Abstract

This paper explores how ‘place’ is conceptualised and mobilised in health policy and considers the implications of this. Using the on-going spatial reorganizing of the English NHS as an exemplar, we draw upon relational geographies of place for illumination. We focus on the introduction of ‘Sustainability and Transformation Plans’ (STPs): positioned to support improvements in care and relieve financial pressures within the health and social care system. STP implementation requires collaboration between organizations within 44 bounded territories that must reach ‘local’ consensus about service redesign under conditions of unprecedented financial constraint. Emphasising the continued influence of previous reorganizations, we argue that such spatialized practices elude neat containment within coherent territorial geographies. Rather than a technical process financially and spatially ‘fixing’ health and care systems, STPs exemplify post-politics—closing down the political dimensions of policy-making by associating ‘place’ with ‘local’ empowerment to undertake highly resource-constrained management of health systems, distancing responsibility from national political processes. Relational understandings of place thus provide value in understanding health policies and systems, and help to identify where and how STPs might experience difficulties.

Keywords

UK; NHS; place; post politics; relational geographies; Sustainability and Transformation Plans; health policy; organizing healthcare

Introduction

> The NHS is facing growing pressures, with finances deteriorating rapidly and patient care likely to suffer as a consequence. …. providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. (Ham and Alderwick 2015, p.3)

This quote, from an influential UK think-tank, highlights policy ideas of relevance to many health systems globally. The diagnosis is simple – the NHS, like other systems, faces growing demand alongside severe financial constraint – but the prescription offered may be less so. 'Place-based systems of care' sound intuitively attractive, evoking co-operation, even homeliness, with 'populations' embedded in 'places' where they receive care. Health systems across Europe have responded to the on-going financial crisis with similar strategies, regionalising service planning and management (Toth 2010), integrating services and shifting care into communities (Mladovsky et al 2012). However, geographic scholarship insists 'place' is not such a simple concept (Cresswell 2004; Massey 1994; 2005; Pred 1984). In this paper, using current English NHS reforms as an exemplar, we employ relational geographic understandings of place to consider the implications of the making of places in health policy.

Medical geography has long understood the importance of place, not only as a background for people's lives, but as an active determinant of health (Macintyre et al. 2002). Kearns and Moon (2002) plot the field, highlighting a turn from geographies of illness to focus upon health/wellness. They explore place within this literature, identifying three approaches: health in specific localities; landscape impacts on

health; and spatial approaches, including multi-level conceptions of places. Cummins et al. (2007) argue that traditional policy approaches have failed to move beyond a Euclidean conception of space as passive 'lines on a map' to incorporate ideas of relationality, whereby places actively produce, and are products of, social relations. This approach sees places as emergent, continuously constituted by the interweaving of interactions and practices through time and space (Graham and Healey 1999). Cummins et al. (2007) argue for scholarship of health and place which takes geography seriously and explores how people experience places differently.

In this context, the role of health policy in shaping places becomes important. For example, Learmonth and Curtis (2013) consider local enactment of national policy, focusing upon 'place-shaping', whilst Gustafsson (1997) calls place 'an underdeveloped variable' in health promotion. These approaches take national policy as given, focusing upon local enactment or effects. Population health is the key outcome variable of interest, with places as modifiers or sites of action. Yet, as McCann and Temenos (2015) highlight, health policies are themselves mobile across time and space. Policy adapts as it travels and gets embedded in places (McCann and Ward 2012; McCann and Temenos 2015).

In social policy more broadly, geographical understandings of place have informed investigations of 'localism'. Clarke and Cochrane (2013, p.11) explore geographies of localism in UK Coalition government policies after 2010, arguing that:

> When localism is used in political discourse, its meaning is often purposefully vague and imprecise. It brings geographical understandings about scale and place together with sets of political understandings about decentralisation, participation, and community, and managerialist

> understandings about efficiency and forms of market delivery – moving easily between each of them, even when their fit is uncertain. It is often intentionally associated, confused, or conflated with local government, local democracy, community, decentralisation, governance, privatisation, civil society etc. for political effect. This is part of what makes localism such an attractive concept capable of being mobilised by all three of the UK's main Westminster-oriented political parties.

Ideas of localism are closely tied to notions of decentralisation. Allen (2006) highlighted the shifting ideologies underpinning the UK government's calls for greater public service decentralisation in the early 2000s. She identifies fluctuating policy narratives, between a utilitarian claim that services responsive to (an assumed to be unproblematic and fixed) 'local' population would be more efficient, and a more critical view, focusing upon the democratic empowerment of local communities. However, what constitutes a meaningful 'community' is unaddressed in such policy rhetoric, and 'empowerment' in practice may simply mean shifting responsibility for cuts to local level (Lowndes and Pratchett, 2012).

Moon and Brown (2001) found local place evoked politically to 'sell' – and resist – a particular policy. Studying proposals to close St Bartholomew's Hospital in London, they explored discursive representations of the hospital in ensuing debates. Rejecting apparently rational delineations of services required to 'meet local needs', campaigners highlighted the hospital's social and symbolic significance, historically embedded and linked with local identities. Moon and Brown (2001, p.58) analyse the eventual decision to reprieve the hospital, arguing:

> ...the Barts case was not just about local residents fighting to save their hospital, it was about a fight over a symbol of place, however imaginary.

This research emphasizes how notions of place in reconfiguring health care landscapes are *contested*. We build on this, using relational geography (Massey 1994; 2005; Painter 2008; 2010) to consider the effects of defining and maintaining geographically-bounded places within current NHS policy. We focus not upon the impacts of such places on the population, but on the work of place in policy rhetoric.

Our contribution is twofold. Firstly, we combine geographical understandings of place with health policy analysis, using a relational geographic approach as a lens through which to make sense of current health policy. We extend Moon and Brown's (2001) approach by considering a broader sweep of policy over time. Secondly, we respond to calls by Andrews et al. (2012) for a publicly-engaged, policy-aware and practically-focused approach to health geography. Taking a multidisciplinary approach, combining geography with health policy scholarship, we provide a rich and empirically grounded account of English health policy enactment. Our geographical lens offers novel insights for addressing the serious issues facing health systems in the aftermath of the global financial crisis.

Our policy focus is on 'Sustainability and Transformation Plans' (STPs) in England. Recently introduced to reduce system fragmentation, these require delineation of 'footprints' within which the 'sustainability' of the health and care system must be addressed. Without altering statutory accountabilities or competition regulations, STPs require organizations to establish 'local' consensus around planning and delivering health and care. This triggers additional funding to address financial deficits and develop new services. In England, the NHS provides most health care,

whilst local government subsidizes social care. STP policy is being driven by NHS organizations, but intends to address both health and social care (NHS England et al, 2015). Whilst acknowledging the importance of local government/social care, in this paper we have chosen to reflect this imbalance by focusing on healthcare and the NHS. The process has been criticised for the limited involvement of patients, local government, and the Third Sector, which makes the development of a consensus position for any given footprint problematic and inevitably partial (Ham et al. 2017). Drawing upon evidence from several sources, including an on-going study of English NHS commissioning, we demonstrate how the boundedness of places evoked by the STP policy rhetoric is problematic by focusing upon the practices of managers, clinicians, and policy makers involved in the spatial re-organizing of health and care systems. We discuss the political effect of this notion of place within health services. We do so by extending links between Massey's (2005) theorisation of place as produced through a multiplicity of spatial relations with Mouffe's (2005, p.9) theorisation of the political as 'the dimension of antagonism … constitutive of human societies' which she distinguishes from politics understood as 'the set of practices through which order is created.' We suggest the hegemonic spatial ordering in the STP policy process treats places as bounded, coherent and singular excluding in the name of consensus, repressing other possibilities.

This paper comprises five sections. First, we provide an historical account of the ways place has figured in UK health policy. Second, we set out our theoretical framework before describing our current study. We then draw this evidence together with observations from public meetings to consider the spatial and political implications of 'place' within health policy. We conclude by considering current STP

developments, and explore the value that theoretical insights from geographic scholarship provide in understanding the implications of health policy orientating around place-based systems of care.

History of place in the NHS

How best to organize and spatially distribute health care services in the UK has exercised policymakers over many years (Mohan 2002). At its inception in 1948, the NHS embodied a model of strong centralized control, with regional variation seen as inequitable (Klein 2012). The Hospital Plan of 1962 sought to standardize care by introducing District General Hospitals (Mohan 2002); services were planned according to the institutions that delivered them. Until the 1973 NHS Reorganisation Act introduced planning for populations (Jonas and Banta 1975), 'place' figured in early NHS policy primarily in so far as hospitals or other services existed in particular places. From 1974-1982, Area Health Authorities, each covering a geographical population which matched a Local Government territory, administered all hospital and community services. They also co-ordinated primary care services, (including those provided by general practitioners (family doctors)) and services requiring collaboration with Local Government e.g. learning disability services.

In 1982 NHS structures were simplified, reducing organizational tiers. District Health Authorities (DHAs), smaller than Area Health Authorities, were given responsibility for service planning, provision and development within their catchment area. These were geographical areas defined as 'centres of population and linked transport routes' (Haynes 1987, p.11), covering between 100,000 and 400,000 people.

Haynes (1987, p9) argues that, whilst the 1974 reorganisation ‘established a framework within which an overall health care strategy for a geographical area might be devised and implemented’, the abolition of Area Health Authorities ‘diluted’ these advantages. In particular, Haynes draws attention to the ‘dislocation’ between services administered by different authorities following the loss of geographic correspondence between them (Haynes 1987, p.17). Policy focus in 1982 was on improving NHS management; DHAs oversaw ‘Units’ (hospitals or community service providers), each led by a newly appointed ‘general manager’.

The next significant reorganization occurred in 1990. The National Health Service and Community Care Act 1990 separated the functions of ‘purchasing’ and ‘providing’ care (Flynn 1997). The intention was to create a ‘quasi market’ in which purchasers bought care for a geographical population from a competing market of providers. In addition to competition (assumed to drive efficiencies), this change eliminated the burdensome ‘cross-boundary’ recharging required to accommodate patients receiving care outside their local area.

In summary, the perceived importance of geographical places and demarcated populations in UK health policy has fluctuated. A centrally-planned, hospital-centric model gave way in 1974 to a service rooted in particular geographies, but this only lasted until 1982, when a focus upon improving management led to health care conceptualized as the sum of service delivery by well-managed ‘units’, overseen by DHAs. From 1991, policy has distinguished between population *needs,* and the field of *diverse providers* necessary to meet those needs. The population is configured as rooted in place, but care providers may attract patients without reference to where they live. In practice, such distinctions are less clear, and the notion of an informal

‘health economy’ has been a feature of the lived world of the NHS (although this term did not become established until the early 2000s). Never clearly defined, always fuzzy around the edges, ‘health economy’ has come to provide a useful short hand for purchasers and providers working together to imagine their local health service in a meaningful way (Exworthy et al. 2010).

The latest major change was the Health and Social Care Act 2012 (HSCA12) which, inter alia, created NHS England—an arm’s length government agency increasingly shaping policy (Exworthy et al. 2016). Although the HSCA12 strengthened provider competition, in 2014, NHS England signalled a shift in policy. The Five Year Forward View (NHS England et al. 2014) assessed the state of the NHS and prescribed remedies to improve health and wellbeing, quality, and efficiency. More detailed guidance was published in 2015 (NHS England et al. 2015), introducing Sustainability and Transformation Plans (STPs):

> We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View… Planning by individual institutions will increasingly be supplemented with planning by place for local populations… As a truly place-based plan, the STPs must cover all areas of CCG [Clinical Commissioning Group] and NHS England commissioned activity… The STP must also cover better integration with local authority services. (NHS England et al. 2015, p.4)

Local organizations (Clinical Commissioning Groups (CCGs; 209 GP led commissioning organizations with statutory responsibility for commissioning most English health care), local authorities, and service providers were given one month

to come together to establish ‘the geographic scope of their STP’ – their ‘transformation footprint’ (NHS England et al. 2015, p.6) – and were required to nominate an individual as leader. The footprints would ‘form a complete national map’ (NHS England et al. 2015, p.6). The guidance goes on:

> …Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required (NHS England et al. 2015, p.6)

By March 2016, 44 STP footprints were defined (average population 1.2 million) (NHS England 2016b) (See Figure 1). Most nominated leaders were from NHS organizations, with only four from local authorities. Crucially, STPs have no statutory basis and existing organizational accountabilities remain unchanged. Plans for the period October 2016—March 2021 had to be submitted to NHS England by October 2016 in order to receive a portion of the £2.1 billion (for 2016/17) Sustainability and Transformation Fund.

[FIGURE 1 ABOUT HERE]

The fund allocates £1.8 billion for ‘sustainability’. Access is tightly controlled, with a focus on ensuring NHS organizations achieve financial balance. This is expected to improve ‘sustainability’ by improving care whilst saving money. What this means practically remains to be seen, but a survey indicates that, for example, a majority of footprints propose downgrading or closing some hospitals (West 2016b). Footprints

whose plans are assessed favourably will then have access to the remainder of the fund for local 'transformation' initiatives. The term 'transformation' is employed rhetorically, with little substantive specification in STP policy documents, and our use of the term reflects this.

Within and alongside these changes, 'place' has (re)appeared in NHS policy rhetoric, with policy documents covering other topics also highlighting 'place-based' planning (NHS England 2015, p.1). In such documents, presentations and press releases, and in the wider lexicon of the NHS, 'place-based' forms the rhetorical core, with STPs presented as vehicles by which the NHS will refocus itself upon local communities, thereby solving problems of fragmentation and a lack of integration.

We have described the evolution of NHS organization in England, with a particular focus on how the concept of 'place' has been used in relevant policy documents and discourse. Table 1 provides a summary.

[TABLE 1 ABOUT HERE]

Thinking relationally about organizing place-based systems

Here, we theorize the spatial construction of place-based systems of health care. We draw upon geographic scholarship examining how places and territories are produced through the intersecting of spatial relations over time (Massey 2005;

Painter 2008), setting out a theoretical framework through which we can explore the formation of STPs.

Place has long been a theoretical concern for geographers (Cresswell 2004; Massey 1994; 2005; Pred 1984). Humanist and phenomenological understandings have tended to ascribe a uniquely *local* sense of place, understood in terms of lived experience, spiritual or emotional attachment and the concrete (Relph 1976; Tuan 1977). Often deriving from Heideggerian modes of dwelling, place here is frequently posited as rooted in history and is at risk of evoking essentialising notions of boundedness, stasis and coherence. By contrast, the imagining of place within Marxist geographical accounts has tended to focus upon the global dynamics of capital that annihilate the significance of place as a consequence of time-space compression (Harvey 1989). Speaking to these long-standing debates within geography relating to the general versus the specific, Massey re-conceptualised place as constituted through a 'constellation of social relations, meeting and weaving together at a particular locus' (Massey 1994, p.154). Places are thus understood to affect, and be affected by, all kinds of different and uneven social relations. Whilst debates continue, there is emerging agreement that places and territories – be they neighbourhoods, cities or nation-states – are actively produced rather than being merely passive backgrounds for social relations.

Thinking about space relationally in this way has implications for theorizing state spaces and how we might understand health system restructuring. Theoretical debates around territorial and relational interpretations of state spaces risk resolving into an unhelpful dualism of places as produced through networks of relations and practices, or as a scalar hierarchy of territories. MacLeavy and Harrison (2010,

p.1040) address this by arguing that apparently pre-given or obvious spatial subdivisions of the state are produced through contestation and transformation:

> …particular consolidations of territory, such as the formation of regional clusters, cities or nation-states have been seen as transient scalar fixes, which are always vulnerable to transformation by new rounds of capital (dis)investment, however concretised they seem.

This is particularly pertinent to the STP process, which valorizes 'natural' communities, and promises investment as the prize for 'success'. We focus upon the spatialized practices and relations of people, organizations and institutions involved in the *provisional* making of territorial state spaces (Painter 2010; Allen and Cochrane 2007). In this way, we retain the importance of the 'regional' or 'national' in the NHS to help recognise how national bodies are simultaneously reaching into and distancing themselves from 'local' STPs.

Aligning with the work of Massey, we posit that places are produced through interweaving of multiple powerful spatial relations, rendering places always under *negotiation* rather than homogenous or bounded (Massey 2005). Rather than places being ascribed a coherent, essential identity, we can understand places as provisional, produced through co-existing heterogeneous relationships, made special through the juxtaposition of spatial trajectories in the 'here-and-now' but also of 'thens and theres' (Massey 2005, p.140). The making of STP places requires us to examine on-going spatial relationships, subjectivities and conflicts among managers and clinicians involved in reorganizing health care. This understanding also requires exploring how current practices are shaped by previous reorganizations that elide neat containment to STP footprints. So, whilst the scale of STPs might resemble

previous territories used to manage health services over the years, the terms of their construction have changed.

Relational geographies thus help us to question the construction of STP places as bounded totalities (Painter 2008), as implied in policy documents. We are not arguing that territorial conceptions of place do not exist, but that they are socially constructed through more than proximate relations, and they have a social effect. As such, we focus upon what this particular construction of place *does* within health policy and how this is linked to notions of 'sustainability'. We seek to explore how this way of thinking about place-based systems in current policy impacts upon the practices of actors implementing such changes, and consider what relationships, associations and connections are denied by constructing places as locally-bounded wholes.

This theoretical position helps us consider how the STP policy and associated processes may downplay the ways in which 'place can be a political project' (Massey 2004, p.17), arguing that claims surrounding apparently 'natural' spatial boundaries must be treated with caution. We can connect Massey's work on place with Mouffe's (1993) understanding of post-politics, to contest the implicit neutrality of bounded STP places, which are presented as a technical exercise to achieve sustainability. However, imagining STPs as bounded places that local health service organizations – along with social care organizations, and even local enterprise partnerships – have to resolve challenges *within* is not a politically neutral activity. Place in NHS policy is here mobilized to create 'local consensus' (among managers and clinicians, not citizens) around notions of financial sustainability, which in turn take as given the Government's imposition of NHS financial stringency and cuts to local authority

allocations. This forecloses questioning of the political decisions that underlie the current situation in the NHS. Thus, a relational understanding of place allows us to examine the spatial practices of organizing the NHS into bounded territories and consider the effects of such conceptualization.

Methods

We employ two sources of evidence in this paper. Firstly, we present data from qualitative interviews with senior NHS managers in two 'health economies' in England from an on-going study exploring the impact of the HSCA12 on the operation and outcomes of NHS commissioning. Respondents (101) include CCG staff (managers and clinicians), NHS England staff and local authority commissioners. Interviews, lasting approximately one hour, focused upon experiences of commissioning pre and post HSCA12 and explored issues of salience to the interviewee in their organisational context. Although some interviews took place before the STP process began, repeatedly our respondents returned to the question of defining 'our place' and 'our footprint', puzzling over the multiple scales and overlapping areas of responsibility relevant to their work. Secondly, we report evidence from public speeches made by senior policy makers involved in the STP process, exploring how place is articulated and presumed to act by those responsible for developing the policy.

Results

The spatial formation of place-based identities/entities

In this section, we examine how notions of 'place' within the NHS are negotiated and contested. STPs are intended to *transform* relationships between health and social care organizations *within* each place (NHS England et al. 2014). Yet, we suggest that the spatial formation of such relationships defies neat geographical designation. For instance, policy guidance instructs each STP 'footprint' to consider patient flows in its definition (NHS England et al. 2015, p.6). Patient flow refers to care-seeking behaviours, with individuals making decisions based upon proximity to home/work, service reputation, previous experiences, and socio-culturally mediated perceptions of health and illness. With health care provision concentrated in cities, people from surroundings areas travel to seek care. Thus, flows of patients beyond an STP footprint's boundaries will have impact within *and* beyond that footprint, illustrating the inherent tension between the fixing of geographical boundaries and flows, and connections and relationships that exceed and resist such boundaries.

STP policy requires the definition of 44 discrete sub-national units. The guidance implies that each place should correspond to a pre-existing 'natural' NHS and local government sub-system. Yet in practice, the processes of delineation are more complex, the product of particular social-spatial relations. For instance, one CCG manager illustrates the challenge of locating the place for which her organization is responsible:

> It's the population of Town X, but actually ...we look a little bit further than Town X, because our patients don't just go in Town X for their care, …only 60 per cent of acute care for Town X residents is provided within Town X, you know, the other 40 per cent goes to Town Y and all sorts of other different places. [CCG, ID4446]

Thus, associations exceed Town X and connect with ‘all sorts of other different places’, showing how the social relations that produce places stretch out and constitute places elsewhere (Massey 2005).

That is not to say that territories are no longer important. Rather, it suggests the need to pay attention to the *terms* of the relations that produce these particular boundaries and their associated identities. In a large metropolitan area, NHS England managers were concerned about one CCG that experienced difficulties establishing its organizational structure. A senior CCG manager explained that these difficulties stemmed from attempts to reconcile the interests of several GP sub-groups, one of which felt strongly that they should form a separate CCG:

> … we now have one organisation that has three localities, and they're predominantly one of those localities. So they've maintained an identity, they've maintained a voice, they've got their representation. But it took a long time to get there because we've got some very strong-minded people and quite obviously are standing up for what they believe to be the right thing to do. [CCG, ID7679]

Thus, longstanding relationships between groups of GPs have created pockets of identity and forged particular alliances, in part through responses to previous reforms. Hammond (2015), building on Exworthy et al. (1999), uses a geographical metaphor – ‘sedimentation’ – to describe this, suggesting that the form taken by NHS organizations is shaped by the ‘laying down’ – albeit somewhat haphazardly – of ‘strata’ from previous policies. This sedimentation of associations arising from waves of reorganization can be understood as occurring not only in the dimension of the temporal, but also that of the *spatial*, as different associations and relationships

between health care organizations meet, intersect and collide (Massey, 2005). Therefore, the places these relationships help produce are continuously (re-)produced and contested rather than 'natural'.

In a major English city, two CCGs had been established. Several interviewees lamented the fact that having two CCGs rather than one created difficulties. One explained:

> I think the other reason why there isn't a single CCG for [the city] was because there was no single GP leader that everyone will sign up to. So [CCG A] Chair and [CCG B] Chair are very different individuals, got very different approaches to primary care and commissioning and people have generally aligned themselves behind one or the other really. [CCG, ID5998]

The desire to protect established shared identities among GPs took on distinct territorial dimensions through the insistence on having two discrete CCGs. Yet, in practice, these places were far from discrete:

> In this city the fact that neither CCG A nor CCG B have actually a real geography is awkward……there's an official map that makes it look like we're contiguous and then there's a real map that's …a bit of a hodge podge of [GP] practices. [CCG, ID6814]

Attempts to pin down organizational structures to some kind of geographical 'reality' resolve to a bounded 'common sense' notion of place. As the difficulties of these CCG interviewees highlights, however, the formation of identities and entities is negotiated and relationally produced.

Drawing boundaries around a particular territory for health and social care is an attempt to present a coherent and stable representation of a place. We suggest that the formation of STP places arises out of previous NHS restructurings, which have shaped and been shaped by relationships between different individuals and organizations. This leads us to examine more closely the *terms* of these relations (and non-relations) before considering how these apparently coherent spatial entities are supposed to hold together.

Local health economies and the Health and Social Care Act 2012

The informal, subjective notion of a 'health economy' has been an important feature of NHS inter-organizational dynamics. In this section we explore how the networked associations and tacit arrangements that constituted these non-exclusively defined places were disrupted by the HSCA12, and consider how this influences the designation of STP footprints as singular articulations of 'places'.

Historically, whilst formal policy post-1991 required NHS organizations to compete with one another, there was an implicit understanding of local interdependences and willingness to, at times, sacrifice organizational interests in favour of a perceived greater good. Whilst local health economies were rarely clearly defined, those within them had a 'common sense' understanding of what the term meant and which organizations were included (Exworthy et al. 2010, p.31). For example, Checkland et al. (2012, p.12) found that managers within Primary Care Trusts (the local commissioning organizations that preceded CCGs), whilst clear about the need to balance their books, were not inclined to do this at the expense of other local organizations. This was supported by informal strategies which formed part of the relational norms operating between contracting parties by which commissioners and

providers came together privately to ensure overall financial balance (Allen and Petsoulas, 2016). Exworthy and Frosini (2008) similarly found that Primary Care Trust managers were reluctant to exercise autonomy because they did not want to 'destabilize' other local organizations.

Longstanding relationships such as these were significantly altered by the HSCA12, which was likened by one interviewee to 'moving beaches as well as moving the deckchairs' [CCG, ID3666]. Organizations were abolished and new ones created; people in long established roles moved elsewhere or were made redundant, disconnecting their accumulated local knowledge and experience:

> … we went from a very big PCT management base with lots of skills, lots of experiences, by the time we got to that last 12 months I was the only person on the executive that had any experience of the local area. All of the other directors had either been moved on or had found other things. [CCG, ID7679]

This erosion of institutional knowledge occurred alongside significant changes in responsibilities, creating confusion. One CCG manager recounted the story of a meeting between organizations to plan vaccinations:

> … we all recognise there's a bit of an issue… who's actually going to do the work? It was… a clear articulation I guess of some of the uncertainty ….. So whose job is it to sort out flu vaccinations, we just couldn't… no-one could answer it that clearly. We all agree there is a problem, none of us can agree who takes the action! [CCG, ID3271]

Policy-driven reorganizations of health care systems are costly in terms of staff stress and reduced performance (Walshe 2016). We suggest that the HSCA12 led to loss of institutional memory, coupled with uncertainty over who held particular responsibilities, whilst promoting increased competition in the market of health service provision. This in turn disrupted health economies. Despite – or perhaps because of – this, NHS England dictates that, through the STP process, health systems must specify their boundaries, nominate a single leader, and agree plans that spell out how services will be reconfigured to meet the financial challenge. However, the explicit articulation of the boundaries and composition of health economies undermines what has historically been their key quality: their useful ambiguity, which allowed burden sharing not necessarily spelt out publicly.

STPs foreclosing the political

Here, we focus upon the power relations embedded within the spatialized social practices of managing and organizing the English NHS. The STP process is portrayed as a technical exercise, requiring presentation of a pragmatic consensus about how health and care systems can be made sustainable. We have outlined how constructions of place within the NHS are shaped by previous reorganizations, through alliances and conflicts, and thus how STPs are shaped by past events. We draw upon Mouffe's (2013, p.27) conceptualisation of 'sedimented hegemonic practices', the accumulation of power-laden practices that seek to stabilize a given order and fix social institutions in supposedly common sense or inevitable ways. Through this we see how STPs are presented so that there is now no alternative but for 'big *local* choices' (Simon Stevens, Chief Executive (NHS England 2016a) our emphasis) to be made around 'reconfiguring' and 'rationalizing' services. This

process has largely taken place without democratic oversight, yet is necessary for local organizations to obtain national funding to plug deficits. We suggest its effect is to limit wider questioning over the politics of past and present *national* policy, in relation to NHS funding and the consequence of cuts to local authority social care budgets, whilst avoiding any explicit challenge to the longstanding policy consensus that embedded market relations and associated organizational forms in the NHS. For example, there is little attention to how the mandated 'big local choices' around hospital-based services within an STP that has hospitals built through private finance initiative (PFI) – contracts which involve long-term lease back agreements with the private sector (Raco 2016) – will be directly shaped by relations with international financiers, not local state actors, even if there are consequences for non-PFI hospitals nearby.

The emergence of STPs follows repeated reorganizations, framed as a means of enhancing 'local empowerment' and 'autonomy' of NHS organizations, alongside increased patient choice and competition (Department of Health 2010). Locating the 'local' within these reforms is not straightforward. There has undoubtedly been a complex 'layering' of different territorial 'footprints', some of which have emerged through locally-driven practices, others imposed by central bodies. CCGs, for instance, were created with the aspiration that they would more effectively represent interests of local professionals and their patients. Their geographical coverage was not predefined, with GP practices urged to come together to establish themselves in locally meaningful ways (Department of Health 2010). They were presented in policy rhetoric as local entities that would operate with greater autonomy. However, CCGs exist within a complex regime of accountability and control that eludes neat definition

519 as the ‘local’, and CCG interviewees report a progressively reduced ability to
520 exercise autonomy (Checkland et al. 2013).

521 We may draw parallels with the new localism agenda that has gathered momentum
522 in the UK since 2010. Although current support for localism has similarities and
523 differences with the previous New Labour administration (cf. Clarke and Cochrane
524 2013), of significance is what Featherstone et al. (2012, p.177) term ‘austerity
525 localism’. They argue that the ‘local’ is identified as a site for intervention whereby
526 demarcated places are required to resolve seemingly internal conflicts given the
527 ‘right support’ from national bodies. With STPs, we can see how ‘places’ and ‘the
528 local’ are being conflated, as normative justification for addressing socio-politically
529 mediated financial challenges:

530 > … we talk about the financial gap in the NHS, people quite readily reach
531 > for the £30 billion or £22 billion… and I think the challenge we have is
532 > trying to take what was effectively a national story and say ‘*how can we*
533 > *make that something that is owned and understood at a local level?*’ So
534 > the national story is all pretty abstract, it’s abstract in terms of where those
535 > gaps are, it’s abstract in terms of who owns them and who’s able to do
536 > something about them. *So the STP process was really launched as an*
537 > *attempt to support local areas to really own their local burden of that*
538 > *challenge and articulate what they needed to do to address it*… [Paul
539 > Dinkin, involved in the STP process with NHS Improvement and NHS
540 > England, speaking at a King’s Fund conference, 7.6.16; our emphasis]

541 Thus, STPs are a policy articulation of the imperative to manage ‘financial
542 sustainability’ by working together in ‘place-based’ systems, each of which will ‘own’

a portion of the national financial challenge. STP definition is presented as a neutral, technical procedure (NHS England et al. 2014). However, emerging without public consultation or Parliamentary debate, the process has been characterized by its extra-legislative form; the financial 'fixing' of the NHS has become equated with an apparent *spatial* fixing in STPs.

This conceptualization of place within the STP process insists each place should speak with one voice, overseen by a single leader, with tensions locally contained. This apparent singular local narrative may be problematic; as Mouffe (2005, p.11) argues, 'every consensus is based on acts of exclusion'. The STP process is presented as a sensible and progressive development, its inevitability and urgency bolstered by the financial context. Some STP footprints have been prescribed with leaders inserted by NHS England, and all have multiple 'must dos' to qualify for funding, yet STPs are presented as apolitical and value neutral. There is an implicit assumption that it does not matter who the leaders are, and that all organizations will be willing to cede authority to the STP – and its leader – because it serves an unequivocal greater interest given the circumstances.

STPs exist in the shadow of the HSCA12, which embedded competition with claims of improving quality. However, competition is downplayed in the STP process, replaced rhetorically by calls for place-based 'partnership' working. This extract reveals the expectation from an NHS England programme director that NHS organizations within an STP 'footprint' would develop a coherent local vision and consensus:

> We are looking for ambitious health economies who can articulate their care model, as opposed to an organizational form, and that know what

> they are about and have strong partnerships that even when we stress test it they're going to be able to coherently demonstrate that the providers are speaking with a common language. Yes, there will be tensions within the system but they are willing to work through those and that there is a common goal in terms of the delivery of population health within that local system. [Louise Watson (National MCP Care Model Lead and Deputy Programme Director, New Care Models Programme, NHS England), speaking at a King's Fund conference, 7.6.16]

The STP process attempts to 'bottle and label' health and care economies and the inter-organizational collaborations that constitute them. However, as demonstrated above, local collaborative relationships evolved gradually over time and were tested by the fragmentation arising from the HSCA12. Perhaps most crucially, health economies were historically plural and subjective because defining their exact composition and boundaries was not necessary for them to fulfil their function. By contrast, NHS England requires STP footprints to be fixed.

Places are thus treated as bounded totalities within which separate NHS (and other) organizations must hold together as one, in spite of fragmented relations that have accumulated over many structural reorganizations. Mouffe (1993, p.149) argues that '[i]nstead of trying to erase the traces of power and exclusion, democratic politics requires that they be brought to the fore, making them visible so that they can enter the terrain of contestation'. Managing STP places as local, singular and bounded has the spatial effect of closing down contesting voices – not least from the broader workforce and public (Anonymous NHS manager 2016) – denying the dimension of

590 the political (Massey 2005). In short, place risks becoming a hegemonic discourse in
591 the NHS that excludes in the name of local consensus.

592

593 **Discussion: spatial and financial 'fixing' of the NHS**

594 STPs position 'place' as a self-evidently correct organizing principle for the English
595 health and care system. The policy can be understood as a strategy to increase
596 control over health budgets by defining them in relation to specific places, exerting
597 financial incentives for organizations to collaborate to address deficits, and ascribing
598 responsibility to these places for any 'local' failures. Yet, the policy does little to take
599 account of the effects of previous NHS reorganizations, and the relational and
600 uneven ways that places are constituted. We have illustrated the residual effects of
601 such reorganizations, situating this recent focus on place in NHS policy history. In
602 STP documentation, the fixing of place is implicitly treated as straightforward, to be
603 rapidly achieved to support 'transformation', but this conceals the embedded power
604 relations. The policy has operationalized place as a control tool, rhetorically insisting
605 that place equates with the (desirable) 'local'. This involves ascribing single identities
606 to plural and subjective health economies. This spatial fixing of places ties
607 demarcated topographical areas to incentives and penalties in the name of
608 'sustainability' and 'transformation' to meet efficiency targets and access tightly
609 controlled state funding.

610 However, understanding places as constantly under construction and negotiation
611 highlights that such spatial formation is not straightforward. If we follow Massey's
612 (2005) theorization of space as the dimension of a multiplicity of social relations

613 intersecting, the designation of place in current NHS policy can be argued to have
614 the effect of spatial closure, whereby solutions to problems in health and care
615 systems are to be found internally. A relational understanding of the spatial practices
616 that constitute the NHS helps us examine entities that may appear stable, yet whose
617 boundaries are changing, contested and overlapping. Of importance are the *terms* of
618 attempts to define these relations. The positioning of STPs as an expression of
619 'local' consensus is problematic because it defines place as a hegemonic spatial
620 ordering that represses democratic contestation, lacking political channels for
621 alternatives. Thinking about space and place relationally has implications for health
622 service policy and those involved in STP processes. We argue for recognition that
623 places cannot necessarily be easily bounded. Whilst not denying that health service
624 delivery requires require specification of territories, we suggest that there must also
625 be recognition of the terms and effect of their production shaped by the politics of
626 austerity. We emphasize the need to appreciate the histories composing the inter-
627 related families of organizations in geographical localities.

628 These STP 'places' cannot be equated to 'local' areas that are spatially separate
629 from 'central' bodies, as they are negotiated through the meeting of local, regional
630 and central actors, bodies and processes. For example, the process, interests and
631 actors involved in determining STP leaders has lacked transparency, and caution is
632 required in presenting them as speaking as a singular voice for their STP and its
633 population. The presentation of places as neutral and uncontested 'lines on a map'
634 brackets out important questions of ('local') politics and power which, unaddressed,
635 may derail the positive effects of collaboration. Policy makers require awareness of,

and sensitivity to, the complex issues around power, politics, representation and history that STPs embody if their stated objectives are to be met.

There appears little appetite for further legislative change in the NHS. Nevertheless, STPs do represent a de facto reorganization, and the Chief Executive of NHS England recently suggested that they may require a 'firmer footing' (West 2016a). Without this, it is uncertain how STPs will reconcile their role and exercise power over CCGs, in particular, given the statutory responsibilities of the latter. Reports suggest some CCG members are questioning the legitimacy of STP governance processes and highlighting associated democratic deficiencies (Thomas 2016). Some local authorities have rejected drafts of STP plans, citing concerns about service cuts and transparency (Thomas and Gammie 2016). Their STPs, apparently, do not speak for them and the interests of their place.

'Place' has developed significant traction as an organizing principle in the English health system, and is now positioned as an axiomatically necessary approach. Counter to this shift towards place being 'technical' or an inevitable progression, we argue that such imposition of 'place' risks foreclosing the political, suppressing or 'turning down the noise' on political contestation through evoking notions of local consensus. Internationally, other health systems have undergone, and continue to experience, regionalisation reforms that similarly espouse increased localism. In Italy, for example, a policy attempting to decentralize health care, shifting budgetary responsibility to regions, has exacerbated existing inequalities (Toth 2010). This underlines the wider applicability of the issues that we have raised. Through tracing associations and practices that constitute particular places, we have analysed how placed-based identities/entities are relationally produced and mediated. We

encourage both health scholars and policy makers in all jurisdictions to be attentive to the *spatial dimension*s of power in the on-going reorganisation of health services.

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799 FIGURE 1 *The 44 STP geographical footprints in England (NHS England, 2016b)*

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Era	Administrative units	Underpinning principle	Interpretation of place visible in policy documents and discourse
Pre 1974	Atomized providers – hospitals & GPs	Centralized planning	Providers exist in particular places
1974-1982	Area Health Authorities coterminous with Local Authorities and Family Practitioner Committees Hospitals subject to planning by Area Health Authorities	Planning for a geographical population	Geographical place as the building block of the NHS
1982-1990	District Health Authorities – covering smaller populations than Area Health Authorities. Some loss of correspondence with Local Authority/FPC footprints	Managed 'units' delivering care	Provider units exist in particular places
1990-1997	Health Authorities – bring together responsibility for GP, community and hospital services NHS Trusts introduced – quasi-independent providers of care	Purchasing split from providing in a quasi-market	Purchasers cover a geographical population, purchasing care from dispersed and competing non place-based providers
1997-2010	Primary Care Groups, moving to Primary Care Trusts Provider NHS Trusts, plus 'Foundation Trusts' introduced – more independent than NHS Trusts	Initial retreat from market rhetoric, but from 2003 market and 'choice' re-emphasized	As above – geographical population configured as having health care 'needs', met by geographically dispersed competing providers
2010-2014	Clinical Commissioning Groups (CCGs) All Trusts to become FTs	Competition enshrined in law, with new regulator (Monitor)	As above
2014 onwards	Sustainability and Transformation Plans introduced	No legislative change but shift in policy focus to co-operation between purchasers and providers in a geographical place (publication of Five Year Forward View by NHS England)	Planning across organisations for geographical places presented as the solution to the problem of fragmented care and financial deficits (market competition de-emphasized but not challenged)

804 TABLE 1 *The development of NHS organization in relation to place, pre 1974 to*

805 *present*

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