Introduction

Public service reforms are inherently spatial (Yanow 1995). They happen within spaces – *the environment, the community*, *the home*; they create or change spaces –*schools, hospitals, prisons*; and they change the relationship between time and space – *public transportation*, *communication technologies*. Before the 1970s, spaces tended to be regarded as relatively neutral 'containers' of social activity (Thrift 2006). Since this time, a 'spatial turn' has occurred across the social sciences with spaces now seen as socially constructed; infused with meaning, interest and ideology; and productive of social relations that reflect prevailing cultural, economic or political institutions (Thrift 2006). Space has become a central concern for understanding the mediation of structure and agency whereby social practices are viewed as shaped by, but also constitutive of spaces (Kornberger and Clegg 2004). In its broadest sense, this papers contributes to a 'spatial turn' within public policy and management examining, in particular, how prevailing political and managerial interests interact with the day-to-day practices of service delivery, via the medium of organisational space.

Our paper focuses on the organisational spaces created through Public-Private Partnerships (PPPs). PPPs involve a formal collaboration between public agencies and private enterprises in the planning, construction and management of public services (Kooperjan 2005). They are often advocated for enabling the sharing of resources and risks in the modernisation of services (Yescombe 2011). Some PPPs involve relatively 'loose' contractual partnerships for financing, designing and constructing infrastructure (concessions), whilst other involve more 'tight' cooperation in the on-going co-production of services (alliances) (Hodge and Greve 2007). PPPs are interesting because they combine the distinct organising logics or cultures of public and private sectors in what are described as 'hybrid' organisational forms (Bishop and

Waring 2016; Skelcher 2007). This is especially the case for 'tight' partnership arrangements that combine, for example, workforce and performance management methods usually associated with private enterprise, with the service ethos and regulatory standards of the public sector (Waring et al. 2013). Research suggests the combination of these divergent logics can lead to tensions in the organisation of services (Bishop and Waring 2016).

PPPs are often characterised by their architectural innovation (Edelenbos and Teisman 2008), yet there has been only partial consideration of how the blurring of public and private cultures is manifest in spatial organisation. Turning to the literature on organisational space, PPPs illustrate what are increasingly known as 'hybrid spaces'; spaces that blur spatial boundaries, combine different interests and produce shifting social identities (Burrell and Dale 2014). Taking this idea as our point of departure, we ask how the spatial organisation of PPPs reflects the blurring of sectoral cultures, and how it transforms the social practices of professionals and service users. In developing our analysis, we draw on Michel Foucault's (1986) concept of 'heterotopia', which describes a type of 'other' space where paradoxical cultures are combined, and where social practices and relations of power are disrupted. We see this concept as especially suited to the study of hybrid spaces. The empirical focus of our paper is the design and operation of hospital PPPs within the English National Health Service (NHS), specifically Independent Sector Treatment Centres (ISTCs).

Social spaces and hybrid spaces

It is beyond the scope of our paper to review the literature on space. It nevertheless remains important to sketch out some of the key ideas that frame our interest in hybrid spaces. Henri Lefebvre (1991) is widely regarded as having a significant influence on the contemporary

study of space. His work argues against a static or absolute notion of space, suggesting instead that spaces are socially constructed in the context of prevailing social, political and economic structures, and are productive of social practices and relations of power that reflect these structures. His approach considers how spaces are produced through the interplay between three different perspectives: the 'conceived', 'perceived' and 'lived'. That is, the way space is conceived by planners as abstract designs reflecting particular ideologies (representations of space); the way space is perceived, thought about or imagined by those who inhabit it in the context of their shared history (representational space); and the way spaces is lived or experienced in terms of daily routines and rhythm (spatial practice).

For scholars of political economy, the spaces of the market, the factory or the office reflect and reinforce the ideologies of neoliberalism (Harvey 2006; Massey 1999). The spatial organisation of the workplace, for example, is integral to managing the division of labour (Burrell and Dale 2014). The spatial organisation of work can have an hegemonic function through obscuring underlying relations of power and giving workers the illusion of empowerment, fostering entrepreneurial identities, and provoking positive emotional responses (Dale and Burrell 2008). However, the contemporary study of space eschews structural determinism. Spaces are equally the product of human creativity and sites for emergent social practices that challenge, as much as recreate, social structures. According to Kornberger and Clegg (2004: 1094) '*space is the medium and outcome of the actions it recursively organizes*.'

Of relevance to our understanding of PPPs as hybrid organisations, is the growing significance of 'hybrid' spaces in contemporary society (Burrell and Dale 2014). In urban studies, the idea of 'mixed-use' space describes 'projects' that combine residential,

commercial and entertainment elements (Grant 2002). These enable new forms of community participation and engender new cultural practices, e.g. changing relationship between work and leisure. More broadly, hybrid spaces blur the boundaries between public and private, real and virtual, or nature and culture (de Souza e Silva 2006; Kluitenberg 2006; Whatmore 2002). A prominent example is the practice of holding a private telephone conversation in a public space, or using public spaces for commercial business. Other examples including the 'home-gym', 'online classroom', or 'coffee-shop office'. Hybrid spaces are interesting because they combine multiple purposes, logics or cultural frames, and produce shifting identities and relations of power (Burrell and Dale 2014). Returning to Lefebvre (1991), they call for attention to the way spaces are conceived at the confluence of multiple purposes, how they are perceived in multiple ways, and how they might produce contradictory social practices. Although the terms 'public' and 'private' are used in a slightly different ways within public policy, i.e. referring to economic sector, PPPs can be interpreted as a new type of hybrid space that blurs the logics of public and private sector. To elaborate our thinking on these hybrid spaces, we highlight the relevance of Foucault's concept of 'heterotopia'.

Hybrid spaces and heterotopia

Foucault's work is concerned with understanding how 'regimes of truth' constitute the subjects of which they speak, and positions these subjects in relations of power (Foucault 1980). 'Regimes of truth' are the established ideas, facts and knowledge that a given culture accepts as truthful or accurate; which are articulated through various discourses, technologies and institutions and that together represent a complex apparatus of knowledge/power (Foucault 1980). Foucault's work offers a trialectic understanding of 'space-knowledge-power' (Elden and Crampton 2007), where relations of power between discursively

constituted subjects are located within discursively constituted spaces. In his earlier historical studies, for example, Foucault (1994, 2001) describes the asylum and clinic as spaces where the 'insane' and 'sick' are made the subjects of classification, surveillance and control (Philo 2000). In *Discipline and Punish*, Foucault (1991) offers a more explicit examination of way spaces, such as prisons, realise disciplinary power through forms of enclosure, partitioning and surveillance, as exemplified by the panopticon.

Foucault's other contribution to the study of space is his concept of heterotopia (Foucault 1986). This was sketched-out in *The Order of Things* (Foucault 2002) to describe the possibilities for disorder brought about by the linking of 'things' that in are some way incongruous or 'out of place'. The incongruence of heterotopias undermines language, dissolve myths and '*make it impossible to name this and that*' (Foucault, 2002: xix). The theme of being 'out of place' was subsequently developed in his 'Other Spaces' lecture to the *Cercle d'etudes architecturals* in 1967. Here, Foucault depicts utopias and heterotopias as places in which prevailing social relations are transformed; but whilst utopias remain imagined, he saw heterotopias as very real places that:

> '*…have the curious property of being in relation with all the other sites, but in such a way as to suspect, neutralize, or invert the sets of relations that they happen to designate, mirror or reflect*' (Foucault 1986: 23).

Foucault elaborates the concept along six lines. First, although heterotopias vary across time and place, all cultures have them. Second, heterotopias take a variety of forms, have more than one meaning or function, and can change over time. Third, heterotopias juxtapose multiple meanings that would normally be incompatible in wider society. Fourth,

heterotopias are linked to particular periods of time, and can change the relationship between past, present and future. Fifth, heterotopias have boundaries and passages of entry that separate them from the rest of society. Finally, heterotopias have functions in relation to other spaces in society, through providing alternative spaces to reconcile the confusions of the real world.

Through his lecture Foucault delineates different types of heterotopias. He describes, for example, pre-modern 'crisis heterotopia' or sacred spaces for people experiencing profound life changes, such as adolescents, expectant mothers or the elderly. In contemporary society, these become the 'heterotopias of deviation' such as the school, the hospital or retirement village. In his discussion of the changing meanings of heterotopias, he gives the example of the cemetery which was once located in the centre of the community to maintain a connection with the deceased, but with new understandings of disease cemeteries have moved to the margins.

Foucault's concept has found widespread application, with many places interpreted as heterotopias, such as beaches, urban gardens, museums, shopping centres (Andriotis 2010; Chatzidakis et al. 2011; Heatherington 1997; Kern 2008; Lord 2006). Of relevance to our study is the interpretation of hospitals as 'heterotopias of deviation' where particular relations of power are realised for the construction and control of medically constituted subjects. Street and Coleman (2012) suggest the hospital qualifies as a heterotopia because of its paradoxical character of being ordered and disordered, stable and unstable, of being separated from, but still part of the wider community. White et al. (2012) describe contemporary hospitals as shaped by different, and often competing 'political-economic' and 'clinical' logics. They suggest the tensions between these logics are accommodated through what they term a

‘temporalizing of heterotopia’, by which competing logics find expression through spatially and temporally bounded social relationships within the hospital.

However, the heterotopia concept remains controversial, in part because of discrepancies between translations (De Cauter and Dehaene 2008), and because it was little developed by Foucault before his death (Johnson 2013). The likes of Harvey (2007) and Saldanha (2008) see the concept as naïve and banal, where almost any place can be interpreted as a heterotopia. Saldanha (2008) suggests it reinforces a structuralist perspective, treating space as static and totalising. This critique is often levelled at Foucault, with the suggestion that his work focuses on the structural power of discourse, whilst treating subjects as docile and non-agential. With regards to heterotopia, for example, there is almost no place for individual actors in experiencing divergent meanings, or little indication of how these ‘other places’ are created, maintained or dissolved. Following Soja (1996), we suggest there is a need to reconnect the heterotopia concept with Foucault’s wider work, especially his later writing on subjectification and ethics (see also Beckett et al. 2017).

Although Foucault’s earlier studies can give the impression of structural determinism, his later work on neoliberal governmentality and the ‘care of the self’ describe how subjects are constituted to be actively concerned with governing their own entrepreneurial or moral behaviours (Foucault, 1990, 2007). Modern governmentality involves the internalisation of governing mentalities, calculations and technologies, but importantly the willingness of subjects to participate in their own subjectification (Foucault 2007). Although ‘moral codes’ might prescribe expected ‘moral conduct’, his understanding of ‘ethics’ describes how it is only through an actor’s self-reflective relationships with themselves that they become a subject of a moral code (or resist it) (Foucault 1990). As such, Foucault saw moral conduct as

a voluntary choice; albeit one often guided by pastoral actors (Martin and Waring 2018). In an interview published in 1984, Foucault challenged the interpretation of his work as being deterministic:

> "What I tried to analyse were … the way in which individuals, in their struggles, in their confrontations, in their projects, freely constitute themselves as subjects of their practice or, on the contrary, reject the practices in which they are expected to participate. I firmly believe in human freedom….The type of analysis reveals the precariousness, the nonnecessity, and the instability of things. All this absolutely linked to a practice and to strategies that are themselves unstable and changing." (Foucault 2000: 399)

It is Foucault's description of 'precariousness' and 'instability' as a condition for 'unstable' and 'changing' practices that we see as resonating with his concept of heterotopia. We interpret heterotopias as spaces that are embedded within and resembling customary spaces found within wider society; but they are also different spaces to the extent that are separated from the wider society and because they combine incompatible meanings or rationalities that disrupt established relations of power found within the wider society. We suggest the disruption created by the juxtaposition of competing rationalities has the potential to complicate how actors internalise a coherent subjectivity, thereby necessitating heightened forms of self-reflexive agency as they navigate competing normative expectations (Beckett et al. 2017; Waring and Latif 2017). This possibility for heterotopian agency is described in Venkatesans (2009) study of the commercialisation of traditional Indian craftwork, where marginal craft workers are re-positioned to the centre of prestigious social spaces with the intent of making these subjects valuable. Significantly, craft workers actively remake their

traditional subjectivities within these new spaces in order to realise their own sense of worth. In a similar way, our paper seeks to link these aspects of Foucault's work in our analysis of PPPs as hybrid organisational spaces. Specifically, we ask how do hospital PPPs combine different logics of care, how do they transform the social practices of professionals and service users, and how do those who inhabit these spaces contest the spatial (re-) organisation of public services.

The Study

The case of Independent Sector Treatment Centres (ISTCs)

PPPs have become a prominent model for global health service modernisation. In countries where healthcare service have been organised through the public sector, PPPs have been interpreted as challenging established service values (Waring et al. 2013). The English National Health Service (NHS) has been at the forefront of PPP use. In the 1990s, financial partnerships were used to secure investment for new hospitals, reducing the need for public borrowing. In the early 2000s, private involvement in the management and delivery of frontline services was encouraged. Since 2010, reforms have created more open and competitive markets in which services have been contracted to private providers working in partnership with the NHS (Department of Health 2010).

Our study investigated a type of healthcare PPP introduced from the mid-2000s, called an Independent Sector Treatment Centre (ISTC). These are modelled on North American 'surgi-centres' to provide routine elective diagnostic and treatment services. Health policies presented ISTCs as helping to reduce waiting times by expanding service capacity, with

private contractors not only helping to '*build new hospitals but to provide NHS patients with the operations they need'* (Department of Health 2000: 15). Policies describe ISTCs as stimulating productivity and innovation, especially in technology adoption and workforce management:

> *'…spearheading the NHS drive to modernise and improve patient care, drawing on international best practice to introduce innovative ways of working.*' (Department of Health 2005: 8)

Research on ISTCs highlights a number of controversies (Gabbay et al. 2011). For instance, ISTCs have been criticised in relation to their value for money (Bate and Robert 2006), for diverting high-volume, low-risk cases to the private sector and leaving NHS services with more complex and costly cases (Pollock 2008). Our paper develops a novel spatial analysis of these facilities, recognising that these new care spaces are not straightforward extensions of corporate healthcare within the NHS, but represent a hybrid space as a consequence of the partnership between public and private sector.

Data collection

Our research involved comparative ethnographic research within three ISTCs. Two were operated by a European business, and the other by a North American. The study sites were purposively selected to understand variations in ownership and management. The North American ISTC was designed, constructed and opened between 2006-8, and the European ISTCs between 2008-9. The primary study was carried out between 2008-10, with follow-up data collection carried out in the two European ISTCs between 2011-12 (the North American

ISTC ceased operations in 2010). The study received favourable ethical approval through standard research governance processes.

Data collection involved non-participation observations within each ISTC, including an initial period of 4-6 months, with follow-up observations to investigate emergent issues. Over 700 hours of observations were undertaken in clinics, operating theatres, wards, reception areas, staff rooms and rest areas, and management offices. Descriptive observations were recorded in hand-written journals, and summary records were typed-up. Across all sites, 16 semi-structured interviews were carried out with service leaders, designers, senior clinical representatives, and managerial staff; and 72 interviews were carried out with representatives of clinical (medical, nursing, therapists, allied health professionals), and managerial staff in the two European ISTC sites.

Data analysis

Data analysis was informed by the principles of interpretative grounded theory (Strauss and Corbin 1990). Observational records and interview transcripts were analysed using computer software (nVivo v9). This involved an iterative process of coding, constant comparison, and elaboration of emerging themes. Observational data was analysed in terms of researchers' perceived spatial organisation of care, with authors reflecting upon their interpretation through regular meetings. Interview data was analysed to understand the perceptions and experiences of those involved in the design and management of the ISTCs, as well as patients and professionals involved in frontline care. The emergent findings were related back to one another, such as how observed patterns of interaction within a given space were talked about in interviews. Analysis focused on the conception of the ISTCs as a particular form of hospital, looking at the different discursive influence on spatial design, and then analysing

how these different rationalities were articulated and experienced within the spatial practices of the ISTCs. To ensure the anonymity of the ISTCs we are limited in the use of photographic evidence, and rely primarily on 'rich description'.

Findings

Sectoral influences on ISTC design

We look first at how the organising logics of private and public partners shaped the configuration of the ISTCs. The aspirations of policy-makers were echoed by the private sector executives who talked of the ISTCs as transforming the '*out-dated model of NHS care*' and giving tax-payers better '*value for money*'. Beyond such proclamations, corporate leaders saw the ISTCs as an opportunity to enter the '*lucrative*' NHS market. A major consideration was the extent to which the ISTCs would realise return on investment and secure future NHS contracts. These aspirations were found to influence the spatial configuration of the ISTCs, with leaders emphasising the importance of spatial productivity and consumer aesthetics.

The emphasis on productivity was observed during a site visit to one ISTC under construction, where the design team explained how the spatial layout created '*flow*' so that patients moved seamlessly between treatment areas, thereby reducing waste and enabling better management of work processes. This involved positioning clinical departments and treatment areas sequentially as a type of circuit. As suggested by one ISTC manager, these ideas were explicitly borrowed from the manufacturing sector:

'*There is no reason healthcare can't be organised like Toyota. Lean principles have been applied to other hospital settings, and that's exactly what we need to do if we want to show a return on our investment.*'

Corporate leaders' ambitions for aesthetic qualities tended to focus on '*enhancing consumer experience*'. This involved creating a hospital that '*does not feel like a hospital*'. For some, this was conceived in relatively narrow terms, such as the design of carpets and curtains, or catering facilities. Other ISTC leaders, however, saw this in broader terms, as fostering a unique, even emotional customer relationship between the ISTC and patients.

'*I think that this is going to be a fantastic building and it should be a fantastic service and if you get the relationships right with the NHS Trust, this could be really great for patients.*'

'*We want patients to feel different about their care. Their experience of the Centre should be different from* [hospital name]'

For NHS leaders, the ISTC policy was (somewhat surprisingly) welcomed as an opportunity to modernise NHS service. A relevant contextual finding was that, in all three sites, strategic leaders had been considering ways to reorganise 'elective' and 'urgent' care. The policy was interpreted by NHS managers as a way to reduce organisational complexity through transferring routine elective care to the ISTCs, which would benefit from investment in new facilities:

'*… it is very much driven by the acute Trust because of that original problem around emergency/elective split and the kind of problem we were having meeting demand on the emergency services*'

'*If we separated out the planned patients it would allow us to manage the emergency patients a lot better. So, the treatment centre idea was sort of born as part of that.*'

Some NHS managers did not envisage ISTCs as separate hospitals, but rather as annexed facilities. Although benefiting from new facilities, it was assumed the overall experience of care would remain similar to existing NHS services. Strategic regional leaders and commissioners described themselves as setting and monitoring the standards of care through service contracts: '*we determine the level of service we are willing to transfer to the contractor*'. There also remained many dependencies between the NHS and private partners in terms of continuity of care, but even more aesthetic choices, i.e. curtains and carpets needed to comply with NHS hygiene and safety standards. Perhaps more prominent was the requirement for ISTCs to be co-branded, with NHS logos displayed alongside those of the private partner. As described by one ISTC Manager:

'the services are incredibly complicated, in that it's not as if you can just physically detach them from the Trust and the various connection that they've got and transfer easily over to the Treatment Centre'.

Our findings suggest there were subtle differences in how partners conceived the ISTCs and, importantly, the extent to which their expectations influenced design. Private partners appeared to have more direct influence on design because they were leading the funding and

provision of these new services, whilst NHS partners assumed they were influencing the standards of care. We next look at how these influences shaped the spatial organisation of care within the ISTCs, focusing on the experiences and perceptions of patients and professionals. An initial observation is that in all ISTCs there was a spatial separation between 'public' areas and 'clinical' treatment areas, with highly controlled movement between the two. This kind of separation is arguably common to all hospitals, but in the ISTCs it enabled the management of different organising imperatives.

The Public Spaces of the 'Consumer-Traveller'

With their bright colours, high-gloss panelling and glass facades, each ISTC outwardly appeared different from the Victorian and post-war hospitals that were probably more familiar local patients. Each ISTC was entered through a lobby area that acted as a boundary-crossing point, further suggesting to patients they were *not* entering a typical NHS hospital. These entrance areas were relatively sparse, with art work, plant installations and displaying the company logo (usually alongside a smaller NHS logo). Each had a 'Welcome Desk' at which receptionists, in corporate uniforms, greeted patients and confirmed their appointments. In some ways, they resembled the type of reception found in a hotel or office. We observed how many patients asked reception staff if they were '*in the right place*' as if they did not expect these surroundings from an NHS facility.

Once through these passage points, each ISTC had open-plan waiting areas where patients were provided with comfortable seating, newspapers, televisions and refreshments. One could accommodate over 70 people, and the others around 30-40 people. Although such communal spaces are common to most hospitals, in the ISTCs they resembled the rest-area of a motorway service-station or departure lounge of an airport. The design of furniture, carpets

and artwork reflected the corporate branding and colours of the private company. In two of the waiting areas, corporate logos and mottos festooned the walls. Significantly, the usual symbolic markers of NHS care were absent, including limited use of the word 'patient', no reference to words such as 'hospital' or 'clinic'; and clinical departments were designated as numbered 'Gateways' or 'Lounges' rather than 'surgery' or 'radiology'.

Patients reported to their allocated 'Gateway' or 'Lounge' prior to their appointment. Here, we observed further parallels with the travel sector, with patients reporting to a 'Check-in Desk', where their paperwork was reviewed. At their allotted appointment time, patients were escorted through the Gateway's access point into the clinical area of the ISTC. Whilst waiting, patients were free to move around the public areas to read magazines, watch television or purchase refreshment. The other notable feature was the almost complete absence staff in recognisable clinical uniforms. Rather patients tended to interact with receptionist or concierge staff. Our overriding reflection was that these spaces were configured to replicate the types of spaces found in travel or retail, and aimed at relating to 'consumer-travellers' on a healthcare 'journey', rather than patients. Yet, there remained some marked differences with air travel, in so much that designer goods, expensive luggage or signals of adventure were all absent.

The way patients experienced these public spaces often appeared to jar with their expectations of NHS care. Although most were probably familiar with airports or service stations, they were not necessarily expecting to experience these spaces in the healthcare context. As one patient commented: '*it's very nice but it's not what I expect*'. Many patients had previously attended their local NHS hospitals, and reported a degree of uncertainty in how to act in the ISTC space. We observed how some patients appeared 'lost' in both a

physical and symbolic sense. For example, they would present to multiple reception areas and seemed ill-at-ease with the open plan waiting, tending to cluster around their designated 'lounge' or 'gateway'. A number of patients were heard to ask relatives about the meaning of the 'gateways' and make jokes about '*going on holiday*'. A few patients made more explicit reference to the ISTCs being different from the NHS, and not having the 'right' ethos care:

> *'It just feeds different, it's nice, like a private hospital. But I'm not sure where I'm going to be honest, and I don't get the feeling we matter much here. I just want to see the doctor*'.

It seemed there was a degree of incongruence between what patients expected from NHS care and what they experienced in the public spaces of the ISTCs. Despite similarities with air travel or retail, these were not immediately understandable to patients, and any assumed familiarity in design became unfamiliar in practice because it was 'out of place'; that is, patients did not see themselves as being on a journey, but rather as there to receive care.

The Clinical Spaces of the Productive Professional

We look next at the how the clinical spaces of the ISTCs were experienced by patients and professionals, such as consultation rooms, operating theatres or radiology suites. These areas were separated from the public areas, with patients only gaining entry through designated access-point under the supervision of clinical staff. Interestingly, these spaces resembled more traditional clinical settings, with an emphasis on care-related activities, the use of clinical signage, and even displaying NHS-branded posters, information booklets, guidelines and safety notices. Perhaps more significant was the visible presence of clinical staff in

standard (NHS) uniform busily interacting with patients. For many patients, these clinical spaces were more familiar, although a number commented on how they appeared cleaner or better quality than their usual NHS hospital (perhaps because they were new):

> '*You go through the door and then you know you are in a hospital.*'

> '*It's really impressive. You can almost smell the wet paint. Everything is brand new, and it works*'.

A central corridor ran through these clinical spaces along which different consultation and treatment rooms were zoned as linked departments. As described above, these spaces were designed to enable 'flow' and we observed, for example, how patients were escorted through their 'gateway' to a corresponding consultation room, as notes and equipment were brought in from nearby administration or store rooms; and when patients were escorted to their treatment areas, more equipment arrived to coincide with their treatment. Although there were inevitable breakdowns in such routines, it did resemble a finely choreographed system made possible by the spatial arrangement of work.

Clinical staff remarked that the daily patterns of work seemed more structured and coordinated than within the NHS. For example, there were few internal waiting areas; and when bottlenecks did occur they could be managed through 'queuing' patients in the public areas. Clinicians also remarked that scheduling patients and managing resources in different organisational spaces made their work appear more ordered. And yet, clinicians also commented that such order had somehow undermined the more intangible aspects of clinical teamwork. One nurse said '*it feels rather controlled at times*' and others suggested that the

lack of opportunity for interaction made it difficult to share important information between areas:

> '*You just feel isolated. If you are put in theatre…the only people you see are the people you are in theatre with…we used to see a lot of people and we used to meet up.*'

The spatial re-organisation of work was observed further inside clinical departments. A prominent issue raised by staff was the 're-zoning' of work spaces, i.e. changing the established boundaries between professional tasks. An illustrative example was observed in the pre- and post- surgery areas, which were combined into a single open-plan space with pre-surgical patients located along one wall, and post-surgical recovery on another. For service leaders, this enabled more dynamic monitoring of care flows and flexible allocation of staff. Although clinical staff acknowledged such benefits, they were concerned about the impact on their professional responsibilities and identities. As one nurse said: '*I work in recovery and I shouldn't always be working across other people's areas*.' We observed how some nurses seemed intent on maintaining their professional boundaries by marking out territories in shared clinic spaces through the use of equipment or patient records.

Clinicians expressed two further concerns about the spatial re-organisation of work. The first related to the potential for prevailing NHS work standards to be compromised, especially where the work environment was perceived as more concerned with productivity than quality. A surgeon in one ISTC captured this tension:

'*The place is organised to maximise the number of patient through the door and out the door, but are they getting the right care?*'

This concern was elaborated in terms of the time-limited interactions between clinicians, e.g. at handover, and between clinicians and patients, e.g. in consultation, which could reduce the thoroughness of decision-making. In response, clinicians enacted strategies to re-assert a more desirable workflow, which also appeared to have a spatial dimension, in so much that theatre spaces remained relatively outside of management control. This included pausing or slowing down activities to re-gain a more manageable pace. Similarly, in one ISTC nurses re-introduced clinical handover procedures previously used within the NHS to ensure the transfer of patients maintained expected 'professional standards'. In this sense, nurses reasserted control, and a more desirable professional identity, within the inner clinical spaces of the ISTC:

'*We know what we are doing. We don't need to be told how to do things differently…we've all been doing this together for years*.'

A second concern was associated with the idea that the ISTCs afforded greater management control over professional work, especially for monitoring work flow. In one ISTC this was observed in the way managers would use spatial vantage points to gauge patient flow. The use of ICTs in conjunction with space was also evident, with recording systems linked to the passage of the patient through the different spatial settings to monitor work rates. However, clinical staff were often reticent about the use of this tracking software, and indeed could be seen to congregate and converse in the back corridors which were spatial remote from the main patient flow and management scrutiny. It could be suggested that this was a deliberate

attempt to avoid the management's observation. As one surgeon argued, '*this isn't like any other business, this is medicine, and it can't be managed like a factory*'.

Discussion

Hospitals have previously been interpreted as heterotopian spaces due to their paradoxical qualities and combination of incongruent logics (Coleman and Street 2012; White et al. 2012). With the growing significance of PPPs in the design, construction and management of hospital infrastructure, our study examined whether these 'hybrid' organisational spaces might be interpreted as a further example of a Foucauldian heterotopia; and if so, how are potentially incompatible organising logics brought together, how do they transform or disrupt social practices and relations of power, and how might actors within these spaces challenge these social practices.

Our study shows how the spatial configuration of the ISTCs was shaped by, at least, three discursive influences, but significantly, with varying degrees of influence. Whilst health policies created the possibility for spatial hybridity with imperatives for service innovation (Department of Health 2000), these were translated by private and public sector actors in different, but surprisingly complementary ways. For private partners, spatial configuration needed to address commercial aspirations, especially for return on investment, by producing more productive and customer-friendly services. For public partners, ISTCs were an opportunity to manage demand for NHS care by working with the private sector to expand and modernise service capacity, but with the assumption that NHS standards would be assured through contractual or regulatory influence. Although both public and private partners influenced spatial design, our study suggests private partners had a more direct and substantial influence than the public partners. It is widely recognised that PPPs vary in terms

of the balance of public/private sector involvement (Hodge and Greve 2010), and our study supports the observation that private partners often lead on funding, designing and constructing new facilities (Yescombe 2011). This affords private partners greater influence on the spatial configuration of services, including the realisation of private sector priorities for commercial gain, possibly ahead of public value. Through relying of contractual obligations and regulatory oversight, public sector partners might be viewed as ceding their influence on the spatial organisation of services, and therefore limiting their influence on how public services are actually delivered and experiences. Although heterotopias are described as juxtaposing incompatible discourses (Foucault, 1986), our study suggests the influence of such discourses might be uneven, and that some meanings may be more influential than others, possibly because of the ability of certain actors to bring their cultural imperatives to bear on heterotopian spaces more than others.

Our study also findings that the incompatibilities between cultural meanings were accommodate through the use of 'frontstage' (public) and 'backstage' (clinical) spaces. This supports White et al.'s (2012) view that tensions between 'political-economic' and 'clinical' logics are managed through spatial and temporal boundaries within hospital heterotopias. These types of tensions have arguably become an enduring feature of contemporary public policy, with growing pressures for welfare services to emulate the market relationships (Clarke et al. 2007). Previous research notes the blurring of welfare and consumerism in similar hospital infrastructure projects (Cooper et al. 2001; Gesler 1992). For PPPs, the blurring of these different logics is arguably a more explicit and, as discussed above, influenced by private partners. Our findings suggests that private partners can design these internal spatial boundaries to manage the tensions between these logics, perhaps in ways that hides the more commercial aspects of private healthcare. In this sense, PPP hospitals are not

only ‘heterotopias of deviations’ (Foucault 1986) but possibly ‘heterotopias of commercialisation’ or ‘privatisation’; that extend commercial structures and consumer sensibilities into public service spaces that have traditionally been devised around professional-bureaucratic functions.

Extending this line of analysis, our study explores how the spatial configuration of PPPs can reconstitute the social practices and relationships of professionals and service users. Through their frontstage spaces, the ISTCs promoted more active consumerist identities (Clarke et al. 2007), redolent less of ‘patients’ seeking ‘care’, and more of ‘customers’ on a ‘journey’. Although patients might be familiar with this consumerist-traveller identity in other commercial spaces, there was uncertainty in how to perform these identities in the health care environment. The explicit intent of designers to emulate retail-consumer spaces, and the challenges faced by patients in determining their role within these spaces, might lead to the interpretation that the ISTCs are a type of *non-place* (Auge 2009). Whilst this might be the case for the ‘frontstage’ spaces, patients appeared more at ease with their role and identity in the ‘backstage’ clinical spaces, where the usual markers of NHS care were found and patients assumed a more customary and passive ‘sick role’. As elaborated below, it seemed that patients actively preferred a more ‘traditional’ patient identity, and felt uneasy with the active consumer role.

Spatial configuration also influenced professional practice of all clinicians, fostering more productive and homogeneous professional identities. A large body of research describes the reconstitution of public service professionalism and research on workplace change similarly shows how spaces articulate expectations about occupational practice and identity (Burrell and Dale 2014). Again, our study found the reconstitution of professional practices was far

from straightforward, with notable areas of resistance that, importantly, were made possible through the use of 'hidden' spaces. For example, clinicians used more concealed 'clinical spaces' to re-assert the routine of work usually associated with NHS care.

Building on these discussion points, our study seeks to enrich Foucault's concept of heterotopia by exploring the possibilities for human agency where juxtaposed cultures disrupt established relations of power. Despite widespread application, the concept remains the subject of debate and criticism (Harvey 2007). For some, it is excessively structural (Saldanha 2008), which may be accounted for by its development within a particular period of Foucault's thinking (Johnson 2013). We have tried to reconnect the concept of heterotopia with Foucault's later work on the way subjects internalise (or resist) moral imperatives (see also Beckett et al. 2017), and how this is often shaped by their self-reflexive agency (Foucault 1991; 2000) We suggest that possibilities for human agency are heightened within heterotopias spaces because they juxtapose incompatible discourses that disrupt established subjectivities, thereby necessitating actors to re-consider their own subjectivity and position within these spaces. The incongruence, even competition between cultural meanings means that actors have to make choices about which rationalities or imperatives they should follow and internalise. We show, for example, how patients found the consumer-traveller space as both familiar *and* unfamiliar, because this was in a sense 'out of place' in the hospital space. In response, patients seemed to actively accept their passive patient role in backstage spaces, whilst questioning the active consumer role in the frontstage. In similar ways, professionals found the spatialized expectations for productivity as challenging their professional identities, and were able to re-assert forms of control within 'clinical spaces'. Although incompatible discourses can be reconciled through temporal-spatial boundaries (White et al. 2012), our study suggests that where inconsistencies and instability persist between discourses, actors

find new possibilities for agency as they seek to resolve these tensions. Research shows that when faced with multiple and changing discourses, it becomes difficult for subjects to internalise a stable and coherent sense of self, leading to fragile or unstable regimes forms of governmentality (Waring and Latif 2017). Moreover, as subjects try to reconcile divergent expectations they engage in forms of agency that can be transformative of social expectations and further disrupt expected relations of power. For example, creating new professional boundaries and identities. As such, heterotopias might be seen as spaces within which social relations are inverted or disrupted, not only through the influence of incompatible discourses, but because of the agency involved in trying to creatively reconcile these incompatible discourses.

In conclusion, hybrid spaces have become an increasingly prominent feature of everyday life (Burrell and Dale 2014), and closer attention is needed to the ways these are conceived, perceived and lived as ambiguous spaces (Lefevbe 1991). We suggest Foucault's heterotopia concept offers an important perspective for thinking about this hybridity, especially for understanding the production of social practices and power relations in spaces that are constituted at the confluence of multiple, paradoxical discourses. For scholars of public policy and management, hybrid organisations have become a significant feature of public service reform, where the traditional boundaries between sectors, professions and organisations become blurred (Skelcher 2007). Although architectural innovation often features in policy, there has been limited analysis of PPPs as 'hybrid spaces'. Our paper has sought to contribute to, and further encourage a 'spatial turn' within public policy and management through examining how PPPs, as prominent vehicles for public service reform, might be interpreted as a hybrid organisational spaces, and looking at how these hybrid spaces blur different sectoral logics and transform the everyday practices of public service

delivery. This involves developing an analysis of space that goes beyond ‘outward’ design features, and attends instead to the meanings, interests and ideologies that permeate space.

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