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Nigel D. CADWELL
Heriot Watt University

Jens K. ROEHRICH
University of Bath

Gerard GEORGE
Singapore Management University, ggeorge@smu.edu.sg

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Social Value Creation and Relational Coordination in Public-Private Collaborations

Nigel D. Caldwell, Jens K. Roehrich and Gerard George

Heriot Watt University; University of Bath; Lee Kong Chian School of Business at Singapore Management University

ABSTRACT Public-private collaborations, or hybrid organizational forms, are often difficult to organize because of disparate goals, incentives, and management practices. Some of this misalignment is addressed structurally or contractually, but not the management processes and practices. In this study, we examine how the coordination of these social and work relationships, or relational coordination, affects task performance and the creation of social value. We employ a dyadic perspective on two long-term relationships that are part of a wider ecosystem. We illustrate the social value creation process, identifying mutual knowledge and goal alignment, as necessary to create relational coordination. We find that the degree of professional embeddedness moderates the link between coordination and task performance, and explore the role that organizational and ecosystem experiences play. We develop a model of how relational coordination influences social value creation in hybrids. The findings have implications for social value creation, hybrid collaborations, and organizational design.

Keywords: healthcare, hybrid organizational forms, public-private partnerships, relational coordination, social value creation

INTRODUCTION

Value creation is at the core of management research and practice, central to utilizing public-private collaborations is that value will be created that could not have been achieved by either party acting independently. Value in public-private ties is broadly defined as the sum or entirety of benefits obtainable from the exchange (Kivleniece and

Address for reprints: Jens K. Roehrich, HPC Supply Chain Innovation Lab, Information, Decisions and Operations Division, School of Management, University of Bath, BA2 7AY, UK (j.roehrich@bath.ac.uk).

Nigel D. Caldwell and Jens K. Roehrich have contributed equally to this paper.

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Quelin, 2012). The private sector literature on organizational alliances and partnerships views value creation in relational terms, and suggests that collaboration generates opportunities where organizational resources and capabilities can be pooled to create new sources of value (Dyer and Singh, 1998; Dyer, 1997; Poppo et al., 2008; Priem, 2007). Yet extant literature on public-private collaborations offers limited insights into the mechanics of how social value is created.

Social value creation in hybrid organizational forms is a significant problem because the odds are stacked against success, with alliances reported to be statistically more likely to fail than to succeed (Kale and Singh, 2009; Park and Ungson, 2001). Yet the growing literature on public-private partnerships (PPPs) (Boyne, 2002; Kivleniece and Quelin, 2012; Mahoney et al., 2009) only reflects governments' optimistic choices as PPPs are increasingly utilized around the world. Social value is created when the hybrid organizational form generates positive societal outcomes beyond that created by either actor working alone or within its sector. There are many positives for why a hybrid collaboration may outperform either sector acting alone such as: the value of networking (Le Ber and Branzei, 2010; Lepak et al., 2007; Tsai and Ghoshal, 1998), complementary resources (Madhok and Tallman, 1998), and being able to address bigger societal agendas (Klein et al., 2010; Pitelis, 2009).

The issue then for a hybrid collaboration is how to coordinate and align performance across public and private partners, characterized by, for instance, different knowledge bases, divergent goals and (public and private) values, and stark differences in organizational experience; only with highly effective coordination then can a hybrid claim to exceed within sector value creation (Carlile, 2004; Kivleniece and Quelin, 2012). For example, Rangan et al. (2006) suggest that a PPP creates a context with high governance costs from contracting, coordinating, and enforcing – primarily due to misaligned goals, incentives, and organizational practices. Existing literature recommends deploying either a contractual or relational perspective for coordination, or combining both; with arguably a tendency toward the contractual elements (e.g., Ariño et al., 2014; Puranam and Vanneste, 2009). However, given the long-term nature of these contracts and the unpredictability of the contexts in which they operate, contracts may be necessarily incomplete and cannot fully mitigate the risks of under-performance of either (public or private) party (Roehrich and Lewis, 2014). Thus, there is a need for coordination of the relationship itself such that the public-private collaboration could successfully adapt to emergent constraints during the tenure of the contract. In addition, there is a further inherent tension between creating value for the community or society at large (i.e., social value) and the rents that can be appropriated by the private firm (i.e., economic value). An overt focus on economic value, even if contractually appropriate, might create tensions with the public partner when decisions are needed to accommodate changing policy environments. In such cases, we expect that hybrids that can effectively coordinate relationships, might be able to counterbalance contractual incompleteness.

Thus, this study seeks to answer the following research question: *How are public-private collaborations coordinated to create social value?* To address this question we examine public-private collaborations operating under the umbrella of a national ecosystem of PPPs. By examining the dyadic level of analysis, we offer a yet underexplored perspective on social value creation (Mahoney et al., 2009). More specifically, we investigate two long-

term PPPs in the UK healthcare sector. The two public-private collaborations both have an equivalent value of 150 Million British Pounds over a 30 year tenure. The two case studies are supplemented with 42 interviews resulting in 1,285 transcribed pages, and provide a rich perspective of the relational dynamics in these two public-private collaborations.

The study offers three distinct contributions. First, we propose that to create social value in hybrid organizational forms, relational coordination over and above contractual safeguards is necessary, and that relational coordination is the outcome of mutual knowledge and goal alignment. Second, in public-private collaborations we propose the level of professional embeddedness critically impacts task performance in terms of professionals' engagement with task performance and also that professionalization creates a tacit context not always accounted for. Healthcare professionals in particular possess specific knowledge of processes and context (Kyriatsis et al., 2016) which is vital to drive task performance in hybrids, but needs to be effectively exploited in the public-private relationship. Third, we identify an 'experience' effect where two levels of experience, organizational and ecosystem, influence social value creation in hybrid organizational forms.

THEORY

Public-private collaborations are largely designed, managed, and run by professionals from both sectors, yet the role of individuals and how they may influence processes and actions has been largely ignored in extant studies (Schillebeeckx et al., 2016). One of the key challenges to create social value must then be to coordinate working, not just across public and private sectors, but managing highly professionalized individuals working across professional boundaries, and the need for mutual knowledge. Mutual knowledge is knowledge that the communicating parties share in common and know they share (Cramton, 2001; Kotha et al., 2013). Mutual knowledge in inter-organizational relationships is vital as it increases the likelihood that communication will be understood and enables individuals and organizations to act as if they can predict others' actions (Hoopes and Postrel, 1999; Puranam et al., 2012). Thus, without effective communication there will be problems with relational coordination – the management of task interdependencies in the context of relationships (Gittell, 2001). '[M]utual knowledge is considered to be a precondition for effective communication and the performance of cooperative work' (Cramton, 2001, p. 349) and a lack of mutual knowledge impacts negatively on working relationships (Carlile, 2004).

Why then in a healthcare PPP should mutual knowledge be any more of an issue than in any collaboration? In terms of relational coordination the problem is that the public partner, certainly in healthcare, has strong and multiple professional identities and cultures (Kyriatsis et al., 2016), and each will have its own professional language, making healthcare public-private relationships an interesting context to study. Indeed one key way of improving mutual knowledge is through direct knowledge (Cramton, 2001); first hand observation, having the same experiences, going to the same meetings. But what if the private partner has multiple contracts and frequently moves personnel between sites? Personnel turnover (Carley, 1992) is very common in the construction

industry which historically has always specialized jobs, a potential obstacle to building up mutual knowledge and relationships.

The second element of relational coordination necessary to create social value in a hybrid collaboration, is the need to align the goals of partners from different sectors (Carlile, 2004; Gulati et al., 2012). Yet predictably the partners enter the hybrid with outcome misalignment, which means that expectations regarding the product or service to be achieved are not shared across organizations. A private organization's goals can be defined in terms of continuing existence and exploiting some form of gains from the joint efforts of their individual members (Puranam et al., 2014). Regarding value, one key difference in comparing public-private relationships to purely private ties, is that public-private relationships consciously entail not only private value for the dyad, but also broader, diffused social benefits and costs to the society at large (Brinkerhoff and Brinkerhoff, 2011). Thus, professional healthcare staff will have an expectation for example that they deliver a service that is egalitarian, and that offers equality of access, and where speed is not a primary concern.

Private value, in contrast, is predicated on economic or monetary values with often a short-term focus, in construction quick mobilization, quick deployment, and on to the next site is a key driver of profit, the paraphernalia of relationships threatens that speed of response. Where outcomes can be aligned is through the private partner's need for a good reputation in the 'place between market and government' those corridors where key figures are senior politicians (Wood and Wright, 2015, p. 280). There is also a potential temporal misalignment between the timeframes of healthcare professionals and for example their 'bottom up culture' which essentially emphasizes consensual decision making at the expense of speed (Flier et al., 2003). Public agents such as healthcare professionals are actively involved in hybrid arrangements to pursue broader societal goals (Cabral et al., 2013). Temporal alignment is needed to ensure that phasing of efforts across public and private partners is understood across both partners. Thus, private and public organizations should develop a clear understanding of each other's goals and develop mutual knowledge to drive value creation.

The aim of the private sector is to appropriate created value via rents and the aim of public organizations is to create appropriable value for beneficiaries (Klein et al., 2010). Thus, given the sectors' different goals and incentives (to create social versus private value), the alignment of goals to bridge partners' diverging and misaligned interests, and mutual understanding, is needed to drive relational coordination in public-private relationships (Boyne, 2002). Coordination, in the form of inter-personal relationships and contracts, will drive the level of task performance outcome achieved when interdependent actors from public and private sectors come together (Park and Ungson, 2001; Puranam and Vanneste, 2009). Thus, the ability of interdependent actors to coordinate actions stems from mutual knowledge and goal alignment. Relational coordination is vital to achieve task performance (Gully et al., 1995; Wood, 1986) which then drives social value creation.

Hybrid relationships are characterized by professionals and their embeddedness – the structure of interconnection surrounding a relationship (Chua et al., 2008) – or the level of engagement with the public-private relationship. In sectors such as healthcare, professionals in the form of doctors and nurses may offer a tacit understanding of the hybrid

relationship's context which is needed to achieve task performance (Erez and Kanfer, 1983; Harrison et al., 2002). Healthcare PPPs in the UK (the study's context) are seen as one segment of an on-going, national ecosystem of PPPs with an ambitious value creation agenda. The UK healthcare sector has seen the establishment of a myriad of large-scale PPPs between 1990 and 2009, constituting a government-initiated drive to stimulate value creation across the healthcare sector (Hutton, 2004). The wider ecosystem and the number of PPPs in the healthcare sector and other sectors such as education and transportation allows organizational experience for public and private partners to accumulate (Argote and Miron-Spektor, 2011). Experience may help social value creation by effectively developing routines and processes (Vural et al., 2013).

RESEARCH SETTING

Public-private interactions led the way to create various hybrid organizational arrangements including cross-sector partnerships and public-private partnerships (e.g., Le Ber and Branzei, 2010; Roehrich et al., 2014). These public-private relationships are defined as 'any long-term collaborative relationships between one or more private actors and public bodies that combine public sector management or oversight with a private partner's resources and competencies for direct provision of a public good or service' (Kivleniece and Quelin, 2012, p. 273). Public-private collaborations are now a global phenomenon and the UK has led the world in deploying them. For instance, in the UK, over 650 PPPs for hospitals, schools, bridges, and roads are deployed, accounting for a value of over £60bn (H.M. Treasury, 2016).

The study investigates the UK healthcare sector as it constitutes the sector with the highest number and value of PPP contracts let apart from transportation (H.M. Treasury, 2016). The healthcare sector is considered as suffering market failure (McKee et al., 2006), and constitutes a sector where key social values are created. These social values may range from operational efficiency in delivering medical services, care-giving, and maintenance services to design efficiency in new build hospitals. The selected PPPs are characterized by their long-term nature, spanning 30-years of public-private collaboration, and by a multiplicity of actors involved such as various government bodies, construction, and facilities management (FM) companies, technical and financial advisors, and banks (Barlow et al., 2013). The principal parties of PPPs are a public organization, for instance, a National Health Service (NHS) Trust or a council and a private organization such as a construction company. The private organization is responsible for design and build of the hospital and subsequently delivers FM services including upgrades, catering, and cleaning throughout the operate phase.

RESEARCH METHODS

Research Approach and Case Selection

Our study seeks to elaborate theory in public-private relationships utilizing an in-depth multiple case study approach, aiming to identify explanations of complex phenomena in their natural context (Eisenhardt and Graebner, 2007). The majority of existing studies

Table I. Overview of key case characteristics

	<i>General Hospital</i>	<i>Specialized Hospital</i>
Primary public-private relationship	NHS Trust – construction company; construction of new health infrastructure and service delivery	NHS Trust – construction company; construction of new health infrastructure and service delivery
Financial close	1998	2004
In operation since	2002	2006
Contract value and length	approx. £150m; 30 years	approx. £150m; 30 years
Case background	<ul style="list-style-type: none"> • Prior hospital offered very limited healthcare capacity. • Steadily increasing demand on the old town center hospital. • New hospital to centralize a few other health facilities into one large hospital. 	<ul style="list-style-type: none"> • New children’s hospital adjacent to NHS hospital. • Shortfall in the standard of basic healthcare services, thus effecting the provision of healthcare services. • Existing financial constraints led the NHS Trust to assess PPP procurement route.

on social value creation offer limited analysis of the roles of relational coordination and professional embeddedness at a dyadic level. This study provides a detailed and systematic analysis across two long-term healthcare PPPs (Table I) which were purposively and theoretically sampled (Shah and Corley, 2006). The sampling logic follows Pettigrew’s (1990) suggestion to select polar types (high and low performing relationships in terms of social value being realized) and that in order to investigate cases in-depth, one or two detailed cases are sufficient.

The investigated cases had a number of unique qualities that made them logical candidates for sampling. First, both PPPs are sampled based on their differences regarding approaches to, and outcomes of, social value. The research design and sampling logic followed Langley’s (1999) recommendations, ensuring that both cases were set far enough apart in time (roughly a decade) to ensure the research picked up on strategic changes to PPPs. Although, inevitably, the two relationships differ in some aspects, they were both established public-private relationships and had reached the service delivery phase at the time of the research (i.e., the hospitals were in operation). More specifically, General Hospital (GH) was initiated at the beginning of the UK healthcare PPP initiative in the mid-1990s. Second, the same private sector organization delivered both hospitals, but working with two separate public organizations (i.e., NHS Trusts), aiding understanding of possible changes in creating and capturing social value in the dyad. Third, primary and secondary datasets were collected by following both dyads over time, thus offering a unique opportunity to investigate social value. As both public sector organizations are legally required to be transparent and accountable for their actions, extensive documentation is available in the public domain, and the study was complemented by secondary material such as organizations’ internal reports and presentations, and government reports (Suddaby, 2006). All fieldwork was conducted while the PPPs

Table II. Additional examples of data

Themes	Sub-dimension	Representative quotes
1. Relational Coordination	Mutual Knowledge Goal alignment	<p>General Hospital (GH)</p> <p>‘How should we build up any relationship with them [private partner] or exchange valuable information if there are always some new people on the team? [...] I did not really feel that, for instance, the team that built the hospital talked to the design team or the operate team. [...] you constantly need to figure out who is in charge at this particular moment in time [...]’. (Project Director, PuP)</p> <p>‘For them [PrP], it was mainly about making money and building the hospital as quickly as possible so that we get in and pay “rent”. [...] For us it is important to deliver high quality medical services effectively to our patients’ (Head of Estate, PuP).</p> <p>Specialized Hospital (SH)</p> <p>‘The healthcare sector is very specific and we definitely understand that we need them [healthcare professionals] as much as they need us. [...] For instance, the night sly or linking corridor innovations were really only possible when better understanding what they need to effectively deliver medical services.’ (Project Manager, PrP)</p> <p>‘Having a high-quality hospital is key here as we need to think about our patients and delivering high-quality medical services over the next 30 years or so. [...] It did take some time, but they [PrP] do now much better understand our position thanks to regular meetings and information exchange.’ (Project Director, PuP)</p>
	Professional embeddedness	<p>‘There are some very innovative methods we brought to this hospital. For instance, you now have motorized maintenance equipment which helps to clean the hospital much faster and to a much higher standard. [...] This only became possible when talking to staff [PuP] to understand how often the hospital needed to be cleaned and which areas were most important to clean even more frequently. [...] You need to develop an understanding and I guess appreciation too of what they [medical professionals] are doing here’ (General Manager, PrP).</p> <p>‘We needed to set up some joint workshops with them [PrP] to develop some joint understanding of what was needed from a medical perspective. In hindsight, we should have set up these workshops much earlier’ (Senior Nurse A, PuP).</p> <p>‘We also have a linking corridor here in this hospital with three different levels to combat infections etc. One level for patients, one for clinical staff and one for visitors. I think this is very innovative. [...] This was only possible after some senior nurses and doctors talked us through how a hospital operations on a daily basis and the fact that infections are one of the key priorities to tackle here’ (Project Manager, PrP).</p> <p>‘I think we had to translate our demands in much clearer, simpler language to them [PrP’s management team]. For example, they did not understand a particular disease and what is needed in the hospital. So we basically sat down with them and explained what is needed including the patient pathway through the hospital’ (Senior Nurse A, PuP).</p>

Table II. Continued

Themes	Sub-dimension	Representative quotes
		<div style="display: flex; justify-content: space-between;"> General Hospital (GH) Specialized Hospital (SH) </div>
3. Experiential Effects	Organizational Experience Ecosystem Experience	<p>‘Our experience gained from other PPPs in the transportation sector definitely helped us. We brought over some of our senior management who previously worked on transportation PPPs and they shared their knowledge with us’ (Project Director, PrP).</p> <p>‘We were one of the first healthcare PPPs in the country. [...] Everything took longer, from contract negotiation which took 5 years to construction to sorting out operational issues at the opening. [...] We could not rely on much outside help’ (Project Director, PuP).</p> <p>‘Innovation? That is difficult to say. [long pause] They are using some motorized cleaning equipment here. That obviously saves time and manpower and helps to keep the hospital clean. Ultimately, this was driven by us [PuP] as they [PrP] were only rushing to complete the construction of the hospital with very limited attention to our needs’ (Head of Estate, PuP).</p>
4. Professionals Drive Task Performance	Social value creation	<p>The ceiling lighting was quite innovative, mimicking a night sky [...] This was something driven by my colleagues because we thought about our young patients and how we could best treat them. [...] It definitely adds to a much more pleasant treating environment for our patients’ (Senior Nurse B, PuP).</p> <p>‘They [healthcare professionals] did help us a lot in improving the hospital design. As an example, the linking corridor was a great idea initiated by one of their medical teams. [...] It really helped to mitigate risks for infections. [...] We also have now installed this in another PPP hospital’ (Project Manager, PrP).</p>

were 'live developments', to capture real-time data on decisions, perceptions, and expectations.

In General Hospital case, both public and private partners possessed very limited experience in contracting for and managing PPPs. The PPP was governed by a tailored contract between the public partner (PuP), an NHS Trust, and the private partner (PrP), a construction and FM company. Both parties took nearly five years to negotiate a detailed agreement addressing multiple governance issues ranging from regular reporting and information sharing, performance measuring, auditing to dispute resolution procedures. There are accompanying agreements, such as equity and loan agreements that govern the multiplicity of different relationships with, for instance, banks, in the wider PPP network. The Specialized Hospital (SH), a children's hospital adjacent to a general hospital, was established in the early 2000s. This hospital was governed by a centrally provided contract, customized via a 2.5-year negotiation process. The private partner had in the meantime acquired substantial experience in delivering healthcare PPPs, having been successful in securing a number of other PPPs. For the NHS Trust (public partner) in SH case this was their first PPP.

Data Collection and Analysis

Two of the authors followed both PPPs over five years, conducting 42 semi-structured, face-to-face interviews with different key stakeholders (Appendix A). Overall, interview recording resulted in 1,285 pages of interview transcription. A network of organizations are involved in these PPPs including but not limited to the public and private organization, nurses, and consultants, calling for interviews involving different perspectives. Each of the PPPs investigated spanned up to 14 years and interviews were guided by an interview protocol. In order to circumvent validity and reliability problems, a number of techniques were deployed that helped to overcome bias introduced by the respondents' memory lapse and distortion (Gibbert et al., 2008). For instance, these included: building the narrative from the account of diverse interviewees from public and private partnering organizations, different organizational hierarchy levels, multiple functional areas, and across a relationship's history. Also, the study relied on organizational documents and relevant secondary data from government sources, professional associations, and media.

Data collection and analysis processes were conducted in parallel based on how data matched existing or emerging understanding of the phenomena under study (Strauss and Corbin, 1990). This 'ground-up' approach helped to develop theory which is closely linked to our rich datasets (Golden-Biddell and Locke, 1997). Initial findings were presented in two 30 page case reports which formed the basis for subsequent discussions with key informants to verify accuracy. Analysis included broader codes such as case organization, background information, and more specific codes zooming in on the concepts under study such as relational coordination and professionals' engagement levels. Our data analysis process followed recommendations by Strauss and Corbin (1990). First, the researchers separately created a list of first-order codes based on extant literature. Where this process identified differences, the researchers jointly worked on the discrepancies until finalizing a working scheme of codes to individually recode the first case

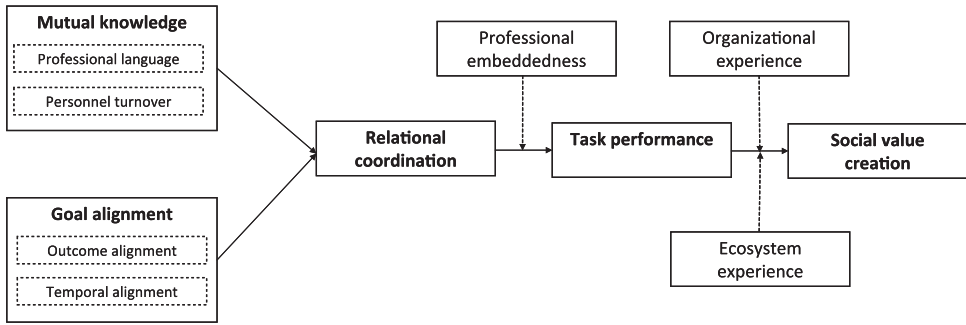


Figure 1. Social value creation in public-private hybrids

and then code the second case. The researchers also added to the coding scheme practices that arose from the data analysis but which had not appeared in extant literature. Coding was not finalized until consensus had been reached on each construct and the process forced 100 per cent interrater reliability. The continuous reappearing of findings and verification of comprehension throughout the analysis stage signified that saturation was reached. The analysis focused on investigating patterns across both public-private dyads.

RELATIONAL COORDINATION IN PUBLIC-PRIVATE HYBRIDS

We wanted to understand how public-private collaborations embedded in an ecosystem of similar collaborations organize to create social value. As we analysed our data from the cases, repeatedly we found relational coordination, which impacts task performance and social value creation, but for relational coordination to be operational, two key factors, namely goal alignment and mutual knowledge, needed to be present (Figure 1). Below we present our findings organized by the core themes (please see further data examples in Table II).

Mutual Knowledge

Professional language. Findings indicated that a gap existed in mutual understanding between key professionals (i.e., public sector's healthcare professionals and private partner's management) in the General Hospital. For instance, Senior Nurse A (PuP, GH) mentioned that: 'We [nurses and doctors] felt quite often talked at rather than listened to with regards to the hospital design. We brought forward a number of ideas of how to best design the new hospital to mitigate, for instance, infection risks and further improve the patient environment'. This observation was supported by the Commercial Director (PrP, GH): 'I do not really see much value in involving doctors and nurses in the design. They mainly want more things, do not really understand the cost implications, and cause further time delays'. This limited mutual understanding led to frustrations in General Hospital: 'I quite often felt that I should better keep my mouth shut rather than raise my concerns in how best to design the hospital. If it was not written in the contract, it very often was not worth bringing up later' (Senior Nurse B, PuP). In contrast, we see the healthcare professional opinion being sought out and the development of mutual knowledge in Specialized Hospital: 'I think it did take us a while to admit that we are not healthcare specialists

and that we do not have all the relevant knowledge to get all of the hospital design right from the start. Some of the more senior nurses and doctors have helped us in coming up with some nice innovations' [Director of Business Development, PrP]. This was echoed by the public partner's professionals: 'I think it is fair to say that it took a few joint workshops, building up inter-personal relationships, and a bit of pushing for our ideas from our side, but they [private partner] do understand that the healthcare context is very different and probably much more challenging than the sectors they [PrP] worked previously in' [Senior Nurse A, PuP, SH]. Thus, developing a mutual language was important for professionals from both partnering organizations 'to bridge the language barriers' [Project Director, PrP, SH].

Personnel turnover. A constant theme of the interviews was the transient nature of the private sector employee roles – they were constantly being switched between the private partner's other PPPs – i.e., both investigated hospitals were not ever the private partner's sole focus. This was supported by a comment from the Project Manager A (PuP; GH): 'There were so little chances to nurture a relationship with them [PrP] and drive innovation and value creation. [...] The constant team and personnel changes were really disturbing and frustrating to us'. However, essentially the same comment – that the private partner's focus was always on the bigger picture (i.e., the wider PPP ecosystem) of which this particular hospital was only 'a pawn or piece in the wider game' was cogently expressed by Specialized Hospital. 'Although we had a Project Director and two of his Project Managers staying throughout the initial years of the PPP, there was still some high staff turnover from their [PrP] side when compared to us [PuP]. I was really surprised to constantly see a new team coming in [...]' (Project Manager A, PuP, SH). A comment from the private partner confirms that the private partner had to rethink this high staff turnover. 'We did learn in later projects that we should keep a few key people throughout the project phases – from construction to operation. This helped to ensure smoother transitions and an upkeep of key inter-personal relationships' (Project Director, PrP, SH).

Goal Alignment

Outcome alignment. The private partner is only paid once the hospital is in operation, thus the speed at which the new infrastructure would be available was a core driver for the private actor. Quickness included using modularity, in terms of off-site construction of repeatable spaces such as ward blocks. Modularity helped to speed up construction and minimized disruptions in the construction phase which was especially important for SH as it was built adjacent to a fully operating hospital. However, whilst the goal of quick construction was achieved (where the private partner could easily comprehend the potential cost saving build speed brings), several public partner respondents suggested that 'the installed modular spaces were of low quality' (HR Director, PuP, GH). A common theme in the public partner interviews was that in look and feel they 'gave the new site the air of "glorified porta cabins"' (Project Manager B, PuP, GH); yet the private partner felt proud that they had utilized modularity to get the job done quickly and effectively. In contrast, the public organization aimed to 'achieve the best possible quality hospital infrastructure possible to make it a great environment to be a member of staff or a patient' (Senior Nurse B, PuP, SH). The private partner did slightly adjust their approach in the Specialized Hospital: 'We learnt that we needed to ensure that we are "on the same page" with regards to hospital building

and service provision. [...] We did spend some more time in aligning our views [PuP and PrP] during the construction phase' (Project Manager, PrP, GH). Thus, the private partner wanted speed of construction, but the public partner's goal was the patient experience and that the work environment of the hospital supported healthcare delivery.

Temporal alignment. Similar to a misalignment in outcomes, both cases highlighted temporal misalignments. While private sector professionals were focused on 'ensuring that the long-term contract was fulfilled' (Program Director, PrP, GH), the public sector professionals were focused on 'offering high quality medical services in a high-quality hospital' (Senior Nurse A, PuP, SH). The Commercial Manager (PrP; GH) mentioned that: 'It is important to get the hospital up and running as soon as possible and then focus on meeting all contractual criteria of service delivery with regards to portering, cleaning, and maintenance services over the hospital's lifecycle'. In contrast, the public sector aimed to deliver a high-quality hospital which would then 'offer a good healing environment' for their patients. This was supported by Senior Nurse B (PuP, SH) drawing out the fact that 'we tried always very hard to create a high quality hospital, considering the fact that it will need to last us for 30+ years. A nice healing environment is important for our small patients and their parents and we [healthcare professionals] are responsible to make this happen'. This temporal misalignment was recognized by PuP staff once the hospital opened. 'Initially they [PrP] rushed with the construction so much to open the hospital. Now that the hospital is in operation, they seem to be very slow in reacting to possible changes which we need quickly in order to deliver effective services to our patients' (Senior Nurse B, PuP, GH). Across both PPPs, the private partner seems to have come to view alignment as important: 'I think we are taking joint steps to learn about how and when to address certain issues with service provision. [...] I think we are getting closer to be better aligned.' (Commercial Director, PrP, SH).

RELATIONAL COORDINATION AND TASK PERFORMANCE

We observed the importance of relational coordination and professional embeddedness.

Driving Task Performance through Relational Coordination

'We never felt really involved in the design and construction process of the hospital. We were given a tour of the hospital a few days before opening, but had otherwise very limited interaction with them [PrP]' (Finance Director, PuP, GH). After a few early attempts at 'forced socialization' between private and public partners our findings on GH show something of a retreat on both sides into a demarcated relationship. For instance, the private partner without consulting the public partner had included design for expansion by converting office space into additional ward space if required. This demarcation of roles was underlined by a statement from the Program Director (PrP): 'What would they [healthcare professionals] really know and can contribute to the design of the hospital? [...] I think they would just ask for this and that without any consideration of how much this all costs'.

What is apparent in the Specialized Hospital data is a much closer engagement between public and private partner. 'There was definitely some mutual contributions to problem solving and therefore joint innovation and creation of good things in the hospital as we very quickly realized the limitations and gaps in the contract we negotiated' (Project Manager B, PuP). Key individuals met frequently to exchange information, address problems, and discuss future

project milestones. *‘Throughout the construction phase, we had a good working relationship. We ensured office co-location. [...] He is just down the corridor. So instead of sending an email, I walk down to his office and discuss any problems’* (Project Manager A, PuP, SH). Moreover, interviewees reported how both public and private partners ensured that *‘senior nurses and doctors were frequently invited to comment on design plans in the early project phase. During the construction phase, we asked for their input. [...] For example, thanks to their input and telling us how they intend to use wards, we changed the ward layout such as the position of sinks. This may seem to be a minor issue, but may have a huge impact when caring for a patient’* (Project Manager, PrP, SH).

These close cross-sector working relationships extended to service delivery performance. When SH opened, the Director of Business Development (PrP, SH) found that the porters were not at the entrance hall to guide patients and visitors and they were not answering phones. *‘It took as a while to find out what [had] happened. Basically, nurses were using porters to walk patients to different parts of the hospital for their treatments. This meant that porters were sometimes occupied for 30mins and nobody picked up the phone. [...] We needed to sort this out asap and we provided porters with portable radios so that they could be contacted directly. We also sat down with senior nurses to find more suitable ways of walking our patients across the hospital. I think we found an amenable solution now to best utilize the porters’ and nurses’ time most efficiently’*. These examples show a depth of engagement between the public and private partner. The Technical Advisor (PrP, SH) stated that over an 18-month period performance standards had been raised significantly in SH because of the joint working initiatives focused on restructuring the way in which certain medical and non-medical services were provided.

Professional Embeddedness

An example of design enhancement in the Specialized Hospital was a linking corridor designed to combat infection risks through different access levels for patients and their families, nurses and doctors, and service providers. *‘Both organizations worked together during the initial phase to deliver the linking corridor’* (Project Director, PuP, SH). This comment was explicitly supported by the private partner, *‘[...] there were a lot of close working initiatives with the linking corridor’* (Program Director, PrP). *‘We [healthcare professionals] were asked on multiple occasions to provide detailed feedback on the hospital design. This was really helpful as we are the ones delivering medical services to our patients. We discussed together the idea of a multi-layered linking corridor’* (Senior Nurse B, PuP). As the hospital treats susceptible young patients the linking corridor and its three different levels was a very successful innovation; it ensures that young patients are not unnecessarily exposed (e.g., to incoming deliveries) and infection levels are kept at a minimum.

Such openness and collaboration was unique to Specialized Hospital. In General Hospital proposals to improve task performance made solely by healthcare professionals, met resistance. For instance, the Ex-Finance Director (PuP) complained that it was their own initiative and persistence that had pushed through change in the face of disinterest from the private partner. *‘If I were them [PrP], I would be pushing the added value. You just do not get that, it is like pulling teeth. It is taken six months for us to get them interested in putting technology in, the ride-on cleaners. The hospital’s long stretches of corridors are better serviced by these motorized cleaners. This is much cleaner and quicker, less manpower is needed and thus saves money’*.

In the Specialized Hospital, medical staff worked alongside the private partner's project team. A site visit by a couple of senior nurses to a children's hospital in the US led to replicating a ceiling lighting design that mimicked a night sky. *'It might sound like a small change, but it provides a more homely surrounding than the normal NHS lighting. This is important for our young patients and helps them to feel more homely and have a better, less scary, hospital experience which positively impacts on the healing process'* (Senior Nurse A, PuP). *'The first time we heard about the idea of installing a night sky ceiling, we were very supportive of this. It was not specified in the initial contract, but we saw the benefits of having this installed in a children's hospital. We worked closely with them [PuP's project team and medical staff] to ensure all was installed properly'* (Project Director, PrP). The outcome of this healthcare professional driven initiative was greatly received by patients: *'We had so many children and their parents saying to us how great the night sky is. It creates a much nicer environment in which our little patients can recover'* (Senior Nurse B, PuP). The ceiling attracted the attention of the media which the private partner leveraged to create demonstrable photo and PR friendly evidence for potential clients. *'I would be lying if I said that the night sky ceiling was not a great boost for us and our PPP business. This has definitely helped to further secure some contracts'* (General Manager, PrP).

TASK PERFORMANCE AND SOCIAL VALUE CREATION

We observed that social value creation is impacted by organizational experience and ecosystem experience.

Organizational Experience

In GH, the private partner's personnel came with some experience acquired through PPPs in other sectors (transportation), and therefore a pragmatist's confidence that they knew what was needed and could get the job done. Most public partner personnel had never worked in a PPP. This was reflected in the finding that the GH PPP appeared to be run by the private partner, leading to information imbalances and thus that values in the PPP were not equitably distributed. *'The private partner's team was able, with their previous experience, professional knowledge of costs, the relationship between speed and cost in construction, and experience of contractual governance to limit the role of social relationships with the public partner. They [PrP] are very commercially driven and do not always understand our concerns. [...] You really need to build-up inter-personal relationships to solve some problems, but they did not really care'* (Ex-Finance Director, PuP, GH).

By the time the GH contractor built Specialized Hospital, the national PPP ecosystem had been operating for over a decade, and the contractor had *'further practiced and well-honed processes to install PPP infrastructure quickly and cost efficiently as we have acquired substantial experience in the healthcare PPP market and other markets'* (Project Director, PrP, SH). SH was the Trust's first PPP, but their project team was run by a Project Director who transferred from a different healthcare PPP and brought with her another PPP experienced Project Manager.

Ecosystem Experience

The wider PPP ecosystem evolved significantly between the investigated cases. *'We were one of the first healthcare PPPs in the country. [...] Everything took longer, from contract negotiation which took 5 years to construction to sorting out operational issues at the opening. [...] We could not rely on much outside help'* (Project Director, PuP, GH). The early GH carried the risk and uncertainty associated with pioneering. Working with healthcare professionals could exacerbate that risk, adding expense and creating further delay. In contrast, the public partner in SH case was now supported by a Private Finance Unit (PFU) set up by the UK Treasury to improve PPP management processes and impose standard contracts. PFU consisted of a taskforce to provide central co-ordination of new PPPs and specialized skills in areas such as finance and contracting. Its main responsibilities were to standardize processes and train staff in public sector organizations how to manage PPPs; mitigating the public sector partner's limited experience and capabilities. The standard contract form (used in SH), initiated by the PFU, substantially reduced negotiation times in later PPPs, and helped setting up new hospitals faster and at a lower cost (H.M. Treasury, 2016). *'The PFU definitely helped us in providing a standard contract which we then used to enter negotiations with the private partner. They also helped us with the initial negotiation and management process, all of which we were not really familiar with'* (Project Manager B, PuP, SH). Access to accumulated ecosystem knowledge of how to contract for and manage PPPs was vital for both parties to coordinate exceeding within sector social value creation. For instance, Strategic Manager (PuP, SH) indicated that: *'A PPP expert from the PFU came to us and spent time with some Senior Nurses and our key managers. We really got a much better understanding of how best to work with the private partner to ensure that our concerns are acknowledged too'*.

HOW DO PUBLIC PRIVATE HYBRIDS COORDINATE TO CREATE SOCIAL VALUE?

In examining the two case studies, we have presented evidence for the role of relational coordination in task performance and social value creation. In this section, we draw out the identified relationships between core constructs (Figure 1) and discuss the implications for theories of social value creation, hybrid collaborations and organizational design.

Relational Coordination and Organizational Design

Figure 1 illustrates our findings on the management processes and practices necessary to support relational coordination in public-private collaborations; grounded first in developing mutual knowledge (Kotha et al., 2013) and working towards achieving goal alignment (Gulati et al., 2012). Mutual knowledge development was attained through listening to, and valuing the other parties' professional language and the expertise that language expressed. Developing mutual knowledge was also critically enabled by the private partner having finally acknowledged the corrosive impact on relationships of continual staff turnover by the time of the Specialized Hospital; directly addressing this divisive practice through a policy of maintaining a few key staff across all project phases.

However, generating the management practice of an ability to communicate does not of itself create the content of management processes.

Our findings in Figure 1 position goal alignment in combination with developing mutual knowledge. Beyond some understanding and appreciation of the other parties' expertise, practical matters of goals, outcomes, milestones, and timelines are necessary to create relational coordination and these have to be broadly aligned. The findings report on the lack of joint working, even of regular meetings in the early GH case, and of how the private organization saw only costs and little value in dialogue. The private organization worked in isolation even attempting to future proof some of the new infrastructure without consulting hospital staff (section 'Driving Task Performance through Relational Coordination'). Coordination was not a goal, the private organization's emphasis is on speed and completion, through prioritizing having the hospital finished, speed itself becomes a mechanism that the private partner uses to exclude the public partner. The results in the General Hospital of a lack of relational coordination are sub-optimal task performance and social value creation.

In the later SH case, we find relational coordination joint working and consultation, and examples of social value creation enabled by mutual knowledge and goal alignment. The issue of engagement is a substantive difference between the two cases. Our model identifies the need for both communication and alignment; that neither would work alone, specialist knowledge would not be accessible without relational coordination (Hoopes and Postrel, 1999). The communication and alignment constructs in the model reduce the benefits of either party working unilaterally and reduce the risks in coordination observed in the GH case, creating a self-reinforcing pattern to underpin relational coordination.

Proposition 1a: A public-private collaboration climate supporting the development of professional language and minimizing personnel turnover is positively associated with development of mutual knowledge.

Proposition 1b: A public-private collaboration climate supporting outcome alignment and temporal alignment is positively associated with goal alignment.

Proposition 1c: Mutual knowledge and goal alignment in public-private collaborations is positively associated with higher levels of relational coordination.

Task Performance and Social Value Creation

Our findings report a contrast in the level of healthcare professionals' engagement between the two cases. Only in Specialized Hospital are healthcare professionals providing their specialist knowledge and engaging with the private organization. In SH healthcare professionals did not see the private partner as a threat to their identity making and re-making as professionals (Adler and Kwon, 2013; Reay et al., 2013). Our model then shows professional embeddedness as mediating how relational coordination will impact task performance – high embeddedness in SH resulting in healthcare professional led task performance like the children's ward night sky and an infection reducing linking corridor. In the GH case the private partner's reluctance to acknowledge and work with

professionals eschewed a need for mutual knowledge (Puranam et al., 2012) and goal alignment. The result in GH is the dis-engagement and poor embeddedness of professionals, resulting in suboptimal outcomes lacking healthcare professional input.

Between GH and SH we reported the establishment of a government unit to support PPPs and that this unit issued a standardized PPP contract that could easily be adapted. This new simplified contract played a role in reducing the risk the private organization placed on working closely with the public sector, co-ordination was simplified (Puranam and Vanneste, 2009). Given the private partner's initial use of speed in GH to mitigate collaboration, a key factor in achieving increased alignment of goals was the private partner feeling it was economically feasible to include ideas from the public partner. In turn, healthcare professionals from the public partner felt that their expertise and professional knowledge (Harrison et al., 2002) of healthcare processes was valued and had a direct impact on tasks. We observed mutual risk reduction then as a necessary enabler of professional embeddedness and its mediating effect on task performance.

Proposition 2: A climate of professional embeddedness positively moderates the effect of relational coordination on task performance in public-private collaborations. Specifically, relational coordination improves task performance when professional embeddedness is high.

Ecosystem and Organizational Experience

We find that social value creation in public-private collaborations is moderated by prior experience. Extant literature rarely comments on public-private relationships that are set in the wider context of an ecosystem of related hybrid relationships. For example, over the ten year gap between GH and SH, healthcare professionals would have had some exposure to other PPPs, have heard war stories, read profession specific journals on other PPPs; all inputs that reduce the risk to identify formation (Adler and Kwon, 2013). The concept of such PPPs, their routines and processes would be better understood with time and the volume of such initiatives; and crucially stakeholders' expectations would have become grounded in the realities of previous hospital infrastructure outcomes.

Figure 1 reflects our finding that the private organization is not solely preoccupied with the infrastructure project at hand, they are also functioning at the level of the ecosystem of PPPs. For example, their continued personnel rotation (albeit somewhat mitigated in SH) suggests these individuals had learnt something valuable and transferable which created complementary resources (Madhok and Tallman, 1998), and were creating additional value for the private organization in other parts of the ecosystem. The next section argues for the need in public-private collaborations to appreciate the role such eco-systems can play within a private organization that is operating at the ecosystem level.

Where the hybrid created social value beyond what each party acting alone could deliver (Le Ber and Brnzei, 2010; Lepak et al., 2007) the private organization is able to leverage their contribution to social value creation into economic value creation. We earlier described the private organization's business model as 'quick mobilization, deployment and on to the next site'. It is vital for these large private sector organizations

to have a pipeline of work (Puranam et al., 2014) – what we termed ‘the next site’, but such national pipelines of work are only achieved through personal networks and ties with politicians and civil servants (Kivleniece and Quelin, 2012). At the highest level senior management prioritizes ‘new business’ and the contacts and connections that seeking new, and retaining existing business, entails. Wood and Wright (2015, p. 272) describe ‘the nurturing of an ecosystem of oligopolistic firms reliant on state procurement and contracting, public–private partnerships, private finance initiatives, and/or outsourcing on beneficial terms’. In other words, we propose that creating social value can also feed the un-appeaseable pipeline of further contracts, the most important economic value for the private partner.

In our case social value was created through the hybrid [re]creating a night sky scene in a children’s hospital which won acclaim from all stakeholders including the media; but it only came about through being able to tap into the hospital’s healthcare professionals’ US network or social capital (Tsai and Ghoshal, 1998). Similarly, through joint working (using complementary resources, Madhok and Tallman, 1998), in SH the hybrid were able to come up with novel linking corridors that brought international recognition, prizes, and associated public relations and political benefits. Finally, such successes of hybrid working deliver another crucial element of social value creation; being able to address bigger social agendas (Cabral et al., 2013; Klein et al., 2010).

Proposition 3: Organizational and ecosystem experience positively moderates the relationship between task performance and social value creation in public-private collaborations. Specifically, task performance improves the likelihood of social value creation when organizational experience and ecosystem experience are high.

Limitations and Further Research

The study’s focus was on social value, without an accompanying view of economic capital used or expended; therefore it may take an optimistic view of processes and outcomes. Similarly, we study a formalized, stable, and regulated form of hybrid collaboration, embedded in an ecosystem of other public-private collaborations. The investigated hybrid relationships involve infrastructure and service delivery, future studies should explore our findings in hybrids with different characteristics. We adopt a particular view of professionals which may be considered western-centric; however we draw a rare attention to the contribution, positive or negative, professionals may play in the outcome of a public-private relationship. Finally, while we explore two healthcare PPPs in depth, future research could adopt quantitative methods to test the proposed model and contributions across sectors and countries.

CONCLUSIONS

This study addressed how public-private collaborations coordinate the mobilization of their collective resources to outperform within sector value creation, therefore creating social value. The study makes three distinct theoretical contributions.

First, that to create social value in public-private collaborations, relational coordination is vital and the outcome of mutual knowledge and goal alignment. Relational coordination and social value offers a departure from structural/economic arguments around value creation in hybrids. Our findings from the case studies reveal that relational coordination becomes a complement to contractual safeguards in hybrid collaborations. Effective relationships were able to handle unforeseen exigencies that could not have otherwise been resolved through contracts. The micro-behaviours underpinning how these relationships are managed add to the literature on organizational design by providing a much-needed behavioural lens. This behavioural approach complements the literature on alliances and organizational design, which has acknowledged the importance of relationships, but has provided limited evidence of its micro-foundations.

Second, the level of professional embeddedness is identified as impacting task performance; the more engaged professionals are (here healthcare professionals) the better task performance and the higher the opportunity for social value creation. Our emphasis on professionals in social value creation in public-private collaborations also provides a tacit context not always accounted for in extant studies. The healthcare context highlights the importance of professional identity and practices in organizational research. Professional embeddedness is often overlooked in hybrid collaborations. Admittedly, the healthcare providers (doctors and nurses) tend to be less interested in the policy and contractual phases, but their professional identity and values place a strong emphasis on social value. Yet, it is the effort of resolving problems through a professional lens that provided more creative implementation solutions to the private provider. Though public-private collaboration research seldom accounts for employee behaviours, our study highlights the importance of professional values in social value creation.

Third, we propose that the potential for value creation through relational coordination to manage task performance is impacted by two experience levels; organizational experience and ecosystem experience. Experience is often encoded into routines or processes, as well as a broader approach to resolving misaligned goals and incentives. We find that while ecosystem experience helps in improving the contractual processes and the framework for policy formulation and implementation, organizational experience provides the underpinning that ensure effective coordination and performance. Together, both forms of experience help hybrids create societal value beyond their economic performance goals.

Managerial implications emerge from the study. First, in public-private collaborations an approach based on ensuring mutual knowledge and goal alignment can contribute to more social value creation than approaches which rely solely on contractual safeguards. Second, that where a hybrid organizational form heavily involves professionals, aligning professional identities with the goals of the hybrid, whilst resource consuming, ensures engagement and offers the opportunity for task performance and social value creation. Finally, managers from both partners need to strive at achieving mutual knowledge and goal alignment to drive relational coordination which is vital to realize task performance and social value creation. Taken together, these pragmatic insights have the potential to further enhance task performance and social value in public-private collaborations.

APPENDIX: RECORD OF FIELDWORK

#	Position	Organization	Interview length (mins)	Experience PPP/healthcare sector (years)
General Hospital				
1	General Manager A	Private partner	90	<5/0
2	Ex-CEO	Public partner	97	0/>10
3	Project Manager	Private partner	115	<5/0
4	Program Director	Private partner	84	<5/<5
5	FM Director	Private partner	94	<5/0
6	Commercial Director	Private partner	87	<5/0
7	HR Director	Public partner	85	0/>10
8	Board Director	Bank	78	<5/<5
9	Project Director	Public partner	96	0/<5
10	Consultant A	Private Finance Unit (PFU)	88	<10/<10
11	Manager – operate phase	Private partner	115	<5/<5
12	Commercial Manager	Private partner	78	<5/0
13	Project Manager A	Public partner	103	0/<5
14	Project Manager B	Public partner	87	0/<5
15	Senior Nurse A	Public partner	61	0/>10
16	Director of Business Development	Private partner	86	<5/<5
17	Project Director	Private partner	94	<5/<5
18	Ex-Finance Director	Public partner	93	0/<10
19	Senior Nurse B	Public partner	54	0/>10
20	Manager – build phase	Private partner	102	<5/<5
21	Project Director	Private partner	82	<5/<5
22	Consultant B	Private Finance Unit (PFU)	46	<10/<10
23	Head of Estate	Public partner	110	0/>10
24	Finance Director	Public partner	97	0/>10
25	Technical Consultant	Public partner	57	<5/>10
26	General Manager B	Private partner	105	<5/<5
27	Project Director	Public partner	98	0/<5
28	Manager	Department of Health (DoH)	68	<5/>10
Specialized Hospital				
29	Project Manager	Private partner	97	<10/<5
30	Strategic Manager	Public partner	114	<10/<5
31	Consultant C	Private Finance Unit (PFU)	59	<10/<5
32	Project Manager A	Public partner	96	<10/<5
33	Project Manager B	Public partner	102	0/<5
34	Director of Business Development	Private partner	78	>10/<10
35	Program Director	Private partner	78	>10/>5
36	Project Director	Public partner	96	<10/<10
37	Board Director	Bank	43	>10/>10
38	General Manager	Private partner	97	>5/<5
39	Project Director	Private partner	84	>10/>5
40	Senior Nurse A	Public partner	117	0/>10
41	Technical Advisor	Private Partner	67	<5/>10
42	Senior Nurse B	Public partner	54	0/>10
<i>Overall:</i>			3,632 (60.5h)	

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