda and I am one of the key business managers here and I get a two minute slot, seriously, two minutes and that's to talk about the whole [clinical] diagnostic service. It's not good communication, it's not productive" AH3, Technician Manager, Acute Health.

The inability to fully discuss issues, and for any planned discussion to be constrained and curtailed in this way, has led to a sense of mistrust and feeling that the unit is operated in an autocratic way, an approach inadvertently confirmed by AH8, Senior Consultant in charge of the unit. When interviewed, he specified that he ran all his meetings to a strict timetable and emphasised that the unit had to operate in this way to ensure an efficient process. This meant that the meetings were not organised for discussion but for disseminating information to be received by the attendees.

This approach has led to disenfranchisement from the decision-making process. Consequently, team managers were not able to meaningfully represent their teams, and the staff within them, in management decisions. Staff responses and attitudes to these practices reveal a disaffected and negative attitude, as a sign of lack of trust between staff and the organisation. Information that is communicated is unilateral, without expectation of comment or meaningful consultation. Consequently, staff are

disengaged and frequently do not attend meetings held to discuss matters that may affect the future operations of the clinical unit.

One example that occurred a month prior to the interviews, concerned the Mutuals In Health programme mentioned in Chapter 4. A series of workshops and meetings were held to explore whether the clinical unit could be converted to a PSM, which would be a significant change. If this had happened the staff would have been transferred out of Acute Health into a newly formed organisation. Approximately 90 members of staff were potentially affected by the proposal. Two workshops were held to discuss the proposed changes, but were attended by only five and seven members of staff respectively out of the total number affected. This lack of engagement in the communication and consultation process reflected a belief that the exercise was not intended to genuinely gather views and opinions from staff. AH4, reflected on these meetings:

> "I mean just going back to that we were allowed to take part in that [workshop] but very few of us could get there and I am sure there were other people who would have liked to have got there...but there were very few there and I think the [workshop facilitators] were very disappointed with the turn out...that's because it was short notice, inappropriate time to get there...but all that came from the top because that is what they set up and you can have no trust in that system because all we get is this is where you're allowed to join in...and even though you were asked for your input into the model when the models were presented, you were not allowed to vote on which model or say what you thought" AH4, Technician, Acute Health

Hierarchy was a recurrent theme within Acute Health. AH1, the Matron and the most senior nurse interviewed, described a chain of command:

> "…so the matron role would be one of the senior nurses or nursing roles within the organisation…we would feed directly in terms of the organisational structure…I would oversee [ward manager] and line manage [ward manager] as a direct report to me… and then my line manager would be the deputy director of nursing to the chief nurse and that's [it] in terms of organisational structure…" AH1, Matron, Acute Health

AH1 described her interaction with the ward as mainly with the ward manager without detailed interaction with the nursing team, with the majority of her time

spent at divisional and governance meetings or working groups around specific problems. This indicated a lack of direct interaction with nursing staff, relying on the hierarchy of the ward manager to communicate with them.

This was re-enforced when staff did attempt to raise issues, with resistance from the organisation if they are not dealt through a chain of hierarchy. AH6 spoke about concerns that she had raised recently. After speaking to her ward manager, she felt that these concerns were not being addressed and she had not heard anything in response. She therefore decided to pass on the concerns in e-mail to the Chief Executive directly, bypassing the recognised hierarchy:

> "I've highlighted some concerns to the Chief Executive via email about a month ago and I've had so much grief about it, I can't even tell you...but it seems like [pause] everybody at this trust is like, 'Oh my God! You didn't send an e-mail to [Chief Executive]?' … Because at the moment, I have to go through my Manager, then my Matron, then my Chief Nurse – she takes (apparently that's as far as I'm supposed to take it, which is why my email has made a bit of a fuss) and then she's supposed to take it further up the hierarchy." AH6, Senior Sister, Acute Health.

The hierarchical approach and limit on the managerial levels beyond which AH6 is entitled to communicate, suggests staff access to decision-makers is curtailed on a day-to-day basis and reflects both the chain of command expressed by AH1, the command and control environment referred to by AH3 and the scale of Acute Health as an organisation. This manifested itself in a considerable lack of trust, particularly amongst those who had worked at Acute Health for a long period of time:

> "I do think that there are still a core of historical staff who were finding it difficult to move away from a blame culture and that is sort of slowly the progress at the moment if I'm honest. And I think that is were the issue lies and it's trying to not win them over but looking to break those barriers down, look at new ways of working so that I don't think it's [Acute Health] as a whole, I think it's an individual group of people that are finding it difficult to move forward" AH2, Ward Manager, Acute Health.

Consultants also expressed dissatisfaction with the decision-making process in the unit, albeit with a different emphasis. AH7 discussed how those who made decisions were remote from the day-to-day work of the unit:

> "One of the problems we have now is that we have some managers, obviously, who may not be fully aware of the situation or the needs. I'm not blaming them, they may not have had the right experience, because they are not elected, they have been just appointed…And this is what is happening at the moment. The managers are being shifted like this, without their having applied knowledge of this place and the department and the requirements." AH7, Consultant, Acute Health.

This leads to decisions being made for non-clinical related reasons, which AH7 thought could be overcome if there were elected representatives from the unit on the decision-making forums, experienced in appropriate matters. This would also give staff more say in who their managers were. The Council does not fulfil this function, being an organisation wide body and without managerial input. The staff Governors are not elected by the unit, but by staff constituencies representing wider divisional groups, such as clinical and elective services, as well as corporate and facilities.

The NHS Foundation Trust voice model appears not to have been successful. AH9, Director of Strategy and AH10, Chief Executive, recognised the failings of the Public Benefit Corporation and membership structure generally, as a means of encouraging voice within the organisation. AH10, in an exploratory interview, highlighted the possibility of a "Foundation Trust Plus" model to enhance the role of staff membership and increasing participation. AH9, in a separate exploratory interview, suggested that this model may involve separation of the organisation into smaller units, as was envisaged by the Mutuals In Health pathfinder, removing clinical units from the wider Acute Health. They would be combined into integrated services, with smaller teams and less hierarchical structures, with greater community and patient involvement. Both of these were in recognition of the limited mutuality of existing voice and transparency structures.

The voice structures introduced by the NHS Foundation Trust model, namely membership and Council, have not been effective, therefore, in actualising staff voice. This is notwithstanding the Public Benefit Corporation model's claim to mutualism. Acute Health has relatively weak staff voice structures within its organisation, leading to staff, as employees and clinicians, developing mistrust and disengagement, and believing they do not have an effective voice in the organisation. Directors make decisions, with limited recourse to staff views.

7.3.2 Community Health

Voice configurations give staff in Community Health potential to engage in a participative and equal power relationship within the organisation, beyond the positioned-practices of employee. This represents significant change to positioned-practices previously adopted in the Local Authority, where staff adopted the role of employee only. How staff inhabit those different roles, influences whether the structures and generative mechanisms of staff voice are actualised so that mutualism is able to emerge as causal powers are activated.

As shareholders, staff at Community Health were preparing for an annual general meeting, or AGM, at the time the participant interviews were being conducted. There would be a number of issues affecting the Articles and changes, as a consequence of these issues, voted on by staff in their role as shareholder. This was the first AGM to occur and to prepare staff for a new experience, workshops were convened to discuss the issues arising, some of which related to setting the culture and values of the organisation.

The rationale behind the workshops was to give staff an understanding of these issues. This was part of an approach by the directors to engender a new form of decision-making, and break from the previous hierarchical arrangement in the Local Authority where managers imposed decisions on staff, and the staff accepted those decisions with minimal consultation. Introducing a more inclusive approach, was a positive attempt to use the structures of the new organisational form to effect changes in how decisions are made:

> "I think that we've got to change the relationships between the managers and the workforce. It's got to become much more partnership and a collaborative way of working than 'it's always been very hierarchical'." CH2, Assistant Manager, Community Health

The beginning of this changed relationship was demonstrated by how staff are working to ensure that the staff board is an effective representative body and that it has the capability of contributing to Board decisions. There had been an issue with the scheduled Staff Board meetings not being correctly synchronised:

> "… we had our Staff Board a few weeks ago, and then the Board of Directors should have had…we should have had another Staff Board, to see what was

> actually brought up, but it didn't happen that way. So certain things happened at the Board of Directors which quite a few of us aren't happy about. But we can't really say anything about that because it's already been passed. But from now on, before the…we have our Staff Board just a week or two before theirs, so we've got a bit of knowhow about what's actually being mentioned." CH10, Level Two Support Worker and Staff Board Member, Community Health.

The ability of the staff to dissent, and for the issues they raise to be addressed by the Board to their satisfaction, demonstrates a willingness in the early stages of the organisation for both staff and directors to try to find ways of making the mechanisms around decision-making effective and meaningful, and so engaging and actualising these mechanisms. There is evidence of a differentiated approach inherent in CH10's description of "our Staff Board" and "theirs", indicating there was not a unified approach yet. Notwithstanding, it appeared both employees and managers were co-ordinating to make voice structures work to give staff an effective voice.

This is also the case in relation to sharing of information and transparency. CH3 contrasted positively the amount and quality of information that was shared at Community Health with the position when the service was owned and operated by the Local Authority. Often, the previous position involved staff not obtaining information that was pertinent to them or their service, or obtaining information after it had reached the public domain:

> "And you usually find out the night before on the news, with the Local Authority. And the staff would come in and say 'Is this happening?' and we'd say 'We don't know about that yet'". CH3, Deputy Manager, Community Health.

Efforts to alter these relationships, and re-balance the dynamic between staff and management, are not wholly straightforward. A director with primary responsibility for engaging with the Staff Board exhibited discomfort with what she was tasked with doing, sharing information she would not have done in a senior position at the Local Authority:

> "I think it is around trust. I think it was trust, my little bit of a wobble with this information going to the staff board, because it wouldn't be information that normally would be shared with staff. I thought, it does feel different, but

> it has to happen and I'm sure that the more it happens, the more that that will become the norm and it will start to feel not right not sharing things. I think it will be based on trust." CH5, Director of Strategy, Community Health.

Her response was to consult other directors and discuss this issue, before starting to feel more comfortable about what she was doing. Notwithstanding previous attitudes forged in a different decision-making and information-sharing environment, there is a gradual embracing of the mechanisms relating to voice and transparency by senior members of Community Health's Board and managers.

Staff, in their positioned-practice of employee, consider the Staff Board and Staff Director as key conduits of employee views. This was both in terms of communicating information to the staff, so that they were well informed and in communicating views from the staff to the board, so that they could be taken into account in decision-making.

As with managers, a change in attitudes amongst staff is also occurring. CH9 referred to a general level of mistrust when working at the Local Authority, and a belief that managers had hidden agendas. She admitted that due to this prevailing lack of trust there had been considerable resistance from staff initially to the transfer of the service out of the Local Authority into Community Health. She was one of the staff members who had felt this and had exhibited resistance to the plans in the early stages. Now, however, she felt that the transfer to Community Health had given an opportunity to re-set the relationship between staff and management:

> "But yeah, now's the opportunity to create that trust and that is the whole idea of having a staff director and a staff board, isn't it? I think it's sort of about the general issues, day-to-day issues that people want to know…They just want to know am I still going to be working at such and such a place? What's happening with our place? Are we going to get some more staff? What are we working towards here? What's our goal? What's our ethos in this building? You know, that kind of thing. And we'd lost that really. We had lost it. So we need to let people know what we're doing." CH9 Level One Support Worker, Community Health.

What becomes apparent is that the voice configurations that are embedded in Community Health around decision-making and transparency are starting to change behaviours within the organisation, both for staff and for directors and managers.

Managers and directors are sharing information with staff that they would not have done previously. Staff, in turn, are beginning to utilise the Staff Board forum to receive and communicate information and views. These views, via the Staff Director, are then taken into account at the Board.

The actualisation of generative mechanisms of participation and transparency are enabling emergence of new phenomena that were not previously present in the Local Authority. These emergent phenomena of trust, reciprocity and co-operation are being generated through the causal powers of the voice configuration.

7.3.3 Psychological Health

Analysing the different levels of decision-making helps examine how staff engage with the structures and mechanisms surrounding employee voice in Psychological Health. An example of the powers attributable to staff through their role as shareholder was apparent during the interviews, because they coincided with an on-going exercise to review the guiding principles comprised within the Articles, which in turn had guided the organisation in their decision-making since inception. These principles included following NHS founding principles, partnership working, staff involvement, co-operation with other public sector bodies, minimising their impact on the environment and re-investing profits into the service (Articles of Association, Psychological Health).

As it had been five years since the organisation was founded, staff and managers believed that there should be a review of these principles, with a view to changing them in the event that they were no longer considered relevant. The only changes permitted are through a majority vote at the AGM, with all staff having a say and a vote as shareholders. A majority of staff would need to agree to the changes, which would then result in an amended set of Articles, or rules, for the organisation to follow and be bound by.

In order to achieve maximum participation and discussion, staff were engaging in a number of workshops and meetings, called values meetings, in advance of the AGM, focused on reviewing existing principles in the light of the current operations and looking at various alternatives. This would result in a meaningful vote, if required, at the AGM, with all of the staff having had their opinion heard in the run up to the

vote. Staff were able to challenge whether the principles or values that had originally been included in the organisation where still relevant:

> "Almost like we make them real, and we define them, and we were discussing them in one of the meetings, and actually the staff had said there is something that, as a staff group, we feel like we've messed up on those values, and that kind of thing. And they felt able to say actually [engagement with communities] is something that we do, and this is how we do it, but it isn't reflected in these values, sort of quite openly. And I said well how about adding it somewhere?" PH4, Operational Manager, Psychological Health.

The decision-making generative mechanisms of voice and participation are fully engaged here by employees and managers. There was a forum for staff to express their views, receptiveness amongst managers to take into account what was said and staff were actively engaging with the process, giving views and opinions.

At Board level, embracing participation has permeated into the decision-making processes to remove autocratic approaches and encourage collective voice. PH7 emphasised that decision-making was a collective enterprise:

> "With the Board, it's taking the lead in terms of having a lot of influence, but when it comes down to the really big decisions, it's not all down to me, it's up to the collective. Sometimes they may look to leave it to me, but I will bring it back to the Board because that's not a sensible thing to do." PH7, Managing Director, Psychological Health.

Other examples cited were recent discussions that had taken place about staff shortages. A number of potential solutions were proposed, including for staff to do extra clinical sessions as overtime. This was discussed in-depth at both the Board and in staff team meetings. A consensus was reached that this would put too much pressure on staff workloads. As a counselling and psychotherapy service, managers and staff agreed overtime was inappropriate and not beneficial to staff well being. Alternative solutions that did not involve increasing individual workloads were being sought, which would be agreed to only with a consensus between staff and managers. There is a link back to the vocation element discussed in Chapter 6 concerning shared benefit. Staff privileged their role as effective clinicians and quality of delivery, over additional overtime wages, and managers supported this.

Examples of openness and participation presented in interviews ranged from significant operational issues such as these staffing shortages, to less business focused ones concerning the decoration and colour scheme for new offices:

> "I'm involved in a lot of the decision making, and things like that, and all staff actually, we do a lot of staff engagement here. Like when we moved to this office, everybody was involved in the colours, and the décor, the furniture that we were buying. So we have a lot of staff voice here, which is important." PH3, Administrative Manager, Psychological Health

Outside of formal meetings and decision-making forums, such as Board and AGM, there is a level of participation in decision-making that comprises openness, and willingness that everyone's voice should be heard. Therefore, whilst some suggestions may not be taken forward, that will only happen after there has been a full hearing of a particular member of staff's idea or suggestion:

> "So if somebody comes up with something, and somebody said something like we were wondering what to do with some room, and someone was like, "Why don't we have it as a games room or sleep pods, or something like that?' And somebody's like, 'Woah, why would you want to?' And it's like no, no, let people come up with any ideas, it doesn't matter. We might take something from it. Let's consider it." PH2, Psychological Wellbeing Practitioner, Psychological Health.

Staff have a representative on the Board, who has been elected by the other staff in a democratic, one member one vote process. Her role is to take issues from staff to the Board for discussion, and to feedback what has been said at the Board to the staff. The aim is to aid participation in decision-making and to facilitate transparency. The staff director is seen to perform a useful role, with staff expressing satisfaction with both the position and how it operates.

However, there was a sense that her role was not fully utilised by staff, and that the staff director did not get as much engagement from staff as might be expected. When this was explored in interviews with non-managers, the reason given for this was that the organisation was so open and transparent, and that there were so many opportunities to contribute views and participate, that the staff representative was often not required. This was expressed by a number of staff, summarised by PH8:

> "But she [staff rep] said recently actually that people don't use her as much as she thought that they would, but my take on that is that people feel that their managers that work within here are so approachable that you almost don't need that in between person…But in terms of day-to-day things, the managers are so visible and so approachable that you almost don't need a middle man, like you can just go straight there. So I think that's perhaps why she doesn't get used as much as she probably thought she would." PH8 Trainee Psychological Wellbeing Practitioner, Psychological Health.

This is an example of how the practices of transparency and staff participation that emerge at multiple levels in the organisation over time, both formal and informal, can work towards making some of the formal staff representative mechanisms less relevant. By building practices based on openness and listening, the need to rely on mechanistic methods of participation becomes less frequent.

In Psychological Health, passage of time since formation and normalisation of information flows between management, staff and board have made participation in decisions an every-day process. Consequently, staff respond to the ability to participate positively. Staff considered their views and opinions to be valued and this can be encapsulated in the concept of voice, with staff views actively heard and respected within the organisation, and implemented where appropriate. The less experienced staff at Psychological Health talked about the inclusiveness and openness of decision-making within the organisation, which they expressed in a positive way as being integrated into the every day activities:

> "I think it's a really good way for everyone to sort of share ideas, and for us to keep updated on where the organisation's at, where we want to be, how we're going to get there, and get ideas from everybody as well, not just thinking well the management have had this meeting, and they've fed back to us that this is what happened. Like we're very much part of that meeting, and of what's going to happen next, and things like that." PH9, Psychological Wellbeing Practitioner, Psychological Health.

It is apparent that the levels of participation in decision-making that exists in practice at Psychological Health matches the intentions of the structure and rules that were incorporated into both of the organisations to promote such participation. Further, staff and managers have internalised staff voice, both in terms of participation in

decision-making and expectations around information flow. This has led to increased levels of trust, reciprocity and co-operation between the staff and management.

7.3.4 Comparing cases

Analysis of the data between cases highlights decision-making structures occur at what can be divided into three levels within the respective organisations. At the macro-level, the setting and changing of the organisation's rules of engagement, usually found in its constitutional documents, provides an overarching framework within which all other decision-making processes are subordinate. Any decisions by the Board or by directors are made within this framework. The agents with capacity to alter this framework have ultimate, albeit not necessarily day-to-day, control of the organisation. In Acute Health these agents are the UK Government. In both Community Health and Psychological Health it is the employees as shareholders.

The next level is the meso-level and constitutes formal decision-making capacity for operational matters. The Board, and any delegated authorities to its executive directors, is responsible for strategic direction and operational matters. At all times, the powers and capabilities of the Board and its delegates are constrained and enabled by the overarching framework set at the macro level. Any Board decisions or actions of executive directors must be within the authority delegated by the relevant constitutional rules. In Acute Health these are the constitution of the NHS Foundation Trust whilst for both Community Health and Psychological Health it is their respective Articles of Association.

The final level comprises day-to-day activities. These are usually informal, although they can follow formal procedures and rules, and involve on-the-ground direction and decisions made by teams, managers and clinicians as they go about their daily activities. They are constrained and enabled by the strategic and operational decisions made by the Board and the Executive Directors. For example, they may be operating within a financial budget set by the Board and so any decisions made will not permit them to spend money on their activities outside set limits. These decisions are made at the micro-level.

These three levels of decision-making, macro, meso and micro, provide a helpful framework to compare cases and how actors and agents participate in decision-making. They are not as relevant for the other mutual configurations, as decision-

making is more stratified in organisations than ownership and shared benefit. Table 7.3 divides the various powers that are actualised in each case study at each of these levels, to assess the extent of staff participation in the key resources of decision-making and information. The analysis here is slightly different from that in Sections 5.3.4 and 6.3.4 in that the three levels at which interactions take place are capable of being recognised and defined.

Table 7.3 Comparison of employee voice between case studies at three levels

LEVEL	**Types of interaction at each level**	**Acute Health**	**Community Health**	**Psychological Health**
MACRO	Staff power to change/influence constitutional documents	No	Yes	Yes
	Staff powers to elect directors	No	Yes	Yes
	Staff power to set direction of organisation	No	Yes	Yes
MESO	Staff power to achieve representation at Board meetings	No	Yes	Yes
	Board minutes and other information shared freely	No	Yes	Yes
	Staff Council or Staff Board to represent and discuss views of staff and make representations to the Board	Partial (staff representatives on Council)	Yes	No
MICRO	Non-hierarchical day-to-day decision making	No	Partial	Yes
	Inherently transparent organisation	No	Partial	Yes
	Inclusiveness and openness of decision-making	No	Partial	Yes

Source: Case study data

At macro-level, employees at Acute Health have no voice, with no capability to change or influence the rules that govern the organisation. This is contrasted with both Community Health and Psychological Health. In both organisations staff have the power to change rules and introduce new ones. Further, they elect some directors in their role as shareholder, whereas executive directors in Acute Health are

appointed with no direct staff involvement. Through collective action, as a majority, staff in both Community Health and Psychological Health can set the direction of the organisation, as they were doing through preparation for the AGM and values workshops respectively.

At the meso-level, staff have powers to be represented at Board meetings and to receive full information from those meetings at both Community Health and Psychological Health. In both cases they have exercised these powers enthusiastically, and managers and directors have encouraged this. In this regard, staff voice mechanisms have been engaged and actualised. This is not the case at Acute Health, where employees do not have any of these powers. Although employees have partial representation through the Council, it is limited with staff not engaging with it. This can be compared to the Staff Board at Community Health, which is active and working to be effective through staff activity, with the main Board acknowledging their role, sharing information and listening and responding to their requests.

At the micro-level, voice mechanisms at Psychological Health have translated into day-to-day openness and participation in decision-making. Without formal mechanisms at this level, over time the macro and meso-level voice configurations have become embedded so that they are internalised by staff and managers in informal ways. As discussed in Section 5.3.4, a dispersal of leadership occurs through staff participation in decision-making. In addition, the domain of effective service delivery, which the staff share as a community of practice, is influencing the decision-making process within this distributed leadership approach. Consensus occurs as managers and staff coalesce around shared ideals and perspectives in a similar manner to the interactions between employee voice, distributed leadership and communities of practice in Section 2.4.

This internalisation and distribution of leadership has started to occur at Community Health, but not to the same degree and so these mechanisms are only partially activated. Possible reasons for this could be attributable to the larger, multi-site nature of Community Health, the less time that the organisation has been in existence, and the still recent Local Authority legacy that permeates behaviours of staff and managers, which may not have resulted in the same levels of distributed leadership as in Psychological Health. Another reason could be the lack of effective communities of practice emerging, given the dispersed nature of Community

Health's services compared to Psychological Health, where staff are mainly delivering similar mental health services.

Acute Health, on the other hand, has not embraced any of the micro-level behaviours into its day-to-day activities. These are hierarchical, opaque and restrictive, rather than non-hierarchical, transparent and inclusive. The causal configurations of membership, conceived to be mutual when formed, have not challenged prevailing configurations of hierarchy and managerialism that existed prior to introduction of the Public Benefit Corporation model to Acute Health. In this sense, whilst there has been introduction of mutual type mechanisms, there has not emerged any mutualism or disruption of leader-follower relations.

7.4 Conclusion

Chapter 2 suggested the proposition that the generative mechanisms of voice, participation in decision-making, democracy and transparency operating within organisations, if engaged and actualised by staff, could lead to emergence of mutualism. Mutualism has been conceptualised as emergence of trust, reciprocity and co-operation in pursuit of a common purpose over time. Through the mechanisms identified in this chapter, there is evidence that this is occurring, particularly in Psychological Health and to lesser extent in Community Health. A reason for this is the interaction between a number of generative mechanisms operating at multiple levels of decision-making. These mechanisms, through agential engagement in the form of employees and managers, are enabling emergent mutual relations to develop. Chapter 8 will discuss possible theoretical applications that may explain how this interaction operates in respective contexts.

In contrast, where these mechanisms are not present, or where they may exist but are not sufficiently engaged and actualised, as is the case in Acute Health, non mutual behaviours arise, with managers engaging and actualising confidentiality, command and control and hierarchical structures. Staff exhibit disengaged behaviours and mistrust in managerial decision-making, notwithstanding the existence of mutual type membership structures and staff representation on the Council of Governors.

This suggests that the PSMs approach to date is likely to be ineffective as far as generating mutualism is concerned. Forming new entities with employee owned structures is no guarantee that mutualism will emerge. The process is much more

complex and requires an understanding of mutualism as an emergent concept, not merely as organisational practices. A complete explanation that would assist PSM development, accounts not only for organisational structures, but also generative mechanisms and the role of agents operating in context who engage and actualise these mechanisms. Without this, morphostasis, not morphogenesis, occurs with mutualism remaining a dormant, unexercised power.

Chapter 8 Discussion: mutualism and mutual practices in PSMs.

8.1 Introduction

Central to Public Service Mutual, or PSM, policy since 2010 is an aim to increase employee participation, by transferring service providers out of public ownership and into newly formed independent organisations owned or controlled by staff. By incorporating the terminology of "mutualism" extensively, there is a reasonable expectation that these new organisations will embrace both the philosophy of mutualism and its practices (Davies and Yeoman, 2013, p. 2). The aim of this research has been to investigate if this is the case, by exploring whether PSMs possess mutual practices and the process through which mutuality emerges.

Mutualism is both an idea about a set of co-operative social relations pursuing a common aim, and interrelated structures that comprise those relations, made up of trust, co-operation, reciprocity and common purpose operating over time. Both the idea and relations of mutualism mediate each other, and its practices, which are operationalised through a series of causal configurations. These mutual configurations of ownership, shared benefit, voice and transparency affect, and are affected by, the idea and relations of mutualism. When mutualism emerges, the causal powers of reciprocity, trust, co-operation and common purpose are engaged through agents actualising generative mechanisms and interacting with mutual configurations.

From a review of existing literature on PSMs and mutualism, a number of research questions were formulated, which are now ready to be answered. This chapter first summarises the results of the research carried out to provide a foundation for the discussion that follows. Each of the research questions is then answered in turn,

considered in the context of the research carried out and how the findings relate to, and differ from, the existing literature on PSMs and mutuality. There then follows a discussion about suggestions for further research into PSMs, acknowledging some of the limitations of the research conducted here. The chapter concludes with a summary of what the research, and this thesis, contributes to mutualism and PSM policy and how the gaps in the literature identified in Chapter 2 have been filled, as well as some reflections on the process of carrying out this research and the future for PSMs.

8.2 Summary of the research results

Two sequential phases of research were conducted, a large N survey followed by in-depth comparative case studies of three organisations. Together they sought to explore the four causal configurations, identified from the literature reviewed in Chapter 2, as comprising mutual practices. A causal configuration is a framework, drawn from Fleetwood (2004, p. 47), to examine phenomena and investigate causal powers. Used as a heuristic, it helps to abstract in more detail what makes up the social structures and generative mechanisms of mutual practices that can have an effect. Each configuration comprises a cluster of social structures (necessary relations required for a structure to exist), positioned-practices (roles and associated practices that agents adopt within any structure), resources, generative mechanisms and causal powers. Acting together they have the capacity to impinge on the actions of agents, shaping outcomes.

A survey of healthcare providers in NW England identified regularities concerning the four mutual configurations, when investigating their distribution amongst Public Trading, Private Profit Oriented and Social Trading organisations delivering healthcare. There was only limited evidence of these configurations being present in Private Profit Oriented organisations, whereas voice and transparency configurations occurred in Public Trading organisations, and all four were present in Social Trading organisations to some degree, particularly within the small number of PSMs that were part of the sample.

To investigate further, in-depth comparative case studies between three healthcare organisations were conducted. To analyse similarities and differences between both Public and Social Trading types of organisations, a NHS Foundation Trust with some

mutual traits (membership body) was compared with two PSMs. This enabled PSMs to be contrasted with a public sector owned organisation claiming to be mutual (Allen et al, 2012, p. 241) and also to compare between the two PSMs themselves. The research findings are summarised below, highlighting a number of separate, but interrelated, causal powers that were identified within each of the PSMs, albeit to differing degrees, that did not exist in the same form within the Public Trading case study.

8.2.1 Identifying causal powers

One of the rationales in using a causal configuration framework was to provide a method by which generative mechanisms could be isolated. In breaking down social structures in this way, it is possible to abstract and compare from the data different mechanisms and their associated causal powers. To highlight the findings, a version of Kempster and Parry's (2014, p. 106) framework (Table 8.1) for comparing causal powers and highlighting different patterns of causality has been adapted.

By clustering the findings as themes that emerged from the research data, they can be re-described and re-contextualised on a case-by-case basis to highlight similarities and differences. This process identified likely generative mechanisms with causal powers within the respective configurations that may have explanatory capacity. To provide a contrastive account of the respective powers, Table 8.1 categorises these as either A, B and C, following Kempster and Parry's comparative framework (2014, p. 106), with the results of the research transposed onto this framework.

Category A is present in a particular context and has similar effect across cases. For example, Equal Property Rights is a generative mechanism relating to equal share ownership found in both Community Health and Psychological Health, with a similar effect in both across a number of positioned-practices (shareholder, employee and owner). It has causal powers associated with co-operation and reciprocity, as well as common purpose. Category B mechanisms and powers are also present in a particular context, but are observed to generate a different set of events across cases. An example here is the membership generative mechanism. It was observed in all three cases (contexts) but created a sense of ownership in Community Health and Psychological Health but not in Acute Health. The associated causal powers of this sense of ownership were trust and co-operation evidence in Community Health and Psychological Health, which were less prevalent in Acute Health.

Table 8.1 Comparison of causal powers from analysis of three case studies.

Acute Health	**Community Health**	**Psychological Health**
Category A	**Category A**	**Category A**
None	Equal Property Rights Democracy (participation) Ownership/responsibility Equal participation in benefits Collective Motivation	Equal Property Rights Democracy (participation) Ownership/responsibility Equal participation in benefits Collective Motivation
Category B	**Category B**	**Category B**
Transparency: limited to Board Voice: limited participation, no engagement with elections Flexibility: inflexible: resistant to change Autonomy: limited team autonomy only Patient centred: public service ethos and professional Membership: not valued Trust: low staff trust Managerialism: high	Transparency: expected but emerging slowly Voice: organisation wide and at board but not yet fully integrated Flexibility: more options available; decisions made more quickly Autonomy: decisions bespoke to organisation Patient centred: public service ethos, professional, common purpose Membership: engenders community, valued by staff Trust: transition mistrust to trust Managerialism: inherited from Local Authority but transition to flat management structure	Transparency: fully transparent organisation Voice: organisation wide and board, also fully integrated Flexibility: more options available, decision made quickly, receptive to change Autonomy: decisions bespoke to organisation Patient centred: public service ethos, professional, common purpose Membership: engaged fully, sense of community, valued by staff Trust: High trust levels Managerialism: managers act as clinicians and managers
Category C	**Category C**	**Category C**
Secretary of State powers: UK Government control Public sector funding: exogenously set Hierarchy: multiple layers of management Control: managerial control exercised	None	None

Source: Adapted from Kempster and Parry (2014, p. 106) and case study data

Category C are those which are context specific to a case and do not appear in any form in another case. The confidentiality of information privileged to the Board at Acute Health is an example of this class of generative mechanism, one that does not

appear in each of the PSMs where transparency has been established. Confidentiality acts as a causal power, with a tendency to generate mistrust amongst staff at Acute Health.

By classifying in this way, the most likely generative mechanisms that have causal powers for mutuality to emerge from, and influence the operation of, mutual practices can be isolated and then compared and contrasted. Similar and contrasting causal powers and generative mechanisms provide a foundation for potential theories to explain the emergence of mutualism. These can then be applied to answer the research questions.

Table 8.1 reveals a fruitful area of discussion centres on the Category A mechanisms that appear to have similar effect within both of Community Health and Psychological Health. These include equal property rights and so egalitarianism, equal participation, participative democracy, shared economic benefit and collective motivation. These will be discussed in Sections 8.3.1 and 8.3.2. Those mechanisms that are context specific, Category C, are also discussed in these sections, highlighting how PSMs differ from public sector organisations delivering healthcare services. Category B powers indicate areas where different outcomes occur in different contexts, and the reasons for these differences are discussed in Sections 8.3.3 and 8.3.4.

8.3 Discussing the results

Chapter 2 presented a number of research questions arising out of the literature applicable to PSMs and mutuality. The following sections take each of these in turn, to answer them in the context of the research results and the existing theory and concepts from the literature.

8.3.1 What distinguishes PSMs from other organisations delivering healthcare public services?

The definition of PSMs, and in particular that adopted by the DCMS Mutuals Team (2017) focuses on three factors: (1) employee control, (2) organisations that have left the public sector and (3) continuing to deliver public services. The research data accords with these factors as distinguishing PSMs from other organisations

delivering healthcare public services. Each of the case studies that were classified as PSMs by the DCMS Mutuals Team (2017) complied with each element of this definition. Notwithstanding this, the research reveals a more complex picture.

The four causal configurations of ownership, shared benefit, staff voice and informational transparency, together with employee participation in them, generally concern the first section of the Cabinet Office definition: employee control. In investigating these four configurations, however, the other aspects of the PSM definition proved influential (leaving the public sector and continuing to provide public services) in that they each impinged on the operation of those four mutual configurations. As such they are worth noting here before discussing distinguishing features.

That PSMs have left the public sector, and are not newly formed organisations, means that each carries with it into its new status antecedent social structures, generative mechanisms, positioned-practices and tendencies from its previous existence as a state owned and operated entity. As the research data from Community Health demonstrated, these antecedents conflict with newly introduced causal configurations intended to provide greater degrees of employee control. For example, the level of informational transparency (Category B in Table 8.1) was new to employees at Community Health, who had previously experienced limited information flows at the Local Authority. Whilst the new transparency arrangements were welcome, staff were not experienced at handling information or knew how to process information effectively in decision-making activities. Managers were addressing this by holding workshops and team meetings where information about the organisation was discussed. In the early stages this was a new experience, requiring new behaviours to be developed, for both staff and managers.

One director, uncomfortable about sharing information not previously shared, had spent time consulting others to reach a position where she was able to do this freely. For staff, workshops were required to enable a fully informed decision to be made. Informational transparency continues to be a developing process for both staff and managers, as a consequence of the structures inherited from their previous incarnation as a Local Authority owned entity.

In contrast, at Psychological Health, a longer period had elapsed since they had left the public sector and so there had been more opportunities for information to flow more fully and freely. Staff achieved a greater understanding of what influenced

decisions and were able to incorporate this knowledge into their decision-making processes. The level of transparency that had developed over time was such that formal processes were no longer considered a priority, as information was shared informally at all levels of the organisation and staff felt included. Here, the context created by the transparency configuration, the information sharing mechanisms and its reproduction by managers and staff over time has resulted in transparency as an embedded idea and practice. In turn, it feeds into voice mechanisms, such as weekly values meetings, with staff able to fully participate in discussion and decision-making processes. This is an example of morphogenesis (Archer, 1995, p. 157), with structural change occurring over time as agents are enabled by the generative mechanisms of transparency to activate the related voice mechanisms to effect change in decision-making structures.

That PSMs continue to deliver public services, and the type of service they deliver, also influences the causal configurations that may emerge. Some PSMs are profit making, such as MyCSP, mentioned in Section 2.5. In contrast, both of the PSM case studies researched here elected not to distribute surpluses to owners, reflecting their genesis as an organisation that had originally been part of the public sector, with a public sector ethos, not prioritising profit generation or individual gain.

The difference in how surpluses are treated between the two PSM case studies and MyCSP can be attributed to the services they carry out. Both of the former deliver healthcare services, which are free at the point of delivery. MyCSP manages the civil service pension fund, and as such is a management operation rather than a public service. The type of service that PSMs carry on when they leave the public sector, therefore, influences how they are configured, such as whether they are profit distributing or not. A service such as healthcare, which had previously been delivered by the NHS or a Local Authority, on the evidence from the case studies, will be more likely to be configured as not for profit distribution, unlike a PSM which is delivering management functions only, such as MyCSP. The type of public service and the previous public body delivering them, therefore, is influential in the causal configurations within any new PSM.

Turning to what distinguishes PSMs, both the survey data and data gathered from the three case studies provided a number of areas where PSMs demonstrate marked differences in organisational structure to justify them as a separate type of organisation. The impact of alternative structural and cultural properties was

examined in different case studies, with the similar ownership arrangements of Community Health and Psychological Health, where ownership had transferred from local government and the NHS to employees. This compared with Acute Health, where ownership remained with the NHS.

Notwithstanding the adoption of membership body formats by NHS Foundation Trusts (Allen et al., 2011, p. 80) they remain state-owned. This is not the case with the two PSMs, which are both independent, and autonomously owned. They exist in legal form as Community Interest Companies, owned by their respective staff, and so each is a member owned business (Birchall, 2011, p. 170), albeit without employee investment. In this sense, PSMs can be classified as "Third sector organisations (including social enterprises)" (Allen et al., 2011, p. 81), with no capital contributions attributable to shares. This classification does not mention mutualism or mutuality, which accords with data from Psychological Health, which staff described as a social enterprise rather than a mutual. That they were included on the DCMS Mutuals Team interactive map of PSMs was a surprise to the managing director.

The literature concerning co-operative and mutual enterprises privileges ownership as a key differentiator in determining whether or not an organisation is a mutual one (Birchall, 2012, p. 147). Ownership was identified in Chapter 2 as more than a typology. It can contain significant structural and cultural properties that aid emergence of mutualism, through the capacity to challenge corporate agency that dominates resources within an organisation and the ideational (cultural) hegemony of existing generative mechanisms that historically exist in public sector state owned organisations, such as Acute Health.

In line with previous findings by Allen et al (2012, p. 253) into NHS Foundation Trusts, nothing derived from research into Acute Health classifies it as a mutual organisation, notwithstanding its member body status. Its ownership remains with the state not with members, and any surpluses gained by the operations of Acute Health cannot be distributed to members. Its membership alone does not make the organisation a mutual one in practice.

In addition, the research confirms Allen et al's (2012, p. 253) assertions that notwithstanding the membership and governance structure, there is very little evidence of staff being involved in decision-making either at a macro (constitutional rules) or meso (board) level. This implies that any staff involvement in the

ownership, decision-making and shared benefits, which the New Mutualist authors claim to be critical to a mutual organisation (Leadbeater and Christie 1999; Rogers 1999; Birchall, 2012) are not present in Acute Health.

As reasons for this, Allen et al (2012, p. 253) highlighted the lack of a link between membership and being an employee; active membership is not a condition or requirement of employment. This was supported by the research into Acute Health, where all but six employees were members, but this level of participation was attributed to an opt-out membership policy for staff. Employees are automatically enrolled as members unless they actively decide not to be. Whilst all staff interviewed were members because they had not opted out, they were not active members, and did not participate in elections of governors nor concerned themselves with who the governors were.

Allen et al. (2012, p. 253) claim lack of ownership as an underpinning reason for this type of indifference, and certainly both Community Health and Psychological Health, where membership and ownership are coterminous, both indicate that there may be such a causal link. However, the research carried out suggests there may be a more complex set of causal powers at play than the direct link between ownership and membership or the wider point they make about membership being voluntary.

The interaction between ownership, voice, transparency and shared benefits does not map directly onto mutualism. The structures and generative mechanisms comprised within each of these configurations operate to develop trust, reciprocity and co-operation, causal powers that work towards a common purpose over time. This is not linear and sequential, but messy and iterative. It is through these multiple interactions and feedback loops that membership becomes an effective structure for change, not through one-to-one mapping between membership and ownership, as Allen et al. (2012, p. 253) have suggested.

Both Community Health and Psychological Health, through equal value shareholdings, high levels of democratic participation in decision-making and governance, informational transparency and benefit sharing, can be considered mutual organisations in Birchall's (2011, p. 170) sense of a member owned entity. This is despite there being no mention of mutuality within the Community Interest Company legal definition, nor in the respective constitution and rules of either organisation or even in the discourse of Psychological Health's employees.

The research findings show the presence of high levels of transparency and participation in decision-making, which are embedded in the constitutional rules of both Community Health and Psychological Health, whilst also being embodied in the day-to-day practices of staff and managers, albeit to different degrees. The sense of ownership that comes with having an equal share in the organisation may contribute to staff actively participating in governance and other structures. In addition, the levels of information sharing, and ease and encouragement with which staff can participate in decisions, plus active forums to do so, increase levels of participation throughout each organisation. As will be discussed in Sections 8.3.4 and 8.3.5, this suggests that mutuality is beginning to emerge, weakly in the case of Community Health, but more strongly in Psychological Health, regardless of name or legal form of the organisation.

The distinctions, then, between PSMs and other public healthcare organisations such as Acute Health lie in their respective causal configurations concerning ownership, decision-making, transparency and shared economic benefit. The next question concerns these configurations and the generative mechanisms operating within them.

8.3.2 What generative mechanisms operate within PSMs compared to public sector organisations delivering healthcare?

A number of generative mechanisms were identified as present in the two PSMs, but not in Acute Health. In contrast, a number of mechanisms where found in Acute Health that are the antithesis of those in the PSMs. In particular, confidentiality, hierarchy, control and managerialism, all identified from the research data in Acute Health, contrast significantly with transparency, egalitarianism, participative democracy and employee participation, which were found to various degrees in both Community Health and Psychological Health (see Table 8.1).

Applying concepts developed in Chapter 2 demonstrates that a number of generative mechanisms are significant to the operation and practice of mutuality within PSMs, each with a participative element to them. These are egalitarianism, equal property rights, participative democracy, sense of ownership/responsibility, shared economic outcomes and collective motivations. Each of these mechanisms is present in one or more of the four mutual configurations of ownership, voice, transparency and shared benefit.

Democracy (Rogers, 1999, p. 32) is a key aspect of mutuality and so a potential theoretical explanation of possible generative mechanisms within mutual causal configurations. When actualised, democracy provides causal powers associated with mutuality and mutual organisations. Participative democratic principles, both direct and representative, are present within each of the PSM cases, operating at multiple levels of decision-making.

This conceptualisation of democracy is also in keeping with one of the principles of the International Co-operative Alliance (2017), which states that a co-operative should have democratic member control, with members creating the organisation's rules, and decisions made, with equal voting rights. This latter principle aligns with the form of participative democracy present in the rules and norms of each of the PSM case studies. As a theoretical concept to describe the democracy mechanism in the PSM cases, participative democracy, with every member taking part on an equal basis, is an appropriate concept to explain what is happening.

However, rather than being enshrined in the legal form of the organisation *ab initio*, as is the case with a traditional co-operative organisation (Allen et al, 2011, p. 82), in the respective PSMs these principles were incorporated by choice. The research shows that, notwithstanding the legal form selected, participative democratic mechanisms existed within each of the PSMs. This is in contrast to Acute Health, where a form of representative democracy exists, and is enshrined in the relevant constitution of Acute Health through legislation, but which staff had not engaged with. In essence it is not effective. Both PSMs possess participatory democratic generative mechanisms that have been fully actualised. This is similar to the way democratic mechanisms are incorporated into fully mutual organisations associated with member owned co-operatives (Birchall, 2011, p. 170). How this mechanism has been actualised in the PSMs, and why it has not in Acute Health, is discussed in Section 8.3.3

A second generative mechanism that is revealed by the research to be operational within PSMs is egalitarianism, encompassing a belief that all are equal, a foundational principle of co-operatives and mutualism (Rogers, 1999, p. 32). In the context of a bounded organisation such as a PSM, however, the concept requires greater specificity to relate solely to the operations of relevant members within the organisation, rather than the society wide applicability of the some of the New Mutualist authors discussed in Chapter 2, such as Rogers (1999, p. 32).

In both PSMs, egalitarianism is enjoyed through a number of causal configurations. It starts from the shareholding structure, where every member of staff eligible for shares is granted one share of equal worth and value to every other share. This egalitarian mechanism also runs through the democratic principles of decision-making (one member one vote) and participation in economic benefits of the organisation (everyone participates equally through reinvestment of surpluses rather than distribution of profits based on performance).

Howieson (2016, p. 668) has linked egalitarianism with shared benefit, which was also identified in the research. This link can be taken further, and include participative democracy and equal access to information as well. All of the generative mechanisms identified in the research as generating mutual outcomes are underpinned with the principle of equal participation for all members through egalitarian generative mechanisms.

Equal access to information, as part of a causal configuration based around transparency, is a third generative mechanism present in both PSMs, but which is absent in Acute Health. Instead, the opposite mechanism of confidentiality is the most prevalent information mechanism in Acute Health, with managers and the board mandated to maintain confidentiality at all times. This is in contrast to both PSMs, where transparency is a founding concept of the rules of each organisation, as well as having been enacted on a day-to-day basis. Rogers (1999, p. 32) cites openness and transparency as key tenets of mutuality, engendered to foster the causal powers of reciprocity and trust.

The final generative mechanism relates to equal participation in the economic benefits of the organisation. As a member owned organisation, the staff in each PSM can set the rules, and as shareholders have determined that any surpluses are to be re-invested in the organisation to promote their social mission and the sustainability of the business. These have become the shared, or common, purpose of the organisation and its members. By aligning staff with a common purpose (patient centred and social mission) the generative mechanism fits with the state funded services that the organisations are delivering. With the absence of profit, social mission and delivering quality patient services are aims binding staff to a common purpose.

A patient centric focus was one area where all three entities expressed a similar common purpose as being the reason they are part of the organisation. Consultants, nurses and technicians at Acute Health said that doing the best for the patient was the

reason the organisation existed, and a rationale behind their motivations to do their job. This was repeated throughout Community Health and Psychological Health, with slight variation in terminology, but similar sentiment. However, the two PSMs went further than just patient focus, and talked about their social mission, which was generally concerned with a contribution to their community's health and well being. This difference between Acute Health and the two PSMs represented an additional common purpose to the patient centric focus that is prevalent in public sector healthcare organisations, with a wider aim of a social mission focused on helping the community that each PSM served.

Four causal configurations have been identified from the research as operating within PSMs, incorporating separate generative mechanisms, each with some form of full and/or equal participation as a key component. This leads to a conceptualisation of the generative mechanisms based on full and equal participation in ownership, economic benefit, decision-making and information by all employees (managers and staff). This is different to employee control, as suggested by Le Grand (2012, p.10) and the DCMS Mutuals Team (2017), which does not go as far as the full and equal participation the research suggests. PSMs are not necessarily defined by employee control and a more complex form of mutual causal powers is in operation. As will be discussed in Section 8.3.5, these causal powers include trust, reciprocity and co-operation, as opposed to control and hierarchy.

8.3.3 How do agents interact with these generative mechanisms in PSMs in comparison to public sector organisations delivering healthcare?

The following discussion examines the research through the lens of corporate and primary agency (Archer, 1995, p. 259; Archer, 2003, p. 124) as a framework to answer the question of how agents interact with the respective generative mechanisms that have been identified in Section 8.3.2. The distinction between corporate and primary agency is explained more thoroughly in Chapter 1. Through the possession of the means to influence and shape structural and cultural formation, corporate agents organise and promote their goals and aims and thus affect the context within which primary agents operate. In contrast, primary agents do not have the same influence over systemic organisations, nor do they express their goals or organise in the same way as corporate agents.

When Psychological Health transferred out of the NHS to become an independent organisation, senior managers and board members within the organisation promoted ideas of autonomy, independence, flexibility and social mission, along with the acquisition of organisational resources associated with ownership and financial participation. As CH6, the Chairman, said in Chapter 5, a conscious choice was made so that the organisational form was congruent with their aims. These are the properties of corporate agency (Archer 1995, p. 263).

Likewise, for Community Health, the leaders of the original Local Authority service directorate influenced the form of the organisation when the transition was being planned. In meetings with staff, reinvestment of all surpluses back into the organisation and creating an employee-owned entity dedicated to providing a service to the community were themes discussed and agreed. These discussions led to the causal configurations of ownership and shared benefits that were embedded into the structures of Community Health from the outset. As with Psychological Health, these were conscious choices to create social structures to match social aims of all employees.

Corporate agency in Psychological Health has not resulted in the protection of antecedent practices through adoption of the same homogenous bank of cultural ideas and structural resources from the NHS that managers previously experienced, and which were identified to be present in Acute Health. An example of this occurs in the data where there has been a rejection of the policy to reduce administrative staff that occurred in the previous host organisation. Instead, Psychological Health tripled the number of administrative staff in an effort to free clinician time so that they can concentrate on patients. This is contrary to prevailing NHS practice, and represents activated corporate agency in pursuance of flexibility and autonomy.

Possible explanations for this outcome may be the development of distributed leadership practices, where multiple voices are heard, combined with communities of practice around service delivery, as discussed in Sections 2.4, 5.3.4 and 7.3.4. The decision-making processes have moved away from the top down leadership of the NHS. Instead, a dispersed leadership model reflects consensus on quality of service delivery through enabling clinicians to focus on their practice areas. Psychological Health agreed a course of action reflecting a community of practice not dominated by cost efficiency, as the previous NHS entity was, but rather one where quality outcomes are prioritised.

There has been less progress made by Community Health in releasing the organisation from antecedent practices. There was evidence in the data of staff following previous ways of working, such as remaining at their original work site rather than operate on multiple sites across geographic areas, as was intended in the new organisation. Many of the procedures operated by the Local Authority are also still present within Community Health. A reason suggested for this was the early stages of the organisation and the short time since its transition, with the intention that changes would be effected over time to develop processes and practices that were bespoke to Community Health.

This suggests corporate agency at Community Health is at a less advanced stage than in Psychological Health. Possible reasons for this from the data, as well as the time period elapsed since transition, include respective sizes of organisations. When Psychological Health left the NHS there were eleven employees, whereas there were 240 in Community Health. This would imply a simpler process to introduce changes, and for primary agency to become corporate agency, amongst eleven people compared to 240.

Another reason suggested may be the comparative demographic profile of staff at each organisation. There was evidence in the data that Community Health's staff were longer serving, compared to Psychological Health where two thirds of the staff were new to the organisation since transition. This would mean that new staff were joining an organisation without any antecedent attitudes from the previous incarnation of Psychological Health, unlike Community Health were it is broadly the same staff bringing similar approaches that they had experienced in the Local Authority. This emphasises the importance of agency in the successful development of mutualism within PSMs, an issue that was overlooked by Le Grand (2011) in the evidence cited to support PSMs discussed in Chapter 2. Moving from primary agency to corporate agency is a significant step in embedding mutual practices, with implications for the development of PSMs. Strategies to enable such transition are required as part of the process, as well as introducing the relevant causal configurations to the organisation.

In contrast, the hierarchy and control managerialism present in Acute Health provided clear differentiation between the goals of the corporate agents, comprising senior management, and the individual projects of the primary agents, such as nurses, technician and administrative staff. The interaction between corporate agency and

primary agency can be seen in operation in the following example from the research findings.

The Matron in charge of nurses at Acute Health engaged primarily with only the ward Manager, who then dealt with the ward nurses. In the other direction of the hierarchical chain of command, the Matron engaged with the deputy Chief Nurse. Here, the corporate agency of the organisation's hierarchy is reproduced. When a nurse tried to subvert this hierarchy, as AH6 did, and e-mailed the Chief Executive direct, she acted as a primary agent and the corporate agency around the hierarchy disapproved of her actions. She was then discouraged from doing it again. Corporate agency reproduces hierarchy and control, and, as leader-follower prevails, primary agency is limited to isolated action.

Through group interaction, the structural and cultural properties of Acute Health delineate the extent of corporate agency and differentiate it from primary agency (Archer, 1995, p. 264). This occurs with managers at Acute Health maintaining distance from staff, both in terms of access to decision-making and through hierarchical means. The difficulty faced by AH6 trying to supersede the hierarchy with her e-mail to the Chief Executive is an example of the distance placed between management and staff to maintain hierarchy and control, with limited evidence of distributed leadership.

Through corporate agency of the senior management team, the structures of managerialism and hierarchy, together with the cultural properties of control, are promoted and maintained for primary agents to work within. By distancing the senior management team from day to day operations, their corporate agency maintains a managerial socio-cultural system, restricting the ability of staff to actualise the powers of voice and transparency that are part of the mutual structural properties introduced through the NHS Foundation Trust model.

Staff have engaged in limited corporate agency, but that has been intermittent and on a team-by-team basis. The nurses have introduced procedures and processes around the theme of responsibility in an effort to revitalise the nursing staff, using some processes not employed elsewhere in the organisation. An example of this type of community of practice was AH2, a Ward Manager at Acute Health, asking nurses to run their own meetings, with her on hand to mediate but not lead. This resulted in limited engagement initially, but as nurses realised that they had a greater team voice, they have started to engage with issues.

The technicians conducted similar behaviours, with their own limited corporate agency emerging over time in their resistance to the hierarchy and command and control environment. The corporate agency of the technicians can be contrasted with that of the nurses. The technicians exhibited an isolationism, and otherness about the organisation, which bound them together. The corporate agency of the nurses, on the other hand, emanated from a new cohort of managers, with a mandate to improve quality following the issues of performance at Acute Health that were discussed in Chapter 4.

Contrasts occur at different levels in the organisation. The strong hierarchical nature of the chain of command from the nurse on the ward, through line managers, with each step adhered to and enforced, with limited or no feedback, re-enforces existing managerial tendencies. This is at the expense of the actualisation of the mutual structural and cultural properties intended to increase participation in the decision-making functions of Acute Health, through the operation of generative mechanisms that are part of the causal configurations of voice and transparency. Within each of the nurse and technician cohorts, a different team ethos prevails, but not one induced by formal voice mechanisms, such as those introduced through membership.

A different picture emerged at Psychological Health and Community Health. By leaving the NHS and Local Authority respectively, structural and cultural emergent properties of staff ownership have allowed the senior management team to promote mutual strategies of participation, voice and transparency through the organisations, rather than traditional command and control strategies prevalent in Acute Health. In turn, working within this context, primary agents have found congruence with their own personal projects, and have embraced the structures of voice, ownership, transparency and participation in shared economic benefits into their working lives, becoming themselves corporate agents.

An example of this was explained by PH7, in Chapter 6, in how career advancement training by staff at Psychological Health was funded. This started as a personal project, with staff keen to receive training in new skills to improve their careers and marketability in the profession. By funding training through the organisation, and using shared surpluses, enhanced training has become a benefit that improves staff career development and organisational performance. In time, the primary agency of staff seeking training becomes the corporate agency, and community of practice, of re-invested surpluses in improved organisational quality.

In Community Health, examples of personal projects by staff congruent with corporate agency promoted by senior management are mainly seen in efforts to reduce costs and increase sustainability as a business. Individual staff proposed new business ideas and cost saving measures, or actively engaged in cost reduction measures such as switching off lights and changing suppliers to cheaper local ones. This is not universal, and there were suggestions that not all staff were embracing the mutual ethos to the degree exhibited in Psychological Health.

Notwithstanding the differences between Psychological Health and Community Health, expanding the cohort of corporate agency has ensured that structural and cultural emergent properties of mutualism (reciprocity, co-operation, common benefit) have been actualised through agential interaction with the generative mechanisms, so that their powers are capable of operating within the organisation, albeit to differing degrees. In this way, the corporate agency operating within Psychological Health has the effect of enabling the structural and cultural powers attributed to mutualism to operate, with the prospects of mutualism emerging over time, whilst corporate agency in Community Health is beginning to have this effect but at a much earlier stage. The corporate agency of Acute Health, on the other hand, acts as a barrier, by blocking the emergence of mutualism notwithstanding its membership structure.

Having set out a framework within which to examine how agents interact with generative mechanisms, Section 8.3.4. applies various theories to this framework to explain why agents make the decisions they do.

8.3.4 What enables and/or constrains the operation of these generative mechanisms within PSMs?

The discussion in Section 8.3.3, concerning how different agents within organisations engage with various mechanisms, draws attention to those aspects of the literature that deal with the concepts of trust, reciprocity and co-operation. The high levels of trust exhibited between staff and the organisation at Psychological Health, and the co-terminus actualisation of mechanisms associated with mutual configurations, can be contrasted with the low levels of trust exhibited in Acute Health, where no such actualisation had taken place. To understand and explain the enablers and constraints of the operation of those generative mechanisms, the following discussion re-visits the theories and concepts of trust, reciprocity and co-

operation reviewed in Chapter 2 to examine whether those theories adequately explain the actualisation of these mechanisms.

As discussed in Chapter 2, trust is a complex social structure within organisations that has the capacity to organise interactions. How trust relations interact will be determined by the existing and pre-existing causal configurations present within the organisation, with continual interaction between agents of stasis (managers engaged in hierarchy and command and control) seeking to reproduce existing relations and agents of change (managers and staff engaged in voice and transparency) seeking to transform them (Reed, 2001, p. 216).

Applying the outcome of the discussion of corporate and primary agency in Section 8.3.3, degrees of trust will emerge through the actions of those purveyors of stability and change within the organisation. Where corporate agents in Acute Health embodied hierarchy and control, using existing managerial and rule based causal powers to continue these social structures, then stability or morphostasis emerged at the expense of the trust structures that were intended to be engaged through the membership arrangements.

The contrasting corporate agency at Psychological Health embodied a different set of causal powers, with mutual practices of participation, voice and transparency emerging within the organisation, rather than traditional hierarchy and control practices that had been prevalent in the NHS. These mutual practices sit alongside administrative processes that were adopted from the NHS, such as financial and human resource practices. Trust structures prevail over control in those circumstances as staff engage in mutual practices, even within the strong structural constraints of antecedent historical practices from the NHS.

In Community Health, an interim position was apparent from the data. Staff engaged with mutual practices to different degrees and at different rates of engagement, so that trust between the staff and the organisation (acting through management) was in a state of flux. An example of this from the data was the “othering” of the Board by a member of the staff board. Whilst there was evidence of strong engagement with the process of voice through the staff board, there remains a degree of “us and them” through the staff board member’s descriptions of the two boards. This suggests a transitional period.

The findings from Psychological Health support Reed's (2001, p. 217) assertions about opportunities within existing structures enabling innovative organisational causal configurations, such as staff ownership and resource participation here, to overcome the status quo. This enables complex social structures such as trust to be re-combined to generate greater trust at the expense of managerial control. At the same time, the more disparate, transitional position in Community Health emphasises the complex nature of trust relations. New causal configurations reflecting mutual practices do not automatically cause trust to emerge.

Once trust has been increased through the operations of structures and mechanisms in the organisation, with control from managerial sources dissipating, reciprocity and co-operation are also enabled through vertical and horizontal relations within these structures (Sanders and Shyns, 2006, p. 514). The research supports the conceptualisation of "…equivalence, immediacy and interest…" as being relevant to how staff treat reciprocal and co-operative relations within PSMs. In both Community Health and Psychological Health, staff valued what they received in return for their contribution, whilst also expecting that the mutual benefits of reciprocity and co-operation would eventually emerge to theirs, and the organisations', collective benefit. Their interests coincide with that of the respective organisations. These were sustainability, social purpose and continued employment in Community Health and social purpose, workplace enjoyment and career development in Psychological Health.

The complex interaction of these elements of mutuality has the effect of enabling the generative mechanisms to be actualised. Through trust, reciprocity and co-operation, staff experienced their own interests and projects promoted in equivalent ways to the organisation. There is unity of purpose and desired outcome, which encourages staff to participate in the mechanisms that are present. At the same time, managers are moving away from traditional hierarchy and control processes to encourage such participation.

By contrast, hierarchy and control and associated managerialism remain within Acute Health, and as such have crowded out the membership-related mechanisms. Trust between staff and managers is low, whilst managerial control is high. This is not a direct relationship, because there was also limited evidence of co-operation and reciprocity between staff and managers at Acute Health. What co-operation took place, however, occurred at local level, not organisation wide, with relations within

teams demonstrating higher levels of trust, as well as reciprocity operating within teams.

Vertically, between staff and managers, dealings were transacted on a rule based, contractual mechanism, such as employment contracts and collective bargaining agreements with trade unions (Sanders and Shyns, 2006, p. 509). This resulted in little co-operation and reciprocity between staff and managers, leading to low trust levels and high managerial control. This brings matters to the final research question to understand these relations.

8.3.5 How can mutuality be conceptualised within PSMs?

The building blocks of a conceptualisation of mutuality comprise key tenets of critical realism: ideally real and socially real entities. Mutuality, when analysed in critical realist terms, is both an ideally real cultural system and socially real structural system. It comprises a cultural system in that it consists of a series of discourses, ideas and concepts based on co-operative social relations in pursuit of a common aim. In this sense mutuality is ideally real and can "…make a difference." (Fleetwood, 2004, p. 33). Mutuality as an ideally real entity has cultural emergent powers (Archer, 1995, p. 179).

Mutuality is also socially real, based on social relations such as co-operation, reciprocity, trust and common purpose (Kellner, 1998, p. 8; Rogers, 1999, p. 32; Howieson, 2016, p. 668). These also have the capability of affecting the world in some way, in the sense that they are a set of relations between humans that are dependent on the actions of social actors in order to be reproduced and transformed. Mutualism cannot be touched or seen, but its effects can be experienced.

A theme arising from the research, which was first identified in the literature, is that the idea and structure of mutuality in PSMs is made up of the inter-relationship of several theoretical concepts. This research identified trust, reciprocity and co-operation in pursuit of a common purpose over time from the literature on mutuality and co-operation as potential theoretical concepts that combine to comprise mutualism. Drawing on the analytical separation referred to above, the ideally real entity of mutuality encompasses these various theoretical concepts as a cultural system, mediated by relations between individuals acting through social structures that reflect the concept or idea of mutuality. In this way a concept of mutuality has

been developed using theories relating to trust, reciprocity, co-operation and common purpose, along with the associated temporal aspects of these concepts (Axelrod, 1984; Reed, 2001, p. 217; Sanders and Schyns, 2006, p. 509).

The literature discussed in Chapter 2 provides a series of theoretical bridges between the four aspects of mutuality identified, with each interacting with the others to reinforce their presence over time. The research carried out into the three case studies broadly confirmed this theoretical approach. Two PSMs at different stages of their lifecycle provided a useful frame to consider the impact of time on the interaction between the four aspects of mutuality, whilst the contrast between a public sector owned organisation and two PSMs provided a comparison between organisations with embedded social structures designed to foster mutuality.

Acute Health staff spoke of high levels of control and hierarchy and low levels of trust and co-operation, with limited reciprocity evident in what was a contractual, rule based relationship between staff and the organisation, acting through the agency of management. The membership and staff representation mechanisms did not generate changes in this balance towards control and away from trust.

This was reflected in part in Community Health, where, due to it being in the early stages of its lifespan, evidence was gathered that some of the antecedents from the public sector organisation it had transferred out of still had residual effect. Mistrust, inflexibility and hierarchical control were still fresh in the recollections of staff interviewed, particularly in the context of the way the organisation left the public sector, with high levels of mistrust evident and suspicions of secret or hidden agendas in operation. The staff in Community Health were predominately long serving members of the public sector host organisation, and so bring with them the cultural and structural systems they inhabited into Community Health, which are still present in the earlier stages of the organisation's new incarnation.

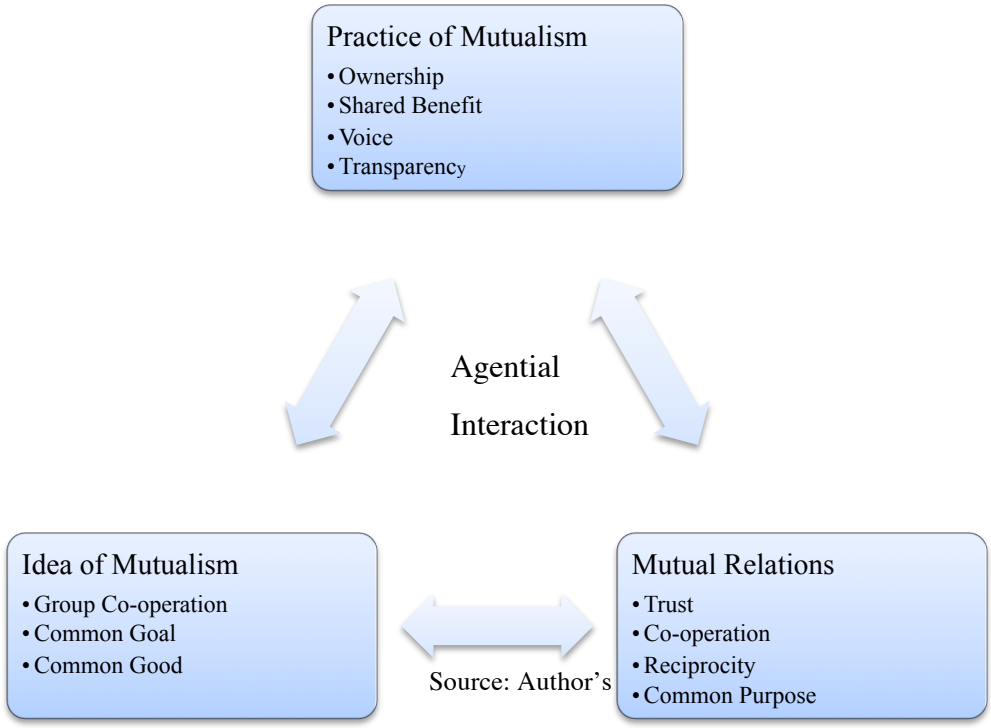
At the same time, trust and co-operation were beginning to emerge in early stages as a consequence of the levels of transparency prevalent and the ability for staff to be heard and participate in decision-making, particularly at the AGM and Board level. A sense of ownership and responsibility was starting to take hold amongst staff, with activities focused on active cost savings through individual staff action and ideas for new income generation.

These mechanisms of staff participation are more advanced in Psychological Health, with the longer lifespan of the organisation creating distance from the antecedent practices of the NHS organisation that they transferred out of. Consequently, staff spoke positively of the participation mechanisms within the organisation, and there was a sense that these were embedded and inhabited by social actors and agents alike. This was evidenced in the high levels of trust exhibited in the organisation and in managers, with limited examples of organisational or managerial control. Co-operation and reciprocity have emerged within the organisation, evidenced by openness about staff pressures and managerial recognition that overtime and more work was not the way to address staffing shortages.

Further, the staff recruitment practices moved away from the reduced administrative functions prevalent in the NHS, designed to reduce headcount and staffing costs. Psychological Health had increased the numbers of administrative support in order to free clinical staff from administrative activities and enable them to focus on their clinics and patients. The freedom to decide how they allocated resource was enabled by being free from external budget constraints not specific to the organisation. With autonomy to focus on their own social mission of treating patients, rather than be constrained by wider NHS issues, staff were able to co-ordinate their efforts towards the same purpose in a co-operative and reciprocal manner.

With these social relations of trust, reciprocity and co-operation embedded within an organisation, they reduce the requirement for control and hierarchy exercised by external owners and internal managers, through diffusion and dispersal of ownership, voice, economic benefit and access to information amongst all employees. At the same time, mutual social relations reduce control and hierarchy in favour of intra-organisational trust, co-operation and reciprocity. The research data has demonstrated that, over time, the causal powers of shared ownership, equal voice, shared participation in economic benefits and transparency increase the embedded nature of these social relations (Figure 8.1).

Figure 8.1: Interaction of the idea, relations and practices of mutualism



Mutualism operates at multiple strata, as a cultural entity, social relations and practices. The interaction between these is complex and iterative, with feedback loops and multiple back and forth as the various structures and mechanisms at each level interact with agents. Through agential interaction at each level, the mechanisms and causal powers are respectively actualised, as in the case of Community Health and Psychological Health, or are not, as in the case of Acute Health.

In summary, one theoretical concept does not explain how mutuality emerges within PSMs. A complex interaction of a number of theoretical concepts is involved. Trust is significant, and encourages both reciprocity and co-operative behaviour, which in turn increase trust and so on. However, what binds these concepts together is a common purpose. When staff engaged in a shared purpose, which they have constructed themselves using their effective voice structures, they appear to activate and actualise the participation mechanisms present in the PSM organisations that are intended to enable mutuality to emerge.

In turn, this generates greater levels of trust, reciprocity and co-operation, which lead to wider and more active participation and so on. It is through these mechanisms and social structures that mutuality, as a cultural system as well as a set of embedded social relations, emerges and strengthens the mutual practices that exist in the organisation. As represented in the two-way arrows in Figure 8.1, this elaboration is constant and multi-directional, with the mutual ideas, relations and practices as emergent entities. This represents an explanatory framework to explore mutualism within PSMs and acts as the base for further research to be carried out.

8.4 Further research

This research project was exploratory, as a necessary step in building a research agenda, reflecting both the early stages of the PSM policy and the disparate state of the mutuality literature. Despite its explorative nature, the research offers some insights into PSMs and how they develop when they have left the public sector, and will serve as a base for future studies and research, offering a framework for the exploration of mutualism within PSMs. Having undertaken this exploratory study, there are a number of areas of further research that would add to the field of mutualism and PSMs.

One such area concerns the development of mutualism and mutual practices within PSMs over time. The investigation in this thesis was cross-sectional, which was helpful in comparing three organisations at different stages of their existence. However, effective research into change in one organisation over time is not possible with this method. A further study could assess the long-term effects of mutual practices in PSMs using longitudinal techniques. The differences identified between Community Health and Psychological Health suggested there might be a temporal element to the emergence of mutualism and the effective actualisation of mutual practices in PSMs. A longitudinal study would permit this to be explored further, and to abstract other entities that enable and prohibit mutualism's emergence.

Research into other sectors of public service delivery would also be worthwhile. This research focussed on one sector where PSMs are operable, the health care sector. Whilst this decision is justified in Chapter 3 due to the high proportion of PSMs in that sector, it is recognised that different sectors provide different contexts for PSMs. The findings relating to mutuality in the health sector, and especially when compared

to NHS organisations, may not be directly applicable to social care, education, leisure or other sector activities.

The reason for this, and consistent with the critical realist approach, is that other sectors may provide differing contexts within which mutualism can emerge. The antecedent structures of PSMs in the health sector may be different from those in library or probation services. Further research is suggested in these areas to explore the differing contexts, again to assist the development and formation of PSMs in different sectors and to aid the policy as it continues.

An issue with this research was that it focussed on a single cohort of participants in PSMs, namely employees. This was justified as current PSM policy, discussed in Chapter 2, prioritises employee owned PSMs. Being limited in this way, however, this research does not offer anything in relation to multi-stakeholder and in particular, service user, mutual organisations. The emergence of mutualism in employee owned PSMs is likely to follow a different path than multi-stakeholder PSMs, where different participant cohorts may have different incentives and priorities. Research into such organisations, using the same framework developed here, could examine these differences, and compare cohorts of participants accordingly. If there were significant enablers and inhibitors to mutualism revealed as a consequence of these different cohorts, then these could be taken into account when designing future PSMs. Further studies investigating the role of multiple-stakeholder PSMs, including service users, would be worthwhile both to develop understanding of mutualism and to inform future policy development.

This thesis has made some suggestions concerning mutualism within PSMs, the generative mechanisms involved and how mutuality might be conceptualised. More work is required on the processes by which mutualism emerges, to develop a deeper understanding of the relationships between mutual relations, such as reciprocity, co-operation, trust and common purpose and mutual practices, such as employee ownership, voice, transparency and shared benefit. The framework developed here shows that there is interaction between the ideas, relations and practices of mutualism. Further empirical research into the extent of this interaction and what encourages the development of mutualism from the operation of mutual practices and vice versa, would be a helpful contribution to the field of mutuality research.

In addition, the processes by which PSMs are formed, and how they separate from public sector organisations, merits further research. Hazenberg and Hall (2016) and

Davies and Yeoman (2013) have begun to theorise this process, but there is further scope to examine the nature of the antecedent cultural and structural systems and emergent powers that subsist at the time of the transition, and how they operate and respond to the newly formed contextual environment. This would add some rich detail to the design and implementation of new PSMs.

There are ancillary areas of potential further research arising from analysis of the data. One is the issue of collectivism and its relationship to public service ethos and the motivations of public service workers. A finding of the research was evidence that staff at both Community Health and Psychological Health each adopted a collectivist, patient centric approach to describing their motivations, when they were working within each organisation. They did this at the expense of individual motivations, such as financial reward. These motivations contributed to the initial structural arrangements of each organisation, with no distribution of profit and all surpluses re-invested. What causes this motivation and the links back to antecedent public sector ethos would be an interesting research project.

Finally, theories relating to employee voice, distributed leadership and communities of practice have been explored to a limited extent in the case studies, but merit further detailed work. There are indications from Psychological Health of a new leadership model emerging from voice mechanisms, resulting in dispersed power and leadership, allied with communities of practice that are influencing decision-making. This new model of leadership deserves further investigation, to explore in greater depth how it emerges and fits with mutual practices.

8.5 Conclusion

This research set out to examine the relationship between mutualism and PSMs. It did this by investigating mutuality in the context of organisations that have been described extensively by the UK Government as mutual. PSMs, as defined and promoted by DCMS Mutuals Team (2017), have been under-researched and under-theorised insofar as they can be considered a mutual form of organisation for delivering public services as an alternative to public sector owned delivery models. A review of the literature on mutuality and co-operation in Chapter 2 revealed that the PSM policy, and the evidence cited, had largely ignored the history and ideas of mutuality and co-operation that stretch back to the early 19th Century. As such, the

policy and the discourse around PSMs, whilst appropriating the terminology of mutualism, is absent an explanatory account of mutuality and mutual practices in their formation, operation and potential benefits.

This thesis offers a framework to address this and to fill some of the gaps that currently exist in PSM evidence and theory. Drawing on the history and practice of mutuality and co-operation, and building on writers in the New Mutualist tradition and recent research into PSMs, it provides a conceptualisation that acknowledges the ideas, the relations and the practices that make up mutualism in organisational form. Beginning from the premise that mutualism is an idea and a set of social relations and practices (Davies and Yeoman, 2013, p. 2; Howieson, 2016, p. 667), and using a critical realist approach, these have been conceptualised as an interrelated set of cultural, structural and agential emergent properties (Archer, 2003, p. 7). The occurrence of cultural and structural powers are contingent on the actions of agents, and this provides a starting point to develop explanatory accounts of mutualism in PSMs and a framework for research starts to emerge.

As an idea with cultural emergent properties, mutualism relates to a group co-operating towards a common goal for common good. Social relations that embrace this idea, and in turn have structural emergent properties, are relations of reciprocity, co-operation and trust in pursuit of a common purpose over time. These interact as relations, and when actualised, operate as causal powers. Mutual practices provide a context for agents to actualise the generative mechanisms that subsist within the structural relations of reciprocity, co-operation, trust and pursuing a common purpose. Mutual practices relevant to PSMs are the causal configurations of employee ownership, employee voice, informational transparency and shared benefit.

Agents, acting reflexively, can actualise the generative mechanisms within these various configurations, by actively participating in ownership through, for example, taking responsibility for the organisation's well-being, engaging with voice forums actively as informed participants and working towards a common goal. If they do, the causal powers of reciprocity, co-operation trust and common purpose that those mutual practice configurations possess, will be activated. Collective responsibility for organisational well being involves reciprocity and co-operation, just as active participation in voice forums and practices both generates and requires trust, reciprocity and co-operation. At all times agents within the organisation work to a common goal.

The empirical findings in this research provide a new understanding of mutualism in PSMs through the use of critical realism, which is used for the first time to research mutuality and PSMs, providing an original insight into the subject. This insight has enabled an explanatory account to be developed that encompasses mutual ideas, relations and practices inter-relating in an organisational context through the actions of agents in their various positioned-practices. Figure 8.1 depicts these inter-actions and provides a framework to examine them.

As such, this thesis has provided a deep insight into how mutualism and mutual practices can operate and emerge within PSMs. The critical realist approach provides a framework to understand not only the causal configurations but also the way that agents within an organisation, at all levels, engage with those configurations. This is important in understanding how mutual practices operate and whether they are likely or not to generate the benefits that are claimed of them. The role of agency was generally absent from the case made for PSMs by Le Grand (2011) and this research fills that gap. Mapping the relevant mutual practices using the framework developed in this thesis, and then collecting data from agents operating within the context of those practices, can help determine whether they are activated or not.

A key strength of the present study was the systematic approach taken to the subject and how this was applied empirically. With such an early stage of development for PSMs, and a policy that had not been based on strong and credible evidence, a first principles approach was required. By considering mutualism historically, a coherent conceptualisation of mutualism and mutual practices was developed within a critical realist framework that then enabled those concepts to be explored empirically. By not adhering to any methodological presuppositions, this could be done flexibly and appropriately for an exploratory study using a range of data collection techniques and analysis, whilst at all times operating within an established ontological meta-theory. This has resulted in a credible set of results derived from samples that were robust and systematically developed, using data collection tools and analysis appropriate to the subject matter and the case studies investigated.

A further strength of the present study was the inclusion of managers, directors and staff as participants when collecting data. Access to employees at different levels in each of the case studies has enabled the analysis carried out to be comprehensive, with data at all levels of the relevant cases, not simply from leaders and influencers. This was also congruent with the subject matter. Mutualism is a democratic and

egalitarian philosophy. It is consistent that research should recognise this and collect data from every level in equal fashion, so that all voices are heard.

This research was borne out of an inherent belief in the power and potential of mutualism as an alternative to public and private sector delivery of public services. There are implications for the practice of PSMs and its policy arising out of this research. The principle implication is that mutualism, as set out here, should be considered fully when designing new forms of PSM. In keeping with that aim, the research was conducted through a Professional Doctorate programme in public policy, rather than a traditional PhD. This was a deliberate choice to try to bring together professional experience with academic study and research. If PSMs and the mutualism agenda are to have applicability and effect in the public policy environment, they will be assisted through a combination of contemporary practice, theory and research. The experience of this thesis shows that access to valid and relevant cases is enhanced through utilising professional contacts and relationships. This in turn provides a rich research environment to examine current policy issues, such as PSMs.

As a philosophy and practice mutualism has the potential to provide a new and different means of addressing the issues that arise in private and public forms. By convincingly eschewing the profit motive and simultaneously avoiding hierarchy and managerialism, mutuality deserves a genuine attempt to design a new organisational delivery model. This research provides a starting point for that exercise and the findings suggest that there is potential for the mutual in Public Service Mutuals.

References

Ackroyd, S. and Karlsson, J.C. (2014). 'Critical Realism, Research Techniques and Research Design' in P. Edwards, J. O'Mahoney and S. Vincent (eds.), *Putting Critical Realism into Practice: A Guide to Research Methods in Organisation Studies*, Oxford: Oxford University Press, pp. 21-45.

Alexander, G., Alli-Errington, O., Beresford. J., Bradley, L., Coole, T., Cross, R., Darcy, C., Fry, E., Galassini, M. and Emily Jayne Schaefer, E.J. (n.d.) *Exploring the Effectiveness of Public Service Mutuals In Comparison to In-house Provision*, Available at: http://socialsciences.exeter.ac.uk/media/universityofexeter/collegeofsocialsciencesandinternationalstudies/politics/projects/mme/Group_Project_Electronic_Copy.pdf [Accessed on 25 August 2017].

Allen, P., Bartlett, W., Perotin, V.B., Zamora, B. and Turner, S. (2011). 'New Forms of Provider in the English National Health Service', *Annals of Public and Cooperative Economics,* Vol. 82, No. 1, pp. 77-95.

Allen, P., Townsend, J., Dempster, P., Wright, J., Hutchings, A. and Keen, J. (2012). 'Organisational Form as a Mechanism to Involve Staff, Public and Users in Public Services: A Study of the Governance of NHS Foundation Trusts', *Social Policy and Administration,* Vol. 46, No.3, pp. 239 – 257.

Appleby, J., Harrison, T., Hawkins, L. and Dixon, A. (2012). *Payment by Results: How can payment systems help to deliver better care?* Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf [Accessed on 8 May 2018].

Archer, M.S. (1995). *Realist social theory: the morphogenetic approach*. Cambridge: Cambridge University Press.

Archer, M.S. (2003). *Structure, Agency and the Internal Conversation*. Cambridge: Cambridge University Press.

Arts, B. and Van Tatenhove, J. (2004). 'Policy and power: A conceptual framework between the 'old' and 'new' policy idioms', *Policy Sciences* Volume 37, pp. 339–356.

Axelrod, R. (1984). *The Evolution of Co-operation*, New York: Basic Books.

Baert, P. (1996). 'Realist philosophy of the social sciences and economics: a critique'. *Cambridge Journal of Economics*, Vol. 20, Issue 3, September, pp. 513-522.

Bates, S.R. (2010). 'Re-structuring Power', *Polity*, Vol. 42, No. 3, pp. 352-376.

Bennett, N., Wise, C., Woods, P. and Harvey, J.A. (2003). *Distributed Leadership*. Nottingham: National College of School Leadership.

Bergene, A. C. (2007). 'Towards a Critical Realist Comparative Methodology: Context-Sensitive Theoretical Comparison'. *Journal of Critical Realism,* Vol. 6, No. 1, pp. 5-27.

Bestor, A.E. (1948). 'The Evolution of the Socialist Vocabulary' *Journal of the History of Ideas*, Vol. 9, No. 3. pp. 259-302.

Bhaskar, R. (1978). *A Realist Theory of Science,* (2nd Edition) Brighton: Harvester Press.

Birchall, J. (1997). *The International Co-operative Movement,* Manchester: Manchester University Press.

Birchall, J. (2001a). 'Introduction', in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 1 - 3.

Birchall, J. (2001b). 'Conclusion: the future of mutuality', in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 243 - 249.

Birchall, J. (2001c). 'Consumer co-operatives in retrospect and prospect' in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 72-94.

Birchall, J. (2011). *People-Centred Businesses: Co-operatives, Mutuals and the Idea of Membership,* Basingstoke: Palgrave Macmillan.

Birchall, J. (2012). 'The Big Society and the "Mutualisation" of Public Services: A Critical Commentary', *The Political Quarterly*, Vol. 82, Issue Supplement s1, pp. 145 – 157.

Birchall, J. and Simmons, R. (2001). 'Member participation in mutuals: a theoretical model' in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 202-225.

Bolden, R. (2011). 'Distributed Leadership in Organizations: A Review of Theory and Research', *International Journal of Management Reviews,* Vol. 13, pp. 251-269.

Bryman, A. (2012). *Social research Methods,* Oxford: Oxford University Press.

Bygstad, B., and Munkvold, B., E. (2011). 'In search of mechanisms: Conducting a critical realist data analysis.' Conference Paper. *Thirty Second International Conference on Information Systems, Shanghai.*

Cabinet Office (2010) 'Francis Maude Launches Pathfinder Mutuals' Available at https://www.gov.uk/government/news/francis-maude-launches-pathfinder-mutuals [Accessed 27 August 2017].

Cabinet Office (2011). 'Backing for Mutuals to Enhance Public Services' Available at: https://www.gov.uk/government/news/backing-for-mutuals-to-enhance-public-services [Accessed 27 August 2017].

Cabinet Office (2014a). 'Cabinet office mutuals reach century success', Available at https://www.gov.uk/government/news/cabinet-office-mutuals-reach-century-success, [Accessed on 27 August 2017].

Cabinet Office (2014b). 'Mutuals In Health: Pathfinder Programme', Available at https://www.gov.uk/government/publications/mutuals-in-health-pathfinder-programme [Accessed 23 August 2017].

CIPFA (2017). *Research into Public Service Mutuals,* London: CIPFA.

Cole, G.D.H. (1944). *A Century of Co-operation,* Manchester: The Co-operative Union Limited.

Collier, A. (1994). *Critical Realism: An introduction to Roy Bhaskar's Philosophy* London: Verso.

Conroy, P. (2012). 'The Promotion of Mutual Organisations to Deliver Public Services: a Policy Networks Analysis', in Caraher, K. and Snell, C. (eds.) *Government, Public Policy and Management: A Reader,* York: SPSW Publishing. pp. 49-66.

Creswell, J. W. (2014). *Research design: Qualitative, Quantitative and Mixed Methods Approaches*, 4th Edition. London: Sage.

Crinson, I. (2007). 'Nursing practice and organisational change within the NHS: a critical realist methodological approach to the analysis of discursive data.' *Methodological Innovations Online*, Vol. 2, No. 2, pp. 32-43.

Cruickshank, J. (2010). 'Knowing Social Reality: A Critique of Bhaskar and Archer's Attempt to Derive a Social Ontology from Lay Knowledge', *Philosophy of the Social Sciences,* Vol. 40, Issue 4, pp. 579–602.

DCMS Mutuals Team, (2017). 'Introduction to Public Service Mutuals – Department for Culture Media and Sport', Available at https://www.gov.uk/guidance/introduction-to-public-service-mutuals [Accessed 27 August 2017].

Danermark, B., Ekstrom, M., Jokobsen, L., & Karlsson, J. C. (2002). *Explaining society: critical realism in the social sciences*. London: Routledge.

Davies, W. and Yeoman, R. (2013). *Becoming a Public Service Mutual: Understanding Tradition and Change*, Available at: http://www.kellogg.ox.ac.uk/wp-content/uploads/2015/11/Becoming-a-public-service-mutual.pdf [Accessed on 27 August 2017].

Dawkins, R. (2016). *The Selfish Gene: 30th Anniversary Edition* Oxford: Oxford University Press.

Day, P. and Klein, R. (2005). *Governance of Foundation Trusts: Dilemmas of Diversity*. London: The Nuffield Trust.

Dayson, K. (2002). *Carpetbaggers and Credit Unions: A Sociological Study into the Paradox of Mutuality in the Late Twentieth Century*, Salford: University of Salford, PhD Thesis.

Delbridge, R. and Edwards, T. (2013). 'Inhabiting Institutions: Critical Realist Refinements to Understanding Institutional Complexity and Change', *Organisation Studies* 0(0), pp. 1-21.

Department for Health (2012). 'Transforming Community Services' Available at http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Healthcare/TCS/index.htm [Accessed 27 August 2017].

Drake, L. and Llewellyn, D.T. (2001). 'The economies of mutuality: a perspective on UK building societies' in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 14-40.

Eldar-Vass, D. (2010). *The Causal Power of Social Structures: Emergence, Structure and Agency*. Cambridge: Cambridge University Press.

Fleetwood, S. (2004). 'An Ontology for Organisation and Management Studies' in Fleetwood, S. and Ackroyd, S. (eds.) *Critical realist Applications in organisation and Management Studies,* London: Routledge. pp. 27-53.

Furlong, P. and Marsh, D. (2010) 'A skin not a sweater: Ontology and epistemology in political science', in D. Marsh and G. Stoker (eds.) *Theory and Methods in Political Science*, Third edition, Basingstoke: Palgrave Macmillan, pp.184-211.

GAfREC (2012) *Governance Arrangements for Research Ethics Committees: A Harmonised View* Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213753/dh_133993.pdf [Accessed on 27 August 2017].

Gohler, G. (2009). '"Power to" and "Power over"', in S. Clegg and M. Haugaard (eds.) *The Sage Handbook of Power*. Thousand Oaks, CA: Sage, pp. 27-39.

Great Britain. Cabinet Office, (2010). *The Coalition: our programme for government* London: Cabinet Office.

HMSO (2003). *Health and Social Care (Community Health and Standards) Act 2003* London: HMSO.

Hargreaves, I. (1999). *New Mutualism in from the Cold,* London: Co-operative Party.

Hay, C. (2002). *Political Analysis* Basingstoke: Palgrave Macmillan.

Hazenberg, R. and Hall, K. (2016). 'Public service mutuals: towards a theoretical understanding of the spin-out process'. *Policy & Politics,* Vol. 44, No. 3, pp. 441–463.

Health and Social Care Act, (2008). *Health and Social Care Act 2008*, Available at http://www.legislation.gov.uk/ukpga/2008/14, [Accessed on 27 August 2017].

Heery, E. (2015). 'Frames of reference and worker participation", in S. Johnstone and P. Ackers (eds.), *Finding a Voice at Work?* pp. 21-43.

Hollis, M. and Smith, S. (1991). *Explaining and Understanding in International Relations* Oxford: Clarendon Press.

Howieson, B. (2016). 'The mutuality metaphor: understanding healthcare provision in NHS Scotland', *Journal of Health Organization and Management*, Volume 30 Issue 4, pp. 666 – 671.

Hoyloake, G. J. (1875). *The History of Co-operation in England Vol. 1: The Pioneer Period, 1812-1844*. London: Trubner and Co.

International Cooperative Alliance, (2017). *Statement of Principles of Cooperatives* http://ica.coop/en/whats-co-op/co-operative-identity-values-principles (accessed 27 August 2017).

Kellner, P (1998). *New Mutualism: the Third Way*, London: Co-operative Party.

Kempster, S. and Parry, K. (2014). 'Critical Realism and Grounded Theory', in P. Edwards, J. O'Mahoney and S. Vincent (eds.), *Putting Critical Realism into Practice: A Guide to Research Methods in Organisation Studies*, Oxford: Oxford University Press, pp. 86-108.

Kropotkin, P. (1904). *Mutual Aid A Factor of Evolution,* London: William Heinemann.

Kuler, S., Gatenby, M., Rees, C., Soane, E. & Truss, K. (2008). *Employee Engagement: A Literature Review*. Kingston University: Kingston Business School Working Paper Series 19.

Lampel, J., Bhalla, A., and Jha, P. (2010). *Model Growth: do Employee-Owned Businesses Deliver Sustainable Performance*. London: Cass Business School.

Lave, J. and Wenger, E. (1991). *Situated Learning: Legitimate Peripheral Participation*. New York: Cambridge University Press.

Le Grand. (2011). *Our Mutual Friends: Making the Case for Public Service Mutuals*. Available at: http://webarchive.nationalarchives.gov.uk/20140402141901/http://mutuals.cabinetoffice.gov.uk/sites/default/files/documents/Mutuals%20Taskforce%20Evidence%20Paper.pdf [Accessed on 27 August 2017].

Le Grand, J. (2012). *Public service mutuals: the next steps*. London, UK: Cabinet Office.

Leadbeater, C. and Christie, I. (1999). *To Our Mutual Advantage*, London: Demos.

Leca, B. and Naccache, B. (2006). 'A Critical Realist Approach To Institutional Entrepreneurship' *Organisation*, Volume 13(5), pp. 627-651.

LocalGov (2012) 'Co -op launches one-stop-shop for council mutuals'. Available at: https://www.localgov.co.uk/Co-op-launches-one-stop-shop-for-council-mutuals/34363 [Accessed 27 August 2017].

Lukes, S. (2005). *Power: A radical View*. Basingstoke: Palgrave Macmillan.

Macleod, D., and Clarke, N. (2008). *Engaging For Success: Enhancing Performance Through Employee Engagement*. London: Department for Business, Innovation and Skills.

Marsh, D. (2010). 'Meta-Theoretical Issues' in G. Stoker and D. Marsh (eds.) *Theory and Methods in Political Science* London: Macmillan pp. 212-231.

Matrix Evidence. (2010). *The Employee Ownership Effect: a Review of the Evidence*. London: Employee Ownership Association.

Maude, F. (2010). 'Mutuals will empower the public sector', *The Guardian,* 12 August 2010. Available at: http://www.guardian.co.uk/commentisfree/2010/aug/12/mutuals-empower-public-sector [Accessed 27 August].

Maude, F. (2011). 'Minister calls for one million co-owners' Available at http://www.publicfinance.co.uk/news/2011/02/minister-calls-one-million-public-sector-co-owners [Accessed 27 August 2017].

Mingers, J. (2001). 'Combining IS Research Methods: Towards a Pluralist Methodology' *Information Systems Research* Vol. 12, No. 3, September, pp. 240-259.

Mingers, J., (2002). 'Realizing Information Systems: Critical Realism as an Underpinning Philosophy for Information Systems'. *ICIS 2002 Proceedings*. Paper 27.

Mingers, J. (2006). *Realising Systems Thinking: Knowledge and Action in Management Science* New York: Springer.

Myers, J. and Maddocks, J (2016). 'New development: Mutual solutions to shaping public service delivery', *Public Money & Management*, Vol. 36, No. 1, pp. 55-60.

National Audit Office (2013). 'Spinning-out MyCSP as a mutual joint venture' Available at: https://www.nao.org.uk/wp-content/uploads/2013/09/10176-001-MyCSP-Book-Copy.pdf [Accessed on 27 August 2017].

NHS Improvement, (2017). NHS Improvement: Quarterly Performance NHS Provider Sector Third Quarter Available at: https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-3-1617/ [Accessed 27 August 2017].

OED Online. (2017). "mutualism, n" Available at: http://www.oed.com/view/Entry/124382?redirectedFrom=mutualism& [Accessed 27 August 2017].

Office of Regulator of CIC (2017). Community Interest Companies Guidance chapters. Available at: https://www.gov.uk/government/publications/community-interest-companies-how-to-form-a-cic [Accessed on 27 August 2017].

O'Mahony, J. and Vincent, S. (2014). 'Critical realism as an empirical project', in P. Edwards, J. O'Mahoney and S. Vincent (eds.), *Putting Critical Realism into Practice: A Guide to Research Methods in Organisation Studies*, Oxford: Oxford University Press, pp. 1-20.

Pawson, R., and Tilley, N. (1997). *Realistic evaluation*. London: SAGE Publications Ltd.

Porpora, D. V. (1989). 'Four Concepts of Social Structure', *Journal for the Theory of Social Behaviour*, Vol. 19, pp. 195–211.

Prichard, A. (2007). 'Justice, Order and Anarchy: The International Political Theory of Pierre-Joseph Proudhon 1809-1865' *Millennium: Journal of International Studies*, 2007. Vol.35. No.3, pp. 623-645.

Reed, M.I. (2001). 'Organisation, Trust and Control: A Realist Analysis' *Organization Studies,* Vo. 22, No. 2, pp. 201 -228.

Ridley-Duff, R. and Bull, M. (2011). *Understanding Social Enterprise: Theory and Practice,* Sage Publications Limited: London.

Roberts, J. (2006). 'Limits to Communities of Practice', *Journal of Management Studies,* Volume 43:3, pp. 623-639.

Rogers, D. (1999). *New Mutualism: The Third Estate,* London: Co-operative Party.

Sanders, K and Schyns, B. (2006). 'Leadership and solidarity behaviour: Consensus in perception of employees within teams', *Personnel Review,* Vol. 35 Issue: 5, pp. 538-556.

Sayer, A. (1992). *Method in Social Science: A Realist Approach*. London: Routledge.

Sayer, A. (2000). *Realism and Social Science*, London: Sage.

Simmons, R. (2008). 'Harnessing Social Enterprise for Local Public Services: The Case of New Leisure Trusts in the UK' *Public Policy and Administration*, Vol. 23, pp. 278-301.

Social Enterprise UK (2018) *Public Service Mutuals: The State of the Sector*. London: Department for Culture Media and Sport.

Smith, C. and Elger, T. (2014). 'Critical Realism and Interviewing Subjects', in P. Edwards, J. O'Mahoney and S. Vincent (eds.), *Putting Critical Realism into Practice: A Guide to Research Methods in Organisation Studies*, Oxford: Oxford University Press, pp. 109-131.

Swartz, C.L. (1927). *What is Mutualism?* New York: Vanguard Press.

Tashakkori, A., and Teddlie, C. (1998). *Mixed Methodology: Combining Qualitative and Quantitative Approaches*. London: Sage.

Turnball, S. (2001). 'The Competitive Advantage of Stakeholder Mutuals', in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 171-201.

Thursfield, D. and Hamblett, J. (2004). 'Human Resource Management: A morphogenetic approach' in Fleetwood, S. and Ackroyd, S. (eds.) *Critical realist Applications in organisation and Management Studies,* London: Routledge. pp. 113-130.

Wenger, E., McDermott, R., and Snyder, W. M. (2002). *Cultivating communities of practice*. Watertown, MA: Harvard Business School Press.

Yeo, S. (2001). 'The new mutualism and Labour's Third Way' in Birchall, J. (ed.) *The New Mutualism in Public Policy,* London: Routledge, pp. 226-242.

Yeoman, R. (2017). 'From Traditional to Innovative Multi-Stakeholder Mutuals: The Case of Rochdale Borough Wide Housing', in Michie, J., Blasi, J.R. and Borzaga, C. (eds.) *Mutual, Co-operative and Co-owned Business,* Oxford: Oxford University Press, pp. 480-498.

Zachariadis, M., Scott, S. and Barrett, M. (2013). 'Methodological Implications of Critical Realism for Mixed Methods Research' *MIS Quarterly* Vol. 37 No. X, pp. 1-25.

Zamagni, V.N. (2013). 'Mutualism' in Bruni, L. and Zamagni, S. (eds.) *Handbook on the Economics of Reciprocity and Social Enterprise*, Cheltenham: Edwards Elgar Publishing Limited, pp. 238-243.

Appendix A Schedule of case study participants

A.1 Acute Health

Participant Code	Role or Job-Title
AH1	Matron
AH2	Ward Manager
AH3	Technician Manager
AH4	Technician
AH5	Technician
AH6	Senior Sister
AH7	Consultant
AH8	Senior Consultant
AH9	Director of Strategy
AH10	Chief Executive

A.2 Community Health

Participant Code	Role or Job-Title
CH1	Level Three Support Worker
CH2	Assistant Manager
CH3	Deputy Manager
CH4	Lead Total Communication Co-ordinator
CH5	Director of Strategy
CH6	Level Two Support Worker
CH7	Service Manager
CH8	Administrative Assistant
CH9	Level One Support Worker
CH10	Level Two Support Worker and Staff Board Member
CH11	Nurse
CH12	Managing Director

A.3 Psychological Health

Participant Code	**Role or Job-Title**
PH1	Clinical Manager
PH2	Psychological Wellbeing Practitioner
PH3	Administrative Manager
PH4	Operational Manager
PH5	Director of Finance
PH6	Chairman
PH7	Managing Director
PH8	Trainee Psychological Wellbeing Practitioner
PH9	Psychological Wellbeing Practitioner
PH10	Psychological Wellbeing Practitioner
PH11	Psychological Wellbeing Practitioner

Appendix B Survey

B.1 Postal Survey

The survey contained in this Appendix is a copy of the postal survey. The content of the online survey is identical, other than some formatting and instructions relating to completion and return of the survey.

Postal Survey of North West Health Providers

The University of Nottingham

Edit this page

Survey of North West Health Provider Organisations

Welcome to this survey of North West Health Provider Organisations, part of a Doctoral research project carried out by Paul Conroy of University of Nottingham.

The survey aims to identify the organisational characteristics of the different types of health provider organisations in the North West by asking questions about how each organisation is constituted, governed and owned, as well as how they operate as regards staff and patients/service users involvement.

Consequently, in the following pages you will be asked a series of questions that relate to these aspects of the organisation that you represent and you are requested to answer as fully as you are able on behalf of the organisation.

The survey is completed anonymously and takes approximately 15 minutes to complete.

This survey contains a number of questions about the organisation you represent. Please answer each question in order by writing the requested information in the box or by clicking on the relevant space.

If you would prefer not to answer any particular question, or where you don't know the answer, please tick "Prefer not to answer" or "Don't know" as appropriate where indicated and move onto the next question.

Questions are **mandatory** unless marked otherwise.

All data collected in this survey will be held anonymously and securely. No personal data is asked for or retained. Although the survey asks for the name of the organisation in the first question, this is purely to track responses from the survey participants and the name of the organisation will not be recorded or published anywhere in the results of the survey to preserve anonymity.

Once the survey has been completed, please return the completed survey in the stamped addressed envelope included with the questionnaire.

Thank you for participating in this survey.

A Name and type of organisation

The following questions are about the type of organisation that you represent

1. **What is the full name of the organisation**

2. Which of the following terms best describes the organisation? (please choose only one)

- ○ Social enterprise
- ○ Charity
- ○ Co-operative
- ○ Independent Private Sector Organisation
- ○ Mutual
- ○ Public Sector Body
- ○ Don't know
- ○ Prefer not to answer
- ○ Other *(please specify)*:

3. Which of the following legal forms best describes the organisation? (please choose only one)

- ○ Company limited by shares (CLS) i.e. a private company with shareholders
- ○ Company limited by guarantee (CLG) i.e. a private company with members
- ○ Community Interest Company i.e. registered with the C I C Regulator
- ○ Industrial Provident Society
- ○ Limited Liability Partnership or other private partnership
- ○ Charitable Incorporated Organisation (CIO)
- ○ Public Body (e.g. a NHS Trust/Local Authority)
- ○ Public Benefit Corporation (NHS Foundation Trust)
- ○ Trust/Unincorporated Association/Voluntary Organisation
- ○ Don't know
- ○ Prefer not to answer
- ○ Other *(please specify)*:

B The organisation's income, profits/surpluses and assets

The following questions concern the organisation's income, its profits/surpluses and the assets of the organisation.

4. What was the approximate annual turnover/income of your organisation in the organisation's last financial accounting year? (please choose only one)

- ○ £1M or less
- ○ More than £1M but less than £5M
- ○ More than or equal to £5M but less than £10M
- ○ More than or equal to £10M but less than £50M
- ○ More than or equal to £50M but less than £250M
- ○ £250M or more
- ○ Don't know
- ○ Prefer not to answer

5. Please rank the following sources of income in priority from the highest proportion of the organisation's income to the lowest.

	Please choose the appropriate number to represent the respective proportion of each source of income received by the organisation, 1 being the highest proportion of income, 2 being the second highest and so on. If the organisation does not receive any particular source of income at all, please indicate as "Not received".If you don't know or would prefer not to answer please indicate in the appropriate box.							
	1	**2**	**3**	**4**	**5**	**Not received**	**Don't know**	**Prefer not to answer**
a. Fees and charges received from an NHS commissioning contract for services to service users	☐	☐	☐	☐	☐	☐	☐	☐
b. Fees and charges received from service users who pay for the services delivered (either directly or through some form of insurance arrangement)	☐	☐	☐	☐	☐	☐	☐	☐
c. Gifts or other receipts received from individuals or organisations as charitable donations	☐	☐	☐	☐	☐	☐	☐	☐
d. Subsidies and/or grant received from the public sector	☐	☐	☐	☐	☐	☐	☐	☐
e. Other sources of income (please specify in Question 6)	☐	☐	☐	☐	☐	☐	☐	☐

6. If you indicated that the organisation receives other sources of income in your answer to Question 5(e) then please specify those sources of income in the box below *(Optional)*

7. Please choose the statement which best describes how the organisation deals with or treats profits/surpluses generated by the organisation (please choose only one)

- ○ The organisation is a for profit organisation and all available profits/surpluses of the organisation are distributed to shareholders and/or members
- ○ The organisation is a not for profit organisation and all available profits/surpluses of the organisation are not distributed but retained and reinvested in the organisation.

- ○ Don't know
- ○ Prefer not to answer

8. Are the assets of the organisation subject to an asset lock (i.e. no assets can be sold or distributed by the organisation other than to another asset locked company)? (Please choose only one)

- ○ Yes
- ○ No
- ○ Don't know
- ○ Prefer not to answer

C About the organisation's staff/employees and volunteers

The following questions concern the staff/employees and volunteers who work for the organisation. When referring to staff and/or employees, this means those persons who work within the organisation who are employed to deliver, or support the delivery, of the services provided by the organisation, including in managerial, professional, administrative, financial and other roles within the organisation. Volunteers means those people who assist the organisation on a voluntary, unpaid basis in relation to delivery of services and/or in fund raising for the organisation.

9. Approximately how many people (actual persons not just full time equivalent), currently work within the organisation? Please include all those who work full or part time and who work as staff or employees or who work for the organisation on any form of fixed term or temporary contract but do not include unpaid volunteers (please choose only one).

- ○ Fewer than 10 people
- ○ More than or equal to 10 people but fewer than 50 people
- ○ More than or equal to 50 people but fewer than 150 people
- ○ More than or equal to 150 people but fewer than 250 people
- ○ More than or equal to 250 people but fewer than 1000 people
- ○ More than or equal to 1000 people but fewer than 5000 people
- ○ 5000 people or more
- ○ Don't know
- ○ Prefer not to answer

10. Does the organisation participate in any of the following activities concerning staff and employees
(select all that apply)

- ☐ Staff or employee councils
- ☐ Mass meetings of staff/employees (e.g. annual conference)
- ☐ Staff forums where decisions affecting the organisation are regularly discussed
- ☐ Team meetings
- ☐ Staff/employee representation on the governance board of the organisation
- ☐ Members of staff/employees as directors of the organisation
- ☐ Employee share schemes
- ☐ Other staff/employee incentive programmes
- ☐ Attitude surveys of staff/employees

- [ ] In house journal/newsletter for staff/employees
- [ ] E-mail communications of information to staff/employees about the organisation
- [ ] Staff/employee noticeboards
- [ ] A dedicated intranet for staff/employee communication
- [ ] Staff/employee handbook
- [ ] Staff/employee suggestion schemes
- [ ] Don't know
- [ ] Prefer not to answer
- [ ] Other *(please specify)*:

11. Does the organisation utilise volunteers (i.e. individuals who give their time free of charge save for re-imbursement of expenses) in the provision of its services? (Please choose only one)

- ○ Yes - if you have answered Yes please now answer questions 11(a)(b)&(c)
- ○ No - Please now go to Question 12
- ○ Don't know - Please now go to Question 12
- ○ Prefer not to answer - Please now go to Question 12

a. Approximately how many volunteers assist the organisation (actual persons not just full time equivalent)? (Please choose only one)

- ○ 10 or fewer
- ○ More than 10 but fewer than 50
- ○ More than or equal to 50 but fewer than 250
- ○ 250 or more
- ○ Don't know
- ○ Prefer not to answer

b. Please describe the roles carried out by any volunteers at your organisation *(select all that apply)*

- [ ] Fundraising
- [ ] Governors/directors/trustees
- [ ] Assisting staff with service delivery
- [ ] Administration
- [ ] Don't know
- [ ] Prefer not to answer
- [ ] Other *(please specify)*:

c. Please indicate which of the following statements best describes the role of volunteers in the organisation (please choose only one)

- ○ Volunteers are an integral part of the organisation and the organisation would not be able to deliver its services without them
- ○ Volunteers are a valuable part of the organisation and their work improves the quality of the organisation's services

Volunteers assist the organisation in delivering its services but the organisation would be able to deliver its services without the assistance of volunteers
Volunteers primarily assist the organisation by raising funds to supplement the organisation's income
Don't know
Prefer not to answer

Please now go to Question 12

D Membership of the organisation

The following questions concern the membership of the organisation

12. Does your organisation comprise members (e.g. a co-operative, company limited by guarantee, voluntary association, mutual, public benefit corporation/Foundation Trust) as differentiated from shareholders in a company limited by shares or partners in a Limited Liability Partnership or other form of partnership? (Please choose only one)

Yes - If you have answered Yes please now answer Questions 12(a) & (b)
No - Please now go to Question 13
Don't know - Please now go to Question 13
Prefer not to answer - Please now go to Question 13

a. Which of the following categories are members of the organisation *(select all that apply)*
Staff/employees
Directors/Trustees
Managers
Patients/service users
Public sector (either public sector organisations or representatives of such organisations)
Members of the community
Don't know
Prefer not to answer
Other *(please specify)*:

b. Is membership of the organisation open to all persons who are willing to become members (i.e. there is no restriction or qualifying conditions to membership)? (Please choose only one)
Yes
No
Don't know
Prefer not to answer

Please now go to Question 13

E Ownership of the organisation

This section concerns who owns the organisation.

13. Who owns the organisation? Please indicate any of the following categories who comprise all or some of the owners of the organisation.
(select all that apply)

- ☐ A trust (on behalf of beneficiaries)
- ☐ Private investors
- ☐ Institutional investors
- ☐ Members of the organisation
- ☐ Staff/employees
- ☐ Managers/Directors
- ☐ A public body (e.g HM Government, a local authority or other public sector)
- ☐ The community
- ☐ Patients/Service users
- ☐ Commissioners of services
- ☐ Suppliers to the organisation
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ Other *(please specify)*:

F Patient and service users' involvement in the organisation's services

The following question relates to the involvement of patients and/or service users in the way the organisation plans and delivers its services to them. Patients and service users means all of the users of the services that the organisation delivers.

14. Which of the following activities have taken place in your organisation during the last 12 months.
(select all that apply)

- ☐ Surveys of patient and service user satisfaction of your organisation's services
- ☐ Peer support groups where your organisation's patients and service users meet with each other to offer advice and support
- ☐ Focus groups of patients and service users
- ☐ Programmes and activities designed to utilise the knowledge of patients and service users as experts in the design and/or delivery of the services your organisation delivers (e.g. expert patient programmes, patient workshops)
- ☐ Activities where patients and service users are actively involved in the planning and/or design of the services your organisation delivers
- ☐ Patients and/or service users as members of your organisation's governance board
- ☐ Patient self-care programmes/activities
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ Other *(please specify)*:

G Governance

The following questions concern the governance of the organisation and how the governance board is constituted. The following questions also deal with how its Directors and/or Trustees are appointed or elected to be directors and/or trustees of the organisation.

15. Who participates in the governance of your organisation, either through voting rights on matters specified by the organisation's constitution and/or through board representation

(select all that apply)

- ☐ Board members/directors/trustees
- ☐ Shareholders
- ☐ Staff/Employees
- ☐ Patients/Service users
- ☐ Community members
- ☐ Representatives from the public sector
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ Other *(please specify)*:

16. Which of the following statements best describes the voting rights specified in the Organisation's constitution? (Please choose only one)

- ○ Voting takes place on a one member one vote basis regardless of shareholding or other ownership rights in the Organisation
- ○ Voting takes place on the basis of the number of shares or other ownership rights held in the Organisation
- ○ Not applicable
- ○ Don't know
- ○ Prefer not to answer

17. How do individuals become members of the Organisation's governance board? (please choose only one)

- ○ Individuals are elected by shareholders
- ○ Individuals are elected by members on a one member one vote basis
- ○ Individuals are appointed by a committee of the Board
- ○ Some individuals are appointed whilst others are elected by shareholders
- ○ Some individuals are appointed whilst others are elected by the members on a one member one vote basis.

- ◯ Don't know
- ◯ Prefer not to answer
- ◯ Other *(please specify)*:

18. Are any of the following represented on the organisation's governance board?

(select all that apply)

- ☐ Staff/employees
- ☐ Patients/Service users
- ☐ Managers/directors
- ☐ Members of the community
- ☐ Representatives of the public sector
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ Other *(please specify)*:

H The Organisation's Primary Purpose

The following question concerns the primary purpose of the Organisation i.e. what is the primary reason for the organisation being in existence.

19. Other than delivering services to service users, please choose which of the following statements best represents the primary purpose or mission of the organisation (please choose only one)

- ◯ The organisation exists primarily to benefit its members
- ◯ The organisation exists primarily to generate returns for its investors and/or shareholders
- ◯ The organisation exists to deliver a dedicated social purpose
- ◯ Don't know
- ◯ Prefer not to answer
- ◯ Other *(please specify)*:

I Concluding questions

The following questions are the final questions in the survey and are asked for administrative purposes.

20. What is the position that you hold in the organisation? *(Optional)*

This question asks for the position in the organisation of the person completing the questionnaire solely for the purpose of supplying a copy of the summary report that will be provided to all participants who complete the survey. It is not mandatory to provide this information. If the information is provided, it will remain anonymous at all times and this information will not appear in any published reports or other publications relating to this data.

21. I may wish to contact your organisation again to carry out further research relating to this project. Please confirm whether or not you would be willing to be contacted again to request further participation? (Please note permission to contact you again does not oblige you to take part in any further research and participation can be refused at any time)

- ○ Yes I would be willing to be contacted again
- ○ No I do not want to be contacted again

If you or your organisation agree to be contacted again, this does not in any way imply consent to participate in further research relating to this project, but merely gives permission for further contact.

22. Please insert the date you completed this questionnaire

(DD-MM-YYYY)

That is the end of the survey.

Thank you for participating.

Please return the completed survey in the stamped addressed envelope provided to:

Paul Conroy

11, Miller's Ford

Low Bentham

Lancaster

LA2 7BF

If you have any questions concerning this survey and/or the research project, please contact Paul Conroy on:

Telephone: 07740 494431

E-mail: lqxpc3@exmail.nottingham.ac.uk

Appendix C SPSS Cluster Analysis Output

Abstract

C.1 Summary of Output Data

The following tables and diagrams comprise summaries of data from the SPSS Output files for the iterative cluster analysis conducted as part of the analysis of the survey data. The order the cluster analysis was carried out was first Hierarchical Ward Cluster Analysis then K Means Cluster Analysis. These two methods were repeated until appropriate cluster variables emerged and then they were applied to the data using Two Step Cluster Analysis. The extracts in this Appendix C comprise final output files from each method, included by way of example.

C.2 Hierarchical Ward Cluster Analysis – Final Output

Hierarchical Ward Cluster Analysis – Final Output

Case Processing Summary[a,b]

Cases					
Valid		Missing		Total	
N	Percent	N	Percent	N	Percent
56	86.2	9	13.8	65	100.0

a. Squared Euclidean Distance used

b. Ward Linkage

Agglomeration Schedule

Stage	Cluster Combined		Coefficients	Stage Cluster First Appears		Next Stage
	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	44	54	.000	0	0	3
2	29	53	.000	0	0	10
3	33	44	.000	0	1	11
4	3	9	.000	0	0	42
5	36	65	.500	0	0	12
6	39	55	1.000	0	0	27
7	6	52	1.500	0	0	19
8	12	38	2.000	0	0	13
9	1	19	2.500	0	0	38
10	23	29	3.167	0	2	27
11	33	46	3.917	3	0	14
12	13	36	4.750	0	5	15
13	5	12	5.583	0	8	31
14	4	33	6.433	0	11	28
15	13	28	7.350	12	0	21
16	8	62	8.350	0	0	41
17	14	41	9.350	0	0	39
18	17	18	10.350	0	0	31
19	6	26	11.850	7	0	43
20	2	15	13.350	0	0	30
21	10	13	15.100	0	15	29
22	58	61	17.100	0	0	23
23	27	58	19.100	0	22	36
24	25	50	21.100	0	0	37
25	22	49	23.100	0	0	40
26	30	40	25.100	0	0	46
27	23	39	27.133	10	6	32
28	4	43	29.367	14	0	48
29	10	21	31.700	21	0	47
30	2	48	34.200	20	0	40
31	5	17	37.067	13	18	38
32	23	32	40.033	27	0	50
33	24	59	43.033	0	0	44
34	35	56	46.033	0	0	52
35	16	47	49.033	0	0	39
36	27	57	52.283	23	0	41
37	11	25	55.617	0	24	42
38	1	5	59.060	9	31	44
39	14	16	62.560	17	35	46
40	2	22	66.160	30	25	43
41	8	27	70.410	16	36	50
42	3	11	74.676	4	37	51
43	2	6	79.326	40	19	47
44	1	24	84.072	38	33	49
45	34	42	89.572	0	0	51
46	14	30	95.072	39	26	49
47	2	10	100.632	43	29	48
48	2	4	108.306	47	28	52
49	1	14	116.017	44	46	54
50	8	23	127.350	41	32	53
51	3	34	147.679	42	45	53
52	2	35	177.619	48	34	54
53	3	8	232.191	51	50	55
54	1	2	323.622	49	52	55
55	1	3	725.786	54	53	0

C.3 K Means Cluster Analysis – Final Output

Iteration History[a]

Iteration	Change in Cluster Centers		
	1	2	3
1	3.941	3.457	2.933
2	.478	1.008	.115
3	.000	.000	.000

a. Convergence achieved due to no or small change in cluster centers. The maximum absolute coordinate change for any center is .000. The current iteration is 3. The minimum distance between initial centers is 6.856.

Number of Cases in each Cluster

Cluster	1	13.000
	2	8.000
	3	35.000
Valid		56.000
Missing		9.000

Initial Cluster Centers

	Cluster		
	1	2	3
Status of organisation (2)	2.00	7.00	1.00
Legal form of organisation (3)	9.00	3.00	2.00
Dealing with profits (7)	2.00	2.00	2.00
Use of volunteers (11)	1.00	2.00	1.00
Owned by Trust	1.00	2.00	2.00
Owned by private investors	2.00	2.00	2.00
Owned by institutional investors	2.00	2.00	2.00
Owned by members	2.00	2.00	1.00
Owned by staff	2.00	2.00	2.00
Owned by managers and directors	2.00	2.00	2.00
Owned by a public body	2.00	2.00	2.00
Owned by the community	2.00	2.00	2.00
Owned by users	2.00	2.00	2.00
Owned by commissioners	2.00	2.00	2.00
Owned by suppliers	2.00	2.00	2.00
Owned by other	2.00	1.00	2.00
Members of the board	1.00	1.00	1.00
Shareholders	2.00	1.00	2.00
Staff as governance	2.00	2.00	2.00
Users as governance	2.00	2.00	1.00
Community as governance	2.00	1.00	2.00
Representatives of public sector as governance	2.00	1.00	2.00
Members of the organisation as governance	2.00	1.00	2.00
Staff on board	2.00	1.00	1.00
Users on board	2.00	2.00	1.00
Managers and/or directors on board	1.00	1.00	1.00
Community on board	1.00	1.00	1.00
Public sector representatives on board	1.00	1.00	2.00
Others on board	2.00	2.00	2.00

Final Cluster Centers

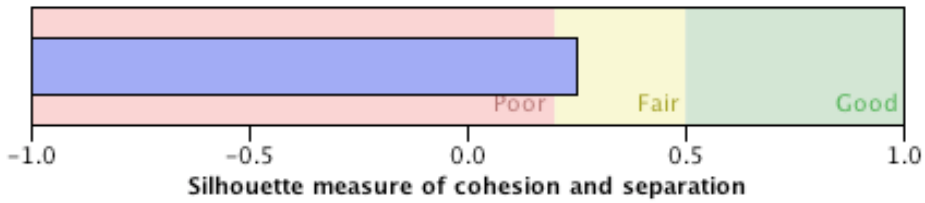
	Cluster		
	1	2	3
Status of organisation (2)	5.69	4.50	3.00
Legal form of organisation (3)	7.62	4.63	1.51
Dealing with profits (7)	2.00	1.38	1.46
Use of volunteers (11)	1.00	1.75	1.54
Owned by Trust	1.92	1.88	1.97
Owned by private investors	2.00	1.88	1.86
Owned by institutional investors	2.00	2.00	1.97
Owned by members	1.92	1.75	1.69
Owned by staff	2.00	2.00	1.86
Owned by managers and directors	2.00	1.63	1.54
Owned by a public body	1.15	1.88	2.00
Owned by the community	2.00	2.00	1.91
Owned by users	2.00	2.00	2.00
Owned by commissioners	2.00	2.00	2.00
Owned by suppliers	2.00	2.00	2.00
Owned by other	2.00	1.88	1.94
Members of the board	1.08	1.00	1.03
Shareholders	2.00	1.75	1.66
Staff as governance	1.62	1.63	1.43
Users as governance	1.69	1.75	1.91
Community as governance	1.85	1.88	1.97
Representatives of public sector as governance	1.62	1.88	2.00
Members of the organisation as governance	2.00	1.88	1.97
Staff on board	1.46	1.63	1.54
Users on board	1.54	2.00	1.89
Managers and/or directors on board	1.23	1.00	1.11
Community on board	1.54	1.75	1.80
Public sector representatives on board	1.46	1.75	1.91
Others on board	2.00	2.00	1.94

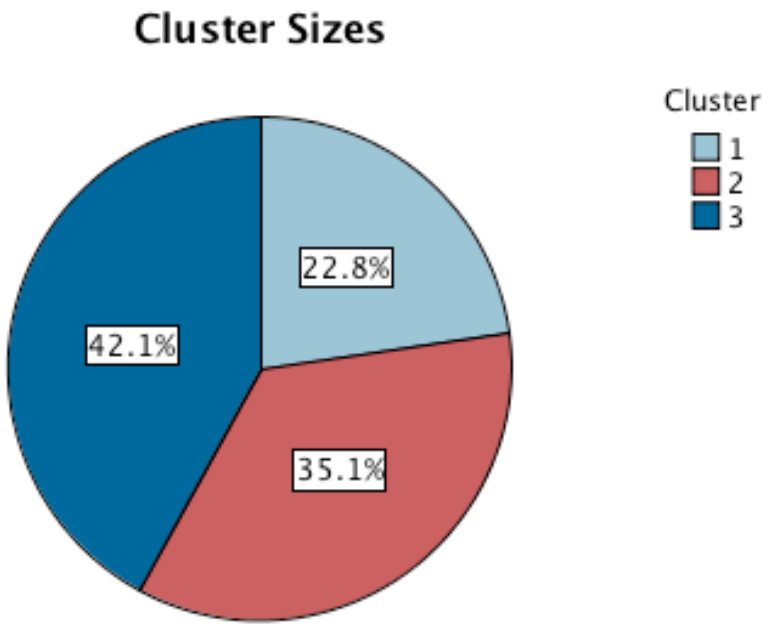
C.4 Two Step Cluster Analysis – Final Output

Model Summary

Algorithm	TwoStep
Inputs	28
Clusters	3

Cluster Quality





Size of Smallest Cluster	13 (22.8%)
Size of Largest Cluster	24 (42.1%)
Ratio of Sizes: Largest Cluster to Smallest Cluster	1.85

Appendix D Interview Topic Guide

D.1 Sample Topic Guide

1. Participant's Role

Can you briefly describe you role here at [Case], what you do day-to-day and how you fit into the organisation?

Probe:

Distinguish between managerial/supervisory and non-managerial roles.

2. Mutualism and mutual organisations

What do you understand by the term mutualism? Mutual organisation?

Probe:

If knowledge of either/both explore what that means to them working at [Case].

Prompt:

Relevance of those terms to [Case]. Do they see [Case] as a mutual organisation? Practising mutuality?

How do they describe [Case] to outsiders?

3. Ownership

Who owns [Case]?

Probe:

What is participant's role in ownership of [Case] if they say they are an owner?

Prompt:

If an owner ask them to describe what this means to them? How do they act as an owner?

If an owner do they own shares? What does being a shareholder mean? What do they do in practice as a shareholder?

4. Participation in decision-making and governance

How do you participate in decision-making in [Case]?

Probe:

Explore the different ways they might participate (shareholder/staff board/staff director/staff meetings)

Explore how much they feel part of the decision-making process or not?

Prompt:

Ask to describe how (staff board/staff director/Governance Council) operates. How were its members selected/appointed? What is their interaction with it?

5. Transparency

How is information shared between the organisation/management and staff?

Probe:

The type of information shared?

The different ways in which information is shared (meetings/e mail/board minutes/other).

The regularity with which it is shared?

Prompt:

How much information is shared and what do they think of that? Enough? Not enough? Too much?

6. Shared Benefit

How do you describe [Case] profit status? What happens to profits/surpluses at [Case]?

Probe:

Ask about reinvestment of surpluses where this is in the Constitution. What do they think of that? What do they think is being achieved by it? Co-operation?

Prompt:

Ask about other benefits received - salaries/career development/training? Are these reciprocal?

[IF NOT ALREADY DISCUSSED UNDER ABOVE TOPICS]

7. Trust

Describe the levels of trust between you/staff and the organisation?

Probe:

If high/low trust why do they think that is?

8. Common Purpose

How would you describe the primary aim of [Case]? What is it here to do/achieve?

9. Additional comments

Do you have anything else you would like to say? Have you any questions for me?

Thank you for your time.

Appendix E Research Ethics Forms

E.1 Sample survey e mail/cover letter

Dear []

My name is Paul Conroy and I am a doctoral researcher at University of Nottingham in the School of Sociology & Social Policy. I am engaged in a Doctoral research project to analyse the various types of organisations delivering health services in England.

As part of this research project I am carrying out a survey of all of the organisations that are currently registered with the Care Quality Commission (CQC) as delivering health services in the North West of England. The purpose of this survey is to identify the different organisational types as differentiated by legal form, governance, ownership, membership and purpose, as well as by volunteer, staff and patient participation.

As a CQC registered provider of healthcare services in the North West of England, I am approaching your organisation [name] to request your participation in this short online survey.

The Research Ethics Committee of the School of Sociology & Social Policy at University of Nottingham has approved this research project. As a survey of health provider organisations only, with no patient or individual staff participation, the survey **does not** require NHS Research Ethics Committee approval or any other external ethics approval.

The survey is confidential and anonymous. Participation in this research is completely voluntary and you may refuse to participate without consequence. However, I would hope that you could spare the time to do so to enable a comprehensive set of results to be collated.

The survey is online and will take between 10 and 15 minutes to complete. You will receive no compensation for participating in the research study, however all respondent organisations will be sent a short summary report of the results which will aggregate the characteristics of the various health providers in the North West (on an anonymous basis), and it is hoped that this will be useful to your organisation as analysis of the types of organisations that are providing healthcare in the North West.

Responses to the survey will only be reported in aggregated form to protect the identity of organisations. Further information regarding the research can be obtained from me, Paul Conroy, either by e mailing me at **lqxpc3@nottingham.ac.uk** or by telephone on **07740 494431**. If you are willing to complete the survey on behalf of your organisation please click on the link below and follow the instructions through to the end of the survey:

https://www.survey.bris.ac.uk/nottingham/nw_healthproviders/

If you consider that someone else in your organisation is better placed to complete the survey could you pass it to them with this cover e-mail.

Thank you for your consideration. Your help is greatly appreciated.

Best wishes

Paul Conroy

Doctoral Researcher

University of Nottingham

School of Sociology & Social Policy

E.2 Participant Information Form

School of Sociology and Social Policy

University of Nottingham

Information for Participants

What is mutual about Public Service Mutuals?

Paul Conroy, a doctoral researcher in the School of Sociology and Social Policy, University of Nottingham, is conducting this research project.

The study is investigating mutualism and associated employee engagement mechanisms, within the delivery of public services, and in particular within the health sector. The research involves comparing three different types of organisations delivering health services, as regards the concept of mutualism and the related employee engagement mechanisms of staff participation in ownership, finances, information, decision-making and governance.

Participants will be interviewed about their perceptions and experiences of the operation of these mechanisms within their organisation. This will take the form of a discussion concerning a number of topics relating to how the relevant mechanisms operate and their potential benefits (including developing trust, reciprocity, employee engagement, transparency and co-operation within the organisation) and reflecting on how these mechanisms operate as regards the organisation. Participants will also be asked questions about their roles and how they go about their day-to-day job in the context of any experiences they have had with participation in decision-making processes, governance, ownership, information and finances.

It is hoped that by participating in the interviews, and reflecting on the topics discussed, participants will increase their own knowledge and understanding of how these mechanisms work in the context of their roles and the organisation.

There are no foreseeable risks to any individual participating in the research nor any costs or inducements involved in taking part.

Participation in the research project is entirely voluntary and any participant may withdraw from the research project at any stage, without having to give any reason and withdrawing will not penalise or disadvantaged the participant in any way. If any

participant does not wish to participate in the research project, they should make that known to the researcher immediately and all participation will cease forthwith.

All information is collected and held on a secure server at the University of Nottingham, accessed only by Paul Conroy. All handwritten notes are held in a locked filing cabinet, again with access only available to Paul Conroy. The information collected will be used solely for the purposes of the research project and nothing else.

The research outputs are a doctoral thesis on mutualism, employee engagement and public service mutuals. In addition, a summary of the findings from the research will be made available to the Participant's organisation, but without any quotes or identifying features from the participants involved. The summary of findings will simply contain an overview of the research findings to assist the organisation in its future thinking around mutualism and employee engagement.

Three organisations are taking part in the research project: an NHS Trust, a recently formed public service mutual health provider and an existing public service mutual which is also delivering health services. A range of staff members from each organisation are being asked to take part and have been asked as representative of all the various roles within the organisation. However, every participant has volunteered to take part following an initial request.

Contact details:

Researcher: Paul Conroy, Tel: 07740 494431 E mail: lqxpc3@exmail.nottingham.ac.uk or write to address below

Supervisor: Professor Bruce Stafford, Tel: 0115 84 67439 E mail: Bruce.Stafford@nottingham.ac.uk or write to the address below

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research then in the first instance please contact the Supervisor. If this does not resolve the matter to your satisfaction then please contact the School's Research Ethics Officer, Dr. Simon Roberts (tel. 0115 84 67767, email: Simon.Roberts@nottingham.ac.uk

Address

School of Sociology and Social Policy

University of Nottingham

Law and Social Sciences Building

University Park

Nottingham, NG7 2RD

E.3 Participant Consent Form

School of Sociology and Social Policy University of Nottingham

Participant Consent Form

What is mutual about Public Service Mutuals?

In signing this consent form I confirm that:	**Yes**	**No**
I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.		
I have had the opportunity to ask questions.		
I understand the purpose of the research project and my involvement in it.		
I understand that my participation is voluntary and I may withdraw from the research project at any stage, without having to give any reason and withdrawing will not penalise or disadvantaged me in any way.		
I understand that while information gained during the study may be published, any information I provide is confidential **(with one exception – see below)**, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published.		
I understand that the researcher may be required to report to the authorities any significant harm to a child/young person (up to the age of 18 years) that he becomes aware of during the research. I agree that such harm may violate the principle of confidentiality.		
I agree that extracts from the interview may be anonymously quoted in any report or publication arising from the research		
I understand that the interview will be recorded using electronic voice recorder		
I understand that data will be securely stored		
I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Officer of the School of Sociology and Social Policy, University of Nottingham, if I wish to make a complaint relating to my		

involvement in the research.		

I agree to take part in the above research project.

Participant's name …… Participant's signature……

Date……

Researcher's name PAUL CONROY Researcher's signature……

Date……..