OCCUPATIONAL THERAPY GRADUATES' PERCEPTIONS AND EXPERIENCES OF INTRAPRENEURSHIP IN CONTRASTING HEALTHCARE PRACTICE CONTEXTS

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Abstract

Recent UK Government rhetoric is calling for healthcare professionals to practice entrepreneurially whilst they are simultaneously being bombarded with restrictive protocols and prescriptive regimens. There is little agreement concerning what entrepreneurship is and the term 'intrapreneurship' has recently entered the literature field denoting the innovative and creative practices *within* an organisation. There is little usable inquiry into this important field, with the healthcare practice context severely lagging behind the wider entrepreneurship debates. This has created a highly pressured and confusing landscape for new occupational therapy graduates to negotiate.

This study details a qualitative exploration into recent occupational therapy graduates' perceptions and experiences of intrapreneurship within two contrasting healthcare practice contexts. The critical realist theorist, Margaret Archer, and her concepts of morphogenesis, the internal conversation and preferred reflexive modes (1982, 2003, 2007), were used as the study framework to explore micro-level structure / agency interactions. Semi-structured interviews, incorporating the completion of life-grids, were carried out with nine participants stratified into two context groups: five located in the statutory healthcare context and four located in the non-statutory. Analysis of the life-grid data alongside elements of the interview data enabled allocation of participants into their preferred reflexive mode of operating their internal conversation. The remaining interview data was subsequently analysed generating emerging themes.

The key research findings were: Margaret Archer's internal conversation and preferred reflexive modes are valuable tools for examining micro-level interactions between occupational therapy graduate agency and the structures they encounter; occupational therapy graduates' reflexive preferences strongly influence their choice of work location and perceptions and experiences of intrapreneurship; personal and professional relationships are highly prized and prioritised above intrapreneurship by statutory located occupational therapy graduates; the statutory healthcare context is profoundly structuring for occupational therapy graduate intrapreneurship; there are abundant and large scale intrapreneurship opportunities in the non-statutory healthcare context; there are substantial costs and downsides to intrapreneurship that are evaluated differently by occupational therapy graduates depending on their reflexive preferences.

This study contributes fresh insights that inform the development of a relevant occupational therapy curriculum and an entrepreneurially conducive practice environment. It also raises awareness of higher education and healthcare policy makers, which will contribute to improved outcomes for fledgling occupational therapy graduates and healthcare service users.

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Abbreviations and Acronyms

AR Autonomous reflexive

CR Communicative reflexive

COT College of Occupational Therapists

RCOT Royal College of Occupational Therapists

DoH Department of Health

DHSC Department of Health and Social Care

EBP Evidence-based practice

FR Fractured reflexive

HCPC Health and Care Professions Council

HE Higher education

NHS National Health Service

PRM Preferred reflexive mode

MR Meta-reflexive

UK United Kingdom

Chapter 1 – Introduction

Entrepreneurship

Occupational therapy education in the UK has recently experienced a crescendo call and increasing pressure for producing graduates who are increasingly 'entrepreneurial' in every aspect of their professional practice. As a UK higher education (HE) based occupational therapist and educator, I have been acutely aware of this loudening call arising from diverse sources. In particular, UK Government rhetoric and policy has been compelling all healthcare practitioners to embrace a greater 'entrepreneurial spirit' (DoH, 2010; 2012) and demands all to challenge the status quo, confront poor practice, be innovative and creative and optimise healthcare service quality for everyone. The volume of this rhetoric has increased with the shocking cases of neglect and poor practice broadcast in media reports of the Francis Inquiry (2013). The inquiry highlighted shocking failures and lack of basic care provided at the Mid-Staffordshire NHS Trust with examples of patients being so thirsty they had to "drink water from vases" and others being "left in dirty bed sheets" (BBC, 2013). Equally as fierce has been the drive within the HE sector, occupational therapy professional body (RCOT) and UK health and care regulatory body (HCPC)[1] to ensure entrepreneurialism is a key feature of pre-registration programmes to deliver 'highly employable' and 'entrepreneurial' graduates into the healthcare workplace. This drive for entrepreneurship is evidence of the three substantial forces that operate on the shaping of the professional occupational therapy curriculum in the UK: Governmental forces through HCPC and National Health Service (NHS) policy, HE sector forces through HE and university policy and occupational therapy professional forces through the RCOT. Where I am currently positioned in HE, I have been personally involved in translating this pressure into embedding these notions of entrepreneurship across our occupational

[1] The Royal College of Occupational Therapists (RCOT) is the occupational therapy professional body. The College of Occupational Therapists (COT) was officially renamed the Royal College of Occupational Therapists on the 19th April 2017 after Her Majesty the Queen gave permission for the royal title. The Health and Care Professions Council (HCPC) is the statutory body that regulates health and social care professional accreditation. They both provide standards for pre-registration education and training in the UK for occupational therapy and wider professional groups.

therapy undergraduate curriculum. Lately, I have become greatly alarmed by the intensity of pressure, speed of developments and the lack of any challenge to this pressure from the occupational therapy profession, healthcare practice and HE colleagues. We all appear to have consumed and fully digested the rhetoric before evaluating its relevance, worth or 'nutritional value'.

An exploration of the more general entrepreneurship literature landscape revealed a heavily contested concept with no clear definition or agreement about its relevance or what is included. Key commentators have been debating and researching since the mid 1700s onwards and more extensively since the 1980s. Explanations focus on who entrepreneurs are, what they do and how they do it (Hisrich, 1990; Schultz, 1990; Shaver and Scott, 2002), on the culture and structure of organisations (Jennings, 1994; Knight, 1989; Pinchot, 1985) and as a foundation for economic progress (Casson, 1982; Say, 1815; Schumpeter, 1934). Narrowing the exploration of the concept of entrepreneurship into the healthcare context revealed substantial variations in how it is translated. The language used in the general and classic entrepreneurship literature was more individualistic, competitive and profit-oriented whereas the language used in the healthcare policy and academic literature was more softened and focused on the benefits of enterprising individuals and teams for the greater good of the organisation and society in general. This translation was mirrored in the general entrepreneurship literature when the focus moved to the relevance of the concept *within* organisations rather than on developing new enterprises. Adding even greater complexity to the literature field, the term 'intrapreneurship' has recently emerged alongside this narrative of entrepreneurship *within* organisations. This term reflects very closely the aspects that I was interested in exploring for our occupational therapy graduates entering the healthcare context as it is an attempt by scholars to define the individual's entrepreneurial 'hands on' activities *within* the organisation whose objectives are concerned with the organisation's benefits rather than for personal gain (Pinchot, 1985; Hisrich, 1990).

A review of the occupational therapy entrepreneurship literature revealed that, whilst entrepreneurship is a positive entity to embrace (Pattison, 2006; McClure,

2011), very little research had been undertaken to explore what it is and how it can be developed and enacted within occupational therapy practice. This indicated that the occupational therapy practice context was severely lagging behind HE developments and Governmental demands for a more entrepreneurial approach to practice. Importantly, I also noted an overarching lack of significant discourse around any disadvantages or downsides of entrepreneurship. This picture paints a highly complex landscape littered with intense pressures, disagreements and little useable inquiry in the occupational therapy entrepreneurship or intrapreneurship fields.

Occupational therapy in the healthcare context

Stepping back from the rhetoric and critically reflecting on the current complex situation has provided space for contemplating the wider landscape and the possible implications for our new occupational therapy graduates entering the reality of practice. It is particularly in the statutory healthcare context where I have been conscious that the highly bureaucratic systems and structures might be restricting opportunities for them to practice with any real autonomy and agency (Phillips and Garman, 2006). Anecdotal evidence further supports this perspective from personal experience, students returning from placement and from new and seasoned practitioners. They report resistance to change, entrenched practices and a plethora of protocol and prescriptive-based interventions in multifarious statutory healthcare contexts. These restrictive systems and structures are part of the wider complex interdependencies at play that have been greatly impacting the statutory UK healthcare context in particular. The UK is only just recovering from the worst global recession since the 1930s, which has resulted in Government policy imposing relentless cuts right across the public sector. This resource squeeze has created a spiralling demand for services alongside Governmental demands for greater efficiencies, innovation, entrepreneurialism and better leadership. These economic, cultural and structural pressures along with conflicting messages have created an immensely complex environment for our fledgling graduates to launch into their early career professional roles.

For the purposes of my study, I will be focusing on entrepreneurial thinking and behaviour *within* practice. I had become increasingly curious about new occupational therapy graduate experiences when they enter the healthcare practice context. I pondered what their perceptions of entrepreneurship might be and if they had found more or less opportunities for it in the statutory compared with the non-statutory healthcare context: the non-statutory context is generally perceived as far less bureaucratic and more responsive to innovation and change[2]. As my reflections progressed and deepened, I began to think further about these two distinct practice contexts and whether certain graduates might be drawn to particular contexts. Would particular graduates be drawn to what they might perceive to be a more or less conducive environment for entrepreneurial thinking and behaviour? What were their experiences once they had settled into their role and had their perceptions changed? These initial questions prompted me to locate a suitable theoretical framework within which to inquire further into these broad issues.

Occupational therapy education

Occupational therapy is an established global healthcare profession emerging early in the 20th Century and is professionally overseen by the World Federation of Occupational Therapists (WFOT). Initially, the profession was involved in working primarily in the mental health field supporting individuals through engagement in various leisure and work activities. During the first and second world wars, the profession also moved into treating those with physical and psychological traumas on return from active service (Turner et al, 2002). Historically, the profession has always been closely aligned with the medical profession and this relationship was cemented as the UK established the NHS in 1948. The first training college, Dorset House on the outskirts of Oxford, was funded and launched in 1930 by Elisabeth

[2] Statutory healthcare context – this includes UK statutory healthcare providers in primary (General Practice) and secondary (hospital) and tertiary (community) care contexts. The non-statutory healthcare context – this includes private, charitable and 3rd sector healthcare organisations or self-employment. 3rd sector organisations are the part of an economy or society comprising non-governmental and non-profit-making organisations or associations including charities, voluntary and community groups, cooperatives, etc. (Oxford English Dictionary, 2018).

Casson (Paterson, 2008). Current UK occupational therapy education is overseen by the Department of Business, Innovation and Skills and is provided in the HE sector. Occupational therapy students are educated by a combination of theory, usually whilst based in the university, and practice, which entails 30% of all courses delivered in various clinical practice contexts. The practice placement education experiences have developed significantly over recent years to incorporate more contemporary work contexts where there may or may not be a qualified occupational therapy practitioner. For example, these contemporary contexts could be located in the private or 3rd sectors or in wider public sector organisations. These contemporary placements reflect the development across the UK in employment options for graduate occupational therapists. In tandem with these placement and work location developments, the curriculum and approach to education has also been developing.

As a seasoned HE-based occupational therapy educator, I have witnessed the push for changes to occupational therapy education influenced by the global neo-liberal agenda, which is discussed in detail in the next chapter. I have experienced the growing demand for more business-minded and entrepreneurial graduates who can lead and influence practice transformations from day one of their first professional post. Within the HE sector, I have also witnessed massification and marketisation policies designed to introduce competition into the sector and to expand the number of graduates to meet the growing UK, so-called, 'skills gap' (Wilson, 2012). I acknowledge the importance of ensuring that we are effectively preparing our graduates for this rapidly changing practice context (COT, 2014; HCPC, 2017). However, I also recognise that it is equally imperative that we equip graduates with the necessary critical thinking skills to question and challenge new ideologies especially when these may conflict with their core professional values. I explain in detail, in the next chapter, how I have the concluded that entrepreneurship and intrapreneurship are relevant concepts that we need to embrace as a profession although we need to remain cognisant of the fact that there could be downsides and negative implications to consider. Within this thesis, I will be using the terms 'intrapreneurship' and 'entrepreneurship' interchangeably as this reflects what is evident in the literature. However, my focus remains on the creativity, innovation

and enterprising activities of occupational therapy graduates *within* their selected professional healthcare work context rather than on setting up new businesses.

Critical realism and Margaret Archer

I approached the study from a critical realist perspective where both the sociological concepts of 'structure' and 'agency' are viewed as real and separate entities that have powers and emergent properties (Bhaskar, 1975, 1989, 1998). I decided to draw on the work of the well-known critical realist philosopher, Margaret Archer, as a suitable theoretical lens to assist my exploration. In particular, her theory of 'morphogenesis', which describes the underlying mechanisms at play that mediate between structural forces and agential powers (Archer, 1982; 1995) [3]. She proposes that agential reflexivity is a mediating factor and she has further developed her theory that describes this reflexivity as the 'internal conversations' that people have. She argues that it is the type of conversation that actually shapes people's lives and what they choose to do. She explains that reflexivity is the way a person interprets the world around them and how they explain it to themselves. It is about the interests that people have, what they think is important, their concerns and life projects and how they can gain any governance over their lives. Archer had identified clusters of modes of different ways that people conduct their internal conversations (Archer, 2003, 2007). She describes these preferred reflexive modes (PRMs) as communicative reflexive (CR), autonomous reflexive (AR), meta-reflexive (MR) and fractured reflexive (FR). Additionally, a person's natal context plays an important role in Archer's theories. Archer's ideas resonated with my own study as I could see that, for occupational therapy graduates, the healthcare environment has become increasingly complex with mixed messages about practicing with an entrepreneurial spirit at the same time as being bombarded with protocols and prescriptive regimens. Commentators in the field have also recognised the long history of cultural

[3] Morphogenesis is a process referring to the complex interchanges that produce a change in a system's given form, structure or state and has an end product: structural elaboration (Archer, 1982:458). Morphogenesis translated from Greek literally means change in form or shape. The term was originally used in biology and has been picked up as a term for social change by social systems theorists like Margaret Archer (1982). She uses the term to identify a realist approach to the structure-agency problem as distinct from the then more prominent approach of structuration theory (Porpora, 2013:25)

morphostasis[4] in the healthcare practice context (Case, 2013), which is certainly a condition that I have been acquainted with from recent practice encounters and the appalling cases of neglect and poor care detailed in the Francis Inquiry report (2013).

Archer's ideas have been very appealing as a framework for my study. Examining occupational therapy intrapreneurship through a sociological lens allowed me to look at the role of the occupational therapist intrapreneur and their human will and how they interact within a structured and changing world to shape it into different forms that materially exist independent of their knowledge of it. Archer attempts to unravel the process of how structure and agency are mediated, which has assisted me to try and understand *how* our graduates might or might not be able to make transformations in practice. Her theories have allowed me to examine the occupational therapy graduates' perceptions and experiences of intrapreneurship from their perspective but also enabled me to look at the possible underlying causes. Whilst there exists other theoretical frameworks I could have used and there are some critical opponents of Archer's arguments, which I discuss in chapter 3, I firmly contend that for my study her ideas have been invaluable. They have helped to unravel the complexities inherent in structure / agency interactions and provided explanations about what might be happening at the nexus of the fledgling occupational therapy graduate and the intrapreneurial opportunities they encounter.

There is some recognition in the literature of a close relationship between agency and entrepreneurship (Barker, 2003; Berger and Luckmann, 1967; Garud et al, 2007). Many suggest that entrepreneurship is simply a modern, socially constructed term for an individual's creative and innovative activities and a proxy for human agency: the capacity of individuals to act independently and make free choices. Whilst I appreciate this position, I pragmatically approached the study from the standpoint where entrepreneurship is a real and relevant concept. It requires occupational therapy graduates' agential reflexivity for circumventing social structural barriers and realising various aspirations in practice. Adopting this standpoint, incorporating

[4] Morphostasis is the situation where a system or social structure remains unchanged as opposed to morphogenesis where a structure changes in a response to interaction from an agent. In sociological terms, the structure is reproduced and not altered (Archer, 1995).

Archer's ideas and being faced with the issues that have emerged from my reflective analysis resulted in focusing the study on three core areas for exploration. Firstly, I considered the individual occupational therapy graduates' perceptions of the contrasting practice contexts and whether their PRM influenced their choice of early career practice context. Secondly, I considered the extremes of practice context environments and wondered if the different sociological features afforded or constrained opportunities for entrepreneurial thinking and behaviour. Lastly, I wondered if there were features regarding the way that occupational therapy graduates conducted their reflexivity, or 'internal conversation', that either facilitated or restricted their capabilities for entrepreneurial thinking and behaviour: for negotiating and traversing the social structural forces. I was aiming to generate a theory of how Archer's ideas and entrepreneurship are associated in relationship to this field of inquiry. These key exploratory areas provided a focus for posing relevant questions to inform the methodological approach and design of my study.

I am firmly of the view that this study is important and warranted at this particular historical moment. As a HE-based occupational therapy education provider, we are preparing graduates for working in an increasingly complex world where they are faced with complicated situations and decisions to make that require a much more adaptable, reflexive and intrapreneurial approach. I strongly suspected that the statutory healthcare context had become more challenging in recent times with great limitations placed on occupational therapists' opportunities for professional artistry in every respect. This study is my attempt to understand occupational therapy graduates' experiences of entrepreneurship in contrasting practice contexts within the framework of Archer's concepts around their modes of 'internal conversation' and their life and work 'concerns'. My intuition was that there could be important connections between the ways that graduates operate their 'internal conversation', their choices of practice context and their perceptions of and capabilities for intrapreneurship in practice. Despite some criticism of Archer's ideas, I am firmly of the view that her notions arising from a realist social theory position are sufficiently robust as an explanatory framework for my sociological-based study. I envisaged the study generating new knowledge in this arena and shedding light on

mechanisms that could be operating at the more individual, micro-level in the healthcare practice context. I contend that the findings will inform the practice context and the development of a relevant curriculum geared to prepare students advantageously for the practice world. Ultimately, my goal was to contribute to improved outcomes for our healthcare service users and to prevent further shocking cases of poor practice and neglect.

Positionality and reflexivity

Awareness and understanding of my position as an insider researcher and the impact of power relations has been critical. I am researching into my own field, both as an academic and as a healthcare professional, and could be riddled with selective memories, careless error, self-centeredness and prejudices (Bridges, 2001; Tinker and Armstrong, 2008; Merton, 1972). My career in the healthcare context spanned 15 years of mental health occupational therapy practice including leadership and management across a range of occupational therapy and multi-professional mental health services. I moved into the occupational therapy HE sector over 17 years ago and for the initial 11 years, retained a role in occupational therapy mental health practice in a local hospital for people with severe and enduring mental health issues. As a researcher, I am currently positioned within the community of occupational therapists in HE who are educating the future occupational therapy workforce.

I grappled strenuously with where to position myself within this research and came to realise that the notion of insider or outsider was not a straightforward one. Although I recognised my position as an insider researcher, as the research participants were all graduates from the university where I am located, I could also be considered as an outsider as I was inquiring into their experiences in healthcare practice contexts where I am not currently working. Additionally, as argued by Bridges (2001), insiders may always be considered outsiders by the very nature of being an inquiring researcher: I was not a newly graduated occupational therapist working within the healthcare context or even a current occupational therapy

practitioner but a HE-based researcher inquiring into their experiences. Despite the debates around this issue, I had concluded that it was important for me to consider myself an insider to ensure I remained fully aware of the potential pitfalls of this positioning.

As an insider researcher, I may also be perceived as possessing substantial positional power: several of the occupational therapy graduate participants have been taught and assessed by me and some will remain with close connections to the BSc (Hons) occupational therapy course team by providing placements, undertaking further study, attending conferences and other collaborative activities. Scanning the 'power within research practice' literature revealed that there was not a definitive, singular accepted approach to viewing the concept of power and, similarly, no optimal relationship identified (Karnieli et al, 2009). Despite this lack of a singular approach, it was clear that there are considerable complexities involved and that it is challenging to comprehend some of the subtleties of the interactions and power relations between the researcher and the participant (Smith, 2006). However, I maintain that the qualitative approach I was taking within my inquiry should aim to reduce power differentials and attempt to encourage a more open and authentic encounter between the occupational therapy graduate participants and myself, as the researcher. This encounter is very different from the more traditional quantitative research, where the researcher is considered to be the primary source of authority (Karnieli et al, 2009).

As I reflected further on my personal approach to the study from a critical realist paradigm of understanding, I recognised that what I was aiming to achieve through my research was, to some extent, emancipatory in nature, which is an important element in Bhaskar's (2009, 2011, 2013) more recent philosophical explanations. I was seeking to understand the root of any occupational therapy graduates' difficulties in practising intrapreneurially and learning how we can better equip future graduates for the complex and challenging healthcare environments that they could be joining. With this overarching emancipatory aim in mind, I became especially keen to ensure that my research was fostering a rebalancing of any power

differentials within the relationship between the participants and myself, as the researcher. This emancipatory approach was not new for me as it mirrored the practices I was familiar with in the healthcare professional context where patient-centred, or client-centred care, is strongly espoused. This type of person-focused approach requires all healthcare professionals to place the patient or client at the centre where they can be empowered to make significant contributions to their care decisions and where they could fully understand their rights (Epstein et al, 2005). I attempted to address any power issues at each stage of the study process and continued to check my approach with supervisors, peers and participants. Specific detail of how I addressed these ethical power issues is provided in chapter 4, which details the research methodology and methods.

Whilst I acknowledge that entirely objective research is non-existent, I had appreciated the need for continual development of my approach to education research practice, which was grounded in critical reflexivity. Critical reflexivity, in this sense, was about making any research decisions through a process of reflection and critical thinking (Finlay, 2002; Curtin and Fossey, 2007; Scheffer and Rubenfeld, 2000). To avoid any of the potential pitfalls, I continually examined my thoughts and actions, kept reflective research notes (Burgess, 1981; Wall et al, 2004) and took part in regular academic supervision and peer support. I viewed this reflexive approach as crucial for working with the subjectivity inherent in this type of qualitative research.

Outline of chapters and thesis structure

This thesis is structured to support ease of navigation through the background justification for the study, research activities undertaken, analysis and conclusions drawn. I have created seven chapters and have summarised the content of each of these chapters below to clearly signpost the reader and enable them to gain an overview and the opportunity to select particular areas of interest for closer scrutiny.

Chapter 2 presents the contextual backdrop to the study. Combined with the introduction, it sets the scene for the thesis and positions the research within the key literature fields, aiming to clearly identify the gaps and silences where it firmly resides. Relevant literature is presented and appraised. It depicts the healthcare entrepreneurship discourse, entrepreneurship research and Margaret Archer's theories, the professional identity, reflexivity and power and culture discourses, the imperative for the occupational therapy profession and the political and economic drivers. This literature appraisal has facilitated the synthesis of the key findings with current debates and what is already known within the literature field, which is discussed in chapter 6. The research questions are introduced at the end of the chapter.

Chapter 3 outlines my approach to the study ontologically from a realist tradition through a macro-level critical realist paradigm. It describes how this paradigm originates from the philosophical work of Roy Bhaskar from the 1970s onwards and explains how useful this has been in offering a realist perspective concerning the structure and agency debate. It explains how I utilised the realist social theorist, Margaret Archer, and her theories and concepts to examine the micro-level interactions of, specifically, new occupational therapy graduates within the healthcare context and their intrapreneurial pursuits. It goes on to explain why and how I integrated Margaret Archer's work concerning her theory of morphogenesis (Archer, 1982, 1995) and her reflexive modes (Archer 2003, 2007) as suitable epistemological tools to underpin the research design and analysis.

Chapter 4 presents and justifies the methodological approach and methods selected for generating, collecting, analysing and interpreting the research data. It explains how the study is viewed through an interpretivist theoretical lens that works coherently with the ontological critical realist approach to structure and agency. Detail is then provided of the structured data collection design that included the use of life grids and semi-structured interviews. The chapter goes on to explain and justify how the participants were recruited and how they engaged with the process. It discusses the ethical issues encountered throughout the research process and

details how these were addressed through the rigorous application of ethical concepts and principles and, more formally, through the University of Nottingham ethical approval process. The chapter concludes with a detailed description of the four key stages of data analysis and interpretation and explains how the analytical approach, from within the chosen methodological and theoretical framework, has effectively facilitated the answering of the research questions.

Chapter 5 presents the findings arising from the analysis of the data generated. It explains how the first stage of the analysis concerned the assigning of the graduates' PRMs as described by Archer (2003, 2007). It goes on to elaborate how the second stage involved thematic analysis of the interview transcripts and a subsequent comparison between the two contrasting healthcare contexts under scrutiny. The chapter is concluded with a summary of the key findings arising from the analysis of the data generated.

Chapter 6 discusses my interpretation of the findings and how they are contextualised against the backdrop of the literature review and theoretical framework. The section closes with a summary of the discussion.

Chapter 7 offers a conclusion to the findings of the research and spotlights the contribution to knowledge, implications for future education practice, professional occupational therapy practice and identifies further useful research. Limitations of the research are also addressed.

Chapter 2 - The study context and current debates

I have journeyed through diverse landscapes and knowledge territories in pursuit of designing this vital study to explore these pressing issues. Searching these knowledge territories and appraising the available literature and wider evidence revealed significant gaps and pressures, providing a compelling mandate for my study. This section aims to present this contextual backdrop concerning the healthcare entrepreneurship discourse, entrepreneurship research and Margaret Archer's theories, the professional identity, reflexivity and power and culture discourses, the imperative for the occupational therapy profession and the political and economic drivers. The section closes with a summary of the background literature reviewed including important gaps exposed and an introduction to chapter 3, which details the theoretical framework selected for underpinning the study.

Healthcare entrepreneurship and intrapreneurship

A review of the occupational therapy entrepreneurship and intrapreneurship discourse had revealed a significant deficiency in the quantity and quality of available literature. For this reason, I widened the search to the healthcare entrepreneurship and general intrapreneurship discourses, which produced much improved results. In this sub-section, I present the literature landscape concerning the understanding and explanation of the concept of entrepreneurship, the comparative experiences of entrepreneurs in small versus large organisations and the individual thinking and behaviour aspects of entrepreneurship. I move on to explain the evolution of the term 'intrapreneurship' and its relevance for the occupational therapy profession, the structural and cultural barriers to entrepreneurship and intrapreneurship, particularly in relation to the highly bureaucratic statutory healthcare context, and the little explored area of relationships and how these might influence the occupational therapy graduates intrapreneurial lives. The sub-section closes with a discussion of the literature concerning possible costs, negative aspects and

downsides of entrepreneurship and intrapreneurship, which I had considered vital to ensure a balanced perspective for the study.

Any attempt to explore the landscape and concept of entrepreneurship will quickly discover that it is a highly contested term with no single definition that is agreed upon by commentators in the field (Filion, 1997; Morris et al, 2001). The entrepreneurship discourse emerged in the early 1700s and in the healthcare arena since the early 1900s. Notably, the entrepreneurship discourse has developed rapidly in size, and sophistication over the last two to three decades. As an explorer in the landscape, I found that the definitions and explanations offered differed significantly depending on where the commentators are located and many agree that it is a socially, or even politically, constructed concept that has no base in reality (Berger and Luckmann, 1967; Downing, 2005). The first commentators tended to emphasise the benefits of entrepreneurship for economic progress (Say, 1815; Schumpeter, 1934) with Cantillon (1680? – 1734), the author of the first economic theory of entrepreneurship, identifying that the willingness to take monetary risk was an important factor in profit making (Hoselitz, 1951). Say (1827), who emphasised the importance of the sound judgement of the entrepreneur, was able to match scientific knowledge with individual desire and could balance these with costs. Schumpeter (1934) developed these ideas and argued that an entrepreneur could innovate and use scientific knowledge to find and launch new combinations of products and services. He was also the first to argue that the entrepreneur could be an employee rather than a business owner: an early nod towards the concept of intrapreneurship. More modern commentators have focused on who entrepreneurs are, their traits and characteristics and how they do it (Hisrich, 1990; Schultz 1990; Shaver and Scott, 2002) and also on the structure and culture of organisations, whether these inhibit or promote entrepreneurial behaviour (Jennings, 1994; Knight, 1989; Pinchot 1985). The wider entrepreneurial discourse explains the historical development of the term and the emphasis that different commentators place on various elements of the concept but it does not proffer a unified, single definition.

There was a wide array of understanding and explanation of entrepreneurship in this healthcare field of inquiry although there did appear to be a thread of agreement running throughout the studies: entrepreneurship concerns making a specific change in something that is advantageous in some way. The advantages related to changes in how someone thinks and behaves, in a structure or process or in what is produced. There was a split of focus on whether individuals and entrepreneurship was about people being employed in healthcare organisations or self-employed within the healthcare industry. The self-employed were offering services into the statutory and private healthcare context. I decided to focus on the healthcare rather than the social care context as occupational therapy professional education in the UK was funded by the Government's Department of Health and Social Care (DHSC) and the majority of graduates work in the healthcare industry post-graduation[5]. Additionally, to facilitate the comparative dimension of the study that aims to emphasise contrasting contexts, I focused on the healthcare statutory and the healthcare non-statutory contexts.

Academic commentary concerning the comparative experiences of entrepreneurs within statutory versus the non-statutory healthcare contexts is virtually non-existent. Widening the search into the general entrepreneurship arena and examining smaller-scale organisations as a proxy for the non-statutory context and large-scale for the statutory context uncovered a similar picture. Whilst there was some discussion around entrepreneurship separately within small and medium sized enterprises and large organisations, there was very little that made any comparison between them or discussed this from the entrepreneur's perspective. What little there was tended to focus on the organisation rather than the individual and discussed their different cultures and capabilities (Szymanska, 2016) and how these might enhance or dampen entrepreneurial activities (Kuratko et al, 2015). A small body of literature did emerge that debated the 3rd sector in comparison with other sectors in terms of job satisfaction, security and quality (Ruuskanen et al, 2016;

[5] There have been recent changes to the funding of healthcare professional education in the UK. As of September 2017, the DHSC no longer provides education funding. Students apply for course fee and living cost loans through the UK Student Finance Company, as all other university students embarking on undergraduate courses. There are some maintenance support grants available for some groups of students to support participation. The student participants within this study had been fully funded by the DHSC.

Cunningham and James, 2009; Kendall, 2009; Kalleberg et al, 2006). Although this literature is interesting, as it loosely relates to the occupational therapy graduates in my study and their different experiences, particularly in the area of autonomy, there is little agreement between scholars about which work sectors provide greater satisfaction. Furthermore, it is not applied directly to entrepreneurs or health professionals. There was a stronger field of literature widely recognising that larger organisations are less capable of fostering the entrepreneurial approach needed within the increasingly globalised market environment compared with smaller organisations (Gibb, 2000; Handy, 1984; 1993). Smaller organisations were generally considered to be less structured, more reflexive and provide better conditions for entrepreneurial behaviour (Gibb, 2000). In response to this mantra, there has been a longstanding worldwide move in larger firms to explore how to foster a more intrapreneurial culture within the organisation (McKinney and McKinney, 1989), to de-centralise and create boundary-less organisations that are more responsive to innovation and change (Ascari et al, 1995). Despite the lack of specific healthcare-based research and commentary, it is clear that our occupational therapy graduates entering the smaller-scale non-statutory healthcare context could well be experiencing an environment better designed to support their intrapreneurial pursuits compared with the larger-scale, bureaucratic statutory healthcare context.

Exploring the healthcare entrepreneurship landscape and noting the thread of agreement concerning the advantageous changes, I became interested in the individual thinking and behaviour aspects. It connected with what I perceived as the mounting pressure demanding that our occupational therapy graduates become more entrepreneurial *within* their practice. The studies that I examined explained this aspect in terms of people becoming more risk-taking, empowered and autonomous (Amo, 2006; Lewis, 2001; Boyce and Shepherd, 2000), becoming perceptive to change, moving out of their comfort zone, pushing back professional boundaries (Exton, 2008; Lewis, 2001), making transformations and becoming agents of change (Amo, 2006; Lockett et al, 2012). These were the attributes and behaviours that we had been attempting to instil in our occupational therapy graduates in preparation for practice.

The more I explored the concept of entrepreneurship and its translation within different contextual spaces, the more I realised the story was not a straightforward one. Whilst the general and classic entrepreneurship literature tended to proffer a more individualistic, competitive and profit-oriented narrative, the healthcare and healthcare professions literature described a very different creature. The language used in the healthcare academic literature, and particularly in healthcare policy documentation, seemed more softened and geared around individuals and teams working for the greater good of the organisation and society. Individuals' creativity and innovation was foregrounded but, strikingly, the profit, competition and new enterprise creation language was far less evident. These language differences were also noted in the general entrepreneurship literature when the focus moved towards taking the concept *into* organisations rather than concentrating on creating new enterprises. These differences, discussed later in the section, could partly be related to the tensions in the UK between the ideologies of communitarianism and individualism (Reich, 1987). In particular, the culture in the public sector that is especially squeamish about individualistic and profit-making notions within the sanctity of publicly funded organisations. To further muddy the waters, the term 'intrapreneurship' has gradually crept into the 'entrepreneurship within organisations' space. The term suggests an attempt by scholars to define the individual's entrepreneurial 'hands on' activity *within* the organisation whose objectives are more aligned with the organisation rather than for personal gain (Pinchot, 1985; Hisrich, 1990). This term does seem to describe the aspects that I am exploring with our occupational therapy graduates and, for this reason, I explain in more detail the concept and the developing scholastic interest.

There is a growing body of evidence over the last 40 years and discussion around the concept of corporate entrepreneurship (Kuratko et al, 2015), which is described as entrepreneurial action on the part of established organisations. The term 'intrapreneurship' has arisen more recently and has been increasingly used alongside, and in place of, corporate entrepreneurship as it centres more on the activities of employees rather than organisation level entrepreneurial activities

(Gawke et al, 2017). A review of the intrapreneurship literature relevant to my study that focuses on the individual entrepreneur, revealed a growing field of studies ranging from concept clarification and characterisation of the intrapreneur through to intrapreneurial behaviours and important factors that can enhance intrapreneurship within the organisation. Antoncic and Hisrich (2001) defined intrapreneurship as "the formation of new development inside the company that would lead to new ventures, new products, services, technologies, administrative practices, strategies, and competitive postures" (2001:498). Bosma et al (2012), amongst others, examined the individuals themselves and characterised the intrapreneur as an employee who plays a lead role in creating and implementing innovations. This move to exploring the employees from a more behavioural perspective was supported by many with Rigtering and Weitzel (2013), in particular, arguing that exploring intrapreneurial behaviour is essential and central to the forming of ideas (West and Farr, 1990), using initiative (Frese et al, 1997) and risk-taking behaviour (Parker and Collins, 2010).

Antoncic and Hisrich (2003) produced a thorough review of the nature and features of intrapreneurship and described how these were different or similar to other concepts related to intrapreneurship, for example, capabilities or corporate innovation (Yariv and Galit, 2017). Many studies following on from this review focused predominantly on intrapreneurship from the organisation's perspective and how the concept is important for the firm's productivity and growth (Antoncic and Antoncic, 2011; Brizek, 2014; Kacperczyk, 2012; Koryak et al, 2015) rather than from the individual's standpoint. Other scholars have accepted the positive nature of the concept and explored internal factors that might enhance intrapreneurship (Alpkan et al, 2010; Koryak et al, 2015; Goodale et al, 2011) with Antoncic and Hisrich (2001) describing the supportive atmosphere needed as 'organisation support'. Whilst the definition of the concept is an important element of the unfolding complexity of the entrepreneurship story, it still maintains somewhat 'fuzzy' boundaries within the growing field of literature. For this reason, I will be using the term interchangeably with entrepreneurship throughout this thesis and my focus is on the innovative,

creative, boundary-pushing and risk-taking activities that occupational therapy graduates have been grappling with rather than the organisation level proposition.

There is an extensive and important narrative within the healthcare entrepreneurship and intrapreneurship literature concerning the barriers that could be encountered when healthcare professionals attempt to exploit opportunities to be intrapreneurial: to challenge the status quo, innovate or change current practice. The barriers are often discussed either in relation to the structural and cultural features of the environment or from a more cognitive psychological framing that highlights the individual's perceptions and responses to arising obstacles. The structure of statutory healthcare services has often been likened to colossal slow-moving mechanisms or even hierarchical, military-style organisations. These metaphors emphasise the expectations of staff to be focusing on their narrow areas of responsibilities, aiming to carry out the organisation's overall mission. The organisation structure refers to how activities, co-ordination and supervision are arranged for meeting the organisation's aims (Pugh and Pugh, 1971). This structural environment is described as conflicting with an entrepreneurially conducive environment as its overarching mission is to deliver predefined services, rather than to create opportunities for achievement or reward (Phillips and Garman, 2006:474). Cornwall and Perlman (1990) argue that organisation goals can actually paralyse people and constrain their entrepreneurial behaviour with Meliones (2000) supporting this contention and suggesting that entrepreneurial activities are more likely to succeed if they actually fit with the organisation's mission.

The roles and responsibilities of professionals in healthcare organisations also create structural barriers. These roles and responsibilities are defined and highly regulated with various standards and traditions involved (Meliones, 2000; Shuck, 2002) giving little movement for innovation by individuals although this has been steadily changing over recent years. A lack of a tradition for networking and collaboration in healthcare between professionals (Elango et al, 2007), as a result of the organisations structure compounding silo working and generating role conflict issues (Phillips and Garman, 2006), has also created significant entrepreneurship barriers.

Institutional policies could also hinder entrepreneurship (Phillips and Garman, 2006) although little is discussed in the healthcare field regarding how they might do this. It may depend on how supporting policies are embedded and adhered to or whether other policies are in conflict with them. A lack of practical assistance such as monetary resources (Borins, 2000; Bates, 1995) and a lack of knowledge of business-oriented knowledge and skills (Elango et al, 2007) for writing and presenting persuasive arguments for innovation to healthcare leaders, have also been identified as notable barriers. Power and control structures and cultural resistance to change prevalent in healthcare organisations, which I cover in more depth later in this section, can also constrain the potential for entrepreneurship (Exton, 2008), with "excessive control by top management" being noted as *the* major obstacle to healthcare entrepreneurial activity (Morris and Jones, 1999:86).

The cognitive behavioural literature focuses on the individual's perceptions of the opportunities and barriers and emphasises that their perceptions are critical factors for success or failure (Krueger, 2008). Commentators also discuss cultural factors like social norms and how these can influence how entrepreneurs perceive opportunities (Morrison, 2000) whilst others discuss the entrepreneur's perception of their self-efficacy in the surmounting of barriers as being important for turning intentions into actions (DuCharme and Brawley, 1995). This 'barriers to healthcare entrepreneurship and intrapreneurship' narrative indicates that our fledgling occupational therapy graduates could be facing extensive challenges when perceiving, evaluating and navigating barriers they encounter. For this reason, the barriers were included within the scope of my study. My intention was to raise awareness for healthcare educators, practice professionals and for the graduating occupational therapists in the hope of better equipping them for their early professional and intrapreneurial life.

Whilst mapping the entrepreneurship literature and thinking about our graduate occupational therapy students in their early career work contexts, I became interested in their relationships with professional peers, friends and family, and how these might influence their intrapreneurial lives. Further exploration of the general

literature around entrepreneurship *within* organisations revealed a gap in the discourse focusing on the importance or influence of relationships on individuals' entrepreneurial pursuits. However, there were wider entrepreneurship debates that included some aspects of relational influences, particularly within the organisation supporting conditions for entrepreneurship (structure) and the psychological, individual and motivational traits (agency) discourses. The organisation support literature tended to focus on the importance of those higher up within the hierarchy in fostering a facilitative internal climate for entrepreneurship rather than on the support of peers, families or friends. Thompson (2004) and Turley (2011) highlighted the need for senior colleague support and Alpkan et al (2010) also emphasised this need alongside a range of other organisation and management support to encourage autonomy in decision-making for entrepreneurship. Buekens (2014) described the value of building a network of allies and corralling others' skills, particularly peer group coaching from other entrepreneurs, to bolster the entrepreneur's activities. However, this research focused on support to be garnered after they had chosen to be intrapreneurial rather than explaining any influence of others on their intrapreneurial ambitions. There was also literature exploring entrepreneurship and cultural resistance to change within organisations. This largely referred to the barriers entrepreneurs encountered from the resistance of others when embarking on intrapreneurial activities (Gray, 2002; Ford et al, 2008). The psychological characteristic literature identified the desire for autonomy as a key individual trait of entrepreneurs (Marques et al, 2013; Begley and Boyd, 1987; Brandstatter, 1997; Hornaday and Aboud, 1971). This strong desire for autonomy could be the key to why relationship influences are missing from the discourse. The intrapreneurs appear to prefer deciding and acting alone unless they require others' support for their innovative projects. Whilst there were elements of wider discourses describing support or impingements on individual entrepreneurs within organisations, there was a distinct paucity of debate regarding the importance, or otherwise, of professional peer and personal relationships involved.

A final significant issue is worthy of note. Whilst reviewing the healthcare entrepreneurship literature, alarmingly, I noticed an extensive gap in the evidence of

any possible costs, negative aspects and downsides of entrepreneurship. The literature largely focused on the advantageous aspects although two commentators alluded to some disadvantages of the healthcare professional setting up their own business (Andrews and Kendall, 2000; Wilson et al, 2003). When widening the search into the broader entrepreneurship and intrapreneurship literature, any costs, downsides or 'dark sides' explored focused on the consequences of failure on the organisation or on the individual if their own business failed. Limited dialogue from some psychologically-oriented literature suggests that many of the difficulties entrepreneurs experience relate to their personality type and traits. Although personality studies have made little progress to date, some suggest that the 'dark side' elements of the entrepreneur's personality can have a detrimental effect on other people within the organisation (Haynes et al, 2015) and can be difficult for managers and peers to deal with (Kets de Vries, 1985). Also, the entrepreneur can pay a heavy price with significant personal or health issues like loneliness, people problems (Boyd and Gumpert, 1983) and unchecked stress leading to physical health issues (Cardon and Patel, 2015).

Those who continually persist in entrepreneurial pursuits are considered, by some scholars, to be "habitual entrepreneurs" (Spivack, et al 2014; Huovinen and Littunen, 2009) and classify this as a psychological and behavioural addiction pattern with its own price tag of negative emotional outcomes and poor health. The costs to the organisation are largely related to the negative economic impact of the failure of the entrepreneur (Roessler and Koellinger, 2012) although, overall, most studies found substantial economic benefits of entrepreneurship for organisations (Vanpraag and Versloot, 2007). With reference to my study, the bulk of these costs, downsides or 'dark sides' found within the wider literature do not relate to the healthcare sector or to the intrapreneurial health professionals under scrutiny. However, there are important learning points and notes of caution to be gleaned for health profession educators, practice leaders and professionals when considering strengthening entrepreneurship within the curriculum and practice context. I also strongly contend that contemporary healthcare professional education, where I am positioned, cannot afford to have a biased perspective regarding this critical agenda. Therefore, my

inquiry included the possible costs and downsides to facilitate a more balanced approach.

In summary, this study focuses on occupational therapy graduates entering into the professional practice workforce within two contrasting healthcare contexts: the statutory and the non-statutory contexts. I approached the study from the assumptive position that entrepreneurship and intrapreneurship are positive entities that we should be endeavouring to instil within our graduates. Furthermore, we should be fostering HE and healthcare practice environments where entrepreneurship and intrapreneurship can flourish whilst remaining aware that there may be potential downsides involved.

Entrepreneurship research and Margaret Archer

There is a growing scholarly interest within in a critical realist approach to the way that entrepreneurship is viewed. Those scholars who have embraced this new approach see the weaknesses inherent in focusing only on the power of the entrepreneurial opportunities and the context in which they reside or on the individual agent giving them sole power as the opportunities are seen as being created by them alone (Kirkpatrick and Ackroyd, 2003). These scholars have recognised the value of this dualist ontological philosophy within the entrepreneurship field for exploring the nature of the organisations and environments where entrepreneurship can flourish (structure) alongside the nature and actions of individuals who make use of the opportunities or create new ones (agency). This approach is explained in greater depth in the next chapter. Exploring this evolving landscape that recognises the value of a critical realist perspective revealed a paucity of published work that acknowledges the critical realist theorist, Margaret Archer, and her theories of morphogenesis and reflexive modes, which is where my study is firmly rooted. The studies that did utilise Archer's work were focused around the use of the morphogenetic sequence to analyse and theorise around existing situations and available research data (Jackson et al, 2015;

Kirkpatrick and Ackroyd, 2003; Müller and Neergaard, 2012), the reflexive modes to thoroughly assess the reasons why some people instigate change within institutions and others do not (Mutch, 2007) and the concepts of 'professional agency' and 'the professional organisation' (Kirkpatrick and Ackroyd, 2003). Interestingly, Mole and Mole (2010), in their publication promoting Archer's theories as an appropriate framework for explaining the interrelationship between the opportunity and the entrepreneur, argued that entrepreneurship is "in essence, the study of the interplay between the structures of society and the agents within it" (20010:231). I have provided an overview of this developing research conversation and explained where my research sits and how it enters into new territory, adding fresh understanding to the field.

Archer's morphogenetic sequence is the main theory that scholars have applied to their largely empirical, and some theoretical, published scholarly contributions to the entrepreneurship field. As outlined in the introduction chapter, Archer's morphogenetic sequence is an attempt to explain how structures and agents interact to make changes to structures (morphogenesis or transformation) or how the structures can remain unchanged (morphostasis or reproduction). Archer's theories are explained in detail within the next chapter. Both Jackson et al (2015) and Müller and Neergaard (2012) carried out empirical research with historical data and utilised the morphogenetic sequence as an analytical tool to explain aspects of the interplay between the structural and agential elements of their concepts under scrutiny. Jackson et al (2015) argued that Archer's morphogenetic model could be used to explain entrepreneurial activity. To support this argument, they examined new business creation in Germany, a country considered to be innovative but not entrepreneurial (innovating within established organisations but not creating new businesses). They applied Archer's morphogenetic model to existing data that described entrepreneurial behaviour in Germany. They found that the pre-existing social and cultural conditions that bear down on agents and how the agents interact, depends on the tensions between structure and culture and how "entrepreneurially friendly" the structures are (Jackson, 2015:318).

Müller and Neergaard (2012) also argued that Archer's morphogenetic cycle was a useful explanatory tool and applied it to explore the nature of the interplay between the rural context and the enterprising agency. They found that entrepreneurs draw from the local context to create 'new' activities, which lead to regional development. They explain that the local context is transformed, creating opportunities for new entrepreneurial activity. Kirkpatrick and Ackroyd (2003) produced an earlier and more theoretical paper and argued that Archer's morphogenesis theory provides academics an alternative way of theorising about professional organisations and processes of change within them. They were concerned with exploring the relationship between 'professional agency' and 'the professional organisation', which is pertinent for the focus of this study, the healthcare context. This particular paper resonated with me as there was some discussion regarding the differing powers that various professionals have within the public sector. They explained that some professions in the public sector that have been supported by the welfare state, like nursing, occupational therapy or social work (Wilding, 1982), are weakened in their powers to negotiate in the workplace. They argued that this weakness contrasts starkly with the professions where the state recognises professional autonomy, like Doctors, Pharmacists or Lawyers. As a consequence, Kirkpatrick and Ackroyd (2003) argued that the state-sponsored professionals are less able to exert influence on structures. I recognised that these power dynamics could also be influencing factors for the occupational therapy graduates within my study who are working as these state-sponsored professionals, attempting to be intrapreneurial within the statutory healthcare context. Whilst these studies have progressed the field, where scholars are attempting to find an explanatory framework for examining the interplay between opportunities and entrepreneurial behaviour, they are positioned more at the organisation level of analysis. My study is located at the more micro, individual level and is concerned with explaining *why* differences in agential activity between individual occupational therapy graduates can be seen.

More recently, Mole and Mole (2010) have entered the growing scholarly space that espouses Archer's morphogenetic model as a useful lens for viewing entrepreneurship. In step with Kirkpatrick and Ackroyd (2003), they also crafted a

theoretical contribution to the debate. However, unlike Kirkpatrick and Ackroyd (2003), who focused solely on Archer's work, Mole and Mole (2010) critiqued other scholars' proposals to strengthen their own position. In their steadfast support of Archer's explanatory framework, they rejected the argument of Sarason et al (2006), recent scholars who build on Shane and Venkataraman's (2000) theory of entrepreneurship (proposing Giddens' structuration theory as a useful observational lens). From my own ontological leanings, I concurred with Mole and Mole's rejection of Giddens' theory as an appropriate epistemological tool to explore the nexus of the entrepreneur (agency) and the opportunities they encounter (structure). Structuration theory, which I explain in more detail in the next chapter, gives far too much weight to the action of agents in the creation of structures and denies any objective causal powers of structure. Conversely, Archer's ontologically dualist approach preferences neither, offering a more balanced perspective and, as such, is described by Mole and Mole as being "useful for practical analysis" (2010:231).

Mutch's (2007) study that sets 'institutional entrepreneurship' within the context of Archer's autonomous reflexive (AR) mode is the most closely related published research to my own study. Mutch set out with the premise that Archer's concept of the AR individual is the most closely aligned with the concept of the entrepreneur and that her conception of agency contributes to the debate around the nature of 'institutional entrepreneurship'. Institutional entrepreneurship is a concept of entrepreneurship at the institutional level of organisation change and has been helpfully defined by Li et al (2006):

> "…an institutional entrepreneur is an innovative person who starts or expands his business venture and in the process helps destroy the prevailing non-market institutions in order for his business venture to be successful. By this definition, an institutional entrepreneur is a businessman, whose ultimate objective is the success of his business venture. However, in order to make his business venture a success, he has to effectively break existing institutions, which are obstacles to his business operation. Thus, his innovation is external, not just within his firm. His efforts and creativity help establish market-oriented institutions". (2006:5)

Mutch's (2007) study is explained as an attempt to go deeper than merely describing the phenomena of agency by venturing to answer the questions about why some people within institutions seem to be instigators of change and others not. This is where Mutch's study bears similarities with my own study as I also attempted to dig more deeply into the underlying reasons for individual differences in intrapreneurial activity, in my case, occupational therapy graduates' intrapreneurial activities within contrasting healthcare contexts. Mutch (2007) uses a single historical case study to demonstrate the usefulness of Archer's reflexivity theory based on her morphogenetic approach. The case study is entitled 'the actions of Andrew Barclay Walker in embedding distinctive practices of public house management in nineteenth century Liverpool'. Mutch aligned this historical entrepreneur with Archer's AR mode to explain his entrepreneurial activities. In conclusion, Mutch argued that the study did begin to scratch the surface of not only looking at the skills that institutional entrepreneurs employ but also *why* they might deploy them in pursuit of their projects (2007:24). However, Mutch recognised that Archer's theories were only one of several other approaches that academics could use to examine the activities of the 'institutional entrepreneur' and also acknowledged the limitations of using a single case study. Whilst this research has added to the evidence base for proposing Archer's reflexive modes as a useful framework, Mutch acknowledges, but largely ignores, Archer's other reflexive modes by selecting *only* the AR mode. Mutch also made assumptions and set out with the premise that the AR would be more closely aligned with a single, 'pre-selected' entrepreneur. I contend that this assumptive approach limited the study and Mutch could have enhanced it by aligning other reflexive modes or by using additional or even comparative case studies to strengthen the argument. Additionally, Mutch is writing about 'institutional entrepreneurs' located at the organisation level and I am interested in occupational therapy intrapreneurs at the individual level of interaction.

As I have already alluded to, exploring this landscape has revealed scant and limited empirical research and none that enters the intrapreneurial, graduate professional healthcare context where my study is located. Whilst the existing studies that

recognised the usefulness of Archer's morphogenetic approach in theorising about *what* is happening in their particular scenarios have illuminated the landscape to an extent, they have not attempted to dig deeper to explain *why* particular phenomena can be observed. Unlike my study, they have not examined the possible micro-level interactions at work at the nexus of the particular structures under scrutiny and the individual agent's actions. Furthermore, they were all located at the organisation level of analysis. In the study that did delve more deeply and was closely related to my own study, Mutch (2007) espoused the notion of the AR as a useful lens with which to view the action of one 'institutional entrepreneur' although, as discussed above, the study was limited by focusing solely on one reflexive mode and the use of a single case study. None of the studies examined 'new healthcare graduates' of any profession, none dealt with the 'intrapreneurship' concept and they were all aligned to the private business context rather than the public 'statutory' healthcare context. I contend that my study, which employs Archer's theories as an illuminating lens to view this healthcare landscape, enters new territories and brings significant new understanding to this substantially under-researched field.

Professional identity

More recently, it is widely acknowledged that professional roles have been constantly changing; the concept of professional identity has become a growing area of UK scholarly interest, including the healthcare professional field (Freidson, 1994; Adams et al, 2006). However, there is scant literature connecting the entrepreneurship discourse with the notion of professional identity. Existing discussion concerns the global neo-liberal public sector reforms and the pressure on healthcare professionals to adapt their identities to become enterprising subjects who change their behaviours to align with Governmental goals (Doolin, 2002; Veenswijk, 2005). In the wider professional identity discourse, the current debates focus on human agency versus bureaucratic structural contexts with culture playing a key role (Trede et al, 2012). Specifically, I have observed little agreement between scholars regarding the definition of 'identity' or about how it is formed or shaped

either in the healthcare professional, HE or employment-based literature. What *is* agreed is that identity development is increasingly fluid and what is expected of professionals is to be strong in self *and* professional identity to successfully traverse the shifting employment market and workforce landscape (Bauman, 2009). I am fully cognisant that the healthcare context brings additional layers of complexity to the debate; healthcare professionals need to develop not only a strong sense of personal identity but also need to learn about boundaries in their own professional groups who have their own particular needs and rights (Clouder, 2005; Dahlgreen et al, 2006). Hence, there is an increasingly important debate and issue for healthcare professions to consider but this is not a major focus for my study.

Whilst I am aware of the discourse and note that professional identity is a factor, I chose not to foreground the concept. My study focused more around entrepreneurial thinking and behaviour in the 'real world' occupational therapy practice context and possible mediating factors. I do give credence to the idea that new occupational therapy graduates will need to develop a sound professional identity as a springboard for any required entrepreneurial activities. However, whilst there is definitely an overlap with my investigative field, it is not a significant enough factor to warrant inclusion.

Reflexivity

There has been a growing interest in the concept of 'reflexivity' in the healthcare professional context since the early 1990s although there is a distinct lack of clarity about exactly what it entails (D'Cruz et al, 2007). This has coincided with a spiralling level of uncertainty inflamed by political modernisation programmes in the UK healthcare context, not least the hike in consumerism demanding best value at all costs. These factors have created an increased pressure on healthcare professionals to make appropriate judgements and to be seen to do the 'right thing' especially for professional bodies and the wider sceptical public (Taylor and White, 2000:12). For the occupational therapy profession and the wider healthcare workforce, this

pressure heralded an unprecedented wave of interest in the concept of 'evidence-based practice' (EBP): a failsafe system for ensuring the efficacy of professional interventions. Scholars have argued the folly of blindly using all research evidence without considering the 'kinds' of knowledge they are using and how they should apply these to make sense of situations and events that they daily confront (Taylor and White, 2000). Others go further and believe that a new kind of 'professional artistry' is needed to go beyond the procedural and logical reasoning required for decision-making in contemporary professional practice. Reflexivity is described as a core component of this professional artistry that we should all be pursuing (Higgs, 2008). Many authors use the term 'reflexivity' and 'critical reflection' interchangeably (D'Cruz et al, 2007). In the main, practising reflexively is seen as the way of blending EBP, practitioner qualities, practice skills and creative imagination to make the most appropriate decisions. It is derived from the acquisition of deep relevant knowledge, extensive experience and significant capabilities for critical reflection (Higgs, 2008).

For occupational therapy, the focus has been on improved reflexivity in the professional practice context and even more prominently in the field of research generation. The tradition of reflexivity within the healthcare professional practice context has largely related to the notions of 'reflective practice' and 'clinical reasoning': learning and decision-making through reflection and critical thinking (Finlay, 2002; Curtin and Fossey, 2007; Scheffer and Rubenfeld, 2000). There has been a strong emphasis within the occupational therapy and wider healthcare professional research agenda on seeing reflexivity as a way of working with subjectivity so that practitioners can "break out of self-referential circles that represents a lot of academic work" (Parker, 2004:25). Cara and MacCrae (2012:80) suggest that a radical and reflexive research agenda will help occupational therapy researchers interrogate and fully appraise the research available and make informed decisions about which to assimilate.

The concept of reflexivity is a relevant aspect within the theoretical framework I have chosen. Archer (2003) argues that human reflexivity is a social process that generates

causal powers and makes us active agents. She advocates that reflexivity depends on the internal conversations that people have and that the type of conversation will impact on how we make our way through the world (Archer, 2003, 2007). She also acknowledges that the world has become increasingly complex with an imperative for greater reflexivity for negotiating social structural powers. For my research, I am primarily centring on Archer's concept of the 'internal conversation' and her reflexive modes. I am examining how occupational therapy graduates operate their internal conversation within the framework of Archer's theory and how this may be influencing them in their choice of practice context and their experiences of entrepreneurship. Consequently, whilst reflexivity is an important concept in Archer's theory, it is not a central component of my study.

Decision-making for intrapreneurship

There is a large body of research literature concerning decision-making for entrepreneurship. Much of the recent literature examines decision-making through a cognitive and behavioural psychology lens and focuses on the thinking and behavioural aspects. A key agreement in the literature is that effective decision-making is an essential component of the entrepreneurial and intrapreneurial process (Porath, 2012). For the newly graduated occupational therapists in this study, there is the initial decision to be intrapreneurial followed by a whole system of decisions to be made for each intrapreneurial action. To add further complexity, these decisions will usually be undertaken in situations where there is great uncertainty as the individual is acting outside of the normal pattern of behaviour expected of them (Porath, 2012). Due to the element of uncertainty, there exists an overlap with the 'risk-taking' conversation within the literature. A great deal of discussion exists concerning *who* the people are that make these decisions and become successful entrepreneurs and *what* is involved in the process. There is some general agreement that critical thinking, statistical reasoning and intuitive judgement are all key components of decision-making for entrepreneurial thinking and behaviour (Liberman and Tversky, 1996; Afiely, 2010; Khaneman, 2005). There is also some

discussion regarding the entrepreneur's perception of risk, with Busenitz (1999) arguing that they might actually perceive less risk in a given situation where they are required to make a decision. However, this research was examining entrepreneurs setting up their own businesses rather than being intrapreneurial within their work context. There is some focus on the 'micro-level' step between the thinking (the idea) and the turning of this potential into action, an intrapreneurial action, but these studies examine these processes through a psychological rather than a sociological lens as I have done. Whilst there is agreement that effective decision-making is essential for the entrepreneurial process, it is not a core concept for my study.

Power and culture in the statutory healthcare context

There is an extensive body of literature that describes the negative, paralysing culture of the NHS and the professional and managerial power struggles that have existed for decades. Whilst power and culture are not central concepts for my study, they are important to touch on as some occupational therapy graduates will be entering a healthcare environment with a power and culture system that could counter, or at least interfere with, their entrepreneurial endeavours.

Examining the literature concerning power within an organisation led me to favour a more post-structuralist approach as a lens to view the UK statutory healthcare context. I found Fairclough's (1989, 1992) commentary on power particularly useful as he claims that the use of language is related to unequal power relations (Addicot and Ferlie, 2007). Post-structuralists, like Fairclough (1989, 1992), consider a structuralist approach as less relevant now as healthcare systems are more complex with differentiated subsystems involved (Ham, 1981; Harrison, 2001). There is a plethora of literature describing the dominance of professionals within healthcare (Thorne, 2002), none more so than the autonomous medical profession that governs their own practice (Fairclough, 1992). This dominance has created an environment where other healthcare stakeholders like managers and service users have been

voiceless (Maynard, 1991). Over the last two decades, there has been a shift in power and autonomy within the healthcare sector towards management functions. The language has been changing to more managerial concepts concerning change management, service improvements and quality management (Ferlie and Fitzgerald, 2002). Working within the healthcare and healthcare HE sectors for over 30 years, I have noted this distinct change in language used by the different stakeholder groups and have personally observed some shift in power transfer from professionals towards managerial demands and, more recently, towards service users and carers through 'involvement policies' (DoH, 2000). These experiences are supported by commentators in the field who argue that professionals are losing power in the health sector with greater managerial authority coming into play (Harrison and Ahmad, 2000).

These existing power struggles are not only between different professional groups and management but there are also different degrees of power residing inside professional groupings (Abbott, 1988; Abbott and Meerabeau, 1988; Freidson, 1994; Ham, 1981). The professional grading structures and the introduction of clinical specialists within the healthcare professions to support progression of staff outside of the managerial framework, create interesting power differentials: newly graduated occupational therapists often find it very challenging when transitioning into early practice roles (Rugg 1999, 2003; Tryssenaar and Perkins 2001; Leonard and Corr, 1998; Barnitt and Salmond, 2000) with little autonomy and authority. To gain credibility and authority, some argue that they need to develop their professional self-concept (Kasar and Muscari, 2000) before they can undertake complex tasks and learn the rules of working with others (Morley, 2009). There is no doubt that occupational therapy graduates are entering a complex healthcare work place that is highly structured and riddled with internal professional and managerial power struggles. Whilst power relations are not a central concept for my study, it is undoubtedly a concept for the occupational therapy educators, practice professionals and leaders to be cognisant of when developing curricula and practice contexts to promote and support intrapreneurship.

The organisation culture of the UK statutory health services and the need for substantial change has been a 'hot topic' for well over two decades. This demand for cultural change was significantly resounded following the high profile Public Inquiry into the failings at the Mid-Staffordshire hospital (Francis, 2013) and the subsequent Government report into patient safety in the NHS (Berwick, 2013). This became a turning point for the UK health services sparking a new wave of focus on changing the culture from the top down. Definitions of culture have ranged from simple statements like, 'it's the way we do things around here' (Balogun and Hailey, 2004), to more in-depth definitions. For example, Schein (1995) attempts to explain it as the embedding of the pattern of shared assumptions into organisation life. The common thread running through the definitions proffered in the literature is that it relates to the elements of beliefs, values, behavioural norms and routines that are shared between people within an organisation (Parmelli et al, 2011). Whilst each different organisation will have a different culture (Szymanska, 2016), Disselkamp (2005) described organisations that promoted a culture of innovation as bearing six main pillars that were supported by the managers: professionalism, commitment, creativity, entrepreneurship and competitiveness; ability to quickly learn and acquire new skills; willingness to take risk and bear the responsibility; flexibility in thinking and action; ambition, enthusiasm, fighting spirit, initiative, success; ability to predict the future (2005:67). With these definitions in mind and when examining the findings of the Public Inquiry (Francis, 2013) and the Patient Safety report (Berwick, 2013), it becomes clear that rather than a culture of innovation and enterprise, a culture of fear, poor quality and uncompassionate care and resistance to change has dominated and been left to flourish within statutory UK healthcare.

In response to these decades long cultural issues, many tools have been developed in an attempt to assess organisation culture within healthcare. Large-scale literature reviews of these tools have been undertaken (Mannion et al, 2005; Jung et al, 2009) with Jung et al (2009) concluding that there was no suitably developed instrument that could successfully assess culture. In a recent UK Government policy document 'Culture Change in the NHS' (DoH, 2015), the then Secretary of State for Health, the RT Hon Jeremy Hunt MP, argued that a lot of changes have already been made since

the Francis Inquiry (2013) but that these must be sustained and embedded and applied rigorously across the entire system (DoH, 2015:3). The document details the key changes introduced to ensure a more transparent and open approach with a safer culture of care. The UK professional statutory bodies (GMC, 2013; NMC, 2015; HCPC, 2016) have supported these Government policy demands by including a drive for openness when mistakes are made and requiring professionals to use new 'whistleblowing' policies that are overseen by the Care Quality Commission (CQC, 2017)[6]. I have experienced this cultural change rhetoric acutely within the health HE sector where there has been a drive for recruiting and developing 'compassionate' healthcare professionals through values-based recruitment methods (HCPC, 2017 NMC, 2010) and values-based curricula designs. This paints a complex and challenging picture of the cultural landscape that our fledgling occupational therapy graduates are joining; there are significant cultural issues agreed and improvement strategies aplenty. Worryingly, if there are no suitable tools for assessing the impact of cultural change programmes, how will organisations know if anything has truly improved.

Pressures shaping professional occupational therapy curricula

Over the last two to three decades, the occupational therapy profession has experienced significant shifts in the level of autonomy and freedoms it has previously enjoyed in the development of the professional education curricula in the UK. These shifts can be described as structural constraints or 'pressures' that have evolved from policy sources governing what is deemed necessary and allowable components of those curricula. The pressures on occupational therapy curricula development can be found rooted in general Governmental direction that has been translated into policy by HE, the statutory health and social care context and from the HCPC and RCOT.

[6] The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. The CQC monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety and publishes what it finds (CQC, 2018).

Occupational therapy is a profession that is regulated through the HCPC and has seen a gradual erosion of its freedoms. The HCPC is an independent council that was created by the Government and is the statutory regulator for a wide range of health and social care professions practicing in the UK. It provides legal protection of professional titles, administers the register of approved professionals and creates the standards for pre-registration education in the UK, including occupational therapy (HCPC, 2017). Although the HCPC is an independent body, it is strongly influenced by changes in social and Governmental direction. These changes are incorporated into the standards for education and training of occupational therapists and govern what goes into the curricula. The responsibility for creating and monitoring the education standards shifted from the professional body (RCOT) to the HCPC in 2002, which was a colossal shift of power that contributed significantly to the erosion of the profession's autonomy to develop as it pleases. The RCOT provides guidance for occupational therapy education providers and is able to accredit programmes if they meet their criteria and standards. However, it is not mandatory for HE to gain accreditation for their occupational therapy programmes although the majority do seek this to ensure competitiveness in the growing undergraduate market place.

The statutory health and social care context has also created significant pressure on how occupational therapy professional curricula should be developed in the UK. The context is the primary employer of occupational therapists and has become increasingly vocal about what kind of graduate professionals it requires to join its highly pressured workforce (the specific demand for HE to produce more entrepreneurial graduates is explained later in this chapter). In the healthcare context in particular, the traditional powers that professions held have been eroding, especially since the introduction of Clinical Governance[7] in the late 1990s. As a result, healthcare professions have been increasingly challenged to change and meet politically-driven expectations such as: quality, networks, partnerships and flexible working practices (Allen and Pilnick, 2005). This erosion of professional power and

[7] Clinical Governance is "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson, 1998:61)

demands for change from the employer side has exerted extensive influence over occupational therapy education providers to meet their growing needs.

Lastly, HE has also become an increasing structural reality for the professional occupational therapy curricula. The HE sector has long been the pillorying post for employers demanding more employable and work-ready graduates and for the Government pressuring for the plugging of the so-called UK 'knowledge and skills gap' (Wilson, 2012). These employer and Governmental demands, along with the increasing marketisation and massification policies of the Conservative Government over the last decade, have generated a highly constraining environment for academics developing professional occupational therapy curricula. Long gone are the freedoms that universities and academics once enjoyed to generate knowledge and develop courses and curricula attuned with their interests. Occupational therapy curricula are now developed under HE policies designed to meet employers' needs, adhere to Government direction and to add profitable market differentiation to the institution's portfolio.

It is clear that the development of the professional occupational therapy curricula has occurred within a highly structured environment pressing in from several powerful fronts. The RCOT, HCPC, HE and statutory healthcare provider demands, along with the challenges imposed by Government drivers, have all played their part in shaping current professional occupational therapy curricula. Freedoms have been eroded for the profession to steer the occupational therapy curriculum and occupational therapy academics are caught in the middle and, as a result, are juggling these pressing demands from within the academy.

The imperative for the occupational therapy profession

Entrepreneurship is especially pertinent for the occupational therapy profession particularly at this juncture in time. It is certainly a relevant concept for other healthcare professional groups but my primary concerns relate to my own profession's graduates. I desire to have an impact on the undergraduate curriculum to support our new graduates in transferring into a practice context that fosters their entrepreneurship and subsequently benefits our end service users. This section aims to explain the three key imperatives for entrepreneurship in the occupational therapy profession.

Firstly, it is aligned with the core philosophy of the profession. Occupational therapists are in the business of enhancing service users' agential powers by challenging the status quo and recognising and creatively adapting environmental constraints to maximise engagement in their desired occupations. As a profession, we have become increasingly connected with this sociological approach rather than the medical model that we were originally aligned with (Brisenden, 1998). As the profession also now has its roots embedded firmly in a sociological base, I decided to aim my study from this perspective. I appreciate that there are different theoretical traditions that I could have approached this matter from. For example, I could have pursued a more psychological route, examining the personality, motivational and behavioural aspects, perhaps. However, I consciously decided that a sociological perspective, which allows me to utilise more modern theorists who view structure and agency as complementary rather than opposing forces, is especially advantageous. Moreover, I had not seen Margaret Archer's ideas in either the healthcare or occupational therapy entrepreneurship discourses, which has provided me with the scope for revealing exciting new insights. It is clear that structure and agency and entrepreneurship are especially relevant concepts for the attention of the occupational therapy profession.

Secondly, it is a professional education and practice imperative. There is a growing argument that the broader aims of professional education have been neglected for

technical competence (Sullivan, 2004). This has resulted in some professionals taking a less ethical and responsible approach to their practice, which could be contributing to the current 'care crisis' in the NHS. In tandem, there has a been a drive from occupational therapy professional and healthcare statutory bodies (COT, 2014; HCPC, 2017) and HE policy for all healthcare undergraduate curricula to embed entrepreneurship, facilitate leadership at all levels and to work across professional boundaries. This is a Government-driven attempt, following high profile failings, to transform the problematic culture in the NHS (Berwick, 2013; Francis, 2013; Keogh, 2013). Many of these new components have already been integrated across my faculty's healthcare professional education curricula[8] and 2019 will launch new curricula, which fully embraces these important notions.

Lastly, there is a noticeable gap in the occupational therapy-based entrepreneurship research. There is some acknowledgement of entrepreneurship regarding: occupational therapists setting up their own businesses (Foto, 1998; McClain et al, 1992); occupational therapists developing emerging areas of practice (Holmes and Scaffa, 2009); the need for occupational therapy education to develop students entrepreneurial skills (McClure, 2011) and the need for the profession to recognise its unique creative and innovative skills and to be entrepreneurial in moving the profession forward (Pattison, 2006). Additionally, there is growing interest and research related to the notion of 'social entrepreneurship', which focuses on the service user's, rather than the occupational therapist's, entrepreneurship. In particular, it highlights where occupational therapists are creating social enterprises with and for service users of various disability backgrounds (Kronenberg, 2011; Van Niekerk, 2008, 2010). Overall, I found an increasing interest in developing entrepreneurship in service users and in building new services or businesses but scant interest in occupational therapists' own thinking and behaviour.

[8] The University Faculty of Health and Life Sciences provides professional healthcare education in physiotherapy, occupational therapy, dietetics, nursing, midwifery, paramedics and operating department practice.

Political and economic drivers

The crescendo call for entrepreneurship has been sensed loudly within the occupational therapy profession, the healthcare practice context and within my own university. This situation compelled me to explore the root of the call and why it had reached such a fever pitch at this time. I found the key factors driving it were located in the current UK and global situation, the march of neoliberal-oriented ideology and Government policy, particularly over the last few decades.

Globally, we have been experiencing the worst recession since the 1930s although there has been steady recovery over the last few years. This upward trend has been encouraging although following the rises enjoyed from 1.7% in 2013 to 3.1% in 2015, the growth has started to decline: it has dropped sharply from the 3.1% high in 2015 to 1.8% in 2016 and is currently 1.7% (World bank, 2017) with a forecast for startling reductions to 1.3% over the next 5 years (BBC, 2017b). Consequently, Government policy has been enforcing severe cuts right across the public sector, which had not relented in line with recent economic improvements. More recently, in the autumn 2017 budget, the Chancellor has "loosened his belt" and provided small cash injections for the struggling NHS and other areas of urgent need (BBC, 2017a). This long-term resource squeeze has created a spiralling demand for services, particularly in the NHS (DoH, 2010, 2012). In tandem, current Government policy is pressing for greater efficiencies along with greater innovation, entrepreneurialism and new leadership. This creates a worryingly complex environment with conflicting messages for our graduates to be entering the healthcare workforce.

The roots of entrepreneurialism can be found in the ideological extreme of individualism. Lodge (1975) describes that each community or nation has arrived at an ideological balance between the prototypes of individualism and communitarianism[9]. Pre-1980s could be described as a more communitarian-

[9] The i*ndividualism* prototype as described by lodge (1975) is the atomistic notion that the community is no more than the sum of the individuals in it. The communitarian prototype is that the community is more than the sum of the individuals in it; the community is organic, not atomistic. The survival and self-respect of individuals depend on the recognition of community needs.

oriented era where people believed that the economic wellbeing of the world revolved around big business, corporations and Government support (Hisrich 1990; Peterson, 1988). However, since the 1980s there has been a wave of liberalism sweeping across the OECD[10] countries propelling individualism, which prompted de-regulation, capital and labour movement and extensive privatisation. In the UK, this wave has been experienced more extensively since the arrival of Margaret Thatcher's Conservative Government in the early 1980s. Her Government saw the communitarian ideology, which had favoured a large welfare state and strong unions, as being damaging to growth (Agell, 1996). The push for entrepreneurialism became accentuated with the supply of entrepreneurial talent being espoused as vital for economic growth, innovation and job creation in the new knowledge economy (Henrekson, 2005). I can see this insidious creep of neoliberal ideology in the UK as pervasive as individuals are encouraged to take responsibility for themselves in every aspect of their lives (Coburn, 2000, 2004; Harvey, 2005). Education and work are seen as key factors in lifting people out of the welfare state (Theodore and Peck, 2001) and enterprise 'in any flavour' appears to be highly prized.

Neoliberal-oriented macro-economic policies have been steadily driving the entrepreneurship agenda across the UK HE and healthcare contexts (Teghtsoonian, 2009). These policies have focused on the disbanding of command and control type structures to more market-based organisation (Toth, 2010). In HE, I have seen the gradual withdrawal of state intervention and the rise of 'massification' policies (Barnett, 2005) and policies related to 'employability and enterprise'. These policies are designed to bring HE and the employment sector closer together with the challenge of creating the 'right skills' to plug the supposed 'skills gap' in the UK economy (Wilson, 2012). Since the 1980s, HE has been compelled through Government policy to create work-ready individuals equipped to meet employers' needs. I have noted that key policy drivers for this push were the 'enterprise in

[10] OECD countries: on the 14th December 1960, 20 countries originally signed the Convention on the Organisation for Economic Co-operation and Development. Since then, 14 other countries have become members of the organisation. OECD uses its wealth of information on a broad range of topics to help governments foster prosperity and fight poverty through economic growth and financial stability. They help ensure the environmental implications of economic and social developments are taken into account (OECD, 2014).

higher education initiatives' of the late 1980s, the Dearing Report (Dearing, 1997) and the more recent Lord Young's report 'Enterprise For All' (Lord Young, 2014). In the healthcare context, the Government has continued to relentlessly pursue policies geared towards privatisation and competition initiatives with a recent one being the 'Any Qualified Provider' policy (DoH, 2012a). This policy allows service users to choose any provider they desire for their course of treatment. I view this as a significant attempt by the Government to entice current statutory healthcare workers to set up their own enterprises and also to welcome new private players onto the scene. Again, this creates a troublesome environment for new occupational therapy graduates although some may well choose a non-traditional and enterprising route into their early career. They might opt for these non-conventional routes if they are finding the cuts in the statutory context are stifling their job opportunities.

A post-modern deconstruction of the entrepreneurship discourse reveals ideologies that are hidden in the gaps and silences. Post-modernists recognise that all knowledge is contextualised by its historical and cultural nature (Agger, 1991) and they stress the importance of symbolic and cultural elements involved in the social construction of reality. Ogbor (2000) argues that a post-modern deconstruction of the entrepreneurship discourse lays bare that it privileges and reinforces the existing power structures of dominant groups in society. I found this deconstruction particularly helpful for my study as I appreciate better the voices of sceptical scholars who believe entrepreneurship to be a constructed concept and a mechanism of the State to propel its ideologies blindly forward.

Exposing the roots of this controversial discourse has provided great illumination for my own study. I have witnessed in my own HE institution that the entrepreneurialism policies related to 'massification' and 'marketisation' are often seen as ways of driving down costs and striving for market domination. They are perceived as dismantling of the original purposes of universities in preserving old and generating new knowledge (Shaw et al, 2003). As a new education scholar, I have become acutely aware of the importance of not being drawn into the ideology but appreciating its history and critics' voices whilst developing my research in this area.

It is my contention that the gaps in the literature and empirical research along with the wider contextual factors discussed above, provided a distinct mandate for my study at this time. The principal literature gaps were concerned with: occupational therapy graduate intrapreneurship; the comparative experiences of intrapreneurs within the statutory versus the non-statutory healthcare contexts; the influence of professional peer and personal relationships on the intrapreneurs activities; the costs or downsides of occupational therapy graduate intrapreneurship and the value or otherwise of Archer's (2003) morphogenesis and reflexive modes theories for exploring micro-level influences on occupational therapy graduate intrapreneurship. My study entered these gaps and illuminated the landscape so that all stakeholders could become more conversant concerning the implications, positive and negative, of the growing entrepreneurial and intrapreneurial mantra. My study was located at the micro (Individual occupational therapy graduate) and meso-level (specific practice context) of inquiry and explored more deeply our occupational therapy graduates' experiences in practice. I inquired into their perceptions and experiences of intrapreneurship alongside the mechanisms that might be at work in mediating their intrapreneurial thinking and action.

The key concepts central to my study are Margaret Archer's notion of the reflexive modes of internal conversations that individuals have, entrepreneurship and intrapreneurship. Margaret Archer's reflexive modes are the types of internal conversations that people have and are the components of reflexivity, which she proposes is the mediating factor between the individual agent and their interaction with the structural world around them. Archer identifies four conversation forms that I have termed 'modes': the communicative reflexive, autonomous reflexive, meta-reflexive and the fractured reflexive modes. The different modes encapsulate individual differences in: the closeness that individuals maintain with their natal context, the level of communication and interaction with others when deciding to act, the level of trust in their internal deliberations and their ability to dovetail their concerns. The modes are not a strict typology but Archer argues that all people tend to operate their internal conversations with a preference for one of these modes and

that this will shape their decision-making and the way they make their way in the world.

Entrepreneurship and intrapreneurship are concepts that are heavily contested within the literature with no clear definitions. Within this study, I have focused on the explanations of entrepreneurship and intrapreneurship that occurs *within* organisations rather than on the development of new enterprises with profit as the key objective. For the purposes of this study, the concepts refer to the hands-on activities within organisations where individuals are attempting to be creative and innovative: where occupational therapy graduates can challenge the status quo, push back boundaries, make transformations and become agents of change for the benefit of the organisation and its service users.

The research questions guiding the study from the outset were:

- What do new occupational therapy graduates perceive entrepreneurship and intrapreneurship to be?

- What are new occupational therapy graduates' perceptions and experiences of entrepreneurial thinking and behaviour in contrasting practice contexts?

- What are the implications of the above for the practice context and future curriculum development?

The next chapter explains how I approached the study ontologically at a macro-level and provides detail and justification for selecting Margaret Archer's theories of morphogenesis and her reflexive modes as suitable analytical tools to support the data collection and analysis.

Chapter 3 – Theoretical framework

A suitable theoretical framework has guided and shaped my exploratory study from within a known body of knowledge. In this chapter, I outline my approach to the study ontologically from a realist tradition through a macro-level critical realist paradigm. Whilst the sparse literature and research to date has supported a critical realist approach to examine the concept of entrepreneurship, none has utilised the realist social theorist, Margaret Archer, and her theories to examine the micro-level interactions of occupational therapy graduates in the healthcare context and their intrapreneurial pursuits. I will go on to explain why and how I integrated Margaret Archer's work concerning her theory of morphogenesis (Archer, 1982, 1995) and her reflexive modes (Archer, 2003, 2007) as suitable epistemological tools to underpin the research design and analysis.

Structure, agency and critical realism

Contemplating structure and agency as sociological forces led me to explore and challenge my own ontological leanings. Establishing a firm view regarding the constituents and nature of the structures where occupational therapy graduates will be working and the degree of agency that they are able to achieve over their practice is especially crucial. There are many definitions of structure and agency that are subject to different interpretations depending upon a scholar's ontological preferences and personal perspectives. A suitable definition that I have found helpful is that from McAnulla (2002) who stated "Fundamentally, the debate concerns the issue of to what extent we as actors have the ability to shape our destiny as against the extent to which our lives are structured in ways out of our control" (2002:271). I have subsequently established that I have more realist leanings as I agree with philosophers who assert that a world exists independent from our thoughts. In particular, I support the critical realist perspective developed by the UK-based philosopher Roy Bhaskar (1975, 1989, 1998), a recently evolved philosophy underpinning social realist theory research; critical realism is a philosophy and not a theoretical idea.

Until the emergence of critical realism philosophy, social scientific accounts have concentrated more heavily on the influence of social powers within society and have neglected the human subjects from the story. Fuller et al (2012) argue that critical realism provides a meta-theoretical framework that allows the taking stock of this dehumanisation and to "find ways to re-humanise ourselves, our cultures and societies" (2012:1). Critical realism derives from dualist ontology and accepts that systems have mind and matter, subject and object elements and that there are real and emerging properties from both the natural and social worlds. Bhaskar (1975) argues that both structure and agency are real and have causal powers in their own right. Other critical realist philosophers like Varela et al (1992) and Harré (1979), have rejected this position and assert that although structures are real, they do not have any causal powers. They argue that causality in the social world remains steadfastly with the individual (Lopez and Potter, 2005). Bhaskar argues against this standpoint and contends that we do not create the social structures but we reproduce and transform them and that they are pre-existing and pre-date us. He also states that social mechanisms can be tested empirically to see if they are real or not (Van Bouwel, 2003).

Although there is no homogenous group (Danermark et al, 2002), critical realists, like Archer (2000), Sayer (2000) and Collier (1990), share a common understanding that natural and social reality should be understood as an open, stratified system of objects with causal powers. A cornerstone of the philosophy assumes that reality is composed of different levels: the biological, psychological, social and cultural levels, for example. These levels are "hierarchically ordered levels where a lower level creates the conditions for, but does not determine, the higher level" (Wikgren 2005:16).

Bhaskar (1975) asserts that there are three domains in which social reality operates: the level of the 'real', the 'actual' and the 'empirical'. According to Bhaskar (1975), at the level of the 'real', there are real mechanisms that exist that have causal powers and generate actual events. These mechanisms exist independent of our knowledge

and understanding of them and the nature of these real objects presents constraints and enablements that effect what *could* happen but do not predetermine what *will* happen (Sayer, 2000). At the level of the 'actual', are the events that are generated and, at the level of the empirical, are the events and experiences that are observable. By way of illustration, I'll present an invented scenario case of wheelchair users being reported as absent from a particular cinema. This example concerns a disability issue, which is highly relevant to the occupational therapy profession that works to reduce barriers and empower those with disabilities to participate in society. The cinema could have policies that preclude non able-bodied people from entering the venue and possibly a staff belief that wheelchair users might block the exits in an emergency situation. These social and cultural mechanisms (policy and beliefs) at the level of the 'real' may generate 'actual' events or actions by staff when confronted with a wheelchair user at the cinema entrance that prevents their entry. These staff actions could be considered as structuring constraints for the wheelchair user in this scenario. The outcome is that we can observe the 'empirical' event that wheelchair users do not attend or cannot be seen at that particular cinema.

When viewing the concept of entrepreneurship from a critical realist paradigm, it could be said that there exists a structured and changing world that materially exists independent of the entrepreneur's knowledge of it. At the same time, there is a role for the entrepreneur and their 'human will' to actively respond to the structured world and to shape it into new or different forms (Chiles et al, 2010). I considered that this critical realist philosophy fitted agreeably with my personal views and was a suitable foundation for exploring new occupational therapy graduates' entrepreneurial experiences within contrasting healthcare contexts.

Margaret Archer's morphogenesis

Margaret Archer is described as one of the most influential of the critical realist philosophers and has devoted much of her work to understanding the interplay

between structure and agency (Porpora, 2013). Archer's work is located within the structure and agency debate that she describes as the "vexatious fact of society" and is "the central sociological problem" that affects sociology scholars and everyone in society going about their everyday lives (Archer 1995:1). Archer's work has been influenced by Lockwood's seminal paper (1964) that emphasises the importance of the distinction between social integration (agency) and system integration (structure) and by Bhaskar's more recent development of critical realism philosophy. Her ideas are particularly appealing as she attempts to unravel the process of how structure and agency are mediated, which helped me to try and understand how our occupational therapy graduates might be, or might not be, able to make transformations or to be 'intrapreneurial' in their practice. Archer rejects other theoretical views that either give too much weight to structural powers, with agents rendered powerless (what she calls downward conflation) or to agents who are totally responsible for the creation and transformation of structures. The structures have no power apart from the action of agents (which she describes as upward conflation) as proposed by an earlier influential philosopher, Giddens and his structuration theory (1984, 1991).

Archer (1995) describes her idea of the morphogenetic cycle with several phases where there is an assumption of a pre-existing structure that conditions how we might interact. This cycle indicates Archer's assertion that changes to structure and the agent's actions are not static and that they occur longitudinally over different time periods, which contrast markedly with Giddens' views. He relies on the actual events to mark time and "changes to structure and the actions of agents are locked together in a duality" (Mole and Mole, 2010:235). In Archer's morphogenesis, the agent 'bumps' up against the structure and social interaction occurs. The result is what she terms a structural elaboration: a change in the structure (transformation). If the agent does not interact with the structure or is unsuccessful in their attempts, this would result in structural morphostatis: the structure remains unchanged (reproduction). If transformation does occur, the resulting elaboration will create new 'relational organisations' with different causational powers, new constraints or

enablements for other groups of agents and potentially new generative mechanisms that influence how things will work in that context.

Archer (1995) explains that an agent's motivations for action at the interaction stage are strongly influenced by previous contextual factors. The factors are described as the individuals' or groups' 'vested interests'. Just because an agent has collided with a structural emergent property it does not necessarily mean they will interact with it. There may be perceived costs involved, strong ideological influences (cultural factors) or they may simply surrender their vested interests for different ones.

Margaret Archer's internal conversation and reflexive modes

Many scholars with various philosophical persuasions have been puzzling over and attempting to explain what is happening at the point of interaction between an agent's and a structure's emergent properties and what mechanisms are involved. It is what happens at this mediating nexus where Archer's developed theory of the internal conversation comes into play. She proposes that agential reflexivity is a mediating factor (or a real generative mechanism) and has further developed her theory that describes this reflexivity as the internal conversations that people have; the individuals evaluate and monitor their personal projects and the evaluation elements are the internal conversations that occur. She argues that the conversations take different forms and lead to different modes of reflexivity and that it is the type of internal conversation that actually guide their actions or 'shape their lives'. In her later work, Archer (2007, 2012) contends that we require greater levels of reflexivity, as the world is growing increasingly complex and challenging. This contention particularly connects with our occupational therapy graduates' situation where they are entering an ever-changing and demanding practice environment, especially within the healthcare context.

In the healthcare practice context, structure and culture are key elements that impinge on occupational therapy graduates' practice. The material structures that

come into play are the resources, position of actors, knowledge, policy etc. In this context, culture is a vital component of structure and includes the plethora of beliefs and ideas that are held by the actors involved. As explained above, realist social theorists contend that structure and culture have real and emergent properties and that these properties can be described as constraints and enablements. They have also tended to focus more on how structural and cultural powers have impinged on agents rather than the other way round. Archer has been more interested in the agents' activities and has been a rare philosophical voice to argue that structural and cultural emergent powers have to be activated by a specific agential enterprise; the emergent properties have to obstruct or assist that enterprise.

Archer (2003, 2007) explains that people will have concerns they care about most. Some will be ultimate concerns and others, subordinate ones. These concerns are formulated into life projects producing a personal pattern where they believe they can live and produce a modus operandi. As the individual gets on with their day-to-day lives, they anticipate reflexively the constraints and enablements that they might meet along the way with their project. They have degrees of freedom and can decide to forge ahead or to not try at all. Also, Archer (2003) stresses that humans are fallible and may be wrong in their forecasts; they might not be aware of the social factors impinging on them and they might mis-diagnose or mis-judge an obstacle or inaccurately evaluate a cost or benefit of interacting with a constraint or enablement.

Archer's theory about reflexivity being the mediating factor between structure and agency includes three key propositions: we all have a private domain of mental reflexivity where we can reflect on and prioritise our own desires and beliefs; this domain is inaccessible to the outside, unless we act on them and that the reflexivity is an active conversation about what we believe and intend to do (Archer, 2003). Critical realism espouses that these conversations are real and efficacious. Archer affirms this and maintains that they have real autonomy and power and have a first-person perspective. She examined these internal conversations in an attempt to explain how agency is able to transform or reproduce structures. Through her

research, Archer found mode-clusters of different ways that people conduct their internal conversations (Archer, 2003, 2007). As introduced earlier, she describes these modes as communicative reflexive (CR), autonomous reflexive (AR), meta-reflexive (MR) and fractured reflexive (FR). I concluded that Archer's ideas had the potential to positively assist me in exploring how our new occupational therapy graduates were interacting with those structural and cultural emergent properties that are so prevalent in the bureaucratic, statutory healthcare context and if they had differing experiences in the contrasting non-statutory healthcare context.

The key features of the dominant modes of reflexivity that Archer had identified were useful for me to consider in relation to my study participants and are now explained in detail.

The people who prefer a CR mode (Archer, 2003:184) demonstrate a high degree of contextual continuity and find contentment with their established practices. They are able to dovetail their concerns and do not tend to trust their inner deliberations. They continually check out their ideas and thoughts externally, especially with family or trusted friends. They tend to replicate their inherited context unless they are jettisoned out of it by uncontrollable circumstances. They have strong ties in their networks that are essential for helping them to make sense of the world. They work hard to "maintain their contextual stability" and tend to avoid conflict with anything that might threaten this (Mutch, 2007:14). They are likely to seek to minimise contact with the broader structures of society and prefer to operate within the "known and given" (Mutch 2007:15).

The people who prefer an AR mode (Archer, 2003:213) are also able to dovetail their concerns. Work was found to be their main priority with interpersonal relations being subordinate to this concern. They are able to uproot themselves in pursuit of the personal projects and their concerns tend to make them loners. They tend to have eventful lives and think and make decisions independently of others. Archer suggests that early contextual discontinuity might be relevant, as they may not have formed very strong ties to a particular community at an early stage. The AR is

described as having an internal conversation which: “its practitioners recognise as being an internal dialogue with themselves and one which they do not need and do not want to be supplemented by external exchanges with other people” (Archer 2003: 210). The ARs are likely to be aware of the constraints and enablements of existing structures that they encounter whilst pursuing their personal projects and “seek to work with and change these to suit their own requirements” (Mutch, 2007:15). The way that ARs manipulate the features of the environment to give them success in their projects, leads Archer (2003:253) to describe them as “strategists”. However, she adds that this does not mean that they will be successful in their endeavours and more successful in their pursuits than the CRs, it simply means that they more readily make attempts.

The people who prefer a MR mode (Archer, 2003:255), more than the other reflexive modes, tend to engage in internal dialogue that adds an additional loop into the conversation: they interrogate their own thoughts. They question their decision-making both before and during activity and can change course if they assess this as important for success. They do not seem to feel contentment in the balance of their personal and professional lives and rarely dovetail their concerns. They can make their own decisions, are not always rooted to a particular context and seem to be both upwardly and downwardly socially mobile.

The people who prefer an FR mode, unlike any of the other reflexive modes, are not able to exert their personal powers to formulate projects and to “monitor themselves and society in pursuit of their designs” (Archer, 2003:298). They do carry out internal conversations but their self-talk gives them little or no instrumental guidance about what to actually do. Archer describes them as impeded or displaced.

Archer believes these modes are universally applicable. I have inquired into the dominant reflexive modes of our recent occupational therapy graduates as part of the study. I realised that these reflexive modes were not a strict typology but found that aligning the graduates within these modes supported the analysis and in answering the research questions.

Bhaskar (1989) argues that the social sciences have an emancipatory potential. Sayer (2004) agrees with this position and argues that critical realism provides a rationale for a more 'critical' social science that is critical of the social practices that it studies (2004:14). I concur with this emancipatory potential and have found that Archer's reflexive modes research has resonated strongly with me when thinking about our occupational therapy graduates launching into their new practice roles. The idea that our graduates' PRMs might have been impacting upon their choice of work location and entrepreneurial activities in practice was very exciting. One of my intuitions was that CRs could be selecting to work in highly structured and bureaucratic contexts that are less challenging to them. Additionally, ARs and MRs may have been frustrated and stifled by the structured contexts and could have opted for a non-statutory outlet as a means for meeting their concerns. I was particularly interested in whether any of the reflexive modes were able to realise their concerns through their occupational therapy practice and whether their perceived opportunities for intrapreneurial thinking and behaviour represented areas of concern for them. I wondered if their aspirations with regards to intrapreneurship and entrepreneurship were different depending on their PRM.

Whilst I have personally found Archer's theoretical ideas compelling and of great utility as a framework for my own sociological-based study, I remain cognisant of commentators who are more critical of them. Following extensive searching, it became noticeable that there is a distinct paucity of written critical commentary surrounding her notions although her work on social theory and education is widely criticised on a more informal basis (King, 1999). I have also concluded that Archer's ideas are not that well known. Where there is more recognition and an embracing of her theoretical work is within the critical realist community that largely resides in Europe (with a small network developing across the Atlantic in the USA). The critique of Archer's work that does exist centres on the rejection of her ideas arising from an interpretivist tradition, on commentators' admonishment for not explaining the philosophical basis for them and her omission in not fully critiquing the philosophers and theorists whom she opposes.

Criticisms of Archer's ideas arising from an interpretivist tradition, are elucidated by King (1999). King posits that there is a powerful rejection of Archer's assertion that structure is an independent causal mechanism that pre-exists and can act on agents. This rejection of her ideas arises from the interpretivist's tradition that insists that society should only be examined and understood in relation to the individual and their relationship to others and not in relation to any objective elements of structure, which is Archer's position (King, 1999:222). King further argues that Archer's writings promote her own ideas regarding the dualist nature of structure and agency but do not provide enough critique of the individualists from the interpretive tradition that she rejects. King posits that Archer is generalising the position of these individualist opponents and hence her own position is not built on firm foundations (King, 1999:203).

A vein of criticism runs throughout the commentaries that admonishes Archer for not fully exploring or explaining the philosophical basis for her ideas and for not fully critiquing the philosophers and theorists who she opposes, particularly the more contemporary ones. An early review of Archer's work by Giesen (1997), although welcoming her contribution to sociological understanding, does accuse her of building upon an established philosophical battleground rather than bringing an entirely fresh angle to the debate. Giesen argues that Archer fails to account for the diversity and refinements of the more contemporary debates surrounding individualism and collectivism and only briefly mentions other philosophers and theorists. An example of Archer's lack of explanation regarding the rejection of other theorists is apparent when she discusses reflexivity and her view of Bourdieu's ideas. Farrugia and Woodman (2015) argue that Archer's focus on 'ultimate concerns' in her theory of reflexivity has been established through a mis-reading, mis-understanding and rejection of Bourdieu's work. It must be noted, however, that these critics of Archer, who are troubled by her critique, are strong proponents of Bourdieu and his approach to reflexivity and practice.

Stones (2001,2005) is another commentator critical of Archer's lack of thoroughness in her rejection of other theorists' ideas, in this case Giddens' structuration theory. However, unlike some other critical scholars, Stones does not reject her ideas outright. His key argument is that Archer's rejection of structuration theory ignores the potential alliance that could be made between the two approaches to provide a more comprehensive framework and fertile ground for practical social analysis (Stones, 2001:177). He proposes that there is not an irreconcilable divide between structuration theory and realist social theory and argues that, although Archer rejects structuration's 'duality', her morphogenetic sequence actually relies on that notion (Stones, 2001:177). It is my assessment that Stones has valued both theorists' ideas and, rather than rejecting one over the other, could see the value of combining the ideas to take social research forward. His critique centred on Archer's vociferous position against structuration that could have blinded her to any potential collaborative benefits.

A further critique of Archer's work is presented by Luckett (2008) who criticises the power of her theory, which emphasises the human causal powers in social theory in the face of post-modernity's "death of the subject" (Luckett, 2008:297). Luckett critiques her view of human causal powers from the standpoint of the more contemporary perspectives of gender studies, post–structuralism and embodiment theories. Luckett argues that examination from these more contemporary perspectives exposes Archer's lack of consideration of inter-subjectivity, language and the complex nature of power. However, Luckett espouses that Archer's analytic dualism supports a disentanglement of the threads of various causes of social situations and helps to identify which situations constrain or enable the individual. Luckett maintains that a more satisfactory synthesis of social realism would be gained if she dealt with the omissions apparent in her theories. Luckett posits that Archer's account of the distinct powers and properties of structure and agency would hold greater weight if she provided a more complete account of irrational desire, inconsistent actions and the internalisation of social structures.

It is my conclusion that Archer's ideas are not well known and have not been around long enough to be tried and tested with extensive academic critique. It could be argued that this lack of recognition and critique is not a solid foundation for launching into social education research studies based on her theories alone. However, I would argue that it is this very lack of recognition and large-scale scrutiny that gives me the opportunity to demonstrate, in a practical way, how her developed theories can contribute to academic debate concerning intrapreneurship. For this study, they can help to unravel the complexities inherent in structure / agency interactions, providing valuable explanations about what might be happening at the nexus of the fledgling occupational therapy graduate and the intrapreneurial opportunities they encounter.

In reaching the decision to appropriate Margaret Archer's theories as a framework to support my research, I had considered other theoretical ideas. Two post-structuralist theorist's ideas that I did consider, Pierre Bourdieu's theory of practice and Michael Foucault's theories around power and knowledge, could have been useful but none of them were as fitting for my purposes as Archer's ideas.

I found Foucault's theories concerning power and knowledge (Foucault, 1980) and how these can influence and shape peoples experiences and actions very interesting, particularly within an organisation setting. I could have used his theories to help explore what could be impacting new occupational therapy graduates when they are attempting to bring about changes in the highly structured and bureaucratic healthcare environment. This could be in terms of the individual graduate and their personal exercising of professional knowledge and power, and also in terms of the disciplinary power exercised by the healthcare institutions, evidenced through hierarchical structures, policies and procedures. Whilst Foucault's ideas would have been valuable to support explanation of the graduates experiences in the practice environment, I did not believe they would have been as helpful in explaining how their perceptions about particular work settings might influence their decision making about where to work.

I also found Bourdieu's theory of practice (1977, 1990), which identifies the importance of the concepts of habitus, field and capital, very intriguing with great potential for underpinning my study. I was also aware that much education research in my supervisory institution had utilised Bourdieu's ideas, which spurred me to consider how his theories could support my exploration. Bourdieu espouses that social structures are reproduced or transformed as a result of a person's habitus. The term habitus, as explained by Bourdieu, refers to the physical embodiment of cultural capital, to the deeply ingrained habits, skills, and dispositions that we possess due to our life experiences. This 'habitus' or internalisation of social structure determines what is and what is not possible for a person. Bourdieu's ideas could have assisted in explaining how occupational therapy graduates' backgrounds might play a part in determining where they see themselves in the social hierarchy and also 'who' is able to be intrapreneurial in the 'field' of healthcare practice. I could have explored more fully the 'field' of healthcare practice and examined what resources are valued and required of new graduates to be successful. After some exploration, I had briefly concluded that to make a success of their intrapreneurial enterprises, occupational therapy graduates must be able to use the capital they have gained from their families and previous experiences within their new healthcare practice 'field'. Although I selected a different theoretical idea, these Bourdieusian concepts could have been important in understanding which occupational therapists would be able to make the transformations needed for the betterment of healthcare in the UK.

These theorist's ideas could have supported me in explaining to some extent 'how' occupational therapy graduates were influenced and 'why' they could be taking particular courses of action. However, they were not able to offer explanation about any 'real mechanisms' at work at the micro-level of interaction between structure and agency, which is where I found Archer's work to be most illuminatory.

Utilising Archer's theories as a framework for my analysis has enabled me to analyse the structural and cultural constraints and enablements that impinged on the new occupational therapy graduates whilst simultaneously enabling me to examine their

lived experiences regarding their actions and responses to the structural constraints and enablements present in their professional working lives. I contend that through this critical realist study, framed within Archer's theories, I am able to enlighten this unexplored landscape with the hope of better preparing our graduates for their early career and longer term professional lives and to awaken their intrapreneurial aspirations.

As the study progressed, I refined my thinking and more specific questions were developed to support the creation of the data collection tools and guide the analysis:

- What are the participant occupational therapy graduates' perceptions of the contrasting practice contexts and does their preferred reflexive mode impact their early work selection?

- Do the structural features of the contrasting work contexts afford or constrain intrapreneurship?

- What are the occupational therapy graduates' experiences of intrapreneurship within their selected work context?

- Do the occupational therapy graduates' PRMs influence their capacity / capabilities for intrapreneurship?

The next chapter details and justifies my approach to the methodology and methods used to collect and analyse suitable study data.

Chapter 4 - Methodology and methods

Within this chapter, I provide an explanation of how I viewed the data through a constructivist epistemological and theoretical lens that fitted coherently with the ontological critical realist approach to structure and agency. I provide detail and justifications of the methods employed for data collection and go on to discuss ethical issues and explain the methods and processes for analysing the generated data.

Ontological and epistemological approach

Within this study, I have been using the term 'critical realism', which has a long history in philosophy, along the lines of how Donald Campbell (1974) first employed the term as a "combination of ontological realism with epistemological constructivism" (Maxwell, 2012:1). That is, there is a 'real world' independent of our perception of it and our understanding of the world is also a construction from our own perspective. Considering this critical realist stance, that incorporates both ontological realism and epistemological constructivism, I decided to draw on qualitative data collection methods. These methods provided me with the flexibility for including a range of data collection tools that fitted coherently with the areas of my inquiry. The types of data collected were based on assumptions that were complementary with critical realism regarding what could legitimately constitute knowledge evidence (Mason, 2002:36).

Exploring data arising from a constructivist paradigm enabled me to listen to the voices of occupational therapy graduates who were embedded in a particular practice or social context. The paradigm facilitated me in exploring their assumptions and beliefs and attempted to uncover why they do what they do and how they perceive and experience intrapreneurship in their particular practice context. I wanted to dig into and understand the lived experiences of their early career practice context through a shared conversation (Bridges, 2001). Also, I inquired into

similarities and differences between groups of occupational therapy graduates employed in different contexts. I used structured tools such as life grids and structured questioning to gain detailed data related to their personal histories and PRMs (Archer, 2003). Moreover, the paradigm supported my use of less structured instruments such as semi-structured interviews to gather rich situated information from the participants concerning their perceptions, beliefs and experiences (Silverman, 2010). Generalising the findings to the wider occupational therapy, and other healthcare, graduate population was not my primary aim as my study was largely exploratory in nature. However, I was hoping that the results of this qualitative study would inform current and future occupational therapy and healthcare education and practice in addition to providing a platform for more extensive research exploration. On a paradigm continuum, my study fell predominantly towards the middle but within the subjectivist rather than objectivist end of the spectrum (Savin-Baden and Major, 2013).

I acknowledge that there were advantages and disadvantages of using a qualitative methodological approach. The key advantages for my study were that it would enable me to answer the research questions in different ways and from a variety of perspectives in addition to facilitating triangulation to some degree for corroborating data about the same phenomenon (Cohen et al, 2011:237). I was also cognisant of the strong argument in the literature contending that purely qualitative methods could be criticised for relying on individuals' perspectives which arise from a particular time and sector of society and not, therefore, relevant for generating general theories (Cohen et al, 2005:27). However, as I was also researching through a critical realist ontological lens, which allowed me to use Archer's theories to examine the influence of the occupational therapy graduates' PRMs, I was not only viewing from the individuals' perspectives. This supplementary approach allowed me to dig more deeply to examine the possible causes of the occupational therapy graduates' perceptions and experiences and this has certainly generated some new understanding within this particular field of inquiry. As a new education researcher, I endeavoured to work reflexively and strove to maintain awareness of the potential hazards as I designed and implemented the research plan.

I concluded that the qualitative methodology fitted coherently alongside the theoretical framework I selected, which is rooted from a critical realist ontology. Critical realism gave me the opportunity to think about knowledge in both the natural and social worlds (Case, 2013) where structure and agency are both viewed as real and separate entities that have powers and emergent properties. I had confidence that the data generated from the different angles of inquiry, located at various points along the interpretivist end of the paradigm spectrum, would be easily combined and would strengthen the arguments arising from the study (Mason, 2002).

Data collection methods

Overview

(Refer to Appendix 1 – diagrammatic representation of the original study design)
I selected data collection methods that facilitated answering the study questions and that worked coherently with a qualitative methodological approach. I opted for a fairly structured framework utilising life grids and semi-structured interviews with a sample of nine recent occupational therapy graduates stratified into two groups from two contrasting healthcare practice contexts. The data was collected over a three-month period from July to September 2016. Initially, factual information concerning the design will be presented followed by a full justification of the study design decisions.

Study design

Qualitative research can be flexibly designed ranging from high levels to low levels of structure. The choice of design depends upon the research questions, the phenomenon to be examined and the skills and preferences of the researcher (Cohen et al, 2011:235). For this study, I assessed the 'best fit' to be a more

structured design as I had predetermined my intention to stratify the sample into two distinct groups for comparison. The comparative component of the design included two distinct practice contexts where recent occupational therapy graduates might select to practice and was used for comparing particular aspects. The two practice contexts under investigation were:

The statutory healthcare context = 5 participants

The non-statutory healthcare context = 4 participants

Two-stage interviews

I carried out face-to-face interviews of 90 minutes maximum duration with each of the nine study participants. The first interview stage was planned to be approximately 30 minutes and focused on completing the life grid data sheet through questioning and discussion (see Appendix 2 – life grid template). This included background education, family, employment and major life events information. Participants were given the opportunity to review the life grid data sheet before the interview and also the information post-interview to ensure all aspects were recorded accurately and any important missing data added. It was made clear to participants that there would be no pressure for them to undertake activities outside of the actual interview session but there were some activities available to prepare themselves if they found this beneficial to them.

Stage two involved a face-to-face interview with each participant of approximately one hour within a semi-structured question format. The interview included some guiding questions to ensure all aspects were covered with some prompting questions, if required. The questions were designed to enable exploration and data collection for the three main research questions and their sub-questions (see Appendix 3 – interview question schedule). Participants were prepared sufficiently before the interview occurred. They were provided with an outline of the topic areas to be covered. Each participant was offered a mutually convenient time and a choice of location for the interview. The locations were in private rooms, free of disturbances and at a time of day where the participants were alert (Briggs et al,

2012). Five of the interviews were carried out in a private room at my university location and four were carried out in a private space in various locations across the UK where the participants were either living or working. Personal safety was paramount with a responsible person made aware of all interview dates, times and locations; a check in and out system was also instigated (Mitchell and Irvine, 2008).

The interviews were all audio-recorded on two devices, as a contingency, in case of technical issues. I noted my initial reflections on each interview immediately afterwards. The interviews were transcribed verbatim during the period from October – December 2016. I, personally, transcribed six of the interviews and, due to time constraints, three were transcribed by a second person. The recordings were transcribed following recognised transcribing guidelines (Kvale and Brinkmann, 2009). The transcripts were emailed to each participant for member checking to ensure accuracy. I listened to the recordings whilst reading the transcriptions a further time to check accuracy and to begin to immerse myself in the participants' narratives.

Participant access and recruitment

The participant sample group were recent graduates from a UK university-based occupational therapy BSc (Hons) programme. They were graduates who had been working as an occupational therapy for between one and two years in the healthcare context and this may have been their first or second post. There were five occupational therapy graduates from the statutory context and four from within the non-statutory context: nine in total. Originally, five from each context had agreed to take part but one withdrew before the interview phase began and, despite significant attempts, I was unable to source another participant from the non-statutory context.

The occupational therapy participants had graduated and were recruited via the university where I am located on a convenience and purposive sampling basis (Briggs et al, 2012:260). Gatekeeper permission from the Head of the occupational therapy

department was sought, approval gained and participants were subsequently recruited via the university's alumni database. An email with an explanatory letter outlining the research aims and participant requirements was sent out to all graduates from 2014 and 2015 cohorts (n=320) inviting interested people to respond via email. The invitation required identification of their post-graduation practice area, location, contact details and year of graduation. A telephone call for providing further clarification was offered to all contacts. The participants were selected on a first come and relevance basis, ensuring there were participants from each practice context. There were 2 male and 7 female participants in the final participant list, which largely reflected the gender mix of the graduate occupational therapy cohorts targeted.

Justification of data collection methods

The structured study design fitted coherently with the ontological lens and the qualitative methodological approach. The design enabled me to manage a number of important aspects of inquiry within a single research study. As I was examining the in-depth experiences and perceptions within two different practice contexts, the comparative design aspect provided me with greater value in terms of relevant data for analysis rather than lots of data generated within a single context (Campbell, 1975:80). I believed that the two contexts selected represented the two ends of a spectrum from a 'highly structured and bureaucratic' versus a 'less structured and agency conducive' environment for new graduate entrants. I believed that these more extreme environments emphasised the socio-cultural features of the practice contexts for occupational therapy graduates under investigation.

In selecting semi-structured interviews as my main data collection tool, I was mindful of the inherent, multifarious pitfalls. I was aware of the issue identified by Cohen et al (2011:410) that the interview is a "social encounter" and, as such, has many problematic features, not least the great potential for interviewer bias and power balance issues. Other data collection methods were considered including participant

observation in the natural work environment and non-directive interviews. However, interviewer bias cannot be totally mitigated through these data collection tools either (Hammersley and Atkinson, 2007). As the researcher, I would have still been filtering the information and discriminating the elements to be selected and analysed.

For more pragmatic reasons, I considered semi-structured interviews to be a convenient way to guide the interview in a realistic timeframe. Additionally, it usefully allowed for some free-floating discussion that aimed to open up shared understanding and encouraged deeper exploration if the participant introduced additional information. The same issues would have been addressed within each interview but the format allowed for some differences where I could probe further depending upon the response (Coleman, 2012:252).

To reduce interview question bias, the interview schedule was discussed and checked with the supervisor and piloted with one participant. In deciding which questions to include, I ensured they were carefully linked to the research aims and questions. To maximise my awareness of potential bias, I utilised Gillham's (2005) three reflective questions before finalising the interview questions:
What do I expect to find?
What would I prefer to find?
What do I hope not to find? (2005:9).
Following these checks, a relevant question schedule, including appropriate sequencing, clearly framed questions and prompting statements, was finalised and agreed.

Alternative approaches were considered for reducing interview bias and addressing any power differentials. For example, I considered the possibility of arranging the interviews to be conducted by an independent person (McNeill, 1990; Bridges, 2001). Whilst this might have been helpful in minimising researcher bias and negative power influence, I decided that it was financially prohibitive, as the research was not externally funded. I also believed this approach might not have generated

as much rich data as important issues may not have been sufficiently pursued by my interviewer proxy.

The life grids were an excellent way of generating specific life data in a quick and structured fashion although they did not allow for rich, thick description that other narrative methods are designed to achieve (Abbas et al, 2013). The life grid information facilitated me to quickly identify a participant's natal context and their family, education and employment trajectory, which strengthened the analysis and identification of each participant's preferred reflexive mode. The life grid format fitted well with the methodology as it produced data that was more towards the middle of the subjectivist / objectivist paradigm continuum and facilitated the comparison between participants individually and in the two practice context groups.

Participants were given the life grid data sheet before and after the interview to maximise the opportunity for as full a data collection as possible and to hand them as much control of the activity as was feasible. Completing the life grid in the same interview allowed me to clarify information and to explore any arising issues that required further depth of inquiry. It also reduced the pressure for busy participants to undertake additional activities outside of the interview session.

I selected new graduates rather than seasoned practitioners for the study as they had experienced the most recent occupational therapy education curriculum as discussed earlier. They were fairly fresh from their undergraduate studies and were considered more likely to be 'bumping' against structural forces as they challenged practices and tried out new ideas. After a year or so, they would have settled somewhat into their new cultural working environment and would have begun to establish their budding professional identities. They were considered to have a more developed awareness of the cultural rules and norms and begun to appreciate 'how things are done around here' (Schein, 1995). However, at this early career stage, they would likely retain an enthusiasm and drive not to slip into poor practice and would want to contribute to improving things. For these reasons, participant inclusion was between one and two years into practice. This precluded graduates

who had not entered practice straight away and had not gained a minimum of one year's experience.

Pilot study

Piloting research interviews and other data collection methods is considered by research experts to be an essential element of any good quality research design (Cohen et al, 2011; Kelley et al, 2003; Silverman, 2010). After the interview schedule and life grid data collection tools had been designed and approved by supervisors, a pilot interview was arranged with one of the original participant recruits. All aspects of the research process were under scrutiny to ensure maximum effectiveness was achieved. Following the pilot interview, personal reflection and interviewee feedback, some of the questions were re-worded to provide greater clarity. As there were no significant changes required, the pilot interview was included in the main study with agreement from the supervisor.

Personal skills

Many commentators emphasised the importance of developing appropriate interviewing skills and sensitivities for this type of qualitative research. As Gillham (2005:7) noted, the interviewer is the research instrument but is also a fallible human being. In assessing my own skills before interviewing the participants, I noted my personal strengths and development needs for this particular study. In terms of strengths, I was able to bring many of the professional skills I have developed over my 30-year career: my lengthy mental health experience, professional counselling and therapeutic skills and general business acumen. Although the interviews were not non-directive and problem-centred, requiring a more therapeutic approach, there was a need to demonstrate some core qualities as described by Carl Rogers (1945), the father of modern day counselling practice. The relevant qualities I brought to the interview process were effective questioning and listening, empathy, congruence, the ability to question without arousing defences and awareness of

ethical issues like confidentiality and safety. I was also able to conduct the interviews with an approach that reduced the impact of any power differentials that may have been present. As an occupational therapy practitioner, I was also bound by the profession's Code of Ethics and Professional Conduct (COT, 2015), which necessitated active reflective practice and regular supervision, both crucial for research practice. Professional academic life had also demanded of me a great deal of flexibility, organisation and project management skills; all were invaluable for managing the wider study requirements of project planning and implementation and being able to adapt quickly where unforeseen problems arose.

With regards to development needs, I am a relatively novice researcher and had not previously undertaken such an in-depth research study at doctoral level. My key skill development areas related to: critical appraisal of others' research; assimilation of current thinking and contested knowledge into my own study; developing a confident academic voice and making an assertive contribution to the current debates. Keeping up to date with scholarly contributions in the knowledge fields that I was exploring and discussing these and other development needs with supervisors and peers, ensured these skills were enhanced appropriately as the study progressed.

Ethical considerations

The study was an attempt to generate public knowledge in the social science arena and involved engagement of human participants who were not positioned equally with me in terms of power, authority and status (Sikes and Potts, 2008). For these reasons, I recognised the importance of the rigorous application of ethical concepts and principles related to confidentiality, anonymity, informed consent, situated ethics and general principles of beneficence and non-maleficence (Piper and Simons, 2011; Silverman, 2010). In preparation for developing an ethically sound study proposal, I had reviewed a number of key guiding documents. Principally, the 'Ethical Guidelines for Education Research' (BERA, 2011), the 'Code of Research Conduct and

Research Ethics' (University of Nottingham, 2013) along with a wide range of literature that provided commentary on specific ethical issues in education and social science research practice. Throughout the data collection methods section, I explained many aspects of how ethical considerations were addressed within the study process. For the purposes of this section, I will outline and expand further on important and relevant ethical issues that were considered.

Relevant formal permissions were sought and gained in order to implement the study plan. I sought and received ethical approval for the study from Nottingham University's Research Ethics Co-ordinator (see Appendix 4 – ethical approval notice). Additionally, my line manager and Head of the Department at my university provided gate-keeper approval to allow access to the study participants via the occupational therapy alumni database.

The study participants were fully informed throughout the research process. A participant information sheet (see Appendix 5 – participant information sheet) and informed consent form had been developed (see Appendix 6 – informed consent form), which appraised each participant about the context and purpose of the research, the methods that were employed and the potential risks for them. All participants were self-selected and signed the consent form to take part in the research. The participant information sheet detailed how participant confidentiality had been addressed and how they were positioned as a collaborator in the research and, as such, were free to review the data generated. They were also given permission to withdraw at any time during the data collection stage. I endeavoured to engage the participants as collaborators, wherever possible, to ensure accuracy and objectivity. This included providing interview questions and the life grid format to facilitate preparation for the interview and opportunities to check the accuracy of data generated in transcripts and life grids (Moustakas, 1994). I committed to update all reviewed data before any analysis was undertaken.

Confidentiality remained paramount throughout the study process. All written and electronically generated information was scrutinised to ensure participant, employer

organisation and any other individual identities remained anonymous. Specifically, during transcription, all participants were given non-traceable pseudonyms to preserve their identity (Punch, 2009). This assurance of confidentiality included presenting and disseminating the research findings in any format and at any time.

Data security was taken seriously at all stages to prevent theft, loss and sabotage. All electronically generated research data was password protected and was stored solely on my university's secure network storage. All paper elements and recording devices were held securely in locked filing cabinets in my university-based office.

Data analysis and interpretation

The main elements of the data analysis occurred during the period from January to June 2017. The analysis was undertaken within a four stage linear process.

1. Familiarisation with the data

Before embarking on any formal analysis, I read and re-read the transcripts to familiarise myself with the data and to immerse myself in the participants' narratives. I went on to summarise the life grid information to create brief participant vignettes that provided an overview and sense of each participant's personal, education and career history to date. I then summarised the transcripts for each participant into a tabulated grid that included the topic and sub-topic areas relating to the interview inquiry areas (see Appendix 7 - example of a participant narrative summary). The purpose was to provide a condensed overview of key extracts from the data.

2. Allocating the participants preferred reflexive modes

I analysed the interview transcripts and life grid data to identify the PRM of each participant (Archer 2003). I read both the entire transcript and the summarised

transcript for each participant alongside the life grid and brief participant vignettes as part of the assessment process (see Appendix 8 – example of a reflexive mode analysis). As a way of enhancing the reliability of this initial assessment, my research supervisor carried out a blind check of one participant's narrative and assigned them into a PRM. The supervisor's assessment agreed with my own, which gave me confidence that the remaining narratives were assessed accurately.

3. Identifying themes

I analysed the summarised interview transcripts to look for any tensions and commonalities to identify key emerging themes and sub-themes arising from their narratives. The identification of themes was also strongly influenced by the research questions, the literature review and the theoretical framework. I coded the themes and reviewed the transcripts many times to refine the emerging themes and sub-themes. The creation of the themes was a continual process of refinement and re-visiting of the narratives, the literature review and the theoretical framework to ensure a thorough approach. A table of the key themes and sub-themes was created and, at that stage, I separated the non-statutory located participants (n=4) from the statutory-based participants (n=5). (See Appendix 9 - emerging themes table). I clearly identified which participant narratives had included a particular theme or sub-theme within the table.

4. Analysis and interpretation of the data

I then analysed the table of themes and sub-themes in two stages. Firstly, I examined the data across all of the nine participant narratives followed by a second stage where I analysed any differences between the two groups of participants depending upon their work location. I created a further table of this analysis to provide an overview of the narrative data (see Appendix 10 – final analysis table). This final analysis stage, including the coding and clustering of key quotations, was used as a basis for sense-making and my interpretation of the data collected and for generating the key findings, which are presented in the next chapter. As part of the

process, I re-read the narratives alongside the identified themes and analysis tables and noted the key structural and agency influences within the narratives. I found it immensely helpful to separately consider this aspect of the theoretical framework and identify areas where the occupational therapy graduates were demonstrating higher degrees of agency and areas where there seemed to be restrictions or influences from social and cultural structures.

I believe that my analytical approach within the methodological and theoretical framework has provided an effective and transparent process. It has facilitated me in plausibly answering the questions that I set out with on this exploratory journey through the colourful, occupational therapy graduate intrapreneurship landscape. The analysis findings are presented in the next chapter followed by the discussion chapter where my interpretation of the findings is discussed and contextualised against the backdrop of the literature review and theoretical framework.

Chapter 5: Research Findings

In this chapter, I present the findings from the analysis of the data collected via the nine semi-structured interviews. A key element of the analysis involved assigning each graduate participant with their preferred reflexive mode (PRM), as described by Archer (2003). As detailed in the previous chapter, Archer had identified clusters of modes of different ways that people conduct their internal conversations (Archer, 2003, 2007). She describes these modes as communicative reflexive (CR), autonomous reflexive (AR), meta-reflexive (MR) and fractured reflexive (FR). The CRs demonstrate contextual continuity, are able to dovetail their concerns, check out their ideas externally and prioritise relationships above work. The ARs are also able to dovetail their concerns. They tend to have eventful lives, are able to think independently and prioritise work above relationships. MRs add an additional loop into their reflexivity: they critique their own thoughts. They rarely dovetail their concerns, are not rooted to a particular context and are often both upwardly and downwardly socially mobile. The FRs are impeded in their reflexivity: they are unable to exert personal powers to inform their projects and their self-talk gives them little or no instrumental guidance. I present the results of this PRM analysis in the first section and describe how the reader should understand and apply these findings to the results of the analysis in the remaining sections. In the second section, I explain how the participants defined entrepreneurship and intrapreneurship and highlight the differences in their definitions depending upon their PRM. In the third section, I describe the starkly contrasting primary factors that influenced the graduates' selection of their early career healthcare context depending on where they were located and their PRM. In the fourth section, I reveal a sharply contrasting picture spotlighting the statutory context as a much less conducive and supportive environment and the non-statutory context as proffering abundant opportunities and greater levels of organisation support for intrapreneurship. These features are described under the sub-headings: opportunities and experiences of intrapreneurship and the barriers encountered. In the fifth section, I detail the significant perceived costs and downsides of intrapreneurship experienced by the

graduates. I expose the similarities and marked differences between the graduate groups in the perceived costs to them as individuals and their relationships. In the final section, I reveal that the way that occupational therapy graduates carry out their internal conversation has a significant influence on their confidence for decision-making for intrapreneurial activities in their workplace. I conclude the chapter with a summary of the key findings arising from the analysis.

For reader clarity, I will mainly be referring to the participant occupational therapy graduates working within the statutory healthcare professional practice context as 'those in the statutory context'. For the participant occupational therapy graduates working within the non-statutory healthcare professional practice context, I will mainly refer to them as 'those in the non-statutory context'[11].

Preferred reflexive modes

The analysis revealed strikingly different preferences for the graduates' modes of internal conversations depending on their selected work location. All five occupational therapy graduates who were working in the statutory healthcare context leaned more towards a CR mode of operating their internal conversation. Conversely, all four graduates who were working within the non-statutory context preferred an AR mode. None of the graduates could be sufficiently aligned to a MR mode or a FR mode. Aligning the graduates with a PRM was not a straightforward activity. They appeared to align with the reflexive modes more on a sliding-scale; the majority of data elements were located in the allotted mode either towards the extreme ends or central area. Two participants, Zoe and Joy, had elements that linked into the MR mode: a limited degree of critiquing their own thoughts but, overall, their preference was aligned on the upper end of the AR mode.
For the remainder of this results section, it should be assumed that if a finding relates to a graduate working in a specific healthcare context i.e. either statutory or a non-statutory, this also relates to the graduates' PRM.

[11] Pseudonyms are used in place of participants' names throughout the chapter to ensure confidentiality.

Defining entrepreneurship and intrapreneurship

The majority of participants understood and defined the concept of entrepreneurship relevant to their working life in terms of thinking creatively and being innovative: generating and implementing new ideas *within* the work context. Their perception was more aligned to what recent commentators have coined 'intrapreneurship': being entrepreneurial within an organisation. Some participants appreciated that entrepreneurship can also refer to the more classic and general definition elements relating to the creation of new enterprises for social and / or personal profit. They all had aspirations to be intrapreneurial within their work context but explained their view of intrapreneurial activity with a different focus depending on their chosen work context and, hence, their PRM.

Those in the statutory context, who preferred a CR mode, included the importance of being creative and having new ideas. However, when describing the purpose of intrapreneurship they focused more on the efficient use of resources and improving elements of the service that are already in existence rather than about pushing back boundaries, challenging practice and generating new resources and services. Sam demonstrated this when he commented:

So I would say intrapreneurship is more about using the organisation's resources to achieve things more efficiently. Make cost savings and hopefully improve the service in the process really. (Sam)

He also made reference to the impact of cost pressures and budget constraints that he had experienced in the NHS:

Of course the book doesn't stop with Band 8 and above [senior managers], going to back to what my boss said, I think that even down to you know, assistants and Band 5's [assistant and entrant level staff]… we should all be looking for ways to operate the organisation more effectively and not spend as much money. (Sam)

Sam appeared to lack confidence in his ability to make any successful improvements to services and seemed constrained by the structures inherent in the work setting.

He could not see himself breaking through the structures and found difficulty describing what could be transformed or created outside of what was already in existence.

Contrastingly, those in the non-statutory context who preferred an AR mode expressed a more empowered and transformative view of their intrapreneurship. They explained that intrapreneurship was more about creating and doing new things, seeing new opportunities, pushing back boundaries, developing their skills and knowledge and about overcoming any barriers. Zoe and Joe illustrated some of these views when they commented:

For me it means thinking about what you can do which is kind of outside the realms of what is done so it can be, it's pushing back boundaries for me and being unique in delivering or being in a different way and quite forward thinking. (Zoe)

I suppose for me looking at appreciating your skills and your profession as almost a marketable property really and you are looking at what you can do what your unique skills are what your unique knowledge is and rather than accepting that that can exist within existing structures looking at actually where else could you apply that and that would be within existing settings and looking at expanding occupational therapy within those settings or looking at other areas where occupational therapy could work. (Joe)

Both Zoe and Joe were aware of the structures that were present in their work context. They were able to clearly identify the structures that they encountered, referring to them as boundaries and existing structures and they could describe breaking through these to expand and develop the service and their practice.

It was clearly illustrated through the analysis that there were distinct differences in the way that participants defined and saw their role in intrapreneurship depending on where they were located and their PRM. Those in the statutory context saw their role as ensuring more efficient use of resources and improving services in existence. Their view of their own possibilities for intrapreneurial activity seemed limited by the structural constraints inherent in their workplace. In contrast, the non-statutory graduates appeared more outward-looking and forward-thinking: they could seek

out new opportunities, challenge the status quo, create new services and develop their skills and knowledge. Their views of what they could achieve did not seem to be limited by the structural features of their work setting. They saw beyond the constraints that might be encountered and considered what could be achieved. The way the graduates defined intrapreneurship differed greatly depending on their work location and PRM.

Influences in the selection of early career work context

The graduates all presented as ambitious, positive in their outlook and had clarity in their work and life goals but this was not the complete picture. They had a clear idea of how they saw their personal lives progressing, what they wanted to achieve and also some thoughts on how their professional careers might develop. The majority expressed a desire to be creative at work and to make a difference by developing the services that they were involved in. However, when participants discussed selecting their early career work context and location there were markedly contrasting primary factors that influenced their choices.

For those in the non-statutory context, the influencing factors related to opportunities for intrapreneurship and they were much more motivated by opportunities afforded for higher levels of personal agency. Their negative views of the statutory context were also influential in their selection. This is clearly illustrated by Joe and Joy who expressed a desire to be challenged by the working environment with both noting that they got bored very easily when in non-challenging situations:

I suppose for my professional goals I suppose I am looking for a job which keeps challenging me so I tend to find that is something that evolves over time, I tend to find if I'm doing the same things year on year I tend to get quite bored with that so I like jobs that keep challenging me, where I am learning new skills each year, working with new people each year. (Joe)

Joy demonstrated a unique insight as she had previous work experience within a clinical placement and a brief spell post-graduation in the NHS, did not like it and

quickly moved onto a non-statutory healthcare post. She commented on her negative view of the NHS, which subsequently influenced her move to the non-statutory context:

I couldn't go back into the NHS. I know that much definitely, just for the few roles I've had I know I couldn't go back to something like that. Because I need to have that flexibility, I need to have, and I think that motivates me because it is the unknown I think that drives me… I think referencing the NHS I found it quite boring if I am honest. It was very structured and the rules and policies that you have to follow but it didn't allow me as an occupational therapist to think outside of the box, bring my own thoughts to the drawing board if you like. (Joy)

Both Joe and Joy appeared to enjoy some level of structure at work as they saw this as challenging; they are motivated by challenges and can become quickly frustrated and bored without them. However, Joy, in particular, described her perception of the statutory NHS as being *too* highly structured by the cultural constraints of rules and policies with little time and support to break through these to be intrapreneurial.

Zoe also voiced her negative opinion of the statutory context and added that her job satisfaction would be diminished as she would not be able to use the occupational therapy skills she had developed during her degree training:

I think that my honest opinion of it [statutory sector] is that I think the occupational therapists that I have met that work in the statutory sector are unhappy and the job satisfaction is [low]….I think when I talk about my job it is, I know I do have a lot of job satisfaction and so I don't think I could. Now that I have worked out of it and realise that I can utilise my occupational therapy skills… I think I would find it really restrictive. (Zoe)

Zoe also recognised the extensive structural constraints of the statutory healthcare context and was aware of her own need to work in a role where she could practice more freely.

Joe, Zoe and Joy specifically expressed the strong desire for autonomy at work and highly prized their independent thought and decision-making rights. For Joe, this was expressed as the freedom to explore and apply the occupational therapy philosophy

in the way that he wanted and, referring to a final year non-traditional placement, he was also excited by the prospect of being trusted to develop occupational therapy services independently:

I think that keeps me interested in the role and the other thing as well I wanted a role with quite a high degree of autonomy in it. Which is it's the way I like to work I like to be able to think for myself and being able to apply occupational therapy for myself as well because I think occupational therapy spans across so many different areas and within every area every occupational therapist has got a different way they apply the professional occupational therapy values and philosophy to that area. (Joe)

…it was just so enlightening to have that freedom and to really dig down to what occupational therapy is, what does it stand for, what is its unique skills and how you can apply it and having a role where I again could go in and I am the first occupational therapist in that setting and start to shape that and that excited me as well. (Joe)

Joe had been attracted to a role where he could operate with a high degree of professional autonomy. He was keen to be able to think for himself and he wanted to shape practice rather than simply operate within the structural framework in existence. He saw the non-statutory context as affording him these opportunities.

Those in the non-statutory context were highly driven by the desire to develop their skills and competencies to gain professional credibility. This strong desire resulted in the prioritisation of their work role over personal relationships, salary level and job security. This was illustrated by comments from Joe and Joy:

Yes, there were two roles I was offered when qualified and one was a lot closer to home but was in a setting that I certainly had less experience with the service user group and probably include that I had less interest in that area but it would have been quite a traditional band 5 role which wasn't where I was looking for in my career, my career goals. So I think this role although travelling further, fitted more nicely into where I wanted to be in my career. (Joe)

Joy commented on the choice of her role having some negative elements but that these were outweighed by the positives:

Well the downside is at the moment is the uncertainty of whether or not I am still going to maintain employment after the contract runs out… so financially it is a concern [but] I can honestly say that I haven't experienced anything to date negative about this role. (Joy)

Both Joe and Joy were willing to tolerate some perceived negative structural features in their work setting to maintain a work role where they could also meet their personal concerns. Joe demonstrated high levels of self-efficacy and great confidence in his professional skills; he preferred a role where he had less experience over one where he did not believe he could meet his concerns. For Joy, despite the precarious position she had found herself in with the possibility of losing her job, she still preferred this higher risk setting than returning to the highly structured statutory context.

In contrast, the statutory context located graduates expressed a desire to be intrapreneurial: to be creative and make changes within services. However, these were not primary factors driving their choice of work context. Instead, the priorities steering their work context choice related to the importance of other people and relationships and the lack of confidence in their professional capabilities. They identified early support from senior colleagues in the form of clinical supervision and mentorship along with opportunities to learn from senior colleagues as important influencing factors. For example, Ann and Mia commented:

It's a very good learning post really so that's why I took it really, it was a good learning post..I got a very good vibe from the interview as well and the team etcetera. (Ann)

When I was looking for occupational therapy jobs when I was still at university I felt like I needed to be somewhere where there were other occupational therapists around me that I could learn from. I had that stability and that support really…… I wasn't strong enough to do that [to go into a non-statutory setting] so I wanted some stability of coming into an established team where I could learn, learn from others really. (Mia)

They both placed a high value on the benefits of being with others in a professional team environment where they could receive mentoring support and learn their

occupational therapy 'trade'. For Ann, feeling right, or having a "good vibe" about a work context and the staff, appeared more important than the content of the job. Mia imagined the less structured, non-statutory context as a difficult place to be; she appeared to have low levels of self-efficacy and confidence in her professional skills and ability to circumvent any obstacles encountered.

Unlike the non-statutory graduates, job security, career progression prospects, salary level and the closeness of work to their home, friends and family were vital to those drawn to the statutory context. For example, Eve and Sam commented about the attraction of enhanced job security and the support from working with others:

In the NHS there is a lot more job security and a lot more stability… one of their biggest principles is that they progress their staff….the NHS is just that go to place, there was the preceptorship that I did when I first qualified which helped to support me to transition… it's really essential 'cause you are never prepared enough to be thrown in at the deep end. (Eve)

I would like to develop my career, become good at what I do and be respected by others… I enjoy the camaraderie of working with other people… (Sam)

Eve lacked professional confidence and perceived her first venture into work to be a daunting prospect; any 'life raft' of support that was on offer was tightly seized. For her, the statutory NHS was the only safe option. For Sam, he also lacked professional confidence and valued others at work. He saw his work colleagues as potential friends from whom he could garner approval and respect.

Being located close to family and social contacts were very clear motivating drivers for choosing a work location. Eve had an NHS post further away for a short while post-graduation, but changed to a new NHS job to be closer to family, friends and her social life:

I was closer to here and so the travelling has reduced significantly and so where I was two hours on the train… now I drive and it's just so much more convenient. (Eve)

This was also clearly an important factor for Sam although a fundamental motivator was ensuring maintenance of a happy home environment:

Then when I eventually got the opportunity to apply for a band 5 position in this area I was delighted. Very local to me as well…. I am really just interested in the happiness I have at home domestically really… (Sam)

Both Sam and Eve highly valued and prioritised easy access to their friends and family over a particular type of job role. These were clearly important aspects of their ultimate concerns.

The majority of graduates expressed negative perceptions of the 'other' context. This was either because they acquired a negative experience in that context from placement or work experience or because they perceived it as not affording the 'right' opportunities for meeting their personal and professional needs. A couple were more open to exploring the other context as they could see some of the benefits after having had previous experience in their current location. For example, Amy had two short jobs in the private context and is now considering the statutory context to get more professional support. However, she has had some difficulty securing a position. She stated:

So, I feel that after leaving this job in the second company I felt that I didn't want to be in the private sector all of my working life and that I needed some general experience in the NHS. When I started looking for other jobs a lot of them said 'NHS experience needed'… so I did a couple of interviews and in the feedback they said you did a really good interview, however it was against you and someone else at the end and they had NHS experience and so we chose them. (Amy)

In this example, the NHS employers appeared to preference those who had experience within their organisation despite recognising the skills and experience that Amy could bring to the post. Amy had not wished to be confined for her working future in one context and, therefore, had considered that some NHS experience would be valuable to keep her options open. This demonstrated the highly

bureaucratised nature of the statutory NHS, which had created needless structuring for fledgling occupational therapy graduates to negotiate.

It was heartening to find that all graduates were ambitious to be intrapreneurial as newly graduated occupational therapists. However, this ambition was not realised for all: it was not a principle factor influencing the selection of their early career work context. For graduates in both contexts, they perceived their chosen work setting as affording those factors and opportunities that were a priority for them. For those in the statutory context team-working, location of work close to friends and family, professional support, development and promotion prospects were deciding factors. Contrastingly, those in the non-statutory context favoured work settings where they could be afforded greater levels of personal agency. They prized being continually challenged to keep motivated. They also desired autonomy for their decision-making and wanted respect for their professional contribution. There was also some evidence of the NHS limiting access to roles for those who had begun their careers outside of the NHS. Despite the overarching desire to be intrapreneurial, there were very different factors influencing their early work context choices.

The influence of the occupational therapy degree course

For both groups of participants, there was evidence indicating the various influences that the occupational therapy BSc degree course engendered on their early career intrapreneurship. Overall, there was an expression of enjoyment whilst they were studying, with the practice placement experiences and the academic study elements both being influential in different ways. As noted earlier, the three-month placement in their final year was influential for some of the participants in where they chose to work post-graduation. However, it was also influential in preparing them for intrapreneurial thinking and activity. This was particularly evident in Joe's narrative where he explained that his final year contemporary placement had given him the opportunity to clearly observe occupational therapy's unique skills within a non-

traditional setting and also introduced him to the opportunities afforded for intrapreneurship:

I had a level 3 placement in a contemporary setting where there weren't any occupational therapists there and there hadn't been any previous students and for me it was just so enlightening to have that freedom and to really dig down to what occupational therapy is, what does it stand for, what is its unique skills and how you can apply it and having a role where I again could go in and I am the first occupational therapist in that setting and start to shape that and that excited me as well. (Joe)

Here Joe clearly articulated his desire and capacity to develop the services delivered: to employ his agency to change and shape the organisation structures he encountered. He was excited by this prospect.

The academic elements of the occupational therapy degree course were also influential in introducing the graduates to the concepts of both entrepreneurship and intrapreneurship. During their final year modules, graduates were encouraged to think about the wider context of occupational therapy, the potential reach of the profession and how they would be instrumental as the next generation of therapists to challenge and make changes for improving healthcare and health outcomes. This was reflected in the graduates' narratives as they described the course as helping them to "develop their confidence for pushing boundaries" (Joy) and to "think differently about how things operate" (Sam).

The analysis revealed that the occupational therapy course had been influential in both preparing graduates for practice and for introducing them to the concept and practice of intrapreneurial thinking and behaviour. Some graduates appeared to have developed a greater capacity for approaching and scaling structural obstacles within their practice through academic preparation and when given the opportunity for practicing these within the placement experience.

Constraining and facilitating features for intrapreneurship

In addition to identifying the new graduates ambitions for being intrapreneurial at work, I was also keen to examine if their chosen healthcare context had provided them with the opportunities and support for intrapreneurship. The analysis revealed a sharply contrasting picture highlighting the statutory context as a much less conducive and supportive environment than the non-statutory; the non-statutory context proffered abundant opportunities and greater levels of organisation support. These features are presented as sub-sections entitled 'opportunities and experiences of intrapreneurship' and 'barriers experienced'.

Opportunities and experiences of intrapreneurship

There were some similarities but mainly stark differences in the graduates' perceived opportunities afforded for intrapreneurship and their experiences within the contrasting healthcare contexts.

Those in the non-statutory context described abundant opportunities, both smaller and larger-scale. Most reported that they were actively encouraged to be intrapreneurial: to generate new ideas and bring changes and innovations into many aspects of the work place. Joe went further and commented that he felt trusted by senior colleagues to be intrapreneurial and was considered an expert as the only occupational therapist within that organisation context:

..they acknowledge that I am the expert at what we can do so they allow me a lot of flexibility in how I deliver my interventions as long as I can justify with results afterwards because clearly hard evidence talks within any setting. But I do get a lot of flexibility and so I am allowed to use a lot of intrapreneurial skills within my work so that is a big part of keeping me interested in the role and helps me to feel valued as a role as well and they seem to allow me that freedom it shows their level of confidence in the occupational therapy profession and with me. (Joe)

Justification with some form of evidence for making changes and implementing new ideas was expected to be presented to senior colleagues but there was little challenge and ideas were often supported and funded:

There's not a lot of research out there so if I am looking at justifying why I am looking at doing something I haven't got a great evidence background to back it up so I am relying a lot on the school trusting me to go ahead with it. (Joe)

This contrasted markedly for those in the statutory context. They reported fewer opportunities to be intrapreneurial and described these as much smaller-scale activities within the realms of their normal daily work. For example, being innovative within a therapy session with a service user by using a new technique / approach or by introducing a new way of recording activities for the immediate therapy team. They reported feeling disempowered in their efforts to be intrapreneurial. They experienced being positioned very low within the decision-making hierarchy and that expectation of their intrapreneurship from senior colleagues was minimal. Some commented that if they had an idea for innovation they may be required to pass this on to more senior colleagues for follow up or to an individual who had a designated role for innovation or service improvement. Joy experienced this when she had worked briefly in the NHS and Mia also provides an illustrative comment:

I think it is very difficult to be an [intrapreneur] within the NHS acute hospital setting if I am perfectly honest because I think you have to go up the ranks quite high before any of your thoughts are actually heard and taken on board. (Joy)

We have a couple of people who are leads for innovation so I can go to them and say I've got this great idea and I think this is going to make things better… (Mia)

This perception and experience of a low expectation for intrapreneurship was contradictory to what they described as evident in the organisation policy. Some stated that innovation and service improvement was included in their job description and, for some, time was nominally allotted during the week for 'innovation activities'. Whilst recognising these organisation requirements, they reported a lack of senior expectation and funding for innovation and that competing demands took

priority. On the occasions where they were involved in larger-scale innovations, the executive team required justification and evidence and, even if the ideas were supported, funds were often not forthcoming. Ava experienced this when her team wanted to bring in a new therapeutic intervention that required purchase of some new equipment:

We had a bit of questioning from the Board about why we wanted funding….. we did a small presentation and took research and things into the way, we used a lot of play therapy evidence… so it kind of won them over… everyone slowly got on board but financing was a big hurdle as well just because we couldn't really get anything so we fundraised ourselves and one of our seniors ran a marathon to raise money… (Ava)

In this instance, the staff had found a way around the lack of funding but this approach was not common. Mostly, the lack of resources and support were experienced as unnavigable structural barriers.

In the non-statutory context, the structure and culture appeared much more facilitative for intrapreneurship and there were more opportunities afforded than in the statutory context. There was also a noticeable gap between organisation policy that expected all staff to engage with intrapreneurship and the realities of everyday practice.

Barriers to intrapreneurship

Unsurprisingly, there were more barriers to intrapreneurship described and experienced within the statutory compared with the non-statutory context. For both contexts, although more frequently mentioned by the statutory located graduates, an on-going lack of funding for resources and low staffing levels (resulting in high demands on their time) were identified as pressures. These pressures impacted to varying degrees on their capacity for being intrapreneurial; the statutory graduates experienced negative impacts on capacity more acutely.

The statutory located graduates identified the highly bureaucratic organisation structure alongside a negative culture, adverse influence of others and their own lack of personal motivation and confidence as being barriers to their intrapreneurship. When Joy worked briefly in the NHS, she experienced the organisation's bureaucratic structure as a major barrier to getting ideas agreed and into action. She commented:

I was full of good ideas [in the NHS] and the rest of it but there was always red tape around why I couldn't do something. It was so frustrating. (Joy)

Joy found this situation frustrating and it was a key factor in her move into the non-statutory context; rather than find ways around the structural barriers or "red tape", she moved onto a setting where she perceived greater freedoms for intrapreneurship.

Other structural barriers included cultural rules and norms that created an environment where intrapreneurship was not considered an important aspect of the normal work role for newly qualified graduates. There was also a distinct thread of disempowerment weaving through the statutory located graduates' narratives. Two graduates alluded to the 'power of the many' with Eve also expressing how she felt at the bottom of the hierarchy:

The culture can be challenging, current ideas and current practices as well and the hierarchy. I think 'cause the NHS is so hierarchical, as a band 5 occupational therapist at the moment probably at the bottom of the food chain and then just challenging those that are higher and just making your voice heard especially if you're not the loudest person in the team or the most vocal. (Eve)

I think the biggest thing for me is the culture of the environment…just challenging those ideas the people who have been there for a long time they are difficult to get through to. There are power in numbers… those are some of the barriers I am facing on a smaller scale. (Eve)

Eve experienced significant structural barriers to her intrapreneurial endeavours and she perceived that she had no audible voice in her work place. She believed other

people were playing a significant role in her feeling of disempowerment as she felt that they were not listening to her or taking her ideas on board.

The impact of other people on the statutory graduates capacity for intrapreneurship emerged as a very significant barrier. Some were impacted by the lack of motivation of other people in their team: when ideas or innovations were presented, graduates were often met with the common response that they had 'seen it all before'. Ann experienced this when she had tried to introduce a small-scale change onto a nursing ward in the organisation:

I went on that visual impairment course and I set up some paperwork to go with it. What I found out is that nurses didn't really want to get on board or are very busy. Trying to get the whole ward on board is really difficult it also makes you feel oh I can't be arsed to do this. It's sort of demotivating at times because not everyone is getting on board with it. (Ann)

Ann had become demotivated by her lack of success in getting a new idea into action. Other staff responses had created a barrier, which she perceived as impossible to traverse.

Others were influenced by their fear of others' potential negative perceptions of them if they challenged practice or presented an idea for service improvement. The statutory graduates reported these barriers, and their own general lack of confidence in their capacities, as major factors influencing their intrapreneurship. Ava illustrated this clearly in her comment:

So there's a lot of things that I would love to do within the service that we provide at the moment but it's the fear of knowing that I will be told 'no' because that is not what we do here….it takes a toll a little bit on your confidence in yourself when people shut you down or tell you you can't do things and just because I don't know, I put myself down quite a bit just because I am not very confident. (Ava)

It was not clear if this inability Ava experienced to exert influence at work was through a fear of others' responses or a reality she had actually experienced. Nevertheless, she was disempowered by others' negative responses to her ideas.

Those in the non-statutory context described experiencing far fewer barriers to their intrapreneurship. As mentioned earlier, they did allude to a lack of funding and time as being resource barriers. However, in contrast to their statutory-based colleagues, they appeared to perceive these, and any other barriers, as obstacles to climb over or traverse, not preventing or blocking their intrapreneurial activity. Furthermore, the only barrier mentioned relating to the impact of others was that others might not understand their ideas and innovations when presented. Instead of causing a lack of motivation and action, only feelings of frustration resulted. This was illustrated by Zoe and Amy who commented:

I suppose one of the downsides was other people not understanding the vision… when you meet someone who doesn't think in an entrepreneurial way how do you change their mindset?... [example provided]…we had to be a little bit kind of clever in what we did and not use occupational therapy language but still present stuff so I had to change how I was being and now they're really on board. (Zoe)

I felt after a certain while of being entrepreneurial, things kind of being pushed aside I thought maybe there's nobody interested. I think it was because really so many other things were going on at the time it wasn't a priority for everybody at that time to do or challenge these things, I suppose it was just frustrating. (Amy)

Both Zoe and Amy had become demotivated by the lack of others' engagement with their ideas, however, they did take different approaches to their situations. Zoe had recognised the barrier, looked to her own behaviour and was able to adapt it to get others on board. Amy had also recognised the barrier but assessed it as unmovable and frustration ensued.

It is clear from the analysis that the contextual features of the differing healthcare contexts were influential in impacting the graduates' opportunities and capacities for intrapreneurship. The statutory context revealed less opportunities and more constraining features for intrapreneurship with a very noticeable gap between policy demanding intrapreneurship and real world practice. Conversely, the non-statutory context appeared to offer abundant and larger-scale opportunities with a more

facilitative structure that supported intrapreneurship. This finding is also supported firmly by the literature where these experiences are extensively documented.

Costs and downsides of intrapreneurship

This sparsely explored area was a key focus for my study. Many of the costs described could also be barriers to intrapreneurship. However, the participants only revealed these when directly asked to identify any personal costs associated with intrapreneurship. They had not necessarily experienced the costs personally but they did perceive that there were or could be many costs for them and others.

There was recognition from graduates in both contexts that there were or could be personal costs involved in being intrapreneurial in the workplace. Both groups acknowledged the extra time and cognitive effort involved and the consequences of this on their energy levels and work / life balance. Joe and Zoe commented:

I suppose it's cognitively more taxing. If you're constantly thinking about new ways to develop the profession you constantly feel like you are justifying what you are doing. (Joe)

Just the time factor I suppose,… so if I go to a networking meeting because I want to get new ideas or that it isn't a paid meeting [I would incur costs]. That's something I do but again I always feed it back in so although I have had a really busy week and I have been to a meeting on a Monday and I've not finished 'til half ten I know my manager's not gonna be annoyed if I don't go in at 9. So again the disadvantage [cost] is kind of outweighed. If you are always thinking entrepreneurial it can be tiring… . That's the only thing [cost] but I enjoy it, I enjoy because I find it quite creative, probably meets that creative need that I have. (Zoe)

These comments from Zoe also illustrated that the non-statutory graduates experienced some costs for intrapreneurship but added that the costs were 'worth it': the costs were outweighed by the benefits.

Interestingly, those in the non-statutory context tended to focus these costs on the impact for them personally, whereas those in the statutory context focused more on

the risk to their relationships with others. For instance, the statutory graduates discussed the negative impact on their on-going confidence and motivation if others rejected their creative ideas or if their plans failed. Again, they expressed fear of the negative perception of others around them and the risk, or possible implication, of being isolated within the team or of being taken advantage of by others. Sam described these costs in terms of being resented by others if they were trying to introduce ideas and changes. He had experienced the costs of intrapreneurship by observing a new practitioner in the organisation as they attempted to bring in a barrage of changes and improvements. Sam had admitted that he didn't like change so he had seen the costs for this person from the 'other side':

Sometimes you try too hard to change things and you will be resented for it…. I do think that before you start anything there has got to be, you have got to see a reasonable outcome … So that is very much a cost because it made me want to distance myself from that person…. And to me it was coming across as arrogance because I thought you are a new practitioner you have just started here. (Sam)

Sam had seen the cost of being intrapreneurial for another person and this had the impact of 'putting him off' stepping out confidently to be innovative and intrapreneurial as a new occupational therapy graduate.

Those in the non-statutory context discussed their own possible frustration if their ideas were rejected and the risk that things may 'go wrong' and their job security being at risk if mistakes were made. Joe and Amy commented:

There are greater risks involved for your job security I would say. In that if you stick to the one thing you know it's more likely to be seen as your area, your expertise in a secure employment whereas if you are constantly looking to develop you maybe don't have that, [….] it's high risk as well I suppose things can very much go wrong. Again, you would be using your reasoning and ethical principles to manage that risk and you would only go ahead with it if you thought it was positive risk but with any risk it can go wrong and it's more likely to go wrong if you're being intrapreneurial. (Joe)

I felt it was quite frustrating to pluck up the courage to be confident enough to put new ideas forward and to challenge things in my unit and then to have those pushed aside. (Amy)

These findings illustrated that there were significant perceived costs involved for occupational therapy graduates being intrapreneurial in the healthcare workplace. Both groups of graduates reported the extra time and effort involved. However, the costs perceived by the statutory graduates related to the negative impact on relationships, whereas the costs for the non-statutory graduates related to their personal costs. The impact on their current and future intrapreneurialism is less clear.

Reflexivity in decision-making for intrapreneurship

I explored the occupational therapy graduates' decision-making capacities within their PRM and the possible impact on their intrapreneurship in their chosen work context. Effective decision-making is a key component of bringing ideas into action. I found that the way that occupational therapy graduates carried out their internal conversation had a significant influence on their confidence in decision-making for intrapreneurial activities in their workplace.

Those in the non-statutory context who preferred an AR mode had a greater capacity and confidence for intrapreneurship compared with those in the statutory context who preferred a CR mode. For instance, the statutory located graduates reported spending a lot of time communicating with others to garner their views and in undertaking large amounts of research when making a decision. They spent less time on their own internal deliberations and expressed little confidence in their decision-making capacity. Two statutory graduates went further and reported that they had little or no confidence in their decision-making and one, Eve, reported that she often relied entirely on others to make decisions:

I do honestly, I struggle with decision-making sometimes, especially with really big decisions because I am indecisive to begin with and I always want to accommodate as many options as I can but I don't feel I have the capacity to, so I feel like I do really need someone to put me in line and say no you're being silly, this is what I think you should do and present it in a way that I can understand. (Eve)

Interestingly, two statutory graduates reported relying more on their feelings and instincts to make decisions. Ann described this as experiencing a gut feeling and Eve explained this as imagining herself in the various scenarios and considering how she felt whilst there. If she felt uncomfortable, she would not take that decision:

I will also sort of visualise things that I can see myself doing and in certain positions and if it doesn't sort of sit right with me then that's also a way for me to make decisions….what I fantasise about just envisioned it or if it doesn't feel ok it's probably not for me because I think I am really sensitive to my feelings and my

emotions and if I don't feel comfortable in a situation I would probably stay away from it. I do like to listen to my instincts. (Eve)

I usually get that gut feeling that I'm doing the right sort of thing. (Ann)

Eve had so little confidence in her capacity for independent decision-making that she relied not only on guidance from others but also on how she felt when visualising herself in various positions. Ann also relied on physical sensation through her "gut feeling" rather than on her capacity to think through the options to reach a decision.

These findings differed greatly for those in the non-statutory context who preferred an AR mode. They spent less time communicating with others and researching although, interestingly, more time with their internal deliberations by weighing up things in their own mind. They all felt very confident in their decision-making capacities and much less influenced by others when deciding to take action or be intrapreneurial. The majority tended to make their decision first and then 'tell others'. Amy illustrated this when she discussed making her decision to go to university:

I think once I have got an idea into my head that I want to do something it does stay quite firm and I do think about the pros and cons of it for quite a while for example with [deciding to] going to university….. I did think about it for a number of months, weighed up the pros and cons but when I realised that it was the right time and I definitely wanted to do it I went ahead and told people and started booking things. (Amy)

Amy took time to make her decisions but when she *had* decided, she became firm about her choice and it was not until she had reached that position that she informed others. She did not allow others' views to interfere with her decision-making process.

The exploration revealed that the way the graduates carried out their internal conversation significantly impacted their confidence in decision-making for intrapreneurial action. The graduates located in the non-statutory context who

preferred an AR reflexive mode had a greater capacity and confidence for intrapreneurship compared with those in the statutory context who preferred a CR mode.

Findings summary

This chapter has presented the findings of the research following extensive analysis of the data collected via nine interviews with newly graduated occupational therapists in their early career roles within the healthcare context. Despite some strong similarities, overall, there were stark differences between the graduates depending on their selected work context. I revealed early on that their PRM was clearly linked to the context where they worked: those in the statutory context preferred a CR mode of operating their internal conversation and those in the non-statutory context preferred an AR mode. Moving on to explore the graduates' perceptions of intrapreneurship indicated distinct differences in their definitions and how they viewed their role in it. Those in the statutory context emphasised the efficient use of resources to improve existing services, whereas those in the non-statutory context stressed that seeking out opportunities for innovation and creating *new* services were key. All of the fledgling graduates had intrapreneurial ambitions but these desires were not the full set of drivers steering the selection of their early career posts. The non-statutory graduates were largely driven by opportunities afforded for intrapreneurship and maximised personal agency; the statutory graduates were steered by their lower professional confidence and opportunities afforded for support, mentoring and learning.

The academic and practice placement elements of the occupational therapy BSc degree course had positively influenced the graduates' intrapreneurial thinking and behaviour. Once they were embedded in their chosen context it was interesting to note their dissimilar experiences of the organisation support for intrapreneurship, opportunities afforded and barriers encountered. The non-statutory graduates described a wealth of wide-ranging opportunities for intrapreneurship. They

experienced organisation openness to new ideas, received ample support and perceived fewer barriers for which they appeared well-equipped to circumnavigate. Their statutory located colleagues described much smaller-scale opportunities within the scope of their normal daily work. Moreover, a noticeable gap emerged between the high organisation expectations for intrapreneurship observed in policy and the reality of practice. They were disempowered in numerous ways with minimal expectations from lower and middle management, high competing demands on time and extensive barriers perceived, which they appeared ill-equipped to traverse. Furthermore, the analysis revealed significant costs involved in intrapreneurship. Both groups of graduates reported the extra time and effort involved. However, the costs perceived by the statutory graduates focused on the negative impact on relationships, whereas the costs for the non-statutory graduates focused on their personal costs. When relating these findings to Margaret Archer's PRMs, I found that those who preferred a CR mode appeared less able to circumnavigate the structural forces inherent within their selected statutory workplace as effectively as those who preferred an AR mode in the non-statutory context. They appeared to need considerable support and preferred working in teams alongside and learning from others, whereas those who preferred an AR mode appeared much more self-reliant and autonomous in their decision-making and intrapreneurial activity.

In the next chapter, I discuss what I have assessed to be the key research findings within the context of the literature review and in light of Margaret Archer's theories. I selected the findings that were particularly notable or added knew understanding to the field. Those findings assessed as less important were omitted: the different ways that the graduates defined entrepreneurship and intrapreneurship and the influence of the occupational therapy BSc degree course on the graduates' work location and intrapreneurial choices.

Chapter 6: Discussion

In this chapter, I bring together the key findings from the study and discuss these in relation to what is already known within the literature and research field. The chapter is sub-divided into three sections. In the first section, I discuss the importance and relevance of Margaret Archer's theory of the internal conversation and how her reflexive modes usefully apply to my field of study: the intrapreneurship of occupational therapy graduates. I discuss how her theories have shed light on graduates' work context choice and their intrapreneurship aspirations and activities. I also discuss a key finding regarding the importance of relationships and how they are differently valued depending on the graduates' PRMs. In the second section, I discuss how the structural features of the contrasting healthcare contexts constrained or facilitated occupational therapy graduates' intrapreneurship within the study. Much of these findings support what is already known in the literature, however, I add to the field by discussing how critical realist philosophy and Archer's theories have shed light on how the occupational therapy graduates have been interacting with the structures in these particular healthcare contexts. In the final section, I expose and discuss the sparsely explored area of the costs and downsides involved in intrapreneurship for the occupational therapy graduates in this study. The chapter is closed with a full summary of the discussion and an introduction to the final concluding chapter.

The usefulness of Margaret Archer's reflexive modes

I had been extensively involved in developing and teaching two final year modules: one that emphasised the importance of occupational therapy students developing their leadership capabilities and another designed to explore and augment their intrapreneurial capacities. The key purpose of these modules was to equip the students for entering the healthcare workforce with capacities to challenge practices and make changes from day one. Through undertaking the modules, they were fully enlightened regarding the issues around poor practice, particularly the shocking

cases of neglect identified in recent Government reports and inquiries (Berwick, 2013; Francis, 2013; Keough, 2013). We emphasised the part that they would play in improving and shaping future healthcare for the benefit of service users. Furthermore, they were encouraged to be pioneers, taking the occupational therapy philosophy into new practice areas to expand the reach and influence of the profession. At this pre-graduation point, the majority of students seemed to embrace the idea of intrapreneurship to varying degrees and expressed a desire to be pioneering out in practice. However, it was noticeable that some were enthusiastic to launch into new areas of practice and some preferred to enter the more traditional statutory context.

I became interested in why some students were enthusiastic to be pioneering and expand the profession into new areas and some were keen to launch their career within the statutory context. Anecdotally, I was also aware of feedback from practitioners, and from personally visiting students on placement, that it was difficult for them to be agents of change, particularly in the statutory healthcare context. Through my scholastic endeavours, I became intrigued by the concepts of structure and agency. I questioned how our graduate occupational therapists were able to gain any governance within their professional lives and how they were interacting with the structures, especially those inherent in the healthcare workplace. I wondered whether they possessed the capacity to be the vital agents of change demanded. As introduced in earlier chapters, I dug deeper and became interested in the critical realist, Margaret Archer, and her theoretical work. I speculated if her theories could shed light on any causal mechanisms that could be operating in influencing our graduates' selection of early career posts and their perceptions and experiences of intrapreneurship. The results of my exploration are exciting and reveal that Archer's theory works admirably in helping to explain what might be going on at the more micro-level of interaction with our fledgling occupational therapy graduates. The findings revealed that making decisions concerning their early career work roles and how they perceive and experience opportunities afforded for intrapreneurship, are closely associated with their PRMs. The next two sub-sections address key themes related to how Archer's work has shed light on the specific areas of work context

choice, perceptions and experiences of intrapreneurship and the value of relationships.

Work context choice and intrapreneurship

The analysis revealed that both groups of occupational therapy graduates had a negative perception of the context that they did not select. Moreover, their views were particularly polarised and they used overtly negative language. Those preferring an AR mode described the statutory context as boring, overly structured with too many rules and no opportunities for being challenged. Those preferring a CR mode described the non-statutory context as being unsupportive with too much autonomy and low job security. I had not fully explored the root of these views within the interviews although some proffered explanations that they had personal experience on placement of the opposing context with others relying on hearsay from friends, colleagues and university lecturers. To some extent, these differing views also reflected what I found in the scant and loosely related literature that compared the 3rd sector with other sectors (Ruuskanen et al, 2016; Cunningham and James 2009; Kendall 2009; Kalleberg et al, 2006) and with small compared to larger organisations (Gibb, 2000; Handy 1984, 1993). There was debate regarding the job satisfaction, security and work place quality in the 3rd sector compared with other sectors but little agreement between scholars regarding which sector provided greater satisfaction. Also, smaller organisations, as a proxy for the non-statutory context, were generally found to be more reflexive and provide better conditions for entrepreneurship compared with larger-scale organisations, like the statutory healthcare context (Gibb, 2000). Whilst no literature existed that specifically examined the healthcare context and the health professionals within them, what *did* exist dimly reflected the occupational therapy graduates' views; there was disagreement between the graduates concerning the positive and negative structuring features of each context but they both agreed that greater autonomy could be experienced within the smaller, non-statutory context.

Whilst the literature partly explained the views of the graduates because it related to the different type of context they were evaluating through their personal experience and knowledge, it did not explain why any differences existed between them. This is an area where Archer's theories concerning the internal conversations that people have and their PRMs have been very enlightening. Her theories provide a possible explanation for why the graduates preferring an AR mode would view a highly structuring context with little opportunity for autonomy so negatively and why those preferring a CR mode would view a less structuring context with greater opportunity for autonomy, with equal distaste. Those who preferred an AR mode highly prized autonomy in their decision-making and relied little on others and those who preferred a CR mode favoured more supportive and secure environments, closer to their natal context. Furthermore, this could explain why there was little agreement in the literature about which type of organisation provided greater job satisfaction. It is my contention that researchers have focused on organisation structural features rather than on individual agents and different people will experience different levels of job satisfaction in various work contexts because they will elevate some work role elements above others.

The findings highlighted that all the study occupational therapy graduates were ambitious to be intrapreneurial at work but there were very different primary factors that influenced their selection of early career post. Those preferring an AR mode were attracted by what they perceived as opportunities for intrapreneurship: to have autonomy in decision-making and higher levels of challenge. Those preferring a CR mode were more attracted by job security, a supportive learning environment and being close to the home setting. These were the key drivers steering their early career work location choices. Considering Archer's theories has indicated what may be underlying the motivations behind these graduate occupational therapists' choices. Those preferring a CR mode are described by Archer as less trusting of their decision-making capacities and tend to prioritise family and home over work and those preferring an AR mode are described as much more autonomous in their decision-making and inclined to prioritise work over relationships (Archer, 2003). It is clear that these reflexive preferences have quite accurately described what I found in

the sample groups. These findings have challenged me to consider how this apparent channelling of occupational therapy graduates into these particular settings could have been contributing to the reproduction of patterns of thinking and behaviour or 'culture' that might be detrimental to their intrapreneurship, especially in the statutory context. I have also been challenged to consider how this new understanding could shape the development of a new occupational therapy curriculum and how we could support occupational therapy students and graduates to become more effective agents of change wherever they choose to practice and whatever the degree of structuring they encounter.

Archer's theory was useful in illuminating any underlying mechanisms at play regarding the differences revealed in the occupational therapy graduates' perceptions and experiences of intrapreneurship within the contrasting healthcare contexts under scrutiny. Archer's theory was especially helpful when analysing the interview data in relation to the way that graduates perceived and prioritised the opportunities available, their perceptions of the barriers they encountered and their individual confidence in their decision-making capacities.

The way that the occupational therapy graduates perceived the opportunities for intrapreneurship was highly impacted by their PRMs. Other research has examined the entrepreneurial individual and focused on describing who they are: their characteristics, what they do and how they do it (Hisrich, 1990; Schultz, 1990; Shaver and Scott, 2002). However, they failed to fully explain any underlying mechanisms operating that could impact the entrepreneurs' perceptions of the opportunities open to them. More specifically, the way that the occupational therapy graduates prioritised intrapreneurship along with other professional activities was significantly different depending on their reflexive preferences. Those in the non-statutory context who preferred a CR mode, perceived large-scale and abundant opportunities, whereas those in the statutory context who preferred an AR mode, perceived fewer, smaller-scale opportunities. The statutory located graduates perceived very low expectations for their intrapreneurial activity and their priorities were focused on becoming part of the team and learning from more experienced

colleagues. This starkly contrasted with the non-statutory located graduates who highly prioritised their intrapreneurship, particularly the impact they desired to generate in their new post.

These findings fit well with Archer's descriptions of her reflexive mode preferences. Archer describes the individuals who prefer an AR mode as more oriented to work and achievement rather than people and relationships and vice versa for those who prefer a CR mode. The graduates' perceptions of the different scale and quantity of opportunities in the contrasting contexts could well be accurate although I would argue that if those preferring an AR or a CR mode were prioritising different factors when assessing the opportunities open to them, then this could have influenced how they viewed those opportunities. For illustration, if the graduates preferring a CR mode were enthusiastic to fit in and were not too confident in their professional skills and capabilities, then they would not have been looking too closely at any expectations or prospects for intrapreneurship. They may have been more blinkered to intrapreneurial opportunities than their colleagues preferring an AR mode. Archer's theory assisted greatly in understanding how graduates might view the opportunities for intrapreneurship and how they prioritise these around their various professional work activities.

The occupational therapy graduates' perceptions of intrapreneurship barriers were firmly shaped by their PRM. Both groups of occupational therapy graduates described a range of barriers within their contrasting work contexts. These barriers were largely reflected in the literature that identified the structural and cultural barriers (Exton, 2008; Phillips and Garman, 2005; Cornwall and Perlman, 1990; Meliones, 2000) and the psychologically framed perceptions and responses to barriers by healthcare entrepreneurs (DuCharme and Brawley, 1995; Morrison, 2000). Although these commentators discussed a wide range of barriers, they did little to address any differences in individual's perceptions of them and how these might influence their intrapreneurial behaviour in the healthcare context. Both groups of occupational therapy graduates included a variety of resource pressures such as restricted time, lack of funding and poor staffing levels as barriers. However,

those graduates preferring a CR mode described many more barriers including a lack of support from peers and senior colleagues. Interestingly, the way they perceived these encountered barriers were entirely different depending upon their PRM. The barriers appeared as insurmountable obstacles to the graduates preferring a CR mode and, conversely, viewed as entities to climb or traverse for those preferring an AR mode.

Archer's theory adeptly illustrates the possible reasons for these stark differences. In sociological, structure and agency terms, these barriers are structural forces that the graduates are encountering. They require a substantial degree of agency to successfully traverse structural obstacles and Archer asserts that those preferring a CR mode will experience more difficulty when encountering them. Archer's theory sheds light on why this may be occurring as she proposes that those preferring a CR mode are more content in their established practices and may avoid butting up against barriers, where feasible. They may be unwittingly reproducing the stagnant culture evident in the statutory context. Conversely, those preferring an AR mode are more geared for scaling barriers as they relish the challenge and are less influenced by negative forces around them. It is my assertion that understanding these influences and preferences is important so that in the healthcare HE sector we can raise our students' awareness regarding their own PRM. This could support them in learning how to approach intrapreneurship barriers differently when launching into real world practice. This raising of awareness could also disrupt the evident channelling of graduates into particular sectors and could facilitate them in considering work roles in the opposing healthcare context. This disruption could create a positive impact on the respective organisations' cultures. Archer's theory has brightly illuminated what may be happening at the micro-level of interaction when our graduates encounter structuring barriers to their intrapreneurship. Raising awareness of these issues may assist occupational therapy graduates in becoming more successful when approaching and scaling any obstacles to intrapreneurship that they encounter.

The way that the occupational therapy graduates in the study carried out their internal conversation had a strong influence on their confidence for decision-making for intrapreneurship. It is widely agreed in the literature that effective decision-making is a key ingredient for entrepreneurial action (Porath, 2012). With this agreement in mind, it was interesting to observe that the occupational therapy graduates demonstrated differing levels of confidence in their decision-making capacities depending upon their PRM. Those preferring an AR mode described higher levels of confidence than their CR counterparts. Furthermore, they demonstrated a greater sense of self-reliance in the way they deliberated internally over intrapreneurial scenarios and options. They also spent substantial time searching out and interrogating external reference material. This resonated, to some degree, with key commentators who identified that this critical thinking and reasoning, where the graduates are weighing up options by examining external evidence and past experiences, are key ingredients for successful decision-making (Ariely, 2010; Khaneman, 2005; Liberman and Tversky, 1996).

Archer describes those preferring a CR mode as untrusting of their own internal deliberations and those preferring an AR mode as much more independent and confident in their decision-making capacities. Additionally, feelings and instincts also played a significant role for many of them. Occasionally, if a decision 'felt' right because they felt comfortable when picturing themselves in that scenario, they would lean towards that option. This could be the 'intuitive judgement' included by some commentators as a key ingredient for entrepreneurial decision-making (Afiely, 2010; Khaneman, 2005; Liberman and Tversky, 1996). However, it is not clear whether all the 'key ingredients' mentioned need to be present for maximum effectiveness. Whilst examining what is involved in the graduates' deliberations through a psychological lens has been somewhat helpful, viewing these findings through Archer's PRM lens has added greater illumination. Archer describes those preferring a CR mode as untrusting of their own internal deliberations and those preferring an AR mode as more independent and confident in their decision-making. Understanding how an individual's self-talk might be giving them instrumental guidance for effective decision-making or for tackling a barrier to intrapreneurship, is

highly valuable. Archer's ideas possess great utility for shedding light on the possible mechanisms at play within reflexivity for occupational therapy graduates' decision-making when they are deliberating over potential intrapreneurial action.

The value of relationships

A key finding arising from my study was the strong thread intricately woven throughout the graduate narratives: the importance of others and the value of relationships. It was interesting to discover that the value placed on relationships was prioritised differently depending upon the occupational therapy graduates' PRMs. Those preferring a CR mode placed a high value on others' opinions and views of them as individual therapists, prioritised personal relationships above work opportunities and people featured strongly as structural barriers blocking their intrapreneurship. For those preferring an AR mode, less importance was placed on relationships and others' views, particularly when making work selection decisions, evaluating decision-making for intrapreneurial activity and when negotiating barriers to intrapreneurship. In this section, I discuss these findings with an emphasis on the prioritisation of relationships in early career work selection, the role of relationships in decision-making and how the graduates viewed their position in relationship to others within their selected organisation. I conclude by emphasising how Margaret Archer's theories have shed light, aiding my analysis of the graduates' narratives, especially in relation to the differing importance of relationships.

Relationships played a key role in new occupational therapy graduates' early careers. Interestingly, the graduates prioritised relationships differently depending on their PRM. This finding was eminently evident when exploring their work selection priorities within their early career. Those preferring a CR mode were heavily influenced by the location of the work context and it was important for their work to be close to their home environment with friends and family for support. For those who preferred an AR mode, the story was quite different. Whilst they valued their friends and family, these were not priorities for them in terms of work location.

Instead, they were attracted by the opportunities that the role offered for career development and intrapreneurship opportunities, rather than located close to home for reduced travel time and family support. Furthermore, when evaluating the potential posts on offer, both groups were looking for, and prioritising, different relationship aspects within the context and job role. Those preferring a CR mode focused on what professional support they could expect and were keen to join an established team. They appeared less confident in their professional knowledge and skills and believed that joining a team would enable them to learn from more experienced occupational therapists. Conversely, those preferring an AR mode were not looking for support from other occupational therapists. Instead, they were scouting for opportunities where they could practice autonomously and where they were not restricted by existing team culture and practices. This desire for autonomy was mirrored in the psychological traits-oriented literature arguing that a desire for autonomy is a key individual characteristic of entrepreneurs (Marques et al, 2013; Begley and Boyd 1987; Brandstatter, 1997; Hornaday and Aboud, 1971). However, the commentators failed to discuss or compare the characteristics of any non-entrepreneurs and there was limited research specifically related to the healthcare context where the study occupational therapy graduates were located.

It is my assertion that preferring team-work, desiring professional support and mentorship and wanting to stay close to important personal relationships indicates that those preferring a CR mode are less autonomous and more reliant on others compared with their AR counterparts; those preferring a CR mode seemed to highly value relationships. These findings are elucidated when viewing through Archer's PRM lens. She explains that those preferring a CR mode tend not to stray too far from their natal context; they are able to dovetail their concerns and are less trusting of their internal deliberations than people preferring other reflexive modes. I acknowledge that the graduates in this study are at an early career stage and the picture may look very different over time once they become established professionals.

The role of relationships in graduate occupational therapists' decision-making for intrapreneurship and their perception of the people barriers involved varied greatly depending on their PRMs. The graduates preferring a CR mode appeared more influenced by others and their relationships when making decisions, contrasting sharply with the graduates preferring an AR mode. They spent much longer communicating with others, garnering their views and incorporating these into their intrapreneurship decision-making processes. Moreover, they were sensitive to others' negativity and experienced the risk to their relationships more acutely as barriers to their intrapreneurship than their AR counterparts. When they challenged practice or put new ideas forward, others' lack of motivation and negative perception of them were perceived as insurmountable obstacles. These relationship factors, coupled with lower confidence in their capacity for intrapreneurship, has compelled me to conclude that the graduates in the study preferring a CR mode were less well-equipped for intrapreneurship during their early career work roles compared with their AR counterparts. Those preferring an AR mode relied heavily on their own internal deliberations and they only perceived a lack of others' understanding as a potential barrier to their intrapreneurship. This lack of others' understanding caused some personal frustration, however, they were able to find a way through to convert their intrapreneurial ideas into action. This finding concurs with some elements of the literature in the field. Research identifying the support required for entrepreneurship within organisations emphasised the need for senior colleague support (Thompson, 2004; Turley, 2011) with Alpkan et al (2010) adding that it would also encourage autonomy in decision-making. Gray (2002) and Ford et al (2008) noted the importance of other people for entrepreneurs in that they sometimes create measures of resistance to their ideas. These scholars have discussed the relevance and impact of others but they failed to discuss how and why different entrepreneurs might be reacting dissimilarly towards those influences. Archer, however, does provide some insights. She explains how and why people may be interacting with others, which was eminently useful when considering how our occupational therapy graduates' decision-making could be impacted by relationships. The graduates preferring a CR mode required greater levels of human interaction and support when making decisions for intrapreneurial action and were more

adversely impacted by the negative influence of others, compared with their AR fellows.

How the occupational therapy graduates saw themselves positioned in relationship to others within their selected organisations' structures was markedly different depending on their PRMs. The graduates preferring an AR mode located in the non-statutory context perceived themselves as located fairly high within the hierarchy endowed with significant positional power. This finding aligns with commentators who identified that smaller, or 3rd sector, organisations are more responsive to innovation and change and more able to provide suitable conditions for entrepreneurship as they are less hierarchical and have less formalised boundaries and structures (Ascari et al, 1995; Gibb, 2000; Handy, 1993). The graduates preferring an AR mode experienced a less structuring environment and felt supported by senior colleagues to be intrapreneurial and empowered to challenge practice and bring new ideas to the table. Some described that they were regarded as experts, partly due to their 'lone therapist' status. In contrast, their CR counterparts perceived themselves as positioned very low within the organisation hierarchy or "food chain" (Eve) with little power, support or expectation for intrapreneurship. This finding is supported within the occupational therapy graduate 'transitioning into practice literature' and the wider 'professional power' discourse. Occupational therapy graduates find the transition into their early practice roles challenging (Rugg, 1999, 2003; Tryssenaar and Perkins, 2001; Leonard and Corr, 1998; Barnitt and Salmond, 2000) and there are differing degrees of power residing within professional groupings (Abbott, 1988; Abbott and Meerabeau, 1988; Freidson, 1994; Ham, 1981); new healthcare graduates find themselves positioned with little authority or power. It is less clear whether the graduates preferring an AR mode would have the same perspective and experience if they were located in the highly bureaucratised statutory context and vice versa for the graduates preferring a CR mode. However, evidence from the narratives of the graduates' perspectives of the opposing context leads me to suspect that it is more the PRM that is influencing their perspective of power position, rather than the context alone. Those preferring an AR mode perceived more organisation structural constraints in the statutory compared

with their non-statutory work context. The constraints related to a perceived lack of resources and the lack of opportunity to innovate or to do things differently due to the highly prescriptive nature of the therapeutic work involved. This highly prescriptive nature of therapeutic work, in the form of 'care-pathways' and 'protocol-based care', is structuring healthcare professionals' practice and reflects the erosion of professional autonomy through Government regulation and demands for uniformed service provision. There was no mention of any negative impact of others, where they saw themselves in relationship to others, their personal confidence, intrapreneurial capacity or power position as influencing factors. The perception of the non-statutory context by those preferring a CR mode was further revealing. In describing their perception of the opposing context, they included a lack of direction from others, too much autonomy and a need for high levels of personal and professional confidence to be intrapreneurial. These factors all reveal the importance of relationships with others for the graduates preferring a CR mode and a perceived lack of power in their position as a new graduate occupational therapist.

Margaret Archer's theories have been crucial in developing my understanding of why relationships could be more important and influential for different occupational therapy graduates depending on their PRMs. Archer emphasises the greater importance of other people for those preferring a CR mode of operating their internal conversation compared with those preferring alternative modes. She stresses the lack of trust in their own internal deliberations and the importance they place on communicating with others as part of the reflexive process. Her theory has shed light on why occupational therapy graduates who prefer an AR mode and are attracted to the non-statutory context might be less influenced by others. She asserts that ARs are able to make decisions independently with their own internal self-talk providing sufficient instrumental guidance. This illustrates why these graduates might be less inclined to select a work context where there will be a lot of pressure to fit in and replicate current therapy provision and more likely to choose a work context that supports their need for autonomy and provides opportunities for intrapreneurship. However, it could be desirable to support the graduates, whilst still in the education setting, to consider how they could positively impact their less

preferred work context. They could choose this different work setting and disrupt the existing culture and bring about positive changes for the benefit of service users.

Structure and culture

The findings from the research have established that the occupational therapy graduates in the study were attracted to working in what they perceived as a healthcare practice environment that met their personal and professional needs. I have also illustrated that the graduates' PRMs are strongly linked to the type of healthcare environment they select and they have very different expectations and experiences when they begin their early career posts.

In this section, I focus more closely on what our occupational therapy graduates are encountering in real world practice with regards to the structural features and cultural aspects of their respective healthcare organisations. I discuss how critical realist philosophy has been a useful explanatory tool for gaining a richer understanding of how our graduate 'agents' are interacting with the 'real' structures they encounter and how different theorists have approached the structure / agency issue, in this regard. I move on to explain more deeply how the structural and cultural features and aspects that were evident in the graduates' narratives, and described extensively within the literature, could either be facilitators or constrainers for their intrapreneurial ambitions.

Explanatory philosophy and theory

Critical realist philosophy and the work of critical realist theorists has been invaluable for generating a deeper understanding of how the occupational therapy graduate 'agents' in the study have been interacting with the structural and cultural features of their respective practice contexts. Although the theoretical ideas underpinning the study have been discussed at length in earlier chapters, I believe it pertinent to explain more clearly how elements of critical realist philosophy and theory have

facilitated the process of analysing the data and exploring what might be going on at a deeper, micro-level of interaction. According to critical realist philosophy, structure and agency are ontologically separate strata of reality with their own distinct properties and powers (Archer, 2003; Bhaskar, 1975). Within my study, the occupational therapy graduates are encountering 'real' social-structural and cultural mechanisms with their own emergent powers that are generating or shaping actual events. The results of these events are located at the 'observable, empirical level', as described by Bhaskar (1975), and these are the behaviours and activities I observed through the study narratives and from anecdotal evidence. Viewing through a critical realist lens, I can identify 'real' mechanisms that could be operating, which have contributed to 'actual' observable events: in particular, the events of graduates not engaging in significant intrapreneurial activity in the statutory healthcare context. The real mechanisms at play could be: the team belief that innovation is not a responsibility for new graduates and managers requiring graduates to pass their ideas onto others. Viewing the narratives through a critical realist lens has provided me with a framework that assists me in understanding and explaining the unseen causes of what can be seen within the graduates' narratives.

Drawing specifically on Archer's work has provided the opportunity to analyse and discuss the structural features of the contrasting healthcare contexts separately to the intrapreneurial activities of the occupational therapy graduate 'agents'. Critical realist philosophy contends that structures have their own emergent properties and that they are distinct from agential powers as they operate in different time-frames. A further critical realist assertion is that structures are already in existence and they pre-date the action of the agent (Bhaskar, 1975). In particular, Archer proposes that, because they are already in existence and are ontologically independent, they have equal status and can be analysed separately. This explanation has been decidedly helpful in supporting me in examining the structural features and mechanisms separately from the occupational therapy graduate activities. Additionally, it has facilitated me in fruitfully comparing the two different healthcare contexts to reveal any differences in the type and quantity of structural mechanisms that could be influencing the graduates' intrapreneurial activities. I found Giddens' theory of

structuration to be less helpful for my particular study. I agree with Archer that his assertion that structure only exists internally in agents as memory elements and externally as the result of social activity is an unbalanced explanation. Archer described this view as upward conflation as it gives too much weight to the agents who are described as having the lone ability to reproduce and transform society. Examining more closely the structural and cultural features of each healthcare context separately from the activities of the occupational therapy graduates has been highly valuable.

The structural and cultural features and emergent powers of the contrasting healthcare contexts might well be facilitating or constraining the occupational therapy graduates' intrapreneurship. Realist social theorists recognise that these structural and cultural emergent properties arise from people and have causal efficacy (Bhaskar, 1989); they are considered socially constructed but have real emergent power. They have also identified that there are constraints and enablements, which derive from the emergent properties of the social strata that condition agents and can either facilitate or impede personal projects: in this case, the occupational therapy graduates' intrapreneurial aspirations. Archer (2003) describes the activation of causal powers of constraints or enablements as entirely dependent on the use of personal emergent properties to formulate agential projects. Unlike other realist social theorists, Archer has not predominantly focused on how the 'real' structural and cultural properties have impacted on social agents. She has developed understanding in this area and argues that there must be mediating 'real' mechanisms at play that influence how agents use their personal powers to take action in different situations. As discussed earlier, this relatively new explanation of the internal conversation as a constituent of human reflexivity and as the mediating mechanism was really helpful for me. It supported me in discovering how our graduates were able or not to make changes in their respective practice contexts. However, for this section, I have chosen to focus the discussion on my analysis of the emerging structural and cultural features in the contrasting healthcare contexts separately from the possible action or re-action of the occupational therapy graduate agents. I was interested to see what differences there were in the contexts

and how their distinct emergent properties might be either constrictive or facilitatory in nature.

Critical realist philosophy and theory has proven to be especially helpful for explaining more deeply what may have been occurring at the micro-level of interaction influencing new occupational therapy graduates' intrapreneurship. Using a critical realist lens has assisted me in identifying some 'real' underlying mechanisms that might be at play, creating the observable behaviours and activities I encountered. The graduate occupational therapy narratives revealed that they could be encountering these 'real' structural mechanisms with their own emergent powers that are impacting upon or 'shaping' their intrapreneurial behaviours and activities. Critical realist theorists describe these mechanisms as structural and cultural constraints and enablements. It has been productive to closely inspect these structures with their emergent powers in each of the contexts and I reveal the sharp contrasts unearthed in the following sub-section.

Structural and cultural constraints and enablements

The constraints and enablements described by critical realist theorists are the potential causal powers of structural and cultural emergent properties (Archer, 2003). As introduced in earlier chapters, there is a substantial body of sociological scholarly work regarding the concepts of organisation structure and culture and particularly around the colossal, bureaucratic statutory UK health services. The organisation structure refers to how activities, co-ordination and supervision are arranged for meeting the organisations' aims (Pugh and Pugh, 1971) and includes professional organisation, work allocation, reporting lines, policies, job descriptions etc. The culture is part of structure and relates to the elements of beliefs, values, behavioural norms and routines that are shared between people within an organisation (Parmelli et al, 2011). In this sub-section, I examine separately the structural and cultural features that were evident within the contrasting healthcare contexts and discuss how their differing features may have been constraining or

enabling forces that impinged on the graduates' intrapreneurship. Whilst discussing the value of such scrutiny, I also acknowledge the complexities ingrained in the separate analysis of any structural emergent properties in isolation from agential actions of the occupational therapy graduates.

The study revealed substantially different organisation structural characteristics within the contrasting healthcare contexts. Within the statutory context, it transpired that there was a greater abundance of structural features appearing to cause difficulties or 'constraints' for the fledgling graduates' intrapreneurship compared with the non-statutory context. I noted a highly complex organisation punctuated with a multi-layered, hierarchical structure with long chains of command and a narrow span of control for individuals. At a more local team level, the narratives revealed highly structured and prescriptive care pathways for therapy that offered little room for professional creativity and artistry and a lack of access to relevant resources and other sources of support. When they did make attempts to be intrapreneurial, high levels of justification and evidence were required to gain support. This caused little surprise as many organisation and social theorists have long recognised these structural characteristics of the UK statutory healthcare context (Phillips and Garman, 2006; Janssen and Moors, 2013). It is also important to note the sprinkling of enabling features reported by some graduates within that context: the organisation level policies stating the responsibility of staff to be innovative and creative and the detailing of this requirement, including allocated time, within the job description. However, these 'enablements' were rendered powerless by the strong cultural constraints exposed and are discussed later in this section.

In stark contrast, the non-statutory context revealed far fewer structural constraining features and many more 'enablements' for intrapreneurship. There were smaller, less complex, flatter organisation structures with shorter chains of command and wider spans of control; smaller organisations are considered much more reflexive and provide better conditions for entrepreneurial behaviour (Gibb, 2000). Also, there appeared fewer formal structures to contend with such as policies and protocol

around access to resources and support for intrapreneurship. There were some constraints identified by the non-statutory graduates: lower pay, a lack of clinical supervision, limited access to professional support and high job role demands. However, these were not assessed as impinging too strongly at present on their intrapreneurship. There were significantly more constraining structural features with power to impinge on the occupational therapy graduates' intrapreneurship observed within the statutory healthcare context yet stronger enabling features revealed within the non-statutory context.

The occupational therapy graduates experienced different cultural features in the form of norms of behaviour and beliefs depending on their healthcare work context and these constrained or enabled their aspirations for intrapreneurship to varying extents. Within the statutory context, I uncovered a more constraining culture for intrapreneurship, which contrasted sharply with their non-statutory peers who were experiencing a far stronger enabling culture. The extensive literature related to the cultural problems of the UK statutory healthcare context mirrors these findings: a culture of fear, poor quality and uncompassionate care and resistance to change has dominated and been left to flourish (Berwick, 2013; Case, 2013; Francis, 2013; Keogh, 2013). The statutory graduates experienced low expectations for intrapreneurship from senior colleagues and were often asked to pass their ideas on to more senior staff that were endowed with 'innovation', 'service improvement' or 'transformation' as part of their role. When some graduates did attempt to challenge or change things, they were met with disempowered and poorly motivated teams, suppressing any signs of their intrapreneurial life. In distinct contrast, the non-statutory graduates experienced a notably more supportive culture with encouragement from senior colleagues to bring in new ideas and try things out. This also reflects the literature, which suggests that smaller and medium sized organisations, in this case, either private, charitable or 3rd sector organisations, are more capable of fostering an entrepreneurial approach compared with larger ones, which are considered more structured and less reflexive (Gibb, 2000; Handy, 1984; 1993). Some of the non-statutory located graduates also believed they were trusted and respected as experts and felt empowered with a strong intrapreneurial voice.

The only described constraint was the frustration at the lack of understanding, recognition and adoption of their creative ideas. Strong cultural constraints revealed within the narratives of the statutory located graduates mirrors closely the weighty discourse found in the literature.

The structural and cultural impingements upon the study occupational therapy graduates' intrapreneurial aspirations within these sharply contrasting healthcare contexts, paints a highly complex picture. It is clear that structure and culture do not always harmonise and structural and agential 'doings' can be analysed separately, however, to gain a fuller picture, the interaction between them should also be scrutinised. I found that some of the structural features appearing within the organisation level statutory context were in place as facilitatory mechanisms to support the intrapreneurship of staff. However, as noted earlier, the ingrained negative and paralysed culture revealed within the narratives has rendered the senior management desires and the organisation policies impotent, creating the 'morphostatic culture' described fittingly by Case (2013). Furthermore, there was limited support in the non-statutory context for the on-going professional development of new graduates. They reported lower pay, a lack of clinical supervision, limited access to professional support and high job role demands. There were hints within the narratives that in the longer term this could negatively impact their motivation to remain in the context and continue to be inspired for intrapreneurship. These unveiled complexities have led me to conclude that examining the structural components separately to the agential actions has not considered any interplay between the two entities. It is unclear whether the structural and cultural constraints and enablements experienced in either context would be perceived and responded to differently by occupational therapy graduates preferring other reflexive modes. Although both the organisation and the graduate agents' structural emergent powers can be examined independently, this does not create a complete picture; the actions of both are inextricably entwined and interdependent. A more fruitful explanation could be achieved if they are examined separately followed by a probing of the potential interactions.

Archer (2003) recognises the fallibility of humans as agents who might not be aware of the social factors impinging on them. She asserts that humans can anticipate reflexively what constraints and enablements might bump into their projects and decide not to try; as fallible humans they might be wrong in their forecasts. The occupational therapy graduates preferring a CR mode located in the statutory context might be anticipating the barriers they are facing and, even though they are keen to be intrapreneurial, they decide not to try. They may well be wrongly assessing the power of the emergent constraints. I suggest that we could raise awareness and develop their confidence to sample the opposing context and find alternative ways to meet their concerns. There are clearly more organisation structural and cultural constraining features present within the statutory healthcare context and stronger enabling features within the non-statutory context, which is supported by current thinking and literature. Whilst it has been useful to examine these features in isolation, a much fuller and inclusive picture could be revealed if they were analysed alongside the agential activities. I do recognise there is some limited research in existence, looking at this particular issue. Notably, I found recent proponents of Archer's work for explaining the interrelationship between the opportunity and the entrepreneur (Mole and Mole, 2010; Mutch, 2007) with Mole and Mole (2010) espousing their view that entrepreneurship is actually the study of this micro-level nexus. These analytical complexities are key to why I have found critical realist theories, and especially Archer's approaches and ideas, helpful for supporting my analysis and shedding light on the more micro-level of structure / agency interactions embedded within the graduate narratives. I do, however, acknowledge that the study is limited by its small sample size and the non-statutory organisations may not be representative in size and complexity of the wider context.

The costs and downsides of intrapreneurship

At an early stage of exploration into the healthcare entrepreneurship and intrapreneurship literature landscape, I identified an extensive gap concerning any downsides or costs involved. In recognition of this omission, I endeavoured to

incorporate this little explored topic into my inquiry. The findings revealed that the study occupational therapy graduates considered many actual and potential costs for their intrapreneurship with some expressing that knowledge of these costs were impairing their actions. I acknowledge that many of the costs and downsides revealed in the graduates' narratives were both experienced and imagined for themselves and others. Therefore, these costs and downsides cannot be assumed as representing the experiences of the general occupational therapy graduate or wider healthcare professional population. Nevertheless, these are important factors that were significantly impacting on the occupational therapy graduates' intrapreneurial activity within this study and could suggest what may be occurring more widely. In this section, I discuss the various ways that occupational therapy graduates are experiencing the costs and downsides of intrapreneurship with particular reference to the impact of Archer's theory concerning how they may be prioritising their concerns. I move on to discuss how the graduates weigh up the costs and risks involved and how profitable Archer's theory has been for understanding why the costs are evaluated differently depending on their PRMs.

The occupational therapy graduates experienced the costs of intrapreneurship with a few similarities but predominantly with marked differences. Both groups of graduates described the pursuit of intrapreneurial activities as being both tiring and cognitively taxing. The graduates explained how this was, or could, take a toll on their energy levels and their work / life balance. When examining the narrative data more closely, those preferring an AR mode described costs and downsides that were personal and, in contrast, those preferring a CR mode described costs related to the risks for their relationships. The AR graduates explained that potential risks of intrapreneurship could be severe and that their job could be at risk if things went awry. This view of the personal side of any costs contrasted starkly with the CR graduates who were far more concerned with the potential loss of relationship if they pushed their ideas forward or challenged practice. They mentioned the risk of being personally rejected and isolated by others and that they might be taken advantage of if they exhibited enthusiasm to bring in new ideas and make extra effort. Although the 'costs of entrepreneurship' literature did not specifically relate

to the healthcare context, there were findings that did link to the wider psychology-focused 'entrepreneurship' literature concerning the 'dark side' of the entrepreneurial personality: the detrimental effect on other people within the organisation (Haynes et al, 2015), the difficulty for managers and peers to deal with them (Kets de Vries, 1985) and the entrepreneur potentially paying a heavy price with significant personal or health issues like loneliness and people problems (Boyd and Gumpert, 1983). The graduates preferring a CR mode recognised the potential negative perception of others, which could lead to their isolation or 'loneliness'. These psychological-oriented assertions fail to explain why different entrepreneurs might be weighing up the costs differently before embarking upon activities. However, these findings do sit agreeably with Archer's explanations of how people prioritise and subordinate their concerns depending on their preferred mode of operating their internal deliberations. It is unmistakable that those in the study who prefer an AR mode are not considering impacts or costs for their relationships with others but on their own personal risks. Furthermore, because they prioritise work above relationships, they are willing to take the risks where they hold that the benefits outweigh any costs. In contrast, those preferring a CR mode view these costs, against the backdrop of their prioritised concerns, as too weighty to ignore and, thus, often take an avoiding stance towards intrapreneurship.

Weighing up the potential future costs of intrapreneurship in advance may adversely impact the occupational therapy graduates' stance towards intrapreneurial action. This was pertinent for the graduates preferring a CR mode as they were clear that the costs outweighed any benefits when considering their intrapreneurial opportunities at work. I have already established, by viewing this stance through Archer's PRM lens, that these occupational therapy graduates have ultimate concerns that focus on the importance of relationships with others and which are prioritised over subordinate concerns. When they reflexively deliberate over their intrapreneurial activities, such as challenging practice or contemplating suggesting alternative approaches, they will be weighing up a wide range of likely risks. If their deliberations conclude that an action may result in rejection or isolation, as featured in their narratives, this could result in them taking a stance of avoidance towards the

opportunity. For the graduates preferring an AR mode, the risks are present but, as these are weighed up internally alongside their prioritised concerns, they do not appear to adversely impact their intrapreneurial actions. The risks are not sufficiently prioritised above their desire to be intrapreneurial and effective at work. There was some discussion in the literature regarding the entrepreneur's perception of risk, with Busenitz (1999) arguing they might actually perceive less risk in a given situation where they are required to make a decision. However, this research was not wholly aligned with my study as it examined the concept of the entrepreneur setting up a new business rather than being intrapreneurial within an organisation. Whilst this does offer some explanation about *who* entrepreneurs are and *how* they might perceive the impact of risk, it does not offer any insights, as Archer achieves, about *why* they might be doing this and *why* non-entrepreneurs or others might be weighing up risks differently.

Challenging occupational therapy graduates' assessment of risk and / or costs associated with their intrapreneurship could generate a more positive stance towards taking action. A central aim of the occupational therapy education curricula is to prepare graduates who can enter the healthcare work place as confident intrapreneurs with the overarching intention of providing excellent, effective and compassionate care for those requiring professional intervention. If some of our graduates are exiting university without the necessary confidence and capacity for intrapreneurship and are entering structurally unsupportive healthcare work environments, it is unlikely that they will ever feel sufficiently-equipped to rise to this challenge. I strongly assert that it is within the pre-graduation HE sector where the strongest impact could be made. Graduates could be better-equipped through enhanced risk evaluation skills to more effectively assess any intrapreneurship risks and costs. This study, underpinned by relevant theory, has shed light on the differences that graduates displayed in their deliberations concerning any costs and downsides involved in intrapreneurship. If students were better informed about their PRM and the potential pitfalls in making assumptions and miscalculations about risks, then they may be better prepared for intrapreneurship in real world practice

and, hence, transform rather than reproduce some of the paralysing cultures that exist.

Discussion summary

This study has generated exciting new insights into why our fledgling occupational therapy graduates are selecting contrasting healthcare work contexts and why they have different perceptions and experiences of intrapreneurship within their early career posts. The findings revealed the great utility gained from applying the critical realist, Margaret Archer, and her theory concerning the internal conversations that people have, their PRMs and the influence this has on the way that they make their way in the world. Her theory supported me in uncovering the possible reasons why fledgling occupational therapy graduates were selecting contrasting healthcare work contexts, perceiving and experiencing the opportunities for intrapreneurship differently and placing varying importance on the value of relationships within their personal and professional lives. The findings also revealed how the differing structural and cultural features were constraining or facilitating occupational therapy graduates' intrapreneurship and exposed the disparate perceptions and experiences of the costs and downsides involved. Furthermore, it was very noticeable that the occupational therapy graduates' experiences were profoundly structured by Government regulation and societal demands translated into healthcare policies that have gradually eroded professional practice autonomy.

Considering Archer's theories has indicated what may be underlying the motivations behind the occupational therapy graduates' work location choices, confidence for decision-making, perceptions, experiences and prioritisation of intrapreneurship and any barriers involved. Those in the non-statutory context, who preferred an AR mode, were attracted to their context by what they perceived as opportunities for intrapreneurship and to have autonomy in decision-making with higher levels of challenge. They highly prioritised their intrapreneurship, particularly the impact they desired to generate in their new post, and they perceived large-scale and abundant

opportunities within their chosen work context. They were confident in their decision-making, demonstrated a greater sense of self-reliance in the way that they deliberated internally over intrapreneurial scenarios and options and viewed any barriers to their intrapreneurship as entities to climb or traverse. Those in the statutory context, who preferred a CR mode, were more attracted by job security, a supportive learning environment and being close to their home setting. They perceived fewer, smaller-scale opportunities and experienced very low expectations for their intrapreneurial activity: their priorities were focused on becoming part of, and learning from, an experienced team. Although both groups included a variety of resource pressures such as restricted time, lack of funding and poor staffing levels as barriers to intrapreneurship, the statutory-based graduates described substantially more barriers including a lack of support from peers and senior colleagues. Many viewed these barriers as insurmountable obstacles.

Whilst examining what is involved in the graduates' decision-making deliberations through a psychological, behavioural and cognitive lens was somewhat helpful, viewing these findings through Archer's PRM lens added greater illumination. Archer's ideas regarding reflexive mode preferences have been highly valuable for shedding light on the possible mechanisms at play within reflexivity for decision-making for our occupational therapy graduates i.e. when they are deliberating over where to work, potential intrapreneurial action and how to tackle any barriers involved. Those preferring a CR mode are described by Archer as less trusting of their internal deliberations and decision-making capacities and tend to prioritise family, home and relationships over work. Archer asserts that those preferring a CR mode will experience more difficulty when encountering such barriers. She proposes that they are more content in their established practices and may avoid butting up against barriers, if possible. Archer describes those preferring an AR mode as considerably more autonomous and confident in their decision-making and inclined to prioritise work and achievement over relationships. They enjoy higher levels of agency and are better geared for scaling barriers as they relish the challenge and are less influenced by negative forces around them. Understanding how an occupational therapy graduate's 'self-talk' might be giving them instrumental guidance for

effective decision-making for work choices, intrapreneurial action or for tackling any barriers to intrapreneurship, has been extraordinarily valuable.

It was noteworthy to discover that the value placed on relationships was viewed differently dependent upon the occupational therapy graduates' work location and allocated PRMs. Those located in the statutory context preferring a CR mode, placed a high value on others' opinions of them, prioritised personal relationships above work opportunities and people featured strongly as structural barriers blocking their intrapreneurship. For those located in the non-statutory context preferring an AR mode, less importance was placed on relationships and others' views particularly when making work selection decisions, evaluating decision-making for intrapreneurial activity and when negotiating any associated barriers. Those preferring a CR mode were heavily influenced by the location of the work context and considered it vital for their work to be close to their home environment with friends and family for support. They were less confident in their professional knowledge and skills and believed that joining a team would provide enhanced learning opportunities. When making decisions, they were more influenced by their relationships, spending considerably longer communicating with others, garnering their views and incorporating these into the process. They were more sensitive to others' negativity and perceived the risk to their relationships more acutely as barriers to their intrapreneurship. They perceived themselves as positioned very low within the organisation hierarchy with little power, support or expectation for intrapreneurship. They viewed the non-statutory context negatively describing a lack of direction from others, too much autonomy and a need for elevated levels of personal and professional confidence to be intrapreneurial. Those preferring an AR mode valued their friends and family but prioritised the opportunities for their career development and intrapreneurship rather than being close to home for convenience and support. They scouted for opportunities where they could practice autonomously and were not restricted by existing team culture and practices. They appeared better-equipped for intrapreneurship, relying heavily on their own internal deliberations for decision-making. They viewed themselves as located fairly high within the organisation hierarchy endowed with significant positional power. In this

lofty position, they experienced encouragement to be intrapreneurial by senior colleagues and empowered to challenge practice and bring new ideas to the table. Those preferring a CR mode highly valued relationships, were less autonomous and more reliant on others compared with their AR counterparts.

The findings pertaining to the differing importance occupational therapy graduates placed on relationships are elucidated more comprehensively when viewed through Archer's PRM lens. Archer explains that those preferring a CR mode tend not to stray too far from their natal context, are able to dovetail their concerns and are less trusting of their internal deliberations than people preferring other reflexive modes. Archer further explains that those preferring an AR mode are also able to dovetail their concerns, however, they are not closely attached to their natal context and they make decisions independently with their own internal self-talk providing sufficient instrumental guidance. Viewing these findings through Archer's lens has shed light on why those graduates preferring an AR mode might be less inclined to select a work context where there would be a lot of pressure to fit in, replicate current therapy provision but more disposed to choose one that affords intrapreneurship opportunities and supports their desire for autonomy. This developed understanding is highly useful for HE based healthcare educators, occupational therapy leaders and experienced practitioners.

Examining more closely the structural and cultural features of each healthcare context separately from the activities of the occupational therapy graduates has proved to be immensely valuable. I was interested to see what differences there were in the contexts and how their distinct emergent properties might be either constrictive or facilitatory in nature. I discovered bounteous organisation structural and cultural constraining features in the statutory healthcare context and stronger enabling features in the non-statutory context, which is supported by current thinking and literature. Within the statutory context, the structural and cultural features that were choking any signs of intrapreneurial life included: excessive hierarchy, organisation complexity, narrow spans of control and disempowered, poorly motivated teams. Furthermore, the highly prescriptive nature of therapeutic

work, in the form of 'care-pathways' and 'protocol-based care', was structuring the occupational therapists' professional practice and reflected the erosion of professional autonomy through Government regulation and demands for uniformed service provision. Within the non-statutory context, there were less complex structural features alongside a more supportive culture with encouragement from senior colleagues to bring in new ideas and try things out. A handful of constraining features were noted but these were not impinging too strongly on the graduates' intrapreneurship. There was limited support in the non-statutory context for the new graduates' clinical supervision and on-going professional development. Whilst these were not adversely impacting the graduates currently, there were hints that, in the longer term, these could negatively impact their motivation to be intrapreneurial and even to remain working in the context.

The occupational therapy graduates perceived and experienced differences in the costs and downsides of intrapreneurship and they weighed them up differently depending on their PRM. The study graduates considered many actual and potential costs for their intrapreneurship with some reporting that knowledge of these costs were impairing their own intrapreneurial activity. Both groups of graduates described the pursuit of intrapreneurial activities as being both tiring and cognitively taxing, which could impact their well-being and work / life balance. Those in the study who preferred a CR mode related many of the costs to the possible adverse impact on their personal and professional relationships. Conversely, those who preferred an AR mode were not considering impacts or costs on their relationships but on their own personal risks. The assessed personal risks were not sufficiently prioritised above the desire to be intrapreneurial and effective at work. These findings work seamlessly with Archer's explanations of how people prioritise and subordinate their concerns depending on their preferred mode of operating their internal deliberations. Archer asserts that those preferring an AR mode prioritise work above relationships. This elucidates why those in the non-statutory context were willing to accept the risks of experiencing the costs as they believed the benefits outweighed them. In contrast, those preferring a CR mode viewed these

costs to their prioritised concerns as too weighty to ignore and took an avoiding stance towards intrapreneurship.

The final chapter draws pertinent conclusions from the analysis and discussion of the findings from my study. I highlight, what I consider to be the primary and secondary findings and explain their contribution to new knowledge and understanding within the field of 'occupational therapy graduate intrapreneurship' as they launch into their early career posts in various professional contexts. I also indicate the implications for practice and provide recommendations for occupational therapy HE, occupational therapy professional practice leaders and practitioners and the imperative for further research in the field.

Chapter 7 - Conclusion

Within this concluding chapter, I convey how my research findings answer the questions posed and how they meet the overarching aims that I initially set out with. The key findings are presented with an explanation of how the study contributes to the knowledge and understanding within the sparsely explored field of occupational therapy graduate intrapreneurship. I then consider the implications of the findings for HE based occupational therapy educators, policy makers, professional practice leaders and occupational therapy graduates launching into their early career practice roles. The chapter closes with the limitations of the study and the opportunities for further research to expand understanding in this important area and then highlights my own experiential learning derived from the research process.

My research journey was launched and shaped by specific aims. I set out to explore and better understand our occupational therapy graduates' perceptions and experiences of intrapreneurship within the framework of Archer's concepts concerning their internal conversations and their preferred reflexive modes. Although I had some inclinations about what could be occurring, the study was exploratory and I was motivated to see what would emerge from my research that examined what might be happening at a more micro-level of structure / agency interaction, supported by Archer's ideas. I was anticipating examining more deeply our graduates' experiences rather than simply describing the phenomenon that I could observe. I wanted to answer questions about *why* some occupational therapy graduates might have different perceptions about what intrapreneurship could be, choose different contexts to work in and have different experiences of intrapreneurship in their contrasting healthcare work contexts. My overarching aim was to inform the practice context and the development of a relevant curriculum geared to prepare our occupational therapy graduates advantageously for practice and ultimately to contribute to improved outcomes for healthcare service users.

The wider perspectives that were relevant to the study were outlined in the literature review where I examined the research landscape and knowledge territories associated with my area of focus. The literature specifically pertinent to 'occupational therapy graduate intrapreneurship' was particularly sparse so I widened my search into the broader landscape to provide a contextual backdrop to the study. The search parameters included healthcare entrepreneurship, entrepreneurship and Margret Archer's theories, professional identity, reflexivity, power and culture in healthcare, the imperative for the occupational therapy profession and the political and economic drivers. The theoretical framework chapter explained and justified why I approached the study from a critical realist position and utilised Margaret Archer's concepts of the internal conversation and preferred reflexive modes to underpin the study methods and the interpretation of the findings. In the methodology and methods chapter, I explain how I used various qualitative data collection tools that worked coherently with critical realism's ontological realism and epistemological constructivism. The subsequent thematic analysis revealed the key emerging themes: the usefulness of Archer's concept of the internal conversation, work context choice and intrapreneurship, the value of relationships, structural and cultural constraints and enablements and the costs and downsides of intrapreneurship.

Contribution to knowledge and understanding in the field

This study has generated new insights into why fledgling occupational therapy graduates are selecting different healthcare work contexts and their differing perceptions and experiences of intrapreneurship within their early career roles. The principal learning and contribution to knowledge has emerged from the appropriation of the critical realist, Margaret Archer, and her theory of morphogenesis and her concepts of the internal conversation and preferred reflexive modes and the influence these have on the way new occupational therapy graduates make their way in the professional occupational therapy world. Archer's theories identify agential reflexivity as the mediating factor between structure and agency

and she describes this reflexivity as the internal conversations that people have. She argues that the internal conversations have real emergent power, take different forms and lead to different modes of reflexivity. She describes these modes as communicative reflexive, autonomous reflexive, meta-reflexive and fractured reflexive. The communicative reflexives demonstrate contextual continuity, are able to dovetail their concerns, check out their ideas externally and prioritise relationships above work. The autonomous reflexives are also able to dovetail their concerns. They tend to have eventful lives, are able to think independently and prioritise work above relationships. Meta-reflexives add an additional loop into their reflexivity: they critique their own thoughts. They rarely dovetail their concerns, are not rooted to a particular context and are often both upwardly and downwardly socially mobile. The fractured reflexives are impeded in their reflexivity: they are unable to exert personal powers to inform their projects and their self-talk gives the little or no instrumental guidance. Archer's ideas have been helpful in supporting my analysis and understanding of the complex interrelationship between the occupational therapy graduates' intrapreneurship and the intrapreneurial opportunities they encounter. The findings also support what is already known in the literature concerning the structuring impact of state-level policies upon the autonomy of the occupational therapy profession in the predominantly statutory-based healthcare services. Further new insights emerged concerning the different value that the new occupational therapy graduates placed on their personal and professional relationships and how they perceived and experienced any risks or costs of intrapreneurship.

Utilising Archer's theory concerning the graduates' preferred reflexive modes of operating their internal conversations revealed that all of the occupational therapy graduates located in the statutory healthcare context preferred a communicative reflexive mode and all those located in the non-statutory context preferred an autonomous reflexive mode. Further analysis of the graduates' narratives, in light of Archer's explanations, provided greater illumination of the possible reasons for these, often, stark differences. The study findings revealed that those occupational therapy graduates who had preferred a communicative reflexive mode were attracted to a work setting where they could remain close to their natal context and

where they perceived improved career prospects and mentoring support from seasoned practitioners. Personal and professional relationships were highly valued by the occupational therapy graduates and they prioritised these over any desire they possessed to be intrapreneurial. For those who preferred an autonomous reflexive mode, they were attracted to a work setting perceived as providing greater opportunities for their intrapreneurship, even if this meant moving further away from friends and family and joining an organisation where they were the lone occupational therapy practitioner. For these occupational therapy graduates, personal and professional relationship concerns were subordinated to opportunities for greater levels of agency.

As the study progressed, I became acutely aware of the significant macro, meso and micro-level structuring of the occupational therapy graduates' activities in their early career lives.

At the macro-level, the structuring stemmed from Government policy and direction that originated from societal and political pressures. These pressures culminated in increased state regulation of the healthcare professions, which has gradually eroded professional autonomy, and national level policy demanding high quality, innovative and protocol-based care for service users. Furthermore, HE policy governing occupational therapy professional education has created pressure for HE institutions to develop curricula that equips graduates to launch into their early posts ready to lead and innovate.

I noticed at the meso-level, that the structuring derived from the structures and cultures of the healthcare organisations. Much of this organisation level structuring was rooted from the macro-level Government direction translated into organisational policy, systems and processes. Noticeably, the magnitude of the structuring differed greatly between the contrasting healthcare contexts under scrutiny. In the statutory context, the structures and systems were highly complex with professions grouped into silos where opportunities for networking and cross-fertilisation were severely restricted. No doubt, this contributed to the paralysing culture described and discussed extensively in the literature and was also eminently

evident in the occupational therapy graduates' narratives. The non-statutory organisations appeared far less structuring as they were smaller, flatter, less complex and not as bureaucratic yet possessed a favourable culture that encouraged intrapreneurship. However, it is important to note that the occupational therapy professionals within both contexts remain structured through statutory regulation and professional body guidance, which limits, to some extent, their individual freedoms in the scope of their practice. Both healthcare contexts were demanding intrapreneurship but the statutory context provided little organisation support and was clearly more structuring for the intrapreneurship of the fledgling occupational therapy graduates at this meso-level.

At the micro-level, the structuring originated from the one-to-one interactions between the occupational therapy graduates and their HE educators, professional practice managers, work peers and personal friends and family. Within the professional setting, the structuring related to pressures exerted by those in immediate authority. This applied both during their education and in their new work setting, reinforcing organisation policy and professional values that fledgling graduates must adhere to. Close work peers reinforce organisation cultural norms and pressurise the graduates to fit in to 'how things are done around here'. Within their personal lives, significant family and friends' cultural norms and values also generate expectations concerning the new graduates' activities and behaviour. My study has revealed there are differences in the way that the newly graduated occupational therapists experienced these macro, meso and micro-level structures and how they transformed (morphogenesis) or reproduced (morphostasis) them, depending on their reflexive preferences.

The statutory healthcare context was perceived as profoundly structuring and choking for occupational therapy graduate agency by both groups of occupational therapy graduates. The non-statutory context was perceived and experienced as a less structuring environment where larger-scale opportunities for intrapreneurship existed. In the statutory context, there appeared a mismatch between what was demanded concerning intrapreneurship or 'entrepreneurial behaviour' at an

organisation level with what was experienced by the graduates at the practice level. Specifically, the occupational therapy graduates' job descriptions and organisation level policy identified their responsibility and role for innovation. However, there was little expectation from team level managers and many organisations had specific functions and roles for service improvement and transformation where individuals were required to pass on their ideas for change. Those graduates preferring an autonomous reflexive mode avoided these constraining environments as they saw limited opportunity for meeting their intrapreneurial concerns. Conversely, these environments were attractive to those preferring a communicative reflexive mode but their intrapreneurial aspirations were not sufficiently prioritised to push through structuring barriers to significantly transform practice. An outlying finding raised great cause for concern. One study graduate in the non-statutory context had been thwarted in their attempt to move to the statutory context through lack of statutory-based experience. This prejudicial policy and lack of foresight could indicate that the statutory context has been missing out on attracting intrapreneurial professionals who could be the crucial agents of change.

How the occupational therapy graduates perceived and tackled any structuring barriers they encountered to their intrapreneurial endeavours within their chosen context was also strongly influenced by their preferred reflexive modes. Those located in the non-statutory context were brimming with confidence in their decision-making capacities and perceived any barriers to their intrapreneurship as obstacles to surmount or traverse. The graduates located in the statutory context were less confident and trusting of their decision-making capacities for intrapreneurial action. Many were put off by the lack of motivation of others, the lack of organised support for intrapreneurship, including ineffective systems and processes and the prospect of being outcast if they challenged current practice. Overall, they were not as robustly equipped for accurately assessing the structural barriers they faced and any risks involved. Examining these findings through Archer's lens has provided great illumination. She asserts that humans can anticipate reflexively what constraints and enablements might bump into their projects and, as they are fallible, they might be wrong in their forecasts and decide not to move

forward. Considering Archer's assertion, those graduates preferring a communicative reflexive mode may be wrongly assessing the power of the structuring constraints or barriers and, although they do have embers of desire to be intrapreneurial, they often decide to walk away.

The costs and downsides of intrapreneurship is a relatively unexplored field of inquiry and for this reason became an important element of my study. The costs and downsides proffered were plentiful for the study occupational therapy graduates. Interestingly, how they saw and experienced these costs and downsides was markedly different when viewing the narratives through Archer's preferred reflexive mode lens. Both groups of occupational therapy graduates reported the personal costs of engaging in intrapreneurial activity as being cognitively taxing and tiring and impacting negatively on their well-being and work / life balance. Those in the non-statutory context preferring an autonomous reflexive mode described the costs that related to them personally when things go wrong. Those in the statutory context described the costs as related to the risks for their personal and professional relationships if they tried to challenge and change things. They also believed that their overall confidence and motivation levels would fall if they were not supported in their intrapreneurial pursuits. I propose that this different assessment of the costs of intrapreneurship is understood more clearly through Archer's lens. Her explanations of how people prioritise and subordinate their concerns depending on their preferred reflexive modes shed much light upon what was revealed in the narratives. Those preferring an autonomous reflexive mode were willing to take the risks and bear the costs of intrapreneurship as they believed the benefits outweighed them. Conversely, those preferring a communicative reflexive mode viewed these costs to their prioritised concerns as too weighty to ignore and often avoided the opportunities encountered.

The study revealed that the occupational therapy graduates preferred either a communicative reflexive or an autonomous reflexive mode of operating their internal conversation. Further revelations identified that these two groups perceived and experienced things differently and this impacted upon their early career choices

and actions. There was also strong evidence of the macro, meso and micro-level structuring of the recently graduated occupational therapist's intrapreneurship, however, this structuring was magnified in the meso-level statutory healthcare organisations compared with the non-statutory. Archer's ideas have helped me to pick apart and examine more closely what I observed in the occupational therapy graduates' narratives and to understand and explain why these differences may have occurred. If I had simply examined the graduates' actions and inquired into their reasoning for their early work choices and experiences of intrapreneurship without a theoretical framework, I would not have uncovered any possible underlying causes for my observations. This inquiry would not have enlightened what might happen for future occupational therapy graduates and, perhaps, the wider healthcare professional population. I would have been able to describe *what* was happening but not tendered any explanations about *why* or proffered suggestions about how employers and educators could introduce change to promote greater intrapreneurship.

Implications of the study findings

There are significant implications of this learning for occupational therapy HE educators, healthcare policy makers and occupational therapy leaders and practitioners. The implications are highlighted, along with proposed recommendations to support future occupational therapy graduates in their intrapreneurial endeavours. The proposals are suggestions for the development of the occupational therapy curriculum and the creation of a more supportive and conducive professional practice culture. They are designed to enhance occupational therapy graduate agency, minimise the structuring impact of the current UK healthcare context and, ultimately, to promote safer, innovative service user care. It is vital that all stakeholders take responsibility, disrupt current cultures and transform state funded healthcare to eliminate the appalling instances of care witnessed recently: ensuring there are no more reports of vulnerable patients drinking out of vases or laying in dirty bed sheets.

The HE occupational therapy curriculum should be developed to assist occupational therapy graduates to make informed assessments and choices through raised awareness and skill enhancement. My key proposal is that HE based educators should raise students' awareness regarding their internal conversations and preferred reflexive modes and the impact this may be having on their decision-making capacity and subsequent intrapreneurial endeavours. Understanding how the graduates' self-talk might be providing instrumental guidance for effective decision-making for work location choices, intrapreneurial action, tackling barriers and weighing up risks and costs to intrapreneurship would be highly valuable. Graduates should consider the benefits of alternative approaches to garnering relevant support and information. Those preferring a communicative reflexive mode might see the benefit of additional internal deliberations and checking out a range of supporting material. Having an alternative view may prompt them to rely less on feelings and enable them to experience a more objective and balanced approach. Those preferring an autonomous reflexive mode could widen their pre-decision deliberations to include others' views, thus, providing a more balanced perspective. Raising occupational therapy graduates' awareness of the impact of their own reflexive preferences and developing their decision-making skills would support them in making better decisions and, ultimately, in their intrapreneurial pursuits.

Occupational therapy HE educators could also support occupational therapy graduates to consider alternative work locations where they could still meet their prioritised concerns. They could raise the graduates' awareness regarding Archer's theory to spotlight their reflexive preferences and how this might influence their work location choices. This learning could occur during the final year modules associated with leadership and management and the development of entrepreneurial skills. To provide a balanced approach, other sociological theories concerning could also be introduced that would provide students with a greater understanding of structure / agency explanations concerning their decision making activities. Having a developed awareness could assist them to look more broadly at what factors they are taking into account and could facilitate a more balanced

weighing up of pros and cons. More specifically, this could assist those preferring a communicative reflexive mode by encouraging them to explore how they could acquire the relationship and mentor support from alternative sources if they were interested in sampling an alternative healthcare context without the fear of isolation. There are formal opportunities for gaining professional mentor support through occupational therapy professional networks including the specialist sections of the RCOT. Additionally, many occupational therapists are able to provide informal mentoring and students could be informed about how to access these support mechanisms when they graduate. Raising occupational therapy graduates' awareness of their preferred reflexive modes could support them in making more informed choices concerning their early career work location. This could disrupt the channelling of particular graduates into particular contexts and support the statutory healthcare service in attracting occupational therapy graduates who prioritise intrapreneurship and are better equipped for transforming rather than replicating current practice.

Raising awareness of the impact of the occupational therapy graduates' preferred reflexive modes could also positively support them when they encounter structuring barriers to their intrapreneurship. Understanding that their reflexive preferences could be impacting their weighing up of the size and power of a barrier would be of substantial benefit. The occupational therapy HE curriculum should be developed to provide graduates with enhanced personal tools and practical skills to bolster their confidence when approaching a barrier. For illustration, the graduates could be skilled up to consider different approaches to planning and selling the benefits of an intrapreneurial idea to key stakeholders and could be supported to hone their presentation skills. They could be encouraged to take time to assess barriers they face with the opportunity to practice their skills in a supportive learning environment before they graduate. The graduate's enhance skills could support practice colleagues and managers for weighing up an intrapreneurial idea before dismissing it out of hand. The more intrapreneurial success the occupational therapy graduate achieves, the greater the chance of future attempts. Raising awareness of their preferred reflexive modes and enhancing their practical skills could enhance

occupational therapy graduates' success when attempting to scale any structuring barriers encountered.

It is vital that all stakeholders recognise that there are risks and costs involved in intrapreneurship. Occupational therapy HE educators should raise occupational therapy graduates' awareness of these risks and costs and not 'gloss over' them to provide them with a balanced picture of the reality of practice life. If they were better informed about their preferred reflexive mode and the potential pitfalls in making assumptions and miscalculations about risks and costs, then they would be undeterred when things go wrong and better prepared for intrapreneurship in the real world. The graduates should be enlightened about the longer-term impact of having a negative stance towards intrapreneurship on them personally and on future healthcare service provision. This learning could take place within the final year modules associated with leadership and management and entrepreneurship. They could be encouraged, through group discussion, to consider the wide range of risks and costs to themselves and their service users of being intrapreneurial graduates as opposed to taking a more negative stance. Equipping occupational therapy graduates to more accurately evaluate the costs and risks involved will support them in making more informed choices concerning their intrapreneurial opportunities and prepare them for transforming practice.

There are substantial learning opportunities arising from this study that could inform healthcare practice leaders to reduce the impact of structuring barriers for the creation of more conducive and supportive environments for occupational therapy graduate intrapreneurship and the transformation of services.

At the organisation level, effective systems and processes and cultural change programmes could be designed to create a more receptive environment for occupational therapy graduates' intrapreneurship and those of the wider practice teams. It is vital that a supportive culture is fostered where healthcare practitioners, including recently graduated occupational therapists, are encouraged to raise awareness of poor practice, bring new ideas and innovations to the table and are

supported to implement these without fear of opposition or failure. The significance of the graduate's job description could be emphasised through the organisation's appraisal process. There were examples where the job description included specific responsibilities for innovation and service improvement. These responsibilities could be more detailed and require an objective to be included in each staff member's annual appraisal. The trend for creating organisation level functions and specific roles for service improvement and transformation should be reassessed. The study evidenced that these policies had a structuring effect and removed responsibility for intrapreneurship away from practitioners and teams. Consideration should be given to align these policies and ensure that their purposes are integrated and enacted throughout the entire system. Furthermore, statutory context leaders should be acting to attract those healthcare workers who could be agents of change rather than blocking their recruitment due to a lack of state experience. This is especially pertinent as those preferring an autonomous reflexive mode could bring intrapreneurial capabilities that could disrupt and shift the prevailing culture. Failure to reassess and adapt current policy, systems and processes could perpetuate the reproduction of the stagnating environment that exists in the UK statutory health service today.

At the team and service level, practice leaders should create their own team environment that is more supportive for intrapreneurial activities, both within the non-statutory and the larger, more bureaucratic, statutory contexts. Practice leaders should challenge negative cultures in the immediate therapy team that could kill off signs of intrapreneurial life before germination can take place. They could provide the right support and quality mentorship, tailored to the occupational therapy graduates' individual needs and designed for empowerment and development of their reflexivity. This enhanced support could be provided through the clinical supervision system that is already in existence. In addition to encouraging reflection concerning service user assessment and interventions, the supervisor could also discuss their intrapreneurship development. Additionally, they could create safe spaces for team staff to suggest ideas for improvement and actively encourage the challenging of current thinking and practice without fear of rejection or reproach.

These spaces should be elevated in importance to ensure prioritisation and acceptance as an essential component of everyday work. There are significant opportunities at the occupational therapy team and service level for the creation of cultural environments where creativity and innovation could flourish.

At the national level, there are implications for the occupational therapy professional body (RCOT), the statutory regulator of the health and care professions (HCPC) and the Government's Department of Health and Social Care (DHSC) to recognise their essential role in developing policies and guidance to support intrapreneurship in practice. Specifically, the RCOT practice guidance documents and the HCPC education and training standards should emphasise more strongly the importance of intrapreneurship, including the evidence based case for graduate intrapreneurship education and also the costs and downsides involved. They should provide more detailed guidance for *how* to develop and promote an intrapreneurial approach in our occupational therapy graduates and in the established occupational therapy workforce. This could include a guidance document providing the background theory and research involved and specific direction concerning organisation level policy development, implementation guidance and plentiful examples of good practice. The Government should develop more detailed national policies designed to establish an environment and culture within all health and social care contexts that prioritises and supports an intrapreneurial approach. Importantly, effective national level tools need to be determined, developed and implemented that can accurately measure the success of cultural change programmes so that we know when change has occurred. The Government's rhetoric calling for a greater 'entrepreneurial spirit' should now be effectuated at every level of health and social care services through relevant policy, guidance and effective audit tools for measuring success.

This research has demonstrated the importance of having a greater understanding of the factors that are influencing occupational therapy graduate choices of work location and experiences of intrapreneurship within the broader framework of structure / agency interaction theory. This better understanding will inform the future development of the HE occupational therapy healthcare curriculum and

professional practice leaders and healthcare policy makers to ensure a more conducive environment for the future intrapreneurship of fledgling occupational therapy graduates, culminating in improved service user care. Occupational therapy graduates will be better informed about the realities of healthcare practice and be advantageously equipped for their early career roles, their intrapreneurship and, subsequently, challenging and transforming unacceptable service user care.

Summary of key conclusions

- Margaret Archer's concepts of the internal conversation and preferred reflexive modes are valuable tools for examining the micro-level interactions between occupational therapy graduates' agency and the structures they encounter in their early career roles and intrapreneurial pursuits.

- The occupational therapy graduates' reflexive preferences strongly influence their choice of work location and perceptions and experiences of intrapreneurship. Occupational therapy HE educators should inform occupational therapy graduates and raise awareness concerning their preferred reflexive modes alongside the potential influences on their decision-making capacities. If occupational therapy graduates are fully informed, they could make better choices and the channelling of particular graduates into particular health care contexts could be substantially disrupted. Furthermore, the statutory context could benefit from attracting the more intrapreneurially-focused graduates, preferring an autonomous reflexive mode, to challenge and transform stagnant practice cultures.

- Personal and professional relationships are highly prized and prioritised above intrapreneurship concerns by statutory located occupational therapy graduates preferring a communicative reflexive mode. In marked contrast, those in the non-statutory context preferring an autonomous reflexive mode, subordinate relationship concerns to their intrapreneurial concerns. Raising

practice leaders' awareness of these differing concerns would equip them to provide more tailored peer support and mentoring, thus, empowering occupational therapy graduates in their intrapreneurial pursuits.

- The statutory healthcare context is profoundly structuring occupational therapy graduate intrapreneurship. This finding confirms what is found in the literature, which emphasises the highly bureaucratised and stagnated nature of UK state-funded healthcare that stifles professional autonomy and innovative practice.

- Also, more numerous and larger-scale opportunities abound for intrapreneurship in the non-statutory healthcare context compared with the statutory. There are fewer structuring factors but strengthened support for intrapreneurship in the non-statutory context. The Government, HCPC and RCOT should provide augmented guidance and support for practice leaders to cultivate a favourable culture, allowing intrapreneurship to flourish.

- The statutory healthcare context exposes a mismatch between hefty demands for intrapreneurship at the national and organisation level and the experiential realities of occupational therapy graduates in practice. Expectations for intrapreneurship are paltry with functions and roles assigned for innovation located higher up the chain of command. Policies, systems and processes promoting intrapreneurship should be fully aligned, integrated and enacted throughout the entire system to support the transformation of the paralysed, perilous culture evident today.

- Occupational therapy graduates perceive and experience structuring barriers to their intrapreneurship differently depending on their preferred reflexive modes. Those preferring an autonomous reflexive mode are more confident in their decision-making capacities and view barriers as obstacles to overcome. Those preferring a communicative reflexive mode are less confident and perceive barriers as insurmountable.

- Also, those preferring a communicative reflexive mode often wrongly assess the power of encountered barriers and, although they possess intrapreneurial desires, they frequently walk away. A developed occupational therapy curriculum that raises graduates' awareness of their reflexive preferences and enhances personal and practical skills should bolster confidence for successfully scaling intrapreneurship barriers. In turn, this will support more innovative and safer service user care.

- There are substantial costs and downsides of intrapreneurship that are largely ignored in the literature. These costs are experienced differently by occupational therapy graduates depending on their preferred reflexive modes. The costs should be widely acknowledged and all occupational therapy graduates equipped for accurately evaluating these costs alongside the potential benefits.

Study limitations and proposals for further research

Research is subject to various limitations, which may influence the strength of a study's impact. My study was in-depth rather than broad-based and incorporated nine participants in two practice contexts for the pragmatic reasons of time and funding constraints. As a result, there were only five participants in the statutory and four in the non-statutory context, which could be considered a limiting factor. I was not intending to make large-scale generalisations and, therefore, considered that the low participant numbers would not be an issue. Aligning each graduate with a specific reflexive mode proved challenging and, although my research supervisor checked the alignment method, another researcher may have achieved different results. Additionally, no graduate in the group of 9 participants could be sufficiently aligned with the meta or fractured reflexive modes, which could have limited the potential learning from the study. Another limiting factor is that the study only included participants from a single HE institution. Consequently, there may be other variables at play concerning any aspect of that institution that I was not aware of

which could have impacted on the quality and usefulness of the study outcomes. Additionally, involving a novice and insider researcher can come with its own limiting factors. I could have been fixated on my own agenda or blinded to important emerging phenomena. I may have made fundamental mistakes in any element of the study design or its implementation. These issues were hopefully addressed by my critically reflexive approach and through regular supervision with an expert researcher.

As a novice researcher, I have found it challenging to fully capture structure within the study findings, discussion and conclusion and believe there are a number of possible reasons for this. I utilised Archer's ideas as a framework for the study and she heavily focuses on the agent's activities, contending that structural and emergent powers have to be activated by specific agential enterprise. Archer's approach was a move away from mainstream realist social theorists who had tended to focus more on how structures and cultural powers have impacted agents. Additionally, my exploratory study was located at the individual, micro-level of analysis where I was particularly intent on listening to the occupational therapy graduates' voices and exploring in depth their perceptions and experiences. These factors have created some difficulties for me in focusing away from individual occupational therapy graduate agents to look more widely and fully capture the structures that impinge on their intrapreneurial pursuits.

Due to the small number of participants in my study, further research, including samples from larger cohorts, could be beneficial. This would either strengthen my arguments, or indeed, reveal a different picture. Samples from larger cohorts could see occupational therapy graduates aligned to the missing modes, which could add substantial learning. As my study was limited to a single HE institution and professional group, it would be useful to examine if the learning was transferable to occupational therapy graduates from other institutions and other healthcare professional groups. I also suggest that a longitudinal study that examined if these experiences of occupational therapy graduates with differing PRMs would be changed over time as they became more embedded in their professional careers. I

believe these research proposals would be useful in supporting healthcare professionals to better understand what could be influencing their intrapreneurial pursuits and, thus, better inform future healthcare education and practice development.

Personal learning from the research process

My personal learning throughout this research journey has been immense. My steepest area of learning relates to the maintenance of motivation and momentum over the last six years of work, which has been both challenging yet highly rewarding. To keep on track, I came to understand the importance of regular support on the journey. I have especially benefitted from peer support from others undertaking doctoral research who have enthused me and challenged my thinking and ideas. I have also enjoyed expert supervision and mentoring from an experienced researcher who has gently steered me when I've veered off track or become lost in the detail. Developing my research capabilities and confidence has involved learning a raft of new knowledge and skills. I have learnt the importance of asking the right questions to explore what is happening and learned about different methodologies and methods to gather relevant data. I now understand more clearly the differing perspectives on what constitutes knowledge and the different ways that knowledge can be generated. I have grappled with theory and now appreciate better the importance and benefits of underpinning research from within a known body of knowledge. Using a theoretical framework has strongly supported the design of my study and the examination and explanation of the results. I am excited to be pushing the boundaries of knowledge and contributing to the advancement of debates in the occupational therapy education and intrapreneurship fields. Perhaps of greatest significance has been my growing appreciation of the value of a critically reflexive approach; I now better appreciate the importance of continually reflecting on what I am doing and adapting my thinking and action whenever and wherever appropriate.

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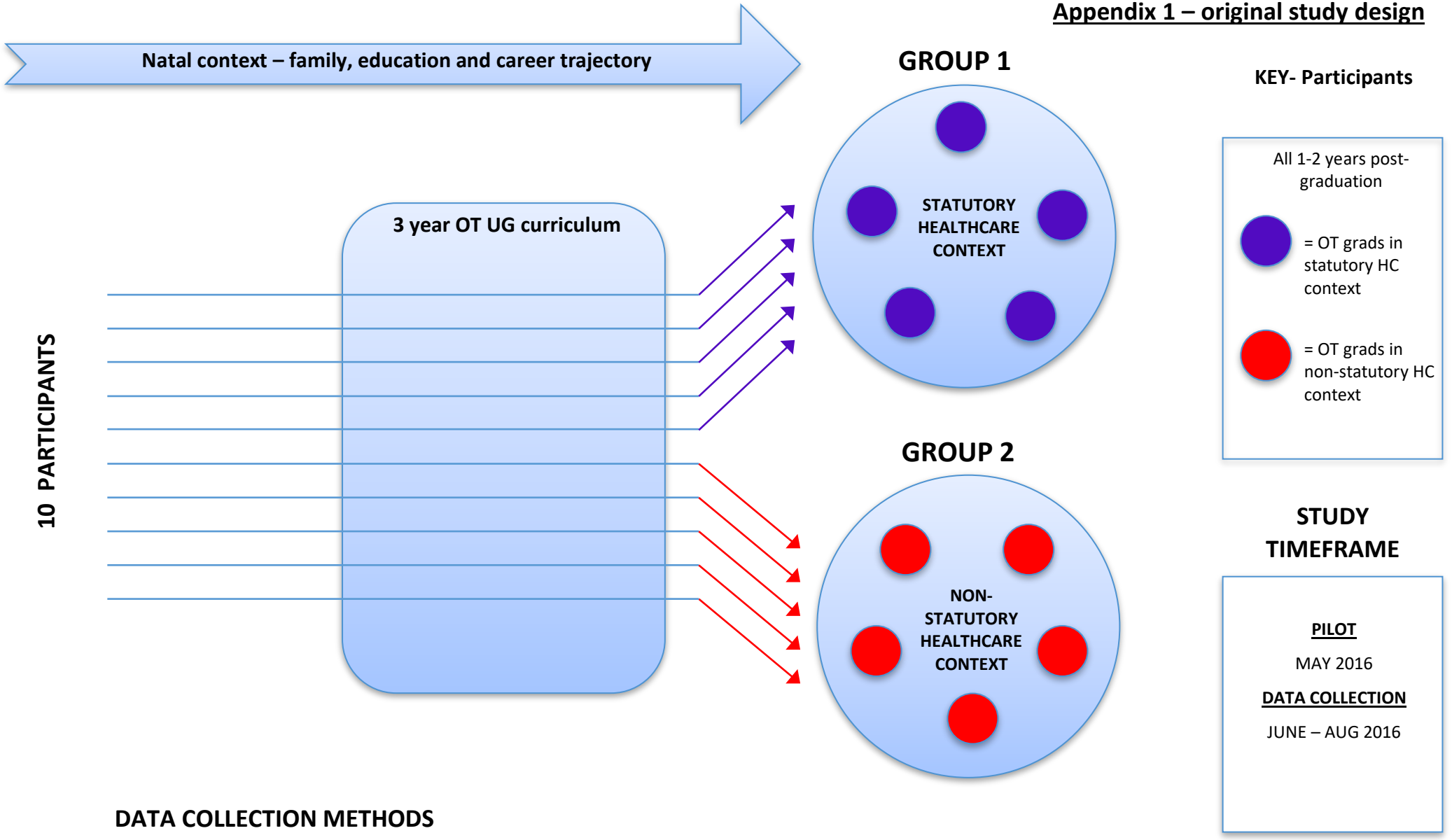
Appendices

List of Appendices

Appendix 1 – original study design



LIFE GRID DATA COLLECTION

Appendix 2 – life grid template

Section 1 – Personal Information

1. What is your name?
2. What date did you complete the life grid on?
3. What is your age?
4. What is your gender?
5. What is your current relationship situation? (married/civil partnership/single..)
6. Do you have children? What age are they? Do they live with you?
7. Do you have a disability?
    a. If yes, does it affect your educational/work experience or performance?

8. Parent's/guardians highest education qualification? Dad: Mum:
9. Parent's/guardians current/former occupations (if retired)? Dad: Mum:
10. Do you have siblings? Gender, age?
    a. What are your siblings' highest qualifications? 1
    2
    3
    b. What are you siblings' occupations? 1
    2
    3
11. When did you graduate as an occupational therapist?
12. What was your degree classification?
13. What work roles have you had since graduation? (dates, speciality, location, hospital/community, statutory/non-statutory)
    1
    2
    3
14. Have you moved away from your family for higher education or work?
15. Are there any other major factors which you believe have affected your experience of and achievement within higher education?

Section 2: LIFE GRID

Complete relevant age ranges	EDUCATION	FAMILY	WORK	SIGNIFICANT EVENTS OR PERIODS Either +ve or -ve
Age 3-5				
Age 5-11				
Age 11-18				
Age 25 - 40				
Age 40+				

Appendix 3 – interview question schedule

Interview and pre-interview schedule

Personal data – gain this pre-interview on life grid – confirm in interview

- Current job details, place of work, type of clinical setting, length of time in post, any other post-graduation, year of graduation (occupational therapy)

1. Life concerns/projects/practices – degree of dovetailing

1.1. What motivates you in your life (personal and professional), what interests you? (explore primary and other concerns)
1.2. Have you any personal life goals?
1.3. Why are you working in your current clinical setting (healthcare/statutory/non-statutory)?
1.4. What are you hoping to achieve through your professional work?
1.5. What particular opportunities/downsides do you consider the practice setting has offered/not offered you as a professional occupational therapist in relation to your motivations/interests/life goals?
1.6. What has been helpful/obstructive to fulfilling your life goals?
1.7. How satisfied are you currently in relation to your home/work and life goals? Could you talk about any sacrifices and regrets?
1.8. What do you envisage/hope your work will be like in 5-10 years?
1.9. What influences, if any, has the occupational therapy degree programme had on your choice of work setting?

2. Preferred reflexive mode (relate to entrepreneurship and choice of practice context)

I am exploring how people think and make decisions (explain, emphasising that there is no right and wrong ways and that we are all different)

2.1. Could you describe/talk me through how you came to the decision to embark on the occupational therapy degree programme (or how you chose your first graduate occupational therapy job?) prompts:
  2.1.1. Did you consult with others?
  2.1.2. What/who were the main influences?
  2.1.3. What were your self talk/thought/reflection processes?
2.2. Could you give another example of a decision you made recently and explain how you came to your decision? (prompts as above if required)
2.3. In general, how confident are you in your ability to make decisions?

3. **Entre/intrapreneurship experiences –** explain after 3:1 or before if required – There are different aspects and views – can be related to setting up a new business and making profit but can also be within an organisation and role: risk-taking, doing things differently, challenging practice/status quo, having a new idea and carrying it out, pushing back professional boundaries, autonomous decision making, seeing something that needs changing and doing something about it.

3.1. What does entre/intrapreneurship mean to you?
3.2. Is it relevant to you as an occupational therapy graduate in the healthcare setting? If yes, how?
3.3. Have you aspirations for your entre/intrapreneurship in your work? If yes, what are they? If no, could you explain why?
3.4. Are there opportunities for entre/intrapreneurship in your setting?

3.5. Have you been entre/intrapreneurial in your practice? Examples? How did you think/deliberate and plan these?
3.6. Were there any barriers you encountered or factors that assisted you?
3.7. From your perspective are there any negative aspects/downsides/costs to being intra/entrepreneurial that you have encountered?
3.8. From your perspective, how much opportunity is there for doing your own things – doing things that you think are important as an occupational therapy in your practice setting (professional autonomy)?

Thank you for your time etc

Appendix 4 – ethical approval notice

2015/66

School of Education – PGR Research Ethics Comments Form

Name **Sarah Goy**
Supervisors **Simon McGrath and Monica McLean**
Course **EdD**
Title of Research Project: Entrepreneurship and the realities of Occupational Therapy Practice
Is this a resubmission? Yes **Date statement of research ethics received by Research Office:** 09/03/16

Reviewer C Summary Review		
Date of review		
Outcome of review	**Revise and Resubmit**	
	Approved	Subject to email confirmation of the conditions below

Comments:

Sarah has responded helpfully to the comments made about her previous ethics application. The application can be approved subject to confirmation of the following:

1. The ethics review panel remain concerned that data will be stored at another university rather than at Nottingham. PhD students can apply for storage space and have remote access to it. Please confirm this possibility has been explored. If storage at Nottingham remains unsatisfactory or impossible please confirm that Sarah's workplace is confident about storing research. Please confirm whether they require ethical approval to store data on their system.
2. Confirm the email contact will be changed to a Nottingham university email.
3. Confirm whether transcripts of the interviews will be provided to the participants so they can check, verify and amend these data? If not, say why not?
4. Confirm what gatekeeper is in place and how the ethical consideration regarding the use of a gatekeeper can be met.

Responses to these queries can be made by email.

Appendix 5 – participant information sheet

Information Sheet For Prospective Participants

Dear (participant name),

Following our recent contact via email, I am now writing to you to formally request for you to participate in the research study that I am conducting.

*** What is the research about?**

The aim of the research is to explore recently graduated occupational therapists thoughts and experiences of entrepreneurship in different healthcare practice settings. It is hoped that by increasing our understanding of our occupational therapy graduates early career experiences it will help us to better prepare them whilst they are undertaking university-studies.

*** Why have I been selected?**

You have been selected as you have recently graduated from (a university) occupational therapy undergraduate course and are working in a healthcare practice setting.

*** Do I have to take part?**

No. Participation in this research is entirely voluntary and you only need to take part if you would like to.

*** What is involved?**

Participating in the research will involve a 90 minute interview, audio recorded at a time and place that would cause least disruption and be most convenient to you. Part of the interview will include completing a 'life grid' together which is designed to collect brief information about your family, education and work background.

*** What are the risks associated with this research?**

There are minimum assessed risks to you taking part in this research. Talking about past life events may be uncomfortable for some people and you would be able to stop the interview at any point for a break or to withdraw altogether. There will be no pressure to talk about things that you don't wish to.

*** What are the benefits of taking part?**

Taking part will provide you with the opportunity to reflect on and explore your experiences as a new graduate entering the healthcare professional workforce. By sharing your thoughts and experiences you will be contributing to the development of the professional education of future therapists.

*** Can I withdraw?**

Participation is voluntary and if you wish to withdraw, you can do so without giving any reason. You can state your wish to withdraw during the interview or via email or telephone call after the interview up until one calendar month after the interview date.

*** How will my data be protected and kept confidential?**

Your confidentiality will be a top priority. All information related to the research and your interview recording and transcript will be kept securely at (a university) for a period of seven years. Hard copies will be kept in a locked filing cabinet and I will retain all sets of keys. Electronic copies will be stored on the university's secure server and will be password protected. Your real name will not be used in any report or presentation of the research findings and any comments you make will not be traceable back to you. You must be aware that I would be forced to consider disclosure of certain information where there are strong grounds for believing that not doing so will result in harm to you or others or the continuation of illegal activity.

*** What if things go wrong? Who can I complain to?**

If you re not happy with any aspect of the research whilst you are taking part you can contact my research supervisor, Professor Simon McGrath at the School of Education at Nottingham University. His email address and telephone number are: (email and tel: number)

I am hoping to conduct the interviews over the next few weeks, so I am keen to hear from you if you agree to take part in my research and we can arrange a suitable time to meet. You will be required to sign the attached consent form before the interview starts.

Yours sincerely,

Sarah Roe

Education Doctorate research student,
School of Education
University of Nottingham.
Email:
Tel:
Mobile:

Appendix 6 – informed consent form

RESEARCH PARTICIPANT CONSENT FORM
University of Nottingham

Project title *'Occupational therapy graduates' perceptions and experiences of entrepreneurship in contrasting healthcare practice contexts'*
Researcher's name - Sarah Roe **Supervisor's name -** Simon McGrath

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw form the research project at any stage and that this will not affect my status now and in the future.
- I understand that whilst information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that I will be audiotaped during the interview.
- I understand that data will be stored in the strictest of confidence and will only be reported in an anonymised form. Electronic copies of the data will be stored on the secure [a university] server in a location that is password protected and only accessible to the researcher. Hard copies will be stored in a locked filing cabinet in a security protected locked office at [a university].

Where it is absolutely necessary to do so in the cause of compiling the thesis, the researcher and those directly involved in the research (the supervisor and research examiners) may be granted limited restricted access to the necessary elements of the data. This may be to check accuracy of the data reported in the thesis. Any access to the data would have to be requested through the University of Nottingham Research Ethics Co-ordinator who would decide if permission is granted for restricted access.

I will be informed if it is necessary for the researcher to be forced to consider disclosure of certain information where there are strong grounds for believing that not doing so will result in harm to myself or others, or (the continuation of) illegal activity.

- 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 Co-ordinator of the School of Education, University of Nottingham, if I wish make a complaint relating to my involvement in the research.

Signed……(research participant)

Print name……**Date**……

Contact details
Researcher: Sarah Roe (email)
Supervisor: Simon McGrath (email)
School of Education Research Ethics Co-ordinator: educationresearchethics@nottingham.ac.uk

Appendix 7 – example of a participant narrative summary

Zoe Initial analysis – non-statutory health care – autonomous reflexive

Summary from the life grid template:

[redacted]

Topic area	Sub topic	Data summary
Career goals		[redacted]
Life goals		
Career choice	Occupational therapy	[redacted]
	Links to occupational therapy course	
	Work setting	[redacted]

		[redacted]
	Future goals	
Regrets/ satisfaction		
Decision-making	How	
Entre/ intrapreneurship	Definition/view	
	Opportunities in work	

	Experiences / barriers	[redacted]
Costs/downsides		
Past experiences influencing current E/I		

Zoe - Tendency towards autonomous reflexive – (some areas meta-reflexive)

Appendix 8 – example of a reflexive mode analysis

Mode criteria/area	Interview evidence	Analysis
Degree of contextual continuity	[redacted]	[redacted]
Degree of dovetailing of concerns	[redacted]	[redacted]
Relationship to inherited context	[redacted]	[redacted]
Work and relationship priorities	[redacted]	[redacted]
Social mobility – direction	[redacted]	[redacted]
Degree of independence in decision making vs external checking	[redacted]	[redacted]

	[redacted]	
Degree of critiquing own thoughts	[redacted]	[redacted]

Appendix 9 – emerging themes table

Theme area	Emerging themes	Participants Non-statutory				Participants Statutory				
		Amy	Joe	Zoe	Joy	Mia	Ann	Ava	Sam	Eve
Career and life goals	Wants to be skilled and competent									
	Ambitious and wants to achieve at work									
	Wants to be challenged in job/ gets bored									
	Wants to lead									
	Wants to create or develop a service									
	Salary not important									
	Wanting new experiences/travel/meeting new people									
	Has clarity of life and work goals – (determination)									
	Wants degree of autonomy									
	Wants to make changes in current work setting									
	Friends and family are important – motivators/ recognition									
	Has a key/important person/mentor in work									
	Mentions promotion (to higher grade) mentions grade ambition									
	Unsure about motivations and interests									
Current work setting relationship to occupational therapy course	Had a contemporary/role emerging non-stat placement (didn't like, needed direction)									
	Did a career narrative – helped me explore my options/ specialty									
	Had a placement in the service/setting									
Why chose Statutory sector	Always wanted NHS									
	Enjoys acute NHS work									
	Large organisation									
	Career prospects/progression									

	Might like to work in non-statutory in the future									
	Job security									
	Support available -supervision and mentorship									
	More learning opportunities with senior professionals/support for course									
	Wasn't confident when first qualified									
	Team-working opportunities									
	Did have experience in non –stat – didn't like it (wouldn't go back)									
	Routine, less responsibility									
	It's near for travel									
Down sides experiences/perception of Statutory sector	Works late occasionally									
	Small team not much career progression									
	Social life has reduced significantly									
	Dictated and prescriptive									
	Constraints on what you can do – no thinking outside of the box									
	People are unhappy									
	Less job security									
	Clockwatching – time pressure									
	Less time for gathering info/implementation									
	Just equipment provision and adaptation									
	Not occupational therapy (Physio occupational therapy)									
	Boring									
	Budget issues - rationing									
Why chose non-statutory sector	Want to have autonomy and apply occupational therapy philosophy personally, think outside of the box – independent thought and decision making									
	Wants to move into the statutory sector but difficult no experience (just got NHS job)									
	Travelling time not important – job type more important									

	Job satisfaction										
	Can manage own time/flexible										
	Demanding but rewarding										
	Not told what to do – you can develop how you want										
	Trust by employer										
	Confident and determined										
	Grow/expand the profession										
Down sides – experience/perception of non-statutory sector	Pay is lower										
	Lack of budget to develop										
	Demands are high and there are sacrifices										
	Maintain own continuing professional development – HCPC registration										
	Arrange own supervision										
	Manage own stress										
	Lack of support										
	In at the deep end/sink or swim/too difficult										
	Lack of direction										
	Need to be confident and strong										
	Badly organised/no structure										
	It's NOT occupational therapy										
	Stressful/tiring										
	Too much autonomy										
	Less job security										
	Less opportunities for progression										
Decision making	Communicates with others whilst making decision	A great deal									
		Some									
		None									
	Undertakes research beforehand	A lot of research									
		Some research									
	Weighs up the pros and cons										

	Visualises possible scenarios										
	Takes long time to make decisions										
	Considers worse case scenario										
	Feelings are involved in process										
	Internal conversation	A lot of deliberation									
		Some conversation									
		Two sides argue									
		Verbalises the conversation out loud									
		Thoughts flit around									
		Critiques own thoughts									
	Changes mind	Changes mind sometimes									
		Stays with decision									
	Confidence/trust levels in own decision making	Very confident									
		Fairly confident									
		Little confidence									
		Relies on others to make decisions									
	Decides first and then tells others										
	Spiritual dimension	Prayer part of process									
Definition entre preneurship /intra preneurship	Utilisation of resources	Cost saving									
		Use current resources effectively									
		Use others skills/experiences									
	Improve what exists	Expand/grow provision									
		Continual improvement/adapting									
		Prove effectiveness/evidence									
		Improve peoples lives									
	Using/develop skills & knowledge	Using skills and knowledge									
		Developing skills and knowledge									
		Consider unique skills and knowledge									
		Being confident									
	Taking responsibility	Owning what you are doing									

		Being in control									
	For self improvement	Self progression									
	Thinking/creativity & innovation	Being creative									
		Having new ideas									
	Seeing opportunities	Forward thinking									
		Seeing opportunities									
	Overcoming barriers	Not accepting structures									
		Pushing boundaries									
		Taking risks									
		Change or stagnate									
		Make a success									
Opportunities in work setting	Not part of role	Not in job description									
		Ideas to be fed into senior/innov staff									
		Lower grades not involved/heard									
	Scale of opportunities	No opportunities									
		Small-scale opportunities									
		Abundant opportunities									
	Part of role but no opportunities	Time allotted but demands too high									
	Lack of resources	No funds available									
		Poor staffing levels									
	Org openness to new ideas - culture	Actively encouraged to have ideas									
		Supported to do new things									
		Trusted by senior staff									
		Viewed as the expert									
Experiences in work setting	Importance of others	Entrepreneurial with a colleague									
		Supportive boss									
	Justification and evidence required	Idea presented to Board for approval									
		Pilot scheme – produce evidence									
		Existing research required EBP									

	E.gs – small-scale ideas developed	Develop a spread sheet for service									
		Introduced a group									
		Adapted paperwork									
		E with service users/clients/patients									
		Creativity with existing funds									
		Need to generate funds for approved idea									
Barriers experienced & perceived	Resource issues	Lack of time – high demands									
		Lack of funding available									
		Staffing levels – high demands									
	Org systems and structures	High level of bureaucracy/ structure									
		Hierarchy – 'bottom of food chain'									
	Influence of others	Others motivation – 'seen it all before'									
		Others understanding of vision									
		Lack of support									
	Culture	Cultural rules and norms									
		Power of the many									
	The individuals issues	Lack of confidence– need to be pushy									
		Individual motivation									
		Perception of barrier – 'stile or wall'									
		Fear of others view of you									
		"good enough is good enough" (letter)									
		Not in job description									
		Conflicting agendas with individual									
Costs & downsides of Entre/intra	Risk issues	Job uncertainty/security									
		Things more likely to go wrong if E/I									
		Might be taken advantage of									
		Risk isolation									
	Personal costs/impacts	Difficult – cognitively taxing									
		Tiring									

		Using own time W/L balance									
		Frustration if ideas rejected									
	Reduction in motivation and confidence	Confidence levels fall if ideas rejected									
		Lose motivation if not supported									
		Lose motivation of not successful									
	Perception of others	May be perceived negatively by others									
		Might irritate others									
		Might be resented by others									
Influence of the occupational therapy BSc degree experience	Practice placement influence	Selecting work location									
		Opportunities for intrapreneurship									
	Academic-based studies influence	Thinking differently									
		Developing confidence									

Analysis **Appendix 10 – Final analysis**

Theme area	Across the participant group – All	Differences between stat and non-sat groups
Career and life goals	• A desire to be skilled and competent • Ambitious in wanting to achieve at work and also to gain promotion to a higher grade • Want to be creative and develop a service • Salary is not as important as home and work priorities • A desire to meet new people with some mentioning travelling to have new experiences • Determined and have clarity in their life and work goals	• The non-stats want to be skilled and competent • Non-stats mention wanting to be challenged • Non stats mention salary as not being important • Non-stats desire a degree of autonomy from their job • Stats friends and family are important • Stats mention promotion being important to a higher grade
Decision making	• Communication occurs with others in the decision making process a lot and some • Takes a long time to make decisions • Research is undertaken to inform decision making • Their internal conversation included a lot or some deliberation, a couple described this as an argument and a couple verbalise their conversation as it occurs • The majority were very or fairly confident in their decision making ability	• All the stats mentioned that they spend a great deal of time communicating with others whilst decision making, whereas the non-stats communicated with others to a lesser extent • Stats do a lot of research and the non-stats do some research before decision making *(Non-stats rely more on their own assessment)* • Non-stats decide first and then tell others their decisions • Non-stats mentioned weighing up the pros and cons more often and take longer to make decisions more than stats • All non-stats alluded to high levels of confidence in their decision making whereas the majority of stats had little confidence and two had great difficulty and relied on others for decision making • The majority of the non-stats said they experienced a lot of deliberation and included a two-sided argument occurring.
Why chose the context		<u>Non-Statutory</u> • You can have autonomy and apply the occupational therapy philosophy personally, think outside of the box and have independent

		thought and decision making • The job is more important than travelling distance • You can manage your own time and be flexible • You are trusted and can develop things how you want <u>Statutory</u> • Always wanted to work in the NHS • For career prospects and progression opportunities • For the support, supervision and mentorship that is available • There is more learning opportunities with senior professionals • Had a non-stat experience and didn't like it • It's near for travel
Definition of entreprenership/ intrapreneurship	• All defined this in terms of 'intrapreneurship'-being entrepreneurial within the workplace – not about setting up new business. • Improving what already is in existence in the service • Using and developing skills and knowledge • Thinking creatively, new ideas and innovation • Overcoming barriers to enterprise – taking risks, pushing back boundaries.	• Stat included efficient utilisation of resources • Stat included that it is about being creative • Non stat more often said it's about developing and using skills and knowledge • Non stats included elements around overcoming barriers
Opportunities for entrepreneurship	• There are abundant and smaller-scale opportunities to be intrapreneurial.	• Stat experience smaller-scale opportunities • Non-stat experience abundant opportunities • Some Stats mentioned that it isn't part of their role at their grade and they feed their ideas to other people responsible • Some Stats reported that they had time allotted for innovation but the demands on time were too high • All the non-stats reported that there was organization openness to new ideas – they were actively encouraged to have new ideas and supported to do new things
Experiences	• Justification and evidence is required for developing service/innovation	• In the non-stat sector the ideas had to be justified for approval and many presented to the board for approval with one needing to

	• A range of examples of entrepreneurial ideas were provided	provide pilot study evidence
Barriers to entrepreneurship	• Lack of funding and staffing levels leading to high demands on time for entrepreneurship	• The stats perceived many more barriers to entrepreneurship than the non-stats • The stats included lack of funding and staffing levels leading to high demands on time for entrepreneurship • Stats mention organisation structural barriers 'bottom of the food chain' • Stats include a focus on others as important for creating barriers – motivation and power of others • Stats mention lack of personal confidence and motivation as barriers
Costs & downsides of entrepreneurship	• There are personal costs – it is more taxing and tiring and affects work life balance • Your motivation can be affected if you are not successful in being entrepreneurial	• The stats include their confidence levels falling and their motivation falling if they are not supported • The stats include the costs including the negative perception of others • Stats include risks relating to others – isolation and being taken advantage of whereas the non-stats mention the risks of job security and the possibility of things going wrong
Influence of the occupational therapy BSc degree course	• The placement experience influenced the selection of work location • The academic elements of the degree supported graduates in thinking differently and developing confidence for intrapreneurship	•