

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 reprieve 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

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798

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

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| <b>Era</b>   | <b>Administrative units</b>   | <b>Underpinning principle</b>   | <b>Interpretation of place visible in policy documents and discourse</b>   |
|--------------|---|---|--|
| 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<br>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<br>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<br>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)<br>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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