

A matter of (good) faith?

Smith, Chris Q; Williams, Iestyn; Leggett, Will

DOI:

[10.1016/j.socscimed.2023.116553](https://doi.org/10.1016/j.socscimed.2023.116553)

License:

Creative Commons: Attribution (CC BY)

Document Version

Publisher's PDF, also known as Version of record

Citation for published version (Harvard):

Smith, CQ, Williams, I & Leggett, W 2024, 'A matter of (good) faith? Understanding the interplay of power and the moral agency of managers in healthcare service reconfiguration', *Social Science and Medicine*, vol. 342, 116553. <https://doi.org/10.1016/j.socscimed.2023.116553>

[Link to publication on Research at Birmingham portal](#)

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.



A matter of (good) faith? Understanding the interplay of power and the moral agency of managers in healthcare service reconfiguration

Chris Q. Smith^{a,*}, Iestyn Williams^b, Will Leggett^a

^a Department of Social Policy, Sociology and Criminology, School of Social Policy, University of Birmingham, Edgbaston, Birmingham, B15 2TT, United Kingdom

^b Health Services Management Centre (HSMC), School of Social Policy, University of Birmingham, Edgbaston, Birmingham, B15 2TT, United Kingdom

ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:

Service change
Health service reconfiguration
Major systems change
Moral background
Epistemic governance
Sociology of morality
Qualitative research

ABSTRACT

Previous studies of service reconfiguration in healthcare have explored the influence of power on processes and outcomes. However, in these accounts the moral agency of managers is often underemphasised. This paper draws on the theoretical tools provided by the sociology of morality to help deepen understanding of the interaction between power and moral agency in service reconfiguration in healthcare. It presents results from a qualitative study of a pan-organisational service reconfiguration in the NHS in England, involving nineteen in-depth interviews with those leading the change and the analysis of twelve programme documents. We combine concepts of *the moral background* and *epistemic governance* to interpret participants' conviction that the service change was 'the right thing to do'. The paper shows how epistemic work carried out by service change regulations shaped the moral background within which participants worked. This, in turn, channelled their moral agency – specifically their commitment to patient care – in a way that also reflected central priorities. The paper adds to sociological understandings of service reconfiguration through considering the interaction of structure, agency and power, while also developing the concept of the moral background to show how power relations can influence moral beliefs.

1. Introduction

Despite being a well-established area of scholarship, the research literature on health system reconfiguration contains surprisingly little direct exploration of the moral agency of the healthcare managers involved. From the 'instrumental evaluative' perspective pervasive in research on this topic, managers are assumed to be rational actors seeking to devise and implement optimal care models in response to new challenges on services (Fulop et al., 2012; Jones et al., 2019, p.1221). Much of this literature is concerned with the impediments to introducing evidence-based programmes of service change, with opposition – for example from patient and public representatives – characterised as a 'monolithic obstacle to progress' (Stewart, 2019, p.1251). Faced with partisan resistance to change the challenge is portrayed primarily as one of *leadership*, that is, how managers deploy leadership skills and techniques to avoid the derailing of unpopular but necessary improvement (Williams et al., 2021).

There is a growing body of work which questions the assumption that the actions of managers undertaking service reconfiguration are entirely evidence based. For example, studies have pointed to the questionable

empirical foundation of these changes, particularly with respect to the centralisation of specialist services (Bhattarai et al., 2016; Black et al., 2022). It is increasingly argued that narratives regarding 'evidence' and 'reform' should not be taken at face value. Instead, scholars have critiqued such 'technicist' accounts which, they argue, reflect the values embodied in means-end rationality which can obscure other legitimate value concerns (Cribb, 2018; Jones et al., 2019).

Sociological perspectives have been crucial in making sense of the role of this technocratic discourse, and the social and cultural dynamics involved in service change more generally (Jones et al., 2019). Such accounts underline the central importance of narrative as a precursor to reorganisation, showing how managers must engage in collective reason-giving processes prior to enacting change. They can therefore be useful in understanding how ideological and moral debates regarding the imposition of major changes to health services are framed, and how this can serve to challenge or reinforce existing power structures. Drawing attention to such attendant meanings, cultural dimensions and social processes has enabled critical perspectives to come into view, foregrounding alternative viewpoints and experiences, including those of patients and the public (Stewart, 2019). A wider analytical lens also

* Corresponding author.

E-mail addresses: C.Q.Smith.1@bham.ac.uk (C.Q. Smith), I.P.Williams@bham.ac.uk (I. Williams), W.P.Leggett@bham.ac.uk (W. Leggett).

<https://doi.org/10.1016/j.socscimed.2023.116553>

Received 27 June 2023; Received in revised form 12 December 2023; Accepted 22 December 2023

Available online 24 December 2023

0277-9536/© 2024 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

brings into focus the complex web of interconnections that exist between healthcare facilities and their geographical communities, and the important role they can perform as symbolic totems of local life (Davidson et al., 2019).

These critical accounts serve to problematise the tendency towards technicism in health policy narratives. However, the subtleties and contradictions in the motivations of those leading or implementing reorganisation processes are often overlooked, especially given the ambiguous roles many occupy, spanning 'back office' management and front-line clinical responsibilities (Hyde et al., 2016). Therefore, many of these more critical accounts do not specifically seek to understand the moral agency of those planning and implementing reorganisation processes. Instead, the actions of local change leaders are typically portrayed as either largely an expression of political ideology and/or social position, or as active attempts to subvert local interests. For example, some examine how knowledge and evidence are mobilised as 'hierarchical techniques of power' (Fraser et al., 2017) or as part of a 'biopolitical intervention' to use medical forms of knowledge to legitimize political upheaval (Fraser et al., 2019). Others show how evidence is deployed as a 'rhetorical strategy' to shift focus from financial to clinical rationales to thereby mitigate community resistance to change (Jones and Exworthy, 2015), or how technicist language is used to 'camouflage coercive and punitive forms of performance management' (Jones et al., 2019, p.1228). Scholars have also examined how professionals actively pursue their own strategic interests during change, including engaging in various forms of institutional work to enhance their own status (Currie et al., 2012).

This scholarship therefore provides a divergent view on service change to that of technicist accounts, focusing on power relations and interests rather than the effectiveness and proficiency of managers. Waring et al. (2023, p.241) characterise such strains in the literature as providing either a 'behavioural view of leaders' political competencies and skills' or a 'critical and structural view that explains micro-politics in terms of macro-political interest'. They plot a route through these by examining 'the types of behaviours and skills used by leaders when confronting local manifestations of macro-political tension in meaning, rewards and power'. Their synthesis helps to ward against both naivety and over-determinism. However, the specifically normative or moral content of these meaning-making processes is not central to their subsequent analysis. Further exploration and explication of these elements is therefore required, especially given that moral claims over what is *good* in reconfiguration – e.g. pooling expertise and resources, empowering patients, protecting communities – often lie at the heart of conflicts over plans and processes.

This paper draws on the sociology of morality, in conjunction with a qualitative study of a pan-organisational service reconfiguration in the NHS in England, to provide a deeper understanding of the interaction between power and the moral agency of management actors. Specifically, we show how the concept of the moral background – when used in concert with epistemic governance – can elucidate how the moral motivations of managers are channelled, rather than determined or overridden, by the power relations they work within. In so doing, we provide a sociologically informed account that gives due consideration to both power and moral agency in analysing how service reconfiguration processes unfold.

2. Theoretical framework: the sociology of morality

The sociology of morality can be defined as 'the sociological investigation of the nature, causes, and consequences of people's ideas about the good and the right' (Abend, 2008, p.87). It investigates the historical and cultural variations in what is seen as moral, and explores the processes that create and sustain morality (Hitlin and Vaisey, 2013, p.54). As such, sociological perspectives foreground the role of *social context* as a key explanatory factor for understanding variations and conflicts in moral positions. This can encompass a range of issues, connecting norms

and values to identities, narratives, symbolic boundaries, cognitive schemas and institutions (p.54).

A key contributor to the *new* sociology of morality is Gabriel Abend. Abend's work has a number of elements, including thick moral concepts; the sociology of decision making; and a sociological critique of the neuroscientific understanding of morality (Abend, 2018a, 2018b, 2019). Associated with each of these is the conceptual framework developed by Abend (2014) of *the moral background*. Abend argues that the academic study of morality can involve distinct objects of inquiry including the readily observable 'first-order' morality, and the more implicit, relatively underexplored second order 'moral background'. First order morality is 'the level of people's moral judgements and beliefs' (p.16), and can include understandings regarding what specific actions, practices and beliefs are right, good, obligatory, appropriate, and admirable (p.32). Examples include beliefs regarding whether a service reconfiguration is right or wrong.

Underpinning every first order moral belief is a *moral background*, i. e., a set of tacit assumptions regarding the nature of morality in a particular social context (Abend, 2014, pp.29-31). These 'para-moral' phenomena include the ideas, tools, and theories that enable and constrain first order beliefs and judgements. They are often unconsciously held by social actors and not immediately visible, but can be inferred through empirical data (p.53). The moral background therefore provides a conceptual tool to account for the cultural and institutional conditions which make specific moral norms, values and judgements possible (Abend, 2022). Such an understanding of morality draws attention to the role of social and historical context in moral judgement, 'as what counts as a possible moral explanation, moral action, or moral object vary over time and across groups' (Hirschman, 2018, p.643).

While these background phenomena circumscribe first order morality, they do not 'fully prescribe the concrete moral stances that people adopt' (Livne, 2018, p.640). Abend (2014) argues:

... if you take one society or group, there will very likely be differences regarding the kinds of moral arguments made, the methods used, the reasons given, and the objectivity assumptions held ... On the other hand, given a society or group, not any grounds, method, or reason are possible. (p.68)

The moral background is therefore not deterministic. Instead Abend's approach foregrounds the way individuals actively make judgements and form beliefs, while also examining how these are enabled and constrained by a wider social context. This allows for an *active moral agency* – wherein individuals hold moral dispositions and commitments that enable them to actively make judgements (Sayer, 2011) – while also providing a sociological understanding of how this agency is channelled through the social structures they operate within. This makes it particularly well suited for the study of organisations involved in service reconfiguration, where individual managers and senior clinicians are actively required to make decisions but within notable constraints.

2.1. Dimensions of the moral background

Abend (2014) identifies six background elements, but the three that are most salient in this study are groundings, metaphysics, and objects of evaluation. For a discussion of the remaining elements and their application to reorganisation see Smith (2020). The three elements covered in this paper are:

- *Groundings* - Moral stances are typically anchored in a justification which individuals and organisations use to legitimize their position (Abend, 2014; Livne, 2018). Abend refers to these explanations as *groundings*: the socially acceptable reasons people invoke when they need to justify a first order moral belief or judgement as moral or immoral. The idea of groundings has similarities with Boltanski and Thévenot's (1999) idea of *regimes of justification* (Livne, 2018).

However, while their account details a finite number of justifications people can use, Abend sees infinite possibilities for how moral backgrounds could be configured (Livne, 2018). Therefore, while each social setting will only have a limited number of groundings that can be used, there are 'no a priori substantive constraints' on what groundings can be (Abend, 2014, p.35).

- *Metaphysics* - First order morality is also informed by shared understandings regarding the nature of reality. Abend refers to this as metaphysics: the 'metaphysical pictures or assumptions that ordinary people and social practices, institutions, and understandings manifest' (Abend, 2014, p.50). These can include assumptions about time, reality, space, being and human nature upon which first order moral beliefs are predicated (pp.50-1).
- *Objects of evaluation* - This refers to underlying understandings about what objects are open to moral evaluation (Abend, 2014). It draws attention to how societies and groups differ regarding the 'objects that are capable of being morally evaluated' (p.40). These might include: people, states of affairs, groups, organisations, motives, and the results of actions (pp.40-2). This concept therefore introduces the idea that individuals will often take cues, either knowingly or unknowingly, from their social context regarding what issues require moral judgement.

This framework provides a sociological toolkit for an in-depth exploration of moral beliefs and how they relate to the social context in which they are formed. As such, it offers a valuable resource for providing a more sophisticated view of the moral agency of managers involved in service reconfigurations. However, its ability to do this is constrained by the relative absence in the framework of power relationships as a factor in shaping the various levels of moral belief. For example, Abend does not explore how the moral background interacts with economic relations or other structural phenomena (Somers, 2018). This is problematic for the study of service change as no theory can suffice if it does not account for the unequal power relationships identified in the empirical literature. In apparent recognition of this, Abend has stated that power could play an important role in explaining 'how moral background elements come into being; how they rise, fall, coexist, compete, and change' (Abend, 2014, p.371). Given the centrality of power in shaping service change processes, these provide an ideal setting in which to explore how social power might come to influence the moral background. This will therefore help incorporate valuable elements of critical perspectives on service reconfiguration discussed in the introduction, while also allowing conceptual space to consider the moral agency of managers involved.

2.2. The moral background and epistemic governance

The concept of epistemic governance (Alasuutari and Qadir, 2014, 2019) introduces a mechanism through which power relations can be seen to condition the moral background, and therefore also people's moral beliefs and judgements. This describes how social power often operates in policy making through epistemic work, wherein the tools of governance influence people's basic understandings about reality, the world and their immediate circumstances. Alasuutari and Qadir define governance as 'efforts to bring about change (or maintain status quo) in a given social system' (2019, p.3). They argue there are three ever-present objects of epistemic work, each with a 'paradigmatic' and 'practical' dimension:

- *Ontology of the social environment* – epistemic governance works on 'the shared view of what is a truthful and accurate picture of the situation at hand' (2019, p.7). The paradigmatic dimension refers to the tacit, culturally ingrained, foundational understandings of reality, such as the nature of progress or what counts as valid knowledge. The practical dimension is the knowledge produced based on

these established understandings, such as the utilisation of particular facts or evidence that have currency in a social setting (pp.24-5).

- *Norms and ideals* - this includes the extent to which general ideals and principles can convince others about the right thing to do, and what this obliges people to do in a particular situation (2014, p.76). The paradigmatic dimension involves 'a broader sense of what "good" and "desirable" mean and a sense that actions can be classed as such' (2019, p.28). The practical dimension refers to the arguments and reasons actually mobilised for or against a particular action (p.28).
- *Actors and identifications* – epistemic governance also works on 'people's understandings of themselves and others as actors: who they are, what community they belong to, and what other actors there are in the social world' (2014, p.75; 2019, p.7). The paradigmatic dimension refers to baseline conceptions of the nature of actors and agency, such as models of human motivation (e.g. homo economicus) and understandings of the categories that people can belong to (e.g. gender, nationality, class etc.). The practical dimension involves arguments built on such tacit assumptions (2019, p.26).

Those engaged in and subject to epistemic work may not be aware that any process of control is taking place as such tools of governance tend to be utilised as part of routine decision making (Alasuutari and Qadir, 2014, pp.78-9). This moves away from the notion, present in many existing accounts, that there is an actor who 'pulls the strings behind the scenes' (p.69).

There are a number of ways in which such epistemic work on the ontology of the social environment, norms and ideals, and actors and identifications could also influence the moral background (see Fig. 1). Indeed, while not themselves *primarily* focused on theorising morality, Alasuutari and Qadir's work has relevance to the sociology of morality, and they briefly mention the moral background in reference to Taylor's (2004) writing on the issue (Alasuutari and Qadir, 2014, p.77, 2019, p.28). The three elements of the moral background discussed in this article could connect to objects of epistemic governance in the following ways:

- *Metaphysics* – Metaphysics can include specific assumptions about reality and human beings (Abend, 2014, pp.50-1). Therefore, work on both the paradigmatic ontology of environment and actors and identifications (particularly with respect to assumptions about human nature, such as whether they are rational or irrational) might also influence first order moral beliefs through metaphysical assumptions.
- *Objects of evaluation* – Underlying assumptions about what objects are open to moral evaluation (Abend, 2014, p.40) might be influenced by two forms of epistemic work. First, work on paradigmatic understandings of norms and ideals includes questions of what can be classified as good and desirable (e.g. individuals, organisations etc.), and therefore also what objects are open to moral evaluation. Work on paradigmatic understandings of actors and identifications also includes beliefs regarding what groups (e.g. organisations) people belong to, which will often form the objects people evaluate.
- *Groundings* - The reasons people and organisations use to legitimize their positions will be influenced by epistemic work on both paradigmatic and practical dimensions of norms and ideals. Paradigmatic work will influence the socially acceptable justifications available to individuals and their persuasive potential. Practical work will relate to how these reasons are used to justify particular courses of action.

The day to day processes of governance on objects of epistemic work will therefore also influence the moral background. As such, combining the moral background and epistemic governance can provide an analytical framework to show how individual moral judgements are subtly channelled through a social context which is influenced by power relations.

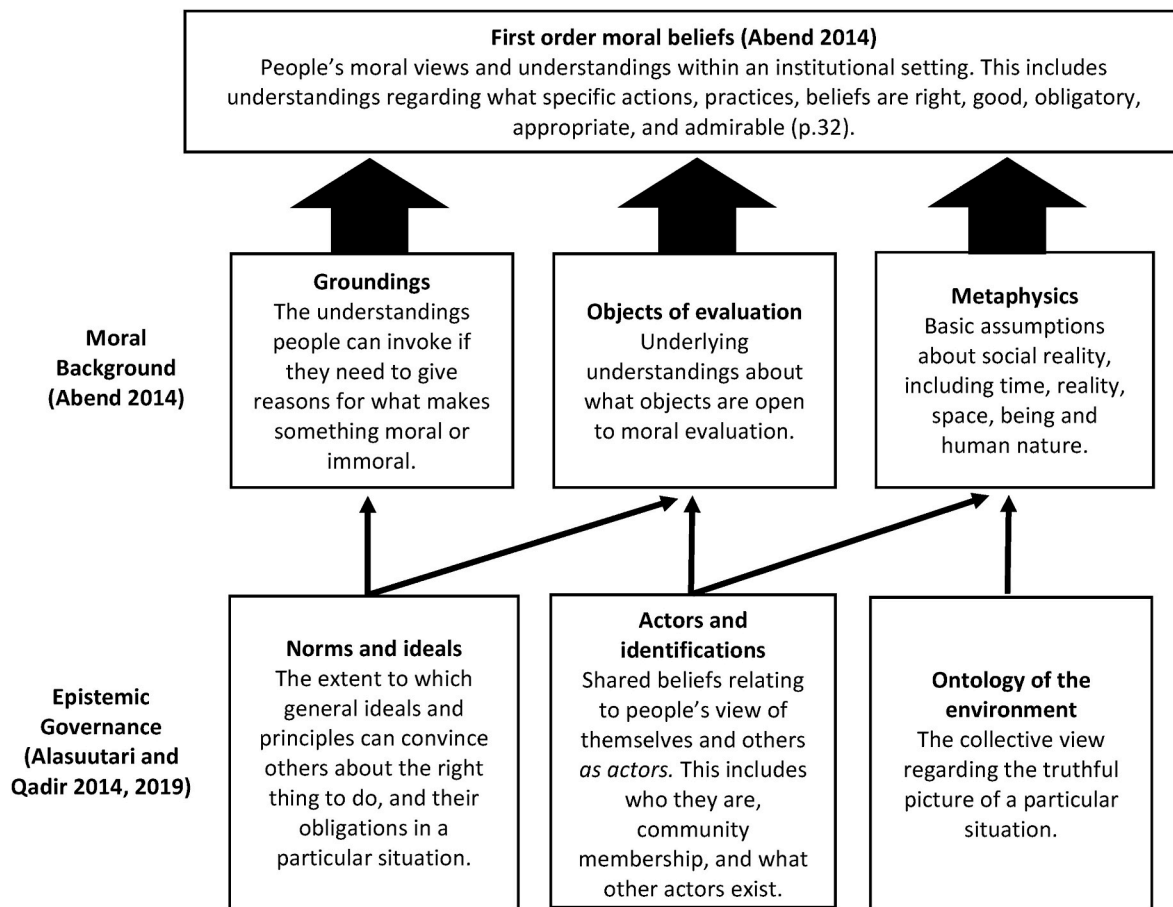


Fig. 1. Conceptual parallels between epistemic governance and moral background.

We will now explore how this conceptual combination can be utilised to understand the moral beliefs held by those involved in planning a specific case study of service change in the NHS: The Moving Up programme.

3. Methodology

3.1. Background to selected case

The Moving Up programme was a service reconfiguration in the NHS in England, centred around the reorganisation of the emergency and planned services of one acute trust. It was designed to make decisions on behalf of three areas: Bloughton, Whitdon and Grenham. Prior to the reconfiguration, services were spread across two sites: one in Whitdon and one in Bloughton, both of which had their own planned and emergency provision. The reconfiguration of acute services was stated by the programme as being driven by three factors: workforce, infrastructure and financial sustainability (Moving Up, 2019). Establishing safe levels of staffing was a concern as the Acute Trust had recently been inspected and adjudged to be 'inadequate', with particular safety concerns (Care Quality Commission, 2018). The finances of the Acute Trust were also in decline, with deficits of approximately £30 million at the time of data collection (Acute Trust, 2019).

By the time fieldwork began in 2018, the programme had been running for approximately five years and had gone through a number of stages, including the development of a new model of care; a lengthy options appraisal process to reduce a long list of possibilities to two options; and a subsequent public consultation. The two options taken out to consultation were:

- Option 1 – bulk of planned services in Bloughton and emergency services in Whitdon.
- Option 2 – bulk of planned services in Whitdon and emergency services in Bloughton.

At the time of data collection, the programme was in the process of moving from planning to implementation, having concluded the public consultation and gained approval to pursue Option 1. During the planning phase, the change was led by two local service planning bodies ('Clinical Commissioning Groups' (CCGs)): one representing Whitdon and one representing Bloughton. There were also three other core members of the programme: two NHS provider trusts (one community trust and one acute) and an additional commissioner. Like many reconfigurations involving the moving of emergency services, Moving Up had attracted substantial controversy.

3.2. Research aims

Data collection was carried out as part of a broader project examining the application of a range of sociological concepts – all related to moral phenomena, including the moral background – to understanding service change in the NHS. The research aimed to use the concepts to enhance understanding of the empirical setting, while also using the empirical work to develop and refine said concepts. The research was therefore a *qualifying case study* (Vincent and Wapshott, 2014). These begin with a theory, which is then qualified in relation to a social context. This process helps both to develop the theory and to better understand the causal properties operating in the case being studied.

3.3. Recruitment and sampling

Sampling focused on gaining a range of perspectives from those most closely involved in the programme. As part of this approach, interviews are expected to offer some insights into the underlying context and mechanisms behind social processes. However, the accounts of individual interviewees are unlikely to be systematic and the researcher must work to develop a more comprehensive analysis of the powers and entities at play (Smith and Elger, 2014, pp.120-1). Participants were drawn from the two main decision-making committees within Moving Up: the Programme Board (PB), responsible for planning the service change, and the Joint Governing Body (JGB), made up of the two lead CCGs (Whitdon and Bloughton). Within this, participants were recruited through a mixture of non-probability, purposive sampling – specifically theoretical sampling – and convenience sampling. Recruitment ceased once data saturation was reached, when new data no longer helped to identify novel insights (Flick, 2014, p.172).

Ethical approval was received from the University of Birmingham and the NHS Health Research Authority. All individuals, organisations, job titles, and the name of the service change itself have been anonymised using pseudonyms.

3.4. Rapport and researcher positionality

Facilitating open responses was particularly important for this research given the focus on understanding the moral commitments of participants. The principles of confidentiality and neutrality are established means of encouraging open responses when interviewing elite participants (Solarino and Aguinis, 2021), and these principles were put into practice for this research. Confidentiality was explicitly established as part of the informed consent process and also stated prior to each interview. Organisational permission was also received from a senior manager in each core organisation involved in Moving Up. Neutrality – referring to creating a sense of understanding to encourage interviewees to ‘open up’ (Solarino and Aguinis, 2021, pp.661-2) – was established primarily through the lead researcher’s own positionality as a former NHS employee. This helped facilitate a level of shared identity and therefore also understanding and rapport building (Collins and McNulty, 2020), including through the use of a shared knowledge and language relating to healthcare structures and cultures. While such strategies do not guarantee complete candour, they do make openness more likely by reaffirming confidentiality and neutrality for participants.

3.5. Data collection

The lead author conducted all fieldwork for the study between December 2018 and June 2019. This used a mixture of qualitative face-to-face and telephone interviews as the primary form of data collection. These were in-depth, semi structured interviews with one person at a time used to understand people’s feelings, views on past events, and interpretation of the world around them (Merriam and Tisdell, 2016). This facilitated the analysis of ‘the social contexts, constraints, and resources within which ... informants act’ (Smith and Elger, 2014, p.111). This method was appropriate for applying the moral background: first, it encompasses an examination of surface level (i.e. first order) moral views of individuals; second, it enables a deeper exploration of how individual beliefs related to the context level ‘background’ moral phenomena. Nineteen interviews were carried out with members of the two main decision-making committees for the programme, lasting an average of 58 min. All interviews were digitally recorded and manually transcribed by the lead author. All participants gave informed consent to take part in the research.

Official programme documents were also included as a secondary form of data. This allows interview data to be subjected to further critical scrutiny in relation to other sources (Smith and Elger, 2014, p.119). The high volume of programme documents generated during Moving Up

therefore provided a useful secondary data source to complement interviews. All documents analysed were publicly available, with approximately 380 available on the Moving Up website at the time of data collection. For practical reasons, we focused on a subset of the many written documents generated by the change process, although future studies into healthcare service reconfiguration might find it fruitful to analyse documents as the main data source. Therefore, twelve documents were selected for analysis based on their significance in the accounts of research participants. These documents included: the main consultation documents (including the initial case for change, the Pre-Consultation Business Case, the public consultation document itself and a prominent response), terms of reference for the programme, stated principles of joint working, the final report on models of care, the programme execution plan, the options appraisal, the Decision-Making Business Case, and two clinical senate reviews.

3.6. Analysis

Data analysis was carried out in line with Fletcher’s (2017) flexible deductive approach to qualitative data analysis. This involves initially searching for rough trends (‘demi-regularities’) in the data during coding, before then using the inferential strategies of abduction and retrodution. Codes were derived from relevant conceptual frameworks and refined and added to during the early coding process. The final coding framework was then discussed and agreed by the authors before the majority of transcripts were coded. The final framework included first-order moral phenomena – such as duties, obligations and ideals – and more empirically observable background phenomena, particularly groundings. All coding was carried out using the qualitative data analysis package Nvivo 12.

Once coding was complete, analysis moved onto abduction and retrodution. Abduction is the process by which a researcher re-describes empirical observations in line with a new frame of interpretation or theoretical framework (Danermark et al., 2002, pp.91-2). Retrodution involves an exercise of abstraction wherein the researcher identifies or refines their theoretical understanding of an underlying causal power, ‘the type of entity that possesses it, and the mechanism that generates it’ (Elder-Vass, 2012, p.253). When used together, both modes of inference enable the researcher to develop a deeper understanding of social meanings, mechanisms and structures (Danermark et al., 2002).

4. Findings and analysis

In this section we will focus on the prevailing first order moral belief that the centralisation and specialisation of services is good. We will then explore three linked background assumptions which lay behind this first order moral belief. We finish the paper by showing how the concept of epistemic governance provides a way of making sense of how power relations influence moral beliefs within this setting, via the moral background.

4.1. First order moral belief

Most participants articulated the first order moral belief that centralisation of acute services *in general* was good and necessary for improving the quality of care. This was typically based in the view that acute interventions are becoming more complex, thus requiring concentration of expertise in smaller numbers of centres of excellence. Participants believed the attendant benefits outweighed any drawbacks such as increased patient travel times:

The way the doctors have been trained is changing now ... they’re coming out more specialist now, and research has shown ... if it involves travelling a bit further it’s better to travel a bit further to get to where the specialist doctors [are]. (Andy, Programme Team)

What you are seeing is an evidence base which says ‘you get greater success rates, and better outcomes for patients, if the healthcare professionals specialise in those areas of care’ ... So with that increasing specialisation, there are some problems, because you can have recruitment problems for certain specialities. But it also means that services can be concentrated further away from the local hospital ... (Ryan, Whitdon CCG)

The centralising logic of the programme was therefore seen to directly address the workforce and recruitment issues experienced by the Acute Trust, while also allowing the maintenance or improvement of clinical and safety standards. Such beliefs were also seen to be centrally mandated and supported by the evidence:

Another reason [for the reconfiguration] is that, on a regular basis there are national reviews, of various health services ... information that comes down to us from NHS England saying ‘this is a better way to run health services’. (Dylan, Bloughton CCG)

This belief was also reflected in key programme documents. For example, the Public Consultation Document ([Moving Up, 2018](#)) mentioned research from NHS England (the Arm’s Length Body responsible for overseeing the NHS in England) which purportedly showed that having a single highly specialised emergency care site was safer than having planned and emergency care on the same site. This document also claimed evidence showed this would lead to better results and reduced hospital stays.

4.2. A strongly held moral belief?

The understanding held by participants that centralisation of services was a *moral* good – rather than simply goodness in the sense of being more effective – was typically evidenced by a framing in terms of the ethical commitment to doing what is best for patients. Indeed, some participants made explicit reference to how this underlying commitment formed a common thread among all those involved, despite differences in agendas and interests. As Riley stated:

... a lot of NHS managers are so passionate about ‘we’ve been given this money to develop services, there are other areas who’ve not been given anywhere near that much, or haven’t been given anything, and we want to do the best for our patients’. So there’s always that drive and passion. (Riley, Programme Team)

So I know from the work I do that patients are not getting the best care that they could, I’m not saying it’s poor care, I’m just saying it could be better, given the resources that we’ve got. So ... I think that separating out planned care from emergency care is absolutely the right thing to do ... there are such quality benefits in separating out, and patient experience benefits in separating out planned care from emergency care. (Morgan, Bloughton CCG)

The view of doing the best for patients was therefore deeply embedded in the perspectives of interviewees. This commitment was mirrored in the Decision-Making Business Case, which stated patients to be ‘at the heart’ of everything done on the programme ([Moving Up, 2019](#)). Added to this, it was important for several participants to clearly state the programme was not driven by financial considerations:

The imperative [of the programme] was about ‘how do we improve clinical outcomes for patients?’ And that should always be the primary driver. Money was never a driver behind this. (Eli, Bloughton CCG)

It’s not a cuts exercise, it’s not been imposed by Whitehall, it’s not just been done by managers in grey suits. It’s been based on clinicians’ views ... [and] we’re coming to what we feel is the best solution for the people of Whitdon, Bloughton and Grenham ... I will go to my grave assured that we’ve tried to do the right thing ... I’m convinced that this is the right thing to do. (Elliot, Whitdon CCG)

As discussed earlier in the paper, many existing sociological accounts of service change may treat such claims with suspicion. Investigating the moral background allows for the possibility that such claims are made in good faith, as we will now explore further.

4.3. Grounding, metaphysical belief and object of non-evaluation

A major grounding for the first order moral belief in the virtues of centralisation was that it was clearly shown by evidence that, despite the complex organisational processes involved, such a move would directly improve outcomes for patients. This was underpinned by the (in Abend’s terms) metaphysical belief that healthcare demand is predictable and, to some extent, controllable and this belief led to a high degree of confidence in the validity and reliability of the supporting evidence. Indeed, participants believed that it was possible to accurately predict the impact of service change on how people will use services and their health outcomes. Such an underlying worldview is consistent with a broadly positivistic view of knowledge and evidence. As [Joullié \(2016\)](#) argues, such a philosophical perspective ‘is the current dominating worldview within management academia’ and is often accompanied by a managerial focus on evidence (p.159). This perspective emphasises value-neutrality, sees human behaviour as predictable and patterned, and has an overarching focus on evidence-based action grounded in facts rather than moral convictions (p.167). This helps to explain why evidence was such a strong grounding for the first order moral belief in the value of centralisation and specialisation.

This view was most clearly communicated within the Pre-Consultation Business Case ([Moving Up, 2017](#)). This presented a brief discussion of a small number of apparently successful centralisation programmes carried out within the Acute Trust and one outside of the Trust. It also claimed that the new model of care would be in line with best practice guidance and national policy. More specifically, the two-site model was presented by participants as based on several specific calculations regarding demand and capacity also detailed in the Pre-Consultation Business Case. This took activity data from the Acute Trust and applied an ‘algorithm’ to it to determine future patient need, including projections for A&E attendances, non-elective inpatients, elective inpatients, and outpatients. The reduced bed numbers of the new configuration were also based on assumptions regarding patient flow: such as improved discharges, appropriate use of service, and more efficient bed management. When asked, participants showed a high level of confidence that the clinical model would be achieved once the programme was implemented.

At the same time, participants also consistently claimed the reorganisation was not driven by financial concerns, despite the stated aim of cost improvements and financial sustainability. Instead, financial matters were usually presented as facts regarding the context of the local healthcare economy that needed to be considered, rather than a matter of moral debate or evaluation. For example, when discussing the financial issues of the local healthcare economy, Charlie stated:

I think it’s about the finances of the NHS [overall]. We know, the Institute for Fiscal Studies, [the NHS Confederation] and the King’s Fund have all looked at the amount of money in the NHS, and there isn’t enough to provide everything that the people want it to provide, and so we have to work out how to make best use of the resources we’ve got, because we can go a long way to being more efficient, and this is part of that efficiency drive. (Charlie, Whitdon CCG)

Here Charlie frames the financial situation as largely driven by national factors over which those involved in *Moving Up* have no control, leaving them little choice but to reorganise care to deal with these realities. There is therefore no implication of a moral agent that holds any responsibility for these financial difficulties, and there was rarely any discussion about whether the situation was a result of long-term local or national policy decisions.

A common way to interpret participants’ positions on the evidence

base of the service change – and their tendency to avoid citing financial imperatives when advocating their plans – is to claim such arguments are mobilised strategically in service to power interests. Such a perspective is commonly applied in the critical literature on evidence-based policy and management. This argues that the notion of value-free evidence is often deployed ‘instrumentally to neutralise ideologies and to hide power asymmetries from decision making’ (Saltelli and Giampietro, 2017, p.63). From this perspective the language of evidence-based policy/management is essentially rhetoric for political manoeuvring, used to obscure the pursuit of particular interests (Learmonth, 2009; Learmonth, 2006, p.1090). However, such assumptions are hard to prove, and it is also plausible that managers genuinely believe that the solutions they advocate will deal with problems effectively, irrespective of whether they align with the priorities of dominant bodies (i.e. central government and NHS England) (Jones and Exworthy, 2015, p.202; Learmonth and Harding, 2006, p.254). The concept of epistemic governance provides a useful way of demonstrating how this may be the case, despite such beliefs also being conditioned by power relations.

4.4. Epistemic governance

An alternative to the above perspectives is to use the concept of epistemic governance to understand participants’ metaphysical assumption that the world is predictable and plannable, and the status of finances as an object of non-evaluation. This provides a subtler understanding of the influence of power that does not negate the moral agency – i.e. the commitment to improving patient care – of those responsible for planning and delivering service change. Specifically, governance structures shaped the metaphysical assumptions and objects of evaluation of the context participants operated within. This was through the

epistemic work said structures carried out on the paradigmatic ontology of environment, norms and ideals, and actors and identifications. In so doing, governance structures were able to inflate participants’ confidence in the grounding of evidence of benefits to patients, and obscure finances as a moral issue. This introduces a way of interpreting their positions on evidence and finances not as intentional acts of obfuscation, but an outcome of governance structures channelling participants’ moral commitment to improving patient outcomes in a way that aligned with central priorities.

In terms of confidence in evidence, the governance structures for NHS service change carried out this epistemic work in two ways. The first was through the sheer weight of evidence the programme was required to provide to NHS England. This worked to create a paradigmatic ontology of environment wherein the quantity of evidence was seen as demonstrating its strength. The regulations surrounding service change give NHS England the power to approve or deny funding based on a staged assurance process. They also grant them the power to set the terms with respect to their requirements for the approval of the service change. Indeed, the approval process is long and detailed, with several evidence requirements placed on commissioners. The process is demonstrated by the flow chart in Fig. 2, taken from the service change guidelines (NHS England, 2018, p.37).

In concrete terms, this process, particularly the stage two checkpoint, required commissioners to generate several detailed documents over a three-year period to provide:

- Evidence of the impact of the proposed change on patient outcomes
- Analysis of travel times
- Evidence of how the service change will address health inequalities
- Details of how the reconfiguration will impact local government services

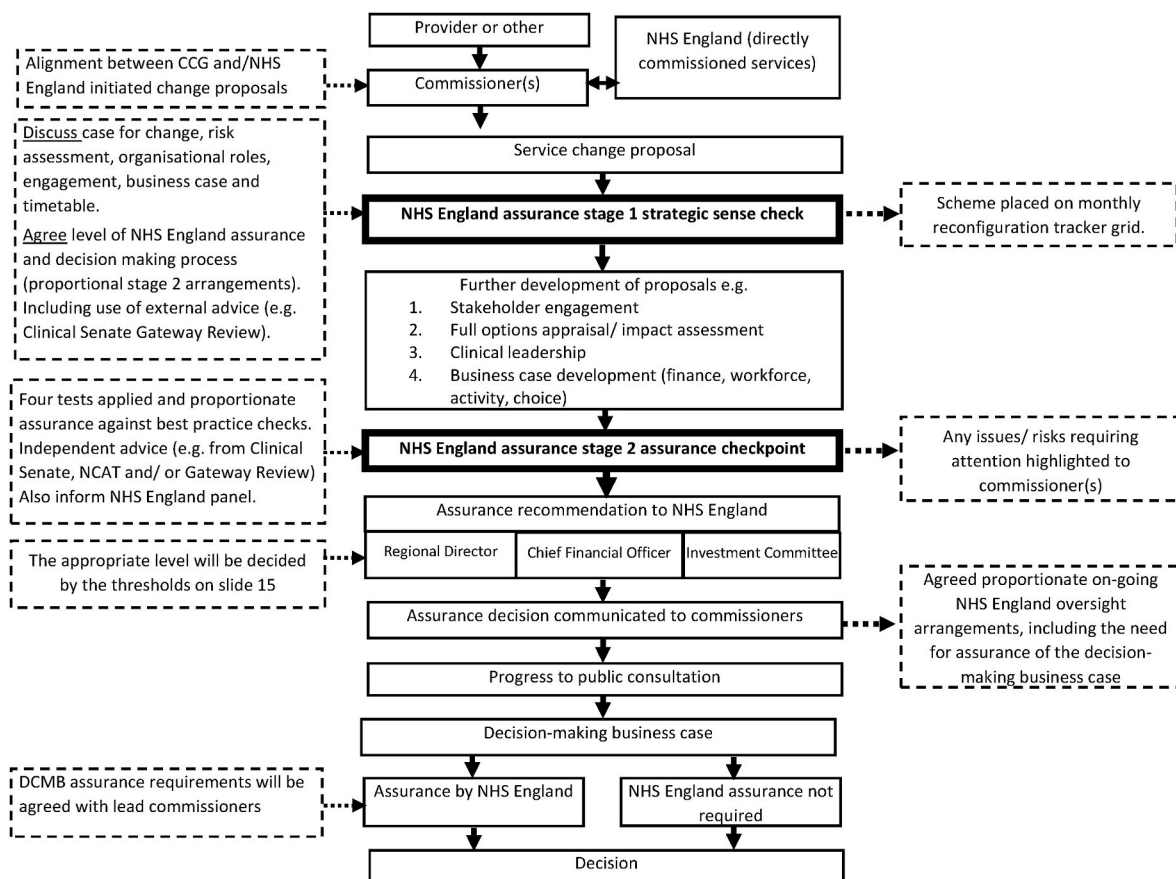


Fig. 2. Overview of the NHS England (2018, p.37) Service Change Assurance Process.

- Evidence that the options put forward are ‘affordable, clinically viable and deliverable’ (p.42)

The documents generated by Moving Up to meet these and other requirements included:

- A presentation of evidence for review by the Clinical Senate (and follow-up answers to evidence requests)
- Various reports commissioned from management consultancies on travel times, activity modelling etc.
- An Integrated Impact Assessment
- A full options appraisal
- A pre-consultation business case and final business case

The amount of evidence required by NHS England seems to have conditioned participants to believe that the reconfiguration would bring about several benefits to patients. Indeed, many participants stressed the sheer *volume* of what had been provided, and clearly felt this demonstrated the rigour of the evidence. For example, when asked about what she thought public opposition to the plans was based in, one participant stated:

I think it is fear, but I don't think that is justified. Because ... obviously we've got lots of clinical evidence that's saying 'this is why we've got to move things to provide better outcomes etc.' So we can evidence it, but people somehow just don't want to listen ... (Dylan, Bloughton CCG)

This is revealing of a general mindset among participants regarding how the volume of evidence, not the quality, was reason enough to back the preferred option. Such a belief was clearly amplified by the service change process, which itself required commissioners to produce several evidence submissions over a long period of time to get changes approved.

The second way the service change process carried out epistemic work on the paradigmatic ontology of environment was through repetition in the guidance and regulations that evidence could be used to prove benefits to patient care. This contributed to a metaphysical view of the environment as plannable and predictable. Indeed, the framing of a ‘clear, clinical evidence base’ as one of the ‘tests’ the service change must pass (NHS England, 2018, p.9) reinforced the idea that such levels of certainty could be attained. This notion was further reinforced by the idea that those leading service change could gain extra certainty in this evidence through having it reviewed by ‘independent’ bodies such as clinical senates. This step is recommended by NHS England (2018):

to assess the strength of the clinical case for change as to whether the proposed changes are supported by a clear clinical evidence base and will improve the quality of the service provided. (p.17) [our emphasis]

The effect of such governance structures was to create a strong faith in the process as a means of ensuring certainty. Participants felt the evidence had been clear enough to accurately weigh the costs against the benefits to the patient population when deciding how to configure services. Such a process was presented as logical and straightforward – as the evidence speaking for itself. Indeed, when asked about how the service change had been justified to the public one participant stated:

I'm not sure it's [the preferred option] been justified. I think what we've done is gone through a process which said 'we've had a look at the prevailing circumstance, we've had a look at the available money, we've had a look at the available evidence and this is the best clinical solution we can come up with'. (Terry, Whitdon CCG)

Here the decision-making process is presented as a simple exercise of following the evidence. It reflects a general confidence by those interviewed that evidence shows the new clinical model will improve patient outcomes. Such an opinion was also expressed by Danny when discussing his reasons for supporting the preferred option:

So there's already been a detailed process to come up with a recommendation of a preferred option and that was based on quite a rigorous scoring process, both financial and non-financial. And the Joint Committee was effectively asked to ratify that decision, and the only way you wouldn't agree with that decision is if you disagree with the process that had been gone through to come up with that recommendation. (Danny, Whitdon CCG)

Hence, when the regulatory requirements participants were subject to are considered, their belief in a predictable, plannable world is understandable. Participants spent years complying with a process which asked for large amounts of evidence, consistently described as capable of providing a solid foundation for projecting improvements in patient outcomes. Within such a context, supporting centralising initiatives such as Moving Up becomes a way for managers to express their underlying ethical commitment to improving patient outcomes, despite also being implicitly influenced by the power relations they work within.

Epistemic governance also worked to remove finances as an object of evaluation in how the preferred option was selected, thus making participants less likely to view this as a key factor driving the change (particularly when compared to evidence of improved patient outcomes). This was evident through the workings of the options appraisal system, which separated out financial and non-financial considerations. Epistemic governance also worked to ensure that most of the moral deliberation and decision-making was focused on non-financial aspects, with the financial appraisal largely deferred to accounting professionals. This separation meant that the main decision-making panel – consisting of a range of NHS and other stakeholder organisations from several different managerial and clinical roles – did not directly discuss budgetary considerations, instead focusing on issues of accessibility, quality, workforce and delivery. This process included use of decision tools, thereby engendering an atmosphere of open and transparent decision-making. By contrast, the concurrent financial appraisal process was closed and narrowly circumscribed. Here the appraisal seems to have been primarily carried out by finance teams in line with Department of Health and Treasury guidance. As Eli reflected:

The financial ones [options appraisals] tend to just be the [Chief Financial Officers] working in darkened rooms with their teams. The non-financial benefits, we had a panel of I think ... about 25 or 30 people. (Eli, Bloughton CCG)

Financial appraisal involved the evaluation of each option in terms of capital, revenue and opportunity costs. This led to a range of outputs relating to income and expenditure and value for money. Taken together, these financial considerations were given equal weight to non-financial considerations. However, they were much less visible to participants because the process was effectively structured to make this the sole responsibility of financial professionals. This epistemic work therefore operated on paradigmatic assumptions regarding both actors and identifications – by reinforcing the distinction between ‘financial’ and ‘non-financial’ professions – and norms and ideals – by classifying financial matters as a category that cannot be classed as moral or immoral. As such, finances were again presented to the Moving Up participants as something that were fixed and that they had little control over, which created an implicit understanding that they were not open to moral debate as part of the options appraisal process. This form of epistemic governance therefore helps account for why finances were not considered an object of evaluation for participants.

5. Conclusion

Many managers charged with delivering service reconfiguration express a deeply held commitment to improving the quality of care for patients, and claim they seek to do this through following the evidence. However, these reconfigurations are commonly met with resistance from local communities, and the status of the evidence used to justify

change is often questionable. Much existing sociological research deals with this apparent contradiction by assuming managers instrumentally use evidence to serve dominant power interests, particularly through pursuing fiscal restraint. However, this perspective does not fully account for the moral agency of managers directly involved in planning and implementing service change.

In this paper we have provided an alternative way of conceptualising the influence of power on service reconfiguration which accounts for managers' moral commitment to improving patient care, while also showing how power relations are able to subtly channel this commitment. This is through combining the concepts of the moral background and epistemic governance, and applying this understanding to a qualitative case study of service change in the NHS in England. Specifically, we have shown how the belief that Moving Up was the right thing to do was based in the grounding that evidence shows that the proposed centralisation would benefit patients. This grounding, in turn, was based in the metaphysical belief in a predictable and plannable world, and a view that finances were not an object of evaluation. Finally, we have shown how these moral background assumptions were subject to the epistemic work carried out by the NHS England assurance process and the way the programme was structured. This acted through paradigmatic assumptions – regarding ontology of environment, norms and ideals, and actors and identifications – to implicitly condition managers to have a strong faith that the service change was the right thing to do because it was based in clear evidence of benefit to patients, and was not driven by financial considerations.

The paper has therefore provided a novel sociological framework on the interaction of power and moral agency in service reconfiguration in healthcare, while also developing the concept of the moral background by showing how it is shaped by power relations. This provides theoretical contributions to both existing understandings of healthcare reform and policy-making, and conceptualisations of the interaction between power and morality in health contexts. In so doing, it initiates conversations between health policy researchers, professionals, organisations, regulators and management on the one hand, and sociologists of morality and social theorists interested in the cultural basis of social life on the other. In these ways, we hope our analysis will have application beyond the specific field of health policy and reform, to enable examination of how epistemic, ideational, and moral background variables can shape practices and have tangible, material consequences. Future scholarship might seek to fuse these insights with classic accounts of how power operates through 'perceptions, cognitions and preferences' (Lukes, 2005, p.28).

While this paper has focused on the interaction of systems of governance with moral agency, future research could also explore the creation of said systems to excavate their design and the intentions of those behind them. Equally, while this study has focused on managers as *objects* of epistemic work, further studies could also examine the extent to which managers carry out epistemic work themselves. This could help further elucidate both the moral agency of managers, the subtle workings of power, and how they interact in this context.

CRediT authorship contribution statement

Chris Q. Smith: Writing - original draft preparation (lead), Conceptualisation (lead), Formal analysis (lead), Funding acquisition (lead), Investigation (lead), Methodology (lead), Visualisation (lead), Project administration (lead), Writing - review & editing (equal). **Iestyn Williams:** Supervision (equal), Writing - review & editing (equal), Funding acquisition (supporting), Methodology (supporting), Formal analysis (supporting), Project administration (supporting). **Will Leggett:** Supervision (equal), Writing - review & editing (supporting), Funding acquisition (supporting), Methodology (supporting), Formal analysis (supporting), Project administration (supporting).

Declaration of competing interest

No conflicts of interest to declare.

Data availability

The authors do not have permission to share data.

Acknowledgments

This paper is based on a doctoral research project carried out by the lead author and supervised by the co-authors. The first year was supported by a one-year studentship provided by the College of Social Sciences at the University of Birmingham. The second and third years were supported by a studentship from the Economic and Social Research Council (ESRC) Midlands Graduate School Doctoral Training Partnership [award reference - 1925667].

We would like to thank the Economic and Social Research Council (ESRC) and University of Birmingham for funding the research. We would also like to thank the anonymous reviewers for their constructive and helpful feedback on the paper.

References

- Abend, G., 2008. Two main problems in the sociology of morality. *Theor. Soc.* 37 (2), 87–125.
- Abend, G., 2014. *The Moral Background: An Inquiry into the History of Business Ethics*. Princeton University Press, Princeton and Oxford.
- Abend, G., 2018a. Outline of a sociology of decisionism. *Br. J. Sociol.* 69, 237–264.
- Abend, G., 2018b. The love of neuroscience: a sociological account. *Socio. Theor.* 36 (1), 88–116.
- Abend, G., 2019. Thick concepts and sociological research. *Socio. Theor.* 37 (3), 209–233.
- Abend, G., 2022. Making things possible. *Socio. Methods Res.* 51 (1), 68–107.
- Acute Trust, 2019. Annual Report and Accounts [anonimised document].
- Alasuutari, P., Qadir, A., 2014. Epistemic governance: an approach to the politics of policy-making. *Eur. J. Cult. Polit. Sociol.* 1 (1), 67–84.
- Alasuutari, P., Qadir, A., 2019. *Epistemic Governance: Social Change in the Modern World*. Springer International Publishing AG, Cham [Online] Available from: ProQuest Ebook Central. (Accessed 16 August 2022).
- Bhattarai, N., McMeekin, P., Price, C., Vale, L., 2016. Economic evaluations on centralisation of specialised healthcare services: a systematic review of methods. *BMJ Open* 6 (5), e011214.
- Black, G.B., Wood, V.J., Ramsay, A.L.G., Vindrola-Padros, C., Perry, C., Clarke, C.S., Levermore, C., Pritchard-Jones, K., Bex, A., Tran, M.G.B., Shackley, D.C., Hines, J., Mughal, M.M., Fulop, N.J., 2022. Loss associated with subtractive health service change: the case of specialist cancer centralization in England. *J. Health Serv. Res. Policy* 27 (4), 301–312.
- Boltanski, L., Thévenot, L., 1999. The sociology of critical capacity. *Eur. J. Soc. Theory* 2 (3), 359–377.
- Care Quality Commission, 2018. *CQC Inspection Report for Acute Trust* [anonimised document].
- Collins, H., McNulty, Y., 2020. Insider status: (Re)framing researcher positionality in international human resource management studies. *Ger. J. Hum. Resour. Manag.* 34 (2), 202–227.
- Cribb, A., 2018. Improvement science meets improvement scholarship: reframing research for better healthcare. *Health Care Anal.* 26 (2), 109–123.
- Currie, G., Lockett, A., Finn, R., Martin, G., Waring, J., 2012. Institutional work to maintain professional power: recreating the model of medical professionalism. *Organ. Stud.* 33 (7), 937–962.
- Danermark, B., Ekström, M., Jakobsen, L., Karlsson, J.C., 2002. *Explaining Society: Critical Realism in the Social Sciences*. Routledge, London and New York.
- Davidson, D., Paine, A.E., Glasby, J., Williams, I., Tucker, H., Crilly, T., Crilly, J., Le Mesurier, N., Mohan, J., Kameräde, D., Seamark, D., Marriott, J., 2019. Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study. *Health Serv. Deliv. Res.* 7 (1).
- Elder-Vass, D., 2012. *The Reality of Social Construction*. Cambridge University Press, Cambridge.
- Fletcher, A.J., 2017. Applying critical realism in qualitative research: methodology meets method. *Int. J. Soc. Res. Methodol.* 20 (2), 181–194.
- Flick, U., 2014. *An Introduction to Qualitative Research*, fifth ed. Sage, London.
- Fraser, A., Baeza, J.I., Boaz, A., 2017. 'Holding the line': a qualitative study of the role of evidence in early phase decision-making in the reconfiguration of stroke services in London. *Health Res. Pol. Syst.* 15 (45).
- Fraser, A., Baeza, J., Boaz, A., Ferlie, E., 2019. Biopolitics, space and hospital reconfiguration. *Soc. Sci. Med.* 230, 111–121.
- Fulop, N., Walters, R., Perri, Spurgeon, P., 2012. Implementing changes to hospital services: factors influencing the process and 'results' of reconfiguration. *Health Pol.* 104 (2), 128–135.

- Hirschman, D., 2018. 'Moral backgrounds and business ethics' on Gabriel Abend's, the Moral Background, an Inquiry into the History of Business Ethics, Princeton NJ, Princeton University Press, 2014. Soc. Econ. Rev. 16 (3), 637–655.
- Hitlin, S., Vaisey, S., 2013. The new sociology of morality. Annu. Rev. Sociol. 39 (1), 51–68.
- Hyde, P., Granter, E., Hassard, J., McCann, L., 2016. Deconstructing the Welfare State: Managing Healthcare in the Age of Reform. Routledge, London and New York.
- Jones, L., Exworthy, M., 2015. Framing in policy processes: a case study from hospital planning in the National Health Service in England. Soc. Sci. Med. 124, 196–204.
- Jones, L., Fraser, A., Stewart, E., 2019. Exploring the neglected and hidden dimensions of large-scale healthcare change. Sociol. Health Illness 41 (7), 1221–1235.
- Joullié, J.E., 2016. The philosophical foundations of management thought. Acad. Manag. Learn. Educ. 15 (1), 157–179.
- Learmonth, M., 2006. Is there such a thing as 'evidence based management'? a commentary on Rousseau's 2005 presidential address. Acad. Manag. Rev. 31 (4), 1089–1091.
- Learmonth, M., 2009. Rhetoric and evidence: the case of evidence-based management. In: Buchanan, D., Bryman, A (Eds.), The SAGE Handbook of Organizational Research Methods. Sage, London, pp. 93–109.
- Learmonth, M., Harding, N., 2006. Evidence-based management: the very idea. Publ. Adm. 84 (2), 245–266.
- Livne, R., 2018. 'In search of social backgrounds' on Gabriel Abend's, the Moral Background, an Inquiry into the History of Business Ethics, Princeton NJ, Princeton University Press, 2014. Soc. Econ. Rev. 16 (3), 637–655.
- Lukes, S., 2005. Power: A Radical View, second ed. Red Globe Press, London.
- Merriam, S.B., Tisdell, E.J., 2016. Qualitative Research: a Guide to Design and Implementation. fourth ed. Jossey-Bass. John Wiley & Sons, CA.
- Moving Up, 2017. *Pre-Consultation Business Case* [anonymised programme document]. Moving Up, 2018. *Moving up: Public Consultation* [anonymised programme document]. Moving Up, 2019. *Decision Making Business Case* [anonymised programme document].
- NHS England, 2018. **Planning, Assuring and Delivering Service Change for Patients** [Online] Available from: <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>. (Accessed 29 January 2020).
- Saltelli, A., Giampietro, M., 2017. What is wrong with evidence based policy, and how can it be improved? Futures 91, 62–71.
- Sayer, A., 2011. Why Things Matter to People: Social Science, Values and Ethical Life. Cambridge University Press, Cambridge.
- Smith, C., Elger, T., 2014. Critical realism and interviewing subjects. In: Edwards, P.K., O'Mahoney, J., Vincent, S. (Eds.), Studying Organizations Using Critical Realism: A Practical Guide. Oxford University Press, Oxford, pp. 109–131.
- Smith, C.Q., 2020. **Moral Economy and the NHS: The Normative Dimension of Service Reconfiguration**. Ph.D Thesis. University of Birmingham. Available at: <https://etheses.bham.ac.uk/id/eprint/11448/> (Accessed 27 December 2023).
- Solarino, A.M., Aguinis, H., 2021. Challenges and best-practice recommendations for designing and conducting interviews with elite informants. J. Manag. Stud. 58, 649–672.
- Somers, M.R., 2018. 'The moral economy of the business crowd: it's moral backgrounds all the way down' on Gabriel Abend's, the Moral Background, an Inquiry into the History of Business Ethics, Princeton NJ, Princeton University Press, 2014. Soc. Econ. Rev. 16 (3), 637–655.
- Stewart, E., 2019. A sociology of public responses to hospital change and closure. Sociol. Health Illness 41 (7), 1251–1269.
- Taylor, C., 2004. Modern Social Imaginaries. Duke University Press, Durham, NC.
- Vincent, S., Wapshot, R., 2014. Critical realism and the organizational case study: a guide to discovering institutional mechanisms. In: Edwards, P.K., O'Mahoney, J., Vincent, S. (Eds.), Studying Organizations Using Critical Realism: A Practical Guide. Oxford University Press, Oxford, pp. 148–167.
- Waring, J., Bishop, S., Black, G., Clarke, J.M., Exworthy, M., Fulop, N.J., Hartley, J., Ramsay, A., Roe, B., 2023. Navigating the micro-politics of major system change: the implementation of Sustainability Transformation Partnerships in the English health and care system. J. Health Serv. Res. Policy 28 (4), 233–243.
- Williams, I., Harlock, J., Robert, G., Kimberly, J., Mannion, R., 2021. Is the end in sight? A study of how and why services are decommissioned in the English National Health Service. Sociol. Health Illness 43 (2), 441–458.