

1 **Abstract**

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

19

20 **Keywords**

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

23

24

25 **Introduction**

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

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

44 Medical geography has long understood the importance of place, not only as a
45 background for people's lives, but as an active determinant of health (Macintyre et al.
46 2002). Kearns and Moon (2002) plot the field, highlighting a turn from geographies of
47 illness to focus upon health/wellness. They explore place within this literature,
48 identifying three approaches: health in specific localities; landscape impacts on

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

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

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

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

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

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

89 Moon and Brown (2001) found local place evoked politically to 'sell' – and resist – a
90 particular policy. Studying proposals to close St Bartholomew's Hospital in London,
91 they explored discursive representations of the hospital in ensuing debates.

92 Rejecting apparently rational delineations of services required to 'meet local needs',
93 campaigners highlighted the hospital's social and symbolic significance, historically
94 embedded and linked with local identities. Moon and Brown (2001, p.58) analyse the
95 eventual decision to reprove the hospital, arguing:

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

98 This research emphasizes how notions of place in reconfiguring health care
99 landscapes are *contested*. We build on this, using relational geography (Massey
100 1994; 2005; Painter 2008; 2010) to consider the effects of defining and maintaining
101 geographically-bounded places within current NHS policy. We focus not upon the
102 impacts of such places on the population, but on the work of place in policy rhetoric.

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

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

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

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

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

147

148 **History of place in the NHS**

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

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

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

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

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

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

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

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

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

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

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

223 By March 2016, 44 STP footprints were defined (average population 1.2 million)
224 (NHS England 2016b) (See Figure 1). Most nominated leaders were from NHS
225 organizations, with only four from local authorities. Crucially, STPs have no statutory
226 basis and existing organizational accountabilities remain unchanged. Plans for the
227 period October 2016—March 2021 had to be submitted to NHS England by October
228 2016 in order to receive a portion of the £2.1 billion (for 2016/17) Sustainability and
229 Transformation Fund.

230

231 [FIGURE 1 ABOUT HERE]

232

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

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

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

248

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

252

253 [TABLE 1 ABOUT HERE]

254

255 **Thinking relationally about organizing place-based systems**

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

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

261 Place has long been a theoretical concern for geographers (Cresswell 2004; Massey
262 1994; 2005; Pred 1984). Humanist and phenomenological understandings have
263 tended to ascribe a uniquely *local* sense of place, understood in terms of lived
264 experience, spiritual or emotional attachment and the concrete (Relph 1976; Tuan
265 1977). Often deriving from Heideggerian modes of dwelling, place here is frequently
266 posited as rooted in history and is at risk of evoking essentialising notions of
267 boundedness, stasis and coherence. By contrast, the imagining of place within
268 Marxist geographical accounts has tended to focus upon the global dynamics of
269 capital that annihilate the significance of place as a consequence of time-space
270 compression (Harvey 1989). Speaking to these long-standing debates within
271 geography relating to the general versus the specific, Massey re-conceptualised
272 place as constituted through a 'constellation of social relations, meeting and weaving
273 together at a particular locus' (Massey 1994, p.154). Places are thus understood to
274 affect, and be affected by, all kinds of different and uneven social relations. Whilst
275 debates continue, there is emerging agreement that places and territories – be they
276 neighbourhoods, cities or nation-states – are actively produced rather than being
277 merely passive backgrounds for social relations.

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

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

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

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

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

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

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

319 This theoretical position helps us consider how the STP policy and associated
320 processes may downplay the ways in which 'place can be a political project' (Massey
321 2004, p.17), arguing that claims surrounding apparently 'natural' spatial boundaries
322 must be treated with caution. We can connect Massey's work on place with Mouffe's
323 (1993) understanding of post-politics, to contest the implicit neutrality of bounded
324 STP places, which are presented as a technical exercise to achieve sustainability.
325 However, imagining STPs as bounded places that local health service organizations
326 – along with social care organizations, and even local enterprise partnerships – have
327 to resolve challenges *within* is not a politically neutral activity. Place in NHS policy is
328 here mobilized to create 'local consensus' (among managers and clinicians, not
329 citizens) around notions of financial sustainability, which in turn take as given the
330 Government's imposition of NHS financial stringency and cuts to local authority

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

335

336 **Methods**

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

351

352 **Results**

353 ***The spatial formation of place-based identities/entities***

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

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

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

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

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

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

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

402 between health care organizations meet, intersect and collide (Massey, 2005).

403 Therefore, the places these relationships help produce are continuously (re-

404)produced and contested rather than 'natural'.

405 In a major English city, two CCGs had been established. Several interviewees

406 lamented the fact that having two CCGs rather than one created difficulties. One

407 explained:

408 I think the other reason why there isn't a single CCG for [the city] was

409 because there was no single GP leader that everyone will sign up to. So

410 [CCG A] Chair and [CCG B] Chair are very different individuals, got very

411 different approaches to primary care and commissioning and people have

412 generally aligned themselves behind one or the other really. [CCG,

413 ID5998]

414 The desire to protect established shared identities among GPs took on distinct

415 territorial dimensions through the insistence on having two discrete CCGs. Yet, in

416 practice, these places were far from discrete:

417 In this city the fact that neither CCG A nor CCG B have actually a real

418 geography is awkward.....there's an official map that makes it look like

419 we're contiguous and then there's a real map that's ...a bit of a hodge

420 podge of [GP] practices. [CCG, ID6814]

421 Attempts to pin down organizational structures to some kind of geographical 'reality'

422 resolve to a bounded 'common sense' notion of place. As the difficulties of these

423 CCG interviewees highlights, however, the formation of identities and entities is

424 negotiated and relationally produced.

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

432 ***Local health economies and the Health and Social Care Act 2012***

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

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

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

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

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

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

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

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

482 ***STPs foreclosing the political***

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

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

507 The emergence of STPs follows repeated reorganizations, framed as a means of
508 enhancing 'local empowerment' and 'autonomy' of NHS organizations, alongside
509 increased patient choice and competition (Department of Health 2010). Locating the
510 'local' within these reforms is not straightforward. There has undoubtedly been a
511 complex 'layering' of different territorial 'footprints', some of which have emerged
512 through locally-driven practices, others imposed by central bodies. CCGs, for
513 instance, were created with the aspiration that they would more effectively represent
514 interests of local professionals and their patients. Their geographical coverage was
515 not predefined, with GP practices urged to come together to establish themselves in
516 locally meaningful ways (Department of Health 2010). They were presented in policy
517 rhetoric as local entities that would operate with greater autonomy. However, CCGs
518 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'

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

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

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

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

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

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

582 Places are thus treated as bounded totalities within which separate NHS (and other)
583 organizations must hold together as one, in spite of fragmented relations that have
584 accumulated over many structural reorganizations. Mouffe (1993, p.149) argues that
585 '[i]nstead of trying to erase the traces of power and exclusion, democratic politics
586 requires that they be brought to the fore, making them visible so that they can enter
587 the terrain of contestation'. Managing STP places as local, singular and bounded has
588 the spatial effect of closing down contesting voices – not least from the broader
589 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,

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

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

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

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

662

663 **References**

664 Allen, J. and Cochrane, A. (2007). Beyond the territorial fix: regional assemblages,
665 politics and power. *Regional Studies*,41(9),pp.1161–1175.

666 Allen, P. (2006).New localism in the English National Health Service: what is it for?
667 *Health Policy*,79(2–3),pp.244–252.

668 Allen, P. and Petsoulas, C. (2016).Pricing in the English NHS quasi market: a
669 national study of the allocation of financial risk through contracts. *Public Money and*
670 *Management*,36(5),pp.341-348

671 Andrews, G.J. et al. (2012).Arguments in health geography: on sub-disciplinary
672 progress, observation, translation. *Geography Compass*,6(6),pp.351–383.

673 Anonymous NHS manager. (2016).NHS plans could bring benefits but we're barred
674 from telling the public. *The Guardian*.[online].:

675 <https://www.theguardian.com/healthcare-network/views-from-the-nhs->

676 [frontline/2016/aug/26/nhs-plans-bring-benefits-barred-telling-public-sustainability-](https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/2016/aug/26/nhs-plans-bring-benefits-barred-telling-public-sustainability-)

677 [transformation-plans](https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/2016/aug/26/nhs-plans-bring-benefits-barred-telling-public-sustainability-transformation-plans) [Accessed 21/10/16].

678 Checkland, K. et al. (2012).Commissioning in the English National Health Service:
679 what's the problem? *Journal of Social Policy*,41(03),pp.533–550.

680 Checkland, K. et al. (2013).Accountable to whom, for what? An exploration of the
681 early development of Clinical Commissioning Groups in the English NHS. *BMJ*
682 *Open*,3(12),p.e003769.

683 Clarke, N. and Cochrane, A. (2013).Geographies and politics of localism: the
684 localism of the United Kingdom's coalition government. *Political*
685 *Geography*,34,pp.10–23.

686 Cresswell, T. (2004). *Place: a short introduction*. Oxford:Blackwell.

687 Cummins, S. et al. (2007).Understanding and representing 'place' in health research:
688 A relational approach. *Social Science & Medicine*,65(9),pp.1825–1838.

689 Department of Health. (2010).*Equity and excellence: liberating the NHS*. London:
690 The Stationery Office.[online]
691 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAn](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)
692 [dGuidance/DH_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)[Accessed 21/3/11].

693 Exworthy, M. et al. (2010).Decentralisation and performance: autonomy and
694 incentives in local health economies. *NIHR-SDO Programme Project (08/1618/125)*.
695 [online][http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO_FR_08-1618-](http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO_FR_08-1618-125_V01.pdf)
696 [125_V01.pdf](http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO_FR_08-1618-125_V01.pdf)[Accessed 12/6/17].

697 Exworthy, M. and Frosini, F. (2008).Room for manoeuvre? Explaining local
698 autonomy in the English National Health Service. *Health Policy*,86(2–3),pp.204–212.

699 Exworthy, M., Mannion, R. and Powell, M. eds. (2016).*Dismantling the NHS?:*
700 *evaluating the impact of health reforms*. Bristol:Policy Press.

701 Exworthy, M., Powell, M. and Mohan, J. (1999).Markets, bureaucracy and public
702 management: the NHS: quasi-market, quasi-hierarchy and quasi-network? *Public*
703 *Money & Management*,19(4),pp.15–22.

704 Featherstone, D. et al. (2012).Progressive localism and the construction of political
705 alternatives. *Transactions of the Institute of British Geographers*,37(2),pp.177–182.

706 Flynn, R. (1997).*Contracting for health: quasi-markets and the National Health*
707 *Service*. Oxford:Oxford University Press.

708 Graham, S. and Healey, P. (1999).Relational concepts of space and place: issues
709 for planning theory and practice. *European Planning Studies*,7(5),pp.623–646.

710 Gustafsson, U. (1997).Improving the nation’s health: the relevance of place in
711 English health policy. *Health & Place*,3(4),pp.281–284.

712 Ham, C. et al. (2017).*Delivering sustainability and transformation plans: from*
713 *ambitious proposals to credible plans*. The King’s Fund.

714 Ham, C. and Alderwick, H. (2015).*Place-based systems of care*. The King’s Fund.

715 Hammond, J. (2015).*Health policy, the politics of governance and change: the*
716 *introduction of Clinical Commissioning Groups in context*. PhD. The University of
717 Manchester.

718 Harvey, D. (1989).*The condition of postmodernity*. Oxford:Blackwell.

719 Haynes, R. (1987).*The geography of health services in Britain*. London:Croom Helm.

720 Jonas, S. and Banta, D. (1975). The 1974 reorganization of the British National
721 Health Service: An analysis. *Journal of Community Health*,1(2),pp.91–105.

722 Kearns, R. and Moon, G. (2002). From medical to health geography: novelty, place
723 and theory after a decade of change. *Progress in Human Geography*,26(5),pp.605–
724 625.

725 Klein, R. (2012). The politics of participation. In *Politics, health, and health care:
726 selected essays*. New Haven:Yale University Press, pp.406–420.

727 Learmonth, A. and Curtis, S. (2013). Place shaping to create health and wellbeing
728 using health impact assessment: health geography applied to develop evidence-
729 based practice. *Health & Place*,24,pp.20–22.

730 Lowndes, V., & Pratchett, L. (2012). Local Governance under the Coalition
731 Government: Austerity, Localism and the ‘Big Society’. *Local Government Studies*,
732 38,pp.21-40.

733 Macintyre, S., Ellaway, A. and Cummins, S. (2002). Place effects on health: how can
734 we conceptualise, operationalise and measure them? *Social Science &
735 Medicine*,55(1),pp.125–139.

736 MacLeavy, J. and Harrison, J. (2010). New state spatialities: perspectives on state,
737 space, and scalar geographies. *Antipode*,42(5),pp.1037–1046.

738 Massey, D. (1994). *Space, place and gender*. Minneapolis:University of Minnesota
739 Press.

740 Massey, D. (2004). Geographies of responsibility. *Geografiska Annaler: Series B,*
741 *Human Geography*,86(1),pp.5–18.

742 Massey, D. (2005). *For space*. London:SAGE.

743 McCann, E. and Temenos, C. (2015). Mobilizing drug consumption rooms: inter-
744 place networks and harm reduction drug policy. *Health & Place*,31,pp.216–223.

745 McCann, E. and Ward, K. (2012). Policy assemblages, mobilities and mutations:
746 toward a multidisciplinary conversation. *Political Studies Review*,10(3),pp.325–332.

747 Mladovsky, P., Srivastava, D., Cylus, J., Karanikolos, M., Evetovits, T., Thomson, S.
748 and McKee, M. (2012). Health policy in the financial crisis. *Eurohealth*,18(1),pp.3-6.

749 Mohan, J. (2002). *Planning, markets and hospitals*. London:Routledge.

750 Moon, G. and Brown, T. (2001). Closing Barts: community and resistance in
751 contemporary UK hospital policy. *Environment and Planning D: Society and*
752 *Space*,19(1),pp.43–59.

753 Mouffe, C. (1993). *The return of the political*. London:Verso.

754 Mouffe, C. (2005). *On the political*. London:Psychology Press.

755 Mouffe, C. (2013). *Agonistics: thinking the world politically*. London:Verso Books.

756 NHS England. (2015).Primary care co-commissioning submission and approval
757 process for 2015/16.[online][https://www.england.nhs.uk/wp-](https://www.england.nhs.uk/wp-content/uploads/2015/06/sub-process-1516-joint-1617-del-arrange.pdf)
758 [content/uploads/2015/06/sub-process-1516-joint-1617-del-arrange.pdf](https://www.england.nhs.uk/wp-content/uploads/2015/06/sub-process-1516-joint-1617-del-arrange.pdf)[Accessed
759 12/6/17].

760 NHS England. (2016a).Health and care bodies reveal the map that will transform
761 healthcare in England. *NHS England*. [online].
762 <https://www.england.nhs.uk/2016/03/footprint-areas/> [Accessed 12/6/17].

763 NHS England. (2016b).Sustainability and transformation plan
764 footprints. [online][https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-](https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf)
765 [footprints-march-2016.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf). [Accessed 12/6/17]

766 NHS England et al. (2014). *Five year forward view*. London:NHS England.

767 NHS England et al. (2015). *Delivering the Forward View: NHS planning guidance*
768 *2016/17 – 2020/21*.

769 Painter, J. (2008).Cartographic anxiety and the search for regionality. *Environment*
770 *and Planning A*,40(2),pp.342–361.

771 Painter, J. (2010).Rethinking territory. *Antipode*,42(5),pp.1090–1118.

772 Pred, A. (1984).Place as historically contingent process: structuration and the time-
773 geography of becoming places. *Annals of the Association of American*
774 *Geographers*,74(2),pp.279–297.

775 Raco, M. (2016).*State-led privatisation and the demise of the democratic state:*
776 *welfare reform and localism in an era of regulatory capitalism*. London:Routledge.

777 Relph, E. (1976).*Place and placelessness*. London:Pion.

778 Thomas, R. (2016).CCG leader: STP approval process ‘not democratic’. *Health*
779 *Service Journal*. [online]www.hsj.co.uk/hsj-local/pcts/city-and-hackney-teaching-

780 pct/ccg-leader-stp-approval-process-not-democratic/7005242.article[Accessed
781 17/6/17].

782 Thomas, R. and Gammie, J. (2016).Seven councils reject STP submissions. *Health*
783 *Service Journal*. [online][https://www.hsj.co.uk/topics/service-design/seven-councils-](https://www.hsj.co.uk/topics/service-design/seven-councils-reject-stp-submissions/7013023.article)
784 [reject-stp-submissions/7013023.article](https://www.hsj.co.uk/topics/service-design/seven-councils-reject-stp-submissions/7013023.article)[Accessed 12/6/17].

785 Toth, F. (2010).Healthcare policies over the last 20 years: Reforms and counter-
786 reforms. *Health Policy*,95(1),pp.82–89.

787 Tuan, Y. (1977).*Space and place: the perspective of experience*. London:Edward
788 Arnold.

789 Walshe, K. (2016).The NHS ignores the law at its peril. *Health Service*
790 *Journal*. [online][https://www.hsj.co.uk/topics/policy-and-regulation/the-nhs-ignores-](https://www.hsj.co.uk/topics/policy-and-regulation/the-nhs-ignores-the-law-at-its-peril/7010133.article)
791 [the-law-at-its-peril/7010133.article](https://www.hsj.co.uk/topics/policy-and-regulation/the-nhs-ignores-the-law-at-its-peril/7010133.article)[Accessed 12/6/17].

792 West, D. (2016a).Stevens floats ‘combined authorities’ for the NHS. *Health Service*
793 *Journal*. [online][www.hsj.co.uk/sectors/commissioning/exclusive-stevens-floats-](http://www.hsj.co.uk/sectors/commissioning/exclusive-stevens-floats-combined-authorities-for-the-nhs/7004897.article)
794 [combined-authorities-for-the-nhs/7004897.article](http://www.hsj.co.uk/sectors/commissioning/exclusive-stevens-floats-combined-authorities-for-the-nhs/7004897.article)[Accessed 12/6/17].

795 West, D. (2016b).Survey reveals STPs’ service change priorities. *Health Service*
796 *Journal*. [online][https://www.hsj.co.uk/sectors/commissioning/exclusive-survey-](https://www.hsj.co.uk/sectors/commissioning/exclusive-survey-reveals-stps-service-change-priorities/7012728.article)
797 [reveals-stps-service-change-priorities/7012728.article](https://www.hsj.co.uk/sectors/commissioning/exclusive-survey-reveals-stps-service-change-priorities/7012728.article)[Accessed 12/6/17].



798

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

800

801

802

803

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*

806