# Mapping the Public Sector Diaspora: towards a model of inter-sectoral cultural hybridity using evidence from the English health reform


## Abstract

Public service reforms increasingly blur the boundaries between public and private sectors, involving hybrid modes of service organisation and delivery. With growing numbers of public services being transferred to private or mutual ownership, the paper interprets such reforms as a *public sector diaspora*. Drawing upon the cultural theory and diaspora studies the paper proposes a model of inter-sectoral hybridisation that centres on the possibilities for cultural disruption, adaption and hybridity in the in-between spaces of migration and re-settlement. Focusing on reforms within the English National Health Service, the paper presents an ethnographic account of the transfer of doctors, nurses, practitioners and healthcare assistants from a public hospital to an Independent Sector Treatment Centre, exploring their different experiences of migration and re-settlement and, in turn, cultural hybridity. The model addresses a conceptual gap within the public policy and management literature by elaborating the antecedents, processes and forms of hybridisation.

## Introduction

Contemporary public service reforms blur the boundaries between public and private sector, involving 'hybrid' modes of governing, organising and delivering public services (Billis, 2010; Boyne, 2002; Ferlie et al. 1996). A prominent example is where public services are contracted-out or privatised (Milward, 1994), i.e. where public organisations and workforces are transferred to the ownership and management of the private sector. In the wake of the global economic crisis policy-makers, for example, in Canada have shown renewed interest the privatisation of selected health and welfare services (Boardman and Vining, 2012), in the UK private and social enterprises are entering emerging markets for health, education and welfare services (Alcock, 2012), and in Greece and Spain large sections of public infrastructure are being privatised (Greek Ministry of Finance, 2013). However, transferring financial and administrative responsibilities and, more broadly, organising across sectoral boundaries is often complicated by divergent funding arrangements, governance systems and employment conditions (Hodge and Greave, 2007; Marchington et al 2005). Of specific interest to this paper, the blurring of sectors brings together cultures that are often described as having divergent 'motives' (interest and rewards), 'values' (utility or benefits) and 'norms' (accountability and commitment) (Perry and Wise, 1990; Pratchett and Wingfield, 1996; Hebson et al. 2003). The management of cultures remains a significant theme of contemporary public policy, but there is little understanding of how cultural differences are reconciled in the context of inter-sectoral working, whether public values are substituted for those of private enterprise, or whether new 'hybrid cultures' are emerging.

Despite growing theoretical interest in public service 'hybrids', the public policy and management literature remains relatively under-developed (Billis, 2010). It is not always clear, for instance, *what* attributes are brought together; *how* 'character traits' combine; or *why*

certain qualities become ‘dominant’. As such, the paper turns to research within the fields of culture and migration studies, where the concepts hybrid and hybridisation are well-developed in the analysis of multiculturalism, post-colonialism and globalisation (Ackermann, 2012; Pieterse, 2001; Yao, 2003). Within this broad field, diaspora studies offers especially relevant insight on cultural hybridity with its attention to the ways ethnic cultures are maintained, transformed or blurred as communities migrate from some home and resettle in new territories (Brubaker 2005; Cohen, 2008). The diaspora literature is applicable to contemporary public service reforms in two ways. First, it might be suggested we are witnessing a *public sector diaspora* with the dispersal (transfer or privatisation) of a distinct community (public sector workforce) to a new environment (private sector), where divergent cultures interact and combine. In this sense the diaspora concept is a descriptive metaphor (Burbaker, 2005). Second, diaspora research explores how cultures interact, adapt and blur through the spaces of migration and resettlement (Cohen, 2008, Kalra et al 2005). In this sense, it provides a basis for analysing how hybridisation occurs through liminal or transitional spaces. Drawing on this literature, the paper contributes to theory on public service hybrids by developing a model of the antecedents (migration), processes (re-settlement) and forms of cultural hybridisation.

This model is used to analyse recent reforms within the English National Health Services (NHS). Although the NHS is often characterised as a socialised healthcare system, it has been at the forefront of public service reforms, including contracting-out, managed-markets and public-private partnerships (Ferlie, et al 1996). It exemplifies the trend towards inter-sectoral collaboration and privatisation, with policies extending opportunities for private businesses to own and manage public healthcare (Author; Department of Health, 2010; Hall, et al. 2012). To develop its analysis of these reforms, the paper outlines its theoretical approach drawing on cultural theory and diaspora studies. It then relates its analytical framework to

contemporary public service reforms and presents the case of the English NHS. After describing the study methods, the paper examines the dispersal and resettlement of healthcare workers as they move from the public to the private sectors, focussing in particular on the interaction and blurring of cultures. The paper then explores the implications of these changes and discusses whether the diaspora metaphor is relevant to contemporary public service hybrids.

**Hybridisation & Diaspora**

The study of 'hybrids' has a long history in anthropology, sociology, and more recently public management and organisational studies (Ackermann, 2012; Ferlie et al. 1996; Noordegraff, 2007; Oliver and Montgomery, 2000; Pieterse, 2001). It is arguably developed most in the field of cultural theory, especially in the analysis of multiculturalism, ethnic displacements and post-colonialism (Pieterse, 2001). Hybridity has been interpreted as 'inter-breeding' and a threat to ethnic 'purity' (Young, 1995); as the subjugation of local cultures to colonial hegemony (Pieterse, 2001); as a basis for post-colonial resistance (Bhabha, 1994), and for describing more global and cosmopolitan cultures (Stephenson, 2003).

Cultural hybridity is often described through biological metaphors, such as 'cross-fertilisation' (Yao, 2003), but might better interpreted as involving social practices of acculturation (learning), adaptation (modification) and appropriation (borrowing). Ackermann (2012) describes three common metaphors, including 'borrowing' (the imitation of another's cultural elements); 'mixing' (the fusion of cultural elements) and 'translating' (the movement of cultural attributes to new contexts). Without wishing to refashion these typologies, a number of linked issues are highlighted. First, typologies of 'hybridity' are usually developed with reference to the processes of 'hybridisation', i.e. the hybrid form has

antecedents in the interaction of cultural elements (Yao, 2003). Second, hybridisation calls into question established cultural boundaries and involves instances of both intentional and passive boundary maintenance, negotiation and change (Ackermann, 2012; Pieterse, 2001). Third, the negotiation of boundaries is inherently political and framed by prevailing patterns of influence and power (Clifford, 1994; Pieterse, 2001). Reflecting these observations, cultural hybridity is less concerned with the fusion of fixed cultures into a new form, but more about the liminal, in-between or hybrid spaces where cultural boundaries are disrupted and social groups learn, adapt and borrow (Bhabha, 1994).

Analysis of these 'in-between' or 'marginal' spaces (Weisberger, 1992) is especially developed in the study of diasporas (Bhabha, 1994; Smith and Leavy, 2008). Diaspora research attends to the way cultural affiliations are maintained or transformed as ethnic groups migrate from a 'homeland' and resettle in new territories (Bhabha, 1994; Brubaker, 2005; Cohen, 2008; Safran, 1999). As such, it highlights the possibilities for cultural boundaries to be disrupted as communities move between places. Most classical accounts focus on 'victim diasporas', especially Jewish Diasporas, to understand how cultural affiliations are maintained following 'dispersal', especially the commitment to 'homeland' (Cohen, 2008). More recent studies focus less on fixed cultural boundaries and more upon the possibilities for cultural attributes to become "separated from existing practices and recombined with new forms" (Pieterse, 2004: 64) as communities travel through and adapt to 'in-between' spaces (Clifford, 1994; Fortier, 2000). Rather than commitment to homeland or shared identities, diaspora research considers the emergence of partial identities, pluralistic selves and a 'double consciousness' as communities are neither 'there' or 'here' (Smith and Leavy, 2008).

Of relevance to this paper, diaspora research shows how cultural hybridity is a political process (Esman, 2009; Webner, 2004). As argued by Clifford (1994: 319) "diaspora cultures are, to varying degrees, produced by regimes of political domination and economic inequality". Diaspora communities often face hostility and resistance, are expected to adopt host-like practices; and can be reticent about change (Cohen, 2008). As such, the hybrid 'space' is characterised by encounter, conflict, adaptation and blending (Bhabha, 1994; Kalra et al, 2005; Lobell and Mauceri, 2004; Lo 2002). These interactions are framed by prevailing social inequalities within and between host and migrant communities. For example, diaspora communities are rarely homogenous, but include those privileged by certain resources and more able to mobilise interests; equally, those hosts resistant to 'outsiders' are often most disadvantaged and threatened by newcomers (Esman, 2009).

Drawing on the diaspora literature, a model of cultural hybridisation is proposed that describes the processes or 'spaces' of change (fig. 1). The *migration* space relates to the underlying reasons for relocation and the antecedents of hybridisation. Diasporas are triggered by a range of 'push' or 'pull' factors (Cohen, 2008; Esman, 2009), for example, 'victim diasporas' involve forced migration (ethnic cleansing, slavery), whereas others move for new opportunities (trade, colonial, employment). Migration frames attachments to 'home' and willingness to embrace new cultures. For example, economic migrants may be less rewarded in, and have less commitment to their established affiliations, whereas those forced from to migrant may want to maintain some sense of shared commitment (Kalra et al. 2005). It is important to consider differences *within* migrant communities, such as 'first movers' and 'followers'. Early re-settlers often have fewer support structures, but benefit from less competition, can exploit available opportunities and act as advocates for later arrivals (Esman, 2009). The migration processes also shapes the responsiveness of the host as to whether migrants are viewed as a legitimate 'refugees' or as a threat to limited resources.

This often depends upon the structure of available opportunities within the host community. The migration stage is therefore a precursor to cultural hybridisation by shaping the subsequent preferences and interactions of re-settlement.

The *re-settlement* space focuses on the interaction between host and migrant communities, including their preference for interaction and the extent of conflict (Berry, 1997; Lo, 2002). Esman (2009) suggests this illustrated by the 'opportunity structures' offered by the host and the 'integrative inclinations' of the migrant. Opportunity structures reflect the attitudes of the host community about the migrant culture, which can include being 'receptive' of pluralistic cultures; seeking to substitute and 'absorb' migrant cultures into the mainstream culture; or being more 'hostile' by seeking to 'segregate' migrants and/or 'exploiting' them for the benefit of the host. These responses reflect the host's underlying views about the maintenance of their own cultural boundaries, their inclinations to interacts, their views about the antecedents of migration, and the wider socio-economic opportunities or threats posed by the migrant community (Berry, 1997). Research attests to how migrant communities often experience hostility with limits on civil rights, access to education and physical abuse (Cohen, 2008).

Migrant communities also have divergent preferences for interaction and cultural change. These can include the desire to 'integrate' with the mainstream by acquiring practices (language, dress) of the wider population for societal acceptance; to remain 'separate' from host and maintain cultural boundaries; which often involves efforts to 'recreate' elements of the home culture; or more 'return' home (Safran, 1999). As above, these inclinations are shaped by the causes of migration, the inclination to interact, opportunities presented by the host, and available socio-economic resources (Esman, 2009). Leadership and mobilisation activities have a key role in shaping preferences, with community leaders often at the

forefront of hybridisation as they acquire the social, legal and cultural attributes necessary to straddle two worlds (Bhabha, 1994). Moreover, this interaction is framed by wider social, economic and political forces, especially with regards to issues of class and gender, within both migrant and host communities (Esman, 2009). This can mean that sections of a migrant community might have different experiences of migration and re-settlement according to their relative status.

The extent of *cultural change and hybridisation* is a consequence of the interaction between host and migrant communities. More traditional accounts focus on maintaining 'pure' cultural boundaries, or conversely cultures being assimilation into mainstream institutions (Cohen, 2008; Esman, 2009). Contemporary research focuses more on the blurring of cultural boundaries including possibilities for both host and migrant communities to learn from each other (acculturation), to modify respective practices (adaptation) and to borrow or mimic elements (appropriation) (Ackermann, 2012). These instances of hybridity are inherently contingent upon the preceding stages of migration and re-settlement. For example, groups that seek to maintain their distinct cultures but also utilise new employment opportunities may mimic cultural elements to enable interaction, without weakening underlying values. Alternatively, interaction may afford opportunities for mutual learning and the fusion of attributes into new cultural practices. As well as avoiding essentialist definitions of 'pure' or 'tainted' cultures, it is important to recognise the positive and negative aspects of hybridity. Although hybridity might provide a basis of resistance or liberation (Bhabha, 1994), it can also involve exploitation or marginalisation as hybrid cultures are ghetto-ized or treated as second-class citizens (Cohen, 2008). Moreover, the experiences of cultural change are not uniform but reflect differences within both migrant and host communities in terms of their socio-economic resources, mobilisation strategies and interaction inclinations. This tentative

model offers a basis for analysing cultural hybridity in relation to the in-between spaces involved in diaspora-type migrations and re-settlements.

**Inter-sectoral hybridity and the Public Sector Diaspora**

The paper applies the diaspora metaphor and the above analytical model to contemporary public service reforms. Specifically, the paper interprets policy-makers' renewed interest in privatisation, contracting-out and inter-sectoral working as involving a *public sector diaspora* where established public sector organisations and workforces are transferred to the ownership and management of the private sector. This migration brings together potential divergent 'sectoral cultures' and, through the resettlement of public workers in the private sector environment, these cultural boundaries might be expected to interact and blur. In other words, reforms create the type of unsettled, liminal or in-between spaces associated with diaspora and hybrid cultures.

This view is premised on the idea that public and private sectors have distinct cultures, in terms of their 'motives' (interest and rewards), 'values' (utility or benefits) and 'norms' (accountability and commitment). Perry and Wise (1990) suggest that, unlike private sector workers, public employees are motivated by an attraction to 'political governance', 'civic duty', 'compassion' and 'self-sacrifice'. Similarly, Pratchett and Wingfield (1996) suggest public sector organisations are characterised by an ethos of 'political accountability'; 'bureaucratic behaviour'; serving the 'public interest'; and 'loyalty'. These cultures are not necessarily confined to nations with large public sectors, but are found with more mixed modes of public service, such as the US (Perry and Wise, 1990). In contrast, the private sector is often described as motivated by private reward, with an emphasis on entrepreneurial,

competitive and more exploitative practices, and where standards of behaviour are defined in relation to instrumental achievement of goals.

Two important clarifications might be made to this general view. First, sectoral cultures are not homogeneous or totalising, but vary according to service area (health, education, welfare) and the influence of corresponding professional and organisational cultures (medicine, teaching, social work). Public sector cultures are typically acquired through professional socialisation and reinforced through particular modes of organising, such as prevailing accountability structures and client interaction (McDonough, 2006; Perry, 1997; Pratchett and Wingfield, 1996). Although public service professions might share broadly similar aspirations around serving the public good or ethical standards of behaviour, these professions are characterised by distinct epistemic boundaries, value systems, customary practices, identities and status hierarchies (Pratt et al 2006). The manifestation of public sector culture is mediated or refracted through these distinct professional cultures, which can also transcend organisational and sectoral boundaries as members develop careers in multiple public and private workplaces. As such, it is important to consider how professional cultures interact with sector cultures, especially through inter-sectoral working. Second, the organisational context of public service work also enacts a powerful influence and represents a further layer through which sectoral cultures are mediated. Moreover, research suggests the ideologies of the market, entrepreneurship, consumerism and individualism have eroded or 'colonised' traditional public sector motives, values and norms (Berg, 2006; Cooke et al, 2005; Hebson et al 2003; Rondeaux, 2006). This can be seen with the widespread use of business and management practices; the commercialisation and marketization of services; and the growth of inter-sectoral partnerships. As such, public sector cultures are increasingly framed and managed in ways that align with the ideologies of New Public Management (Hebson et al. 2003)

As well as private sector ideologies and cultures being introduced *into* public sector organisations, reforms involve the transfer of public sector organisations and workforces *out to* the private sector, i.e. contracting out, privatisation or inter-sectoral working. This offers new opportunities for cultural hybridity based on the dispersal of public organisations and workforces to the private sector. Drawing upon the above model, the possibility for inter-sectoral cultural hybridity can be analysed through three linked questions. First, how do public workers perceive the reason for their migration and how do these perceptions frame subsequent preferences about re-settlement? Second, how do migrant and host cultures interact during re-settlement, taking into account the preferences of both private employers and public workers about cultural maintenance and change? Finally, what forms of cultural change are brought about through these hybrid spaces and how might these be explained according to the processes of migration and re-settlement? Reflecting the above observations, however, this also needs to consider how change is influenced by additional occupational and organisational cultures that overlay or mediate sectoral cultures.

*A healthcare diaspora*

The paper examines reforms within the English NHS. Like other public services, there is growing political pressure to reduce the scale and burden of public healthcare through a mixed economy of care (Ovretveit, 1996). In the NHS, this follows an established history of out-sourcing, private finance and public-private partnerships (Author), with recent policies requiring locality groups of family doctors to commission specialist services from an increasingly diverse market of 'qualified' providers (DH, 2010). This creates opportunities for private firms and social enterprises to enter the 'NHS marketplace' through either establishing new service providers or acquiring management and ownership responsibility of

care providers previously operating by the public sector, especially community-based or elective services (Hall et al. 2012).

A prominent example of this growing trend was the introduction of Independent Sector Treatment Centres (ISTCs) in the mid-2000s. Modelled on North American and European 'surgi-centres', ISTCs provide relatively low-risk, scheduled, day-based care. They are described as utilising the expertise and resources of the private sector to expand service capacity, reduce waiting times and increase patient choice (DH, 2000, 2005). Although required to comply with prevailing regulatory frameworks, ISTCs are private firms, functioning as relatively independent providers of care contracted by locality NHS commissioners (DH, 2005). ISTCs have attracted significant debate with research suggesting improvements in patient experience, clinical quality and operational productivity, but often based upon tighter selection of low-risk patients and relatively higher levels of funding (Author; Bate and Robert, 2006; Gabbay et al 2010).

Early ISTCs were introduced as ‘supplementary’ providers of care (i.e. alongside public hospitals), but later incarnations were developed as ‘substitute’ providers (i.e. assuming operational responsibility for NHS services). These involve the transfer of existing NHS services to the ownership and management of private firms, thereby providing an illustrative case study of the types of public service diaspora outlined above. This transfer often involves large sections of the NHS workforce included doctors, nurses, and other practitioners associated with or employed to provide the transferred services. The transfer of these occupational groups highlights new possibilities for cultural boundaries to become disrupted and new cultural affiliations to emerge, possibly with the private sector. As suggested above, however, these occupational groups are far from homogenous but have relatively distinct cultures and forms of influence within service organisation. As such, it might is likely that

these groups will have divergent experiences of migration, resettlement, and, in turn, forms of cultural change. Drawing upon the above model, the study examines the experiences of dispersal, re-settlement and cultural change from the perspectives of these different groups.

**The study**

The paper presents an ethnographic account of the transfer of NHS services (e.g. orthopaedics, vascular, gynaecology, dermatology) and associated clinical professionals from a regional public hospital to a privately managed ISTC, carried out between 2008 and 2010. It focuses on the common and distinct experiences of four groups: medical doctors (c15-20 in total moved), nurses (c30), practitioners (radiologist, operating practitioners, physiotherapists) (c20), and health care assistants (HCAs) (c20). It was anticipated these groups would have different experiences as a reflection of their distinct professional cultures and also contractual arrangements, with nurses, clinical practitioners and HCAs transferred on a permanent full-time contract, but with protected employment rights and pension entitlements, and medical staff through partial secondment, and with most retaining NHS work.

The study involved non-participant observations from 2 months prior and 12 months following the transfer of services to the ISTC. Data collection commenced in the NHS hospital with regular observations in effected departments and clinics to characterise the values, norms and motives of those to be transferred. Observations continued up to the last day of working within the NHS and re-commenced in the ISTC for a sustained period of 6 months, including day-to-day activities in clinics, rest areas, team briefings and management meetings. A further period of 6 months was used to explore change over time and clarify analytical categories. Observations were undertaken with ISTC managers to understand their

strategies in relation to the transferred workforce through attending weekly and monthly planning meetings, HR activities, and induction events. Alongside observations, staff were engaged in informal conversations to clarify events. In total, over 400 hours of observations were recorded in handwritten journals, with separate reflective interpretations. In addition, 40 semi-structured interviews were carried out with representatives from managers (7), doctors (15), nurses (9), clinical practitioners (5) and HCAs (4). These developed reflective narratives about the transfer, including changes in work organisation, and relationships between managers and clinicians. All interviews were digitally recorded and transcribed verbatim.

Data analysis followed an iterative and interpretative process of close reading, coding, constant comparison, elaboration of emerging themes and re-engaging with wider literature (Strauss and Corbin, 1998). Observation records and interview transcripts were entered in the software package *Atlas ti* and initially open-coded through close reading to describe the general experiences of clinicians and managers. First order codes were subsequently analysed to develop for their coherence and consistency and then re-analysed to identify second order codes and then thematic overarching categories. All codes and categories were continuously reviewed for their internal consistency, boundaries and relationships, involving independent academic colleagues. As analysis progressed, empirical codes were related to the proposed model to focus on the themes 'migration', 're-settlement' and 'cultural change' (see figure 2 and 3). The findings first present a brief overview of the ISTC environment into which staff were transferred before describing the experiences of doctors, nurses and practitioners (combined for analysis) and HCAs.

<Figure 2 & 3>

**Findings**

*The ISTC Environment*

Clinical staff experienced both continuity and change in the organisation and ethos of care within the ISTC. The service was organised with an overriding emphasis on operational productivity and performance management, manifest in managers' aspirations around achieving targets for clinic/theatre usage, throughput, waiting times and cancelled procedures, and the reformulation of clinical processes as a means of meeting these. Although such modes of service organisation are found in both public and private sectors, they appeared, in contrast to the NHS, as illustrating a production or factory-like model of healthcare (see also Turner et al. 2011). The priority given to productivity was seen by many staff and managers as driven by the need to make the ISTC commercially viable. This was often expressed in terms of competing within an NHS marketplace, with a focus on winning contracts from commissioners. There was also an overarching language of meeting the expectations of 'customers' rather than the needs of patients, and widespread use of ideas more commonly associated with retail. In short, the underlying values of the ISTC were aligned closely to those of private enterprise and focused on delivering more efficient and income-generating care.

> '*This is a business at the end of the day, we have got to make it work financially*'. (Manager)

> '*We had a lot of changes in the pathways, we got all new paperwork, new assessment folders, these are our new guidelines as to what we have to do*' (Nurse)

Notwithstanding these observations, ISTC leaders presented an ethos that focused less on productivity and business, and more on patient care and professionalism. Significant was the construction and the circulation of a 'statement of principles', i.e. memos, posters and induction materials. These principles centred on providing the highest standards of care;

enabling clinicians to excel; and providing value to the local health economy. ISTC leaders aligned these principles with more traditional public sector and professional values, for example, reiterating that '*care is free at the point of use*'. Managers also downplayed the links with profit making, and where challenged by staff, argued that public service and private enterprise were not '*mutually exclusive*'. Specifically, if the ISTC could deliver an improved service and *still* generate income, this evidently revealed a flaw with the NHS. Managers often talked of their desire to foster a more inclusive culture that empowers clinicians "*to do their best*':

> '*We are trying to create a new culture, a new way of working that is better for the clinicians because they feel like they have the power and for the patients because they feel they are at the centre of everything we do*' (Manager)

Although ISTC managers worked hard to promote the importance of professionalism and patient experience, it was apparent to many that a deeper set of values and norms around volume-based productivity, cost-control and customer satisfaction were guiding service organisation. The study therefore explored how healthcare professionals interacted with these aspects of ISTCs culture through their migration and resettlement.

### *Doctors*

Doctors were generally optimistic about their transfer to the ISTC, seeing it as the '*future of healthcare*' and '*freedom*' from NHS bureaucracy. There were few concerns about the impact on medical quality or public healthcare, because *they* would still be providing care '*free at the point of use*'.

*'The whole NHS is changing and there's going to be more units like this…I should feel quite lucky to have this experience.'* (Anaesthetist)

Most doctors believed the private sector might restore core aspects of their 'professionalism' which had been compromised by NHS with managers, especially the sense of medical autonomy and reduce political interference. As one doctors described '*you can't be a proper doctor in the NHS anymore'*. Accordingly, doctors seemed to align the idea of public healthcare less with public 'sector' and more with public 'professionalism'. Many doctors had prior experience of 'private practice' and looked forward to receiving similar rewards and benefits in the ISTC for their '*NHS work*'.

*'I suppose I got dissatisfied with the NHS in the mid-90s and have looked for other opportunities… I got involved with some specialists in business marketing and looked for ways to offer independent consultancy…. But the ISTC changed all that. It gave me something that pulled all this together.'* (Surgeon)

Importantly, the majority of doctors were seconded to the ISTC on a 'sessional basis', with only a proportion of their work moved (usually 2-3 days a week). They could also influence which work was transferred, i.e. number of clinics, whilst those expressing concern could remain in the NHS. In comparison to other clinicians, doctors were both more positive about and retained greater influence over the migration, which was a 'selective opportunity' to restore their professionalism.

Upon arriving in the ISTC, the doctors experienced little discontinuity in their work, e.g. '*surgery is still surgery*' and often described improvements in service organisations, e.g. newer equipment and fewer delays. Doctors generally saw managers as innovative and willing to change practices that seemed ineffective. This approach was especially welcomed where their own recommendations were taken up by manager, such as new clinical schedules

or teamwork patterns. More broadly, doctors seemed to welcome the more commercial and '*entrepreneurial spirit*' of the ISTC, which was driven by transparent business objectives rather than politically-motivated targets. They also welcomed the management approach and their own opportunities to participate in service leadership and influence service planning, especially where this resulted in gain personal financial reward. Furthermore, the generally seemed ambivalent about public ownership and showed few connections to the NHS, in a large part because *they* remained the primary provider of care.

> *'I am 100% committed to making this work. I want to it to succeed and to prove all the doubters that the ISTC can do things differently and out-perform the NHS'*
> (Surgeon)

In parallel, ISTC managers were eager to secure the endorsement of doctors, without which the service might have struggled for operational performance. Unlike other groups, managers flattered doctors, claiming to '*trust in professional expertise*' and not wishing to interfere in medical work. They also encouraged doctors to take on leadership roles and offered financial incentives for helping the ISTC meet performance expectations. ISTC managers were therefore eager to enrol doctors into a more commercialised model of healthcare, and seemed surprised at the limited resistance from doctors.

> *'We believe that by putting doctors front and centre the service will better meet the needs of patients and our investors will be confident in our longer term success'*
> *(ISTC Executive)*

More than the other groups, doctors aligned with the business-type ethos of the ISTC. They actively sought to engage in and learn about private care, referring to US-based care providers as role-models for the UK. They also became active in translating business strategy into service improvements and persuading recalcitrant staff about the benefits of the ISTC.

The hybrid position of doctors emerged as they worked between the ISTC and the wider workforce, but typically where they mobilised the interests of the former.

> '*It's not for all doctors but I like being a part of the ISTC, it is a way for me to take more responsibility for my patients and to actually see the rewards for what I do'* (Surgeon)

> '[Company name] *should be an example to the rest of the NHS…the public sector can't compete on these terms because we provide a better patient experience*' (Doctor)

The disruption of doctors' cultural boundaries appeared to involve the acquisition of cultural elements associated with more commercial and business-type healthcare, in the place of more bureaucratic and politically motivated practices associated with public healthcare. Importantly, doctors continued to define their cultural boundaries in terms of core professional values and standards, especially for patient-centred care. As such, the overriding sense of cultural hybridity centred on the acquisition and blurring of business and professional cultures.

### *Nurses and Practitioners*

The experiences of nurses and practitioners were markedly different. Few had been consulted in the decision-making processes, except for a tour of the facility. Most were concerned about working in an organisation drive by '*profit-making*' and '*cutting corners*' at the expense of professional standards and patient safety. They also worried the transfer might be permanent with uncertainties about pay, pensions and career development. All nurses and practitioners were given the option to maintain employment in other areas of the NHS hospital, but with

the possibility of demotion and a sense of commitment to their clinical community few took this option. As such, the transfer to the ISTC was seen as relatively forced, with limited choice.

> '*It was explained to us, you come across here or we can't guarantee you're a job. so it was like you are either seconded or on your own'* (Practitioner)

> '*I didn't personally want to move and I don't think a lot of people did either. We were just basically told that if we didn't come over they couldn't promise us a job*' (Nurse)

The early experiences of the ISTC brought to the fore nurses' and practitioners' unresolved concerns about clinical standards and patient care. These concerns were targeted at the material manifestations of ISTC approach, such as performance management systems and new care pathways, which were interpreted as '*pushing through more and more patients*' without consideration to quality. Many nurses and practitioners distanced themselves from the ISTC and presented themselves as "*not a part of the ISTC*" and as safeguarding standards from the risks associated with the ISTC approach. This included re-creating teamwork practices and reporting channels previously followed in the NHS, such as clerking procedures.

> '*To bring NHS staff into a private facility was a hell of a change because we are not private staff. They do things differently, everything is cost run and they have tried to bring us round to their way of thinking and it just doesn't compute*' (Nurse)

ISTC managers were apprehensive about these '*out-dated*' practices and worked hard to change nurses' and practitioners' attitudes through a series of engagement activities. Through training events, away-days and workshops managers reiterated their aspirations for clinical excellence, service quality and public value. Significantly, performance and clinical outcome

data were used as evidence that clinical standards were not slipping, e.g. feedback scores and infection rates. At the same time, managers accepted some re-created practices where evidence also showed improved outcomes, suggesting a degree of give-and-take. Through these interactions nurses and practitioners gradually softened in their attitude and appeared to follow '*the ISTC way of working*'.

> '*We have worked hard to bring the nurses into the fold. It seemed unfair that doctors could more easily earn the rewards but nurses were different, so we have look into it and are finding that nurses are realising the benefits for their patients and themselves*' (Manager)

For those not willing to align with ISTC, a different approach was eventually used. A prominent example was a group of '*trouble-makers*' who refused to follow new procedures and remained openly critical about private ownership. These nurses were approached individually and shown evidence of service standards, and then threatened with 'official' disciplinary action for breaching policy. At the same time, managers tried to '*break-up the rabble*' by changing shift patterns of disruptive individuals so that they did not work together.

Nurses and practitioners experienced a more negotiated process of change. This might suggest nurses and practitioners had a stronger commitment to the NHS and public sector, and possibly less experience of private sector employment, hence their anxiety. They were also less privileged and welcomed in the ISTC. As such, they took a more pragmatic, blended approach; remaining commitment to their professional standards and the value of public healthcare but also adopting practices where they seemed to support these underlying values. Significantly, change was not one-way as ISTC managers also accepted some of the re-created practice if they were shown to be effective. Managers also recognised that patients

could not always be treated like 'customers' and had specific health-needs to be addressed through well-developed professional skills, not standardised pathways.

> "*It is better in many ways, you know, even the way we treat patients now is more as people and less as numbers. It just took some convincing I suppose*." (Nurse)

> "*I still have concerns about who actually owns this place and who we are working for but I just put the patient first*." (Nurse)

*HCAs*

By comparison, the migration of HCAs involved little engagement, guidance or support. Most saw it as relatively forced upon them both by the NHS and ISTC employers. This negative experience was compounded by the veiled, and sometimes explicit, threat of unemployment if they did not accept the move. Many were led to believe the ISTC might employ their own 'private' HCAs and there few alternative employment opportunities given wider economic constraints. The anxiety about employment overshadowed other concerns about clinical standards and few made reference to the importance of public ownership. As such, HCAs experienced a forced transition and heightened sense of vulnerability.

> '*What does this mean for me in the longer term? Do I have to stop saying I work for the NHS, will I lose my entitlements? I don't know the answers*'. (HCA).

Upon arriving in the ISTC, their concerns about employment insecurity were exacerbated with managers making it clear that these groups were '*unqualified*' and easily replaced. Although managers engaged HCAs, at with others, to promote the underlying ethos of care, they seemed less concerned with supporting their transition or changing attitudes. Instead,

expectations around new working practices, shift patterns and alignment with service values were linked to employment security. At the same time, the additional HCAs were recruited directly from the private sector thereby creating a sense of internal competition for roles. As such, HCAs were confronted with a relatively hostile and stark environment that offered little choice or scope for influence.

> '*There are two groups, there are people who work for the ISTC and the people that worked for the NHS…the people who work for the ISTC have always worked privately so they think they are better than us…they treat you like a second class citizen*' (HCA)

Although HCAs shared the concerns of nurses, their precarious employment offered limited scope to re-create NHS customs or challenge ISTC practices. HCAs' lack of professional status and shared standards of work meant it was difficult to find common arguments or principles around which resist ISTC managers. As such, HCAs showed little inclination to change their circumstances and, overtime, most appeared to accept and adopt the ISTC approach by adhering to expected behaviours. This did not involve an unquestioning acceptance of ISTC values, but rather a form of superficial imitation, where they gave the impression of change, but still harboured resentment. This enabled HCAs to survive in the new environment but to still see themselves as distinct.

> '*I just try to fit in. If I was working in another place I wouldn't expect it to be like the NHS and this is what it's like here…it more like the real world*' (HCA)

**Discussion**

The study shows how, like other diasporas, the transfer of public healthcare services and workforces to a private healthcare provider introduces new possibilities or 'spaces' for

cultural hybridity as cultural boundaries and affiliations are disrupted, negotiated and blurred. The study finds little evidence of strong cultural maintenance or complete assimilation, rather different patterns of adjustment, which reflect differences in the migration and resettlement processes, as well as wider inequalities within the healthcare workforce. The proposed model of cultural hybridisation offers a framework for described and explaining these patterns and for offering very tentative propositions about the processes of cultural hybridisation.

For doctors, change might be interpreted as a form of *'acculturation'*, where they sought to learn the values, customs and practices of private healthcare, and to acquire formal membership roles within the new community (Esman, 2008). This path towards integration stemmed from their willingness to embrace the autonomy and commercial opportunities offered by the ISTC, and also ISTC managers' receptivity to doctors, especially their specialist skills. As such, there was a degree of mutual receptivity for both communities that led to doctors to align within and integrate into a more business-like way of working.

> P1: Hybridisation through the acculturation into the host culture is likely where migration is seen as an opportunity to acquire new rewards and sources of meaningful affiliation, and where the host is receptive to the resources and capabilities of the migrant.

For nurses and practitioners, change was a more nuanced, negotiated and led some mutual *'adaptation'*. At first, they maintained separate practices, even recreating customs from the NHS, which stemmed from their reluctance to leave the NHS and concerns about service quality. Change was brought about by ISTC leaders need to engage these professionals, not least for service continuity, and to enrol them into more mainstream practice. As such, managers worked to persuade nurses and practitioners of the standards of care and allowed

some customary practices to continue. This led to *dual-directed* change and mutual blurring at the margins of everyday practice, but this did not undermine the core values.

> P2: Hybridisation through adaptation of both migrant and host cultures is likely where migration is unwelcome but more host and migrant recognise potential challenges to their pre-existing cultures, but where some inter-dependence requires a degree of mutual adaptation to find co-existence

For HCAs, change was less positive or negotiated and might be described as the necessary *'appropriation'* or mimicking of behaviours as a basis of survival in a hostile environment. They exhibited a marginal position within the ISTC where they were neither valued nor able to leave (Weisberger, 1992) and responded by adoption new practices and customs in order to maintain some form of employment. However, the adoption of practice was not deep assimilation but rather shallow or a superficial, i.e. sufficient to maintain employment, as HCAs show little underlying commitment to *either* public or private sector.

> P3: Hybridisation through assimilation is likely where migration is forces and resettlement is negative requiring superficial appropriation of symbolic elements for survival.

The findings reveal how these patterns of cultural hybridity are conditioned or shaped by a number of significant factors that are particularly pertinent to public services, especially were reform involves the transfer of public workforces to the ownership and management of the private sector. First, it highlights the importance of the migration stage as an antecedent to cultural disruption and framing subsequent preferences for interaction. Comparing the three clinical groups there were differences in the *extent of choice* (forced or voluntary), *perceptions of relatively benefit* (positive or negative) and *degree of permanence* (for now or forever). For those with greater choice, reward and flexibility (doctors) the move to the

private sector was less unsettling with interaction offering new possibilities and rewards (and they remain able to opt-out if these opportunities were not forthcoming). For those with little choice, less reward and no flexibility (HCAs, nurses) it was a highly uncertain unsettling transition, resulting in a degree of reticent about interaction and sense of wishing to return 'home'.

Second the findings reveal how resettling or, more broadly, working across sectoral boundaries resembles a negotiated order (Strauss et al 1963) with both 'winners' and 'losers'. Much like other diasporas these negotiations and unequal outcomes were framed by wider social inequalities and status hierarchies (Clifford, 1994). In the case of the ISTC, this was primarily associated with professional status and power, but it is important not to disregard issues of gender and possibly ethnicity. For doctors (mostly white males) integration within the ISTC offer not only liberation from the NHS but also professional advancement, influence in service leadership and financial reward. For nurses, practitioners and HCAs (mostly female and a greater proportion being non-white) there was limited scope for, or inclination towards integration, and they were offered few rewards and only limited influence in service organisation, and some were treated like second-class citizens, especially HCAs. In the absence of other data, the analysis highlights the influence of professional *expertise*, *status* and *cohesion* as linked factors that might account for the differences observed. Specifically, doctors and nurses were privileged by their expert knowledge and specialist contributions the new service. These skilled occupations could not easily be replaced, which necessitated a degree of receptivity and give-and-take on the part of ISTC managers. Those without such skills could, by comparison be treated harshly, and subject to more forceful control, as they could more easily be replaced. Doctors and nurses were also privileged by well-defined and nationally-recognised professional status and membership. Adherence to these professional and ethical standards transcended the specific workplace, with both doctors

and nurses counter new ways of working where they were seen as undermining their professional practice. In contrast HCAs were not able to appeal to national professional codes and found that work organisation at the discretion of local service managers. Stemming from these observations, doctors and nurses were also privileged by a shared sense of identity, togetherness or cohesion around which they could rally and mobilise to advance their collective interests, for example in resistance to unethical practices. In contrast, HCAs lacked professional cohesion or solidarity, remaining relatively individualistic and offering little collective opposition. This in turn made it more possible for managers to more strictly control instances of resistance or opposition.

Extending this line of interpretation, the study reveals aspects of cultural hybridity that were not initially anticipated. The paper set out to understand the hybridisation of sectoral cultures, but the observed patterns of hybridity were more clearly between occupational and business cultures. This was exemplified by the doctors who embraced a more commercial and business-like environment because it might restore their sense of professionalism. Arguably, the history of the medical profession is grounded in the marketplace, not public bureaucracy (Freidson, 1970), and many doctors continue to work outside of the public NHS. As such, relocating to the private sector was interpreted for some as a return to professionalism; which turns the idea of a diaspora on its head (see below). The blurring between professional and business cultures was also seen with nurses. Although they maintained affiliation to public sector values, they were guided primarily by professional standards of care. Even HCAs showed little commitment to the public sector, but rather to sense of employment security. The study tentatively suggests the conceptualisation of an overarching public sector 'culture' is possibly overstated, with only limited salience in contemporary public service organisation. This might reflect nearly three decades of management-inspired reform and commercialisation (Boyne, 2002). However, it might also suggest that what is often described

as ‘public sector culture’ is more often a result of the motives, values and norms of ‘public professionalism’ whereby professional socialisation and collegiality provides the overriding sense of affiliation and identification, over and above organisation or sector (Perry, 1997; McDonough, 2006). This does not undermine the analytical utility of the diaspora metaphor or model, but suggests the sources of cultural hybridity might be broader than sector.

At the outset, the paper suggested contemporary public service reforms might be interpreted as involving a *public sector diaspora*. This metaphor offers a relatively novel and theoretically-rich approach for analysing cultural hybridisation (sectoral or professional). It might be questioned, however, whether this case study, or other instances of reform, qualify as a diaspora. For example, the doctors in this study retained a form of ‘dual-citizenship’ and seemed to be returning to, not leaving, their market homeland. It might be argued, therefore, the diaspora metaphor does not necessarily apply to the types of migration associated with privatisation, contracting-out or inter-sectoral working. It is important to reiterate that in this paper diaspora is conceived in terms of dislocation, adaptation and hybridity, rather than fixed cultural boundaries or ‘homeland’ (Brubaker, 2005; Clifford, 1994). In line with contemporary cultural theory, the diaspora metaphor draws attention to the ‘in-between’ spaces involved during displacement and movement. This means that prior experience of other places (sectors) does not undermine the metaphor, but rather these experiences or affiliations need to be considered in the analysis. For example, many population movements involve ‘early movers’ who settle in advance of the wider community, and also those who move between territories in the form of ‘tourists’ or ‘ambassadors’ (Cohen, 2008). In short, the diaspora concept is not used to describe cultural affiliations to home, but rather to explore the possibilities for change found in the in-between spaces of dislocation and re-settlement.

Accepting the above point, there is scope to test the idea of a public sector diaspora, both as a metaphor and for analysing cultural hybridity. The study reports on a single service case

study within the English health sector. Further research might consider instances of privatisation or inter-sectoral working in other services areas, such as social care, education or transport. Equally, it might also be possible to apply the proposed model to other analytical levels of public service hybridity, especially role-based hybridity such as professional-managerial hybrids (Noordegraff, 2007; Waring and Currie, 2009). For example, it might elaborate why actors move into these roles and how they interact with different communities thereby negotiating their affiliations and boundaries. The study also raises novel questions for those managing the transfer of services across sectoral boundaries, which might also be the focus of subsequent research. The key dilemmas for public 'sector' leaders relate to the antecedents of migration, and how they might reduce anxiety and uncertainty. In this study, contractual arrangements were presented as a *fait accompli* with little choice, except for certain powerful groups. Managers might consider ways of engaging staff in decision-making or how to prepare them for the move. Private sector leaders face parallel issues, especially for maintaining service continuity despite the uncertainty of change. This might involve activities to rapidly transition and resettle staff before to making more incremental changes. The study also highlights the value of inducements and incentives for change, which can help garner staff support. A further consideration might be to develop relevant exit strategies to transition workers back to the public sector or other organisations. This is likely to be complicated by prevailing employment regulations, but again it represents a relatively new site for public management research (Marchington et al. 2005)

## Concluding Remarks

The paper suggests that contemporary public service reforms might be interpreted as involving a *public sector diaspora* and presenting new possibilities for *cultural hybridity*.

This idea reflects evidence that reforms are increasingly based upon the transfer of public sector organisations and workforces to private ownership and management. In line with contemporary cultural theory, diasporas are conceptualised, less as boundary maintenance or commitments to homeland, and more as dislocation, adaptation and hybridity (Clifford, 1994). The in-between or liminal 'space' associated with diaspora create possibilities for cultures to interact, adapt and blur. Drawing on these ideas, the paper proposes a model of cultural hybridisation that accounts for the antecedents of migration and the interactions of resettlement as a means of examining cultural hybridity. Applying this model to contemporary reforms within the English NHS, it suggests that the idea of cultural hybrid at the inter-sectoral level is complicated by the persistence of occupational cultures and hierarchies within the public service workforce. These result in a varied picture of culture hybridity based, less on inter-sectoral hybridity and more on business-professional hybridity. These new instances of hybridity can, for some, involve new opportunities for liberation or advancement, whereas for others they represent more oppressive regimes. The paper suggests the proposed model remains useful as a heuristic device for analysing both the spaces of diaspora and the interactions involved in cultural hybridisation.

**References**

Ackermann, A. (2012) 'Cultural Hybridity: between metaphor and empiricism' in Stockhammer, P. (ed.) *Conceptualizing Cultural Hybridization*, Berlin: Springer.

Alcock, P. (2010) "Building the Big Society: a new policy environment for the third sector in England" *Voluntary Sector Review*, vol.1(3), pp.379-89

Bate, P. and Robert, G. (2006) ‘‘Build it and they will come’ – or will they? Choice, policy paradoxes and the case of NHS treatment centres’, *Policy and Politics*, vol.34(4), pp.651-72.

Berg, A. (2006) ‘Transforming public services – transforming the public servant’ *International Journal of Public Sector Management*, vol.19(6), pp.556-568.

Berry, J. (1997) ‘Immigration, acculturation and adaptation’ *Applied Pyshcology*, vol.46, pp.5-68

Berry, J. (2005) ‘Accultration: living successfully in two cultures, *International Journal of Intercultural Relations*, vol.29, pp.697-712.

Bhabha, H. (1994) *The Location of Culture*, London: Routledge.

Billis, D. (2010) ‘Towards a theory of theory of hybrid organisations’, in Billis, D. (ed.) *Hybrid Organisations and the Third Sector*, London: Palgrave Macmillan

Boardman, A. and Vining, A. (2012) *A Review and Assessment of Privatization in* Canada, School of Public Policy Research Paper, University of Calgary.

Boyne, G. (2002) ‘Public and private management: what’s the difference? *Journal of Management Studies*, vol.39, pp.97-122.

Brubaker, R. (2005) ‘The “diaspora” diaspora’ *Ethnic and Racial Studies*, vol. 28(1), pp.1-9.

Clifford, J. (1994) ‘Diasporas’ *Cultural Anthropology*, vol.9(3), pp.302-338.

Cohen, R. (2008) *Global Diasporas: an introduction*, London: Routledge.

Cooke, F., Hebson, G. and Carroll, M. (2005) ‘Commitment and identity across organizational boundaries’ in Marchington, M P., Grimshaw, D., Rubery, J., Willmott, H.

(2005) *Fragmenting Work: Blurring Organisational Boundaries and Disordering Hierarchies.* Oxford University Press.

Department of Health (2010) *Equity and Excellence*, London: TSO

Department of Health (2005) *Treatment Centres: delivering faster, quality care and choice for patients*, London, TSO

Esman, M. (2009) *Diaspora in the Contemporary World*, Cambridge: Polity Press.

Evetts, J. (2003) 'The sociological analysis of professionalism' *International Sociology*, vol.18(2), pp.395-415.

Ferlie, E.Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996) *The New Public Management in Action*, Oxford: Oxford University Press

Ferlie, E., Fitzgerald, L., McGivern G., Dopson, S. and Bennett, C. (2013) *Making Wicked Problems Governable?*, Oxford: Oxford University Press.

Fortier, A. (2000) *Migrant belongings: memory, space, identity*, Oxford: Berg.

Hall, K., Miller, R. and Millar, R. (2012) 'Jumped or Pushed: What Motivates NHS Staff to Set up a Social Enterprise?' *Social Enterprise Journal*, 8(1), pp. 49-62.

Hodge, G. and Greve, C. (2007) 'Public-Private Partnerships: an international performance review' *Public Administration Review*, vol.67(3), pp545-58.

Gabbay, J., Le May, A., Pope, C., Robert, G, Bate, P and Elston, M. (2011) *Organisational Innovation in health services*, Bristol: Policy Press.

Greek Ministry of Finance (2013) 'Greece announces privatisation plans' *Hellenic Republic Ministry of Finance,* (http://www.minfin.gr/portal/en/resource/contentObject/id/2f09efef-f916-4450-8236-de0606f1e12d). [accessed February 2014]

Hebson, G., Grimshaw, D. and Marchington, M (2003) 'PPPs and the changing public sector ethos: case study evidence from health and local authority sectors *Work, Employment and Society*, vol.17(3), pp.481-501.

Hodge, Graeme A. and Carsten Greve. 2009. PPPs: the passage of time permits sober reflection. *Economic Affairs*, 29(1), pp.33-9.

Hood, C. (1991) 'A public management for all seasons?' *Public Administration*, vol.69, pp.3-19.

Kalra, V., Kaur, R. and Hutnyk, J. (2005) *Diaspora and Hybridity* , London: Sage.

Lo, S. (2002) 'Diaspora Regime into Nation: mediating hybrid nationhood in Taiwan, *Diasporic Communication*, vol. 9(1), pp.65-84.

Lobell, S. and Mauceri, P. (2004) *Ethnic Conflict and International Politics*, London: Palgrave.

Marchington, M P., Grimshaw, D., Rubery, J., Willmott, H. (2005) *Fragmenting Work: Blurring Organisational Boundaries and Disordering Hierarchies.* Oxford University Press.

McDonough, P. (2006) 'Habitus and the practice of public service' *Work, Employment and Society*, vol.20(4), pp.629-647.

Milward, H. (1994). 'Implications for contracting out: New roles for the hollow state', in P. Ingraham, B. S. Romzek et al. (Eds.) *New paradigms for government: Issues for the changing public service* , San Francisco: Josey-Bass.

Noordegraaf, M. (2007) 'From 'Pure' to 'Hybrid' professionalism'. *Administration and Society,* 39(6), 761-85.

Oliver, A. and Montgomery, K. (2000) 'Creating hybrid organizational forms from parental blueprints: the emergence and evolution of knowledge firms' *Human Relations*, vol.35(1), pp.35-56.

Ovretveit, J. (1996) 'Beyond the public-private debate: the mixed economy of health' *Health Policy*, vol.35, pp.75-93.

Perry, J. (1997) 'The antecedents of public service motivation' *Journal of Public Administration Research and Theory*, vol.7(2): 181-87

Perry, J. and Wise, L. (1990) 'The motivational base of public service' *Public Administration Review*, Vol. 50:3, pp. 367-373.

Pieterse, J. (2001) 'Hybridity, so what?: The anti-Hybridity Backlash and the Riddles of Recognition' *Theory, Culture and Society*, vol. 18, pp.219-45.

Pieterse, J. (2004) *Globalization & Culture. Global Mèlange.* Oxford: Rowman

Pratchett, L. and Wingfield, M. (1996) 'Petty bureaucracy and woolly minded liberalism? The changing ethos of local government officers' *Public Administration*, vol.74(4), pp.639-656.

Pratt, M., Rockmann, K. and Kaufmann, J. (2006) 'Constructing professional identity: the role of work and identity learning cycles in the customization of identity among medical residents' *Academy of Management Journal*, vol.49(2), pp.235-262

Rondeaux, G. (2006) 'Modernizing public administration: the impact on organisational identities' *International Journal of Public Sector Management*, vol.19(6), pp.569-584.

Safran, W. (1999) 'Comparing diasporas: a review essay' *Diaspora*, vol.8(3), pp.225-307.

Savas, E.S. 2000. *Privatization and Public Private Partnerships*, New York: Seven Bridge Press.

Smith, K. and Leavy, P. (2008) *Hybrid Identities: Theoretical and Empirical Examinations*, Leiden: BRILL.

Stackman, R., Connor, P. and Becker, B. (2006) 'Sectoral Ethos: An Investigation of the Personal Values Systems of Female and Male Managers in the Public and Private Sectors' *Journal of Public Administration Research and Theory*, vol.16(4), pp.577-597.

Strauss, A., Schatzman, L., Ehrlich, D., Bucher, R. and Sabshin, M. (1963) ' The hospital and it's negotiated order', in Freidson, E. (ed.) *The Hospital in Modern Society*, New York: Free Press.

Strauss, Anselm and Julia Corbin. 1998. *Basics of qualitative research*, London; Sage.

Strangleman, R. and Roberts, (1999) 'Looking through the window of opportunity: The cultural cleansing of workplace identity, *Sociology*, 33, 1, 47-67.

Stephenson, N. (2003) *Cultural Citizenship*, Maidenhead: Open University Press.

Stross, B. (1999) 'The hybrid metaphor: from biology to culture' *Journal of American Folklore*, vol.112(45), pp. 254-67

Turner, S., Allen, P., Bartlett, W. and Perotin, V. (2011) 'Innovation and the English National Health Servuce: a qualitative study of the independent sector treatment centre programme' *Social Science and Medicine*, vol.73(4), pp.522-9.

Waring, J. and Currie, G. (2009) 'Managing expert knowledge: organisational challenges and managerial futures for the UK medical profession' *Organization Studies*, vol.30(7), pp.755-778.

Weisberger, A. (1992) 'Marginality and its Directions', *Sociological Forum,* vol.7(3), pp.425-446.

Yao, S. (2003) 'Taxonomizing hybridity' *Textual Practice*, vol.17(2), pp.357-78.

Young R. (1995) *Colonial Desire: hybridity in theory, culture and race*, London: Routledge/