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Becoming hybrid: The negotiated order on the front line of public–private partnerships

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Abstract

This article examines how tensions in institutional logics, created in the formation of hybrid organizations, are played out, and partially resolved, through micro-level interactions within everyday work. Drawing on the negotiated order perspective, our research examined how the 'context', 'processes' and 'outcomes' of micro-level negotiations reflect and mitigate tensions between institutional logics. Our ethnographic study of a public–private partnership within the English healthcare system identified tensions within the hybrid organization around organizational goals and values, work activities, hierarchies and the materials and technologies of work. We also identified processes of negotiation between actors, which contributed to negotiated settlements, at times combining elements of parent institutional logics, and at other times serving to keep parent logics distinct. The article demonstrates the relevance of negotiated order perspective to current institutional logics literature on hybrid organizations.

Keywords

ethnography, hybrid organizations, institutional logics, institutional tensions, negotiated order, organizational change

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Introduction

Hybridity has emerged as a prominent theme within contemporary studies of work and organizations (Billis, 2010; Oliver and Montgomery, 2000; Skelcher and Smith, 2014). This reflects the proliferation of new organizational and inter-organizational forms that combine ways of organizing traditional and divergent institutional fields. A common illustration is the growth of inter-sectoral partnerships in the modernization of public services, where the distinct resources, capabilities and values of public-, private- and third-sector organizations are combined to address complex problems (Brown et al., 2003; Evers, 2005; Ferlie et al., 2011; Hodge et al., 2010; Mackintosh et al., 1994; Osborne, 2009; Sørensen and Torfing, 2009).

Hybridity poses important theoretical questions to organizational researchers, as it leads us to consider how contradictions between 'genealogical parents' (Oliver and Montgomery, 2000) are resolved, and the consequences for the character and sustainability of hybrids (Battilana and Dorado, 2010; Boland, et al., 2008; Evers, 2005). These questions are underpinned by research that identifies key challenges in the formation of organizational hybrids. At the inter-organizational level this includes problems of governance and decision-making where there are divergent understandings of accountability and risk (Boardman and Vining, 2010; Mair et al., 2015; Toms et al., 2011). At the organizational level this includes the struggle to establish organizational structures and processes that maintain the advantages of the parent organizations while satisfying divergent demands for market efficiency, professional collegiality and/or public value (Chambre, 2002; Miller, 2001; Stott and Tracey, 2007; Thomasson, 2009). At the interpersonal level this includes workplace conflicts created by contrasting forms of work organization, management and/or finance, or about the purpose, meaning and value of work (Hebson et al., 2003; Sanders and McClellan, 2012; Smith, 2012).

The above challenges have been interpreted as stemming from institutional differences between parent organizations (Oliver and Montgomery, 2000). In particular, the institutional logics perspective considers how hybrid organizations are formed through the interaction, mediation and resolution of multiple institutional logics. It offers an analytical approach that highlights the connections and contradictions between field-level institutions, organizational practices and individual identities (Battilana and Lee, 2014; Skelcher and Smith, 2014). That said, the institutional analysis of hybrids has predominantly remained at the inter-organizational and organizational levels (Reay and Hinings, 2009; Smets and Jarzabkowski, 2013). However, it has long been recognized that organizational forms are contingent upon, and emergent through, the situated work of 'street-level' actors (Lipsky, 1980) and institutional theory more broadly has begun to focus on the micro-level determinants of institutional phenomena (Lawrence et al., 2009; Powell and Colyvas, 2008). This suggests that emerging hybrid configurations are not only the product of field-level institutions, but also of the ways divergent institutions are articulated, mediated and reconstituted through the practices and strategies of micro-level actors. Adopting this view, our article addresses the recent call for research on the micro-processes of hybridization (Battilana and Lee, 2014), especially the '*process by which plural institutional logics are constructed, contested, and negotiated, the ways in which settlements are reached between them*' (Skelcher and Smith, 2014: 13).

The approach taken in this article is informed by Strauss's negotiated order perspective (Strauss, 1978; Strauss et al., 1963). This directs attention away from the structural determinates of organizational practices to the micro-level negotiations through which work practices and organizational processes become routinized as relatively stable social order. This approach offers an important contribution to the prevailing institutional perspective, and addresses appeals for research to re-focus on everyday work (Bechky, 2011). Specifically, our article asks how micro-level negotiations within emerging hybrid organizations reflect and reconcile broader institutional tensions and how these negotiations contribute to the new hybrid organizational order.

Presenting an ethnographic study of a recent public–private hybrid in the English health sector, our article makes three contributions. First, we present a novel empirical account to develop a conceptual framework for understanding the relationships between the context, processes and outcomes of negotiation. Second, we develop an understanding of how integrative and distributive negotiations contribute to a dynamic view of hybridization, in which elements of organizations can move towards particular parent logics, or become blended between logics, through interpersonal interaction. Third, we contribute to the longstanding negotiated order perspective by linking this work to contemporary theorizing on institutional logics, elaborating the concept of structural context through understanding of institutional heterogeneity.

Managing institutional tensions in hybrid forms

The institutional logics perspective emphasizes how modes of organizing are shaped by prevailing symbolic systems and historical patterns of material practice that provide the frames of references through which social practices are produced and reproduced (Friedland and Alford, 1991; Thornton, 2004). From this perspective, logics frame actors' decisions to produce modes of organizing that are logic consistent. It is increasingly recognized, however, that institutional fields can be characterized by multiple, sometimes competing or blurred logics (Goodrick and Reay, 2011; Greenwood et al., 2010). With particular reference to organizational hybridity, the institutional logic perspective brings to light how multiple logics can combine or compete to promote novel practices, identities and modes of organizing (Battilana and Dorado, 2010; Greenwood et al., 2010; Pache and Santos, 2013a; Purdy and Gray, 2009; Thornton and Ocasio, 2008). The presence of multiple logics is particularly evident in the context of contemporary public-service reforms where reconfiguration of the institutional boundaries between sectors creates conflict between logics of professionalism, state bureaucracy, the market and social welfare (Billis, 2010; Kitchener, 2002; Meyer et al., 2014, Reay and Hinings, 2009).

One long-recognized way organizations can maintain legitimacy in the face of competing institutional pressures or logics is through institutional de-coupling (Basu et al., 1999; DiMaggio and Powell, 1983; Meyer and Rowen, 1977). That is, organizations exhibit conformity to one logic through 'front stage' symbolic displays, but conformity to another logic in their 'backstage' activities. More recent studies of hybrid organizations develop the idea of 'blended' responses to heterogeneous logics (Pache and Santos, 2013a; Reay and Hinings, 2009; Skelcher and Smith, 2014). Drawing together recent

literature, Battilana and Lee (2014) identify how social enterprises overcome tensions in parent logics by configuring and combining different organizational 'elements' to adhere to one or the other logic, including inter-organizational relationships, culture, organizational design, workforce composition and organizational activities. Similarly, Pache and Santos (2013b) identify several potential reactions to competing institutional demands within hybrids, namely ignorance, compliance, resistance, combination and compartmentalization, with individuals' reactions influenced by their previous relations to each of the parent institutions.

To date, however, the institutional logics perspective has tended to focus on the 'top-down' influence of field-level institutional differences, with less consideration of how micro-level practices involve the interpretation, negotiation and reconstitution of these tensions to influence the hybrid organizational form (McPherson and Sauder, 2013; Smets et al., 2012). The scope for micro-level practices to influence emergent organizational forms is particularly significant during periods of public–private hybridization where the amalgamation of prevailing institutions creates ambiguities and opportunities for change. Importantly, these micro-level processes involve interaction between actors accustomed to divergent forms of work organization, and professional groups who may be expected to shape the resultant organizational form. To address this gap we draw upon the negotiated order perspective.

The negotiated order of cross-sector hybrids

Following in the symbolic interactionist tradition, Strauss and colleagues advanced the negotiated order perspective as an alternative to more structural sociology, suggesting that social order emerges from the on-going micro-negotiations of social actors (Day and Day, 1977; Goffman, 1983; Strauss, 1978). These negotiations create, maintain and transform social organization and, in turn, social institutions. Studying the social organization of psychiatric care, Strauss and colleagues showed how formal structures and rules only partially directed the organization of social relationships between doctors, nurses and patients, with formal rules 'stretched, negotiated and argued about' in day-to-day interactions (Strauss et al., 1963: 153). For example, the timing and distribution of work, accepted values and goals, inter-group relations and demarcations between professional groups were all negotiated through micro-level interactions (see also Abbott, 1988; Svensson, 1996).

Although the negotiated order concept can lack specificity (Allen, 1997), past research typically highlights three elements of the negotiation process. First, there are (more or less explicit) disagreements about given activities or situations; second, interactions around these disagreements are characterized by processes of negotiation or exchange, rather than direct authority or force; and third, settlements are reached that maintain or transform social order (Day and Day, 1977; Maines, 1982; Maines and Charlton, 1985; Mesler, 1989; O'Toole and O'Toole, 1981; Strauss, 1978; Thomas, 1984). Extant literature has identified forms of negotiation including trade-offs, deals and pacts, compromises, exchanges and silent bargains (Day and Day, 1977; Maines, 1982; Mesler, 1989; O'Toole and O'Toole, 1981; Thomas, 1984). Although these are often richly described, there is no typology of negotiations that links negotiations to outcomes.

Of relevance to our study is the role of social structure, or divergent institutional logics, in both precipitating and being re-constituted through negotiation. Like other interactionist studies, the negotiated order perspective has been criticized for neglecting the influence of structure, formal rules and historical practices (Day and Day, 1977; Fine, 1984). However, Strauss's work makes explicit reference to these structural influences as both triggering and framing negotiation. Later work described the recursive process by which the 'structural context' (established relationships, rules and hierarchies) and the specific 'negotiation context' (the disagreement, actors and opportunities for interaction) frame interactions, which contribute to emergent social order (Maines, 1982). For example, changing structural contexts are more likely to give rise to significant disagreement and overt negotiations, whereas stable contexts foster tacit social agreements (Allen, 1997; Hall and Spencer-Hall, 1982).

The negotiation order perspective provides a relevant conceptual approach for the institutional analysis of hybrid organization – specifically, how micro-level negotiations reflect and reconcile underlying institutional tensions and contribute to the new hybrid organizational order. In light of recent institutional theory, the structural context for hybrid organizations can be viewed in terms of the constellation of supra-organizational institutional logics (Friedland and Alford, 1991; Thornton, 2004), which also shape the local 'negotiating context' in terms of the tangible disagreements and interactional opportunities around which negotiations transpire. Elaborating this idea, programmes of hybridization alter the 'structural context' by bringing together multiple institutional logics, in our case those which dominate the public and private sectors, with each placing potentially contradictory obligations on behaviour and exposing actors to material practices and symbolic systems from which they have been previously insulated (Thornton et al., 2012). Studies of outsourcing, contracting and strategic partnerships have shown how new inter-organizational arrangements generate multiple points of cross-boundary interaction, outside of the formal organizational hierarchy (Brannen and Salk, 2000; Marchington et al., 2005; Nathan and Mitroff, 1991). Further, these interactions can be the site for uncertainty and conflict within the workplace (Marchington et al., 2005; Rubery et al., 2004; Smith, 2012).

Combining the negotiated order view with the institutional logics perspective provides a distinct theoretical basis for understanding the antecedent structural conditions of negotiations within hybrid organizations and the potential for negotiations to contribute to hybrid configurations. Building on this, we ask how micro-level negotiations within emerging hybrid organizations reflect and reconcile underlying structural tensions associated with divergent parent logics, and how these negotiations contribute to the new hybrid organizational order. To answer these questions, our study explores a case of public–private partnership (PPP) in healthcare, introduced below.

Case study: Public–private partnerships in healthcare

On a global level, PPPs have become central to the modernization of public services, involving many forms of collaborations and agreements between public and practice organizations (Hodge et al., 2010). Mirroring the literature on hybrids, literature on PPPs has tended to focus on structural or 'upstream' issues, commonly including typologies of

partnership configuration, financial contracting and the governance of risk (Hodge et al., 2010; Osborne, 2009).

Beyond this, research has described how embedded institutional differences between sectors impacts on the nature of relations between partner organizations (Field and Peck, 2003; Klijn and Teisman; 2003). For example, studies have investigated the impact of such differences on performance objectives, employment relations and the supply of labour, as well as public-service cultures, identities and work practices (MacKenzie, 2000, 2008; Marchington et al., 2005; Rubery et al., 2004). This latter work demonstrates how privatization and public-sector sub-contracting can lead to disordered hierarchies and complex power relationships as high status, skilled and specialized public-service work is transferred to third-party providers. Although such studies highlight tensions within PPPs, they have tended to focus on organizational management and the impact on the workforce rather than the scope for these tensions to provide the foundations for negotiation, hybridization or wider institutional change.

The English National Health Service (NHS) is an exemplary focus for investigating the negotiated order of hybrid organizations. Since the late 1990s, NHS reforms have involved the co- or private-financing of new hospital buildings, based on relatively 'loose' contractual arrangements (Hodge et al., 2010). Since the early 2000s, public policy has extended opportunities for public and private-sector organizations to work in more 'tight' relationships to design and deliver frontline services, including relatively new modes of service organization. As an example of increasingly 'tight' public–private relations, our case examines the introduction of an Independent Sector Treatment Centre (ISTC) between 2009 and 2011. ISTC were introduced to expand provision of, and promote innovation in, public healthcare through involving private companies in the financing, organization and management of non-urgent or elective care.

ISTCs are an important site of hybridization for several reasons. First, healthcare remains a prominent site for analysing the interaction and hybridization of divergent logics, and previous research has extensively described how the dominant professional–bureaucratic logic of healthcare has been challenged by commercial and market–managerial logics in marketization reforms (Kitchener, 2002; Reay and Hinings, 2009; Scott, 2001), providing the institutional context for this study. Second, ISTCs illustrate a fundamental change in the organizing of English healthcare, representing one of the first examples of private companies assuming responsibility for managing public acute healthcare through long-term partnership (Gabbay et al., 2011; Pollock and Godden, 2008; Waring and Bishop, 2011). Third, through assuming responsibility for the delivery of NHS services, private companies are required to manage health professionals previously employed in NHS hospitals, creating a multi-employer, multi-sectoral workplace and opening new sites for cross-sector interaction. ISTCs therefore provide a novel site for the analysis of hybrid organizations as a negotiated order, with public clinical staff and private managers brought together to produce health services within new workplace relations.

Our case study ISTC was developed through partnership between public-sector (NHS) commissioners and hospitals and a private healthcare firm ('UKHealth'), a new market entrant with the financial support of a larger European healthcare company. This ISTC involved the construction of a new hospital facility, with 13 medical specialisms transferred from a local NHS hospital to the privately managed facility. Services were

commissioned by the local NHS, with an annual value of approximately £40m for an initial five years. The ISTC was led by senior executives and middle managers from UKHealth. A large pool of clinicians (approximately 800) were seconded from the local NHS hospital on either a 'sessional' or full-time basis, including nurses, doctors, healthcare assistants, technicians and administrators. For these staff, NHS terms and conditions of work were protected within the ISTC.

The research involved an 18-month ethnographic study covering the design, development and opening of the ISTC. Ethnography allowed for rich contextual insight into the day-to-day organization of work within the ISTC, including close attention to micro-level negotiations (Fischer and Dirsmith, 1995). Following an ethnographic approach, our study aimed to develop an insider's perspective and to locate the situated and negotiated meanings of different staff groups within a wider organizational context (Fetterman, 1998). Over 300 hours of observations were conducted within non-clinical and administrative settings, for example, management meetings and training events, and in a range of clinical settings, including wards, clinics and operating rooms. These were recorded in handwritten field journals before being typed up. The observations examined how work practices were established through the interaction between ISTC policies and procedures, and pre-existing clinical practices and customs carried over from the NHS.

Alongside observations, a large number of informal interviews were carried out to develop observations, also recorded in field journals. In addition, 38 semi-structured recorded and transcribed interviews were carried out with different staff representatives to explore their experiences of work organization in the ISTC (the respondents are listed in Table 1; some roles are generalized for anonymity). Documentary evidence was collected, including contract terms, standard operating procedures, patient pathways, regulations, key performance indicators (KPIs), work role descriptions and employment contracts.

Data analysis initially involved open coding of data in light of the sensitizing concepts and debates informing the study. This was followed by iterative coding, whereby data were subject to close reading and thematic analysis, and where authors regularly met to review codes to determine their consistency, boundaries and relationships. Through this process of constant comparison and relating codes back to existing theories, conceptual categories and themes were developed. The case narrative is presented to convey the tensions underpinning cross-sector interactions within the new ISTC before moving on to highlight processes of interpersonal negotiation.

Findings

Logic tensions and workplace disagreements

Our findings first describe how the ISTC represented a novel site in which the prevailing professional–bureaucratic logic of the NHS and the market–managerial logic of UKHealth were brought together. The ISTC was seen by the UKHealth planning team as an opportunity for a radical change in English publicly funded healthcare, which has been dominated by NHS organizations. However, the realization of this vision required working closely with, and securing the cooperation of, the NHS clinical workforce whose work was transferred into the ISTC. Interviews highlighted notable tensions

Table 1. Interview respondents and role backgrounds.

Respondent ID	ISTC work role (full-time in ISTC unless stated)	Career background prior to ISTC
Doctor 1, 2, 3, 4	Consultant anaesthetists (1/2 – 1 day per week)	Trained and full career in NHS (average18 years)
Doctor 5, 6, 7, 8	Consultant surgeons (1/2 – 1 day per week)	Trained and full career in NHS (average 16.5 years)
Doctor 9, 10	Registrar surgeons (1 day per week)	Trained and full career in NHS (average 8 years)
Doctor 11	Consultant physician (2 days per week)	Trained overseas (12 years). Worked in NHS (5 years)
Sister 1	Department lead nurse	Trained and worked in NHS (8 years), recently in private hospital (5 years)
Sister 2	Department lead nurse	Trained and worked overseas (11 years). Worked in NHS (4 years)
Sister 3, 4	Department lead nurses	Trained and full career in NHS (average 16 years)
Nurse 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	Staff grade nurses	Trained and full career NHS (average 14 years)
Nurse 11	Staff grade nurse	Trained overseas (7 years). Worked in NHS (4 years)
ODP 1	Operating department practitioner	Trained in NHS. Full career in private hospitals (13 years)
ODP 2, 3	Operating department practitioners	Trained and full career in NHS (average 14 years)
HCA 1, 2	Healthcare assistants	Trained and full career in NHS (average 4 years)
UKHealth manager 1	Planning and contract manager	NHS manager (10 years). Private healthcare manager (5 years)
UKHealth manager 2	Planning and contract manager	NHS management (10 years). Private hospital manager (3 years)
UKHealth manager 3	Senior function manager	NHS manager (5 years). Private hospital manager (4 years).
UKHealth manager 4	Senior function manager	NHS manager (6 years)
UKHealth manager 5	Senior function manager	Retail management (18 years)
UKHealth manager 6	Senior exec manager	Consultant surgeon, trained and worked NHS (15 years). Worked in private hospital (13 years)
UKHealth manager 7	Senior exec manager	Consultant surgeon, trained and worked NHS (10 years). Worked in private hospital (8 years)

ISTC = Independent Sector Treatment Centre.

between the underpinning logics of UKHealth managers and NHS clinicians, centred around issues of service values and goals, working practices, systems of hierarchy, and the material and technological aspects of work (Table 2).

Table 2. Logic tensions, disagreements and provisional settlements.

Area of tension within parent logics	Associated workplace disagreement	Provisional settlement
Goals and values: Public-service (NHS) vs organizational performance (UKHealth) 'If we succeed in this contract, everyone wins because we can show business incentives can be the basis for doing things better'. (UKHealth Manager 6) 'It's now run by a commercial company and they have different overriding goals to the NHS. These are not necessarily competing ideals, but not always compatible'. (Doctor 2) 'The private sector is geared more towards numbers, how many they have done and how many have got to be done'. (Nurse 7) 'I think it's a much more managed environment, and I think there is a greater emphasis on economic issues'. (Doctor 5) 'Well it is driven by profit there is no doubt about it, money is much higher on the agenda'. (Sister 3)	*Importance of reaching and evidencing Key Performance Indicators (KPIs)* Frequent meetings arranged to improve data relating to KPIs and audit. The managerial important of these additional targets was not recognized by NHS staff. As one nurse stated, 'their focus is basically paperwork' (Nurse 7). Another stated, 'You spend all this time filling out paperwork and basically you were repeating yourself'. (Sister 2)	Paperwork and audit reviewed and simplified following clinical input.
	Priority of customer service Post-appointment 'client feedback' calls were made and written into first ISTC standard operating procedures (SOPs); NHS staff routinely overlooked these unless there was a clinical need for follow-up: 'it's takes time and also if I'm honest I feel a bit stupid asking like "how did you find the service"'. (Nurse 1)	Customer feedback calls gradually faded out and replaced with voluntary feedback cards left in public spaces to be completed voluntarily by patients.
	Publication of individual and departmental performance measures UKHealth initiative to publish performance measures on patient volumes and markers of clinical quality. Seen by doctors as potentially undermining collegiality and altering the mix of patients doctors would accept to treat.	Publication of smaller range of performance measures and removal of performance measures from staff appraisal.
Work processes: Professional autonomy (NHS) vs efficient operations management (UKHealth) 'It was an opportunity, we started with a blank sheet so we could really look at how to make this run as efficiently as possible'. (UKHealth Manager 3)	*Off-site scheduling and contact centre* Major change in the work process initiated by private managers to move patient scheduling to an off-site contact centre. Identified as 'unworkable' by doctors who had previously held responsibility for scheduling their own list.	Off-site contact centre scrapped with patient appointment administration re-linked to departments.

(Continued)

Table 2. (Continued)

Area of tension within parent logics	Associated workplace disagreement	Provisional settlement
'We have had a lot of changes with the care pathways … We have just had a new assessment folder, so they are our guidelines as to what we have to do now'. (Nurse 6) 'I had never been in a private organization and I didn't know how they functioned. It is so different to the NHS and even now I would say that the standards of care and what is expected from you is different'. (Sister 4)	*Nursing job roles organized around patient pathways* Innovation introduced by private managers to have more defined nursing roles linked to explicit patient pathway documents. Presented a challenge to nurses who were previously given more autonomy. 'What is particularly difficult I think is having these guidelines for surgery'. (Nurse 4)	Reduced management scrutiny over roles and greater autonomy given to nursing teams to organize work.
Hierarchy: Devolved professional (NHS) vs integrated corporate (UKHealth) 'I think expectations, even my expectations and those of the staff, I don't think we would be as closely monitored as we are being'. (Sister 3) 'It's one of the things, [the NHS staff] are not really used to having other people coming and saying look, can we do this better'. (UKHealth Manager 3). 'There is the UKHealth operations manager who is in charge of the department as well but we don't go to her unless we have to, we always go up through [NHS hierarchy] first'. (Nurse 8) 'The boss we had in the old unit was the only boss but now we know there is some boss on top of them as well if you know what I mean. It is not just their voice we are hearing it is the top ones as well'. (Nurse 11)	*Departmental line management duplication* Split between senior nurses and new public managers. Private managers were employed within each clinical department alongside senior NHS nurses, resulting in divisions of responsibility and control. As one healthcare assistant stated, 'If you go to one of our [NHS] sisters and say "we need this changing, we cannot work like this", they say "it is not my problem, talk to UKHealth, it is their building"'. (HCA 1)	Greater separation of management responsibilities between 'business' and 'clinical' aspects of organization, with line management responsibilities handed back to clinical staff.
	Employment decisions Responsibility for clinical hiring decisions initially with new private managers. Identified as problematic by NHS staff as new staff were not seen as having sufficient experience or quality.	Increased involvement of senior NHS nurses in recruitment decisions, with system of joint approval by senior nurses and UKHealth managers.

(Continued)

Table 2. (Continued)

Area of tension within parent logics	Associated workplace disagreement	Provisional settlement
Materials and environment: Evolved professional (NHS) vs managerially designed 'Well it's a much bigger place, and some of the facilities are fantastic, but it's bigger, really Americanized, the design'. (Nurse 2) 'We could custom-build this to fit around what we actually do here, [the department in the old hospital] was just a mess – not fit for purpose'. (UKHealth Manager 1) 'It was a huge thing coming over here in terms of the building, from a staff point of view I think they felt neglected'. (Sister 3)	*Layout of wards* Larger ward and department areas, designed in line with new patient pathways to encourage patient flow; these were the focus of common complaints amongst clinical staff as greater distance between colleagues. As one nurse stated, because of the size 'I hardly speak to anyone any more'. (Nurse 5) *Standardized equipment* Equipment for operations was standardized and pre-packed. Doctors complained that these were not tailored to their needs and often wasteful as not all equipment was needed.	Changes made to location of movable equipment following clinical input. More fixed elements of building layout remained unchanged. Standardized equipment remained in place, with decisions for deviation made on a case-by-case basis.

While interviews were helpful in identifying institutional tensions at an abstract level, observations within the workplace allowed us to elaborate specific episodes of disagreement between UKHealth and NHS clinicians associated with each of these tensions. These were especially prominent within points of routine cross-boundary interaction between public and private actors, including daily departmental meetings with UKHealth managers and senior NHS nurses, weekly management walk-arounds and briefing sessions, and senior-level management and governance meetings between UKHealth executives and NHS medical leaders. These interactions were prominent sites for 'issues' and 'problems' to be explicitly worked out. Table 2 summarizes the emergent tensions, illustrative workplace disagreements and provisional settlements, described further below.

Processes of negotiation

The study identified a number of negotiation processes and tactics through which UKHealth and NHS clinicians worked through and sought to resolve the disagreements emerging in the creation of the ISTC.

Forming coalitions and relationships. One common way NHS clinicians sought to negotiate new forms of work organization within the ISTC was to draw support from embedded social networks carried over from their former NHS hospital. These were used to resist new ways of working and re-assert customary practices established within the NHS. Although contractual and bureaucratic rules placed all NHS staff under the supervision of UKHealth managers, considerable informal (interpersonal) and formal (professional and expert) forms of influence were retained amongst NHS group cultures and

occupational hierarchies. For example, NHS doctors maintained close collegial relations with other doctors within their specialisms, and nurses continued to report to their senior-grade nurses or doctors rather than to UKHealth managers:

> Definitely I think the [NHS] clinical leads have the most weight and the most control. (Sister 2)

> If [anaesthetists] say 'I won't do the anaesthetic' what can you do? You can't say 'well I will go and get another anaesthetist then', you could try but you wouldn't find one. (Sister 1)

Clinical networks were used to resist new ways of working and re-assert customary practices established within the NHS. A prominent example of this was observed with doctors' reactions to a new off-site patient booking centre. This had been initiated by UKHealth managers to allow central management of patient appointments in line with contracted waiting times. However, doctors saw this as undermining their ability to safely manage their own caseload and prioritize patients according to the clinical expertise:

> Previously I would just sit down with my secretary and … generally we got it right. But here you had no idea how many patients were on the list and how many would turn up. It could be two it could be 20, and it was just impossible. (Doctor 7)

After an initial period of using the new system, senior doctors collected anecdotal evidence about the problems their medical colleagues were experiencing, and organized meetings to present a collective response to UKHealth managers. Although managers were immediately dismissive of 'the old guard', they also recognized that patient throughput was below target; and following sustained collective lobbying from doctors, the decision was made to bring this administrative function into the ISTC main building, thereby placing it back under medical control:

> I found it frustrating because I always used to just pop into my secretary who was doing the booking and make sure we were going to be maximizing utilization and make any small changes that might need to be made … it's been a bit of a struggle but I am working my way back to the system that we used to have [in the NHS hospital] that worked really well. (Doctor 8)

UKHealth managers acknowledged that these existing clinical networks presented a significant challenge to their aspirations for service innovation. As patterns of relationships were increasingly understood, managers purposefully identified senior nurses and other clinicians with high levels of influence within peer networks. These 'local leaders' were then the focus of attempts to build cross-organizational cooperation, and managers worked to persuade them of the benefits of change: 'We are really trying now to bridge the gap and get some of the key people to come with us on this, to see how we can do things better' (UKHealth Manager 6).

Rhetoric and legitimacy. A second related process of negotiation was the use of rhetorical arguments to promote preferred ways of working and undermine the coherence or legitimacy of alternative perspectives. In episodes of disagreement, NHS staff would typically position their arguments in terms of clinical expertise and experience, and challenge aspects of the ISTC along three lines. First, clinicians argued that proposed changes

would undermine clinical standards and threaten quality, for example promoting quantity over safety. In this regard, appeals were made to 'professional' standards and regulations that were seen as superseding local organizational expectations. Second, clinicians argued that similar initiatives had already been tried in the NHS and shown to be ineffective. This appeared to be an effective strategy as UKHealth managers often wanted to be seen as innovative and not replicating activities found in the NHS. Third, clinicians promoted their collective wisdom and argued that their proximity to the 'frontline' made them better placed to devise change:

> I don't think [the UKHealth managers] can understand that one assessment can take 10 minutes and another can take an hour and a half, [they] expect everybody to get through within the set time of 20 minutes and it isn't always possible. (Nurse 6)

> Some of us have been doing this together for about 20 years, if there was a way to save time and make things more efficient do you not think we would have done it by now? (Sister 3)

In light of resistance, UKHealth managers increasingly appreciated the need to convince NHS staff of the value and necessity of new ISTC approaches to work. UKHealth managers had initially presented a vision of stark transformational change and dramatic increases in efficiency, but in the face of clinicians' arguments this was consciously moderated, with managers adopting 'softer' rhetoric that emphasized shared values around improving services for patients and the potential to expand successful services. Change was advocated in terms of the benefits for patients and professionals rather than to the organization:

> Our rationale for doing the TC in the first place and for the Trust to engage in it is it would be a catalyst for change and it would kind of shine a light on the way we do things at the moment. And we would get real opportunities that we could transfer from patient to patient. (UKHealth Manager 1)

> We are really having to enforce that message now, we are for the NHS patients of [the city] and this is a government backed initiative. (UKHealth Manager 4)

On an individual level, NHS staff were asked to help 'find the best solutions together' (UKHealth Manager 3). These messages were put forward through a series of education and training initiatives, aimed at spreading new norms of practice:

> We hold fortnightly 'Change' workshops for staff developing on some of the differences around the way things have to be managed in the independent sector, to improve their familiarity with the regulations. (UKHealth Manager 3)

In adopting these messages, the relationship between the NHS and UKHealth was re-cast from one of contractual competition, to one based on partnership and joint working. This could be seen as an attempt to mitigate the extent of difference between public and private objective and present a sense of continuity for NHS:

> It's a constant education I think from our point of view that we need to get NHS people on board with a more sort of business perspective … but at the end of the day we have to be very balanced about this because there is often a patient at the end of all these decisions. (UKHealth Manager 5)

Trade-offs and bargains. A third process of negotiation was for UKHealth managers and NHS clinicians to identify trade-offs and bargains to balance divergent understandings of work. The clearest example of explicit deal-making was the move to offer financial incentive to doctors working in the ISTC. This included offering share purchase options as well as bonuses for hitting targeted volumes: 'We want to make it so it's in their interests to treat patients as efficiently as absolutely possible' (UKHealth Manager 6).

Although these were often presented as rewards for meeting performance targets, they might also be interpreted as compensating doctors for compliance and support for new ways of working. For example, productivity bonuses were offered alongside UKHealth management attempts to publish individual and departmental performance measures on throughput and quality. This met with a mixed response from doctors, with some welcoming financial incentives linked to more transparent performance and others concerned about encroaching commercial imperatives onto medical work:

> To be honest, doctors are quite a competitive lot and I think it is quite interesting seeing where I sit [in terms of performance against other doctors]. (Doctor 8)

> Some doctors may think its brilliant to rush patients through and make lots of money, others might be more resistant to that. (Doctor 2)

However, many senior doctors did accept financial incentives. This group were increasingly present at strategic and senior-level meetings, took a pro-active interest in ISTC objectives, and adopted visible roles persuading other colleagues to engage with the ISTC and bridge the gap between UKHealth managers and NHS clinicians.

For other staff groups, UKHealth managers identified different incentives for accepting new ways of working. For example, senior nurses were formally 'handed back' departmental management responsibilities such as team composition, workload planning and recruitment. For nurses, this arrangement was welcome because it was seen as returning control over clinical areas and enabled them to counter the perceived dangers of privatized healthcare, such as prioritizing throughout over quality. For managers, this arrangement also had benefits as it reduced the need for direct management oversight of clinical work, and increased the involvement of clinical leaders in decision-making and change processes:

> We have got more control now over who we get in. Some of the people they were recruiting were just not up to our standard so this is a big step forward. (Sister 3)

> We've now made lots [of changes to UKHealth work plans]. Some we have actually taken a bit further now and we are starting to look more at the patient's pathway, i.e. how do we get that patient to theatre in as quickly a time as possible. (Sister 1)

As these quotes suggest, trading off control over clinical work for the active engagement of staff, alongside attempts to build new relationships and modify rhetoric, did appear to stimulate points of cooperation, and led to clinical leaders accepting some responsibility for delivering performance and throughput targets of the ISTC.

Outcomes of negotiations

The above negotiated processes appeared to allow provisional settlements to several early points of disagreement between NHS staff and UKHealth managers (see Table 2). Seen together, settlements contributed to a number of important changes to the hybrid organizational arrangements. First, there was a redefinition and refocusing of the remit or reach of management in the organization of clinical tasks. UKHealth managers partially withdrew from departmental-level administration and narrowed their focus on wider contract management, and the overarching performance of the ISTC, including issues of finance and accounting, marketing, collecting performance data and preparing for inspections and quality reports:

> Obviously we don't see the financial side of things; we just see what surgery needs to be done and what equipment and work is needed to support that. Someone else is looking at where the best place is to get the cheapest equipment that works and all that kind of stuff, obviously they have that mentality because it is a business. (Sister 2)

> I think the lines are now a lot more blurred and the clinical side is better … but the business side there are certainly still differences. (Doctor 8)

Second, stemming from the above, NHS clinicians reclaimed, and in some instances gained, influence in service administration, from day-to-day task allocation to involvement in strategic planning. For example, doctors with financial interests in the company played an active role in organizational development, and senior nurses were given increased responsibility for meeting throughput targets. This was reflected in the increasing willingness of certain NHS clinical staff to engage with the development of the ISTC: '[UKHealth] are very pro wanting you to make it work and wanting you to develop the centre as you want to develop it. You do feel that you have got more scope to do that' (Sister 1).

Third, although there continued to be tensions between UKHealth managers and NHS clinical staff, there was a common feeling that relations between these groups had 'settled down' over the first year of operation. Settlements for individual disagreements could be seen to set precedents for reciprocity and helped to set ground rules for cross-boundary cooperation:

> You have to have that little bit of give and take and you work with people over time and you get to know how they work, you get to know what they are capable of and how far they are willing to help you. (Sister 2)

> I would say three months ago I would have seriously considered going back to an NHS hospital … I enjoy working here now and that is probably because things have settled down, there is still the odd teething problem in my book that shouldn't be happening, but in the main things are better. (Nurse 7)

Negotiated settlements were also reflected in improvements in overall organizational performance markers. Over the first six months of operation, there were several breaches of key performance indicator (KPIs); of 30 contractual KPIs set, six were breached in a

majority of months. Of particular note, patient complaints were several times higher than the contracted rate, and patient care episodes were less than half the expected levels. In the second six months of opening, care episodes had more than doubled and patient complaints were reduced to below target levels. Although there were still regular breaches of three KPIs related to administrative issues, what were seen as the important targets had been met.

Discussion and conclusions

Previous research on organizational responses to competing institutional logics often takes as its starting point 'upstream' organizational design or configuration (Battilana and Lee, 2014; Pache and Santos, 2013a; Skelcher and Smith, 2014). There has been less attention, however, to the ways in which micro-level interactions both reflect and re-constitute broader institutional tensions. Our study examines these micro-level interactions informed by Strauss's (1978) negotiated order perspective, which brings to light the emergence of social order and patterns of organizing through negotiation strategies of actors embedded within day-to-day organizational life. For our case study, we have examined the interaction of private-sector managers and public-sector health professionals brought together in a hybrid PPP. Reflecting on the findings above, and building on extant literature, we develop a conceptual framework addressing the contribution of micro-level negotiations to the emergence of hybrid organizations.

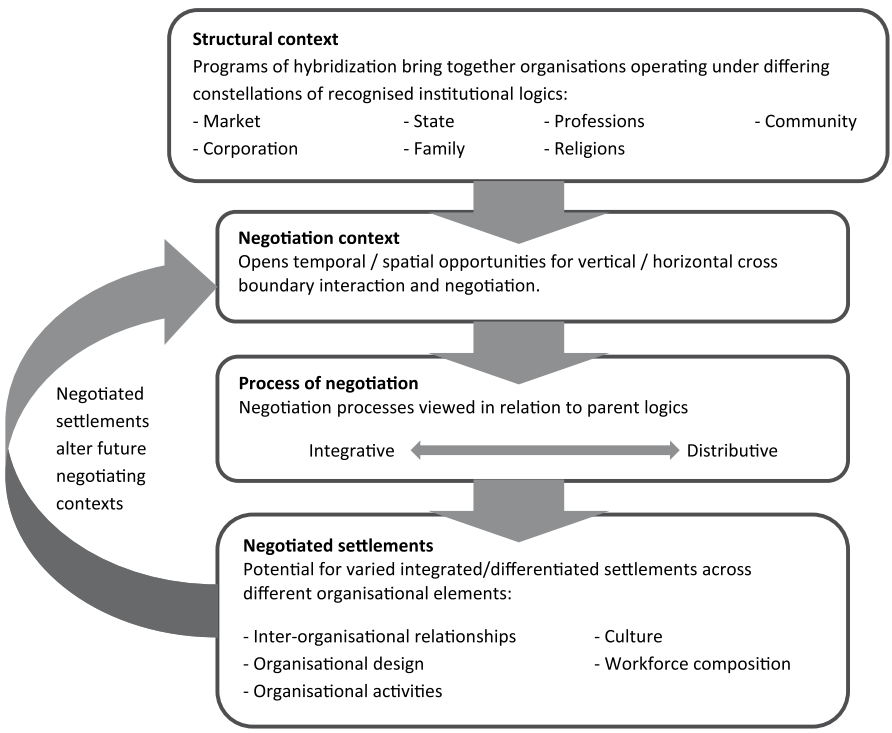

Figure 1. Context and processes of negotiated order within hybrid organisations.

The first stage of our framework draws upon previous research showing how actors from the public and private sectors adhere to professional–bureaucratic and market-efficiency logics characteristic of these respective domains (Battilana and Dorado, 2010; Kitchener, 2002; Klijn and Teisman, 2003; Reay et al., 2006; Scott, 2001). Programmes of hybridization bring together organizations operating under differing constellations of institutional logics, and in our case this is shown to create a number of tensions in terms of values and goals, work processes, hierarchy, and the material and technological aspects of work (see Table 2). The combinations of societal-level institutional logics (Thornton, 2004) represent what Strauss's work (1978) might interpret as the wider 'structural context' of negotiation, as they provide the overriding source of tension and disagreement.

The second stage of our framework identifies how logic tensions result in specific workplace disagreements within the hybrid organizational context. Logic tensions were not only present in the abstract reflections of those affected, but were revealed in specific episodes of disagreement between private managers and public clinical staff in interactions spanning previous organizational and sectoral boundaries. The formation of the ISTC involved the creation of new spatial and temporal opportunities for communication between sectors, bringing competing logics into direct confrontation in the course of everyday work. As identified in previous research (Hebson, et al., 2003; Klijn and Teisman, 2003), cross-sector relationships represented sites of conflict as the overarching differences between parent logics became manifest in contrasting approaches to work organization, priorities and performance. At the same time, our case identified how establishing points of difference and disagreement within these relationships provided the foundations for new forms of social order to be established (Hall and Spencer-Hall, 1982; Nathan and Mitroff, 1991). These might be interpreted as the specific 'negotiation context' that triggers and frames how negotiations unfold over time (Strauss, 1978).

The third stage of our framework identifies how processes of negotiation contribute to dynamic change under the 'push and pull' of competing logics. In our case, we identify how negotiations involved the utilization of 'embedded networks' to present opposition resistance, the performance of 'rhetorical arguments' to question or establish the legitimacy of change, and the development of 'deals and exchanges' to secure cooperation. In each, different types of resources appeared to shape how negotiations played out, and the type of settlement reached, including social networks or capital, claims to expertise, standards or quality, and access to additional material resources. Significantly, these key resources of negotiations are rarely made explicit in existing research on negotiated order (Fine, 1984). Through these negotiation processes, individual disagreements were provisionally settled, which in turn mitigated wider institutional tensions.

Drawing terms from the field of conflict resolution (Lewicki and Litterer, 1985), we elaborate our findings to suggest that the mediation of competing institutional logics through micro-level negotiations might be characterized in one of two ways. First, we found examples of *distributive* negotiations, characterized by a search for concessions weighted towards one or other parent logics, such as attempting to divide the business and clinical responsibilities between the private and public groups. Second, we saw examples of *integrative* negotiations characterized by a search for novel resolutions that seek to satisfy multiple logics simultaneously such as the attempt to identify mutual values through 'softer' forms of rhetoric demonstrated by the private managers. Viewing negotiations on a spectrum of distribution to integration furthers understanding of the

process by which episodes of negotiation relate to the wider structural context by considering how negotiations fit within conflicting institutional logics.

The final stage of our framework identifies how distributive and integrative negotiations at the individual level contribute to hybridization at the organizational level. Returning to the work of Battilana and Lee (2014), we find negotiation processes shaping the position of different 'elements' that make up the hybrid organization, so that each element has the potential to become more 'blended' to multiple logics, or segregated between logics. We related our case findings to the following five elements. (i) *Organizational design* involved an increasing split between parent logics as NHS staff gained authority over clinical activities and UKHealth focused on financial and administrative matters. (ii) *Organizational activities* moved increasingly towards a professional–bureaucratic logic as clinical staff re-asserted existing ways of working, albeit accepting limited forms of change. (iii) *Workforce composition*, although largely fixed by contract, involved some movement towards a professional–bureaucratic logic as clinical leaders gained increasing involvement in the recruitment of 'private' staff. (iv) *Organizational culture* became increasing blended between logics as relationships developed and managers sought points of convergence around clinical quality and patient care. (v) *Inter-organizational relationships* involved an increasingly complex mix of professional–bureaucratic and market-efficiency forms, as multiplex contractual, reciprocal and hierarchical imperatives influenced relations between public and private actors at the micro-level, representing a key interface between partner organizations at the meso-level.

Overall, this presents a processual view of hybridization that links macro-institutional tensions to micro-level negotiations and the resultant hybrid form. Specifically, differences in supra-organizational logics lead to disagreements within the negotiating context, within which subsequent micro-level negotiations contribute to the positioning of each organizational element against competing parent logics. Through this process each organizational element can become more 'blended' to multiple logics, or segregated between logics, over time. Our study contributes to the growing literature on PPPs and the changing relationship between the public and private sectors more generally, by directing attention beyond the structural features of inter-organizational or inter-sectoral working to present a more fine-grained and dynamic picture of negotiated and emergent hybridization.

Supporting previous research on the lived experience, processes and contradictions within public-service outsourcing (Grimshaw et al., 2002; Hebson et al., 2003; MacKenzie 2000, 2002; Smith, 2012), our study challenges the managerialist and functional assumptions embedded within policy-led programmes of market and contractual public-service reforms. In line with these studies, we illustrate how taxonomic distinctions between bureaucratic and market controls are problematic when considering complex public-service sectors operating under multiple forms of regulation and control. Such work provides theoretical and empirical evidence against simplistic notions of market efficiency, as well as more developed arguments for 'boundaryless' networks to promote flows of resources between sectors.

To conclude, our article contributes to the growing body of research concerned with analysing how tensions between institutional logics evident in the formation of hybrid organizations are further manifest in and managed through micro-level negotiations. This presents a picture of hybrids as potentially volatile 'mixtures' rather than 'solutions',

because negotiated settlements remain open to on-going revision, and tensions in the institutional foundations of hybrids are provisionally settled in view of local contexts of work. This study was limited to a single case within a specific type of PPP in the context of UK healthcare. To further identify how the process of hybridization shapes how organizational elements are brought together, additional work is needed on the interactional level in new hybrid organizations, including on the more detailed level of dyadic interactions and dialogue, to consider how tensions are discursively handled, and on the longitudinal level to see how micro- and meso-level negotiations relate to each other during extended contract periods, and indeed contribute to more macro-level institutionalization of sectoral boundaries and domains.

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