MORAL ECONOMY AND THE NHS: THE NORMATIVE DIMENSION OF SERVICE RECONFIGURATION

by

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Abstract

This thesis refines and applies the concept of moral economy to understanding a large-scale service reconfiguration in the NHS. It draws on a qualitative case study informed by critical realism, enabling an enhanced understanding of the way structural forces interact with the moral dimension of NHS organisations. The thesis provides a new sociological perspective on the role of moral beliefs in NHS service change, while developing a distinct moral economy framework which can be applied more widely.

The thesis explores how to conceptualise moral economy with greater precision than existing accounts; how to operationalise the concept into an empirical study; and how to understand the dynamics underpinning moral beliefs and decision making under conditions of organisational change. It is argued that moral economy should be conceived as the study of how moral phenomena are *entwined* with structural relations of political and economic power. Within this, the 'moral' side of moral economy needs to be seen as consisting of a range of *multi-level* phenomena. This distinguishes between morality as a property of social context and as a property of individual subjectivity. With this understanding established, critical realist metatheory is deployed to further develop moral economy for the purpose of studying organisations. Here multiple types of moral and economic phenomena are identified and integrated into a single theoretical framework using a modified version of Abend's (2014) *moral background.* This enables analytical distinctions to be made between the different aspects of morality and structural relations of power, as well as specifying how they interact via reflexive human agents.

This theoretical framework is applied to an empirical case study of a large-scale, inter-organisation service change in the NHS, drawing primarily on interviews with those involved in planning and implementation. It is revealed that a range of moral phenomena – on both contextual and individual levels – interact to create a strong consensus about what is right

within the service change. The thesis analyses this multi-level morality in terms of a particularly subtle mode of entwinement of the moral and economic: *epistemic governance*. The refined moral economy framework developed illuminates how moral beliefs within institutions are underpinned by complex, interdependent webs of meanings, ethical commitments, regulations and power structures. As such, the thesis develops an original approach to moral economy which is particularly well suited to understanding how moral and economic phenomena interact as part of the process of service reconfiguration in the NHS. Through exploring the influence of structure, culture, agency, and social power on individual beliefs and judgements, this thesis also provides a novel sociological perspective on the normative dimension of organisational change.

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Glossary of Abbreviations

A&E – Accident and Emergency services (or ‘emergency services’)

CCG – Clinical Commissioning Group

CR – Critical Realism

CQC – Care Quality Commission

JGB – Joint Governing Body

LA – Local Authority

NHS – National Health Service

NHSE – NHS England

NHSI – NHS Improvement

PB – Programme Board

W&C – Women and Children’s services

Introduction

In recent years, the National Health Service (NHS) in England has been undergoing a period of intense structural and economic change. Healthcare organisations have increasingly had to work together to reconfigure the way services operate in response to a range of financial and operational pressures. As a result of these responses, and similar ones taking place internationally, there is a growing literature on 'system wide health service reconfiguration, mergers and regional hospital service re-design' (Frazer et al 2017: 2). However, this literature is currently dominated by evaluative studies from fields such as health services research, and there are fewer sociological perspectives on the subject (Jones et al 2019). At the same time, several recent studies have explored the way financial and market driven pressures may impinge on the existing norms and ethical values which characterise the day to day work of NHS organisations (e.g. Segar et al 2014, Hughes et al 2011, Jones et al 2013, Forbess 2020, Kerasidou 2019). This makes a sociological informed theoretical approach to the moral dimension of service reconfiguration particularly relevant and timely.

A moral economy framework has the potential to provide such a perspective. The term 'moral economy' has been deployed in an extremely broad way in the academic literature (Simeant 2015, Palomera and Vetta 2016, Carrier 2018). However, at the heart of the conceptualisation used here is the idea that all economic activities are influenced by shared moral understandings, but that these understandings are, in turn, *affected by* economic phenomena in various ways (Sayer 2007: 262). The perspective therefore promises to provide a sociologically informed way of studying how ethical and value considerations inform the work of organisational actors during times of structural and economic change. At the same time, applying the concept to a new context can also help develop the framework so that it can be used to understand similar settings in the future. In this research I therefore aim to both gain an improved understanding of the process of service change *and* develop moral economy as a concept.

Due to the ambiguous and contested meaning of the term ‘moral economy’, the thesis will be split into two distinct parts. The first part consists of the Background, Literature Review, Theory and Methodology chapters. This will aim to deconstruct and reconstruct the concept of moral economy to make it compatible with a study into service reconfiguration in the NHS. In the Background chapter (Chapter 1) I will briefly detail the pressures NHS organisations have been facing in recent years, and the role service reconfiguration has been seen to play in addressing these pressures. I will then argue for the relevance of a moral economy framework for understanding these processes, particularly given the current paucity of sociological perspectives in this area. However, I will also highlight the current imprecision of the concept, showing the importance of the dual concerns of my research to both apply *and develop* the concept of moral economy. I will then move on to use the Literature Review (Chapter 2) to explore the various ways the term ‘moral economy’ is conceptualised in empirical studies most relevant to service reconfiguration in the NHS. Here I will appraise several empirical applications of moral economy to understanding work and organisations. I conclude that the most conceptually robust approaches are those which focus on the ‘moral’ side of moral economy as a ‘multilevel’ phenomenon. This distinguishes between micro (individual lay normativity), meso (collective understandings), and macro (regulatory) levels of morality. I also argue that the ‘economic’ is best seen in terms of structural relations of power that are *entwined* with moral phenomena.

In the Theory chapter (Chapter 3), I further develop how to conceptualise multi-level morality and its entwinement with structural relations of power *within* organisations and workplaces. Here I deploy a critical realist metatheory to draw analytical distinctions between the different layers of morality and structural relations of power. I then use a range of sociological and institutional perspectives to explore how these different phenomena can be understood as existing and interacting within organisations. I particularly focus on the potential of Abend’s (2014) moral background, and its focus on ‘para-moral’ enabling social phenomena, to act

as a key integrating concept to characterise how different levels of morality are connected with each other and with structural relations of power. This is particularly the case where actors are charged with making difficult, and potential contentious, decisions within a complex regulative and normative environment. In the Methodology chapter (Chapter 4) I then proceed to set out how I have applied this theory to an empirical case study of a large-scale, inter-organisation service change in the NHS. I argue for the value of using a flexible qualitative case study research design, informed by critical realist metatheory, to meet the aims of this research. Data collection therefore draws primarily on interviews with those involved in devising and implementing the service change, supported by documentary analysis.

The second part of the thesis consists of three analysis chapters, in which I seek to apply my moral economy framework to understanding service reconfiguration in the NHS and to further develop the concept itself. In the first two analysis chapters (Chapters 5 and 6) I find a large degree of consensus in the professed moral beliefs of participants regarding the service change. This is accompanied by a high level of compatibility between moral background elements, participants' lay normativity, and the overarching regulatory framework. At the same time, there are points where there is less consensus, particularly when there is a disjuncture between different levels of morality. I end my analysis with the third analysis chapter (Chapter 7), where I discuss how this multilevel morality is entwined with structural relations of power within the service change. To do this I draw on the concept of *epistemic governance* (Alasuutari and Qadir 2014). Here I will focus on the way the service change process seems to be structured around central government priorities, and how this is able to subtly influence first order moral beliefs via the moral background. This is in both *direct* and *indirect* ways. With respect to the former, programme and regulatory structures work to shape participants' implicit assumptions regarding the nature of reality, and what they see as an appropriate object of moral evaluation. With respect to the latter, the programme structures also shape *when* certain moral phenomena became relevant

during the service change process. I explore this specifically in relation to the moral authority clinicians hold in the programme, and the way the NHS England (2018) authorisation process only brings this authority into play at points in the process when it cannot clash with financial considerations. I end the study with the Conclusion chapter, where I reflect on how a moral economy framework helps show the way moral beliefs within organisations are underpinned by complex, interdependent webs of meanings, ethical commitments, regulations, and power structures. I argue that, through developing and applying the concept to a case of service reconfiguration in the NHS, I have provided an original sociological approach to moral economy which can be used in the research of similar settings in the future.

Reflexivity

It is established practice in qualitative studies that the researcher seeks to understand their own role in the knowledge creation process (Berger 2015). This can include the role of personal characteristics, personal experiences and pre-existing political and ideological stances (p.220). Such factors can influence the research process in a variety of ways, including access to the field and what kind of information respondents are willing to share (p.220). These biographical features can also affect how the researcher selects an appropriate theoretical lens for making sense of research data; as well as shape the findings and conclusions of the research (p.220). It is this aspect of reflexivity I want to foreground from the outset, as I believe this will help the reader makes sense of why I am drawn to moral economy as a way of understanding the process of service reconfiguration in the NHS.

My choice of research topic and theory is strongly linked to my academic and professional training. I studied sociology at undergraduate and master's level, before going on to complete the NHS management training scheme. As a master's student I was particularly

interested in theories of radical political economy. Indeed, I wrote my master's thesis on whether the Health and Social Care Act 2012, particularly the marketizing reforms within this, represented an example of the dynamics of capital accumulation undermining social citizenship rights. The narrative I presented was a relatively simple one in which the 'bad' forces of capital accumulation undermined and reshaped the 'good' welfare state via the work of national and local policy makers. However, when I started my first placement on the Training Scheme, the more complex ethical realities of managing within such a context quickly became apparent to me. I joined the NHS in 2012 at a time where the politics of austerity were beginning to have a tangible impact of the operational pressures faced by the service. I quickly realised that institutional constraints made the choices available to me severely limited. Some of the activities I believed I would help with, such as developing new services, were simply not options. Instead, all attention seemed to be directed at finding 'cost improvement savings' while continuing to meet key performance targets. I therefore suddenly, and despite my own values and priorities, found myself unwittingly involved in the process by which the government was constraining public finances. Every day I felt like I was being asked to solve a new problem that seemed completely unreasonable, with a range of options that seemed equally undesirable. At the same time, I came to respect many of the managers I worked with who seemed able to deal with these dilemmas and to find fixes for urgent operational problems, albeit short term ones. After I finished the Scheme I left the NHS to work in the third sector; but I did not shed my belief, developed during my master's degree, that many of these dilemmas are generated by inequities in the broader political economic system. However, my experience on the Scheme also allowed me to develop more of an appreciation of the complex ways that political economic forces work through institutional arrangements to create undesirable decisions and dilemmas for people working in them.

This experience has undoubtedly influenced my choice of moral economy as a theoretical lens to understand NHS organisations undergoing service reconfiguration. I originally

encountered the concept while preparing a PhD proposal, and was struck by its potential to bring into focus the interaction of two dimensions that had been central to my own experience. That is, its ability to bring into view the moral concerns and commitments that individuals and organisations have, but also the various economic and structural pressures that shape how these concerns are realised. My understanding of both the moral and economic dimensions has developed over the course of my PhD; but I still believe this central relationship can elucidate an important aspect of the realities of working within NHS organisations, especially at times of change.

Overall approach to this thesis

As stated above, the dual aims of the thesis are to both *develop* moral economy as a concept and *apply* it to a case of service reconfiguration in the NHS. The study therefore involves the overlapping processes of theory development *and* empirical enquiry. I have tried to reflect the enmeshment of these two tasks as much as possible during the writing of this thesis. However, for the sake of clarity and cohesion, I have largely chosen to separate them in how I have structured the thesis. That is, in the Literature Review, Theory and Methodology chapters I largely focus on developing the concept of moral economy, while in the Analysis chapters I focus on how I have applied it empirically. Thus, in the Literature Review I scrutinise how the term has been conceptualised in relevant empirical studies to show the strengths and weaknesses of existing approaches. In the Theory chapter I go on to reconstruct a theoretical approach to moral economy by using sociological theory to build on the most conceptually coherent and relevant approaches I identified in the Literature Review. In the Methodology chapter I then further refine this theoretical approach to make it suitable to apply in a qualitative case study of the process of service change in the NHS. In the analysis chapters I go on to show what I have found through this application. The structure of the thesis may therefore imply a relatively linear relationship between theoretical developments and empirical enquiry, with the former proceeding the latter. However, through

the experience of carrying out this research, I have learnt that this process of developing and applying theory through a qualitative empirical study is necessarily complex and nonlinear. This thesis represents my best attempt to reflect this process in a coherent and accessible way, and in a form that complies with academic conventions. Nevertheless, through applying an orderly structure to my research journey, some of its more iterative aspects may be underplayed. This note is therefore my attempt to be open about this experience while maintaining a logical structure to the thesis.

PART ONE:

DECONSTRUCTING AND

RECONSTRUCTING

MORAL ECONOMY

1. Background: Service Reconfiguration in the NHS and Moral Economy

A moral economy framework has the potential to provide a valuable sociological lens for understanding the current context of the NHS, where several local service reconfigurations are taking place in response to high levels of operational pressure. In this chapter I will outline the policy context surrounding service reconfiguration in recent years. I will also outline the potential insights moral economy can provide for better understanding these processes, but also the need to refine and develop the concept itself.

I conducted this study approximately a year before the Covid-19 outbreak. At this time the main sources of pressure on NHS organisations were the overlapping issues of finances, workforce, and performance. Over the last decade NHS organisations in England have been experiencing rising costs and demand alongside 'a significant slowdown in funding growth' (Kings Fund 2019a). This has led to multiple operational problems in terms of finances, workforce, and performance. With respect to finances, on a national level, between 2011/12 and 2018/19 spending rose by an average of 1.6 percent per year, significantly less than half the historical average of 3.6 percent (Health Foundation 2019). This, combined with higher levels of demand, has created a funding gap which NHS organisations are expected to make up with efficiency savings. However, provider trusts have struggled to deliver these and 'have become increasingly reliant on one-off savings' to meet efficiency targets (National Audit Office 2020: 8). Indeed, recent figures[1] suggest that the financial position of local NHS organisations is extremely fragile. These show provider trusts reporting an overall deficit of £827 million, with Clinical Commissioning Groups[2] (CCGs) reporting an overspend of £150 million (National Audit Office 2020: 7). At the same time, many trusts lack the capital required to 'maintain the estate and support transformation' (p.9), and this has led to a

[1] These figures are from 2018-19 financial year
[2] Clinical Commissioning Groups are bodies charged with purchasing care on behalf of their local populations. They have delegated responsibility for over sixty percent of the NHS budget and are accountable to NHS England.

significant unmet need for investment in NHS buildings (p.34). These financial issues have been compounded by severe and growing workforce shortages. Growth in clinical workforce has not kept pace with increasing needs of NHS providers (NHS England 2019: 8). This has led to shortages of more than one hundred thousand staff, including thirty-six thousand vacancies in nursing (Kings Fund et al 2018). If current trends continue, this will turn into a shortfall of one hundred and eight thousand full-time nurses by 2029 (Beech et al 2019). The performance of NHS providers has also declined in recent years, reaching its worst level since targets were set on several measures (Thorlby at al 2019). This includes the percentage of people waiting four hours or more in A&E (p.6), the percentage waiting sixty-two days or more to begin cancer treatment (p.8), and the percentage of people waiting eighteen weeks or more for non-urgent hospital treatment (p.3). When taken together, NHS organisations are facing huge and growing operational pressures which are generally considered by local and national policy makers to be in serious need of redress.

In response to these pressures, a prevailing feature of NHS England[3] policy has been the call for local organisations to work together to devise and implement large scale service reconfigurations. Such initiatives stretch back to as far as the Call to Action (NHS England 2013). This asked CCGs to work with local authorities, charities, patient groups and members of the public to identify ideas for 'bold and transformative change to how services are delivered' (p.5). The imperative for locally devised service reconfigurations became more pronounced in the Five Year Forward View (NHS England 2014). This argued for the need to improve integration between primary, secondary, tertiary, and social care, calling for local organisations to select and implement 'radical new care delivery options' (p.4). Further guidance on implementing the Five Year Forward View (NHS England 2015) also called for the establishing of *Sustainability and Transformation Plans* (STPs). These required leaders of local NHS organisations and local government to come together to devise plans for

[3] NHS England is the Arms Length Body charged with overseeing the NHS in England and managing its budget.

implementing the Five Year Forward View, with new care models expected to feature prominently in these plans. The same imperatives have continued into the most recent central policy initiative: The Long Term Plan (NHS England 2019). This declares the need for the NHS to shift towards a new service model, with increased integration between primary, community, urgent and social care. Integrated Care Organisations, made up of local NHS organisations, are expected to develop their own strategies to deliver the ambitions of the Long Term Plan in a way that is consistent with those already devised by STPs. As a result of all these policies, there are now multiple reconfigurations underway across the country being planned and/ or implemented by local organisations to meet the intense operational pressures they are under. At the same time, all large reconfigurations take place within a still centralised system. As a result, they are overseen by NHS England and typically must go through their assurance process (NHS England 2018) before being implemented. Service reconfigurations, planned locally but regulated centrally, are therefore a highly prominent part of the current NHS landscape in England.

Service reconfigurations are not just a prominent feature of health policy in England, but are 'an enduring orthodoxy in health systems of high income countries' (Jones et al 2019: 1221). Such reconfiguration can be defined as:

> A deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in locality, region or health care administrative area (Fulop et al 2012: 129).

While there is a growing international literature on 'system wide health service reconfiguration, mergers and regional hospital service re-design' these 'remain poorly understood' (Fraser et al 2017: 1). Indeed, many common beliefs regarding service change, both in evaluative studies and amongst local and national policy makers, seem fundamentally out of step with existing knowledge. For example, many studies present

service change as a technical intervention that will address problems within the healthcare system (Jones 2019: 1221). At the same time, recent studies into the implementation of change show local managers can present their plans as based in clinical evidence of a range of patient safety and outcome benefits (Fraser et al 2017, Jones and Exworthy 2015). However, the actual substance of this evidence can be lacking or contested (Jones and Exworthy 2015: 199) and there is an absence of clear evidence of the clinical benefits of such changes (Jones et al 2019: 1221). At the same time, rather than being straightforward technical exercises, healthcare planning is actually 'inherently political' in nature (Jones et al 2019: 1221), and often publicly contested (Fraser et al 2019: 111). This can relate to several issues, including: lack of confidence in the strength of evidence being put forward (Jones and Exworthy 2015: 201); suspicion of cost cutting (Fulop et al 2012: 132); and the value and meaning communities attach to their local hospitals (Stewart 2019: 1252). Overall then, service reconfiguration is both a highly relevant aspect of policy in the healthcare systems of high income countries, but is also an area that would benefit from more in-depth, critical research into how they are carried out.

This is especially the case for sociological perspectives on service reconfiguration in healthcare. Despite the prominence of large service reconfigurations in health policy, there is currently a dearth of sociological perspectives on the subject. As Jones et al (2019) argue in their review of literature on large scale healthcare change, research in this area tends to be 'dominated by instrumental evaluative' perspectives, particularly health services research (p.1221). This is usually technical in nature, seeking to gauge the success of reconfigurations with reference to narrowly defined economic and clinical outcomes. However, they argue a sociological lens can offer valuable insights into health service reconfigurations by analysing 'the social, cultural and political dimensions of healthcare' (Jones et al 2019: 1222), thus enabling insights that go beyond established ways of thinking about reconfigurations (p.1226). This includes critical perspectives on the role of power, control and systems of governance; as well as the strategies used by actors to frame issues

and advance certain interests. Sociology's contribution also includes a consideration of the role of shared cultural beliefs, assumptions, and ideologies: shedding light on the multiple meanings attached to different aspects of change (Jones et al 2019). There are some recent notable examples of sociological contributions to the literature on service reconfiguration. For example, Stewart (2019) uses a sociological lens to explore the meanings hospitals have for their local communities. This allows them to go beyond the dominant mechanistic and monolithic views of public opposition to show the complex and multifaceted nature of public attitudes towards hospital closures. Fraser et al (2019) also use theories of biopolitics to interpret major service reconfiguration. In doing so, they shed light on political processes and the relationship between knowledge, power and space (p.119). Added to this, Morrell et al (2020) use a narrative perspective to understand how NHS managers cope with and make sense of large-scale change. Specifically, they argue that such a perspective can 'enhance understanding of sociological phenomena within organisations because they are a means of cultural transmission' (p.909). However, while examples of sociological research into service change in the NHS are growing, they are still few, meaning sociology's potential in analysing service reconfiguration in healthcare is still largely unfulfilled.

Moral economy offers a potentially rich sociological framework to provide original insights into service reconfiguration in the NHS; whilst also resonating with recent research into the effects of structural and financial changes on norms and values in NHS organisations. In a broad sense, the concept draws attention to the moral understandings that influence economic activities, and the way economic phenomena can, in turn, affect these understandings (Sayer 2007: 262). This focus resonates with analytical concerns stretching back to the founders of the discipline. This includes Durkheim's interest in the moral dimension of the division of labour in modern economies[4] (Fournier 2013: 140); Weber's attempt to explain the origins of the modern capitalist system with reference to a religiously

[4] In *The Division of Labour in Society*

inspired work ethic[5] (Scaff 2017: 60); and Marx's view that certain moral values constitute an ideology which serves class interests and the dynamic of capitalist accumulation (Kellner 1981: 115). More recently, several scholars have argued for the relevance of moral economy in understanding a range of topics, including consumption (Wheeler 2019), work and employment (Bolton and Laaser 2013), campaigning (Pushkar 2019), and fraud (Leon and Ken 2019). This central focus on the interaction of 'moral' and 'economic' phenomena also resonates with some existing literature on change within the NHS, particularly studies into the impact of the Health and Social Care Act 2012. For example, Segar et al (2014) use Scott's (2008) institutional theory to hypothesise that changes to the 'regulative pillar' in giving GPs budget holding responsibilities could destabilise the 'normative pillar' of the norms and values they hold as patient facing clinicians. Hughes et al (2011) also make the case that structural reforms brought about by the Act could undermine certain 'networks and service norms' that are crucial to facilitating cooperation between commissioners and providers (p.322). Similarly, Jones et al (2013) argue that market based reforms could disrupt inter-organisational collaboration by undermining relationships based on a shared concern for 'the stability of other organisations, and the local health economy as a whole' (p.56). More recent literature also focuses on how the enduring context of financial restraint has impacted upon moral and ethical judgements within the NHS. For example, Forbess (2020) looks at how managers draw on legal style advice to balance ethical and economic calculations within a context of austerity. Kerasidou (2019) also highlights how regulations and structures used to implement efficiency savings within an A&E department influence the exercise of ethical values such as empathy, as well as clinicians' beliefs regarding their duties and obligations. All these studies therefore show the relevance of the core concerns of a moral economy framework for understanding NHS organisations by examining the relationship between moral understandings and economic practices.

[5] In *The Protestant Work Ethic and the Spirit of Capitalism*

Despite the potential of moral economy for developing original insights into the process of service change in the NHS, its possibilities are made problematic by the increasingly diffuse ways in which it has been used in recent years (Siméant 2015, Palomera and Vetta 2016, Carrier 2018). Indeed, there is currently confusion over the precise meaning of the concept (Carrier 2018: 19) and it has been used in different and sometimes contradictory ways across a range of studies (Palomera and Vetta 2016: 414). Several of these interpretations take the concept away from the basic understanding outlined above, which entails a consideration of both economic and moral phenomena. For example, as Siméant (2015) writes, some studies use moral economy as a synonym for culture, outlining an 'economy' of a specific moral framework without reference to its economic dimensions (p.169). Others use the term moral economy to denote alternatives to mainstream economies (Palomera and Vetta 2016: 417), thus limiting its application to capitalist economies. Others also use the term to denote a normative critique of an existing economic practice or arrangement: to evaluate 'economic systems, actions and motives in terms of their effect on peoples' lives' (Sayer 2000a: 80-1). While all these approaches may have their merits, the presence of such multiple interpretations compound the confusion regarding the use of the term. The same can be said of various proposals regarding the future of the concept. For instance, Carrier (2018) proposes the concept should be used to understand the obligations created by economic transactions (p.32); Siméant (2015) that it should be applied specifically to the analysis of humanitarian aid (p.163); and Gotz (2015) as a way of illuminating 'the workings of civil society in the modern world' (p.158). In addition to this, Palomera and Vetta (2016) claim the distinct contribution of moral economy lies in its ability to link the dynamics of capital accumulation with the various norms, meanings and institutions they are entwined with (p.422). However, despite these various conceptualisations, there is currently no consensus as to what moral economy as an analytical approach is, or how it should be applied empirically.

Overall, this discussion shows the potential of moral economy for generating much needed sociological insights into service reconfiguration in the NHS. However, it also shows the limitations in the concept, particularly in lacking a clear definition. This highlights the importance of the dual aims of this thesis: to both *apply* moral economy to understanding the process of service change in the NHS, but also to *develop* the concept itself. The next chapter will take the first step towards doing this by exploring how the concept has been applied in similar contexts to that of NHS organisations.

2. Literature Review: Moral Economy and Work & Organisations

Introduction

Scope of the review

In this chapter I aim to explore how the term 'moral economy' has been used in relevant empirical studies. This will inform how I apply it to understanding the process of service reconfiguration in the NHS. As mentioned in the Background chapter, moral economy has been used in increasingly diffuse ways in recent years (Simeant 2015, Palomera and Vetta 2016, Carrier 2018). I have therefore set several inclusion and exclusion criteria to mark the appropriate boundaries for this literature review. These relate both to the type of empirical setting the concept has been applied to, and to how moral economy has been conceptualised. Please note that while I have mainly focused this literature review on empirical studies, I have included a small number of theoretical papers which discuss how moral economy should be used in empirical studies.

I have not found any empirical literature on the application of moral economy to service reconfiguration, in the NHS or otherwise. I have therefore set a broader focus on how moral economy has been applied to *empirical studies of work and organisations*. This is appropriate given service reconfigurations are workplace activities that necessary take place within and/ or between organisations. As a result, studies that focus on these contexts are likely to provide relevant insights for this study. Added to this, I have also excluded empirical studies carried out on pre-20th century settings. This is because the high level of change that has taken place in workplaces and organisations means that studies which focus on this time are unlikely to be relevant to understanding current NHS organisations.

I have also excluded several studies because they do not conceptualise moral economy in a way that would generate original and relevant insights into the process of service change in

the NHS. Specifically, there are three uses for the concept which I have excluded from this study. These are:

- *Moral economy as a loose synonym for 'cultural'*. As Simeant (2015) writes, such studies outline an 'economy' of a specific moral framework without reference to its economic dimensions. This can include considerations of 'the production, distribution, circulation and use of moral feelings, emotions and values, norms and obligations in the social space' (Fassin 2009: 1257, trans Palomera and Vetta 2016: 414). Such a use is unnecessary given there are already several terms - such as culture, norms and values - that explore the ways in which groups have mutually held meanings (Simeant 2015: 169).

- *Similarly, many studies use the term moral economy to denote alternatives to mainstream economies*. These are depicted as realms existing outside of the market or the state, 'as reciprocity- systems of survival linked to particular groups, often underprivileged ones' (Palomera and Vetta 2016: 417). Such depictions of *a* 'moral economy' tend to offer romanticised versions of alternative, particularly pre-modern, forms of non-market provision. This approach to moral economy is again not relevant to this study. NHS management operates within a highly regulated realm of state provisioning within an advanced capitalist economy. As such, it is difficult to see how studies that focus solely on alternative economies can offer insights into the process of service change in the NHS.

- *The use of the term moral economy to denote a normative critique of an existing economic practice or arrangement.* Sayer (2000a) distinguishes between two modes of moral economy study. The first is the 'analytical' or 'positive' mode. This involves 'the study of the ways in which economic activities, in the broad sense, are influenced by

moral-political norms and sentiments, and how, conversely, those norms are compromised by economic forces' (p.80). However, he argues the term moral economy also has a second, normative, mode, which aims for 'an evaluation of economic systems, actions and motives in terms of their effect on peoples' lives' (p.80-1). The analytical mode is clearly more relevant to the aims of this research, which seeks to undertake an empirical analysis of the process of service change. As a result, studies that *only* present a normative critique have been excluded from the literature review. However, it is important to note that some studies seek to combine analytical and normative modes of moral economy. These have not been excluded from the literature review, as the analytical element makes them relevant to the study.

I have also only included studies that use the term 'moral economy' to describe their theoretical approach. This is because of my overarching aim to both apply and develop this concept specifically. However, it is important to note that there are many theoretical perspectives that cover similar themes without using this terminology, some of which I will examine in the next chapter.

Overall, I have included twenty-nine papers in this this literature review and a full list can be found in Appendix A.

History of the concept

It is a common impulse to seek to define the meaning of terms with respect to their origins (Williams 1983: 20). This is certainly the case in many studies that deploy the term moral economy, which often root their use of the concept in the work of E.P. Thompson on 18th century food riots (Götz 2015). However, in this chapter I have chosen not to use the historical trajectory of the concept as a starting point for understanding how I might apply moral economy to the process of service reconfiguration in the NHS. I have instead departed

from this convention by focusing on its empirical applications to studies of work and organisations, as outlined above. Here I will briefly justify this departure, particularly with reference to the contested nature of Thompson's contribution, and more recent confusion regarding the meaning of the concept.

While it is commonly attributed to the work of E.P. Thompson, the term moral economy has a long history stretching back over 200-years and, within this time, has shown a large diversity of meanings (Götz 2015: 158). This includes: an association with brotherhood, order, and 'social interest' during the French revolution; its use primarily as a religious concept, often used by radical reformers to denote the divine order of the universe, in the 18th and 19th centuries (p.150); and, also in the 19th century, an association with capitalism and socialism, and ideas such as health, knowledge, religion, happiness, reproduction and responsibility (p.151). Despite this long history, it has become common practice in studies deploying moral economy to cite E.P Thompson's article on food riots in eighteenth century England as the proper origin of the concept (Götz 2015: 152). In this paper, Thompson (1971) argues it is necessary to see discontent as emerging from perceived violations of social norms and obligations regarding the proper economic functions of several parties - a 'moral economy of the poor' - in the transition towards more laissez fair policies (p.79).

Given the prominence of Thompson's paper in the literature, it would be reasonable to expect his contribution to be foregrounded in this research. However, a closer examination of Thompson's work reveals that using his conceptualisation as a starting point for this study would be problematic. As Götz (2015) argues, Thompson deploys a very context specific understanding of moral economy that is a relatively minor part of its conceptual history (p.147). Thompson understood moral economy as 'bound to a specific epoch and a particular historical context', using the concept to specifically discuss the way the transition to modern market systems created conflict with more traditional ways of life (p.147). While Thompson did endorse the use of his interpretation of moral economy in peasant studies, he

opposed its use outside of this type of historical formation, fearing that an extension of the concept would result in a loss of focus (Thompson 1991: 340. Cited in Götz 2015: 154). Furthermore, his views are 'analytically confined by their eighteenth-century frame of reference' and do not take account of more modern meanings of the term 'economy' (Götz 2015: 158). As such, the transferability to modern settings, like service reconfiguration in the NHS, is highly disputable. It is therefore somewhat curious that Thompson is so often cited as providing foundations for the use of the term in studies exploring a variety of contemporary contexts, and it would not be appropriate to use his conceptualisation as a starting point for this study.

It is equally difficult to find any one clear theoretical starting point in the more recent history of the concept. As I touched upon in both the Background chapter and the last sub-section, there is confusion over the meaning of the concept and in recent years the term has been deployed in increasingly diffuse ways. Therefore, while there are several proposals for how it should be used going forward, there is currently no agreed meaning of the concept within which to situate this study. Indeed, in a recent article Hann (2018) argues that this 'inflationary usage' has underlined its shortcomings (p.225), stating 'that the time has come to discard the concept altogether as a clumpish reification' (p.231). While I disagree with this conclusion, the lack of consensus regarding the meaning of the term – in both its recent and more distant history – does make it difficult to identify any clear conceptual foundation from which to build for the purposes of this study. This underlines the validity of my approach in this chapter: to begin the exploration of how to apply moral economy to this study by appraising its usage in more recent empirical applications to the relevant contexts of work and organisations.

Structure of the review

The aim of the literature review is to explore how moral economy has been conceptualised in empirical studies about work and organisations. This will help inform the approach I take to my study. To achieve this, I will address how papers conceptualise:

1. The nature of economic phenomena and/or relationships
2. The nature of moral phenomena
3. The relationship between these two dimensions

The level of attention I give to each of these points will be proportionate to the level of disagreement within the literature. I have found the largest point of tension in the literature to revolve around the third point. Namely, some studies primarily focus on how moral and economic dimensions are *entwined* in various ways. They therefore address the complex dynamics between the two, showing how moral understandings can play a role in both supporting and challenging political and economic structures. Other studies treat the moral and economic dimensions of work and organisations as existing in two separate domains in fundamental opposition to one another. Such approaches often see moral understandings as informing thick, ethically desirable working relationships, and economic forces as undermining said relationships. As such, these studies tend to only focus on the antagonism between these two dimensions. Given the large contrast between these two positions, I will evaluate each, in turn, in the first two sections.

With respect to the nature of the moral dimension, there is less tension in the literature between different approaches. Indeed, most studies take a rather broad conceptualisation of what morality is, implicitly equating it with norms, obligations and other forms of informal, intersubjective phenomena. However, there are a few studies which see morality as a multi-faceted phenomenon, existing at the level of regulation and individual values and identity, in

addition to the intersubjective level. Given this contrast, I will dedicate the third section of the Literature Review to evaluating the merits of a multi-level approach to morality.

With respect to the nature of economic relationships, several different implicit conceptualisations are present in the literature. However, there is no clear point of contradiction within these variations. Instead, most implicitly see the economic dimension as relating to economic and political structures of various types, most often ones organised around hierarchical relationships. As a result, I will not address this point in a dedicated section. Instead, I will highlight the different economic relationships explored throughout, and then evaluate them all in terms of their applicability to my study in the chapter conclusion.

It is important to note that, whilst I have only discussed most papers with respect to the point they offer most insights into, I have found some papers to be useful in elucidating more than one of the three aims set out above. These papers appear in multiple sections, although different aspects of the papers are discussed in different sections.

2.1 Economic and moral as entwined

Several studies use a moral economy framework to show the ways in which economic and political relationships are *entwined* with various moral phenomena. This perspective therefore stresses the inter-reliance of the two, but also a dynamic interplay that can lead to contradiction and antagonism. Whilst their conceptual work is not specific to studies of work and organisations, Palomera and Vetta (2016) provide a useful theoretical articulation of the core features of an entwined approach. The main thrust of their argument is that moral economy studies should focus on how the process of capital accumulation is 'always metabolised through particular fields constituted by dynamic combinations of norms, meanings and practices' (p.414). They therefore explicitly reject approaches that see a moral economy as somehow separate from a market economy. Instead, they hold to Booth's

(1994) claim that '[a]ll economies are moral economies', 'including the market societies of late-capitalism' (cited in Palomera and Vetta 2016: 419). Palomera and Vetta hold that the power of the concept is:

> in its capacity to highlight the ambiguous logics and values that guide and sustain livelihood practices, by looking at the dynamic fields of struggle around the boundaries of what is good and acceptable, their power hierarchies and the political projects they might inform (p.415).

This therefore highlights two distinct elements to an entwined approach. The first is a focus on the dynamic inter-play of moral phenomena and power hierarchies, and the second is the way this interplay sits within the broader context of a capitalist political economy. According to Palomera and Vetta (2016), the approach can be used to understand several types of behaviour. While moral economy studies often focus on movements that defy existing orders (p.425), the concept can also be used to understand conformity to certain regimes of power. Thus, it shows a level of compatibility with theories of hegemonic practices (p.427). At the same time, it may also show how certain meanings and values accommodate dominant culture without ever *fully* endorsing it (p.427). Such an understanding therefore highlights the often complex and multifaceted role of moral understandings within power structures.

Several of the papers I have identified broadly fit with Palomera and Vetta's conceptualisation of moral economy, whilst also showing variations in emphasis. Specifically, studies vary on the type of economic hierarchy they focus on, with some foregrounding immediate employment relationships, and others more abstract market relations. Studies also vary on the extent to which they see shared moral understandings as either promoting consensus and solidarity or sowing the seeds of discontent. In addition to this, some studies more explicitly foreground the wider context of a capitalist political economy than others. As I will show, while these differences are significant, the perspective on moral economy remains broadly compatible.

Studies that focus on immediate working relationships

Several studies explore the role moral understandings play in structuring disparate power relations between employers and employees. These draw on a moral economy framework to understand the meanings involved in exploitative work contexts, while also linking these to broader policy regimes. Many such studies use a moral economy framework to show how workers willingly comply with apparently exploitative economic relationships. For example, Hiah and Staring (2016) use a moral economy perspective to explain compliance among undocumented employees to ostensibly exploitative working conditions within the Chinese catering industry in the Netherlands. This ethnographic study considers the ways in which labour relations are influenced not just by formal rules and market pressures, 'but also by informal rules and culturally shared expectations about justice and reciprocity' (p.83). Specifically, they argue that discourses around human trafficking tend to cast employers as offenders and employees as victims (p.98). However, research participants understood this relationship in terms of informal obligations and feelings of justice associated with Guanxi. This refers to specific cultural meanings 'based on the idea of valuing a long-term relationship between the parties and going beyond immediate goals' (p.88). As such, Hiah and Staring use a moral economy perspective to elucidate the cultural meanings behind the participation of employees in these businesses. This analysis is also linked back to the broader legal and policy context of 'crimigration' and the 'Dutch Government's efforts to control Immigration' (p.97-8). The authors therefore use a moral economy framework to understand willing compliance with ostensibly exploitative labour relationships within a broader policy context. Galam (2019) deploys a similar understanding of moral economy to understand acceptance of economic power asymmetries in the patron-client tie of manning agencies[6] and Filipino 'utility men' in the global maritime industry. This relationship is characterised by abusive practices wherein utility manners are exposed to numerous

[6] According to Hiah and Staring, manning agencies are organisations that supply seafarers to ships within the global maritime industry.

‘technologies of servitude’ (p.580). However, Galam argues that this takes place with an underlying patron-client relationship based on mutual obligations which holds:

> The manning agency–utility men relationship involves the agencies delivering on the promise of employment at some future time, a fulfilment contingent on the utility men’s proving themselves worthy of it. (p.586)

Both parties therefore rationalise their adherence to the shared obligations which characterise this practice in different ways. Manning agencies rationalized this in terms of developing the ‘‘proper dispositions’ of a seafarer’ (p.586); while utility manners framed their servitude in terms of improving their life prospects (p.589). Galam also argues that the pay and job security of seafarers is predominantly better than the rest of the Philippines job market. Within this context, submitting to these exploitative working conditions can be a strategic exercise of agency by workers to improve their life prospects. Both studies therefore demonstrate the entwinement of economic power hierarchies with shared moral understandings, showing how the latter supports the former by imbuing exploitative practices with moral meaning. These meanings often make these practices acceptable to social actors, thus allowing economic relationships to continue and reproduce.

This view of entwinement in terms of securing compliance and support for unequal power relations is also present in Stenbacka’s (2019) research. She uses a moral economy framework in her qualitative study to understand relationships between employee migrant farmworkers and employer farmers in Sweden. This is set within the context of an agricultural industry wherein production is increasingly reliant on international migration (p.255). Migrants within this industry are often faced with precarious working conditions, as well as the potential for exploitation and disempowerment by employers (p.256). Despite these risks, Stenbacka identified several ‘practices of care’, existing ‘within a framework of norms and ethical principles’ which are a part of these economic relationships (p.271). Worker and employer relationships were therefore based on mutual responsibilities, such as

a commitment to the task required for ‘farm survival and success’ (p.271) and ‘quasi familial bonds’ (p.272). This again demonstrates how moral economy can be used to show the involvement of shared moral understandings within labour relationships which are also exploitative. As the author notes, the existence of such moral understandings within this economic practice does not mean power relations are non-existent. Instead, this perspective helps to show the diverse forms that relationships informed by economic and social divides can take (p.272). This further helps demonstrate the complex dynamics by which individuals may come to endorse ostensibly exploitative economic relationships.

Other studies share this focus on potentially exploitative employee- employer relations but make the case for moral understandings being a source of both compliance *and* discontent among workers. For example, Khurana’s (2017) study into the experiences of women construction workers in Delhi uses a moral economy framework to show how their actions in dealing with their subordinate position are often guided by ‘ideas of morality and reciprocity in relationships’ (p.921). This is framed within a policy context of reductions in social security where women ‘are increasingly pushed to low-wage, low-productivity occupations’ (p.922). Khurana argues that established moral obligations formed the basis for the acceptance of new forms of control by employers. At the same time, participants showed a willingness to question, although not defy, the actions of employers if they did not respect their right to certain forms of support (p.933). As such, this demonstrates a dual focus on moral understandings securing conformity to hierarchical relations, whilst also providing a potential source of resistance if those in power fail to fulfil their obligations. Similarly, Näre’s (2011) ethnographic study of domestic and care labour relationships amongst migrant workers in Naples focuses on moral understandings as a source of cooperation and discontent. She uses moral economy to highlight how labour contracts are always accompanied by an implicit ‘moral contract’ (p.401). This is ‘based on normative notions of good and bad, reciprocity, shared duties and responsibilities’ that are always under negotiation (p.401). In the case of her research participants, domestic work was ‘based on notions of duty,

gratitude, altruism and familial responsibility', where workers were expected to work out of 'familial duty and affection' rather than economic gain (p.407). At the same time, workers expected employers to treat them with respect (p.407). In this way many experienced this working relationship as familial in nature (p.408). Bonizzoni (2017) draws on Näre's conceptualisation to uncover similar findings in her study into undocumented migrants engaging in employment-based amnesties in Italy. She argues that while family-like working relations often disadvantage employees, they can also draw upon these mutual obligations to negotiate belonging. This is demonstrated by the way some workers turned to their network of Italian families to obtain the fake work contracts required to comply with the law. All these studies therefore help to outline the complex and potentially contradictory nature of entwinement between the moral and economic dimensions, which can simultaneously be a source of solidarity and conflict.

The above studies predominantly focus on how unequal power relations are enmeshed with *shared* moral understandings between groups. However, there are some studies that use moral economy mainly to explore both similarities *and differences* in moral understandings between groups within unequal relations of power. Mulinari (2019) demonstrates this in her qualitative research on the practice of tipping in restaurants in Sweden. This uses moral economy as a 'sensitising concept' to explore 'what customers and workers identify tipping to be and what ideas concerning rights and fairness are embedded in the practice' (p.447). She finds differences in moral understanding between customers and staff regarding workers' entitlement to tips. Customers tended to see tips as a reward to individual workers for eliciting positive emotions (p.442). On the surface staff accepted this idea of tip as reward. However, in practice they felt the tipping system was arbitrary rather than a simple reward for good work, and therefore engaged in tip pooling away from the gaze of managers and customers. This alternative understanding of fairness thus led those in subordinate positions to challenge 'hegemonic discourses of what is defined as entitlement, unequal, fair and rights in the workplace' (p.439). This study therefore adds an important layer to the

entwined approaches to moral economy discussed previously. While in many ways it is consistent with an overarching view of the entwinement of economic hierarchies with moral understandings, it shows that some understandings may be contested or only superficially adhered to. In this case, workers ostensibly accepted the dominant understanding of tipping as fair reward held by customers, but also sought to subvert it via the practice of pooling. This underlines Palomera and Vetta's (2016) point that moral economy can help understand how people in subordinate economic positions accept existing power relations without fully endorsing them.

Studies that focus on more abstract relationships

While the above studies predominantly focus on economic relationships between employers and employees, others focus on how individuals interact with more abstract hierarchical structures. Hence, they share a focus on uneven power relations, but the relations they focus on are more indirect. This, in turn, moves the analytical focus away from day to day interactions in the workplace and more towards questions of how broader systems of economic and political power are related to certain moral understandings and attitudes.

Some such studies examine remote *market mechanisms* and the way these are enmeshed with moral understandings. This is used to counter the view that market forces are themselves autonomous and free from social assumptions and evaluations. Irwin and Bottero (2000) highlight the importance of this perspective in their literature review on the marketization of female labour. While large shifts in employment relations are often characterised within sociology as a disintegration of social influences brought about by market forces (p.261), they argue that:

> The value of 'moral economy' as a perspective lies in its emphasis on the social assumptions, evaluations and norms which structure claims to resources. It offers a more inclusive perspective on 'market economy' since it allows us to

> locate market claims, in all forms, as a set of conventions which are just as much culturally constituted as are changes in gender relations. (p.263)

A major thrust of the paper is therefore to argue that apparently abstract market forces should not be viewed as exogenous to evaluations and norms but enmeshed with them. Developments in the labour market therefore need to be 'analysed as a cultural event' which is based on cultural and social processes (p.267). Van Doorn and Velthuis's (2018) study into the experiences and motivations of adult webcam workers helps to demonstrate this insight in empirical terms. They analyse the system of market competition constructed by the platform Chaturbate to explore the entanglement of the 'sociotechnical construction of markets and the discursive formation of orders of worth' (p.189). Through a content analysis of web forums, they show there are several competitive strategies models use to make money on the platform that are judged to be fair and legitimate in terms of 'the hustle'. This describes a 'committed and honest yet cunning form of entrepreneurship' which is itself based in a 'meritocratic order of worth' (p.185). Thus, their engagement with the platform, and adherence to its rules, is based on shared understandings regarding what constitutes legitimate earning strategies within this system. However, the authors also argue that the algorithmic configuration of the platform makes the hustle more precarious and leads to economic insecurity for many models while the platform continues to extract value from these activities (p.189). The study therefore shows systems of market competition are entwined with the moral understandings of participants engaged within them. This represents a subtle analytical shift from studies that foreground employer-employee relations. Instead of focusing primarily on immediate day to day power dynamics, the authors pay more attention to the workings of an increasingly prevalent form of market construction: online platform-based systems. This shows how a focus on the entwinement of moral and economic dimensions can be extended to less traditional forms of workplace and organisational hierarchy.

Other studies focus on the entwinement of moral understandings with more abstract economic relationships by using moral economy to elucidate wider processes of capital accumulation. For example, Kofti's (2016) study draws on her ethnography in a factory in Bulgaria to shed light on the economic practice of flexible production. She focuses on how hierarchical relations in the industry are maintained by a convergence of several different moral frameworks from different spheres of a worker's life, including 'managerial *and* household practices' (p.433, my emphasis). For example, while many workers believed conditions within the factory to be unfair, some were unwilling to engage in collective action due to the 'economic interests of the household' and how this related to 'moral values of conjugal relations and parenthood' (p.448). In other words, moral commitments from outside of the workplace helped to maintain compliance to precarious employment practices, even by those who acknowledged them to be unfair. Kofti then uses these insights to consider how several different moral spheres are 'entangled' in the increasing 'precaritization of work and life' (p.450). This therefore shifts the analytic lens away from how moral understandings are implicated in inequalities within a specific economic activity, and towards how they can work to maintain broader regimes of accumulation, in this case flexible production. Curely (2017) has a similar focus on broader economic relations, in this case between unions and industry, in his ethnography with native American coal workers pushing for the renewal of a power station lease within the Navajo Nation. The research seeks to account for workers' support for this capital-intensive industry, 'despite years of exploitation and environmental damage' (p.71). It does so by describing a 'subsistence ethic' held by workers based on 'hard work and the maintenance of one's livelihood on ancestral lands' (p.72). The analysis ultimately uses moral economy to give us 'a better understanding of the integration of indigenous peoples into capitalist processes' (p.71), rather than foreground their day to day working lives. Therefore, it also uses a moral economy framework to scrutinise more macro processes of economic and political power.

Additional studies focus on the relationship between systems of welfare support and workplace regulation and individuals, particularly at times of policy change. For example, Dodson's (2007) focus group-based study examines how wage-poor mothers relate to welfare reforms that promote paid work over 'mother work'. She notes that recent reforms advocate a 'dominant ideology that demands primary devotion to work' (p.260). However, this is largely rejected by mothers who prioritise keeping their children safe over compliance with market norms (p.258). Indeed, many believed they had 'the right to refuse the terms of the labour market' if these demands affected their ability to keep their children safe (p.275-6). As a result, participants had developed several creative strategies to circumvent regulations (p.275). This behaviour often led to sanctions and negative moral labels, such as having a poor work ethic (p.276). However, mothers continued to see their resistance as morally justifiable. The study therefore demonstrates a high level of defiance towards state advocated moral norms enshrined in regulation. While such norms still had an impact on mother's lives, through sanctions, these individuals did not accept the moral values implicit in the reforms. This therefore shows a strong contrast with earlier studies that focus on moral economy in terms of fostering cooperation and consensus between dominant and subaltern groups. Bailey et al (2011) share a similar focus on attitudes towards state policy in their qualitative study into the effects of changing industrial relations policy on low paid women in Australia. They use a moral economy framework to explore beliefs regarding how society should function and the popular consensus over what practices are considered acceptable. Specifically, they show how a new policy regime based on neoliberal arguments struggled to be accepted and was strongly contested by recipients. Such policies were justified with respect to moral understandings based on freedom to choose one's contract and the idea of job creation (p.445-6). However, these clashed with 'historically embedded' shared moral understandings intrinsic to existing industrial relations (p.445). These included notions of fairness, responsibility and dignity held by interviewees, and the availability of certain dismissal remedies. The study therefore shows how moral economy can be applied to understanding resistance or acceptance of new policy agendas, and the ways that neoliberal

logics advocated by the state may clash with the moral understandings of those working in industries. Bailey et al's and Dodson's discussions of norms present in state policy also raises an important question regarding the relationship of moral and regulatory phenomenon. Up to this point in the literature review, most studies have carried the implicit assumption that the moral aspect of moral economy exist on the level of informal customs and understandings. While they seek to show how these support or conflict with state policy, they do not tend to examine the moral content of the regulations themselves. However, as Bailey et al and Dodson show, regulations themselves can act as carriers for the moral beliefs of dominant groups. I will come back to this issue in the final part of this chapter, as it relates to an important question regarding how to conceptualise what level of social reality morality exists within.

Conclusion

The studies explored so far have strengths and weakness with respect to the three aims of the chapter to understand how they conceptualise:

1. The nature of economic phenomena and/or relationships
2. The nature of moral phenomena
3. The relationship between these two dimensions

In all these studies the economic dimension refers to hierarchical economic relations within a broader capitalist political economy. However, there is variation of the types of relations this might include. The first set focus on immediate employee and employer relations, particularly those that might appear exploitative (Hiah and Staring 2016, Galam 2019, Stenbacka 2019, Khurana 2017, Näre 2011, Bonizzoni 2017, Mulinari 2019). These explore how power disparities between individuals who work together are mediated by moral understandings that are to some extent shared, even if different groups attach different meanings to these.

The second set consider more abstract relationships. These range from technologically mediated economic relations (van Doorn and Velthuis 2018); the economic practice of flexible production (Kofti 2016); negotiating relationships between individuals, unions and firms (Curely 2017); and policy relations between the state and citizens (Dodson 2007, Bailey et al 2011). This variation is useful in exploring the range of hierarchical relations that can be explored as part of a moral economy study.

Taken together, the studies in this section also help demonstrate the complex ways in which the moral and economic dimension can interact. They show that the moral dimension can mediate the economic in various ways. It can work to facilitate some level of support for hierarchical economic relations (van Doorn and Velthuis 2018, Hiah and Staring 2016, Galam 2019, Stenbacka 2019, Näre 2011, Curely 2017), grudging compliance (Kofti 2016, Khurana 2017), discontent (Bailey et al 2011) or even active opposition and subversion (Dodson 2007, Mulinari 2019). In this section I have therefore highlighted the various complex ways in which the literature shows moral and the economic dimensions to be entwined. Added to this, most studies also show how this entwinement is linked to the workings of a broader political economy or process of accumulation. This shows the distinctive contribution a moral economy perspective can give to the study of work and organisations.

One area where there is little variation within the studies explored so far is in their conceptualisation of the moral. Several different terms are used to describe the moral dimension. This includes: obligations (Galam 2019), orders of worth (van Doorn and Velthuis 2018), moral norms and duties (Näre 2011), moral values (Kofti 2016), shared ideas of fairness (Mulinari 2019, Bailey et al 2011), and conceptions of justice and reciprocity (Hiah and Staring 2016). However, within this variation is uniformity: most studies conceptualise morality as existing on the level of informal norms and customs, separate to both formal regulations, and the meanings and subjective values of individuals. As I will discuss in this

coming section, this does not consider the extent to which morality can be approach as existing on multiple levels.

2.2 Economic and moral as separate

A major divide in the literature is between studies that see hierarchical economic relationships and moral phenomena as entwined, which I have explored above, and those that approach them as largely separate. I will now address the second type of study, arguing them to be more limited because they separate out the moral and the economic dimensions in a way that only allows for a relationship of conflict between the two. They therefore lack a consideration of the complex interactions between moral and economic phenomena discussed in the last section. At the same time, these types of studies do offer more nuanced insights into the nature of moral phenomena, particularly by emphasising its subjective and emotional characteristics. They also provide several additional insights into the various ways that economic phenomena manifest within organisations and the workplace.

Bolton and Laaser's (2013) paper on the applicability of moral economy to the study of work and employment is cited by many of the papers in this section and offers a starting point for considering this more 'separatist' approach. On the surface, their account shares similar concerns to papers that take a more 'entwined' approach. For instance, they criticise authors who 'draw a boundary between the market, social and moral relations in society' (p.513) and hold that economic practices must be seen 'as necessarily complex, enmeshed and shaped by moral sentiments and norms' (p.517). They also argue for the need to use moral economy studies as part of a radical political economy analysis to understand individual actions within contemporary capitalist societies (Bolton and Laaser 2013: 511). Despite these similarities, their approach also contains a key ambiguity which leads to conceptual inconsistencies when applied to empirical studies. This stems from the attempt to promote

the desirability of thick social relations within work and employment, demonstrated by the following extract:

> Moral economy is an analytical framework that gives voice to critical concerns for the workings of an increasingly disconnected capitalism, its inherent tendencies to treat labour as a 'fictitious commodity' and the impact this has on the well-being of individuals and wider society. Hence, at the heart of the approach suggested here is a normative understanding of mutual reciprocality and embedded sociality that raises questions about how to support the human capacity to flourish. (p.508)

Bolton and Laaser present moral economy as allowing for a consideration of spaces outside the market based on thick relationships. This is held in opposition to economic relationships based on 'rationalized views of people and a dominance of exchange and use values logic' (p.509). These two types of relationship are depicted as being in direct antagonism, with the former more ethically desirable than the latter. As Palomera and Vetta (2016) argue when critiquing Bolton and Laaser:

> a key feature of this particular approach to the moral economy concept is the portrayal of norms and values (sustained by specific communities) as inherently positive or good visa-à-vis the fragmenting and individualistic nature of a market without norms. (p.418)

As part of their work scholars such as Bolton and Laaser therefore pursue the normative goal of advocating 'political projects that might foster higher degrees of solidarity' (p.418). This means they largely avoid analysing how moral phenomena can be implicated in economic hierarchies as part of the capital accumulation process. The conceptualisation leads to a less sophisticated analysis of the relations between the two types of phenomena and offers fewer analytical possibilities than those discussed in the last section.

I will now outline four types of moral economy study found in the literature review that broadly fit with Bolton and Laaser's conceptualisation. The first approach focuses on the presence of non-instrumental motives in economic activity (Approach 1). The second and third approach both focus on social relations based on thick social relations, and in opposition to market forces. However, I have split these studies into those that take a 'macro' policy level focus (Approach 2), and those that take a 'micro' organisational level focus (Approach 3). The final approach also views market forces as largely external to relationships based on moral understandings (Approach 4). However, these papers foreground the impact such forces have on the emotional wellbeing of individuals.

Approach 1: Non-instrumental Motives in Economic Activity

These studies make a distinction between the instrumental and non-instrumental motives of individuals when engaging in economic activities, focusing on the importance of the latter. For example, Banks' (2006) research on moral economy and cultural work draws on findings from qualitative interviews to argue that non-instrumental motives shape practices of cultural entrepreneurship. He argues that a sense of place and community among workers has a binding effect and 'can act as focus for social imperatives that mediate and impose limits around the pursuit of instrumental, profit seeking goals' (p.466). Thus, he gives an account of moral motivations being in opposition to self-interested economic motivations. The research also has a normative purpose in seeking to challenge accounts of economic actions that only focus on instrumental action. In so doing, he argues that moral motivations can 'reveal the possibilities for progressive social and political action contained within cultural work' (p.460). This approach highlights the various meanings and motivations individuals attach to workplace action. However, it does not consider how these meanings are implicated within political economic processes and relations of power. This therefore makes it hard to distinguish from works in economic sociology which hold the broader aim of combining 'the analysis of economic interests with an analysis of social relations' (Swedberg

2003: 1). In their study into socialisation within family firms, Vallego and Langa (2010) demonstrate a similar understanding of moral economy in terms of moral and economic motivations by exploring the 'noneconomic links between employers and employees' (p.49). They use a moral economy approach which assumes that 'relations are mediated not only by economic links but also by affective, normative, and symbolic ones' (p.50). However, as with Banks, they do not consider how normative considerations are connected to relations of power. As a result, there is little distinctive about this use of moral economy when compared with economic sociology in general.

Approach 2: Thick social relations in opposition to markets - macro

Some papers approach moral economy as the study of *thick social* relations that are in opposition to market forces. Within this there are two types of empirical focus: a macro focus on the state of a sector or area of employment relations; and a micro focus on workplace settings. Like the above studies, these seek to show the importance of relationships based on reciprocity, trust and moral concern in economic activities. Unlike the above studies, they *do* explore the relationship between moral understandings and political and economic hierarchies. However, they do this in a problematic way by equating the moral dimension with thick social relationships within horizontal power relations, and the economic dimension with amoral hierarchical power relations. These studies therefore provide an idealised view of the former type of relationship, presenting them as existing outside of hierarchical economic relationships and in conflict with them.

Within this interpretation, I have identified two studies that take a macro perspective: focusing on the impact of large-scale policy developments on thick social relationships. Both highlight the presence of thick social relationships while also critiquing the way marketisation undermines these relationships. In their analysis of contingent work, Bolton et al (2012)

begin by proposing a moral economy approach to explore the social side of economic relations. They argue:

> A moral economy lens views employment as a relationship rooted in a web of social dependencies, and considers that 'thick' relations produce valuable ethical surpluses that represent mutuality and human flourishing… We suggest that evaluations informed by moral economy offer a more holistic appraisal of HRM [Human Resources Management] practices such as contingent work, where both economic and social opportunities and costs can be more fully seen. (p.121)

This therefore presents moral economy as a way of appraising economic practices such as contingent work based on the effect they have on thick social relations. Ostensibly their approach fits with the entwined approaches discussed in the last section. Indeed, they commit to the analytic inseparability of 'social values and norms' and 'economic principles', and that these cannot be viewed 'as two independent spheres that influence each other' (Bolton et al 2012:123). However, this formulation is accompanied by a separate concern to provide a normative critique of the way instrumental concerns erode 'thick social relationships within the workplace', undermining mutuality and trust (p.129). Bolton et al therefore argue that contingent work creates a climate wherein 'economic action appears to be wholly a matter of power and self-interest' (p.128). This formulation seems to contain the 'independent spheres' conceptualisation of moral economy they argue against at the start of the paper. That is, they go from saying all economic employment relations are rooted in social values and norms, to criticising contingent work for creating environments dominated by instrumental concerns.

This view of the economic and moral as separate is even starker in Bolton et al's (2016) paper on quality work and employment policy. The paper critiques the move towards flexible labour markets and the negative impact this has on individual job security. It draws on Polanyi's understanding of 'double movement' to argue how non-market institutions such as

trade unions, academics and member states oppose the flexibilization agenda through appeals to social justice. As such, they highlight the 'tensions and contradictions as the logic of capitalism pulls in one direction and the values and norms of a moral economy pull in another' (p.594). This involves an a priori assumption that the concerns of non-market institutions are based in values and norms, whilst the logic of capitalism is a fundamentally different type. This contradicts their own commitment to seeing the two as enmeshed and seems to emanate from a desire to engage in a normative critique of this kind of economic regime. However, this ultimately limits the utility of the term moral economy as, within such a formulation, it is only possible to consider relations of conflict between the moral and economic dimensions. Unlike the papers explored in the last section, this approach is therefore unable to consider the more complex dynamics between the two types of phenomena.

Approach 3: Thick social relations in opposition to markets - micro

Studies that adopt this understanding of moral economy to analyse workplace (micro) settings share a similar limitation in only considering relations of conflict between the moral and economic dimensions. However, unlike the above accounts, such studies do provide useful in-depth accounts of economic practices and the types of economic phenomena to be found in contemporary workplaces and organisations. For example, Bolton and Laaser (2020) deploy this perspective in their longitudinal study into the workplace solidarities of special educational needs teachers. Here they use a moral economy framework to highlight how moral values help 'build and maintain solidarity at work' between staff (p.61). Such solidarity is presented as standing in opposition to new systems of performance management and evaluation. These systems therefore represent an 'attack on their moral economy', violating moral norms and undermining 'established caring practices and systems of reciprocity' (p.65). This exploration of the effects of systems of performance management on moral understandings is a useful illustration of the types of economic phenomena that

can be examined in a moral economy study of work and organisations. However, Bolton and Laaser's focus on *juxtaposing* such systems with thick, moral relationships means they only consider how moral phenomena inform teacher resistance to systems of power. This again means their approach to moral economy provides a less sophisticated analytical lens into the way moral understandings and hierarchical economic relations interact with each other than those discussed in the last section.

Laaser's (2016) research into the hierarchical relations between workers and their managers in banks comes closer to conceptualising moral economy in terms of entwinement between the two dimensions; but ultimately still approaches them as fundamentally separate. Like others in this section, she tends to define moral economy in terms of thick social relationships. Her conception draws particularly on Sayer's (2005. Cited in Laaser 2016: 1004) concept of lay morality, considering how individuals engaged in such relationships draw on their ongoing ethical evaluations of how actions affect the well-being and suffering of themselves and others. Drawing on qualitative interviews, Laaser explores the way performance management systems (PMS) changed the nature of hierarchical relations between workers and managers over 30 years. Interestingly, she largely defines pre-PMS relationships as based on 'a social and moral web that rested on shared moral understandings' (p.1008). These 'were interwoven with inequalities and power asymmetries that structured the employment relationship' (p.1008): something she defines as a type of paternalism (p.1009). This conception of moral economy is therefore similar to those discussed in the last section that allow for the possibility of moral understandings supporting hierarchical economic relationships. However, Laaser separates the moral and economic out when describing the introduction of PMS. In her account, this did not entail a change in the moral understandings underpinning economic relationships, as would be the case in a more entwined approach. Instead, she presents this as a replacement of moral concerns with more instrumental ones; wherein bank workers experienced the 'dismantling of the social and moral web… as a violation of their moral understandings' (p.1013). Laaser therefore

holds that a moral economy approach views 'organisations under capitalism as instrumental institutions that utilise labour to the end of profit maximisation' (p.1005). This again suggests that an a priori premise of moral economy studies should be that moral and economic dimensions are necessarily in conflict. However, it is unclear why this is the case, especially as their paper begins by exploring how hierarchical relations in banks prior to the introduction of PMS *were* informed by shared moral understandings.

This micro understanding of moral economy is not just put into practice by Bolton and Laaser. Umney (2017) uses a similar approach to show how the shared moral understandings of 'function musicians'[7] are actively undermined by market pressures. He draws on interviews with musicians to show how shared expectations, trust networks, patterns of reciprocity and egalitarian norms characterise the 'moral economy' of this form of work. Umney draws a clear distinction between moral economies on the one hand, and 'market economies' on the other (p.847). Specifically, he draws a distinction between the marketized relationship the band-leader has with the buyer, and relationships that 'had elements of a moral economy' between 'fixers'[8] and other bandmembers, based on trust and verbal commitments (p.841). This involves a useful discussion of how various changes in market dynamics put fixers and bandleaders in a difficult position when balancing these pressures with the expectations placed upon them by the bands (p.843). Such market pressures include the introduction of online marketing and the increasing prevalence of young bands, both of which gave more power to clients in pushing down prices. However, these market pressures are only analysed in terms of the way they encroach upon and 'disembed' such moral economies, creating several dilemmas for fixers who were involved in both market and moral economies (p.847). As such this approach shares the same issues present in Bolton and Laaser's conceptualisation of moral economy in assuming market forces are not themselves accompanied by certain moral logics which may clash with more

[7] The term 'function musicians' refers to musicians who play at corporate functions.
[8] Fixers are bandmembers who also acted as a point of contact for buyers.

local ones. It therefore is not primarily concerned with exploring how the dynamics of contemporary capitalism are entwined with moral understandings and norms, but instead treats market and moral economies as two separate types of economic relationship.

A similar approach to moral economy is taken by Noronha et al (2020) in their study into security guards and precarious work. Like others discussed in this section, they deploy an understanding of moral economy which equates it with the study of the thick social relationships that are seen as necessary for human flourishing and dignity, and which are actively in conflict with the market (p.556). They highlight the ways security guards found satisfaction in their work and built resilience to argue that individuals can use their agency in resistance to marketizing tendencies (p.571-2). This included building thick social relations with influential members of client organisations and taking advantage of client's desire to have reliable and experienced workers (p.572). Interestingly, the authors implicitly point to ways that the development of such shared moral understandings may contribute to economic inequalities. Namely, they briefly discuss how guards who work for reputed clients attempt to create an 'intra-occupational hierarchy of worth' between themselves and those working for less respected employers (p.573). This focus hints at how thick social relations may not just stand in opposition to systems of economic inequality but may support them. However, this remains largely unexplored in the article itself, which mostly deploys a similar separatist understanding of moral economy as that of Umney, Laaser and Bolton and Laaser alone.

Approach 4: Emotional Well-being and Economic Processes

A third type of moral economy study which largely treats the moral and economic dimensions as separate deploys the same focus explored above on thick social relations, and the ways these are eroded by economic processes. However, studies within this category draw particular attention to the impact this erosion has on the emotional wellbeing

of subaltern groups. For example, Bryand and Garnham (2014) draw on Sayer's (2000. Cited in Bryand and Garnham 2014: 306) work to define moral economy as a 'framework of norms and ethical principles governing social relations within economic systems'.
They then use this definition to argue that distress amongst Australian grape growers can, in part, be explained by perceived ethical injustices. This paper does include detailed consideration of shifts in the political economy of agriculture, specifically regarding the impact of neoliberal reform and globalisation (p.305). However, its focus is not on 'the structure and moral workings of the political economic system as a whole but rather the perceptions and subjective experiences of farmers concerning the ethics of economic relations within the case study' (p.307). The paper therefore uses a moral economy framework to focus on how the breaking of moral expectations, such as those regarding justice and fairness, has emotional implications for farmers. Economic processes of marketisation and competition are largely left in the background, and the study does not involve an examination of the role moral understandings in the broader operation of political and economic hierarchies.

Sanghera and Satybaldieva (2009) draw on a similar understanding of moral economy in their study of professionals' experiences of marketisation in Kyrgyzstan. This study accepts the basic premise that social phenomena such as norms, rules and institutions are crucial in stabilising market transactions and 'creating social cohesion' (p.921). However, they add to this that 'without moral emotions and institutional safeguards, economic practices and relationships can be distorted' (p.921). They therefore use a moral economy framework to explore the moral sentiments that individuals associate with their work. This includes a consideration of how 'emotions and related beliefs and attitudes have been severely affected by developments in 'real' markets in the public sector, resulting in some cases in dishonesty, lack of sympathy and injury' (p.922). The article does include a useful discussion on the nature of moral emotions and rules that will be addressed in the next section. However, like Bryand and Garnham, the overarching focus is again on the implications for individual

wellbeing of these economic processes, rather than the way these shared moral understandings relate to the operation of economic and political hierarchies.

Conclusion to section

Overall, the studies I have examined in this section deploy a much more limited understanding of the relation between moral and economic dimensions than those examined in this previous section. This is particularly in their tendency to cast a strict distinction between the two, and only conceptualise their relationship in terms of conflict. Despite this, the studies I have explored in this section do offer some useful insights into how moral and economic dimensions can be conceptualised. With respect to the former, they stress that the moral dimension can have emotional content and implications. With respect to the latter, they emphasise a range of additional phenomena (such as performance management systems) that can be considered types of economic relationship.

2.3 Morality as a multi-level phenomenon

Most of the studies explored so far in this chapter assume the moral dimension of moral economy exists as an intersubjective, cultural phenomenon. This includes obligations, orders of worth, moral norms, duties, and shared ideas of fairness, justice, reciprocity, and thick social relations. However, few have sought to critically assess whether this fully captures the nature of morality in work and organisations. In this final section I will explore the few accounts that do scrutinise the nature of the moral dimensions of moral economy. I will begin by outlining Bolton and Laaser's (2013) emphasis on the importance of using a 'multi-layered' moral economy framework (p.521), and how they have applied this in their empirical work. I will then then re-examine some studies I have already reviewed in this chapter to ascertain the extent to which they implicitly deploy a multi-layered understanding of morality. I will finish the chapter with an in-depth discussion of the work of Wheeler (2018, 2019), as

her research represents one of the few examples of a successful empirical application of an explicit 'multi-layered' (2018, p.1271) or 'multilevel' (2019, p.271) understanding of morality[9]. I will then conclude by assessing the applicability of this conceptualisation to my own research topic.

Bolton and Laaser's (2013) formulation of moral economy for the study of work argues for the need to approach morality as a multi-level phenomenon consisting of several layers. These include: the normative dimension of state and organisational policies; the thick social bonds and communities that individuals live within; and the evaluations and deeply felt ethical commitments of individuals. With respect to the last point, they particularly draw on Sayer's concept of lay morality. This sees individuals as constantly making moral evaluations in their day to day lives about 'relations to others, [and] about how people should treat one another in ways conducive to well-being' (Sayer 2005: 951. Cited in Bolton and Laaser 2013: 516). Overall, Bolton and Laaser see a multi-level understanding of morality as highly beneficial, stating:

> Through a combination of these inspirational ideas the moral economy framework presented here connects different layers of analysis that form an analytical bridge between individual agency, institutionalized structures of community, family, social and work organisation and political economy. (p.509)

Bolton and Laaser therefore see morality as acting on the level of individual subjectivity, shared cultural understandings, and regulative contexts. However, this commitment to a multi-level approach to morality is not evident in their later empirical work. Here cultural and agential aspects are subsumed into their concept of thick social relations, and regulative phenomena are not presented as having a normative dimension. For example, in their research on teacher solidarity (2020) they mainly discuss the moral norms of groups and the

[9] Please note, throughout the chapter I will simply refer to this as a 'multi-level' approach to morality.

values of individuals with respect to how they help build 'thick human connections' (p.61). Specifically, they argue that moral norms, such as education as social justice and 'a collective goal to help pupils flourish' (p.62), interact with moral values, such as 'care, recognition, dignity and injustice' (p.63), to build solidarity amongst teachers. Furthermore, organisational policies, in this case increased performance management, are only considered in terms of their tendency to conflict with this solidarity and are not presented as having any moral content. This means Bolton and Laaser's practical application of a multi-level moral economy framework does not examine the interplay of different levels of morality in the way promised by their earlier theoretical work.

While none of the other studies explored so far in this chapter explicitly apply a multi-level understanding of moral economy[10], some do imply the interaction of at least two levels of morality. For example, both Bryant and Garnham (2014) and Sanghera and Satybaldieva (2009) draw on Sayer's work on lay morality to highlight how morality does not just exist on the level of norms but is also laden with subjective emotional responses. The breaking of moral expectations can therefore be accompanied by feelings of outrage, betrayal, injustice, and emotional distress (Bryant and Garnham 2014: 308). Individuals are also conceptualised as beings with moral concerns and commitments, through which they evaluate and deliberate on moral rules, norms and institutions (Sanghera and Satybaldieva 2009: 933). These studies therefore begin to show how the cultural and subjective level of morality can interact, although this is not foregrounded in the analysis. Some studies from the first section also provide insights into the interplay of morality on cultural and policy levels. Dodson's (2007) study into moral economy and wage-poor mothers examines how participants draw

[10] Bolton et al (2016) do say in the abstract of their paper that they offer 'a multi-layered conceptual lens' (p.583) in their article on the moral economy of employment policy. Although they do not overtly return to 'multi-layered' nature of their conceptualisation in the main body of the text, this seems to relate to the combination of the analytic task of *describing* developments in employment policy and the *evaluative* task of providing a normative critique of such developments. As stated earlier in this chapter, such normative interpretations of the moral economy approach have not been included in this literature review, and so I do not consider this multi-layered understanding of moral economy as applicable to my study.

on their own shared understandings of safety and care to defy market norms, enshrined in the welfare regulations they are subject to, regarding the work ethic. This therefore does *implicitly* involved a consideration of two forms of morality: one on the level of the moral norms contained in state backed regulations, the other on the level of shared cultural understandings of what it means to be a mother. Similarly, Bailey et al (2011) show how workers resist the market orientated moral conceptions of industrial relations, contained in state policy, by drawing on their own shared understandings of fairness and responsibility. This again shows an implicit clash of two levels of morality: one on the level of state regulation and the other on the level of shared cultural understandings.

Two studies I have not yet examined, Sayer (2008) and Baur et al (2017), also provide a consideration of the interaction of two or more levels of morality. In their study into food safety culture, Baur et al (2017) argue that food safety governance, backed by state regulation, exerts a moral economy on producers by assessing their safety according to an abstract calculation of risk (p.715). This works by defining 'farms, warehouses, distribution centres and the people who work in them' as good or bad, safe or unsafe (p.726). However, such regulatory activity undermines 'other deeply held values' and excludes 'cultural forms and experiential knowledges associated with long-standing food ways' (p.713). Baur et al therefore show how governance regimes can embody certain moral understandings which, through their formal power, can displace existing cultural values. This again shows the interplay of morality on the level of regulation, and morality on the level of informal shared understandings. In his discussion of the moral economy of universities, Sayer (2008) also shows how regulations can act as carriers for the moral beliefs of dominant groups. Within this Sayer distinguishes between the 'rule-based morality' of work allocation systems, and the 'care-based morality of everyday interpersonal relations' (p.148). As such, he argues that the moral norms reflected by regulations 'are products of domination' (p.154). At the same time, such norms must be validated by the shared moral understandings that exist between academics, who must also make complicated practical judgements when applying these

regulations to everyday practice (p.162). Sayer's account therefore comes closest of all the studies discussed so far to addressing the regulative, cultural and agential aspects of morality within work and organisations. However, this remains largely implicit, and his discussion also lacks any empirical data to back up his assertions. The literature reviewed to this point therefore shows the potential of a multi-level framework, but very few successful *explicit* empirical applications.

Explicit applications of a multi-level approach

I have identified two papers which explicitly adopt and successfully apply a multi-level understanding of morality. These are Wheeler's (2018, 2019) papers on the Moral Economy of Readymade Food, and the Moral Economy of Consumption. In both, Wheeler uses Bolton and Laaser's (2013) framework as a theoretical starting point but expands and elaborates on this in several useful ways. Her approach is also consistent with an entwined view of the interaction between moral and economic dimensions, and she explicitly rejects treating these as 'separate spheres'. As she argues:

> This [the rejection of 'the separate spheres fallacy'] is important because academics should adopt a critical stance to explore the causes and consequences of inequality and injustice within consumer capitalism to both the environment and society, but this critique must be grounded in the context of how markets are made and incessantly negotiated through moral ideas, institutions and practices embedded at the micro, meso and macro levels of the economy. (2019, p.273)

Wheeler's work therefore has the potential to provide an account of moral economy that is both multi-layered and entwined. It provides a crucial illustration of how a multi-level understanding of morality can be conceptualised in a coherent and empirically applicable way. In the remainder of this section I will therefore provide an in-depth exploration of the different levels of morality presented in Wheeler's work, including a consideration of the

macro, meso and micro levels of morality as Wheeler defines them. I will then conclude by discussing how this understanding can be applied to my study.

Wheeler defines the macro-level of morality as 'state regulation of the economy' (2019, p.277) and, unlike Bolton and Laaser's application of the concept, she explicitly treats this level as being, at least to some extent, based in moral ideas. For example, when discussing moral economies of consumption, Wheeler shows how morality on the macro-level can relate to government understandings regarding environmental protection, which are reflected in economic policies promoting recycling (p.279). Wheeler therefore accepts that state regulation has moral content of its own:

> At the first layer, state regulation is acknowledged as a powerful force that creates, promotes and sanctions economic processes that are harmful/ beneficial to humans and environment. (Wheeler 2019: 277)

These policies also operate within broader systems of provision, such as market provision, and this shapes the possibilities for regulatory intervention (2018, p.1277). In the case of ready-made foods (Wheeler 2018), this is highlighted by the way state regulation on behalf of consumers is largely grounded in ideas of individual responsibility and retailer self-governance, reflecting the broader neo-liberal political economy (pp.1287-8). Therefore, unlike Bolton and Laaser, Wheeler shows how regulations can be based on moral ideas and also work in tandem with the structural configuration of systems of provisioning. These insights give her research a similar focus to those papers discussed in the first section, particularly Bailey et al (2011), Dodson (2007), Baur et al (2017) and Sayer (2008), who all show how regulations can act as carriers for the moral beliefs of dominant groups. At the same time, Wheeler's explicit presentation of a multi-level understanding of morality creates more scope for a consideration of how different levels of morality interact with regulative morality, a point I will now explore in more detail.

This capacity of different levels of morality to influence each other is demonstrated by Wheeler's discussion of how an understanding of macro-level morality must also be combined with a consideration of meso and micro levels. Wheeler defines the meso-level as: 'the collective customs and critical discourse through which different groups in society actively moralise the market' (2019, p.277). These collective understandings can work to 'actively challenge, defend and appropriate different understandings of market morality which in turn has the potential to shape the market in line with their image of it' (p.277). This form of morality is therefore broadly consistent with many of the shared moral phenomena discussed so far in this chapter, such as norms, obligations, and orders of worth. It is separate to macro-level morality, but also interacts with it in various way, with the two levels able to challenge or support each other. Wheeler also conceptualises how this meso-level morality interacts with the economic dimension of moral economy. She presents such shared understandings as constituting a key part of how people make sense of their actions within wider economic systems. For example, with respect to readymade foods, meso-level phenomena can include '[c]ultural conventions around what constitutes proper cooking' (Wheeler 2018: 1284), societal understandings of feminine responsibility for cooking (p.1286) and cultural repertoires regarding ideas like self-control and responsibility (p.1274). Individuals actively reflect on these cultural pressures and resources, alongside their own material constraints, to position themselves in ways that can support or challenge existing economic structures when engaging with markets. Furthermore, individuals involved in food manufacturing will themselves try to resonate with such shared understandings when marketing their goods (p.1283). This therefore shows a dynamic synergy between capital accumulation and moral phenomena which is consistent with Palomera and Vetta's vision of moral economy but, by highlighting different levels of morality, also builds on it.

With respect to the micro-level of morality, a conception of active human agency lies at the heart of Wheeler's framework and allows for an understanding of how macro and meso-level morality are manifest within the day-to-day lives of individuals. Wheeler defines the micro-

level as 'the lay normativities of consumers'[11] (Wheeler 2019: 277). This draws on a conception of the human agent put forward by Sayer and discussed previously in this chapter. It sees individuals as involved in ongoing moral evaluations about their day to day lives, informed by questions such as 'what is of value, how to live, what is worth striving for and what is not' (Sayer 2005: 6. Cited in Wheeler 2019: 276). Wheeler draws on this understanding to argue there is an active, agential element to how both macro and meso-level morality is enacted. People reflect on and evaluate the various moral norms, discourses and regulations they are subject to. They are also bearers of ethical concerns themselves and these influence the decisions they make and how they relate to the other levels of morality. As such:

> The third layer bridges the gap between state, institutional and community norms to call attention to lived experiences of diverse consumers going about their daily routines, reflecting upon the things that matter to them and organising their consumption accordingly. (Wheeler 2019: 277)

Wheeler (2018) illustrates this point with respect to mothers' attitudes towards readymade foods. She explains how the women who participated in her research felt the need justify their consumption of readymade food in the home. This happens within a meso-level cultural context of 'hegemonic femininity' and 'what it means to be a good mother', where women still feel a societal responsibility to make non-readymade meals. This also takes place within a macro-level, regulatory context of individual responsibility for healthy eating, and a practical context of 'busy everyday lives' (pp.1285-7). Women can therefore feel a sense of guilt about preparing readymade foods linked to these societal processes, but also to their understandings of their own feminine identity (p.1285). Within this context:

[11] I use the terms 'lay normativity' and 'lay morality' as synonyms in this thesis.

> These women drew on material and cultural resources to position themselves as mothers in control of their children's diets through their exercise of healthy food choices. (Wheeler 2018: 1286)

This presents a view of an active human agent who feels social and regulatory expectations, and guilt around not fulfilling these, but also responds to these to construct their own action in morally justifiable ways. This conception of an active, reflexive agent also shows how people may conform to or resist wider cultural and regulatory expectations. This is illustrated by Wheeler's (2019) use of a moral economy framework to analyse the morality of recycling. Here she argues that lay normativities allow for a consideration of 'how moral imperatives to recycle are negotiated with other everyday demands and life experiences that relate to ideas about what practices ought to be valued' (p.283). Individuals draw on their own concerns and life experiences to justify conforming to or defying wider cultural and regulatory expectations. For example, one participant drew on moralities of care to argue why she did not recycle because she was too busy looking after children to sort through refuse. Another justified taking part in recycling because it helped him generate extra income for his family (p.283). Thus, this perspective allows for a consideration of how various material and moral considerations, including macro and meso-level morality, may impact on individual action, decision making and post-hoc rationalisation. However, it also shows how individuals exercise their agency through their day-to-day micro-level moral concerns, which influence how they relate to these other levels.

Wheeler's multi-level approach to moral economy has three key analytical strengths when combined with the insights developed throughout this chapter. Firstly, by discussing how morality can be analysed on a macro, meso and micro-level, she shows it is possible to integrate the various conceptualisations of morality explored in this chapter under one coherent framework. Secondly, a multi-level understanding of morality also highlights the various, dynamic ways moral and economic dimensions can be entwined and come to

influence individual actions and understandings. This provides a clearer articulation of insights from earlier in this chapter. For example, hegemonic moralities, such as neoliberal conceptions of personal responsibility, can be enshrined in macro-level regulations. Because these normative understandings become underpinned by the power of the state, they may rely on coercive mechanisms (such as sanctions), rather than shared beliefs, to become enacted in day to day life. At the same time, hierarchical power relations will to some extent also have to legitimise themselves with reference to shared, meso-level, moral understandings amongst groups and individual beliefs to have legitimacy. Individuals themselves will also have to draw on these understandings, and the material and regulatory constraints they find themselves subject to, when enacting lay moralities in day to day life. Thus, Wheeler's work shows how entwinement between moral and economic dimensions can take place on all three layers. Thirdly, a multi-level understanding helps to better explain why morality may be a source of compliance, support, or defiance against existing power relationships, as shown in the first section of this chapter. Individuals will evaluate the various cultural, regulative and material pressures and influences they are subject to with reference to their own identities and personal moral concerns. Their varying responses to meso, macro and economic contexts can therefore be understood with respect to these evaluations. Overall then, Wheeler's framework provides a key building block in working towards a suitable moral economy approach for this research.

Despite these clear strengths, a challenge in applying Wheeler's framework to this study is that her concept of moral economy is not primarily geared towards the actions of individuals and groups within the workplace and organisations. Instead, it is mainly designed to understand the relations between consumers and wider systems of provisioning, particularly marketised ones. As a result, the types of moral and economic phenomena that are most influential, and the way they interact, are likely to be significantly different in NHS organisations to those she examines. For example, a large part of Wheeler's analysis of both consumption and ready-made foods focuses on the dynamic of the market and how this

interacts with moral phenomena. However, as I have shown throughout this chapter, this is often not the most prominent form of economic relationships within organisations, where hierarchical forms of bureaucratic control, such organisational hierarchies or performance management systems, are typically more influential. Action within organisations is also generally more structured and subject to formal duties and obligations than the action of consumers. This again makes it likely that a study within this context will need to be sensitised to different types of economic and moral phenomena. Having a moral economy approach that is suitable for use within organisations is particularly important for this research because service reconfigurations in the NHS typically take place within highly structured organisational settings. I am therefore unable to simply adopt Wheeler's approach and apply it to my research. This means I need to engage in extra theoretical work to integrate the insights generated in this chapter into a moral economy framework that can be applied to understand the process of service reconfiguration in the NHS.

Conclusion to chapter

In this chapter I have explored how 'moral economy' is conceptualised in empirical studies about work and organisations. I have done this to inform my approach to using the concept to understand the process of service reconfiguration in the NHS. I have particularly sought to address how studies conceptualise:

1. The nature of economic phenomena and/or relationships
2. The nature of moral phenomena
3. The relationship between these two dimensions

The attention I have given to each point in the chapter has been proportionate to the level of disagreement in the literature. As I found the third point to be the most divisive, I have given it the most attention. Division on this point is structured around two broad positions. The first

holds that the relationship between moral and economic dimensions needs to be approached as a complex and multi-faceted *entwinement*. The second holds moral and economic dimensions to be principally separate and in opposition to each other. I have argued that the first position is sounder, for two reasons. Firstly, approaches that focus on entwinement are more theoretically coherent. These hold that economic and political power structures are always accompanied by, and are to some extent dependent on, moral understandings. At the same time, the dynamic nature of the relationships between the two means that such understandings may not just be the source of compliance and legitimation, but also antagonism and resistance. In contrast, approaches that focus on separation tend to focus on the role moral norms and values play in building thick relationships within groups. The economic dimension is stripped of moral understandings and is characterised as a corrosive and corrupting force which undermines these relations to the detriment of individual and societal wellbeing. This leads to an idealisation of horizontal intra-group relations, whilst also ignoring that systems of economic and political power clearly utilise and promote certain moral understandings to gain legitimacy and support amongst individuals involved in economic practices. These theoretical lacunae therefore feed into the second disadvantage separatist approaches have compared with entwined ones: they offer far fewer analytical possibilities. The a priori characterisation of all systems of economic and political power as amoral means this conception of moral economy can only investigate a dynamic of conflict between corrosive economic forces and thick social relationships. Studies that focus on entwinement, on the other hand, can investigate multiple, diverse dynamics, as I have explored in this chapter. These include, for example, those of solidarity within hierarchical employment relations, adherence to marketized systems, subversion of reimbursement, resistance to new policy, or grudging acceptance of workplace precarity. Therefore, it is clear from the literature that what I have identified as the ‘entwinement’ approach is more desirable than a ‘separatist’ one, when considering the relationship between the moral and the economic.

Despite these strengths, I also found the conceptualisation of moral phenomena within many entwinement and separatist approaches to be broad and one dimensional. Most, though not all, of the studies I reviewed assume that the moral dimension constitutes a form of shared cultural understanding, be it moral norms, obligations, orders of worth, customs or shared values. However, the potential deficits to this approach have been explicitly highlighted in a small number of papers which stress the need to see morality as a multi-level phenomenon. These draw attention to the way in which morality exists within social contexts as a regulatory, cultural, and subjective phenomenon. This brings into sharper focus the role of the state in promoting certain moral understandings over others, and the ways in which state actors will draw on existing moral understandings to legitimate regulations and policy. It also highlights the role of an active individual agent who holds embodied moral concerns and emotions, and who can actively draw upon moral phenomena at a cultural level to make decisions about what is right. In addition to providing a more sophisticated view of what morality is, this also opens more possibilities for articulating the way moral and economic dimensions interact. However, the existing literature does not give a definitive guide to how such a multi-level understanding of morality can be applied to the empirical study of work and organisations. This is particularly important to my research given service reconfiguration in the NHS takes place largely within formal organisational settings, and so the moral economy framework used for this research needs to be sensitised to this type of context. This remains an issue for me to answer in the subsequent Theory chapter.

Throughout this chapter I have also commented on the various ways economic phenomena/ relationships are characterised in the literature. This is the least problematic of the three points discussed, and I have identified several different types of economic relationships all of which are generally coherent with each other. These range from marketized systems of provision, hierarchical relations between employers and employees, platform-based reimbursement systems, abstract market forces, policy regimes, and systems of performance management. All these approaches share a central similarity: they all refer in

some way to hierarchical *structural* relations which are linked with broader systems of economic and political power. Such an understanding is relatively unproblematic as it can incorporate the types of economic relationships I have explored in this chapter. However, it is still necessary for me to provide a more specific definition of the economic dimension to ensure I draw clear analytic boundary with the moral dimension when developing a moral economy framework for use in a new empirical context (NHS organisations). I will therefore also address this point in the next chapter.

Overall then, in this chapter I have shown that, in relation to this study, moral economy is best conceptualised as:

> *A study of the way moral phenomena, on multiple levels, are entwined with structural relations of political and economic power within organisations and workplaces.*

Within this there are unresolved questions I must address in the Theory chapter. These are:

1. How can a multi-level understanding of morality be best conceptualised when applying a moral economy framework to organisations? Specifically, NHS organisations involved in service reconfiguration.
2. How can economic and political structures be best conceptualised to differentiate them from moral phenomena when exploring the process of entwinement?

3. Theoretical Reconstruction of a Multi-Level Moral Economy Framework

Introduction

As a result of the literature review, I have concluded that, for the purposes of this research, moral economy is best conceptualised as:

> *A study of the way moral phenomena, on multiple levels, are entwined with structural relations of political and economic power within organisations and workplaces.*

This provides a useful first step for applying the concept to understand service reconfiguration in the NHS. However, I have also identified two conceptual issues that I need to address before applying the concept in this empirical study. These are:

1. How can a multi-level understanding of morality be best conceptualised when applying a moral economy framework to organisations? Specifically, NHS organisations involved in service reconfiguration.
2. How can economic and political structures be best conceptualised to differentiate them from moral phenomena when exploring the process of entwinement?

In this chapter I will turn to sociological theory to provide answers to these questions. I will do this by taking the following steps:

1. I will begin the chapter by setting out the use of critical realism (CR) as an appropriate meta-theoretical approach to appraise and develop existing conceptual schemas. This is particularly relevant to this research because it makes clear analytical distinctions between different structural, cultural, and agential phenomena. It therefore has

potential compatibility with the various economic and multi-level moral phenomena I discussed in the last chapter.

2. I will use this meta-theory to outline how I will approach the 'economic' dimension of moral economy. Here I will include examples of the empirical manifestations of economic phenomena.

3. I will then use CR to develop an approach to understanding morality as a multi-level phenomenon in the study of organisations. I will separate this into two parts. In the first I will consider morality as a property of social context. This will draw on the work of Durkheim and more recent institutional perspectives to explore the meso and macro-levels of morality, and the distinction between the two. In the second I will focus on morality as a property of the individual. Here I will draw on the concept of lay morality to explore the idea of individuals being the carriers of moral concerns. I will also use Weber's distinction between substantive and formal rationality to explore the importance of the various logics involved in how individuals give meaning to moral phenomena. In addition to this, I will point to possible routes of entwinement between economic and moral dimensions throughout this section.

4. In the final section I will use a modified version Abend's (2014) *moral background* as an integrating concept, to show how these insights can be drawn together into one theory to apply to the empirical study of service change in the NHS. Here I will focus on the usefulness of his distinction between first order morality and the moral background. This allows for a consideration of both the moral beliefs individuals hold, and the various constraining and enabling social and cultural phenomena that influence these beliefs. This is particularly useful for studying contexts, such as NHS organisations undergoing service reconfiguration, where individuals are actively required to form opinions and make decisions.

In achieving the above steps, I will establish a clear theoretical starting point for the study. I will then show how I operationalised this theory into a qualitative case study in the Methodology chapter.

3.1 Justifying critical realism as a unifying meta theory

In the last chapter I showed how the most theoretically coherent approaches to moral economy rely on an understanding of social reality which presupposes the existence of political and economic structural relationships, shared cultural and regulative phenomena, and human agency, all in dynamic interaction with one another. However, I have also shown ambiguities around how multi-level morality is conceptualised within organisations, and the nature of the entwinement between moral and economic phenomena.

These issues are essentially questions of social ontology. They relate to questions of what entities exist, and what powers these entities possess to causally influence the unfolding of social events (Archer 1995: 16-17; Elder-Vass 2012: 19). Critical realism (CR) provides a useful metatheoretical approach for reformulating moral economy as a concept for use in studying service change in the NHS. This is because it encourages close examination of the 'ontological underpinnings' of concepts as part of the research process (Elder-Vass 2007: 228), thus providing the tools to scrutinise and appraise the nature of the moral and economic dimensions of organisations. I will discuss the relationship of ontology and methodology within a critical realist metatheoretical approach in much greater depth in the Methodology chapter. However, for the purposes of this chapter it is simply important to note that the challenge set by the Literature Review - to establish a more conceptually clear approach for applying moral economy to organisations generally, and service change in the NHS specifically - is consistent with CR informed social research.

A CR understanding of social reality also makes explicit distinctions between different levels of social reality in a way which is broadly consistent with Wheeler's (2018, 2019) multi-level moral economy framework. Here, social reality is seen as consisting of a multitude of dynamically interacting *emergent entities*. Critical realist accounts distinguish between three general types of entity. These are: human agency (Archer 2000), and two forms of social structure, which I will refer to as *relational social structures* (Porpora 1989) and *cultural structure* (Archer 1996). Broadly speaking, these types of phenomena are analogous to the elements of the moral economy framework identified in the last chapter. Here relational structure refers to structural relations of political and economic power; cultural structure to the macro and meso level of regulations, norms and customs; and agency to the lay normativity of individuals. According to Archer's (1995) morphogenetic approach, agency plays a particularly important mediating role in linking all these different types of entity together. The central insight of the morphogenetic approach is that structural and cultural phenomena necessarily predate action, but also rely on reflexive human agents to enact and elaborate them in their day-to-day activity (Archer 1995: 76). The structural and cultural entities that make up social context work together to create situational logics which predispose agents to certain courses of action. However, because these entities are relatively autonomous, they do not necessarily complement each other, and may create contradictory logics (p.218). Individuals then draw on their own agential causal powers[12] when interacting as part of these contexts, navigating the various complexities or contradictions. As a result of these interactions, contexts are *elaborated* in a way that leads either to their reproduction: morphostasis, or their transformation: morphogenesis (p.76). This introduces a view of social reality where social contexts condition and guide human behaviour, but do not determine it. It is therefore highly compatible with Wheeler's (2018, 2019) view on the way lay normativity interacts with other levels of morality. Here people operate within 'material and cultural constraints' (2018, p.1287), but are also able to exercise

[12] What Archer (1995) refers to as 'PEPs': people's emergent properties.

their reflexive agency to draw on cultural resources (such as moral discourses and repertoires) in a way which reflects their own values and concerns (2019, p.276). A CR view on culture, structure and agency therefore offers a useful metatheoretical framework for interrogating how a multi-level moral economy approach can be applied to organisations.

3.2 Relational structure, the economic dimension, and organisations

In this section I will demonstrate how a CR understanding of relational structure[13] can be used to characterise economic phenomena within a moral economy framework. This will make it easier to identify these types of phenomena in my research and help clarify how they are entwined with moral phenomena. However, before embarking upon this I will first discuss the relevance to this study of existing definitions of economic phenomena provided by economic sociology.

Economic sociology and economic phenomena

Economic sociology is a natural place to look for a suitable definition of economic phenomena, as this field has been defined as '*the sociological perspective applied to economic phenomena*' (Smelser and Swedberg 2005: 3, their emphasis). However, as I will show in this sub-section, economic sociology only partially helps make sense of the approach to the economic dimension of moral economy I uncovered in the literature review, making a departure from this perspective necessary for this research.

The field of economic sociology has come to increasingly focus on 'socially based description and explanation of economic activity', acting as an alternative to the perspective

[13] Please note that the three main theoretical sources I have used in this section use different terms to describe relational structure. Porpora (1989) mostly uses the term 'structure' or 'relational properties'; Elder-Vass (2010) mostly uses the term 'organisations'; and Vincent and Wappshot (2014) 'configurational phenomena'. Despite these differences, all authors use these terms to describe the same type of entity. As such, for simplicity I have opted to use terminology which is closest to Porpora's.

provided by mainstream economics (Zelizer 2011: 385). It is therefore broadly concerned with concepts such as institutions, culture, structure, and power (Hass 2020: 9-10), and this differs from the underlying focus of mainstream economics on rational choice, competition, and market equilibrium (p.27-9). As part of this, economic sociology tends to approach economic phenomena as types of economic activities and processes, and the sites of this activity. For instance, Zelizer (2011) argues that, in recent years, economic sociology has come to move beyond looking at 'standard economic phenomena, such as labour markets, commodity markets, or corporations' (p.383), to considering 'all forms of production, consumption, distribution, and transfer of assets' (p.384). This includes more formal economic phenomena, such as corporations, firms and financial markets, but also less conventional understandings, such as households, local money communities, pawning, gifts, and remittances (Zelizer 2011: 386-7). Similarly, Smelser and Swedberg (2005) imply economic phenomena to be synonymous with 'that complex of activities which is concerned with the production, distribution, exchange, and consumption of scarce goods and services' (p.3). Harvey (2007) also provides a similar, albeit more specific account, by drawing on and developing Karl Polanyi's work to define the 'economic domain of causality' in terms of instituted economic processes (p.165-6). He identifies four types of mutually interdependent economic processes: transformations of quality (broadly constituting production and provisioning); transformations of appropriation (broadly involving processes of exchange of rights of ownership); transformations of place and time (analogous to changes in distribution of people, objects, and activities over time and across space); and transformations of use (broadly defined as consumption) (p.170-1). Overall then, economic sociologists view the economic dimension in terms of 'institutions and practices in which people are engaged in production, exchange and consumption of physical goods, services, value, and even symbols' (Hass 2020: 11). Thus, from this point of view, economic phenomena can include a large variety of activities, processes and sites for these activities and processes.

Within this broad definition the process of service reconfiguration in the NHS itself can be seen as a type of economic phenomena. The same can be said of the various activities, practices, processes, and contexts explored in the literature review. This includes cultural work (Banks 2006), utility manning (Galam 2019), catering (Hiah and Staring 2016), construction (Khurana 2017), flexible production (Kofti 2016), domestic care and labour (Näre 2011), consumption (Wheeler 2019), function music (Umney 2017), and adult webcam modelling (van Doorn and Velthuis 2018). However, as discussed in the last chapter, much of the literature also suggests a more specific understanding of the economic dimension, approaching this in terms of hierarchical structural relations. This resonates with some core concerns of economic sociology, particularly relating to structure: referring to 'the distribution of relations between social entities that can affect resources and the capacity to act' (Hass 2020: 9). However, it is important to note that this understanding of economic phenomena, which is implicitly prevalent in much of the literature reviewed in the last chapter, is distinct from the conventional understanding of economic phenomena provided by economic sociology outlined above. As a result, this understanding needs to be further built upon in this chapter prior to empirical application. I will therefore use the rest of this section to show how such structural relations can be made sense of through critical realism.

Critical realism and economic phenomena as relational structure

A good starting point for determining the nature of relational structure from a critical realist perspective, and how this applies to organisations, is Porpora's (1989) article on social structure. This defines structure as: 'systems of human relationships among social positions' (p.195). Such relations are established by constitutive rules: the rules which define relationships between social positions, including those of domination (p.208). Relational structure is a distinct causal entity that makes up part of the 'material circumstances in which people must act and which motivate them to act in certain ways' (p.200). Its main causal power is to create 'certain structured interests, resources, powers, constraints and

predicaments which are built into each position by the web of relationships' (p.200). Hierarchical relations or relations of domination are a prominent type of relational structure, particularly when applying this conception to understanding work and organisation. Porpora himself uses the example of the employer- employee relationship as a type of social structure that has causal powers over behaviour. He writes:

> For example, the positions of boss and subordinate in an organisation are certainly established by powerful actors at one point in time by formal, constitutive rules. Those rules give the boss the capabilities of firing, promoting and otherwise affecting the well-being of the subordinate. The rules thereby create a relationship between the position of boss and the position of subordinate that grants certain causal powers to the boss that allow the boss to dominate the subordinate. (p.207)

This demonstrates how formal authority relations within organisations can be conceptualised as a type of relational structure. This resonates with the focus of some of the papers explored in the Literature Review which approach the economic dimension of moral economy in terms of hierarchical workplace relationships.

Elder-Vass (2010) also holds that authority relations are an important feature of organisations and are a particularly prominent characteristic of complex ones (p.161). Authority in organisations often stems from the way the holders of some roles are placed above holders of other roles, thus conferring 'some part of the power of the organisation as a whole on certain role occupants' (p.162). However, other relational factors are also important in conferring authority. Specifically, 'the possession of capital of various kinds' is often a significant source of authority (p.162). For example, the power of business owners over business managers is largely based on this dynamic, as is the authority of shareholders over large businesses (p.162). In some circumstances, a lack of capital may compel those in certain organisations or positions to accept the authority of others, so much so that this relationship may even be considered coercive or exploitative (Elder-Vass 2010: 162). This

helps to highlight that, while authority relations are a prominent form of relational structure, other types of this entity can also be found in organisations. In their chapter on using critical realism in organisational case studies, Vincent and Wapshott (2014) provide further insights into how relational structures might manifest within organisations. This includes contractual relations (p.164); certain forums and the way these are constituted (p.164); forms of financial organisation (such as remuneration systems) (p.154); supervisory regimes (p.154); and management structures (p.153). These phenomena are highly compatible with some of the economic and political power relations discussed in the Literature Review, showing the complementarity of the two approaches.

Within a CR ontology, relational structure is a fundamentally different type of entity to cultural phenomena, but the two are also highly interdependent in a way which is analogous to the entwinement of moral and economic dimensions of moral economy. Several CR scholars stress the importance of treating relational structure as distinct from culture. For example, Elder-Vass (2010) argues that relational structures have 'quite different sorts of causal powers' to cultural phenomena[14] and therefore influence interaction in different ways (p.145). Porpora (1989) also stresses how the power of relational structures to influence human motivation and behaviour is *distinct* from and 'analytically prior to rules, norms and ideology', and thus merits a separate category (pp.208-9). Nevertheless, relational structures and cultural phenomena are also involved in a 'complex web of causal inter-relationships' (Elder-Vass 2010: 167) which is useful to consider for the purposes of a moral economy framework. For example, with respect to relational structures within organisations, these are reliant on wider norms, such as legal norms, or worker norms regarding punctuality and honesty, for their continued functioning (pp.164-6). At the same time, relational structures give individuals in certain roles the power to 'mould the normative environment faced by their members and thus shape their beliefs about their responsibilities and obligations' (Elder-Vass 2010: 164).

[14] Elder-Vass (2010) largely refers to cultural phenomena as 'normative social institutions'.

For example, managers can use their positional power to pressure individuals to conform to a specific norm and apply sanctions if not adhered to (p.164). Cultural phenomena are also able to influence and change relational structures; for example, cultural norms around corruption can work to undermine organisational structures (p.166). Vincent and Wapshott (2014) provide more examples of how relational structures and cultural phenomena can exist in complex and dynamic interaction in organisations. For example, changes in the structure of a workplace towards devolution of power may lead to new norms around self-control and peer regulation, but cultural norms can also lead to resistance to new structuring of human resources (p.153). The willingness to engage in formal challenges to existing power structure in the workplace, though mechanisms such as unions, can also arise from norms around subversion and humour (p.153). Overall, from a CR perspective relational and cultural phenomena are *distinct but interdependent*; and this opens several analytical possibilities for this study in considering the various ways they shape each other and influence social interaction.

In this brief exploration I have shown how equating relational structure with the economic dimension of moral economy is useful in elucidating what phenomena can be considered as 'economic' in organisations. By clearly showing what is unique about these types of phenomena, I have shown how they are analytically distinct from the moral dimension. At the same time, I have also explored some possibilities for how relational structures may interact with cultural phenomena within organisations, thus showing some possible modes of entwinement between moral and economic dimensions. I will continue to build on this exploration in the next section, where I will discuss the cultural, meso-level, of morality.

3.3 Cultural level moral phenomena (regulation and norms) and critical realism

In this section I will explore how morality can be understood as a property of social context, able to constrain and enable social action. I will begin the section by outlining how classic

sociological and institutional theory can help characterise morality as a meso-level emergent cultural phenomenon, distinct from other cultural entities. I will do this by exploring Durkheim's understanding of morality as consisting of duties and ideals. I will then turn to more recent institutional theory to show how Durkheim's insights are still relevant for understanding modern organisations. I will also consider how these perspectives highlight morality as both a constraint and resource. Next, I will use CR metatheory to explore the difference between macro and meso-level moral phenomenon. I will argue that regulations can be approached as a convergence of cultural and constitutive rules and, as a result, provide an important route by which the 'moral' and the 'economic' are entwined.

Durkheim: Duties, Obligations and Ideals

The work of Durkheim provides a useful starting point for demonstrating how morality can exist as a property of what we today refer to institutional culture or context. In his later work Durkheim came to see society as consisting of collective representations: shared beliefs and sentiments (Nemedi 1995: 45). These are different from individual representations which consist of individual thoughts, beliefs and ideas (p.49). Collective representations emerge from those of groups of individuals, to form *sui generis* social facts that exist outside of individuals and exert a causal influence upon them (Sawyer 2002). Like all social facts, collective representations are properties of groups and collectivities. Such collectivities can vary in size and, according to Durkheim (1982), can include 'political society in its entirety or one of the partial groups that it contains' (p.52). Durkheim often approaches morality as a specific *type* of collective representation relating to rules, duties and shared ideals. His writing on professional groups primarily focuses on moral rules and duties. Here morality is defined as 'a system of collective, external and objective rules that determine behaviour' (Turner 2019: viii). Such rules can vary between occupational groups and contexts: what Durkheim labels 'moral particularism' (Durkheim 2019: 6). Durkheim sees civil society, the family, and professional associations as all being capable of having their own duties and

stresses how these can vary, particularly with respect to professional groups (Durkheim, 2019: 5). Such duties are defined by the group and encourage individuals to direct their activity towards group needs. Moral rules and duties have a stabilising effect on individual behaviour, providing constraints and discipline and binding them to the 'maintenance of the community' (Durkheim 2019: 16). Durkheim therefore sees duties as an important collective moral phenomenon which exist above the individual and make organised economic and social activity possible.

Alongside duties, Durkheim sees morality manifesting as shared ideals and conceptions of the good. These are often an implicit aspect of obligations and make them attractive to individuals. Lukes (1973) argues that later in his work Durkheim came to focus on the 'desirability' aspect of morality, and from the 'rules people follow to the moral beliefs expressed by the rules' (p.419). These shared ideals are still a property of the collective but carry an emotional load and can attract individuals towards them (Weiss 2012). This focus on the positive attraction of morality is particularly evident in Durkheim's later work on religion. Here, Durkheim argues that collective beliefs and practices, when strongly held by the group, can become religious in character and take on a sacred quality (Cladis 2001). This does not just apply to religious institutions but also to political, economic and scientific spheres. Indeed, according to Durkheim religion can be found 'wherever public, normative concepts, symbols, or rights are employed' (Cladis 2001: viii), supporting a group's feeling of unity and identity (p.xx). People become members of a moral community and think and act in common with regards to the sacred (p.xxii). Durkheim argues that 'the more sacred a moral rule becomes, the more the element of obligation tends to recede' (Durkheim 1974. Citied in Cladis 2001: xxvii). This means individuals may not experience formal and informal moral rules as constraining or burdensome, but instead will experience these as desirable because of this positive emotional attraction. Individuals therefore do not just subscribe to group morality because of a feeling of constraint, but also because they experience conforming to

such codes as satisfying and fulfilling. For Durkheim every moral rule contains elements of constraint and attraction:

> In fact, moral reality always presents simultaneously these two aspects which cannot, in fact, be isolated. No act has ever been performed as a result of duty alone; it has been necessary for it to appear in some respect good. (Durkheim 1956. Cited in Giddens 1978: 65)

Morality for Durkheim therefore exists as a duality, with both positive and negative aspects for how individuals experience it. The negative side is characterised by a sense of constraint and obligation, while the positive is characterised by commitment to a shared ideal. Some moral rules rely on one form more than the other, but both aspects are present to some extent.

Obligations and ideals in institutional theory

This understanding of morality as duties and ideals is also present in more recent accounts from institutional theory, reaffirming their relevance for understanding modern organisations. The idea that obligations, alongside other phenomena, 'take on a rulelike status in social thought and action' and so 'must be taken into account by actors' is a core aspect of Meyer and Rowan's (1977, p.341) seminal article into institutional theory. This perspective is most clearly articulated by March and Olsen (1989) who, like Durkheim, adopt a predominantly normative understanding of institutions (Scott 2014: 65). They tend to treat institutions as entities that can be carriers of moral duties and obligations. They juxtapose this with the view that action is instrumental, calculated and anticipatory (March and Olsen, 1989: 23). According to March and Olsen then, social actors draw on 'rules of appropriateness', as defined by institutions, to guide actions (p.23). Furthermore, their definition of appropriateness, like Durkheim's concept of ideals, encompasses shared beliefs regarding the good:

> To act appropriately is to proceed according to the institutionalized practices of a collectivity, based on mutual, and often tacit understandings of what is true, reasonable, natural, right, and good. (March and Olsen 2006: 690)

Like Durkheim then, March and Olsen see institutions as influencing behaviour by defining obligations and duties and containing shared ideals regarding what is good. They also see these obligations, duties and shared ideals as being crucial for the functioning of organisations and institutions by providing trust. This is through allowing individuals to anticipate the behaviour of others and be confident they will act in a certain way (March and Olsen 1989: 38). As such, one way that morality can be approached on the meso level in organisations is as institutionally defined obligations/ duties/ moral rules and ideals.

These institutional perspectives also add to Durkheim by showing how moral meaning is not just given but also actively constructed within institutions. Normative action within institutions cannot be conceptualised simply in terms of rule following because everyday situations are complex and the correct application of rules ambiguous. Situations can be framed in multiple ways 'that call forth different rules' (March and Olsen 1989: 24). This focus on the ambiguity and disorder of institutional duties and obligations helps to demonstrate the role individuals have in defining which situations match which duties and obligations, as well as weighing up different obligations when they clash (pp.24-5). Indeed, navigating duties and obligations often requires a level of creativity, intelligence and reflexivity (p.22). As such, a focus on how individuals act in accordance with moral duties and rules is 'only the first step in understanding how rules affect behaviour' (p.24). Individuals must interpret which rules, obligations and ideals best fit a situation, particularly when there is conflict or ambiguity (p.24). For example, GPs who take leadership roles in Clinical Commissioning Groups can feel a conflict between their duty as clinicians to prioritise the needs of the patient, and their responsibilities as commissioners for prioritising, and potentially cutting, budgets (Segar et al 2014: 9). Navigating such competing duties requires interpretation and deliberation which, in

turn, is supported by a range of other cultural phenomena. These include 'the beliefs, paradigms, codes, cultures, and knowledge' that support, elaborate, and sometimes contradict duties and obligations (March and Olsen 1989: 22). This perspective is therefore important in showing how individuals do not just passively follow the moral phenomena which exist as part of their organisational context but must also creatively apply them to navigate complexity. Such navigation, in turn, relies on other cultural phenomena that may not themselves be termed moral but support and enable moral beliefs. I will return to this theme in more depth when I discuss Abend's (2014) conception of the *Moral Background* in the final section of this chapter.

Other interventions from Abend (2012, 2014, 2019) show how certain moral phenomena, particularly thick moral concepts, provide individuals with conceptual repertoires through which to perceive and evaluate the social world. Conceptual repertoires consist mainly of both *thick and thin* moral concepts which help to define what is perceived and noticed as a moral issue (2014, p.37). While the stark division Abend draws between these two types of concept is problematic, it is still useful in highlighting the wide variety of moral phenomena that inform individual perception and evaluation, some of which are more context specific than others. Abend (2019) identifies concepts such as 'right, wrong, duty, and obligation' (p.214) as thin moral concepts. That is to say that even though the object of these concepts might change (e.g. what someone holds to be their duties), the concepts themselves are not context or object dependent, in that 'the empirical world does not guide their application' (2012, p.148). In contrast, thick moral concepts both evaluate *and* describe an object: they tell individuals something about the object which is 'world-guided' (Williams 1985. Cited in Abend 2012). Such concepts include:

> dignity, decency, integrity, piety, responsibility, tolerance, moderation, fanaticism, extremism, despotism, chauvinism, rudeness, uptightness, misery, exploitation, oppression, humanness, hospitality, courage, cruelty, chastity, perversion, obscenity, lewdness, and so on and so forth. (Abend 2012: 150)

According to Abend (2012) thick concepts are also different to thin concepts in that they 'presuppose a complex web of institutions, ideas and practices' (p.157). They are therefore 'ontologically dependent' on them, in that they simply could not exist without being placed within this larger nexus.

The distinction Abend's makes between thick and thin concepts does not seem wholly credible as it implies that 'thin' concepts such as duty have no historical and cultural variability in how they are applied and conceived. Despite this, it is useful in highlighting how some moral concepts - such as right and wrong, and duty and obligation - seem to be relatively simple and general, while others seems to more complex and specific to a certain group or society. Abend offers the example of using the thick moral concept 'materialistic' to describe an individual. To apply this concept presupposes several other factors that make up a social context, including property relations, the notion of profit, and gauges of reasonableness (Abend 2012: 157). Such concepts therefore are heavily dependent on specific meanings or societal or institutional contexts (pp.145-6). This opens the possibility for specific institutional and organisational contexts to have their own 'menus' of concepts. As Abend (2019) argues:

> These thick concepts reflect ideas, distinctions, and categories that are specific to particular societies' concerns, problems, and historical trajectories. Therefore, you can always empirically ask what thick concepts exist in society S at time t. And you can always empirically ask what's on particular societies' and groups' conceptual menus, catalogues, or repertoires. (p.212)

Thus, this allows for a further expansion of the conceptualisation of contextual, institutional morality to include not just duties, obligations, moral rules and ideals, but also the wide variety of context specific moral concepts available to social actors.

Distinguishing between the macro and meso

Developing a multi-layered moral economy framework requires me to makes a distinction between macro (i.e. regulative) and meso (i.e. informal cultural) levels of morality in organisations. However, this is problematic because of the clear overlap that can exist between these two levels. None of the authors discussed so far can provide answers to this issue, as neither Durkheim or March and Olsen make clear distinctions between duties and ideals that exist as shared, informal understandings, and those that are formally enshrined in regulation. However, in his three pillars approach to studying institutions and organisations, Scott (2014) provides a distinctive definition of regulations which serves as a useful starting point for solving this problem. He draws a clear dividing line between the 'normative', 'regulative' and 'cultural' 'pillars' of institutions, defining the regulatory pillar as:

> A stable system of rules, whether formal or informal, backed by surveillance and sanctioning power affecting actors' interests that is accompanied by feelings of guilt or innocence (Scott 2014: 63)

Such stable systems of rules are backed by regulatory processes which include 'the capacity to establish rules, inspect others' conformity to them, and, as necessary, manipulate sanctions – rewards or punishments – in an attempt to influence future behaviour' (p.59). These processes may function through informal mechanisms, such as shunning or shaming, or formal ones – 'assigned to specialized actors such as the police and courts' (p.59). The empirical indicators for this pillar include 'constitutions, laws, codes, rules, directives, regulations, and formal structures of control' (p.62).

Scott contrasts this regulative pillar with the normative pillar, where emphasis is placed 'on normative rules that introduce a prescriptive, evaluative, and obligatory dimension into social life' (Scott 2014: 64). He draws on both Durkheim and March and Olsen in his definition of

the normative pillar, and includes rights, obligations, duties and responsibilities (p.64). He also makes three key distinctions between the normative and regulative pillar:

1. The regulative pillar is accompanied by a logic of instrumentality, whereas the normative is accompanied by a logic of appropriateness. When influenced by the former, 'individuals conform to laws and rules because they seek the attendant rewards or wish to avoid sanctions' (p.62). When influenced by the latter, the central questions confronting individuals are not questions of instrumental gain but instead a feeling of what is appropriate within the given situation (p.65).

2. Regulative rules are more precise than normative ones. They are codified and therefore less open to interpretation (p.60).

3. The regulative pillar has a higher level of 'delegation' than the normative. This refers to the ability of third parties to enforce rules and settle disputes. The regulative pillar is therefore more characterised by hierarchies and authority relationships than the normative (p.60).

By making such clear distinctions between the regulative and normative, Scott's approach appears to fit neatly with the distinction between macro and meso-level morality. However, there are two difficulties with Scott's definition of regulations when applied to this research, as I will discuss below.

Firstly, Scott's understanding that individuals adhere to the regulatory pillar through an *instrumental* logic overlooks Weber's conception of legitimacy. This holds that individuals within bureaucratic organisations often do not follow formal rules and procedures out of a sense of self interest as Scott has it, but through a sense of *legal rational authority*. That is,

‘a belief in the legality of enacted rules and the right of those elevated to authority under such rules to issue commands’ (Weber 1968: 215. Cited in Scaff 2014: 95). In other words:

> In the bureaucratic sphere of human action the legitimacy or “rightness” of decisions depends on a willingness to accept the rationality or ‘correctness’ of following formalized procedures and rules’ (Scaff 2014: 109)

An orientation to legitimacy is different from an instrumental logic because adherence to formal rules is not solely based on a self-interested calculation of the costs and benefits of doing so; instead it is based on a belief in the right of those in authority to make rules and expect people to follow them. For example, an NHS manager may decide to pursue centrally set efficiency targets not because they are worried about the consequences of not doing so, but because they respect the right of central policy makers to impose such targets upon local organisations. Belief in such a legitimate order therefore has a distinct subjective register to both an instrumental logic and a logic of appropriateness but is still essentially moral in that it involves ideas of ‘rightness’. It is therefore appropriate to add this idea of rational authority and legitimacy to Scott’s understanding of the subjective reasons for why people follow regulations.

A second, more complex problem with Scott’s framework is that he does not recognise that several regulations have moral content; and this makes it difficult to reconcile with the idea of macro-level morality contained in this multi-level moral economy framework. Scott mainly sees regulations as formal systems of rules such as constitutions, directives, and structures of control (Scott 2014: 62). His conception of regulations is therefore generally consistent with the understanding of constitutive rules I put forward in the first section of this chapter. However, Scott does not address that several regulations relate to moral concepts such as duties, obligations, and moral rules. This is problematic for my research because people working in NHS organisations typically have several *formalised* duties. Furthermore, these duties are likely to have complex relationships with more tacit, meso-level, moral

understandings. Sometimes they will be in conflict, but often they will reinforce each other. For example, to return to the hypothetical example of an NHS manager charged with delivering efficiency saving, the duty to deliver savings, as defined by central policy makers, may be a formal responsibility in their job description. However, managers working in the NHS may also subscribe to the ideal of financial responsibility as part of a broader public service ethos. Such formal and informal moral understandings may overlap in the case of being asked to find efficiency savings. However, there may also be instances when they clash, such as if the manager is asked to make short terms savings which they believe will lead to higher costs in the long term. Hence, there may be times when an individual expresses a normative commitment to a formal duty or regulation because they are attached to the ideal that corresponds with this regulation. Equally, individuals may adhere to certain formal duties not out of a sense of moral commitment but only out of a sense of legitimacy or an instrumental logic. In its original form, Scott's framework is unable to incorporate such possibilities because it does not acknowledge that many regulations have this normative content. I will therefore use the final part of this section to articulate what macro morality is and how it different from meso-level morality.

The critical realist distinction between constitutive and cultural rules (Porpora 1989) offers a useful way of articulating a distinction between macro and meso-level morality without conflating the former with constitutive rules in the way Scott implicitly does. As I addressed earlier in the chapter, constitutive rules define 'systems of human relationships among social positions' (p.195). As such, they are key to understanding my definition of the economic dimension of moral economy as relational structure. Cultural rules, on the other hand, refer to the norms that inform interaction within these roles and, in a broad sense, encompass meso-level morality. While constitutive and cultural rules are analytically distinct, they are also interrelated in several ways. I suggest that regulative, macro level, moral phenomenon can be understood as a particular type of interrelationship, or entwinement, between these two types of phenomena. Therefore regulative (macro-level) morality can be understood as:

types of cultural phenomena regarding moral rules, duties and obligations which are codified and endorsed by hierarchical constitutive rules.

This definition allows for the existence of morality on a regulative level, while also maintaining a distinction between macro-level morality and relational structure. Indeed, through defining macro-level morality as a type of cultural phenomenon endorsed by constitutive rules, it opens one possible route of entwinement between moral and economic dimensions, which I will come back to in the analysis chapters. This definition also distinguishes between meso and macro morality in a way which permits overlap and conflict between the two. For example, individuals may only act in accordance with macro morality through fear of formal sanctions or a sense of legitimate authority, even if it conflicts with existing meso-level understandings regarding duties and ideals. This seems particularly likely if such a formal duty, rule or obligation has been devised by powerful/authoritative actors and only recently introduced. However, individuals may also follow a formal regulation out of a sense of appropriateness if they are committed to the tacit obligation or ideal that the regulation has formalised. This definition of macro morality therefore provides a logically consistent way of showing how this is distinct from both relational structure and meso-level morality.

Conclusion

Overall, in this section I have shown how meso and macro level moral phenomena can be conceptualised within organisations. On the meso level, these are informal moral rules, duties/ obligations, shared conceptions of what is good or right (ideals), and thick moral concepts. On the macro level moral phenomena can be defined as a type of cultural phenomena regarding moral rules, duties and obligations which are codified and endorsed by hierarchical constitutive rules. This latter definition therefore also provides an important

potential path of entwinement between moral and economic phenomena that I will revisit in the analysis chapters. I will now discuss the final level of this framework - morality as a subjective, micro level, phenomenon - before discussing how to integrate all these insights under a single theoretical approach.

3.4 Morality as a micro/ agential phenomenon

The final aspect of multi-level morality I will explore in this chapter is micro-level morality. In line with the approach taken by Wheeler (2018, 2019), I will mainly draw on Sayer's concept of lay morality to characterise this level, while also showing how it is compatible with a CR perspective on human agency. Thus, here I will seek to make three points:

1. Human agents enter social interaction with a range of values and embodied moral commitments (lay morality). These influence how they think, act, and make decisions.
2. Reflexive human agents play a key mediating role in how moral and economic phenomena, as conceived for this thesis, influence the social world. This is consistent with a critical realist understanding of the relationship between structure and agency.
3. Through this process of mediation, an individual's lay morality will influence how they respond to other moral and economic phenomena.

This discussion will lead straight into the final section of the chapter, where I will explore how a modified version of Abend's (2014) *moral background* can help further clarify this idea of mediation in a way suited for studying the process of service reconfiguration in the NHS.

As I have already discussed through reviewing Wheeler's work, the micro-level of moral economy can be broadly equated with Sayer's concept of lay morality. This, in turn, is broadly consistent with a CR view of human agency and can therefore easily be incorporated into this multi-level framework. Lay morality characterises humans as

evaluative beings who carry commitments regarding 'what is of value, how to live, what is worth striving for and what is not' (Sayer 2005: 6. Cited in Wheeler 2019: 276). This presupposes a view of a reflexive human agent with embodied emotions and sentiments. The idea of humans being as carriers of moral sentiments, emotions and commitments is an important aspect of Sayer's vision of lay morality. An individual's normative standpoints often exist as embodied moral dispositions which help them make judgements about what is good and bad (Sayer 2004). This is also consistent with a critical realist view of human agency, wherein 'emotions are among the main constituents of our inner lives' (Archer 2000: 194). Such emotions 'represent commentaries on our concerns', and these concerns 'make a situation a matter of non-indifference to a person' (p.195). With respect to human agents also being reflexive beings, Sayer (2011) holds that, while embodied moral dispositions and emotions may lead to spontaneous actions, 'ethical reflection' can also play an important role in everyday life (p.170). Moral emotions and sentiments are an important aspect of ethical reflection, both because they give agents information regarding what matters about a situation, and because an emotional response, such as anger about injustice, can prompt this reflection in the first place (pp.146-148). This view of human agency is also consistent with Archer's morphogenetic approach, a central insight of which being that humans are reflexive and able to exercise judgement (and therefore moral judgement). As she writes, the morphogenetic approach involves a human agent:

> who has the properties and powers to monitor their own life, to mediate structural and cultural properties of society, and thus to contribute to societal reproduction or transformation. (Archer 2002: 19)

Within this reflexivity, individuals constantly review their emotional concerns, 'articulate them, monitor them, and transmute them' (Archer 2000: 195). Therefore, micro morality can be conceptualised as lay morality - an individual's moral concerns and dispositions, stemming from their inner life and personal identity - and this is also consistent with a critical realist understanding of agency.

Lay morality plays a key role in how individuals make sense of and decide to act within their social contexts, including how they respond to macro and meso-level moral phenomena and relational structures. The important point here is that, while an individual's moral commitments will often be consistent with the various normative demands and resources they operate within, they may also have personal moral concerns that conflict with this broader environment. Therefore, an individual's lay morality will be in dynamic interaction with cultural discourses, social positions, and cultural scripts, but not determined by these factors (Sanghera 2016: 294). For example, a manager working within a large-scale service reconfiguration involving multiple localities will likely work under the shared meso-level understanding that all populations will be treated equally. However, they may themselves, because of their personal background or upbringing, value one community over others which, in turn, may influence whether they subscribe to this shared expectation or not. This understanding of the interaction of lay morality, as a property of human agents, with other layers of morality is also consistent with a CR understanding of the interaction of structure and agency. Here lay morality can be interpreted as one dimension of people's emergent properties (PEPs): the causal powers of agents that have an independent ontological status to social structure and culture (Archer 1995). Because culture and structure, in this case multi-level morality and relational structure, rely on the properties of human agency to enact and elaborate them in their day-to-day activity (Archer 1995: 76), such phenomena can be highly influential. For example, Archer (2000) argues that cultural rules that dictate what is and is not shameful must also resonate with an individual's own understanding of this to have their intended causal effect (p.216). Of course, this concordance is often evident for many reasons, including the influence of socialisation on human subjectivity (which lies beyond the scope of this thesis). However, for the purposes of the multi-level framework put forward in this chapter, it remains important to note that lay morality has causal powers separate to that of meso and macro-level morality and relational structure.

In this section I have shown how the micro-level of morality can be equated with lay morality: the moral concerns and commitments individuals hold as part of their individual subjectivity. By examining this understanding using a critical realist approach to structure and agency, I have also shown how lay morality can play an important role in the way human agency mediates how meso and macro-level morality and relational structure influence the social world. This is because these phenomena must work through reflexive human agents with their own moral concerns and commitments before being realised in social interaction.

3.5 Integrating multi-level moral economy through the moral background

To this point, I have identified four components of a multi-level moral economy approach to apply to a study of NHS organisations involved in service reconfiguration. These are:

- The hierarchical relational structures that are established by constitutive rules. I have equated this with the 'economic' side of moral economy.
- Cultural phenomena regarding moral rules, duties and obligations which are codified and endorsed by hierarchical constitutive rules. I have equated these with macro-level (or regulative) morality.
- Informal moral rules/ duties/ obligations, shared conceptions of what is good or right (ideals), and thick moral concepts. I have equated this with the meso-level of multi-level morality.
- The lay morality of individuals, consisting of their embodied moral concerns and commitments. This is part of human subjectivity and can influence all the above phenomena through the role human agency plays in mediating the causal influence of relational and cultural structure. I have equated this with the micro-level of morality.

This provides a definition of the phenomena that I will examine in the empirical application of moral economy to a case of service reconfiguration in the NHS. However, while I have

identified that all these phenomena interact via reflexive human agents to influence social interaction, I have not identified a suitable way of conceptualising *how* this process of mediation takes place. I therefore lack a way of showing how all these types of phenomena combine to constrain and enable the social action of individual agents involved in planning and implementing service change in the NHS. In this section I will argue that a modified version of Abend's (2014) *moral background* provides such an integrating concept.

The Moral Background

Abend's (2014) concept the *moral background* provides a way of showing how different moral and para-moral phenomena influence individual beliefs and judgements in the course of social action. He achieves this by distinguishing between first order morality and second order, background, morality. First order morality refers to '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). For example, an individual may judge a business practice as right or wrong, or believe they have moral obligations to carry out a specific act (p.32). Second order morality refers to the range of social phenomena upon which such beliefs and judgements depend: *the moral background.* This includes the ideas, tools, theories, and assumptions that constrain and enable first order phenomenon (summarised in Figure 3.1). For example, when required to morally evaluate a business practice an individual may draw on shared repertoires of moral concepts to describe the act; common understandings of what counts as an acceptable moral justification; and implicit shared beliefs regarding what issues are open to moral evaluation in the first place (p.32). The moral background can be explicit or implicit, and individuals will often not be aware of many of the background assumptions that unpin first order morality (pp.29-31). Abend's approach is useful because it foregrounds the way individual's actively make judgements and form beliefs, but also examines how these are influenced by a wider institutional context made up of various background elements. It is

therefore particularly well suited for the study of organisations involved in service reconfiguration, where individuals are actively required to form opinions and make decisions as part of their work.

In this section I will show that, with some modification, the moral background can provide a way in which all the elements I have discussed in this chapter can be combined into one framework. I will do this by showing how each element of the moral economy framework I have identified can be integrated with Abend's theory. In doing this, I will also address some existing limitations of the concept of the moral background. This is particularly regarding: its lack of specificity about the content of some elements of the background, particularly 'groundings'; the lack of consideration it gives to issues of power; and its lacking of an explicit ontological position regarding the role of human agency in social interaction.

Figure 3.1 – The moral background

First order morality

People's moral views and understandings within an institutional setting. This includes understandings regarding what specific actions, practices, beliefs are right, good, obligatory, appropriate, and admirable (p.32).

Second order morality (the moral background)

This provides an intuitive understanding of the nature of morality. It includes:

Groundings - The understandings people can invoke if they need to give reasons for what makes something moral or immoral (p.36).

Conceptual repertoires - The concepts that help to define what is perceived and noticed as a moral issue (p.37). This includes thick moral concepts.

Object of evaluation - Underlying understandings about what objects are open to moral evaluation (p.40).

Method and argument - The types of moral arguments that are made (e.g. analogical, deductive etc.) and the kinds of evidence that are privileged.

Meta-ethical objectivity - The extent to which morality is seen as a matter of fact or subjective opinion. For instance, do participants tend to take a realist, sceptic or relativist approach to morality?

Metaphysics - This is about 'the metaphysical pictures or assumptions that ordinary people and social practices, institutions, and understandings manifest' (p.50). It can include assumptions about time, reality, space, being and human nature.

Macro and meso-morality and the moral background

The two most relevant aspects of the moral background with respect to meso and macro-level morality are groundings and conceptual repertoires. Many of the contextual level phenomena I have explored in this chapter can be understood as *groundings*: the cultural store of reasons and justifications people invoke to explain and justify their first order moral beliefs and judgements (p.34). Abend (2014) states that there are 'no a priori substantive constraints' on what groundings can be (p.35). Such reasons can be causally efficacious or they can be applied post-hoc to justify a decision, but they all help to define 'what counts as grounding for a normative view' and vary between social settings (p.36). Groundings can be particularly important in formal organisational settings, where explicit justifications for decisions or actions are often a bureaucratic requirement (p.36).

For the purposes of this research I propose that both meso and macro-level moral phenomena, particularly duties/ moral rules/ obligations (formal and informal) and ideals, are treated as types of groundings. When an individual makes a decision regarding the right thing to do in an organisational setting, it is likely they will draw on shared duties (both formal and informal) and ideals when explaining why they have made this decision. For example, when a NHS manager decides to develop a new service for a previously overlooked group they will likely draw on shared moral understandings, such as equity and the imperative to base services on clinical need (Department of Health 2015), to explain why their decision is right. There may also be instances when they draw on notions of legitimate authority to justify their actions. For instance, when following a slow and cumbersome procurement process, they may explain why this should be followed with reference to the legitimacy of these rules. This is not to say that such groundings must be limited to moral reasons, as more practical concerns, such as the availability of funds, may be drawn upon when explaining why a course of action is right. However, it is still likely that meso and macro-level moral phenomena will form an important part of these groundings, making this a valid way of

incorporating them into the moral background. Of course, the extent such ideals and duties genuinely motivate decisions, and are not just used as post-hoc justifications, will often be debatable, and this is an issue I will return to in Chapter 7.

Thick moral concepts are also conceptualised by Abend as existing in the moral background as types of *cultural repertoire.* This therefore shows another way in which meso-level moral phenomena can be viewed as existing within the moral background. According to Abend (2014):

> Conceptual repertoires are the set of concepts that are available to any given group or society, in a given time or place. (p.36)

Abend equates these to the:

> well-known sociological fact… [that] societies differ in how things are classified and grouped, what things are generally perceived and noticed and what things are generally missed, how things are perceived and noticed, and the institutions that rubberstamp systems of perception and classification. (p.37)

Abend holds that this insight is relevant to repertoires of moral concepts in the same way it is relevant to concepts in general. Groups and societies differ in the 'menu' of moral concepts available to them and this both enables and constrains first order morality. Individuals can choose from 'a socially provided repertoire of action concepts' in creative ways, but they cannot control what concepts are deemed acceptable to use (pp.37-38). Both thin and thick moral concepts form part of this conceptual repertoire, and so more general categories such as goodness, duty and appropriateness are relevant to this background element. However, as discussed earlier in this chapter, it is *thick moral concepts* that are more specific to certain social settings, be they whole societies or specific groups. Acknowledgement of this background dimension therefore leads to the empirical questions of 'what concepts are on the menu; which ones are ordered most often, when, and by whom; and how the conceptual

menu got historically constituted' (Abend 2014: 39). Such background understandings therefore have a strong influence on what individual agents can perceive and describe as a moral issue, as well as provide reasons to motivate or justify action. As with other meso-level phenomena, these concepts may therefore also be used as groundings themselves, as well as forming part of the wider perceptual apparatus available to individuals.

The moral background also allows the consideration of the various meso-level phenomenon that are not moral, but support and enable morality. As I have already addressed, according to Abend groundings may theoretically include anything, be it moral or non-moral reasons. However, the remaining aspects of the moral background are almost entirely the preserve of non-moral cultural phenomena. This resonates with March and Olsen's (1989) point, discussed in Section 3.3, that individuals draw on various non-moral cultural phenomena, such as paradigms, when applying and navigating the normative context they operate within (p.22). For example, Abend uses the term *method and argument*, to refer to the implicit rules different social groups have for tackling moral questions. This has two basic components: the formal features that plausible moral arguments have and the types of evidence that are allowed and privileged (Abend 2014: 44-5). Thus, these understandings are not moral in themselves – they do not directly address questions such as right, wrong, good or bad – but they are crucial in facilitating moral beliefs and judgements. Similarly, *objects of evaluation* is premised on the assumption that societies and groups differ with respect to the 'objects that are capable of being morally evaluated' (Abend 2014: 40). The things that evaluations can be about include: people, states of affairs, groups, organisations, motives, and the results of actions (pp.40-2). This concept therefore introduces the crucial idea that individuals will often take cues, either knowingly or unknowingly, from their social context regarding what is and is not an issue that requires moral judgement.

The same contextual variability also applies to the position individuals take on *meta-ethical objectivity*. This refers to the extent to which morality is seen as a matter of fact or subjective

opinion. Significantly for this research, Abend suggests that the practical, goal orientated nature of bureaucratic organisations means they 'lean towards moral realism'. This is because a more relativistic or sceptical meta-ethical perspective would make it difficult to achieve the level of coordination required to achieve these goals (pp.48-9). Finally, the nature of moral beliefs and judgements within certain institutional contexts is also reliant on cultural understandings that influence what individuals perceive the nature of reality to be. Abend refers to this as metaphysics, which relates to the 'metaphysical pictures or assumptions that ordinary people and social practices, institutions, and understandings manifest' (Abend 2014: 50). It can include the assumptions about time, reality, space, being and human nature and capabilities upon which first order moral beliefs might be predicated on; what Abend refers to as anthropological assumptions (pp.50-1). Overall, this helps show the role of para-moral, meso level, cultural phenomena in enabling agents to apply the other levels of morality to day-to-day interaction.

Relational structure and the moral background

The focus on para-moral aspects of social context is important for two reasons. Firstly, as I have shown, it allows for a better understanding of the relationship between specific moral judgements and beliefs, and the institutional context within which individuals operate. This is by expanding the meso-level cultural phenomena that are seen to make up this context to include shared understandings such as metaphysics and objects of evaluation. However, and just as important for this study into moral *economy*, it also opens a further way of understanding how relational structure and shared moral understandings are entwined. Abend (2014) does not directly address on the role of hierarchies and power in his moral background theory but does consider this a potential area of future research. He argues that power could play an important role in explaining 'how moral background elements come into being; how they rise, fall, coexist, compete, and change' (p.371). He also states that it may

be fruitful to consider how the established understandings contained within the moral background implicitly come to privilege certain groups and interests over others (p.371).

This therefore opens a route for considering how structural relations of power, such as constitutive rules regarding funding, organisational hierarchies, and constitutions, may influence moral background elements to privilege certain perspectives. This could be done implicitly though shaping the concepts that exist, what methods are considered valid, and which objects can be evaluated (p.371). For example, those with structural power within organisations have at least some ability to determine what kinds of arguments are most effective, what form these should take, what evidence and reasons are privileged, and what is and is not open to moral evaluation. This, in turn, might reflect wider inequalities, discourses and power relations within society. Understanding how the moral background is shaped by power relations could therefore be a fruitful way of elucidating how different levels of morality are entwined with structural relations of power, particularly in subtle and implicit ways. I will return to this issue in the final analysis chapter (Chapter 7).

Micro-morality and the moral background

Finally, an understanding of how the moral background works can be enhanced by reinterpreting it through the CR view of how human agency interacts with social context. Abend (2014) himself has some difficulty in defining the extent to which the moral background is a property of social context or individuals. Indeed, he identifies two 'unresolved' ontological issues with the moral background (pp.66-8). Firstly, he states that the metaphysical status of the background is unclear; and attempts to resolve this by taking a pragmatic position, arguing he simply sees it as a tool to make sense of an aspect of moral life (p.67). Linked to this, he also argues that the question of 'what the moral background is a property of, whether of individuals, brains, groups, societies, utterances, pieces of writing, situations, or something else' remains unanswered (p.67). He especially has difficulty in

placing whether background elements are a property of the collective or individual, as revealed by the following extract:

> Then, 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. There are social – or group level constraints on, say, which noises will be seen as irrelevant considerations or sheer nonsense, and which noises will be seen as a moral reason or a moral argument. (Abend 2014: 68)

Here Abend struggles to reconcile the idea that the background does not act in a deterministic way – that individuals within groups can deviate from the background elements that are *typically* accepted within that group – with the idea it is a property of social context. He goes on to try to reconcile this by writing:

> Then, we must distinguish two stages or planes. First, what reasons, methods, and grounds are available, and will count as reasons, methods, and grounds. This is a property of a group or society… Second, the likelihood of using one or another is a property of individuals and subgroups, probabilistically. (p.68)

The distinction Abend makes between context and individual, treating the moral background as a property of social context which *may* be drawn upon by individuals, can be strengthened by redescribing it in line with the CR distinction between structure and agency. This can also show how an individual's micro-level lay moral commitments may influence how they interact with the moral background.

A CR perspective holds that contextual phenomena, such as cultural and relational structures, have non-deterministic powers to influence individual action and beliefs. This is because the powers of social and cultural entities are treated as forces that create tendencies, rather than laws that create regularities (Porpora 2015: 49). From this

perspective then, the moral background exists as a set of cultural entities that individuals within a certain context are likely to draw on but from which they may deviate. Furthermore, the powers of human agency, such as consciousness, reflection, and rationality, necessarily mediate the influence of these contextual phenomena on social interaction. The same applies to an individual's lay moral commitments which, as a property of human agency, could influence whether an individual draws upon a certain element of the moral background or not when engaging in social interaction. This, in turn, will influence their first order moral beliefs and judgements. For example, in some NHS planning contexts the operational sustainability of social care providers, which usually exist within the remit of local authorities rather than the NHS, may not be an object of moral evaluation. This will therefore shape the first order moral judgements of social actors in said context regarding how to arrange services, particularly whether they see high levels of patient discharges to social care as acceptable. However, a new employee entering this planning context may have developed, through their past experiences, a deep sense of loyalty to the social care sector as part of their lay morality. This may lead them to reject this background assumption and thus form the first order moral belief that high levels of discharge to social care are unacceptable, leading them to argue with their colleagues. This demonstrates how CR can help articulate the way lay morality may impact on the influence of the moral background on social interaction and the formation of first order moral beliefs. Overall, a critical realist understanding of the interaction of the moral background, as a property of social context, with lay morality, as a property of human agency therefore allows for a dynamic view of how different levels of morality interact. This shows how a critical realist approach to structure and agency can help resolve the ontological ambiguities within Abend's formulation, whilst also allowing a route for lay morality to operate within the same framework as the moral background.

Conclusion to chapter

In this chapter I have set out to answer the two questions derived from the literature review to provide a theoretical starting point for applying the concept of moral economy to service reconfiguration in the NHS. These are:

1. How can a multi-level understanding of morality be best conceptualised when applying a moral economy framework to organisations? Specifically, NHS organisations involved in service reconfiguration.
2. How can economic and political structures be best conceptualised to differentiate them from moral phenomena when exploring the process of entwinement?

I have drawn extensively on critical realist metatheory, as well as a range of sociological perspectives, to answer these questions.

With respect to the first question, I have sought to characterise the macro, meso and micro levels of morality in a way that is suitable for research involving NHS organisations involved in the process of service reconfiguration. Here I have argued the micro level is best conceptualised in terms of the lay morality of reflexive human agents; the meso level as collective ideals, duties and thick moral concepts; and the macro level as a particular form cultural phenomena, specifically duties, obligations and moral rules, which are endorsed by hierarchical constitutive rules. I have also subscribed to a critical realist understanding of the interaction between structure and agency, which holds that the influence of all cultural and structural phenomena on social interaction, including macro and meso-level morality, is mediated by reflexive human agents. I have then argued that, with some modification, the moral background is a suitable way of conceptualising this process of mediation in understanding the role of multi-level morality in service change in the NHS. This is because it foregrounds the concrete judgements and beliefs individuals hold – first order morality –

while also accounting for the influence of a range of contextual background phenomena. Such an approach is therefore well suited for the study of an empirical setting such as service reconfiguration in the NHS, where individuals are actively required to form opinions and make decision about changes to services.

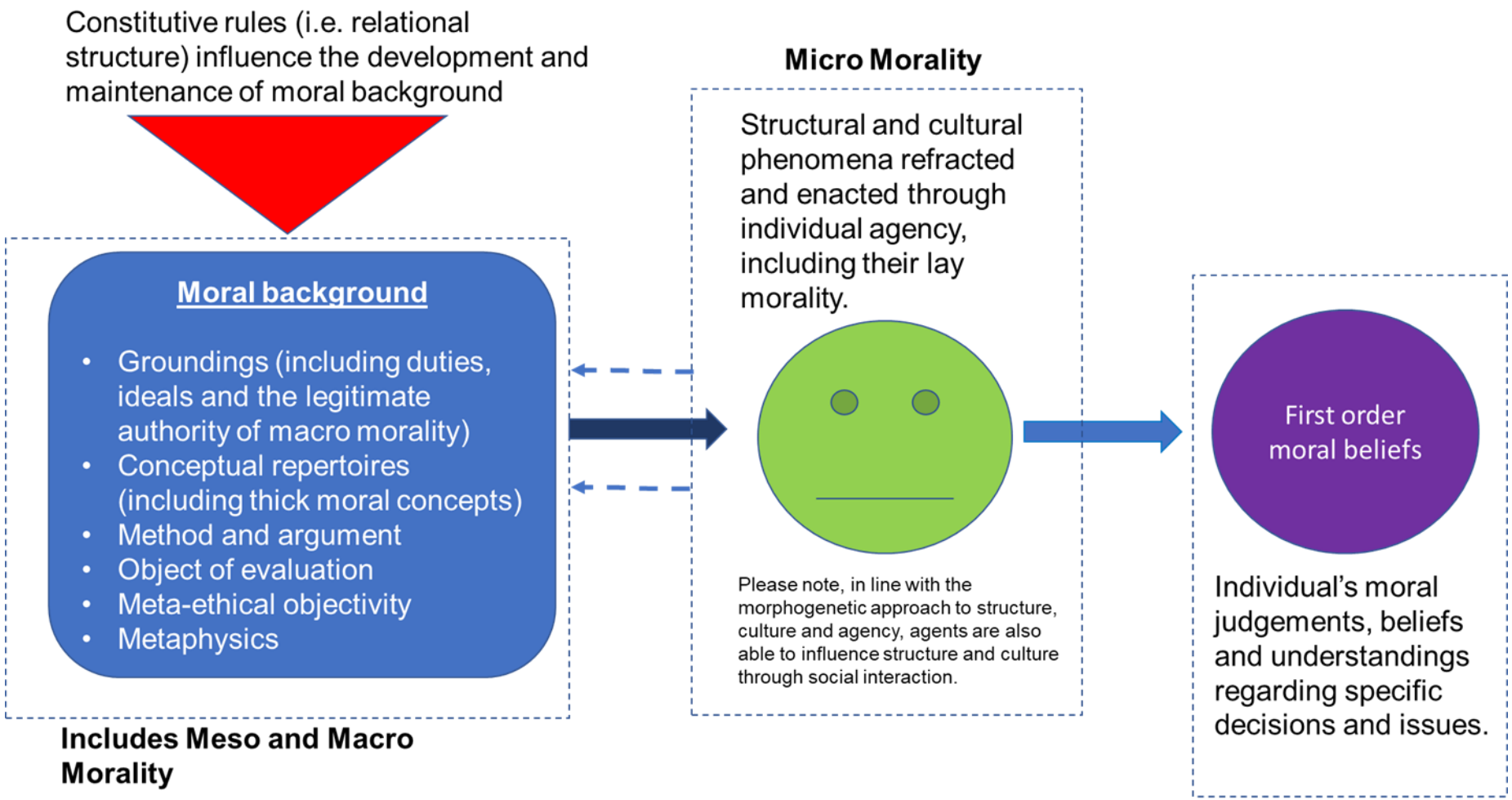
I have therefore gone on to demonstrate how the three levels of morality can be integrated with the moral background. I have showed that my characterisation of the meso and macro levels of morality – drawing on Durkheim, Weber, March and Olsen, and Scott – can be approached as specific types of groundings as part of the moral background. I have also echoed Abend's point that thick moral concepts are a type of cultural repertoire that are contextually specific. These help individuals to both perceive and describe moral issues and can also act as groundings themselves. I have also shown how the moral background allows for a consideration of the non-moral properties of social context which also enable first order morality. Furthermore, I have shown how a critical realist conception of moral agency can add to the moral background. This is through providing a clear analytical separation between non-deterministic cultural and structural phenomena that exist at the level of social context, and the human agents who enact and elaborate these phenomena. In so doing, I have demonstrated how this approach to structure and agency can help explain individual deviation in the use and adoption of moral background elements, particularly if they are contrary to lay moral understandings.

With respect to the second question, I have again used critical realism to define the economic side of moral economy in terms of relational structure and the constitutive rules that form it. This distinguishes it from moral phenomena, which I have defined both in terms of types of cultural phenomena (macro and meso-level morality) and lay morality (micro-level morality). I have also briefly explored two possible ways that these constitutive rules may be entwined with multi-level morality within organisations. The first is through the way constitutive rules can bestow some meso-level moral understandings with legitimate

authority, as well as the threat of sanctions for non-compliance, through enshrining them in formal regulations. The second form of entwinement is the way constitutive rules also allow those in power to - consciously or unconsciously - shape other aspects of the moral background in a way which privileges certain interests and perspectives. I will explore both these modes of entwinement in much greater depth in the final analysis chapter (Chapter 7), where I will link these insights to an empirical case study of service reconfiguration in the NHS.

In this chapter I have therefore set out a theoretical approach to multi-level moral economy that is appropriate to use as a starting point for understanding the process of service reconfiguration in the NHS (see figure 3.2 for a summary). In the next chapter, I will outline how I operationalised this theory into a qualitative case study of service reconfiguration in the NHS.

Figure 3.2 The multi-level moral economy framework to be used in this research



4. Methodology

Introduction

In this thesis I aim to refine and apply the concept of moral economy to better understand the process of service reconfiguration in the NHS and develop the concept itself. So far, I have solely focused on developing a framework that is suitable for studying organisations, particularly NHS organisations undergoing service change. In this chapter I will set out the concrete steps I took to operationalise this framework into an empirical study.

I will do this in two stages. In the first stage, addressed in Section 4.1, I will use critical realism (CR) to show how a qualitative case study is an appropriate approach for both applying and further developing this moral economy framework. Here I will start by outlining how CR bridges the gap between the theoretical and the empirical, before then showing how I used this to develop the research strategy for this project. In the second stage, addressed in all the remaining sections, I will outline how I have approached data collection and analysis in this research. Here I will include a consideration of ethical procedures, case identification, access, recruitment and sampling, research questions, data collection, data analysis, and presentation of the findings. In so doing, I will lay the groundwork for subsequent analysis chapters.

However, before discussing the methodology it is first necessary to provide more context for the empirical case: the Moving on Up programme.[15] First, I will provide detail on the policy context of the NHS around the duration of the programme (2013-2019), particularly the various moral issues and debates at the heart of the most relevant long- and medium-term historical developments. I will then briefly outline the background of the Moving on Up programme in terms of governance, aims, processes, and timelines. The following

[15] Please note, this, and all names of organisations in this chapter, are pseudonyms. Please see the 'Ethical approval and processes' section for more details on anonymisation in this research.

subsection will therefore help situate the study within the broader national policy context whilst also 'lay the groundwork' for a more substantive discussion of the specific empirical case in section 4.3.

National policy context

The history of the NHS is one that reflects both continuity and change regarding the espoused moral concerns at the heart of national policy. Founded in 1948, the NHS was explicitly designed to embody values of comprehensiveness and universality (Klein 2010: V), intended to be fair and available to everyone, funded by central taxation, and free at the point of demand (Powell 2016: 23-4). Successive rounds of national reform from all major parties, including the most recent Health and Social Care Act 2012 (HSCA 2012), have stressed support for the core, founding principles of the NHS (Powell 2016: 23-4), reflecting historical continuity on these issues. The early years of the NHS were also marked by a faith in central planning and collectivism, as well as technocratic rationality and deference to professionals, particularly doctors (Klein 2010: 280-2). However, on these points the NHS has changed significantly, particularly over the last thirty years, and there have been several major institutional and structural reforms (Hunter 2016: 98). Indeed, as I will show below, in its more recent history there has been a notable move away from principles of collectivism, technocratic rationality, and deference to professionals in NHS policy. This is particularly with the shift towards the promotion of competition and choice, which has challenged these more traditional values.

Over the past thirty years NHS policy rhetoric has shifted from promoting a more monolithic, paternalistic service model, to a pluralistic one, with the language of choice and competition becoming increasingly prevalent (Klein 2010: V). This has involved a shift in the outlook of policy makers towards the desirability of a consumer rather than producer driven service, with the patient increasingly conceived as a consumer (Gilbert et al 2014: 371-372). This is

consistent with a broader international perspective, wherein a 'consumerist ethos' has become a key aspect of policy making (Hunter 2016: 161). Since the early 1990s successive governments have sought to introduce market mechanisms into the NHS (Hunter 2016: 38). This has been based on the belief that competition between providers will drive up choice, and therefore also efficiency and quality, for consumers (p.163). This includes: the purchaser-provider split[16] (Hunter 2016: 20); making individual NHS providers (or 'trusts') act like discrete business entities, particularly through striving towards gaining *Foundation Trust* status (p.20); and an increasing focus on getting the private sector to deliver NHS services (Hunter 2016: 175). This consumerist ethos continued to be strongly evident in the latest round of NHS reforms in 2012, wherein much of the rhetoric focused on promoting a 'patient-centred NHS', foregrounding the desirability of giving patients more choice and control over their health (Newbigging 2016: 307-8). However, it is important to note that the ability of such reforms to improve services is highly disputed, with an extensive body of evidence against the claim that measures which promote competition and choice improve patient care (Hunter 2016:190). The reforms have also often been accompanied, somewhat paradoxically, by a focus on 'command and control' of central policy makers through performance targets, something particularly associated with the New Labour years (1997-2010) (Hunter 2016: 102).

Despite the overarching legislative framework being one based on the desirability of competition and choice (Alderwick et al 2019), in recent years national focus has shifted to promoting collaboration, integration, and prevention among NHS organisations. This is particularly aimed at maintaining a comprehensive and universal service in the face of the funding situation I discussed in the Background chapter, wherein rising costs and demand have been accompanied by 'a significant slowdown in funding growth' (Kings Fund 2019a).

[16] The purchaser/ provider split describes the process whereby NHS commissioners use the NHS budget to purchase care from NHS providers for a defined population, ostensibly to promote competition for 'contracts' among providers. This was originally introduced in the NHS in England in the early 1990s (Miller et al 2016: 127).

This has created a large mismatch between patient need and resources, and NHS England has proceeded to try and close this gap by focusing on transformational change in how health and social care organisations are organised (Klein 2015: 621). Since the publication of *The National Health Service Five Year Forward View* in 2014, increasing emphasis has been placed on the desirability of collaboration rather than competition, with integration between services seen as key to managing resources and improving care (Alderwick et al 2019). This includes a requirement for NHS commissioners, providers, and local government to form partnerships to lead local improvements (Alderwick et al 2019). It also involves a focus on improving prevention and reducing the amount of care provided in acute hospitals. As a result of this, several tensions exist in the national policy context of Moving on Up; with much of the regulatory and legislative architecture based on espoused values of choice and competition, but more recent policy directives focused on integration, collaboration, and prevention.

Two other long running themes in NHS policy relevant to the Moving on Up programme are the changing relationship between managers and clinicians, and the oscillation between centralisation and decentralisation (Hunter 2016: 51). This is particularly regarding the shift towards promoting local clinical decision making in commissioning in the HSCA 2012. Prior to these reforms responsibility for commissioning predominantly rested with managerially led Primary Care Trusts (PCTs). However, a key aspect of the HSCA 2012 was to transfer responsibility for commissioning healthcare services to newly established Clinical Commissioning Groups (CCGs), typically to be led by general practitioners (Checkland et al 2016: 149). This attempt to increase the centrality of clinical perspectives to commissioning was largely based on the idea that frontline clinicians, particularly GPs, have important clinical and patient-specific expertise (Checkland et al 2016: 152). As such, clinicians are framed as more appropriate decision makers than managers because they can represent the needs of patients. The move towards giving local clinicians responsibility over commissioning also reflects a rhetorical focus towards *decentralisation* contained in the

HSCA 2012. CCGs were originally intended to have greater local autonomy over decision making than PCTs, operating within a more decentralised system under a national accountability framework (Checkland et al 2018: 378-9). However, recent research suggests that the reforms have not worked out this way in practice, with CCGs feeling limited in their decision space. This is both in terms of an increasingly prescriptive centralised assurance regime and the proliferation of new local organisational architecture (such as care models, networks etc.), creating several complex organisational interactions and interdependencies to manage (Checkland et al 2018: 390-1). Despite this, the local clinical perspective was still generally framed in policy as the most appropriate way of meeting the needs of patients around the time of the programme.

The final long running policy theme relevant to the programme is the increasing attention given in national policy to the desirability of the linked concepts of quality and patient safety. While definitions of quality vary depending on the setting, issues of safety, effectiveness and patient experience are recurrent themes in most quality frameworks (Raleigh and Foot 2010. Cited in Powell and Mannion 2016: 323). As such, themes of quality and safety are enmeshed and often synonymous with each other. In the NHS in England, quality has become more explicitly important from 1998 onwards (Powell and Mannion 2016: 324). This has been driven by a broad policy agenda but also shaped by several high-profile tragic events which have increased their political salience (p.323-5). A statutory ‘duty of quality’ was established by the Health Acts of 1999 and 2003 (p.324) and, as part of this, the Care Quality Commission (CQC) has come to play a particularly prominent role. This was created by the Labour government in 2008 to regulate the quality and safety of health and social care services (Greer et al 2016: 88) and has quickly become a major aspect of regulation within the NHS. Indeed, under the Health and Social Care Act 2012 it was made responsible for guaranteeing the quality of health and social care (p.93). The increasing focus on quality and safety has been strongly influenced by a series of public scandals over quality of care. The most relevant of these for the Moving on Up programme was the several tragic failures

in patient care at Mid-Staffordshire Foundation Trust between 2005-09. Media coverage of this, and the high-profile Francis Inquiry, led to significant concerns over patient safety and have 'formed the basis for a 'moral panic' about standards of care delivered in the UK' (Hutchison 2016: 37). In response, there was much focus in policy discourse around creating a safer NHS orientated around caring values and compassion (Brown et al 2020: 128), and this was particularly prominent around the early stages of the Moving on Up programme.

Local context: The Moving on Up programme

The Moving on Up programme was originally formulated in 2013 to redesign patient care in three areas: Bloughton, Whitdon and Grenham.[17] The programme was designed to address the perceived clinical and financial unviability of acute care in these areas, particularly in the face of constrained national funding and anticipated increases in costs and demand (Moving on Up 2014a). The original case for change includes the intention to design a new pattern of services to better serve the, often differing, needs of the populations of the three areas; to provide more care in the community and at home; and that the change should be led by clinicians and informed by extensive patient and public involvement (Moving on Up 2014a). As I will detail in section 4.3, while these original aims were expansive and not solely focused on reconfiguring acute provision in the area, this had become the predominant focus of the programme by the time I began my fieldwork.

With respect to governance, the programme was predominantly run at a local level, but with significant oversight from national bodies such as NHS England, the CQC, and NHS Improvement.[18] The relationship with NHS England was particularly important as this body was ultimately responsible for authorising the funding for the programme. The day-to-day management of the programme was overseen by a Programme Board (PB) which met

[17] I provide more information on the geographical configuration of the three areas in section 4.3. Please note, the names Bloughton, Whitdon, and Grenham are pseudonyms.
[18] I provide more information on these regulatory relationships in section 4.3.

approximately once a month, while final decision making was held by a Joint Governing Body (JGB), which met on a more ad-hoc basis.[19] By the time I began fieldwork in late 2018 the programme had been running for approximately five years and was reaching its latter stages. Since its since its inception in 2013 it had gone through the following steps:

- The beginning of the development of a new 'model of care' in 2014. This developed several possible 'options' for a new service design.
- An extensive options appraisal process to decide on a preferred option. This began in 2015 and involved an initial shortlisting process to four options (in 2015), an options appraisal workshop (in 2016), and a final decision on two options to take to consultation - with one preferred option - by the PB and JGB (in 2017).
- A public consultation which was started and concluded in 2018 (Moving on Up 2019a).
- In early 2019, soon after the start of my fieldwork, the final option was agreed by the JGB. This marked the beginning of the end of the programme and a move from planning to implementation.

Now I have provided an overview of the empirical case, I will proceed to outline my overall research approach and strategy, before returning to more specific details about the case when outlining my approach to data collection and analysis.

4.1 Research approach and strategy

CR metatheory provides a valuable foundation for moving between conceptual and empirical modes of enquiry for this research for three reasons:

[19] I provide more information on the governance of the programme in Section 4.3 and in Chapter 5.

1. The application and development of social theory is at the heart of CR research, including projects with an empirical element. As I will explore in this section, critical realists hold all knowledge about the social world to be conceptually mediated, and a core aim of social research is to develop better concepts to understand this world. This perspective is particularly well suited to my project, which aims to apply an existing theory to a new context, to both better understand the context and develop the theory.

2. CR research is premised on the idea that the operation of social entities is not always readily observable and can only be elucidated through various techniques of theoretical inference. This draws on the idea of a depth ontology consisting of three levels: the real, the actual and the empirical. This perspective is well suited for my research as, as I noted in the last chapter, many aspects of the moral background are implicit and not readily observable, even to those who are influenced by them. The same point holds for the way moral phenomena are entwined with structural relations of power, wherein the effects of certain interests and hierarchies may not be immediately apparent.

3. As I have already drawn on CR to theoretically integrate different dimensions of moral economy, it is consistent to continue to draw on this perspective.

As I outlined in the last chapter, CR entails an ontological view of a social world made up of different entities and their powers. The three most relevant types of entity for this research are cultural structures/ phenomena, relational structures, and human agency. These are analytically distinct from each other, but also interdependent, with agency playing a pivotal mediating role in the sustaining (morphostasis) or changing (morphogenesis) of relational and cultural structures. For this research, micro-level moral phenomena (lay morality) are conceptualised as an aspect of agency; meso-level phenomena as types of cultural

structure; macro-level phenomena as an interaction of cultural and relational structure; and the economic as relational structure.

According to CR, the task of research is to explain what happens in the social world by generating theoretical knowledge about causal powers and entities (Danermark et al 2002: 1). However, this task is complicated as these entities and causal powers may or may not be empirically observable. This point is demonstrated by the CR depth ontology. This distinguishes between three different 'levels' of reality: the real, the actual and the empirical.

1. *The real* refers to whatever exists, natural or social, regardless of whether we know it or if it presents as an empirical object to us (Sayer 2000b: 11). This is where entities exist, alongside their causal powers and properties. Such causal properties include not only powers, but also liabilities: the susceptibility to certain types of change (p.11). This means that when one entity causes a change in another, this change does not just depend on the power of the 'affecting' entity to bring about the change, but also the 'affected' entity having the liability to be changed in a certain way (Elder-Vass 2010). Therefore, liabilities are 'a variety of emergent causal power – a power to change in certain ways in response to certain stimulus' (p.47).

2. *The actual* refers to the events that occur when the causal properties of entities are activated and interact with each other (Sayer 2000b: 12). It is important to note that the causal properties of real entities are not always active (combining to form events). Despite this, they still exist, regardless of whether they are manifest in events at any particular moment.

3. *The empirical* refers to 'the domain of experience'. Experience can be of the actual or the real. However, it is important to note that events and entities can exist and occur regardless of whether individuals are able to directly experience them (Sayer 2000b:

12). Therefore, unlike empirical realism, critical realism does not attempt to know social phenomena through seeking to extrapolate empirical observations to a larger group of events (Danermark et al 2002: 76). Instead, scientific generalisations refer to 'transfactual conditions' (p.77). These are 'the conditions for something… to be what it is and not something completely different' (p.78). These therefore include the underlying causal properties of social phenomena that are often not directly knowable through empirical data. Such generalisation requires certain inferential techniques to gain theoretical knowledge about an object (p.77), which I will explore later in this section.

The distinction between real, actual and empirical can be used to understand the operation of social entities in several contexts, including those which influence NHS organisations. For example, the National Tariff Payment System (NHS England and NHS Improvement 2019) can be understood as a structural entity which exerts several causal powers over the way the NHS works. This represents a set of constitutive rules which determines how much commissioners must pay providers for providing certain services, as well as how much they can sanction providers for failing to meet national targets. This system therefore operates in the realm of the real and has several causal powers over the flow of finances in the NHS. However, in relation to the actual realm, this system will only exercise these powers in certain circumstances. For example, the power to sanction will only be exercised when a provider fails to deliver a specific target. The system also manifests in the empirical realm through regulations published by NHS Improvement. However, other social entities are less immediately visible, and can only be inferred from the impact they have on individual beliefs and behaviours. For example, Hughes et al (2011) argue that the decision of commissioners to exercise these sanctions is, in practice, also influenced by the 'discrete and relational norms' that exist between commissioners and providers (p.333). These exist on an informal, non-codified level, and encourage cooperative behaviour. They therefore exist in a state of balance with formal financial systems, and can, in certain circumstances, lead

commissioners to decide not to enforce penalties. In critical realist terms these norms are cultural entities which exist in the real realm with the power to influence actual events. However, unlike formal rules, they do not themselves manifest in the empirical realm, and their existence can only be inferred from the beliefs and behaviour of those working within NHS commissioners and providers. This therefore demonstrates how CR allows, and indeed requires, a consideration of the influence of entities that are not directly observable. The moral economy framework I am using involves several such entities and, as such, this makes CR a particularly suitable metatheoretical framework for my research.

Careful development of rigorous theory is extremely important from a CR perspective. This is partly because of the need to generate knowledge about the interaction of potentially unobservable social entities and powers, as discussed above. However, this is also important because critical realists hold that all experience, even of entities that have empirical manifestations, is necessarily mediated by concepts. As Danermark et al (2002) write:

> The empirical domain, which in scientific contexts contains our 'data' or 'facts', is always theory-impregnated or theory-laden. All our data arise in connection with some theory, and thus we do not experience the events in any direct way – which is what the empiricist research tradition claims. Data are always mediated by our theoretical conceptions. (pp.20-21)

As such, whilst critical realists believe there is a reality independent of any one individual's experience of it, they also hold that this reality can only be *known* via the concepts people have of the world. These concepts, in turn, are contextually relative and changeable (Danermark et al 2002: 39).

The central role of concepts in generating knowledge about the world is reflected in the CR distinction between the transitive and intransitive dimensions of reality. The transitive

dimension refers to discourses and theories as resources for science, while the intransitive refers to the objects of science, including physical processes and social phenomena (Sayer 2000b: 10). The latter exists independently of the researcher's perception and experience of it (p.10). The only way social scientists, or indeed any individual operating in their day-to-day lives, can seek to describe and explain social phenomena (the intransitive domain) is through concepts and theories (the transitive) that identify entities and their causal properties. However, there is far from a direct correspondence between concepts and the intransitive objects they seek to describe, and the relationship between the transitive and the intransitive is always partial and fallible. This is for two reasons. Firstly, all knowledge is situated. This means that social actors always perceive the world from a particular cultural, geographical and historical position, making complete knowledge of how the world works impossible (Scott 2005). Secondly, the social world is an extremely complex, open causal system. Within this, an 'unlimited number of ever-changing causal processes operate simultaneously, interfering with each other in irregular ways' (Porpora 2015: 43). That all social systems also involve some degree of human cognition in their creation and maintenance (through the central mediating role of agency) adds to this complexity, as this is in itself 'an intrinsically open system… which potentially might alter any previously observed relationship among social variables' (p.43). This complexity means that any theory will only be able to highlight a limited number of the mechanisms at play in any given situation.

The complex relationship between the transitive and intransitive dimensions of reality make the use of rigorous inferential techniques particularly important from a CR point of view. As I have explored above, the CR approach relies on the use of theory and abstraction to develop explanations about the world. As Sayer (2000b) puts it:

> The objects that social scientists study, be they wars, discourses, institutions, economic activities, identities, kinship or whatever, are concrete in the sense that they are the product of multiple components and forces. Social systems are open and usually complex and messy. Unlike some of the natural sciences,

> we cannot isolate out these components and examine them under controlled conditions. We therefore have to rely on abstraction and careful conceptualization, on attempting to abstract out various components or influences in our heads, and only when we have done this and considered how they combine and interact can we expect to return to the concrete, many-sided object and make sense of it. (p.19)

There are two overlapping inferential strategies a CR researcher has at their disposal to gain such theoretical insights from research data. These are abduction and retroduction. Abduction is the process by which a researcher re-describes empirical observations in line with an existing frame of interpretation or theoretical framework (Danermark et al 2002: 89-90). Doing this allows the research to link observation of individual events or phenomena with a more general structure (such as norms, power relations etc.) (p.89). Retroduction is a process closely linked to abduction that 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: 253). I will examine both inferential strategies, and how I have applied them to my research, later in this chapter.

When it comes to empirical research methods, CR is compatible with a wide range of approaches (Sayer 2000b). Methodological choices should therefore 'depend on the nature of the object of study and what one wants to learn about it' (p.19). The approach to data collection may also evolve during the study, and research design and methods can change as an understanding of the entities and properties being studied develops (Ackroyd and Karlsson 2014: 30). Within this methodological pluralism, however, there are two broad approaches to critical realist research: intensive and extensive. An intensive approach to CR research involves the study of one or a few cases and looks at questions relating to what produces certain changes or how certain processes work in a particular case (Danermark at al 2002). It produces causal explanations 'of the production of certain objects or events,

though not necessarily representative ones.' (Sayer 1992. Cited in Danermark at al 2002: 165). In contrast, an extensive approach involves the study of taxonomic groups, examining regularities and common patterns. It produces descriptive generalizations relative to a certain population which have limited explanatory power (Sayer 1992. Cited in Danermark et al 2002: 165).

The focus of my research makes it best suited to an intensive case study approach. The aim of this research is to develop moral economy as a concept *and* gain an improved understanding of the process of service change in the NHS. An intensive approach allows me to take the various entities I identified in the Theory chapter – including lay morality, an augmented form of the moral background, and constitutive rules – and apply these to better understand the process by which they interact within the specific context of service reconfiguration in the NHS. The research is therefore a *qualifying case study*[20] (Vincent and Wapshott 2014). The aim of this type of critical realist case study is to develop a better explanation of different types of entities operating within a certain social context (such as an organisation) by 'exploring the interactions between powers of different types' (p.158). Such case studies typically begin with a theory that is relatively parsimonious – in that it only highlights certain causal forces at play – which is then *qualified* in relation to a social context. The process of applying the theory helps both to develop the theory itself, and to better understand the causal properties operating in the case being studied. This approach to empirical research is therefore highly relevant to the aims of this research: to refine and apply the concept of moral economy to a case of service reconfiguration in the NHS. I will now move on to the second stage of the chapter, where I will address the practical specifics of how I have designed and executed the study to achieve these aims.

[20] Vincent and Wappshot contrast this type of case study with an *exploratory case study*, the goal of which is to discover the consequences (in a broad sense) of a specific organisational development.

4.2 Overall approach to data collection and analysis

In the literature review and theory chapters I identified the main contours of the moral economy approach I will use for this research. In the last section I also demonstrated how I can draw on critical realist principles to apply these concepts to an intensive case study research design. In this section I will show the practical steps I took to design and carry out the empirical element of my research. To do this, I will begin by reformulating this theoretical understanding into a set of research questions around which I structured data collection and analysis. I will then detail the steps I took to identify and gain access to an appropriate case for my research, before outlining the data collection and analysis techniques I used to provide answers to the research questions.

Research aims and questions

The aims of the empirical element of this research were to apply the theoretical understanding of moral economy – outlined in the theory chapter – to gain an improved understanding of the process of service reconfiguration in the NHS. Through doing so, and in line with the principles of critical realist research, I also aimed to further develop the moral economy concept through data analysis. To achieve these aims, I devised the following research questions to guide data collection and analysis:

1. What relational structures (formed by constitutive rules) are most significant in the Moving on Up programme?

2. What are the most prevalent first order moral beliefs associated with the service reconfiguration?

3. What are participants' lay moral commitments?

4. What is the ‘moral background’ of the first order moral beliefs of participants?
    a) What is the role of duties, ideals, thick moral concepts, and legitimacy within this?
    b) What is the role of para-moral phenomena?
    c) How does this relate to the lay morality of participants?

5. How are these forms of morality entwined with hierarchical relational structure within the service change?

6. What are the implications of the findings of this study for the use of moral economy as a means of understanding service reconfiguration processes?
    a) What modifications can be made to the moral economy approach to make it better suited for studies into the normative dimension of service reconfiguration in the NHS?

I structured the research questions to reflect the layered and multi-faceted nature of the theoretical framework. The first three questions therefore begin by aiming to identify the most significant relational structures connected with the service change in question, as well as the most prevalent first order moral beliefs and lay moral commitments among participants. The fourth research question then seeks to characterise the moral background of the service change. This includes specific consideration of the moral (both meso and macro-level) and para-moral aspects of the background. It also includes a consideration of how these relate to micro-level morality, in line with the discussion of the interaction of lay morality and the moral background in the Theory chapter. I then used the fifth question to add the final layer to this analysis by asking how moral and economic phenomena (i.e. hierarchical relational structures) are entwined. Finally, the sixth question seeks to bring attention back to the central aim of the study by asking what original insights have been

generated about the process of service change in the NHS, and how the empirical application of the concept can help develop moral economy as a theory.

Now I have established the research questions that guided data collection and analysis, I will move onto more the practical aspects of the empirical elements of the research. This includes recruitment, ethical review and processes, data collection and analysis.

4.3 Pre-data collection

Recruitment of case

I used the following criteria when identifying a suitable case study to meet the aims of my research:

- The case had to be a process of service reconfiguration involving one or more NHS organisations. This was a basic criterion to ensure the case study fit with my overarching focus on service change in the NHS.
- This change had to be large and therefore of a sufficient scale to affect several different departments and professional groups.
- The change would preferably be at the stage of detailed planning and/or approaching implementation. This was to ensure that it would be at a stage where participants were being actively required to form first order beliefs and judgements regarding the decision-making process.
- The case would also ideally involve structural changes that are relevant to the general national policy context of financial restraint and austerity, as discussed in the Background chapter. The change in question would therefore need to have financial considerations, such as improving efficiency, as one of its stated aims. This would provide a clear link between the case and the broader national policy context.

As I noted at the start of this thesis, there has been a large degree of change taking place in the NHS in recent years. This made identification of potential case studies fairly easy, as there were several reconfigurations taking place that met my selection criteria at the time of data collection.

I began informally scoping for potential case studies prior to NHS Health Research Authority (NHS HRA) ethical approval, after which I began the formal recruitment process (detailed in the next section). Scoping began in early 2018 and constituted drawing on my own and my co-supervisor's contacts to identify potential gatekeepers to be formally approached once ethical approval was granted. For each of these initial enquiries I sent a briefing explaining the research, and then arranged a phone call to discuss the research further. Most initial conversations led to a further introduction with a senior individual responsible for the service change in question. From this I drew a provisional shortlist of three cases of service reconfiguration that met my selection criteria. Out of these, and in consultation with my co-supervisor, I chose the largest and most complex service change of the three, as we felt this had the most analytical potential. The pseudonym I have given to this service change for the purposes of this research is the Moving on Up programme. I had a conversation with a senior manager involved in the programme in May 2018, where it became apparent that the programme was appropriate for the aims of the research. The senior manager agreed they would, in principle, support the research if and when ethical approval was granted.

Background to the selected case

The Moving on Up programme is a large-scale service reconfiguration in the NHS centred around the reorganisation of the emergency and planned services of one acute trust (referred to as the Acute Trust throughout this thesis). It was designed to make decisions on

behalf of three areas (or 'populations'): Bloughton, Whitdon and Grenham[21], all of which are roughly on the same latitude: with Bloughton to the east, Grenham to the west, and Whitdon in the middle. 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 services. At the time of data collection, the programme had agreed and gained approval for a 'preferred option' involving moving the bulk of emergency services, including Women and Children's (W&C) services, to the Whitdon site, and the bulk of planned services to the Bloughton site. As such, the programme was in the process of moving from 'planning' to 'implementation'. During the planning phase of the programme, the change was led by two Clinical Commissioning Groups (CCGs): one representing Whitdon and one representing Bloughton. However, there were five organisations who were official decisions makers on the programme: the two CCGs, the Acute Trust, a community trust (referred to as the Community Trust throughout this thesis), and a commissioner from Grenham (Grenham Commissioner). The programme also involved several other organisations and stakeholders, as I will discuss in more detail in the first analysis chapter (Chapter 5). It had two main decision-making forums: The Programme Board (PB) and the Joint Governing Body (JGB). At the time of data collection both these forums had recently been dissolved as part of the programme's move from the planning to implementation phase. I will again provide more details of how these forums operated in the first analysis chapter (Chapter 5).

The programme was initially established in response to NHS England's 'Call to Action' (NHS England 2013). This was a national initiative run by NHS England to encourage local healthcare economies to consult with staff, patients and the public, to devise ways of addressing the demand and funding gap within the NHS. Ostensibly this was driven by a combination of the increasing cost of healthcare technology, increasing demand driven by the aging population, and stagnant funding within the context of austerity. Early programme

[21] A large majority of patients who used the Acute Trust's services prior to the reconfiguration were from either Bloughton or Whitdon. However, a significant minority came from Grenham.

documents suggest Moving on Up was originally focused on reconfiguring acute *and* community services simultaneously (Moving on Up 2014b). However, at the time of data collection the programme had become focused solely on reconfiguring acute services, although changing community services remained an ambition for the future.

According to the Decision Making Business Case, the need for the reconfiguration of acute services is driven by three factors: workforce, infrastructure and financial sustainability (Moving on Up 2019a). Clinical workforce, and associated safety issues, is presented in several official documents as the primary reason for the change. According to the Pre-consultation Business Case (Moving on Up 2017), existing staffing levels do not meet the recommended levels for A&E or critical care, particularly in terms of 24/7 consultant cover at both sites. This concern was also corroborated by a recent Care Quality Commission[22] (CQC) inspection of the Acute Trust (CQC 2018a). This gave the Trust an overall rating of inadequate, and an inadequate rating for safety specifically. This report makes multiple mentions of staffing levels as the reason for safety problems at both acute sites, seeing these as insufficient for safe patient care. These issues seem to have been persistent, with similar problems identified in the previous inspection two years previously (CQC 2016). Another perceived driver of the service change is the understanding that physical infrastructure is not 'fit for purpose' to support a functional, modern service. For example, the Decision Making Business Case argues that capital investment is 'desperately' needed, and points to a recent survey that shows a number of aspects of buildings and facilities to be 'unacceptable' (Moving on Up 2019a). The declining finances of the Acute Trust are also clearly considered an area of concern it is hoped the programme will address. This is particularly with respect to the financial deficit within the local healthcare economy and an anticipated increase in demand (Moving on Up 2019a). Indeed, financial performance data

[22] The CQC is the main regulator of the safety of health and social care services in England. All providers must be registered with them before delivering care, and they carry out regular inspections to determine whether services are safe, effective, caring, responsive, and well led (CQC 2017).

contained within annual reports of the Acute Trust reveal that it had gone from a position of breaking even at the start of the programme, to a deficit of approximately £30 million in the most recent figures available (Acute Trust 2019).

It is also important to note that, like many reconfigurations involving the moving of emergency services, Moving on Up has attracted substantial controversy. This is particularly from the Local Authority and campaigners in Bloughton, the area from which emergency services were proposed to be moved. This opposition was an important aspect of the planning phase of the reconfiguration process that I will explore in more detail in the analysis chapters.

4.4 Ethical approval and processes

Approval

The research gained ethical approval from both the University of Birmingham and the NHS Health Research Authority. Proof of this is included in appendices B and C. The processes I describe in this section are consistent with those I presented when I applied for approval. However, as I will discuss, some minor adaptions were made during fieldwork. This is consistent with the nature of qualitative research, which is 'situated and emergent' and cannot solely be conducted according to exact procedures that have been approved prior to fieldwork (Mason 2018: 85).

Recruitment and Consent

I formulated three consent processes for this research. The first was the process for securing organisational consent and the second was the process for securing individual consent from interview participants. When applying for ethical approval I also outlined a third consent process for participant observations. However, during my data collection window

there was only one Programme Board meeting and one public JGB meeting held, both being the last ones of this stage of the programme. While I attended these meetings (the JGB meeting via live streaming online), both were short and did not add any insights beyond what I could already gain through interviews and documentary analysis. As a result, while these meetings were useful in developing my knowledge of the programme in general, I have not referred to them in my analysis. I have therefore not included this consent process in the final write up.

With respect to organisational consent, with the help of my gatekeeper I identified an individual in each of the five lead organisations who could give consent on behalf of their organisation. I then sent a research briefing to them (Appendix D) with details about my research. I also made a meeting available to the senior individual(s) to discuss any concerns and answer any questions, although only two organisations requested this. If the individual was happy for their organisation to take part in the research, I asked them to confirm this in an email. All five organisations I approached consented to take part in the research.

The informed consent process for individuals was more complicated. Feedback from the ethical review process stated that I was not able to obtain an individual's contact details to approach them for an interview without their permission to do this. This meant I had to obtain permission from participants to contact them before contacting them. To recruit participants, I therefore followed two parallel strategies. My gatekeeper arranged for a general email to be sent out to those on the Programme Board and JGB to make them aware of my research and ask them to contact me if they wanted to take part. The second, more successful, strategy I deployed was to ask each interviewee to suggest my next participant, and request they obtain permission for me to contact them. Once I had permission to contact a potential participant, I did so via email. This included a participant information sheet (Appendix E), which included all relevant details about the study, such as the purpose of the study, confidentiality, right to withdraw, data protection and my contact details. I encouraged

participants to ask me any questions they had prior to consenting to take part. If they said they wanted to take part in the research, then I also sent them a consent form (Appendix F) along with another copy of the participant information sheet at least 24 hours before the interview. For interviews conducted over the phone, I gave them the option of filling it out and sending it via email or posting it to me. For interviews carried out face to face, I also brought a copy of the consent form with me to sign. At the start of each interview I offered to give a recap of my research and what I was trying to achieve. I also informed each participant when I started recording.

Confidentiality and Anonymisation

I put several procedures in place, both in the transcription of interviews and write up of research data, to ensure that, as far as is possible, all research data remained anonymous in storage and presentation. Here I aimed to ensure that participants would not be identifiable to anyone but me in both transcripts and research findings. With respect to interviews, I have used pseudonyms rather than actual names for individuals and organisations, and I have also not used actual job titles. I kept a table of pseudonyms linked to the actual identity of individuals on a separate encrypted disk to all my other research data. This meant I would be able to withdraw an individual's data from the study should they request this. These procedures have also helped me to provide confidentiality to participants, as none of the information shared with me has been shared with anyone else in an identifiable way[23].

Data storage

I have stored all typed up field notes, audio recordings, notes from documents, and interview transcripts on an encrypted password protected disk. Data were also backed up on UoB

[23] In the participant information sheet I made clear that, for this type of study, full anonymisation and confidentiality may not be possible if a reader already has detailed knowledge of the service change in question or the local actors involved.

severs in a password-controlled area only accessible to the researcher. Data held on disks will be stored for ten years and then destroyed in accordance with the UoB code of practice for research. For data stored on disks, I will delete this data myself after the 10 years have elapsed. For data stored at UoB, I will ask IT services to ensure a complete and timely removal of this data on my request once the PhD process has been concluded.

Participant Feedback and Involvement

I have sought to engage and obtain feedback from participants throughout the research process. One piece of feedback I received while I was negotiating access to the Moving on Up programme was a concern about anonymisation. Namely, some senior members of the programme wanted to ensure anonymisation was extra thorough because of the political sensitivities surrounding the programme. In response to this, I offered to seek to share a copy of the findings chapter with an appropriate member of staff, once data collection was complete, to assure them that anonymisation had been done appropriately[24]. I also met with my main gatekeeper after finishing data collection in September 2019 to show them how I would anonymise the programme and share some provisional findings.

Once the PhD process is completed, I will seek to proactively share my findings with the organisations involved through presentations and question and answer sessions (Covid-19 restrictions permitting). I will also prepare a summary of the research findings and offer this to those who participated in interviews. Furthermore, a full thesis will be made available to those who request it.

[24] In the end, this offer was not taken up on.

4.5 Data collection

Primary data collection method: Qualitative interviews

I used qualitative interviews as the primary form of data collection for this study. By qualitative interviews I mean in-depth, semi structured, co-present (i.e. face to face and over the telephone) interviews with one person at a time (Mason 2018: 109[25]). I selected this method because it can be used to develop explanations and gain understanding of the attitudes, views, experiences, and emotions of individuals (Matthew and Ross 2010: 223). Furthermore, from a critical realist perspective, interviews can *also* be used 'to analyse the social contexts, constraints, and resources within which… informants act' (Smith and Elger 2014: 111). This method is therefore particularly well suited for my research, wherein I aim to develop a better understanding of the lay moral commitments of individuals; the first-order moral beliefs within the programme; and explain these beliefs with reference to the cultural and structural phenomena that influence them. However, knowledge 'about events and processes, let alone causes and underlying conditions' does not come about as a simple and transparent output of interviews (Smith and Elger 2014: 119). Instead, interviews needed to be utilised in a specific way to meet the requirements of this research and a critical realist meta-theory. I will therefore dedicate much of the rest of this section to detailing how I achieved this with respect to sampling, preparation, interview conduct, and the triangulation with documentary analysis.

Sampling and saturation

Sampling within policy and management-based CR research typically proceeds based on the *expertise* of participants (Pawson and Tilly 1997. Cited in Smith and Elger 2014: 120). In studies into the formulation or implementation of management policies, such as this one, participants are generally recruited based on their knowledge of how such policies unfolded.

[25] Mason does discuss other types of qualitative interview

Thus, their accounts are expected to offer some insights into the underlying context and mechanisms behind these processes. However, such accounts are unlikely to be 'full and systematic' (Smith and Elger 2014: 120). It is up to the researcher 'to see beyond the horizons of specific interviewees' to develop a more comprehensive account of the powers and entities at play (p.121). Sampling a range of perspectives on the process being studied is therefore helpful in gaining this fuller understanding.

I sought to sample a range of perspectives from those with the most expert knowledge of the Moving on Up programme. I focused on the two main decision-making committees within Moving on Up where detailed insider knowledge about the process of service change was most likely to be found. These were: The Programme Board (PB), made up of representatives of all lead organisations and partner organisations, and the Joint Governing Body (JGB), made up of the two lead CCGs (Whitdon and Bloughton). Within this, I recruited participants through a mixture of non-probability, purposive sampling approach – specifically theoretical sampling – and convenience sampling. Theoretical sampling proceeds on the logic that people (or activities, documents etc.) are selected according to whether they have characteristics that are 'likely to help in developing emerging theory' (Seale 2018: 168). It is an appropriate strategy to use 'where initial and often subsequent sampling decisions are driven by a priori theoretical ideas' (Rapley 2014: 59). Indeed, whilst this is often associated with grounded theory, it has become the 'typical form of selecting material in qualitative research' (Flick 2014: 173-4). According to this approach there is an iterative relationship between sampling and analysis (Rapley 2014: 49), wherein analysis goes hand-in-hand with collection, and sampling decisions are ongoing and based on what the study is revealing (Seale 2018: 169). The main theoretical consideration that drove my sampling approach was the extent to which moral and para moral phenomena were truly *shared* across organisations, as this would help me establish whether it existed on the meso-level of morality. With this in mind, I sought to recruit individuals from a range of organisations and clinical and non-clinical backgrounds to take part in my research. In total I approached thirty-

three members of either the Programme Board or the JGB and successfully recruited nineteen participants, carrying out interviews with them between December 2018 and June 2019[26]. I was largely successful in sampling across a range of perspectives, and I have included a table to demonstrate this in the appendices (see Appendix G). However, there were some groups I was not able to recruit from, particularly finance professionals and the independent clinicians involved in the programme.

Much of the sampling for this research was also, inevitably, done based on convenience. Since I was only sampling from two committees, there was only a population of approximately forty individuals from which to draw[27]. Added to this, and as discussed in the ethics section, the restrictions I was subject to in terms of contacting participants also meant I was limited in my ability to approach people. Convenience was a particularly important part of my sampling approach at the start of data collection, when I was still learning about the different groups involved in the programme and so had less knowledge about who I might approach. This is common for the initial stage of data collection, wherein sampling will have a large *convenience* element as the research seeks to get a general feel for the issues at play (Rapley 2014: 55). However, early interviews allowed me to gain a stronger understanding of which perspectives within the programme I needed to capture to gain a fully rounded view, and so these theoretical considerations became more important. This was particularly with respect to differences in perspective between those on the Bloughton and Whitdon side of the change, as I will discuss further in the analysis chapters.

I largely used the criteria of *data saturation* to determine when to finish data collection. Data saturation refers to when the researcher judges that new data are no longer helping to identify novel insights into the phenomena being researched (Flick 2014: 172). This can also

[26] The average length of interview was fifty-eight minutes, with the longest lasting ninety minutes and the shortest lasting twenty-eight minutes.
[27] The Programme Board had approximately twenty-five members and the Joint Governing Body approximately fifteen, although membership of both did change throughout the programme.

be referred to as ‘informational redundancy’ wherein no new insights are emerging from interviews (Seale 2018: 172). Little literature exists on what the criteria are for judging when saturation has been reached (Hennink et al 2017: 591). I therefore attempted to deploy a more formal understanding of data saturation by drawing on Hennink et al’s (2017) concept of *code saturation.* Here I kept track of the codes added after every interview. Once I had stopped adding new codes, I judged code saturation had been reached (see Appendix H for diagram). It is important to note that, in practice, this was done in batches because I was not able to schedule interviews at regular intervals, meaning I often did not always have time to transcribe and code an interview before the next one.

Interview preparation

In line with the CR approach to interviewing discussed above, I prepared the interviews to help generate insights into both individual beliefs, commitments and understandings *and* underlying powers, entities and processes. The first type of insight was intended to help answer Research Question 2 and 3 into first order moral beliefs and lay normativity, the second to answer Research Question 1, 4 and 5 into underlying cultural and structural entities and their interaction. From a critical realist perspective, it is important that these considerations are not just brought in at the data analysis stage, but also help to shape the way interviews are planned and carried out. As Smith and Elger (2014) argue:

> For interviews to yield insights into these features [events, experiences and underlying conditions and processes]… the interchange between interviewer and interviewee has to be informed by an appropriate analytical framework, which can guide questions, frame answers, and suggest probes and direction for further discussion, so as to enhance the depth, texture, and complexity of the accounts being developed. (p.119)

I therefore prepared interviews to generate insights into the underlying processes I sought to uncover. This required me to prepare interviews that could shed light on the kinds of moral and structural phenomena I discussed in the Theory chapter.

My main challenge in preparing the interviews was the need to gather data that was relevant to my interest in such phenomena, while also avoiding dense theoretical language. This was both because I wanted the interviews to be accessible, but also because I wanted to retain flexibility at this stage as to how I would ultimately conceptualise moral economy. I also feared that if I made some of the concepts explicit then the interviews would become leading. For example, if I asked participants about the deeply held moral commitments (i.e. lay morality) that inform their work, I thought them unlikely to say they do not have any for social desirability reasons, even if this was the case. I therefore designed the interviews to encourage participants to reflect on their moral beliefs about the programme and the relational structures they work within without using inaccessible or leading concepts. To do this, I split the interviews into four sections:

1. In the first section I aimed to elicit information about the participant's role within their organisation and the Moving on Up programme. This included their accountabilities and duties. In doing this I had two objectives. Firstly, I wanted to generate information about the constitutive rules that were relevant to the participants and learn where in the organisational and service change hierarchy they sat. Secondly, I wanted to elicit information about what they believed their duties were, which is one of the prominent, and more accessible, moral concepts in my research. In this section I also asked about professional identity, as I believed this might be one way of eliciting information about more deeply held moral commitments and identity.

2. In the second section I aimed to elicit participants' views on the Moving on Up programme itself. Here I explicitly asked for their evaluations of what Moving on Up is

trying to achieve, whether they agree with the final option that had been decided, and what, if any, values it is based on. I also sought their evaluations of the role of different actors in the programme, and how they thought others had behaved.

3. In the third section I asked questions specifically about participants' experience of working with other organisations. While planning the interviews I had learnt that inter-organisational working had been an important, and sometimes challenging, aspect of the programme. I therefore anticipated that participants would have pre-existing moral evaluations regarding how different organisations had acted.

4. In the fourth section I asked about the public consultation. This had only recently been concluded when I started the interviews, and it had been an area of significant work and controversy. I therefore again felt this would be a topic on which participants would have strong moral opinions and beliefs.

I have included a full copy of the interview schedule used in Appendix I.

Interview Conduct

An important aspect of CR interviewing is to acknowledge the interview as a site of meaning construction (Smith and Elgar 2014: 111). This is a common feature of qualitative interviewing in general, which seeks to acknowledge the 'contextual, situational and interactional' nature of knowledge (Mason 2018:112). This requires a researcher 'to be flexible and sensitive to the specific dynamics of each interaction', meaning the interview must be responsive and tailored, rather than completely pre-scripted or standardised (Mason 2018: 113). Therefore, while in each interview I aimed to cover all the points in the interview schedule, I also tried to keep the topics flexible and responsive to the participant's interests. This is in line with how semi-structured interviews are generally carried out, wherein:

> The interviewer has an interview *guide* that serves as a checklist of topics to be covered and a default working and order for the questions, but the wording and order are often substantially modified based on the flow of the interview, and additional unplanned questions are asked to follow up on what the interviewee says. (Robson 2011: 280)

The flexible approach I took to interviews meant I would sometimes ask probing questions where I felt this would yield relevant theoretical insights. For instance, when a participant talked about actions of individuals in other organisations that they disagreed with, I would often ask whether they would behave differently if in the same situation. This helped me to gauge whether participants were aware of any contextual factors (such as conflicting incentives) driving disagreements, or if they felt conflict was just caused by clashes between individual personalities. This flexible style is consistent with a CR approach which emphasises the importance of conducting interviewees around the needs of the developing theory (Smith and Elger 2014: 119).

Alternative data sources: Programme documents

While the interview is a valid primary method to use for this case study, it also has some limitations from a CR perspective. All interviewees have specific 'preoccupations, vantage points, and interests' (Smith and Elger 2014: 122). As such:

> Interviews, from a CR perspective, are necessary for accessing human thought, meaning, and experience, but they are not by themselves an adequate basis for analysing the multiplicity of causal factors in play in social relations. (p.122)

Accounts from interviews therefore 'need to be subjected to critical scrutiny not only in their own terms but also in relation to other sources' (Smith and Elger 2014: 119). This allows them to be 'assessed in terms of their comparative adequacy or completeness, and on this

basis used to test and develop explanatory theories' (p.120). The high volume of programme documents generated during Moving on Up provide a useful secondary data source to complement interviews. It is important to note that, just like the accounts of interviewees, documents are 'socially situated products' (Scott 1990: 34. Cited in Coffey 2014: 375) and cannot be treated as transparent bearers of the phenomena being studied. Indeed, such official documents are 'carefully crafted to meet the demands of external audiences' (Mutch 2014: 229), in this case mainly the requirements of NHS England, and their purpose must always be considered when analysing them. Despite this, documents are still a valuable source for complementing interview data for this research. This is for three reasons:

1. Programme documents show views that have been 'signed off' by both the Programme Board and the JGB. They therefore reflect, at least to some extent, whether certain views, such as what constitutes an appropriate grounding/ justification for the programme, are shared among those involved.

2. Related to this, documents can help in distinguishing between 'front stage' public views, and 'backstage' private views. The difference between the two can be useful in showing the underlying power dynamics which allow some views to be privileged over others.

3. Documents are useful in showing the specific constitutive rules and regulations that govern the programme, as these need to be formally set out in documents. For example, structural configurations of organisations are set out in documents such as organisational charts (Vincent and Wapshott 2014: 160).

In terms of sampling documents, I have mainly focused on those that reveal most about the constitutive rules of the programme or those that were discussed most by participants. This further emphasises how I have used documents as a secondary and complementary data source to interviews.

4.6 Data analysis

I carried out data analysis in line with the principles of abduction and retroduction. Analysis was split into two phases. The first involved transcribing and then coding the data in Nvivo. Here I focused on broadly categorising the data in line with the various concepts I have discussed in the theory section, which act as empirical indicators of moral and economic phenomena. The second stage involved answering the research questions with respect to these categories. This is broadly in line with Fletcher's (2017) flexible deductive approach to qualitative data analysis in critical realist studies. This involves the search for 'demi-regularities' in coding: meaning rough trends in the data. The research begins with a list of codes derived from theory, which are then refined and added to during data analysis. Once coding is complete, the research then moves onto abduction (description of data in line with theory) and retroduction (theoretical enquiry into underlying entities and their properties). In this section I will present the process of coding. In the analysis chapters I will present the outcome of the process of abduction and retroduction.

Coding

I began coding with a large, relatively loose number of categories derived from theory and my contextual knowledge about the programme. This was for both economic (i.e. structural) and moral phenomena. With respect to the former, I sought to identify the most influential 'systems of human relationships among social positions' (Porpora 1989: 195), in keeping with the discussion on relational structure in the Theory chapter. I started with three broad categories:

- Funding and resources – Matters relating to financial flows, systems, and constraints.
- Inter-organisational structures – Relationships between organisations and the constitutive rules that structure these relationships.

- Inter-role structures – Relationships between individual roles and the constitutive rules that structure these relationships.

With respect to moral phenomena, I started with the following categories as empirical indicators of moral phenomena:

- Appropriateness – This concept is included in Abend's (2014) definition of first order morality.
- Legitimacy – Taken from Weber's theory of rational authority (Scaff 2014)
- Moral conflict – I included this category to highlight instances where the moral beliefs of different groups may come into conflict. This reflects insights from both the Literature Review and Theory chapters.
- Duties and obligations – From the work of Durkheim (2019), March and Olsen (1989) and other institutional scholars discussed in the Theory chapter. Abend (2014) also refers to obligations in his definition of first order morality.
- Ideals – This is again borrowed from the work of Durkheim and refers to shared conceptions of the good (Weiss 2012). The concept 'good' is also included in Abend's (2014) definition of first order morality.
- Moral emotions – I Included this to reflect Sayer's (2011) work, which emphasises the importance of emotions when studying people's lay moral commitments.
- Thick moral concepts – Taken from Abend's (2014) moral background.
- Other moral background phenomena – I again took this from Abend's framework although, as I will discuss below, it quickly became apparent that these were not amenable to coding.

Through the processes of coding, some of these categories proved to be more useful than others. For example, it soon became apparent that moral background elements would not

manifest in empirical data in a way that was immediately codable. I therefore moved the consideration of this element entirely into the abduction/ retroduction phase of data analysis. I have included a full list of the codes produced during coding in Appendix J.

After completing coding, I prepared an initial summary of the main themes to discuss with my supervisors and gatekeeper. This included several prominent moral beliefs and concerns, such as: patient safety; the importance of doing what is best for one's population; the high moral esteem given to clinical opinion and evidence; and the importance of 'engaging' with the public. It also included brief discussions on prominent structural considerations, particularly the way financial constraints were generally seen as a contextual constraint rather than a moral consideration. This, alongside the coding, was therefore useful in highlighting demi-regularities in concepts relevant to a moral economy framework. However, the abduction and retroduction stage was most important in applying the framework I have developed to the empirical data. As discussed below, this involved an extensive re-examination of the interview data, alongside relevant documents, to answer the research questions set at the start of this chapter.

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: 91-2). Doing this allows the researcher to link empirical data, such as the accounts of interviewees, to more general structures and entities, such as norms and power relations. It also allows for the testing and development of existing theories based on applying them to new empirical cases. In CR terms, 'abduction becomes a manner of acquiring knowledge of how various phenomena can be part of and explained in relation to structures, internal relations and contexts which are not directly observable' (Danermark et al 2002: 92). Abduction requires the researcher to have a comprehensive knowledge of the theories being applied. Alongside this, it also requires a level of creativity:

> Besides comprehensive knowledge of established alternative theories, models and frames of interpretation, abduction requires a creative reasoning process enabling the researcher to discern relations and connections not evident or obvious – to formulate new ideas about the interconnection of phenomena, to think about something in a different context, an ability to 'see something as something else' (p.93).

Abduction thus allows for the use of theories and frames of interpretation 'to gain a deeper knowledge of social meanings, structures and mechanisms' (p.92). With respect to the theoretical framework applied to this research, abduction requires the re-description of empirical data in line with the concepts of constitutive rules, first order moral beliefs, lay morality and the moral background (including duties, ideals, regulations and thick moral concepts).

The method of retroduction is closely related to abduction, and in practice it can be difficult to differentiate between the two (Danermark et al 2002: 96). Nevertheless, retroduction represents an important part of the CR research process. Retroduction 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: 253). To carry out retroduction, the researcher is required to engage in counterfactual thinking to help understand what is necessary and what is contingent about the entity in question (Danermark et al 2002: 101). With respect to this research, retroduction takes place in two ways. Firstly, it takes place as a natural outworking of abduction. Re-describing data in line with the concepts of this research involves a consideration of what properties the entities described by these concepts have, and how they interact. Secondly, the fifth research question has an explicit retroductive purpose to explore the entwinement of moral and economic phenomena. I will therefore dedicate Chapter 7 to analysing the makeup of these phenomena with respect to the Moving on Up

programme. This will include a consideration of their properties and how they are able to influence each other.

Conclusion to chapter

In this chapter I have shown how I designed an empirical study to apply a moral economy framework to a case of service reconfiguration in the NHS. To do this, I have addressed both metatheoretical considerations and more practical issues related to research design. With respect to metatheory, I have shown how critical realism can be used to conceptualise the relationship between theory and data collection. This is through a separation of the real, actual and empirical realms of reality, and a belief in the centrality of formal theory in generating knowledge about underlying entities and causal properties. I have then set out the practical steps I took to operationalise the research into an empirical study. Here I have shown how the concepts of this research can be applied, through a qualitative case study, to a case of service change in the NHS: the Moving on Up programme. I have argued that by conducting semi-structured interviews with those involved in the programme, alongside analysis of official documents, I have generated data that suit the purposes of this research. I have also argued for the value of using abduction and retroduction interferential strategies to generate knowledge about the underlying moral and economic phenomena involved in the programme.

I will now go on to the second part of the thesis, where I will present the results of applying these inferential strategies to the empirical data. I will do this in three analysis chapters. The first will answer Research Questions 1, 2 and 3; the second will answer Research Question 4; and the third will answer Research Question 5.

PART TWO: APPLYING MORAL ECONOMY TO A CASE OF SERVICE RECONFIGURATION IN THE NHS

Introduction to Analysis Chapters

In these analysis chapters I will describe the empirical data I have collected in line with my theoretical framework. In so doing, I will put the inferential logic of abduction and retroduction into practice.

I have structured these chapters to build from the most empirically visible phenomena to the least, in a way which is consistent with the order of my research questions. Together they form a *layered* approach to analysis, with each chapter going deeper into exploring the unseen workings of cultural and structural phenomena than the last. Therefore, the analysis also becomes more dependent on retroduction as it progresses. In the first analysis chapter (Chapter 5) I will focus on the relational structures most significant to the programme, the first order moral beliefs of participants, and their lay moral commitments. In the second analysis chapter (Chapter 6) I will consider the moral background (augmented in line with the discussion in Chapter 3) that underpinned participants' first order moral beliefs, as well as how this interacted with their lay moral commitments. I will begin this chapter with the two most visible aspects of the background: groundings and conceptual repertoires. I will then discuss the more implicit aspects of the moral background: objects of evaluation, meta-ethical objectivity and metaphysics. I will dedicate the final analysis chapter (Chapter 7) to considering how these forms of morality were entwined with hierarchical relational structure, in answer to Research Question 5.

5. Relational Structure, First Order Moral Beliefs and Lay Morality

5.1 Relational structures and Moving on Up

In this section I will re-describe empirical data from interviews and documents to answer the following research question:

1. What relational structures (formed by constitutive rules) are most significant in the Moving on Up programme?

There were five forms of relational structure most prominent in participants' accounts of how the programme proceeded:

1. The rules that constitute the CCG Joint Governing Body (JGB)
2. The rules that constitute the Programme Board (PB)
3. The configuration of CCGs (including accountability relationships)
4. The rules that constitute the service change approval process
5. The rules that govern how public consultation takes place

I will now describe each of these in turn.

The CCG Joint Governing Body (JGB)

The Joint Governing Body (JGB) was established under the constitution of both CCGs to be the ultimate decision maker for Moving on Up (Bloughton CCG 2017; Whitdon CCG 2017). The terms of reference state that the JGB is convened to act as a decision-making body on behalf of the two CCGs with respect to the recommendations of the Programme Board. This is specifically in terms of the outcome of the option appraisal for the reorganisation of acute hospital services. The committee had equal representation from both CCGs' Governing

Bodies, with decisions based on a majority vote between CCG members. Several 'independent clinicians' from outside the area were brought onto the committee as voting members around a year after it was set up to break deadlocks in decision making (to be discussed later). The membership of the JGB was therefore constituted of:

- An equal number of clinicians from each CCG Governing Body
- An equal number of lay members from each CCG Governing Body
- An equal number of executives from each CCG Governing Body
- Several out of area clinicians
- Several non-voting members. These included patient representatives and council representatives.

Every joint committee meeting was held in public, with each attracting considerable attendance and debate.

The Programme Board (PB)

The Programme Board's purpose was to oversee the programme and make all decisions relating to management of the programme (Moving on Up 2015a). It was composed of representatives from several NHS organisations, including: Bloughton and Whitdon CCG, the Acute Trust, the Community Trust, and Grenham Commissioner. In addition to this, it included several stakeholder representatives, including representatives from the councils of Bloughton, Whitdon and Grenham; community representation organisations from Bloughton and Whitdon; and members of several surrounding healthcare providers and commissioners. The PB had no formal decision-making powers but oversaw all aspects of the programme and made recommendations to the JGB. There were also subcommittees which carried out detailed planning work for the programme, such as workforce planning and travel and transport.

It was the Programme Board that agreed the final option for the reconfiguration, although this had to be 'signed off' by the JGB.

The configuration of the CCGs

The way CCGs are structured revolves around a core regulatory (macro moral) responsibility to commission a range of health services to meet the reasonable needs of their defined population, within a set budget. This is a statutory duty for which they are accountable to the Secretary of State via NHS England (NHS Clinical Commissioners 2019). Each CCG has an Accountable Officer (AO), usually a manager, through whom this accountability relationship runs. At the same time, CCGs are membership organisations with their own internal accountability structures. Specifically, each CCG is made up of member GP practices. These practices elect a Chair of the Governing Body to whom the AO is also accountable. Members of the two Governing Bodies who took part in this research seemed more mindful of the accountability relationship with NHS England, rather than CCG members practices, when it came to the Moving on Up programme.

The commissioning relationship between CCG's and NHS provider trusts also forms an important accountability relationship which was significant to the Moving on Up programme. This usually takes the form of a contractual relationship between the commissioner and trusts. Much of this contract is set at a national level, in that CCGs are statutorily required to commission certain services, and the rates of reimbursement that providers receive is set by national tariffs. However, with this financial relationship come lots of other accountabilities to be managed locally. These can include specifications around quality and safety, which will be monitored regularly, often via performance metrics. With respect to the Moving on Up programme, this accountability relationship was particularly important because it connected the two CCGs to the performance of the Acute Trust. This effectively meant that the safety

and financial issues the Acute Trust was experiencing at the time of data collection were also issues for the CCGs to resolve. This particularly related to the Care Quality Commission (CQC) concerns over patient safety, which was a particular concern for participants from both CCGs.

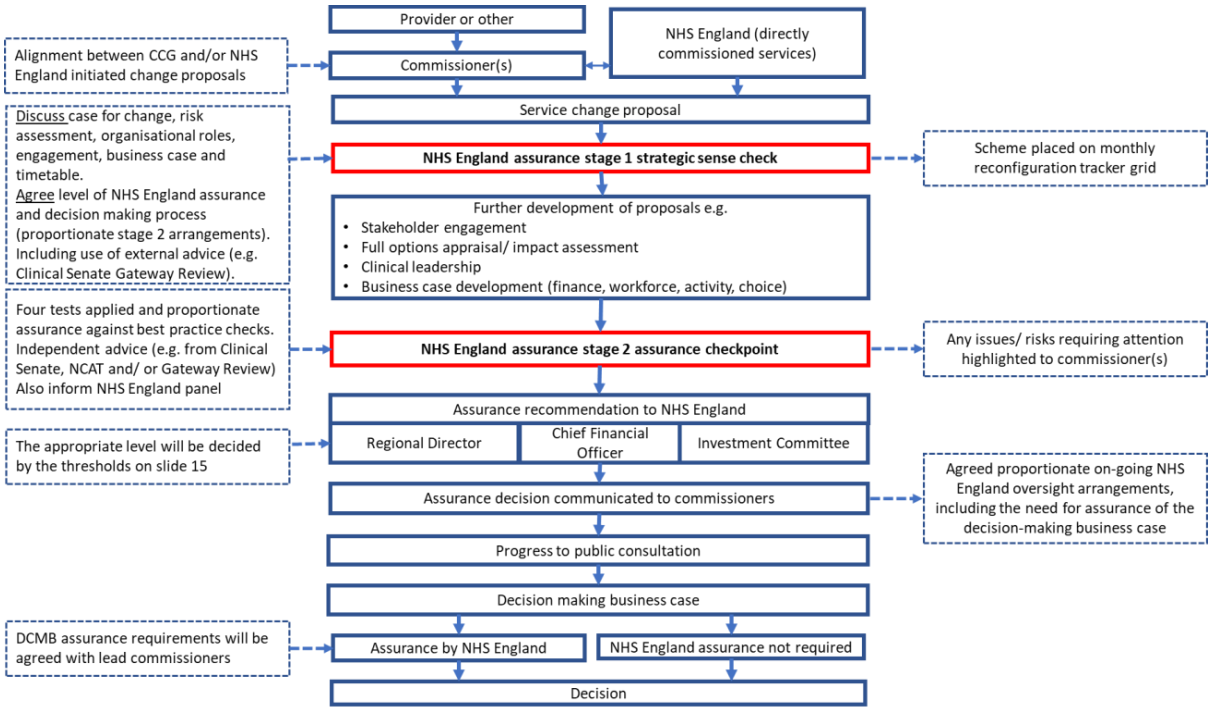
The NHS England service change process

The progression of the programme was structured around NHS England's (2018) assurance process. This required the CCGs to pass five government tests (applied by NHS England) before being authorised to go ahead with a service change. These were:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from clinical commissioners
- A fifth test also details the conditions that need to be met prior to the removal of hospital beds (NHS England 2018)

Since Moving on Up involved a significant degree of capital funding from NHS England, this hierarchical relationship was particularly prominent. Figure 5.1, taken from the NHS England guidance, summarises this process.

Figure 5.1 – The NHS England (2018) Assurance Process



The most important stage of this process for participants seems to have been the 'stage 2 assurance checkpoint', for which several documents had to be prepared. This stage was the point at which the five tests were applied, and NHS England decided whether the plans could progress to the stage of public consultation.

Rules around consultation

The public consultation was also an especially important part of the approval process from the participants' point of view. Commissioners had to consult on plans as a statutory requirement. Furthermore, the Local Authorities involved in the programme had the power to refer Moving on Up to the Secretary of State for Health if they judged it had not been carried out in the correct way, as defined by regulations. This therefore created an extra accountability relationship between the CCG and the Secretary of State with respect to the programme.

In this section I have identified five forms of relational structure that were particularly significant to the Moving on Up programme. I will now proceed to discuss the most prevalent first order moral beliefs related to the Moving on Up programme.

5.2 First order moral beliefs

Introduction

In this section I will focus on the most prevalent first-order moral beliefs that participants expressed in interviews to address the second research question:

2. What are the most prevalent first order moral beliefs associated with the service reconfiguration?

As I explained in the Theory chapter, I will use the term ‘first order morality’ to refer to ‘the level of people’s moral judgements and beliefs’ (Abend 2014: 16). This can include understandings regarding what specific actions, practices and beliefs are right, good, obligatory, appropriate, and admirable (p.32). The first order moral beliefs I will explore in this chapter are as follows:

1) Beliefs regarding the programme being the right thing to do:

- Centralisation is good
- The two-site model is good
- Option 1 is more desirable than Option 2

2) Beliefs regarding joint working and Moving on Up

- Partnership working is desirable, but so are ‘trade offs’
- Bloughton Local Authority has not behaved well

- It is desirable to focus on developing community and preventative services
- The inclusion of Grenham in the service change is appropriate

3) Beliefs regarding interactions with the public

- The consultation was good
- Bloughton Local Authority and the campaign group have behaved poorly

I will now explore each set of first order moral beliefs in turn.

First order moral belief: The programme is the right thing to do

All participants expressed the belief that the programme is the right thing to do to address many of the issues experienced by the local healthcare economy. Interviewees generally framed the programme as good in three senses. Firstly, all agreed that the centralisation of acute services is good, particularly in improving patient outcomes. Secondly, they all agreed that a two-site model is more desirable than the current configuration, particularly in terms of patient access. Finally, they all believed that Option 1 is better than Option 2[28].

This level of support for the programme is not surprising given all participants were involved in planning and/or authorising the reconfiguration in some way. However, while most support was strong, it was also qualified to some extent, with participants recognising the programme had been required to take account of certain material constraints. A small minority of participants gave caveated support for the final preferred option (Option 1), believing it to be the right thing to do but pointing to specific alternatives which, in their

[28] Option 1 and Option 2 were the two options put out to consultation. As I will discuss later, Option 1 involved centralising emergency services in Whitdon and planned services in Bloughton, while Option 2 involved centralising emergency services in Bloughton and planned services in Whitdon. Option 1 was the official preferred option of the Moving on Up programme.

opinion, might be more desirable. However, even the most sceptical individual still believed Moving on Up was more desirable than doing nothing.

The programme is the right thing to do: Centralisation is good

Most participants shared the first order moral belief that centralisation of acute service *in general* is a good and necessary thing that will improve the quality of services. This tended to be based in the view that acute interventions are becoming more complex, thus requiring a greater concentration of expertise on one site to deliver a better standard of care. For example, Andy, a member of the programme team, stated:

> The way the doctors have been trained is changing now and we need to look forward to that as well. So before doctors would have been trained to carry out different specialisms, and 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].

The centralising aspect of the programme was therefore seen to directly address the workforce and recruitment issues experienced by the Acute Trust, while also allowing the maintenance of clinical and safety standards. Participants also saw the benefits of this as outweighing any drawbacks in terms of the constraint of geography, particularly in terms of patient travel times. As Ryan, a member of the Whitdon CCG Governing Body, put it:

> 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 …That's applying particularly to things like accident and emergency, where there is a recognition that the evidence would suggest that for certain conditions don't send someone to their local accident and emergency department, send them to a specialised [unit].

Such a belief was seen to be centrally mandated and supported by the evidence. As Dylan, from Bloughton CCG, also stated:

> Another reason [for the reconfiguration] is that, on a regular basis there is 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'. So… if we take the example of stroke services, a few years ago there was some national evidence that went round the NHS organisations in the whole country saying that if you centralise stroke services you get better outcomes for patients. And then we are mandated to deliver that.

These arguments are also made in official programme documentation. For example, the Public Consultation Document (Moving on Up 2018) mentions research from NHS England which purportedly shows that having one, more specialised, emergency care site is safer. This document also claims evidence shows this leads to better results and reduced hospital stays. This again demonstrates the belief that the Moving on Up programme is good because it will create improvements for patients through centralising services.

<u>The programme is the right thing to do: The two-site model is good</u>

Participants also regularly made the case that the two-site model proposed by the programme will improve care for patients, particularly patient access. For example, Ashley, when answering why action was being taken now, stated:

> Everybody recognises the model, everybody knows it needs to be [Option 1 or Option 2]… You know, planned care/ emergency care … it's going to improve access to healthcare for the whole... So I think, the feeling that this has gone on too long. Them recognising that the model needs to happen, it's either there or the other end of the area. There are trade-offs with both.

Therefore, participants predominantly expressed the belief that a planned care/ emergency care split will improve care for patients, regardless of which way round this is done. The split was expected to help address the staffing issues experienced by the Acute Trust by creating more efficient patient pathways and greater clinical capacity. As Bobby, a senior manager from the Acute Trust, stated:

> So the model seeks to consolidate care in a way that is more effective and allows for 7 day models of care and concentrates senior leadership through 24 hours a day, which is the design of having a single emergency centre for [the area], rather than having the two that we have at present.

The improved cover created by these changes was also expected to make it easier for the Acute Trust to recruit by making working practices more desirable from the point of view of clinicians. This in turn was expected to improve outcomes for patients which, as I will discuss in the next section, was a core concern for participants. The capital investment that will accompany the programme was also expected to lead to improvements in the built environment, further adding to the attractiveness of the Acute Trust as a place to work. Furthermore, most saw the two-site model as the most appropriate solution to workforce and performance issues given the financial constraints of the local healthcare economy. The two-site model was therefore seen to be good in both addressing workforce issues and built environment in a way that will improve patient care *within* a context of financial restraint.

Whilst all participants believed that a two-site model will be better than the current arrangement, two interviewees were considerably less enthusiastic about it than the others, although both still saw it as more desirable than doing nothing. These two participants believed that a hospital in the middle would be better than a two-site model. This was an opinion that was shared by many of interviewees, although most thought it was not realistic because of the cost. However, two participants thought that a new hospital might be

affordable within the money available and so were slightly disappointed with the preferred option. As Manny from Bloughton CCG argued:

> I said to them 'you're talking about £X million here'… which I know is one of the largest single investments by the NHS into a region 'to build one effectively sort of upgraded hospital'…and I say to them 'do you know how much that L [a new hospital] in RF [a different area] costs, to build the new, spanking wonder hospital which is world class?' Answer, £Ymillion [around double the amount given for this programme]. So I mean, £Xmillion [the money available for the programme] for you know a pip squeak, rural hospital. You're joking! But that's the way it goes.

When asked if he still thinks the programme is needed, Manny said yes, as it is the only option available that will allow for investment in the built environment. However, he clearly felt that more could be done with the money available.

<u>The programme is the right thing to do: Option 1 is better than Option 2</u>

Participants also generally believed that the preferred option (Option 1) is the most desirable among all the possible options. Option 1 was generally thought to maximise benefits to patients even though, as discussed above, either would be better than the existing situation. For instance, on whether he had originally had a view as to whether the A&E should be in Bloughton or Whitdon, Elliott, a member of Whitdon CCG, stated:

> I didn't have a strong view. The only thing that made me think [that Option 1 would be better] was as soon as they said we had to take account of the Grenham population, I thought 'that's it then, it's going to be in Whitdon because some element of travel time does have an impact'…but until we had that bit of guidance I really didn't care: if you could make a case for [having the A&E in] Bloughton fine, if you could make a case for Whitdon fine.

This view is also demonstrated by quotes from two participants outside of the CCGs: the first from the Community Trust and the second from the Acute:

> We can see benefits and downsides to all of them, but also we're quite comfortable… because my personal view is it seemed to make more sense to go to Bloughton, but when you start to look at the evidence and the weightings, that wasn't the case so we were quite comfortable as a [Programme] Board in the end to vote for the preferred option.

> Well the hospital hasn't had a particularly strong opinion on which of its two sites… is considered to be the emergency site… But I think what we were clear on was there was a need to make a decision, so I think on our part we're very pleased that the system has endorsed the need to make a decision.

These quotes again show a general belief that the final option is desirable in terms of benefits to patient care, although the difference is considered relatively marginal.

There were a few participants, all from the Bloughton side of the change, who broadly shared the belief the final option is the right thing to do, but also believed a better final model could have been achieved. For two of this group, this was specifically with respect to the location of Women and Children's (W&C) services. As part of the new model, W&C will be moved from the Bloughton site to Whitdon. However, this had been opposed by some. Indeed, earlier on in the programme the two CCGs had been deadlocked partly because of this, and this eventually led to the introduction of independent clinicians to break this deadlock. Reflecting on whether they were happy with the final option, Rowan, from Bloughton CCG, stated:

> Yes and no is the answer to that. So it wasn't my ideal outcome. However, I'm very clear that quality and safety of care for our population will improve as a result of it. So it's going to be better than what we've got now. I think it's an awful shame that we ended up having to throw the Women's and Children's centre into the move, but in the end the things that make the most difference to

> obstetric outcomes are not where the consultant unit is, but what women's health is like preconception and antenatally… it does seem unfair to me that we're taking it away from the place where the highest percentage of deprived families live.

Rowan described a list of mitigations Bloughton CCG has secured to lessen the perceived impact of moving W&C and make it possible to support the preferred option, including travel, accommodation and paediatric cover. Morgan, also from Bloughton CCG, shared a similar view regarding W&C. While she agreed the option is right, particularly with respect to the need to separate out emergency and planned care, she also had a caveat regarding W&C:

> Yes I do think the option that has been signed off is the right thing to do. In terms of one emergency centre, the idea of having the staff with the right skills in the right place, that the patient goes to first time… but there are some things that don't sit comfortably with me personally, particularly around Women and Children's…, it was [originally] determined that it would go to Bloughton because that's where the population health need was the greatest, and now we're saying it has to move because it has to be aligned to ED… That's been a personal rub for me, because I think there could've been ways around that.

Despite these reservations, it is important to note that Morgan was predominately positive about the preferred option.

First order moral belief: Joint working and Moving on Up

Inter-organisational working formed a core part of the service reconfiguration, and participants held several moral beliefs regarding how different organisations had worked together over the course of the programme. I will now explore these in four parts. The first will examine the extent to which participants felt that 'partnership working' is desirable. The second will consider participants' evaluations of the behaviour of Bloughton Local Authority (Bloughton LA), which were largely negative. The third will look at interviewees' belief in the

rightness of developing community services. The final part will consider participants' views regarding the appropriateness of the inclusion of Grenham in the reconfiguration.

Joint working: Partnership working is desirable, but so are trade-offs

Several participants expressed a first order moral belief in the desirability of different organisations working together to serve a greater population. Indeed, this was set out as a central principle in the terms of reference of the JGB, which states that the programme is a collective enterprise where organisations involved work together toward shared goals (Moving on Up Joint Committee 2018). At the same time, the terms of reference also acknowledge that individual organisations will have their own priorities and populations that will also be 'considered' in joint decision making. This highlights a tension which came up repeatedly between the perceived desirability of partnership working and the appropriateness for organisations to focus on the interests of 'their' populations. To resolve this, participants often appealed to the language of 'trade-offs'. For example, when discussing how joint working has been 'excellent' over the life of the programme, Ashley (programme team) stated that joint working had been more difficult at certain 'crunch points' where decisions had to be made. She explained that in these situations:

> That's when you got challenge on what's in the best interest of the whole population and this principle of, you know, trade-offs.

This commitment to trade-offs therefore highlights the importance of compromise based on competing organisational priorities, rather than complete commitment to shared goals. In this way, the term was often used to signal the practical limits of partnership working. Indeed, some participants felt individual organisational interests represented more of a driving force behind the programme than any shared goals. Specifically, that partaking in the programme was a route for securing funds for services in desperate need of investment. This more

negative evaluation of the quality of partnership working in the area came across strongly in Elliott's, from Whitdon CCG, account:

> I think partnership working in the area is abysmal... partnership working is an issue, there is a lack of trust between senior leaders across all organisations [involved] which hasn't helped. So Moving on Up has survived *despite* the problems with partnership working in in the area… I think everyone's agreed Moving on Up has to happen, so they've got it over the line, but it would've been easier if there'd been better partnership working.

This quote shows a scepticism as to the extent to which organisations involved in the service change had been able to embody this principle of partnership working. This again underlines the tension for many participants between the desirability of working towards shared goals, and the responsibilities individuals have to their own organisations.

Joint working: Bloughton LA has not behaved well

A common belief across the majority interviewed was that the Bloughton LA has behaved poorly towards the programme. Throughout the programme Bloughton LA had not taken its seat on the PB and was publicly opposed to the reconfiguration. Most participants therefore believed the LA's engagement with Moving on Up to have been unconstructive and damaging. Indeed, several participants believed Bloughton LA had actively misled the public in their opposition to the programme, and the majority saw their motives as questionable in some way. For example, when talking about the feelings of the Bloughton public towards the programme, Dylan believed the LA had actively spread disinformation to the public while pursuing a 'political' agenda. She gave the example of a misleading flyer:

> So what's happened in Bloughton, for example, is Bloughton council produced a flier, and they mailshotted all of their households in Bloughton with this flyer, which basically said, I mean there's been a lot of propaganda you know 'lives are going to be lost, babies are going to die', all this kind of emotive stuff. So

> they produced information with this kind of message on, which isn't true and isn't helpful. But… it plays on their [the public's] fears.

When asked for specific examples of opposition of the LA and local campaigners to Moving on Up, Terry, Whitdon CCG, also said:

> Either manipulation of stories to the press, or on social media, or legal challenges, or written challenges or, you know, politics being played out in the media for effect.

The use of terms such as 'manipulation' and 'propaganda' denote negative moral evaluations of the LA's behaviour, and these reflect a general consensus that they had not behaved well. Despite this, a minority expressed a more neutral or even understanding position. For instance Eli, from Bloughton CCG, reflected on how he sometimes defends the position of the LA to NHS England:

> I think the council is really interesting though because, and I think this is the same for any council anywhere, and this is not being critical. Unlike me they have to get elected. So the kind of conversation you can have in private is very different to what they will be able to say publicly. And at the moment, I keep saying to colleagues in NHS England when they started moaning about 'the difficult council', I said 'hang on a minute, you have to understand here, this is a council that currently has got a very thin majority. It's up for election next May, and it's the whole council that goes up for election.'

This position casts Bloughton LA in a more reasonable light in terms of the pressures they work within, and does not seem to contain any negative evaluation. Alex, Community Trust, took this a step further was probably the most sympathetic, framing Bloughton's actions in terms of loyalty to the public:

> So some of the people in Bloughton [LA] that I talked about earlier… they may personally or privately agree with the evidence in front of them, but their value

> base makes them come out in support of [Option 2]… and I don't think that's a tribal issue… it's probably a different value of loyalty, or public service. So they can see the politics in their own patch, with a small p not a big P, playing out and the public saying 'this isn't right for Bloughton', even if there's a scientist and they can see on paper 'oh actually it does actually look as though its better'… they're hearing the people of Bloughton, because most of the people of Bloughton couldn't articulate why they think it's better, its emotional.… They're buying into the emotional torment. Or they feel loyal, fundamentally loyal to the place that they live.

This shows a belief that Bloughton LA's actions are understandable in that they are representing the feeling of their electorate, referred to here as their 'tribe'. However, these more positive views of Bloughton LA were in the minority, and several interviewees had a poor view of both their motivations and actions, seeing these as based on narrow political interests and often promoting misinformation. This therefore represents a general first order moral belief that the behaviour of Bloughton LA has been wrong and inappropriate.

Joint working: Community and preventative services should be developed

Many participants noted that the Moving on Up programme had originally been a broader programme looking at reforming both community and acute services. Indeed, several participants expressed support for the principle of moving services into the community as a means of focusing on prevention and long-term conditions management. This was usually based on the idea that the only way of truly addressing the financial issues of the Acute Trust is by improving people's health and preventing admissions. For example, Ashley stated:

> We all know that acute hospitals are not the only solution to improving health. They're there when all else fails, that's my view. I know it's a philosophical view, but if you sort out people in terms of early prevention and people looking after themselves, hospitals become less used don't they? Because you stay well for longer.

Several participants commented that this principle of prevention and moving services into the community was enshrined in the original conception of Moving on Up, mainly because 'keeping care closer to home' had been a key component of the feedback to the original Call to Action consultation. In his response to being asked about the drivers behind Moving on Up, Danny, Whitdon CCG, stated:

> It was driven by necessity to some extent, we just couldn't get the staff to sustain the current provision of services. But [it was] also initially very much driven by 'how can we better provide health provision in Whitdon and Bloughton and Grenham'. And a lot of that was about … effectively [moving] services out of the acute setting [and] more into the community setting... And obviously the latter part is a separate programme of work from Moving on Up, but originally it was a part of Moving on Up.

As suggested by Danny, as the programme progressed it came to focus more on acute services, and the community element got separated into a different programme. For most participants who spoke about it, the separation of the two programmes was presented as a practical decision based on the complexity of keeping the two together. This implied that, ideally, they would have been kept together, but this had not been possible. This point is again summed up by Danny who stated:

> That [the two programmes becoming split] happened really because…of the way the programme stalled in the early days when it was this all-encompassing [thing]... And then, it was sort of pushed back by NHS Improvement because it was deemed unaffordable. And therefore it sort of went into a stagnation phase for a period of time. And then became… largely an acute project more led by the Acute. So in a sense … that sort of all-encompassing view got squashed to some extent from the reality of 'this as a whole isn't affordable at the moment so you have to look at other ways of doing it'. So that split happened really at that stage.

Such a view amongst participants was usually coupled with the assumption that the community work would still be carried out, just in a separate programme. They also stressed the importance of developing better community services for the future of the local healthcare economy in general.

Despite this, it is also important to note that a small minority of participants expressed concern about the prospects of the community reconfiguration and believed Moving on Up had actively taken attention away from this. For example, Alex generally agreed that the community component had been dropped because it made the programme too big and unwieldly. However, she was frustrated with how this had led to a complete focus on the Acute Trust. As she expressed:

> It's been entirely frustrating that there hasn't been the airspace or the focus to actually do something different. I've also seen it as a massive distraction in the system to doing another other sort of transformation.

This shows a fear that Moving on Up is the wrong focus for the local healthcare economy. Kit, from Whitdon Community Representation Group, expressed a similar view that the focus of Moving on Up had been wrong and it had got in the way of more ambitious transformation:

> I just get so dismayed when there is no emphasis on empowering people to look after their own health, and helping them to do it... And I do feel very strongly about it, and I just feel that we've missed so many tricks in [the area] from being focused on the buildings and… improving the facilities, rather than redesigning the services.

No one else stated the belief that the Moving on Up programme had distracted from a broader transformation. However, these opinions do reflect a general belief that developing community provision is extremely important to ensure the quality of services are improved across the local healthcare economy.

Joint working: The inclusion of Grenham is appropriate

As stated earlier, Moving on Up was designed to make decisions on behalf of three areas (i.e. 'populations'): Bloughton, Whitdon and Grenham. These areas are all roughly on the same latitude, with Bloughton to the east, Grenham to the west, and Whitdon in the middle. While Whitdon and Bloughton have traditionally shared several services, Grenham is seen as more separate. The decision to include them in the transformation therefore sparked some controversy within the reconfiguration. As Eli reflected:

> Bloughton don't like Grenham, because they think that small component of Grenham influences the decision… disproportionately. I personally wouldn't necessarily agree with that, because actually I think even if you took Grenham out of the equation, where would you strategically think about is the best site for an emergency department for [the area]? [hypothetical question]

According to Eli, when the programme was formed many from Bloughton CCG believed that, because of the geography of the area, the inclusion of Grenham made it more likely to have the A&E in Whitdon. Whilst most of those interviewed as part of this study, including those from the Bloughton side, believed the inclusion of Grenham was appropriate, one - Manny, Bloughton CCG - did not. He stated:

> And there was huge, huge debate…about, for example, blue lighting, and again the wretched business of how this was going to affect the patients of Grenham, and I used to get very very irritated about that, because this is a Whitdon and Bloughton problem, not a Grenham problem, and [that] the problems of people living out in…Grenham should therefore skew the centring of the… A&E department to Whitdon, rather than for example in in in Bloughton was just very difficult to swallow.

Here the feeling of Grenham's inclusion being inappropriate and wrong seems rooted in a sense of 'them' (Grenham) and 'us' (the rest). While only one interviewee stated support for

this opinion, others suggested that this view is more common among those in Bloughton CCG not immediately involved in Moving on Up, or at least was at an earlier stage of the programme.

First order moral belief: Interactions with the public

Two prominent first order moral beliefs relating to interactions with the public emerged from interviews. The first was that the consultation was good. The second was that campaign groups and Bloughton LA had behaved badly by distorting the programme's communications with the public.

Interactions with the public: The consultation was good

When asked, the overwhelming majority of participants believed the public consultation had been good. This was both in terms of the way it had been carried out, and the number of responses. For instance, Al, from Bloughton Community Representation Group, commented that it had been a good consultation process, reflecting that:

> I've found the programme to be very effective. And… stakeholders have been involved at every stage. And a lot of effort has been put into getting into those hard to reach elements of the community.

Indeed, there was a general belief that the consultation had been comprehensive in gaining feedback. Morgan (Bloughton CCG) even jokingly suggested it may have gone too far, stating:

> We've made sure that we've covered all bases as much as possible. So we probably went way over the top in terms of public consultation. And certainly here in Bloughton we did far more than our Whitdon colleagues did because we knew the challenges that would come from our public and from our local

> authority, so we really went all out to support those events, to have our faces seen in public, to answer our public's questions.

This effort to get responses off as many people as possible, including hard to reach groups, was a particularly important marker of success for participants, as I will discuss in more detail in the next chapter.

Interactions with the public**:** Opposition groups have behaved badly

As I have already noted, Moving on Up was a controversial change and there was significant opposition to it in responses to the public consultation, mainly from the Bloughton area. Participants tended to see this opposition as rooted in a desire to have an A&E unit nearby, and a lack of understanding of the benefits of the programme. Dylan stated:

> When it comes to the NHS…everybody wants everything close to them. Even if it will mean better care for patients… people still seem a little blinkered and they still want it on their doorstep, even though it's probably not going to be the same standard of care.

Despite a belief that the public does not fully understand the change, participants did not tend to blame the public for their lack of understanding. For example Fred, Grenham Commissioner, when asked about why he thought some members of the public opposed Moving on Up, said:

> if I think of, just from the perspective of being a resident human being, the local availability of a blue light ambulance A&E is an enormous personal reassurance. Why would I ever want it to be further away?

While participants did not tend to blame the public for their perceived lack of understanding, they did see 'campaign groups' and Bloughton LA as playing a large part in creating and reinforcing this misunderstanding. Rowan, Bloughton CCG, reflected on the actions of

campaigners in depth when asked about her experience of the public engagement side of Moving on Up:

> Again variable. Sometimes it's been relatively easy, but you've always got these pressure groups, who frankly make life very difficult, and I have observed wilfully twisting evidence and presenting it as facts and just generally taking up a lot of time and energy that really we could've best used in other ways. When we were going to the consultation, quite frequently we'd go along to events and have really useful conversations with individuals, but conversations we've had in public…tend to be taken over by this group of people who, really, were never going to accept anything.

Campaign groups and the LA were therefore seen to have behaved badly by using 'distorted' and 'biased' messaging to turn the public against the programme. This was seen to be driven by a perception that Moving on Up was driven by austerity, a characterisation that many participants objected to. For example, Morgan argued:

> Our campaign groups are taking that political stance that we're underfunded and that…we shouldn't be making these cuts, and for us it's never been about cuts. It is about getting the best care possible for our population, because we're not now [with the current configuration of services]. There is a grain of truth, I often read them and I think 'god, you're right'… but as you read further through the argument it starts to become muddied into 'this is all about austerity' and … it was never about austerity. Yes we've got to reduce our spend[ing], but that was never the key driver for this programme.

This reflects a general perception among participants that the opposition of campaign groups and the LA to Moving on Up is driven by political motivations and based on a flawed understanding of the programme. I will return to these issues in more detail in the next chapter.

This concludes my discussion of the most prominent first order moral beliefs associated with Moving on Up. I will now turn to the lay morality of participants which, as I will show, is related to these beliefs in several ways.

5.3 Lay morality

In this section I seek to answer the following research question:

3. What are participants' lay moral commitments?

I will answer this by building upon the examination of first order moral beliefs in the last section. Here I will identify the elements of these beliefs that were commonly expressed with a high level of passion and conviction. This makes it reasonable to conclude they are part of a participant's lay morality. I have identified three common lay moral commitments among participants: doing what is best for patients; making decisions that are fair to the population; and responsible stewardship of public finances. I will now take each of these commitments in turn.

Participants expressed a strong and near universal commitment to doing what is best for patients. This was often implicitly presented as an ethical 'bottom line', and interviewees clearly saw this as a fundamental aspect of their role in planning a service change. This was reflected in the multiple references participants made to improving patient outcomes throughout interviews. Indeed, some made explicit reference to how this underlying commitment formed a core common thread among all those involved, despite differences in agendas and interests. As Riley stated:

> I think, every organisation had a different agenda and a different reason for getting it [the programme] through... So they've all got different reasons for why they want to do something… And I think the other bit is, 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.

The improvements to patient care participants expected to come from the programme was also persistently used as a moral justification for other beliefs, further showing the importance of these considerations in determining what is right. For instance, the benefit of improving staffing was often framed as good because it would make the Acute Trust a better place to work. However, this was mainly believed to be a good thing because it would make it easier to attract staff and cover rotas, which in turn would improve patient care and access. This is reflected by Eli, a senior manager within Bloughton CCG, who stated:

> And actually, you come to [the area] and you’ve got two A&E departments, both with a rota, which is going to mean effectively you’re going to be on call at… well at its worst it was on call once every third night and once every third weekend. You’re a newly qualified consultant coming out, where are you going to pick to go? Because actually what do you want when you’re a newly appointment consultant? You want support from senior colleagues…Well you’re going to get that in a department of twenty-five. It’s very difficult to do that in a department where spread over two sites you’ve only got four consultants, for example. So workforce was a huge driver. But actually the imperative was about ‘how do we improve clinical outcomes for patients?’

This therefore further shows how the view of doing the best for patients was deeply embedded in the perspectives of interviewees. This was so much so that it acted as an ultimate justification for other moral beliefs, such as the belief that the Acute Trust should be a good place to work.

This was accompanied by an underlying view on fairness which dictated that decisions about patients need to be done on a population rather than individual level. This is reflected in the

multiple references throughout interviews to doing the best for ‘our population’ and making planning decisions that will match population need. Indeed, one participant made a distinction between this perspective and the view of a frontline clinician, who may be more orientated to see the perspective of the individual. Danny, when reflecting on what the process had been like for voting members of the JGB who are also GPs, said:

> A GP has patients who come into their surgery, and they would be taking the view of ‘Oh how am I going to say to these patients I’ve voted for a decision’…basically a lot of those patients are going to think that’s not the right decision. So in a sense they have a more obvious [connection to individual patients] in their day to day role, they represent a particular subset of the population, and therefore it’s more difficult to take a broader view and then be able to justify that.

This shows that a commitment to making decisions that are seen to be in the best interests of the whole population, rather than individuals within it. However, as I have already touched upon and will explore more in the next chapter, there was some variability in perspectives on what constitutes this population. There were two competing definitions that participants grappled with: the view that priority must be given to ‘the greater good’ of the combined population of Whitdon, Bloughton and Grenham, and the view that individuals should serve the population their organisation is solely responsible for. Regarding the latter, this was often defined as a kind of loyalty, with one participant even referring to the influence of ‘tribal’ loyalty on how the service change had progressed. For instance, Alex, from the Community Trust, reflected:

> If you think of an organisation as a tribe, so that’s the patients that they are responsible for or whatever it happens to be. So that tribal value plays out a lot.

Some participants argued that this form of loyalty may be particularly deeply embedded for those who have a longstanding association with the areas involved in the service change

and this could lead to rivalries, conflict and suspicion. For example, Eli noted the historic rivalry between Bloughton and Whitdon, and how this had impacted on the service change process:

> When I first came to Bloughton one of the first things I said to my then chair was 'there's a real inferiority complex about this place'… and he said 'you need to understand the context, there's people with long memories here… when it was a county council and a Whitdon Health Authority there was never any investment into Bloughton'…and he said 'you're still dealing with that'.

This helps show that, while there was a widespread lay moral commitment to serving the interests of patients based on what is best of the *whole population*, there were clear differences in how individuals defined this population. This seemed to vary between individuals, with some possibly experiencing stronger affiliations to a certain locality than others.

Finally, there also seemed to be an underlying lay normative commitment to what might be termed *the responsible stewardship of public finances.* That is, a belief in the need to make services as efficient and effective as possible within the resources available to them. This related both to the present and future state. In relation to the present, this manifested in a belief that a plan is not right unless it fits with available resources. For example, a member of Boughton CCG stated:

> I do believe the vision is the right vision, it's the right vision to go forward, because we have a limited amount of workforce, we have a limited amount of money, and we have to cut our cloth according to our purse.

Whilst other interviewees did suggest a high level of commitment to this idea, it was when talking about future efficiency and effectiveness where the most passion and commitment was communicated. This often took the form of arguments for better preventative and

community services that channel demand away from acute hospitals. This idea seemed to energise many participants and is compatible both with the desire to make services more efficient and effective, and with the desire to improve services for patients. This view is summarised by the following quote from Eli:

> There's two aspects to that [moving services out of the acute sector]. There's the aspect of 'how do we provide care locally'… but actually I think there's a much greater prize to be had in saying 'how do we keep people well?' So how do we … encourage people to self-care, self-manage, use technology in a different way that stops them getting admitted in the first place?

Such a view was presented by several participants as a way of improving services for patients and preventing costly acute admissions. It therefore communicates two lay moral commitments: to improve services for patients and to manage public finances responsibly.

Conclusion to chapter

In this first analysis chapter I have sought to answer the following research questions:

1. What relational structures (formed by constitutive rules) are most significant in the Moving on Up programme?

2. What are the most prevalent first order moral beliefs associated with the service reconfiguration?

3. What are participants' lay moral commitments?

With respect to the first research question, I have argued that there are five prevalent relational structures for the research to take account of. These are:

- The way the CCG JGB is structured to make and authorise decisions.
- The PB and its process for recommending decisions.
- The configuration of the CCGs and the various accountabilities they are subject to.
- The NHS England service change process for authorising service reconfigurations.
- The rules that structure the consultation process, particularly the right of local authorities to challenge outcome of the consultation process.

It is important to note that all these relational structures are *hierarchical* in some way. Together, the JGB and PB were structured in a way that gave them ultimate decision-making power over the final plans for the service change. Equally, the way accountability relations within CCGs are constituted also essentially create two power relations: one to the Secretary of State, and one to member practices. The NHS England service change process also had an important influence on whether the service change proceeded, particularly because of NHS England's decision-making power over capital investments. Finally, the rules around consultation also gave Local Authorities some limited power over CCGs in their ability to appeal the outcome of the consultation process.

With respect to the second research question, I have identified three sets of first order moral beliefs. The first relates to various beliefs about the programme being a good thing. This includes: a belief that centralisation is good for patients; a belief that a two-site model is more desirable than the alternatives; and the belief that Option 1 (emergency services in Whitdon, planned services in Bloughton) is more desirable than option two (emergency services in Bloughton, planned services in Whitdon). While there was a large amount of consensus surrounding these beliefs, there was also some disagreement, particularly regarding the location of Women and Children's services. I will explore the reasons behind this disagreement further in the next chapter.

The second set of first order moral beliefs relate to how organisations worked together as part of the programme. This includes the belief that working towards shared goals is desirable, but so are 'trade-offs'. This also includes the idea that Bloughton LA has not behaved well throughout the programme, and that Grenham's inclusion is appropriate. Added to this, many participants believed it desirable to develop community services, although several participants acknowledged that this had not yet been fully realised in the programme. Each of these first order beliefs raises interesting issues to elaborate in the next chapter.

The final set of first order moral belief I discussed relate to the programme's interactions with the public. Here I identified two prevalent first order moral beliefs. The first is the belief that the consultation was good, mainly in terms of its reach and response rate. The second is that the LA and campaigners have behaved badly by spreading misinformation about the reconfiguration and so obstructing the programme's communications with the public. This discussion also revealed a large contrast between the perceived moral culpability of members of the public who opposed the change (who were generally seen as innocent), and opposition groups who had opposed the change (who were generally seen as morally culpable for this). I will discuss the reasons for this contrast when exploring the moral background of the programme in the next chapter.

With respect to the third research question, I have tried to draw out the most strongly held moral concerns of participants. These are: to improve services for patients; to serve the interests of the population (rather than individuals); and a commitment to the responsible stewardship of public finances. I also began to explore how the meaning of these underlying commitments is influenced by other understandings, such as how a 'population' is defined. I will explore these issues in more detail in the next chapter.

6. The Moral Background of Moving on Up

Introduction

In this second analysis chapter I aim to answer the fourth research question:

4. What is the 'moral background' of the first order moral beliefs of participants?
    a) What is the role of duties, ideals, thick moral concepts, and legitimacy within this?
    b) What is the role of para-moral phenomena?
    c) How does this relate to the lay morality of participants?

In this chapter I will therefore continue to focus on abductive theoretical redescription of the research data. However, through answering the sub-questions I will also begin the process of retroductive inference, wherein I will start to identify the underlying causal powers of the various types of moral and para-moral entities I identified in the Theory chapter. In line with the overall approach I outlined at the start of the analysis chapters, I have also structured the chapter to work from the most to the least empirically visible background phenomena. I have therefore split the chapter into the following sections:

1. Groundings (including ideals, duties and the legitimate authority of regulations)
2. Conceptual repertoires (thick moral concepts)
3. Object of evaluation
4. Meta-ethical objectivity
5. Metaphysics

As part of this, I will explore the internal links between these various background elements, and participants' lay moral commitments. Doing this will allow me to explore the multi-level nature of morality within the service change. It will also help build to the final chapter, where I

will explore how this multi-level morality is entwined with economic (i.e. relational structural) phenomena within the Moving on Up programme.

Please note that of the six dimensions of the moral background I outlined in the theory chapter, I am only exploring five in this chapter. I have left out 'method and argument' because, while I did include this dimension in earlier drafts of my thesis, on reflection it does not add significant insights to my overall analysis.

6.1 Groundings

Groundings are the reasons and justifications that often accompany first order moral phenomena; and individuals often invoke these understandings to explain why a certain belief or practice is right and good (Abend 2014: 34). These reasons come from 'a common cultural store of accounts' and represent a general underlying consensus as to 'what counts as grounding for a normative view' (p.36). As I explored in the Theory chapter, meso and macro-level moral phenomena may manifest as groundings in the form of duties, ideals and legitimate authority respectively. However, the reasons that justify first order moral beliefs are not limited to such understandings and can also relate to more practical issues, such as material constraints. As I also explored in the Theory chapter, groundings can be causally efficacious, or they can be applied post-hoc to justify a decision. Thus, they may be invoked instrumentally or out of genuine belief in the justifications used. This is an issue I will return to in much greater depth in the next chapter.

In this section I explore the most prevalent groundings used to justify the first order moral beliefs I outlined in the last chapter. These are:

1. *Evidence that the service change will improve patient outcomes* – Participants regularly used the grounding that the service reconfiguration is backed by evidence to explain

why the programme is a good thing. They often invoked the idea of evidence-based decision making when explaining why the change is good for the population of patients they serve.

2. *Clinical opinion* – Participants persistently argued that the reconfiguration is supported by clinicians, and this group was presented as having large degree of moral authority, to the extent that their opinion was almost treated as sacred. This moral authority was also drawn upon when resolving disagreements within the service change and seems to have been enshrined in the regulatory rules of the programme.

3. *The need for services to be sustainable and affordable* – The term sustainability was used in two ways by participants to justify first order moral beliefs. The first way was as a synonym for financial constraints. The second way was as an ideal: to signify a future where services are better at keeping patients healthy, and costs are lower as a result.

4. *Politics and the expert ethos* – The 'expert ethos' constitutes an amalgam of the first three groundings. It is a term I have devised to describe the moral worldview of participants, wherein they framed their support for the reconfiguration as primarily driven by a transparent, unbiased weighing of clinical evidence and opinion. Participants presented this as leading to unbiased, impartial decisions: doing what was best for patients within the resources available. As such, drawing on expert opinion was considered a more desirable way of making NHS policy decisions, when compared with decisions based on 'emotional' and 'political' factors. This ethos also acted as a grounding for the belief that the consultation had been good, because it had gathered as much evidence as possible to inform, rather than drive, expert decision making.

5. *The ideal of the 'greater good' versus duty to a specific population* – These two competing groundings lay behind the first order tension I discussed in the last chapter between partnership working and 'trade-offs'.

Grounding One: Evidence that Moving on Up will improve patient outcomes

This grounding holds that evidence shows, with a high degree of confidence, that the planned changes will improve patient outcomes for the populations served by the service change. As such, it played an important role, rhetorically at least, in how participants realised their lay moral commitment to improving services for patients in a way that is fair for the whole population. The detail of this evidence was generally not explored in the interviews. However, the range of evidence drawn upon in justifying the programme is presented in the Pre-consultation Business Case (Moving on Up 2017). This includes:

- Learning from past re-configurations - this largely consists of anecdotal accounts of past centralisation exercises that have improved outcomes for patients.
- Best practice guidance – This argues that the proposed model of care will conform with best practice, thus achieving the potential gains outlined in these documents.
- Compliance with national policy and guidance - Similar to the above, this argues that the new service design will adhere to national policy and guidance, including NICE guidance regarding best practice.
- Multiple benefits arising from new patient pathways and flows (i.e. the clinical model) – This is the largest and broadest area. It contains several claims based on assumed benefits of the new model. For example, the document argues that the new configuration of planned care will lead to a reduction in boarded patients (patients placed in the wrong ward), and then cites evidence to argue reduced boarding will improve performance on mortality, emergency readmission and inpatient discharge timing. Similarly, it also claims reduced boarding will reduce patient moves, and then cites evidence that reduced

patient moves will reduce length of stay. This, in turn, will increase the availability of beds and reduce cancellations, therefore improving patient outcomes.

While the above evidence relates to the merits of a two-site model in general, the public consultation document also provides justification for why Option 1 is preferable to Option 2. This mainly relates to matching patient need with the geography of the new configuration. For example, it argues that a travel time analysis shows Option 1 will involve fewer 'time critical' journeys for patients than Option 2. It is also argues that having emergency care at Whitdon is important in terms of the Trust's position in the region's wider network.

There was little variation between the position set forth in official documents and that put forward by participants in interviews. Most of the claims that Moving on Up will improve patient care were based on assumptions regarding how the new model of care will work and the benefits associated with this. This includes projections regarding capacity, demand, flow, finances and pathways. Taken together these factors were referred to by participants as the 'clinical model'. Participants predominantly expressed high confidence that the new organisation of services will lead to better access and outcomes for patients. As Morgan, from Bloughton CCG, stated:

> In terms of one emergency centre, the idea of having the staff with the right skills in the right place that the patient goes to first time… So I know from the work I do that patients are not getting the best care that they *could*, I'm not saying its poor care, I'm just saying it could be better, given the resources that we've got. So I think that having one emergency centre is the right thing to do. 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.

Here the new model of care is justified in terms of clinical benefits that will emerge from the reconfiguration. Leslie, from Grenham Commissioner, shared this view, arguing for the merits of the two-site model by stating:

> For me the driver was the emergency pathways… so if you look at the emergency pathways… [we have to] organise ourselves in a way that minimises a negative impact or reduces the risk to the population. If you ever look at the clinical evidence base it is clear that for the [shared] population the [single] emergency centre [is preferable].

Here Leslie refers to a clear clinical evidence base to support her beliefs that the two-site model will be better for patients. This was a common reason in interviews for supporting the change, and participants tended to show a high degree of confidence in this evidence. For example, Danny stated:

> I think everyone could justify, quite rightly… because… the whole recommendation decision is based on very sound clinical evidence, why it's the right thing to do. But there will be individuals, you know in the public, who will say 'well you've just made life more difficult for me as an individual' and it's that balance between what's right as a whole doesn't mean that it's right for every single member of the population.

As is implied by Danny's account, 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, one participant – Terry, Whitdon CCG - even questioned the idea that the programme had been justified to the public at all. Instead he implied that communications to the public had simply been the presentation of a logical process. When asked about how the service change had been justified to the public, he argued:

> I'm not sure it's 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'.

Here the process by which the decision had been reached is presented as a natural output of following the evidence. It reflects a general confidence by those interviewed that evidence shows the new clinical model will improve patient outcomes.

Grounding Two: Clinical opinion

The idea that the programme is supported by expert, clinical opinion was also a major grounding for the belief that the programme is the right thing to do. This again appeared to act as a way of channelling an underlying concern for improving patient outcomes into concrete decision making. This was through the belief that practicing clinicians have privileged knowledge of what will improve patient outcomes. As such the term 'clinical' was often invoked as a general ideal to communicate moral desirability or appropriateness, a point I will return to when examining clinical as a thick moral concept in the next section. Within this, *clinicians* were held to have a high degree of moral authority in determining the best course of action for Moving on Up. In practice an appeal to the moral authority of clinicians was often used alongside evidence – for example by the consistent use of the term 'clinical evidence'. However, this was also an important grounding in its own right. It was seen to be particularly important in justifying the two-site model to the public. For example, when asked if being a clinician helped when persuading people about the merits of the service change, one clinical manager stated:

> I think being a clinician adds a whole amount of kudos and gravitas, and weight. I think people do pay more attention because I'm a clinician, particularly because I can give examples of how it affects how I provide services for patients. And that, whilst it is actually a very small part [it] actually provides

> quite a lot of leverage and persuasion…. People can disagree with what we say but ultimately if they're not clinicians and it is a clinical model, then being a clinician is very powerful really.

Other participants also pointed to the nature of the programme as supported by clinicians as a key justification for the two-site model. For example, Elliott (Whitdon CCG) summed this up well when he stated:

> 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 clinician's views…lots of issues have been discussed 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.

Here the two-site model is not just justified in terms of evidence, but also because it is supported by clinicians. A clinical perspective seems to be more valued than a managerial perspective because clinicians are seen to better represent the interests of patients. As Riley, a member of the programme team, stated:

> Some people will never be reassured, irrespective of what happens, but the clinicians from the Acute Trust fully support the model – anyone who knows clinicians will know that they will never put anyone at risk, it's just not in their psyche to put others at risk, but they acknowledge that something has to change to improve healthcare services in this area.

Here clinicians are presented as inherently trustworthy and motivated by patient need, the logical implication being that if they support an option it must be in the best interests of patients.

It was also clear from interviews that the moral authority of clinical opinion had played a key role in resolving differences within the service change, particularly when it came to the

contentious issue of where to place Women and Children's (W&C) services. As I discussed in the previous chapter, despite initial resistance from Bloughton CCG, the programme had eventually decided to move W&C services to Whitdon. The main justification from participants, even those who did not necessarily agree with the decision, as to why this was justifiable was *clinical opinion*. Namely, the position of the Clinical Senate on where W&C should be located. As Morgan recounted when asked about the decision to move W&C services:

> So a full…impact assessment was completed, and that clearly showed that the demographic need was highest in Bloughton. I think Bloughton PCT had fought long and hard for the Women and Children's centre to be here, based on that evidence. The review findings that were done subsequently were really linked into the Clinical Senate saying that Women and Children's needed to be aligned with the emergency centre, and I think that body of the clinical expertise strongly saying that was a real challenge then for our system to disagree with. And whether we would've got it through the approval processes, if we'd gone against a body of clinical support [is doubtful].

Here Morgan is not herself explicitly agreeing or disagreeing with the decision to have W&C in Whitdon. Instead, she is commenting on what is and is not justifiable with respect to the way the service change approval process is structured. NHS England strongly recommends that organisations undergoing service reconfiguration seek the advice of their local clinical senate when formulating their plans (NHS England 2018: 20). The moral esteem granted to clinical opinion is therefore not just a meso level understanding, it also exists on the macro-level of morality through being backed by the constitutive rules of the service change process. This gives clinical opinion both a moral *and* legitimate authority, and it is this legitimate authority which gives it the ability to arbitrate on what is best for patients when there is debate over how to interpret the evidence. This is a point I will return to in much greater detail in the next chapter, where I will explore the interaction of economic and moral phenomena within Moving on Up.

Grounding Three: The need for services to be sustainable and affordable

The term 'sustainability' was used by participants as a grounding in two ways. The first was as a synonym for affordability, to denote the material constraints the programme operated under. This was particularly used as a grounding for justifying why the two-site model is a better option than more costly alternatives. The second use of the term was as an ideal, signifying a future in which acute demand is lower because people are generally healthier. This was a grounding for the belief that developing community and preventative services is a good thing. As I discussed in the last chapter, this vision of service provision really 'struck a chord' with participants, resonating both with their lay normative desire to improve services for the population, and the desire to be responsible stewards of public finances.

With respect to the first meaning of sustainability, this stemmed from an awareness among participants of the structural constraints under which the programme operated. As Charlie, Whitdon CCG, stated when reflecting on the process for deciding on a two-site model:

> I think we initially went back saying a single site is the right answer. And they [NHS England] said 'oh no, I don't think so'. And then we said actually a hot and a cold hospital is the right answer, and again 'that's a bit too expensive, what other models could you come up with?'

He went on to say when asked further about the desirability of a single site model:

> I think all the clinicians would say a new single hospital in the middle that did everything, that's undoubtedly the best answers from a purely clinical and also probably geographical basis. Whereas it's not possible because it's not affordable.

Eli, Bloughton CCG, gave a similar account. When talking about proponents of a single site model, he argued this would not have been sustainable from either a financial or clinical point of view. As he stated:

> Yes, well it was one of the options that had been discounted, but people still go back to 'why can't you do the single site'. … People did say 'why haven't you included that in the public consultation? Why have you only put two options in the public consultation?' And what we said was 'we always said we would only go out to consult on options that were clinically and financially sustainable, and these are the only two'.

Participants were therefore of the view that the finances available for both the programme (in terms of capital investment) and long-term operational costs of the Acute Trust will not increase. This view had clearly been reinforced through interactions with NHS England. Indeed, 'sustainability' forms an important part of NHS England's appraisal process for service reconfigurations, meaning a plan cannot get approval without first demonstrating its affordability (NHS England 2018). As a result, in developing a shortlist of options prior to going out to consultation, those involved in the programme were required to eliminate all options, including a single site one, that were unaffordable in line with Department of Health capital investment manual guidance. Interestingly, participants did not tend to frame their experience of these regulations in terms of legitimate authority: a belief in the right of those above them in the NHS hierarchy to make rules. Instead, they mostly did not tend to perceive these financial constraints as a moral issue at all, but instead a factual one regarding the boundaries of what is practically possible. I will explore this in more detail later in this chapter when I discuss the objects of evaluation of the Moving on Up programme. I will also examine it in the next chapter, as this framing of financial constraints as a factual rather than moral issue represents a key aspect of entwinement between economic and moral phenomena in the Moving on Up programme.

With respect to the second, more idealistic, meaning of sustainability, this was a key justification for the belief that the healthcare economy should focus more on developing community services. Specifically, participants believed that developing community services could make healthcare more operationally and financially sustainable by reducing hospital admissions. As Ashley, a member of the programme team, said:

> We all know that acute hospitals are not the only solution to improving health. They're there when all else fails, that's my view. I know it's a philosophical view, but if you sort out people in terms of early prevention and people looking after themselves, hospitals become less used don't they? Because you stay well for longer.

Community services are therefore presented here as a potential solution to some of the perceived long-term demographic challenges to healthcare. This combines the idea of financial affordability with the idea of improved population health in general. This is presented as a virtuous duality where patients can receive all the care they need, within the resources available. It is distinct from a simple focus on immediate affordability, in that it frames financial and patient outcome goals as aligned rather than in conflict. This vision was articulated by Eli, who, when talking about the need for better long-term conditions management, argued:

> There's two aspects to that... There's the aspect of 'how do we provide care locally', and that could be around things like 'do people really have to go to outpatient appointments and follow-ups and those sort of things' or 'can people be discharged earlier', but actually I think there's a much greater prize to be had in saying 'how do we keep people well?' So how do we …encourage people to self-care, self-manage, use technology in a different way that stops them getting admitted in the first place?

Eli therefore argues for the merits of a 'paradigm shift' which will deliver a more affordable service and provide better care for patients. Such a view is also seen as supported by the

evidence, showing an overlap between these two groundings. As Danny stated when discussing the merits of developing community services:

> I think it was a… recognition that strong clinical evidence from elsewhere that actually keeping people out of hospital is the best way of providing health services to them… [which is] primarily driven by what is better for them clinically rather than financially, but there is obviously also a financial aspect that is… potentially cheaper you know if you can avoid people having to go into a hospital setting all the time.

Given these beliefs, it is perhaps ironic that the Moving on Up programme had shed the community element due to perceived practical constraints. Indeed, the two meanings of sustainability seemed to have come into the conflict here. As Danny later reflected, one of the reasons behind shedding the community element had been feedback from NHS Improvement, who had deemed it 'unaffordable'. This again shows the role perceived practical or factual constraints played in justifying first order moral beliefs, as these helped to define for participants what is possible and achievable.

Grounding Four: The expert ethos and politics

The groundings of clinical authority, evidence and sustainability were often used in concert by participants to underline their certainty that the service change is the best *possible* way of improving outcomes for patients. Together these three groundings formed an 'expert ethos': a meso-level belief that the service change is driven by a transparent, unbiased weighing of clinical evidence and opinion to arrive at the best possible option for patients. This ethos provided a lens not only for how participants saw their support for the programme as right, but also why those who oppose the programme are wrong. As such, the expert ethos also offered a grounding for the negative first order moral beliefs held about organisations and individuals who oppose the programme: mainly Bloughton LA and a prominent campaign group. These groups tended to be framed as motivated by 'politics' rather than expertise.

This view is summed up by Dylan's reflections on the programme. In one answer she stated that Bloughton council had been less involved in the programme than Whitdon council because of 'political reasons'. When asked to expand on any disagreements with the council and others, she stated:

> I think really what we've said already about the locations. Because, when it comes to the NHS… everybody wants everything close to them. Even if it [having services further away] will mean better care for patients, better outcomes for patients, people still seem a little blinkered and they still want it on their doorstep... So I think where the conflict has come from is the suggestion that services might be moved away from where they currently are and where they're nearer to people.

When I asked if she felt this was motivated by a sense of fear, she said:

> Yeah, 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…I do think a lot of it is politics. I think a lot of it is councillors and other politically active people, shall we say, who sort of almost encourage fear when it's not necessary.

Opponents of the change were therefore framed in interviews as indifferent to the evidence, and more interested in responding to public anxiety. While some presented this as an understandable enactment of the LA's role in representing the public, others argued it to be based in a calculated attempt at seeking re-election. For example, Charlie believed a large reason for Bloughton Council's opposition to the programme was that 'they're looking to their elections this year'. Equally when reflecting on Bloughton LA's opposition Ryan, a member of Whitdon CCG governing body, stated:

> The stance that has been taken on some occasions by the council overall in Bloughton… has sometimes seemed to be more confrontational than trying to

> get that cooperative point of view to get the best for the people. Now… it's a difficult situation for that council. They've got elections coming up. They have a narrow majority, the current administration. So understandably standing up for the people of Bloughton is key, but linked to that may be that for those political parties an eye to the election, but also occasionally we've found that information is misrepresented. Now whether that's deliberate or accidental that's harder to tell.

Here Ryan expresses a belief that Bloughton LA has exacerbated the situation by presenting evidence in a misleading way. This may or may not have been deliberate but, regardless of their motives, he clearly feels that the LA has not been primarily motivated by the interests of patients and public in the same way as those involved in the programme.

Similar criteria were also used to describe historic internal opposition to the inclusion of Grenham in Moving on Up by some members of Bloughton CCG. For example, Leslie, from Grenham commissioner, framed the opposition to the inclusion of Grenham as wrong when she stated:

> I think it's possibly because it's about politics [laughs]…. There was so much disinformation at one point, people saying 'well you don't pay for services from the Acute'... I think partly lack of information, disinformation, and I also think if two [other] communities [Whitdon and Bloughton] are very close to each other… it may be easier to direct some of the anger and upset towards the [one that is] further away…. If you think about some of the relationships, these people work with each other day in, day out, and suddenly, we're probably the most distant, and therefore it may be easier just to direct some of that [anger].

Here again the term 'politics' is used to denote an inappropriate view. The term is again used in conjunction with the idea of misunderstanding. However, in this respect it is a misunderstanding of the level of income Grenham commissioner provides to the Acute Trust, thus justifying its inclusion on the Programme Board. As Leslie also argued:

> For us some of the trickiness is that many [from Bloughton] have turned on us and said 'well if we didn't have to deliver services to Grenham the preferred option would be very different'…That sort of opinion's been expressed quite often, and sometimes I think quite aggressively... And when you try… to have a rational conversation with people around 'well we commission 10 per cent of the activity and if we pulled [our funding] from the Acute Trust you would really be in trouble'… So you try…[to] move with the facts of the situation, but it's very hard to engage with people on a rational planning basis when feelings are so high, passionate, and people want to do the best for their local communities or for their particular group of people they're representing.

Here the inclusion of Grenham is justified with respect to 'the facts' regarding the level of activity Grenham provides. Conversely, those opposed to Grenham are framed as driven by emotion. As with the opposition of Bloughton LA and campaign groups to the programme in general, this opposition is presented as, at least in part, an attempt to represent public emotion about the change. However, this was ultimately seen as irrational, counterproductive, and bad for patients in the long term.

The expert ethos therefore also reveals a view of the public and the role of public opinion within the service change. This, in turn, can help explain why, unlike the LA and campaign groups, the public were rarely subject to negative moral evaluation. Participants generally did not expect the public to fully understand the reasoning behind the service change. Instead, they wanted members of the public to trust that the service change is in their best interests because of its basis in evidence and expert, clinical opinion. Public feedback was valued as a way of building further evidence about what issues different groups have and how these can best be met. However, it was generally held that the final decision should ultimately be in the hands of experts. This view was well summarised by Charlie when discussing the purpose of a consultation. He stated:

> I think the consultation has been misinterpreted. The consultation is saying basically 'these are our plans, and these are the things we've considered about

> the plans, and these are the mitigations we've suggested about the plans, is there anything we've not… considered at any stage?... Are there any people that we've missed out?'... It wasn't saying: 'do you like our model, you know it's really nice, will you come and support us and give us a vote of confidence?'… So I think that was what the consultation was about, it wasn't about getting out there to persuade people it was the right model.

When talking further about the consultation, and the view that it is not a referendum, he made the point that only three percent of the population responded, and thus the people publicly opposing it may not be representative:

> In society there is a small number of people who are opposing it, a small number of people who liked it. And the vast majority of people just said 'well actually we're leaving it to you because you're the experts. You're making the best decision you can do with what you've got… and we trust you to do that.' I think that's the take home message I got: the vast majority of people in the area trust us to make the right decision.

This expert ethos grounding helps explain why blame was directed towards 'political' actors rather than the public. While the public were not necessarily expected to understand the evidence behind the decisions, participants believed they should have access to an environment where they can receive the information and trust those making the decision. The activities of campaigners and the council disrupted this and were thus seen as wrong and blameworthy.

The expert ethos also helps explain the reasons participants gave for why the consultation process was good. Namely, the consultation process was a way of building a comprehensive evidence base on the needs of the population. Participants' view that the consultation was good therefore put a strong emphasis on *reach*: the numbers and range of people and groups who had been informed about the change and given feedback (particularly hard to

reach groups). The position is summed up by Eli who, when talking about the quality of the consultation, stated:

> We did a range of things over public consultation, from what we called 'pop up events', we just put a stall into a GP surgery or a supermarket or a health centre or whatever… We had what we called 'market place' events, where it was open for about four or five hours, straddled into an evening so the people who were working could come to it, where we would have tables you know where: emergency care, Women and Children's, general table, etc. etc. with clinicians and managers. So actually people could talk to clinicians about what this is about and why we felt this was the right thing to do... We talked to parish councils…Other types of groups like senior citizens forums. I personally went one evening in Bloughton to talk to the LGBT community, because we were trying to get it out to those hard to reach groups as well.

The idea of reach - that the consultation had involved lots of people and got a high response rate – was often presented as a good and is consistent with the meso-level understanding of the expert ethos. However, the importance of reach was also due to regulations which required the service change to be able to evidence adequate engagement in the event of it being taken to judicial review. As such, the importance of gaining feedback from as many people as possible was often also justified in terms of the legitimate authority of these regulations. For example, when explaining why the programme had decided to employ a specialist to advise on the consultation process, Elliott stated:

> We wanted to take what advice we could from… the leading people in best practice so that we could make sure that we'd done, partly because we wanted to do it right, and partly because I think that there's an inevitability that someone will try to do a judicial review of this because this is a really big issue, so why wouldn't somebody launch a judicial review? So you want to be sure that you've demonstrated you've done everything you possibly could to do the right thing in the right way.

Here Elliott expresses support for both the ideals of the expert ethos, particularly the need

for good reach, but also awareness that the programme must be able to demonstrate adherence to the correct procedures in the events of a judicial review. Such requirements are set out in the stage two gateway of NHS England's (2018) service change approval process (see figure 5.1). This requires CCGs to gain feedback from as many 'stakeholders' as possible, including patients, staff, the public, carers, local authorities, MPs, and partner organisations (p.49). As such, the programme was required by formal regulation to provide a huge amount of evidence demonstrating that it had done this. In this sense, legislation and regulation seem to play a strong role in defining, or at least reinforcing, ideals regarding what a good consultation looks like. This represents a good example of the overlap between meso and macro-level morality discussed in the Theory chapter. That is, participants shared a general view that it is good and appropriate to achieve good reach; but this was also backed up by a belief in the legitimacy of the rules that set these requirements out, and an awareness of the sanctions that exist for non-compliance.

Grounding Five: The desirability of the greater good versus duty to a specific population

The ideal of the 'greater good' was the main grounding for the first order moral belief that partnership working is desirable. At the same time, a sense of duty to the statutorily defined population organisations serve was the main grounding for the belief that 'trade-offs' are desirable. Both these meso-level understandings are strongly linked to participants' lay moral commitment to make decisions that are fair for the whole population. However, these understandings differ in how they define this population, creating dilemmas for individuals. With respect to the ideal of the 'greater good, this is codified in the 'Principles for Joint Working' document. This states a shared concern for 'all the populations' of the areas involved in the change and a desire to 'maximise benefit for that whole population' (Moving on Up 2019b). The implication of this grounding is that it is good to make decisions that are calculated to improve outcomes for the 'whole population', even if this seems to negatively impact on a 'specific population'. However, this is balanced with an acceptance that

organisations must, at least in some cases, look after their own priorities. This is demonstrated by the alternative view that ‘trade-offs’ are the desirable way for organisations to work together. Indeed, this same document states that ‘potential trade-offs’ will be unavoidable, and that the programme will involve several ‘complex and difficult decisions’.

The implicit tension between the first order moral belief in partnership working and that of trade-offs explored in the last chapter was therefore also reflected in the different groundings for these beliefs. Such a tension was also present in the interviews. For example, Eli, Bloughton CCG, demonstrates a commitment to ‘the greater good’. However, his account also implies a tension between achieving this ‘greater good’ and his duty to serve a specific population. When asked about why his organisation had not supported Option 2 when this was the much less controversial option for the area served by his CCG (Bloughton), he argued:

> Because it’s the wrong thing to do. So … I wear two hats. So the issue for me in relation to…Moving on Up is how do we make the right decision that benefits the most? The issue for me as a member of the CCG is ‘how do I make sure that we get the best we possibly can for the population of Bloughton?’…So I think that’s about trying to make sure that we maximise the level that an urgent care centre can operate at, so that at least 60 per cent, ideally more than that, of the population that currently go to A&E would still have their urgent care provision delivered locally.

Here Eli balances these two groundings by trying to maximise the amount of care that stays in Bloughton, reflecting his duty to a specific population, while still maintaining a commitment to the overall configuration, reflecting the ideal of the greater good. However, several participants, particularly those associated with the Bloughton area, acknowledged this to be a difficult balance.

Participants reported the tensions between these two groundings to be particularly evident at key decision points in the programme. The accounts of interviewees suggest that, at these points, the ideal of the greater good played a greater role in how they evaluated the actions of others. For example, several participants attached a negative moral evaluation to Bloughton CCG's initial reluctance to support what would eventually become the preferred option of the JGB (entailing the moving of emergency care and W&C services to Whitdon). This is reflected by the below two quotes, the first from Fred, Grenham Commissioner, the second from Eli, Bloughton CCG:

> What you then struggle with in terms of maintaining that consensus is when you move from those high-level principles closer to the detail of what that would look like in practice. And I guess the experience is that the general principles are fine, but the solutions become more parochial in terms of how they are viewed.

> But I also think the Board are very concerned about Women and Children's services. And again, you know again it's quite emotive… So again you get back to that… that dynamic of 'what's the right question and answer here for the greater good, as opposed to the parochial view?'

The term parochial has pejorative connotations and suggests that, in the context of Moving on Up, serving the interests of an organisation's defined population is less desirable than working for the greater good. However, this negative evaluation was relatively mild. Indeed, acting in the interests of 'your' population was often framed as understandable, suggesting that the grounding of the 'greater good' only had slightly greater normative force than that of serving a specific population. Some even showed overt sympathy for the position that Bloughton CCG were in, expressing the belief that such 'trade-offs' can be hard for organisations to deliver. As Leslie, when asked about whether she felt any sympathy for those in Bloughton CCG, stated:

> I have more than sympathy, I have been in that position before in other areas, and it's very very difficult… which is why I've always tried on the programme board – don't get me wrong, I always fight the corner [of my organisation] – but I've always felt for the people who are desperately trying to reconcile that what their community, or the populations that they're responsible for,…want is not what the process …has come out with, you know, as the final preferred option. So it's very difficult.

The acceptance of the difficulties faced by Bloughton CCG and the need for organisations to focus on the perceived interests of 'their' population suggests that the grounding of 'the greater good' was not as strong as groundings such as *clinical opinion* and *evidence*. Indeed, the grounding of safeguarding the interests of 'their' population also seems a relatively strong one, and most participants recognised they had a duty to a specific population separate from the programme. Some participants believed that this was strengthened by the existing regulatory framework, which largely still encourages organisations to focus on their own needs. For example, when discussing the challenge of different NHS organisations working together towards shared objectives, Bobby, Acute Trust, reflected:

> The governance structures and the legal structures mean that your accountability rests with the organisation that you work for, but there is a moral responsibility to make sure as a system that we're operating in a way that supports the needs of everybody and not just looking through an organisational lens, so I think it's something that is emerging, and I think there is more and more an implied sense that organisations will consider the greater good of the system and the population, and not the organisations.

This implies that the duty to a specific population, whilst clearly existing on the informal meso-level of morality, may also have extra force because it is also more deeply established in macro-morality, therefore carrying the associated legitimate authority and threat of sanctions. This, in turn, may allow this duty to have more force in the decision making of

managers, even though the in-principle commitment to the ideal of the 'greater good' is stronger.

Section conclusion

In this section I have explored five prominent groundings and, in so doing, I have gone some way in answering Research Question 4. Firstly, I have shown how meso-level duties and ideals play a key role within the moral background as groundings. This specifically relates to:

- *The invoking of the term 'clinical' as an ideal to communicate moral desirability or appropriateness* – Participants regularly argued the programme is the right thing to do *because* it is supported by clinical opinion. This reflects the moral authority clinicians have to judge what is best for patients when it comes to decision making within Moving on Up.

- *The ideal of sustainability* – Many participants expressed a commitment to a future model of NHS service delivery where enhanced community provision leads both to better outcomes for patients and reduced costs. This was a key grounding for the first order moral belief that community and preventative services should be developed.

- *The expert ethos* – This ideal represents the belief that decisions regarding service change *should* be driven by a transparent, unbiased weighing of evidence and clinical opinion *made by experts*. This grounding lay behind the first order moral belief that the programme is right, and that those who oppose it are wrong. It also lay behind the belief that the consultation had been conducted in the right way.

- *The ideal of the greater good, and duty to a specific population* –The ideal of the greater good relates to the belief that all organisations should make decisions in the interests of

a shared population. The duty to a specific population, on the other hand, relates to the sense of responsibility those from different organisations felt towards their defined population. These two groundings largely existed in tension in the accounts of participants. As such, they worked to justify the first order moral belief that partnership working is good, and the first order moral belief in the appropriateness of 'trade-offs' respectively.

I have also shown the role of macro-level morality, and the associated feeling of legitimacy, has in these groundings. Namely, I have showed how the moral authority of clinicians is also enshrined in regulations, and the sense of legitimacy this carries played a role in resolving conflicts within the programme. I have also shown how legitimate authority reinforced the meso-level understanding, existing as part of the expert ethos, that 'reach' makes a good consultation. In addition to this, I have explored the possibility that the *regulatory* status of organisations' duty to specific population might partly explain why this seems to have continued to hold a great deal of normative force, despite calls for more partnership working.

Secondly, I have examined the role of para-moral phenomena which, in the case of groundings, relates to non-moral reasons or justifications for first order moral beliefs. These are:

- *The belief that the programme is supported by evidence* – All participants strongly believed that the preferred option is strongly supported by rigorous evidence of improvements to patient outcomes. This was a key grounding for the belief that the programme is the right thing to do.

- *The belief in the need to select an affordable option* – This was largely used to justify why the preferred option is better than a new, more expensive, single site model. Interestingly, while the importance of affordability is stressed in the regulations,

participants rarely expressed this grounding in terms of legitimate authority. Instead, participants tended to frame limited finances as a fixed fact about the context Moving on Up took place within. I will explore this in much greater depth in the next chapter.

Thirdly, all these groundings were also clearly related to participants' lay moral commitments and were often used in a way which enabled them to express these ethical commitments in their decision making. The groundings of evidence, clinical opinion and the expert ethos were all used in ways that foregrounded the need to determine what is best for patients and then act upon this. These groundings were therefore strongly linked to the lay moral commitment of improving services for patients. By the same token, the ideal of the greater good and duty to a specific population were both strongly related to a lay moral commitment to fairness in making decisions on a population level. However, both these groundings define this population in different ways, meaning they provided much less clarity about how to realise this lay moral commitment in practice. Finally, the commitment to responsible use of public finances was articulated by the ideal of sustainability in a way which also resonated with the commitment to improving patient outcomes.

Overall, in this section I have provided partial answers to Research Question 4. I will now continue to explore the moral background of Moving on Up by outlining the most prominent thick moral concepts drawn on by participants as part of their conceptual repertoires.

6.2 Conceptual repertoires

According to Abend (2014) conceptual repertoires 'are the set of concepts that are available to any given group or society, in a given time and place' (p.36). When applied to thick moral concepts, this means that different groups will have different 'menus' of concepts that are 'socially provided' (p.38). These vary across time and space and 'enables and constrains first-order morality' (p.37). Thick moral concepts are complex normative phenomena which

can both describe and evaluate, and are context dependent, in that they 'presuppose a complex web of institutions, ideas and practices' (Abend 2012:157). In this research I have defined thick moral concepts as an aspect of meso-level morality. There is a considerable amount of overlap between these concepts and some of the groundings discussed in the last section. However, it is important to discuss them in their own right to highlight the role their rich, and often context specific, meanings played in the Moving on Up programme. I will now discuss five core thick moral concepts that formed part of the conceptual repertoire available to those involved in the Moving on Up programme.

Concept one: Clinical

As I noted in the Groundings section, the concept 'clinical' commonly implied a special link to the best interests of patients. To be a clinician therefore meant you were intrinsically trustworthy and motivated only by the needs of patients. Indeed, several participants believed the only way to ensure the programme was carried out in the interests of patients was for it to be clinically led. As Dylan stated:

> So all of this, what we're doing it's about improving patient care, and it's really important that it's clinically led. So one of the rules we have to follow as commissioners is to ensure that any service change is led by clinicians.

The concept of 'clinical', when applied to an individual, therefore bestowed them with a special authority which made their input more worthwhile than other types of role. The term was regularly juxtaposed with financial or managerial priorities, which were implied to be less desirable. A clinical perspective was also contrasted with a parochial one. The is reflected in the following statement from Ryan when praising the stance taken by Whitdon Local Authority:

> The stance that Whitdon council has taken has been 'this is a clinical issue. It has to be evidence based on clinical matters... We need to look at this very

> much from what's best for the population from a clinical perspective, rather than taking a parochial view.'

This further shows the meaning of the concept 'clinical' to communicate the idea that the programme is motivated by what is in the best interests of patients, and therefore denote its moral desirability.

The concept of clinical was also used as an adjective for a variety of other terms. This includes: evidence, efficiency, approach, solution, outcomes, and model, the latter being the most common. As above, the concept was used in this way to denote its moral superiority, particularly to programmes driven by financial considerations. This is shown by the following statement from Eli when he described the drivers behind the programme:

> 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. We never talked about money. Now clearly it has to wash its face and it has to stack up. But… as opposed to lots of other major capital projects or reconfiguration projects in the NHS, both that I may have been involved in personally or I've known from elsewhere, where money was the driver, money absolutely wasn't the driver in this. It was around clinical sustainability, workforce sustainability. And there was the financial sustainability but it wasn't about taking cost out necessarily.

Here the concept clinical is added to the words 'outcomes' and 'sustainability' to reinforce the idea that the programme is about improving services for patients rather than saving money. This was also evident when participants talked about the service model devised by the programme. This was referred to repeatedly by interviewees and within programme documents as the 'clinical' model. On one level this is not in itself surprising. It is not an inaccurate or misleading description as the proposed configuration does relate to medical services. However, the prevalence of the term 'clinical model' does seem significant given there are other terms that are commonly used to refer to such processes. For example, NHS

England predominantly use the term ‘model of care’ when referring to their Vanguard programme of service reconfigurations (NHS England, undated) while in the guidance on service reconfigurations issued by NHS England (2018) they use various terms, including ‘service model’ and ‘models of delivery’. The use of the term ‘clinical model’ here seems to therefore evoke a thick moral concept that has high moral status within this context. This, in turn, was used by participants to communicate the idea that the programme is being done for the interests of patients, rather than financial considerations.

Concept Two: Impartiality, objectivity, facts and independence

A group of concepts, including objectivity, impartiality, reasonableness, independence and evidence[29], were used regularly by participants to argue for the rightness of the service change. These were often contrasted with terms such as political, emotional, or parochial to communicate the merits of the service change over the objections made to it. These concepts are strongly linked to the grounding of evidence and were regularly used by participants when arguing that the change is in best the interests of the whole population. This was illustrated by Danny, Whitdon CCG, when he stated:

> I looked at it from that impartial view of ‘what’s best for the whole?’. And it was interesting because before the very first committee… we had a meeting between the two CCGs to… almost to test the views of individuals to make sure that everyone did have that view that we are taking decisions based on the whole population and didn’t have a bias that would mean we couldn’t do that.

Here the idea of impartiality is very much linked to the idea of being able to make the right decision for the whole population represented by the service change. Therefore, as with the grounding of evidence, it was highly compatible with participants’ lay moral commitment to making fair decisions based on the best interests of the whole population. The concept of

[29] For the sake of brevity, I mostly refer to this thick moral concept simply as ‘impartiality’ throughout the thesis.

impartiality seemed particularly important in allowing participants to distinguish themselves from those who opposed to the change, who were largely believed to have done so out of parochialism and bias towards one specific population. For example, Ryan spoke at length about how the actions of Bloughton LA had been lacking factual accuracy and how wearing it had been to try to rebut this. When asked how he thought he would have behaved if he were in the same situation, he stated:

> We've got a duty to represent our populations. That's entirely reasonable. And it could be argued that the case that I make on a regular basis about the needs of rural populations and them not being fairly reflected in national policy would be me doing a very similar thing to our colleagues in Bloughton in standing up for their population. So I've got no problem with organisations advocating for the populations that they serve. The [important] element would be ensuring that the evidence base that's being provided, is fair, reasonable and transparent. So that an objective assessment can be made of that data.

This again demonstrates the grounding that individuals have a duty to represent the interests of the defined population of their organisation. However, such a duty should not come at the expense of objectivity, which is presented as a core moral standard to uphold. Furthermore, this objectivity is not simply a given quality of individuals, but something that has been earned by the programme by going through the appraisal process. As Danny stated:

> 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. So, in a sense, it was in my mind the decision should have been a decision that any independent group of individuals you picked from anywhere [would have supported] … And that would be the idea, that it's a logical, unbiased decision based on the facts and not on a personal preference.

This concept of being ‘unbiased’ in this context includes an awareness of NHS England’s process for appraising the change *and* a belief in the legitimacy of this process. It therefore has some overlap with macro-level morality, in that regulatory structures seem to support this view of unbiased, objective use of evidence. It also contains an understanding of *independence* which is important for understanding objectivity in this context. As I have already discussed, an important event that allowed the programme to move forward was the introduction of ‘independent’ clinicians to break the deadlock on the JGB. The idea of independence was effectively based on the clinicians’ perceived lack of organisational allegiance or bias. As Ashley argued when talking about this deadlock:

> We did some active things to get over the line, because we introduced independent people. So the first time we tried to get a decision it was a split vote… So [Moving on Up was] a collective endeavour to get to a conclusion, but then trying to make a decision [laughs] was not collective initially. So we had to get an independent chair and…independent clinicians to form a view. That’s one thing that helped us get over the line, and helped them think about: well the independents think this, and maybe we should test our position.

As this suggests, independence was seen by participants as allowing individuals to take a dispassionate or unemotional view: to engage with the ‘facts’ of the situation to focus on the greater good. This perspective is also contained within NHS England (2018) guidance, which advocates that clinical leads for service change ‘ensure involvement from senior clinicians not directly connected with the services under review’ (p.17). ‘Independence’, held by those who do not represent a population affected by the change, was therefore seen by participants as helping individuals make rational decisions unaffected by ‘emotional’ considerations.

Concept Three: Political

The concept 'political' was persistently used as the antithesis of being independent and objective. As discussed in the Groundings section, participants used the term to refer to motives that are questionable and unhelpful and ultimately stand in the way of doing the right thing for the patient population. It was therefore regularly contrasted with the more morally desirable evidence-based, impartial, clinical view that participants saw the programme as based in. As Terry argued:

> I think that the general public perception is that buildings are very important and proximity is very important, whereas actually the clinical evidence would suggest, to a great or lesser degree, that isn't true… For example the proposed model for Moving on Up would remove the emergency centre from Bloughton and create a trauma centre in Whitdon. And suddenly [people argue] 'what happens if I have a car crash in Bloughton and my leg's hanging off and I'm bleeding to death' and [we] say 'well actually at the moment you wouldn't go to Bloughton anyway because they've already centralised mayor trauma. You'd either be taken by ambulance or flown to [an out of area hospital]'. So the general level of public understanding is poor. And, of course, such is democracy and politics, you know it's very easy to construct an argument that says 'it cannot possibly be good that we're losing out A&E', from a political lobbying perspective.

Here politics involves 'buying in' to the public's false beliefs and fears regarding the importance of a nearby A&E unit. This, in turn, was seen by participants as obstructive to doing what is right from a clinical and evidence-based perspective. This type of political behaviour was also often, although not always, framed as inherently self-interested and cynical. For instance, when discussing the extent to which the programme had successfully communicated its key messages to the public, Dylan stated:

> I think it's when you're trying to convince the wider population, and then obviously you've got some people with political agendas who are trying to instil

> fear in people as well so you've got to try and combat that, so I think in certain… cases it [the communication of the programme] does work, but then you are sometimes fighting a losing battle with the wider population if you've got political animals to fight.

Here political actors are framed as deliberately playing on people's fears to serve their own agenda. Indeed, despite some participants taking a more understanding perspective on Bloughton LA's actions (as I explored in the last chapter), the term political was overwhelmingly used in a pejorative sense by participants to denote undesirable behaviour.

As explored above, political action was often framed by participants as encouraging and amplifying negative emotions among the public. These emotions, in turn, were often seen as misplaced, and the term political was therefore also used to denote the irrelevance of a concern to the actual substance of the reconfiguration. This idea of political considerations being irrelevant is closely related to the concept of 'political noise'. This came up in interviews on multiple occasions and was used by participants to discuss the disruption caused by the actions of Bloughton LA and campaigners. For example, Bobby, from the Acute Trust, stated:

> Well the hospital hasn't had a particularly strong opinion on which of its two sites…is considered to be the emergency site, which is what's drawn most of the political noise.

The idea of 'political noise' reflects the perception that this opposition is largely disruptive, unhelpful and irrelevant to decision making as part of the service change. This general attitude is summarised by Riley who, when discussing the main campaign group opposed to the programme, stated:

> If you listen to some of the interviews that they've given, some of the most vocal ones. Some of it is political. Some of it is genuine concern about maybe having

> to travel further, and some of it is just… opinion... And you have to have some noise… [because] you need to consider the public… but I think it's when the noise is inaccurate, and you correct it, and the noise stays the same. That's when you think, well actually, it doesn't matter, whatever we say or do… that's always going to be there.

Here again the concept 'political' is contrasted with genuine concern, and 'political noise' is seen as based on inaccurate information and unreasonable resistance to change.

Linked to the concept of political was the idea of parochialism. While both concepts were used to refer to obstacles to the reconfiguration, parochialism was generally seen to be more understandable and not cynical or self-interested like political action. It was often used to describe the attitude of the public to the moving of services. For example, when talking about the public's concerns regarding the moving of Women and Children's and A&E, Ashley stated:

> People…they're parochial about their geography, but people focus on the things that they think are most important to them…but actually sometimes it's really important to get that balance across to them, which is what we tried to do in the consultation… People come with their own…perception about what's important to them don't they? … The biggest disappointment for me is not being able to get across to people that real balance that this is in the best interests of everybody.

Here the parochialism of the public is presented as a natural thing, and so little blame is attached to people for not wanting services to be moved. The term parochial was also used by some participants to describe some members of the programme, particularly from the Bloughton side. Here there was slightly more of a negative moral evaluation applied to being parochial, as there was often an expectation that people involved in the programme should subscribe to the point of view of the greater good. Eli draws this contrast when discussing

his views on the past opposition of the Bloughton CCG's Governing Body to the moving of Women and Children's services. Here he argued:

> So again you get back to that… that dynamic of 'what's the right question and answer here for the greater good, as opposed to the parochial view?'.

Or Ryan, who stated:

> We need to look at this very much from what's best for the population from a clinical perspective, rather than taking a parochial view.

Within these extracts is the implicit assumption that organisations should, to an extent, be able to rise above these parochial concerns. Nevertheless, the concept was used to describe a much more understandable form of opposition to the programme, even among organisations responsible for delivering it. This is best reflected by Leslie's comments, who spoke about the inevitability of a parochial perspective given the way the NHS is regulated and organised. When talking about the past opposition of the Bloughton CCG to the moving of W&C services, she reflected:

> It's the age old thing of, so… my statutory accountabilities are for the residents of Grenham, it is not for the residents of Whitdon, Bloughton and Grenham. Therefore, the trump card will always be held, because of the way which we've organised the health service and local authorities…[is] ultimately parochial, [and] self-preservation, self-protection, whatever, will ultimately trump looking at it at the broader system level.

This shows how parochialism as a concept was, to an extent, seen as understandable. It was also strongly linked to the grounding of duty to a specific population discussed in the last section. Indeed, the point further underlines the idea that this meso-level duty has extra power because it is also enshrined in regulations as a macro-level duty. The negative moral meaning of the concept therefore reflects the belief of participants in the ideal of the greater

good. However, the blame attached to acting this way was less than that associated with political behaviour because many saw it as an inevitable outworking of the way organisations are regulated.

Concept Four: Engagement

Engagement was a common concept within both interviews and documents. It was used both specifically to mean the process of informing and obtaining feedback from the public regarding the service change, and more vaguely as a synonym of 'to communicate with'. It was most commonly used in the former sense, and only ever referred to as a good thing. As Fred, from Grenham Commissioner, specified:

> As a commissioner, obviously part of the purpose of our own engagement is to understand in a very real sense what people felt about these proposals and how it would impact on them. So whatever solution is... and whatever option was agreed, part of our job is to make sure we've identified the impact and the mitigating actions… as a commissioner.

The term was therefore most often used when talking about the consultation. However, it was also used to describe the drivers behind the programme as well with respect to the Call to Action. As such participants saw 'engagement' as providing some credence for the idea that change is needed. For example, Kit, from a Whitdon Community Representation Group, pointed out:

> One of the first major events that…[was] organised was the Call to Action public engagement – this was an initiative set up by the Government… and there was a round of public engagement about what sort of health service did local people want? And…. there were several principles that came out of that, but the key ones I think for Moving on Up is… firstly, that no change is not an option.

In this sense engagement was seen by participants as helping to develop an understanding of what the public want and need so that the health service can then devise the best way of doing this. Such appeals to engagement are also visible in public programme documents. For example, the consultation document (Moving on Up 2018) states that engagement activities have taken place in all three areas and involved seldom heard groups and people with the nine characteristics protected by the Equality Act 2010. It claims this information has been used to determine which option should be chosen and has given decision makers important information about their populations. Engagement as a thick moral concept is therefore used here to denote the importance of giving people information about the programme and listening to their feedback, which is then used as evidence to inform decision making. It was therefore often used alongside the expert ethos, particularly the idea of 'reach', in the accounts of participants. It was generally used to signal that the programme is responding to and meeting the needs of the public.

Concept Five: Sustainability

Alongside being an important grounding in the accounts of participants, sustainability, when used to refer to an ideal future state where services will be better for everyone, was also a prominent thick moral concept. This is specifically with respect to the multiple moral meanings that participants attached to it when communicating the need to end uncertainty about the future of services in the area. As Elliott reflected:

> There's been a number of incidents leading to the CQC imposing conditions on the Acute Trust. And a big contributory factor to those failings in delivering a quality service has been the lack of staff. So in a sense there has been an increasing recognition that things cannot continue as they are, and in fact if the Moving on Up programme didn't go ahead then you would likely have to make a decision just to close one A&E, and that was very much on the cards recently for at least a period of a day, or night, so… as time's gone on its become more and more imperative to make a decision that makes the health provision

> sustainable for the future. So it's making a proactive decision rather than having to react to… 'we've got no alternative but to close something down'.

Such an understanding was therefore not *just* invoked as an ideal, a shared understanding of what is good. It was also used to communicate participants' frustration with the long term and ostensibly escalating issues the local healthcare economy is experiencing; perceived repeated failures to address these issues; and a belief that the situation is worse than it has ever been. In this context, building a sustainable service meant ridding the local healthcare economy of these problems and anxieties and moving towards a future where everything is better for everyone. The extent to which such a vision of sustainable services can be achieved by actions taken by the programme is, of course, highly debatable, and I will explore this in more depth in the next chapter. However, for now it is important to note that many participants invested a great deal of moral meaning in this notion of sustainability.

Section conclusion

In this section I have identified five thick moral concepts that were prevalent meso-level moral understandings in the accounts of participants. These are: clinical, impartiality, political, engagement and sustainability. These concepts are all strongly linked to the groundings discussed in the last section and correspond with many of the ideals and duties which characterise the shared moral worldviews of participants. By dedicating a separate section to these thick moral concepts, I have been able to explore their complex, institutionally specific meanings in more detail and their relationship to participants' first order moral beliefs. With respect to clinical, this was often used to represent doing what is in the best interests of patients according to evidence. This gives clinical roles and clinical objects (such as the clinical model) an enhanced status, particularly when compared to managerial or financial roles and objects. The concept of impartiality embodied the perceived desirability of making decisions in the interests of the whole population based on a transparent interpretation of evidence un-impinged by emotion or bias. In contrast to this, the concept of

politics was predominantly used to signify the opposite: undesirable behaviour based in narrow electoral interests, seeking to appeal to emotion and bias rather than evidence. The concept of engagement represented the desirability of informing and hearing the public, whilst maintaining a detached, evidence-based approach driven by experts. Finally, the concept of sustainability as a thick moral concept related to an ideal future state where services are better at meeting patient needs *and* living within existing resources. In this sense, sustainability was equated with stability, seeing a sustainable future as one which is not characterised by crisis and uncertainty.

I will use the rest of the chapter to discuss the other dimensions of the moral background: the meso-level para-moral phenomena present in the Moving on Up programme. These are all less immediately evident from the data than both groundings and thick moral concepts and so their existence must be inferred from participants' accounts. Despite this, they all played a crucial role in shaping the first order moral beliefs and judgements of participants, as I will show in the remainder of the chapter. I will start with a discussion on the objects of evaluation of the programme, before then discussing the meta-ethical objectivity and main metaphysical assumptions of those involved in the programme. I will also explore the interaction of these phenomena with other aspects of my multi-level moral economy framework throughout, before summarising these connections in the conclusion.

6.3 Objects of evaluation

The moral background element of *objects of evaluation* is premised on the assumption that societies and groups differ with respect to the 'objects that are capable of being morally evaluated' (Abend 2014: 40). Evaluations can be about: people, states of affairs, groups, organisations, motives, and the results of actions (p.40-2). Objects of evaluation therefore play a key role in what situations individuals see as meriting first order moral judgements and beliefs. With respect to this multi-level moral economy framework, objects of evaluation

can also play a key role in influencing when moral phenomena, such as lay morality or ideals, are perceived by individuals as relevant to a situation. In this section I will discuss two areas of moral evaluation: the decisions taken by the programme and the process by which these decisions were arrived at, and the organisations and individuals involved in the programme. Conversely, as I touched upon in the Groundings section, I will also explore the issues of central funding and workforce availability, which were notable for *not* being objects of evaluation despite the large impact they both had on the programme.

The decision taken by the programme and the process by which it was arrived at

One clear object of evaluation for participants was the final decision made by the programme, which had clearly been the subject of much deliberation and justification. Alongside this, participants often also offered evaluations of the *process* by which this decision had been made. As discussed at length earlier in the chapter, two main groundings for the first order moral belief that the programme is the right thing to do were the views that it is backed by extensive evidence and supported by clinical opinion. Participants applied these groundings when explaining the rightness of the final decision and the process through which it had been come. For example, Eli utilised the ideal and thick moral concept of clinical when giving reasons for the first order moral belief that the programme is the right thing to do. As he reflected:

> I think that the process that we tried to follow in coming up with an answer was the right process. So we said this should be clinically driven so we got clinicians together to come up with a clinical model. That was from across all areas….From the clinical model we derived a long list of options around how you might be able to deliver this. So the very original scenario planning had something like 40 options in it, which we narrowed down before we took a long list to a non-financial benefits appraisal panel, to narrow it down to a very small short list, before we went out to public consultation. So I think in terms of process I think that worked relatively well.

The first order moral belief is discussed here *in terms* of the decision made by the programme and the process followed to come to this decision. These are therefore two objects to which participants applied moral judgements, and the groundings that helped them make these judgements, to when discussing whether the programme is right. This perspective regarding proper objects of evaluation also seemed to be supported by the external regulation and standards set by NHS England. This is demonstrated in Terry's reflection on his role, both more broadly and with respect to Moving on Up. When asked what kind of responsibilities he had as part of his role, he stated:

> It could be anything from, the performance on…national indicators… What are your improvement plans, are they appropriate, etc. etc. Right the way through the whole gamut of activity. So, for example, with Moving on Up NHS England will conduct an assurance process around the proposed change, your fitness to answer consultation, whether consultation is properly conducted, and then, coming out of the consultation, the decision making process that's undertaken locally.

The NHS England assurance process therefore contains the same background assumption that the final decision taken by the programme and the process taken to come to this decision are key objects of evaluation. Indeed, it is plausible that this accountability relationship plays an important part in setting these aspects of the moral background. This suggests that relational structure, in this case the hierarchical constitutive rules that form the NHS England assurance process, could play an important role in influencing objects of evaluation. This is a general issue I will explore in much greater depth in the next chapter when exploring the entwinement of relational structures and moral phenomena.

Organisations and individuals involved in the programme

Participants also readily offered evaluations of the way different organisations and individuals had behaved during the service change. Indeed, the assumption that

organisations and individuals involved in the programme are key moral agents, able to behave morally and/ or immorally and therefore are responsible for their actions, lay behind all three sets of first order moral beliefs I discussed in the last chapter. This was particularly evident when they talked about their experience of working with others as part of the service change, and when they discussed how the preferred option had been identified. With respect to the former, as I have already discussed at length, several participants had negative evaluations of the behaviour of Bloughton Local Authority and the main campaign group opposed to the programme. However, such evaluations about those involved in the programme were also often positively directed at certain individuals and organisations. The idea of organisations as things that can be morally evaluated was a particularly prominent part of the accounts that participants gave about the quality of partnership working, which I discussed at length in the first two sections of this chapter. For example, Bobby discussed the importance of organisations considering the 'greater good of the system', suggesting they are things that can be morally judged, in this case with respect to the extent they fulfil the ideal of the greater good. When discussing programme leadership, Charlie also talked about the responsibility of CCGs to lead the programme:

> I think at times different organisations have taken stronger leads. I think certainly getting it through these final stages it's been certainly the CCGs that… have had to drive it through because it's been our responsibility to do.

Similar moral evaluations were also applied to individuals when discussing how the preferred option was identified and agreed to. For example, both Elliott and Morgan praised the individuals who have led the programme:

> It wasn't until [anonymised senior manager] came really that he said 'look…there are discussions but this isn't moving on, we really need to get going with this.' And he sort of really energised that process so he made a significant difference. And also [anonymised senior clinical manager] was very

> strong in terms of outlining from a clinical perspective what needed to happen, so it then did get shoved along.
>
> I think the leadership of the programme has been really important. I think the…[leaders of the programme] have been really driven in their desire to move it forward. And I think a lot of that goes back to the point I made earlier about what we've got isn't working, it isn't the best it can be... I think the fact that the leaders have pulled people together, they've sought external support and advice to counter argument[s], they've used an evidential process to do that.

This therefore shows that both individuals and organisations were treated as objects of evaluation with respect to the how they decided to act, the decisions they made and how they came to these decisions. This was particularly with regards to how they had contributed to arriving at the preferred option and how they had worked with others as part of the process.

Object of non-evaluation: Finances and workforce issues

As discussed above, participants treated the final decision taken by the programme and the process taken to make this decision as matters of moral evaluation. However, they *did not* view the long-term issues Moving on Up ostensibly sought to address, namely a perceived decline in long term finances and workforce availability, as matters for moral evaluation. Instead, these were usually presented as facts regarding the context of the local healthcare economy that need to be considered. 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 of Fiscal studies, [NHS] Confed[eration] and the Kings 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 sort of efficiency drive. Backed up by the

> fact that there isn't the workforce there, that technology is changing, the fact is that there is now so much more specialisation.

Here Charlie frames the financial and workforce situation as largely driven by national factors over which those involved in Moving on Up have little control, except to try and reorganise care to deal with these new realities. There is therefore no implication of a moral agent that holds any responsibility for these financial and workforce difficulties, and there was rarely any discussion about whether the situation was a result of long-term policy decisions made by the government. This contrasts with, for example, participants' tendency to attribute successes or difficulties with partnership working to the good or bad actions of individuals and organisations involved in the programme. Indeed, participants saw it as the responsibility of the programme to find a way of managing these contextual constraints, specifically by moving to a new *sustainable* model of care. As Eli stated:

> So unless you manage demand in a different way, a) You're not going to have the money and, b) You won't have the staff to do it. So you've got to make that paradigm shift around saying: 'well actually how do we get people to stop becoming a type 2 diabetic?' Or if they are a type 2 diabetic getting them off medication and managed by diet. You know it's all those types of things that we need to do differently.

Again the focus here is on doing things differently because of a changing context, but the context itself is not seen as an object of evaluation. This perspective on objects evaluation is particularly noteworthy because it contrasts so sharply with the perspective of a prominent local campaign group. For example, in their consultation response they make the claim that the NHS is underfunded, with low levels of funding compared to other European countries. They go on to call on the government to recognise the needs of all for 'decent healthcare' (Campaign Group 2018). Therefore, unlike those involved in planning and implementing Moving on Up, the campaign group very much sees government funding decisions regarding the NHS an object of moral evaluation. As I discussed in the last chapter, several

participants articulated an awareness of this perspective, but also believed the campaign group had fundamentally misunderstood the issues driving Moving on Up. On the surface participants' view that the programme is not about austerity, despite a general acceptance that deteriorating finances is one of the drivers, seem problematic. I will therefore explore this perspective in much greater depth in the next chapter when discussing the entwinement of moral and economic phenomena.

Section Conclusion

In terms of Research Question 4, this section has shown the role of one set of meso-level para-moral phenomena: objects of evaluation. These work to inform when other moral and para-moral phenomena, such as individuals' lay morality and the thick moral concept of clinical, become active. I have shown the most common objects of evaluation among participants to be: the decisions made by the programme and the process through which decisions were arrived at, and individuals and organisations involved in the programme. I have also discussed how participants did not tend to see the overarching financial and workforce context as an object of evaluation, even though campaign groups opposed to the change certainly did frame this as a bad thing for which they held the government responsible.

While in this section I have identified what the most common objects of evaluation are, I have not sought to theorise *why* this is the case. I will therefore return to this issue in the next chapter. Here I will make specific reference to the constitutive rules organisations operate within, and how this brings certain issues into evaluative focus. This in turn will allow me to focus more on the role of hierarchical relational structure in influencing the accounts of participants.

6.4 Meta-ethical objectivity

Meta-ethical objectivity refers to the extent to which morality is seen as a matter of fact or subjective opinion (Abend 2014). For instance, whether participants tend to take a realist, sceptic, or relativist approach to morality. It is therefore based on the premise that in certain groups, societies or contexts it will be seen as possible to ascertain objective facts about what is right and wrong (moral objectivism), whereas others will not treat moral claims as things that can be categorically true or false beyond personal opinion and preference (moral scepticism) (Abend 2014: 48). Others will hold some notion of moral truth but see this as changing relative to the context or situation (p.49); for example, the belief that an action can be wrong in one country but permissible in another. Such assumptions are important because they generally underpin the types of first order moral judgements individuals make, the beliefs they form, and the resulting actions they take. For instance, Abend hypothesises that many complex organisations and bureaucracies tend towards moral realism; and this enables them to take the decisive action they need to achieve their goals in a way that is not facilitated as well by subjectivist or sceptical perspectives (p.48-9). However, Abend also notes that such meta-ethical assumptions can be hard to identify, and the lines between the different positions are not always clear (p.50). Nevertheless, I will attempt to outline the implicit meta-ethical positions of the participants in my study below.

Moral objectivism

All the first order moral beliefs predominantly grounded in ideas of evidence, clinical opinion, expert ethos, and affordability tended to involve a clear objectivist perspective. These include the belief that the programme is the right thing to do; the belief that Bloughton Local Authority has behaved badly; the view that the healthcare economy has to focus more on community and prevention; and the idea that opposition groups have obstructed Moving on Up from properly communicating the benefits of the reconfiguration to the public, and are wrong for doing this**.**

With respect to the first order moral belief that the programme is the right thing to do, participants tended to take an objectivist perspective. That is, whether the programme is good or bad was not seen as a subjective opinion, but an objective moral fact around which participants expressed a great deal of conviction. This was generally based in two related implicit premises. The first was that a change *must* be good if it leads to improved patient outcomes, reflecting participants' lay moral commitment to improving services for patients. The second, following on directly form the first, was a strong belief that Moving on Up *will* improve services, within the resources available, based on the understanding that evidence and clinical opinion support this view. Thus, participants' belief that the programme is objectively the right thing to do relied on a high level of certainty around both the idea that if an action improves patient outcomes it is generally good, and a high level of confidence that such improvements will be realised by the preferred option. A similar objectivist standpoint was behind the belief that the healthcare economy should focus more on community services and prevention. This again relied on high levels of certainty about the future: firstly, that improved community provision *will* lead to better outcomes for patients, and secondly that healthcare cannot go on as it is because of what is shown by long term financial projections. Participants' conviction that it is right to develop community services was therefore based in a high level of confidence that if preventative and community services are extended, people will both be healthier and use acute services less, leading to better outcomes and lower costs.

The same objectivist position was predominantly taken with first order moral beliefs regarding interactions with the public. The belief that Bloughton Local Authority's behaviour has been wrong was again premised on the view that the programme would clearly be good for a defined population, and that this is shown by evidence. Therefore, to try and oppose Moving on Up, particularly deploying misinformation to do so, was implicitly seen to be objectively wrong. As explored in the last chapter, some participants were less critical of

Bloughton Local Authority, suggesting that, given the electoral pressures they are under, their opposition is understandable. This therefore reflects a more morally relativistic perspective, although it is important to note that this was a minority view and most participants believed Bloughton LA had behaved badly. Similarly, participants also had little doubt that campaigners had behaved badly, particularly in making it more difficult for them to communicate the level of certainty they have about the benefits of the changes to the wider public. The first order moral belief regarding the exemplary nature of the consultation also tended to take a moral objectivist position. There was little variation in views on what constituted a good consultation, with most implicitly holding that a consultation could be held to be *objectively good* if it had good reach and it stood up to regulatory scrutiny.

The meta-ethical position on the belief that it was appropriate to include Grenham in the service change is more difficult to discern. As has been explored, most participants did support Grenham's inclusion based on fairness, particularly given the activity and income they contribute to the Acute Trust. Those from Grenham took an objectivist perspective on this, seeing it as categorically the right thing based on their commissioning relationship with the Acute Trust. However, the one individual I interviewed who was strongly opposed to Grenham's inclusion (Manny, Bloughton CCG) also took an objectivist view, based on the idea of a fundamental difference between 'us' (Bloughton and Whitdon) and 'them' (Grenham). Added to this, there were others who, while supporting the inclusion based on the idea of fairness, seemed to judge some of Bloughton's reservations as partly understandable, suggesting different perspectives are to some extent acceptable. This therefore makes it difficult to judge the overall meta-ethical position of the programme towards the inclusion of Grenham, as perspectives were mixed.

Moral Subjectivism?

Participants tended to take what seemed to be a more subjectivist position with first order moral beliefs relating to partnership working. As I explored in the Groundings section, many participants acknowledged that different organisations tend to view the programme through the prism of the duty they have to serve their defined population. Furthermore, participants often acknowledged this to be reasonable. This therefore reflects a more moral subjectivist, or relativistic, view, where what is right can vary depending on the organisational pressures a certain individual is under. Such a view may therefore seem contradictory when compared with the more moral objectivist standpoint taken by participants on the rightness of the preferred option. After all, if the decision is right because the evidence shows this to be the case, then how can it also be acceptable or understandable for individuals to oppose the change based on the interests of their organisations? This seeming contradiction can be made sense of through examining the implicit objectivism that lies behind this apparent moral relativism. Namely, while participants accepted that individuals would make different moral evaluations based on specific organisational pressures, this was only seen as legitimate because it was accepted that individuals must adhere to their duties. Such duties generally include the need for an individual to protect the interests of their organisation and defined population. As such, the ostensibly relativistic view that it is understandable for organisations to have different priorities was underpinned by an objectivist view that all individuals must take heed of their duties in decision making. The rather mixed opinions of individuals on the feasibility of partnership working therefore reflects a fundamental tension between two moral objectivist positions. On the one hand, evidence and clinical opinion show the preferred option to be objectively right. On the other, every individual has a moral responsibility to take heed of their duties to their organisation.

Section conclusion

In this section I have further explored the role of another set of meso-level para-moral phenomena: meta-ethical objectivity. I have shown that participants' first order moral beliefs tended to contain an implicit assumption of moral objectivism. This, in turn, can account for their strength of opinion regarding their support for the preferred option, and their negative opinions towards Bloughton LA and the campaign group. This strength of opinion was tempered when it came to participants' view of organisations within the change who struggled to subscribe to shared objectives. However, as I have argued, this was not a result of moral subjectivism. Rather, it was due to a clash of two moral realist positions: the belief all organisations *should* protect the interests of their populations, and the belief that the preferred option of Moving on Up is objectively the right thing to do.

6.5 Metaphysical assumptions

Metaphysical assumptions are perhaps the least immediately observable aspect of the moral background, but also highly revealing in understanding the moral worldview of those involved in the Moving on Up programme. This refers to the 'metaphysical pictures or assumptions that ordinary people and social practices, institutions, and understandings manifest' (Abend 2014: 50). It can include the assumptions about time, reality, space, human nature and capabilities upon which first order moral beliefs are often predicated (pp.50-1).

In this section I will discuss two sets of metaphysical assumptions underlying participants' first order moral beliefs. The first relates to the implicit belief in the predictable and plannable nature of the world that informed the way participants interpreted and used evidence. This, in turn, created a high level of confidence that Moving on Up will improve patient outcomes and therefore led to a strong conviction among participants that the reconfiguration is the right thing to do. The second metaphysical assumption I will explore relates to a contradictory

view of human nature expressed by participants which, on the one hand, sees people as rational and informed, but on the other sees them as irrational and in need of guidance. I will take each area in turn, with reference to first order moral beliefs and other background elements.

A predictable, plannable world

The espoused belief of participants that the preferred option will improve outcomes for patients was based on an underlying metaphysical belief that healthcare demand is predictable and, to some extent, controllable. Much of the case for change rested on a 'clinical model' which describes the way services will be provided for patients in the future. This model was regularly described in interviews and documents as evidence based, and participants communicated a high level of certainty about the improvements in outcomes that will come from the new service design. On a general level, participants were very confident that centralisation will lead to better patient outcomes, and that this is clearly shown by the evidence. This view is also communicated within the Pre-consultation Business Case (Moving on Up 2017). This presents 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 claims that the new model of care will be in line with best practice guidance and national policy. More specifically, the two-site model was also presented by participants as being based on several specific calculations regarding demand and capacity which are also detailed in the Pre-consultation Business Case. This takes activity data from the Acute Trust and applies an 'algorithm' to it to determine future patient need. This includes projections for A&E attendances, non-elective inpatients, elective inpatients, and outpatients. The reduced bed numbers of the new configuration are also based on assumptions regarding patient flow: such as improved discharges, appropriate use of service (such as many patients who currently present at A&E presenting at urgent care instead), and more efficient bed management. Activity assumptions were predicated on the view that the yet to

be developed community programme will reduce demand on services. When asked, participants showed a high level of confidence that the clinical model will be achieved once the programme is implemented.

All this shows that participants' interpretation of evidence was based on an underlying belief that this can be used to predict, with accuracy, the impact of service change on how people will use services and how this will affect their health outcomes. This helps to explain why evidence was such a strong grounding for their first order moral belief that the programme is the right thing to do. This metaphysical assumption allows participants to know what will and will not enable them to fulfil their lay moral commitment to improving services for patients. Such an underlying worldview is consistent with a broadly positivistic view of knowledge and evidence. As Joullie (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 action that is evidence based and grounded in facts rather than moral convictions (p.167). However, it is important to note that the assumptions participants made about the effects the reconfiguration will have on patient outcomes are not supported by recent academic studies, and therefore this worldview is highly questionable. I will address this issue in detail in the next chapter, where I will also explore the relationship between the moral background element and hierarchical relational structure within the NHS.

People as both rational and irrational

The second prevailing metaphysical assumption held by participants relates to their view of the human subjectivity of both those working for organisations within the programme and the public. With respect to the public, participants tended to frame them as predominantly irrational and emotional, and not informed enough to make decisions about the future of the

healthcare economy. With respect to organisational actors, they tended to be framed as rational or calculating, and when they opposed the programme they were perceived as doing so in a purposeful way. This therefore demonstrates two different assumptions about the nature of human action contained within the moral background of the Moving on Up programme. These assumptions were implicit in many of the first order moral beliefs and judgements that participants made about joint working and interactions with the public. This includes the view that Bloughton LA has behaved badly in both their interactions with the public and other organisations as part of the programme. It also helps explain why members of the public who opposed the programme were not judged negatively, but campaign groups were.

Members of the public, particularly those opposed to the change, were often cast by participants as having an irrational, emotional attachment to having a close A&E. This reflects the expert ethos discussed in the last chapter, which holds that the ultimate decisions behind the programme should be in the hands of experts because they are the ones who are able to determine what is clinically best for patients and the public. An implicit metaphysical assumption within this is that non-experts are irrational; prone to acting based on emotional responses rather than evidence; and, as such, need to rely on experts to make decisions for them. This point is reinforced by the general absence of negative moral evaluation for members of the public who opposed the programme. Their belief in the importance of a close A&E was seen by participants as incorrect, but also to be expected given the irrational nature of public opinion. The views of the public were still important to participants, as I have already explored in detail when discussing the thick moral concept of engagement. However, the perceived preferences of the public – such as 'joined up' services, care 'closer to home' or having to go to hospital less (Moving on Up 2018) - typically only informed the development of the programme when they concurred with participants' own views regarding how the local healthcare economy needs to change. This explains why public calls for care 'closer to home' were seen as valid when they related to

participants' belief in the importance of community provision, but not when they related to the maintaining of an A&E in Bloughton. Such a view is consistent with Carter and Martin's (2018) ethnography into patient and public involvement (PPI) in NHS STPs. This argues that, while 'public-facing documents maintain the narrative of public ownership and control of the service', there is often a gap between rhetoric and reality when it comes to actual implementation (p.709). In the case of their research, while PPI groups did seem to have some limited influence, the authors conclude that the concerns of NHS England and NHS Improvement tended to be dominant in how the STP programmes progress (p.723-4). A similar pattern is evident here, where the views of the public were only used as justification for the programme when they corresponded to the worldview of those organising it. This is based on an implicit metaphysical belief in the irrationality and emotionality of the public.

This assumption regarding the public was in direct contrast to the view of human subjectivity implicit in participants' views of organisational actors. Here the underlying assumption was predominantly of calculated, rational, and often instrumental action. This was with respect to both those organisational actors who worked on the programme, and those who opposed it. For instance, as I discussed earlier in this chapter, those within Bloughton LA who opposed the programme were generally seen as acting for conscious instrumental reasons, such as to garner favourable public opinion or get re-elected. By the same token, campaign groups were often framed as using the situation with Moving on Up to pursue their anti-austerity political agenda. Even Bloughton CCG's initial opposition to the final option was generally framed in terms of a rational response to regulatory structures which encourage organisations to focus on their own interests over and above 'the greater good'. Therefore, whilst there were instances where organisational actors were also framed as emotional or irrational, it was much more common for them to be framed as rational and calculating – in both positive and negative senses. This background element therefore also worked in tandem with implicit understanding that organisations and individuals involved in the programme are objects of evaluation. This evaluation often related to their ability to properly

follow the service change process and make rational decisions. As such, this metaphysical background assumption also underpinned the grounding of the expert ethos and the thick moral concept of impartiality. Both gave higher moral status to decisions that were arrived at in an objective, impartial and unbiased way and so both imply this to be a basic characteristic, or at least capacity, of how those involved in the programme think.

Section conclusion

In this section I have explored the final, perhaps most implicit, set of meso-level para-moral phenomena of the moral background of Moving on Up: metaphysical assumptions. I have identified two metaphysical assumptions implicit in participants' accounts: the belief in a predictable and plannable world, and view of people as both rational and irrational. With respect to the former, this formed a key part of how participants used and interpretated evidence and therefore why they believed the programme would improve outcomes for patients. With respect to the latter, the view of the public as irrational and organisational actors as rational informed several first order moral judgements on how different individuals and organisations had behaved. It also underpinned other background elements, such as the belief that organisations and individuals involved in the programme are objects of evaluation, the grounding of the expert ethos, and the thick moral concept of impartiality. Both metaphysical assumptions explored in this section therefore formed key aspects of the overall moral worldview implicit in the moral background of the Moving on Up programme.

Conclusion to chapter

In this chapter I have sought to characterise the meso and macro levels of morality within the Moving on Up programme through the concept of the moral background. I have therefore sought to answer the following research question:

4) What is the ‘moral background’ of the first order moral beliefs of participants?

a) What is the role of duties, ideals, thick moral concepts, and legitimacy within this?

b) What is the role of para-moral phenomena?

c) How does this relate to the lay morality of participants?

I have answered these questions by going through each of the five dimensions of the moral background of Moving on Up. Through doing this I have revealed a rich network of interconnected shared assumptions that underpin the most prevalent first order moral beliefs identified in the last chapter. I have included a visual representation of my findings in Figure 6.1.

With respect to question 4a, I have shown how the various meso and macro-level moral phenomena manifest as groundings and/ or thick moral concepts as part of the moral background. There was a large amount of overlap between some of the groundings and thick moral concepts discussed in this chapter and so, for the sake of brevity, I have combined these in the below summary:

- *Clinical* - The term ‘clinical’ was regularly invoked as an ideal to communicate moral desirability or appropriateness, and also existed a thick moral concept which was used to both describe and evaluate. This ideal/ thick moral concept was often used as a grounding for the first order moral belief that the programme is the right thing to do; and individuals and objects that carried the designation ‘clinical’ often had an enhanced level of moral authority. This moral authority was also enshrined in regulations as a macro-level moral phenomena, and this gave certain individuals (particularly the ‘independent clinicians’) and bodies (particularly the Clinical Senate) a level of legitimate authority which reinforced this moral authority. This played a particularly visible role in resolving conflicts within the programme.

- *Sustainability* –This was a moral ideal participants used to communicate a future state of health services where care is organised around prevention and community service, making patient outcomes better and costs lower. As with clinical, this existed as both a general ideal and a more complex thick moral concept. It was regularly invoked as a grounding for the first order moral belief that community and preventative services should be developed, and for the belief that the programme is the right thing to do.

- *The ideal of the greater good* – This was an ideal relating to the need for different organisations to work together for the benefit of a shared population. This worked to justify the first order moral belief that partnership working is good.

- *Duty to a specific population* – This was a duty most participants felt towards the specific defined population their organisation serves and was often perceived as conflicting with the ideal of the greater good. It worked to justify the first order moral belief in the appropriateness of focusing on specific organisational priorities, and the importance of 'trade-offs'. As with the grounding/ thick moral concept of clinical, this duty is also established in regulations, and the sense of legitimacy it evoked in participants seemed to give it a large deal of normative force within the service change, despite calls for more partnership working.

- *The expert ethos* – This shared moral understanding was intricately linked to the groundings of clinical opinion and evidence, and the thick moral concepts of impartiality and political. It represented the belief that decisions regarding service change *should* be driven by a transparent, unbiased weighing of evidence and clinical opinion *made by experts*. This grounding lay behind the first order moral belief that the programme is right, and that those who oppose it are wrong. It also lay behind the belief that the

consultation had been conducted in the right way and was strongly associated with the idea that a good consultation is one that achieves 'reach'. This belief, in turn, was also reinforced by macro-level moral rules regarding what makes a good consultation, giving it legitimate authority and therefore extra normative force.

As I have indicated above, there was generally a high degree of compatibility between meso and macro morality, with the latter sometimes providing extra normative force to the former. However, given the focus of my moral economy framework on exploring the interaction between relational structure, particularly hierarchical relational structure, and moral phenomena, it is important to critically examine when and how this regulatory morality – endorsed by power relations – influenced participants. I will therefore return to this issue in much greater depth in the next chapter.

With respect to Research Question 4b, meso-level para-moral phenomena also had a large influence on the moral background of the programme. Firstly, there were two para-moral groundings for participants' first order moral beliefs. These were:

- *Evidence* - Participants extensively used the grounding that the service reconfiguration is backed by evidence to explain why the programme is the right thing to do.

- *Affordability* – This term was used, often interchangeably with sustainability, to refer to the financial constraints under which the programme operated. It was a key grounding for the belief that the preferred option is the right thing to do over building a new, more expensive, hospital between Whitdon and Bloughton.

There were also a variety of other, more implicit, meso-level para-moral phenomena that influenced other aspects of the background, and therefore also the first order morality of participants. These were:

- *Meta-ethical objectivity* – This largely consisted of a moral objectivist (or realist) view, where in participants tended to frame issues as being categorically right or wrong. This view was implicit, to varying extents, in all of the first order moral beliefs of participants.

- *Objects of evaluation* – Participants tended to see organisations and individuals involved in the programme as objects of evaluation. This included the decisions they made and the process by which they came to these decisions. However, they did not see the financial or workforce issues of the local healthcare economy as an object of evaluation. This is particularly notable as it is in stark contrast to the perspective of a prominent campaign group, which did see this situation as the result of an overarching government austerity agenda.

- *Metaphysical assumptions* – I explored three metaphysical assumptions of participants. The first was the belief in a predictable, plannable world. This was highly influential in informing how participants interpreted and used evidence. It led to them having a high level of confidence that Moving on Up will improve patient outcomes and therefore that it is the right thing to do. Participants also made two contrasting assumptions about human subjectivity. The first was that people are rational, calculating, and purposive, and this was applied to individuals and organisations involved or in opposition to the programme. The second was that people are irrational, and this was applied to members of the public. This metaphysical assumption lay behind several first order moral beliefs and background elements. It was particularly evident in the contrasting judgements participants made about organisational actors who opposed the programme, who were often framed as acting out of 'political' motivations, and members of the public who opposed the programme, who were generally framed as misinformed but innocent.

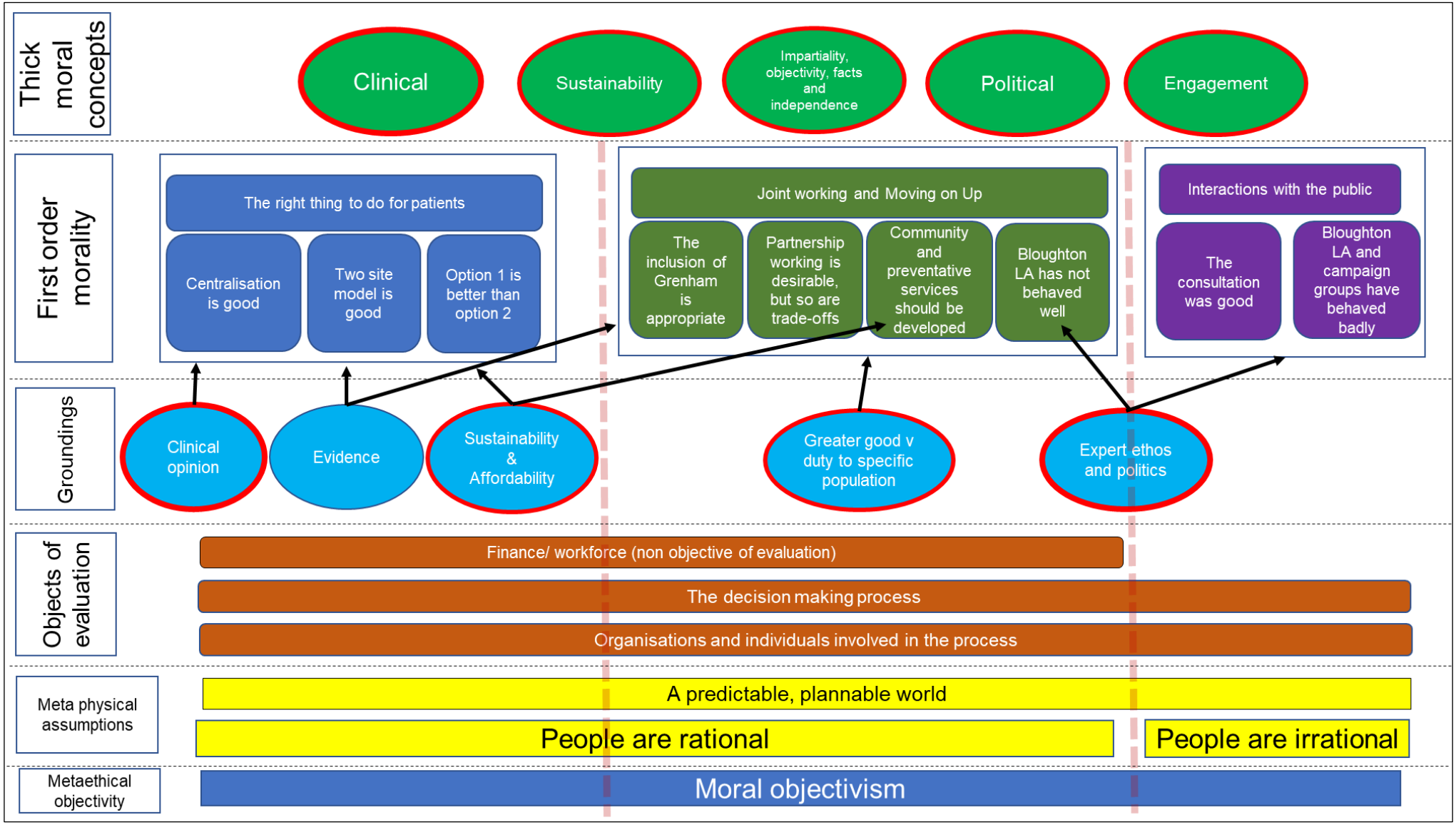
Out of these less visible aspects of the moral background, objects of evaluation and metaphysical assumptions seem particularly relevant to this research. This is both because they had a notable influence on other aspects of the background and participants' first order moral beliefs, and because, on the surface at least, some elements of these background assumptions are problematic. This applies to the metaphysical assumption of a predictable plannable world, which led to a high level of confidence in the ability to use evidence to predict the impact of the programme on patient outcomes. However, this level of confidence does not seem proportionate to what can be inferred from the evidence presented or, as I will discuss in the next chapter, from academic studies carried out on similar reconfigurations. Another influential but problematic background element is the framing of the financial issues of the local healthcare economy as a non-object of evaluation. This was highly influential in how participants conceived the grounding of affordability, which was usually treated as a fact of the context they were working within, rather than a choice made by the government. This therefore strongly influenced participants view that the preferred option is right, as financial issues were not seen as something *anyone* could do anything about. However, as with the metaphysical assumption of a predictable, plannable world, this view seems debatable and worthy of further scrutiny, as, as I will explore in the next section, funding issues are at least in part connected to the decisions made by central government. Given the influential but problematic nature of both these background elements, and the clear link of the latter to the programme's hierarchical relationship with central government funding, I will return to both these issues in the next chapter. Here I will explore the extent to which the problematic nature of these background elements can be understood by considering the relationship between relational structure and moral (and para-moral) phenomena within the Moving on Up programme.

Finally, throughout this chapter I have also sought to answer question 4c by exploring the relationship between background elements and participants' lay moral commitments. Here I have shown how the various background elements allow participants to apply and express

their lay moral commitments to their day-to-day first order moral judgements and beliefs. For instance, the groundings of evidence and clinical opinion allowed participants to show what is and is not in the interests of the patient population. This was further reinforced by the metaphysical belief in a predictable and plannable world, which enabled participants to have a high degree of confidence in these beliefs. By the same token, the thick moral concept of sustainability – which was also used as a grounding – allowed participants to reconcile their commitment to stewardship of public finances with their commitment to improving services. Some background elements also created conflicts for participants in expressing their lay moral commitments. This was particularly the case for the conflict between the groundings of duty to a specific population and the ideal of the greater good. Both groundings ostensibly provided the tools for participants to express their lay moral commitment to making decisions that are fair for the whole population by *defining* this population. However, because they provide different definitions, this created a dilemma for participants. Overall, in this chapter I have therefore shown the importance of lay morality in understanding how participants relate to and draw upon the moral background.

In the next chapter I will build upon these findings to examine the interplay of moral and structural/ economic phenomena. This will therefore add the final layer of analysis to my multi-level moral economy framework.

Figure 6. 1 – The Moral Background of Moving on Up



7. The Entwinement of Multi-level Morality with Relational Structure

Introduction

My aim in this chapter is to explore how the multi-level morality identified in the first two analysis chapters is connected to the constitutive rules of the service change. This will allow me to demonstrate how macro, meso and micro moral phenomena relate to hierarchical relational structure (i.e. structural relations of power). This will add the final layer to the moral economy framework I set out in the theory chapter. In this chapter I will therefore seek to answer the fifth research question:

5. How are these forms of morality entwined with hierarchical relational structure within the service change?

To answer this final question, I will predominantly focus on how the national policy context of financial restraint (i.e. austerity) influenced the programme. As I explored in the first two analysis chapters, participants expressed a strong and consistent belief that the preferred option selected by the Moving on Up programme was grounded in evidence of improved patient outcomes. From their perspective financial matters were, at most, a secondary consideration. To examine the role of finances in the Moving on Up programme I therefore need to use retroductive inference to go beyond the accounts of participants. This will allow me to consider the influence of unseen structural forces. In doing this, I will show how finances had a strong impact on the programme via the constitutive rules that structure it and the organisations within it. This is both in terms of why the programme was seen as necessary, and the process by which the final option was chosen.

I will begin the chapter by establishing that the programme was more influenced by finances, and less by evidence of improved patient outcomes, than participants suggested in interviews. To do this I will draw on academic literature to interrogate some of the more

problematic assumptions within the moral background. The first is that finances are not an appropriate object of moral evaluation for the programme. Here I will show that, contrary to the perception of participants, the constrained financial context of the NHS in recent years bears a high level of responsibility for the difficulties the Moving on Up programme seeks to address. The second element of the moral background I will interrogate is the metaphysical assumption held by participants that evidence can be used to accurately predict the reconfiguration will lead to improved patient outcomes. As discussed in the last chapter, this background element works in tandem with 'finances as a non-object of evaluation' (and other background elements) to support the first order moral belief that the reconfiguration will improve services for patients. However, I will argue that recent evaluations of similar reconfigurations contradict participants' confidence that the change will lead to improved patient outcomes.

I will then explore whether the discrepancy between these background elements and the published evidence can be explained with reference to the interaction of structural relations of power and moral phenomena. Here I will consider two possibilities. The first I label an *instrumentalist* interpretation. This refers to the view that managers and policy makers strategically draw upon ideas such as value-free evidence in defence of existing power interests. The second is *epistemic governance* (Alasuutari and Qadir 2014). This refers to the ways social power can subtly influence the 'shared view of what is a truthful and accurate picture of the situation at hand' (p.73). I argue that the second concept is much more useful for this research, as it allows for a consideration of the interaction of structural power with multi-layered morality without treating the latter as epiphenomenal to the former. It also allows for the possibility of power relations latently influencing the perceptions of those leading Moving on Up. This is more consistent with the accounts of participants who expressed what seemed to be a genuine commitment to improving patient care, but were also implicitly influenced by the government's wider 'austerity' agenda.

I proceed to argue that the constitutive rules of the programme formed a regime of epistemic governance which impacted upon the moral background of Moving on Up in two ways. The first was *directly*, by shaping the objects of evaluation and metaphysical assumptions of participants. Specifically, constitutive rules created the implicit understanding that finances are not an object of evaluation and shaped the metaphysical belief in a predictable, plannable world. These, in turn, encouraged first order moral beliefs that are consistent with the overriding government priority for containing costs, but in a way that is still morally acceptable from the point of view of those implementing the changes. The second form of epistemic governance I will explore is the *indirect* influence constitutive rules had on moral background elements. Here I will focus on the way in which the grounding of the *legitimate authority of clinical opinion* was mobilised through the structure of the service change process. This was done in a way which created the impression of it being driven by *clinicians* and *clinical* evidence, while maintaining overall consistency with the government's austerity agenda. In both cases then, I will explore the ways in which this moral economy framework can elucidate how social power mobilises micro, meso and macro levels of morality and para-morality. Here I define power as the ability of some members of society to achieve their ends over others, knowingly or unknowingly, through their position in a system of structural relations (Lukes 2005. Cited in Hearn 2012: 10). I will therefore show how such power operates via constitutive rules to shape the moral background, thus influencing the first order moral beliefs and judgements of those involved in the Moving on Up programme.

7.1 Interrogating moral background assumptions

Finances as an object of non-evaluation

As I discussed in the last chapter, participants tended to frame the financial constraints that the programme worked within as unavoidable and not a topic of moral evaluation. As a result, while affordability was used in interviews as a grounding for why they believed the

programme is the right thing to do (because of the need of the programme to live within its means), this tended to be framed as secondary to the groundings of clinical opinion and evidence. However, an examination of both the existing national policy context and the circumstances within which the programme was initiated suggests that finances were more significant than many participants suggested. Tough fiscal measures in public spending aimed at reducing the UK's structural deficit has been a key part of the government's NHS policy since 2010 (Hunter 2016: 58). While the NHS has not been subject to the same level of spending restraint as many other areas of the public sector, spending increases have grown at a 'historically slow pace since 2009-10'. Indeed, this only covers approximately one third of increased financial pressures faced by the NHS during that time (Stoye 2018: 3). In other words, over the time of the Moving on Up programme long term funding of NHS organisations has not kept up with the rising costs of demands, such as an aging population, and inputs, such as new medical treatments and technologies (Charlesworth et al 2016).

This context has clearly influenced the Moving on Up programme, both with respect to why the programme was initiated and how it has proceeded. The safety issues the programme sought to address were viewed by participants to be primarily caused by low level of staffing. This, in turn, can be strongly linked with long term government decisions around funding. Indeed, relatively low levels of funding, combined with poor long-term workforce planning is acknowledged to be a key factor behind the difficulty provider trusts have experienced in recent years recruiting to key posts (Kings Fund 2019b). For example, increases in nursing numbers have not met increases in demand (Gershlick and Charlesworth 2019), and this can be linked with several funding decisions made by the government. This includes the decision to cut training places for nurses by 3,400 in 2012/13 compared to the 2008/09 (House of Commons Committee of Public Accounts 2016. Cited in Charlesworth and Lafond 2017: 38), and the removal of the student bursary for nurses in England in 2017 (Beech et al 2019). Finances also had a strong influence on which options were considered for the programme. For instance, a new single site option was ruled out prior to the options

appraisal taking place because the Programme Board was advised this would be unaffordable (Moving on Up 2015b). Added to this, of the four options that were appraised, it was the two that projected the highest savings and the lowest 'cost per benefit' point scores that were put out to consultation. Therefore, finances have had a strong influence over why the programme exists and how it has progressed, despite participants' general belief that these matters are relatively minor.

As I discussed in the last chapter, the first order moral belief of participants that Moving on Up is good because it will improve services was also reliant on a metaphysical assumption that the world is plannable and predictable. They therefore expressed the belief that evidence can be deployed with a high level of certainty to show the positive benefits of the reconfiguration to patients. In interviews they predominantly drew on two types of evidence to back this claim up. The first was that evidence clearly shows that centralisation of services will lead to better patient outcomes. The second was that evidence supports the idea that healthcare organisations can manage acute demand by developing 'upstream' community services. However, recent studies do not support the high level of certainty participants expressed about the benefits of centralisation, or the feasibility of reducing demand through enhanced community provision. For example, with respect to the former, a recent controlled interrupted time series analysis carried out by Knowles et al (2019) on five cases of downgrading or closing emergency departments found 'no evidence that reorganisation of emergency care was associated with a change in population mortality' (p.1). In their retrospective evaluation of the consolidation of three emergency sites into one in Northumbria, Price et al (2020) also found that evidence only 'favours centralisation of emergency care for specific conditions', with less clarity on 'whether broader implementation improves outcomes and efficiency' (p.180). Even with these specific conditions, they state further evaluation is required to confirm that this was directly caused by the service change (p.185). Such findings therefore suggest that a high level of certainty over the benefits to patient outcomes of centralising services is not supported by recent research. The same can

be said for evidence regarding whether acute demand can be reduced by developing community services. Oliver (2019a) describes the empirical evidence for this as 'problematic', citing a range of studies that show no consistent peer-reviewed evidence that attempts to reduce hospital admissions in this way is effective. Elsewhere he has described the policy focus on admission avoidance as 'an elusive holy grail' (2019b). He argues that these ambitions are driven by reductions in bed capacity and increases in demand but are ultimately unrealistic given the evidence. A similar point is made by Hughes (2017), who, when discussing NHS England's New Models of Care programme, argues:

> A dominant discourse has emerged about the value of community-based integrated care, despite failures of integrated care programmes to consistently demonstrate reductions in hospital admissions. (p.72)

This again shows little support in the academic literature for the view that healthcare organisations can control demand for services in the way participants assumed possible. In light of this, the confidence participants showed in the idea that the service change is supported by unbiased, transparent evidence on the benefits it will bring to patients, seems questionable.

This use of evidence, when taken with the beliefs about finances as a non-object of evaluation, somewhat undermines the idea that the preferred option is principally based on improved patient outcomes, and that finances are only a secondary issue. This is significant because, as demonstrated in the last chapter, both sets of ideas – that the benefits of the programme are shown by an unbiased interpretation of evidence, and that finances have not been a primary consideration in decision making – worked in tandem as key building blocks to the first order moral belief that the service change is right. At the same time, it is important to note that the final option chosen by the programme is broadly compatible with central government's austerity policies, particularly with respect to the projected efficiencies of the new service model. This reinforces the need to explore how these background properties

may be influenced by existing power relations. I will now seek to identify a plausible mechanism which could link the metaphysical belief in a predictable and plannable world, and the belief in finance as a non-object of evaluation, to structural relations of power. I propose two interpretations. The first I label an *instrumental* interpretation, while the second is *epistemic governance*.

Instrumental Interpretation

An instrumental interpretation suggests that moral and para-moral phenomena such as ideals, duties and thick moral concepts are mobilised strategically *in service* to power interests. From this perspective, managers consciously present a misleading view of evidence and the role of finances because it suits their interests or the interests of those who sit above them in the NHS hierarchy. Therefore, the evoking of bias-free evidence and the presentation of financial matters as outside the realm of moral evaluation, are largely rhetorical devices used to advance an existing government agenda. A similar perspective has already been applied in the critical literature on evidence-based policy and management. This argues that the notion of value-free evidence – similar to that used by the participants in my study – is often deployed 'instrumentally to neutralise ideologies and to hide power asymmetries from decision making' (Saltelli and Giampietro 2017: 63). From this perspective the use of the language of evidence-based policy/ management is essentially rhetoric for political manoeuvring (Learmonth 2009), used 'as a means to further a particular set of interests and values in organizational life' (Learmonth 2006: 1090. Cited in Learmonth 2009: 96). Indeed, such a criticism is also consistent with the view put forward by the main campaign group opposed to Moving on Up. In the public consultation they criticised leaders of the programme for only using evidence that supports the preferred option, describing this as essentiality dishonest and a form of spin (Campaign Group 2018). They therefore saw the programme as part of a wider austerity project being pursued by the government, to which those charged with devising and implementing Moving on Up are complicit. From this point

of view, similar claims could be made with respect to the status of finances as a non-object of moral evaluation. Removing finances from the realm of moral debate makes it harder to critique, and thus ultimately serves the interests of existing government priorities. Overall, then**,** this instrumental interpretation suggests that, in this context, moral and para-moral beliefs are epiphenomenal to power interests and mainly work as rhetorical devices.

This instrumental interpretation of how policy makers and managers strategically use existing moral and para-moral understandings to justify their actions is also present in existing literature on service reconfiguration in the NHS. However, this also explores the questionability of the extent to which this action is wholly strategic. In their ethnographic study of the centralisation of hospital services, Jones and Exworthy (2015) argue that local and national policy makers drew on medical expertise and knowledge to frame the change as based on evidence and 'clinical necessity', despite the limitations of such evidence. This framing therefore appealed to existing values as a 'rhetorical strategy' to nullify criticism from the public about hospital closures, and ultimately serviced the interests of policy makers. However, Jones and Exworthy also go on to acknowledge the possibility local policy makers are not aware that such rhetorical strategies represent elite interests, and that they genuinely believed that the solutions they advocate will effectively resolve problems (Learmonth and Harding 2006. Cited in Jones and Exworthy 2015: 202). Therefore, while such understandings are deployed strategically to help achieve the aim of implementing the service reconfiguration, such action is not *purely* strategic, as managers will often believe in the justifications they are putting forward. This point is particularly pertinent to my research, where most participants consistently expressed a strong belief that the preferred option is predominantly driven by robust, unbiased evidence of improved outcomes for patients. Indeed, many were baffled that anyone could see the change as anything less than reasonable. Added to this, several interviewees seemed to have a lay normative commitment to improving services for patients and spoke at length about the importance to them of safeguarding patients and protecting their interests. Thus, while it is likely that, at

least to some extent, participants did draw on such understandings strategically when publicly justifying Moving on Up, this does not mean this was done cynically. Instead, it likely reflects a genuine belief in the case they were making, despite the questionable foundations of their background assumptions.

The question therefore remains: *how* did participants come to hold such beliefs – grounded in claims of questionable accuracy – that also worked to justify a preferred option consistent with government priorities? To answer this question, I will turn to the concept of *epistemic governance* as a way of characterising the entwinement of moral and economic phenomenon within the Moving on Up programme. Here I will explore how the constitutive rules through which the programme was structured created a largely unconscious bias among participants to favour decisions also in line with government policy. In doing so, I provide an explanation of how the hierarchical relational structures of the programme worked to *unknowingly* influence moral background assumptions.

Epistemic governance and the moral background

The concept of epistemic governance provides a mechanism by which moral and economic phenomena are entwined which avoids treating the former as epiphenomenal to the latter. *Epistemic governance* (Alasuutari and Qadir 2014) refers to the ever-present ability of governance to influence 'actors' perceptions of the world and its current challenges' (p.67). The term describes how social power often operates in policy making through *epistemic work*, wherein the tools of governance influence and shape people's basic understandings about the world and the situation at hand. While Alasuutari and Qadir are not specific about what these tools consist of, their conception is broad enough to infer that these could include constitutive rules, as defined by critical realism. The idea therefore offers a way of viewing how structural relations of power may influence and mobilise moral phenomena to be consistent with the goals of central government policy. Furthermore, this influence can be

extremely subtle. Alasuutari and Qadir (2014) argue that both those who are engaged in epistemic work, and those who are subject to it, may not be aware that any process of control is taking place. This is because such tools of governance tend to be utilized in the normal course of events as part of routine decision making. It should therefore not be approached as something that is done by individuals, but instead as a *process* of decision making (pp.78-9). This means that when I discuss the epistemic work carried out by the constitutive rules relevant to the Moving on Up programme, it is not my intention to imply that such rules have *purposively* been designed to carry out this work. Indeed, given I have not carried out interviews with central policy makers, the intentions of those who design and maintain these systems of governance is outside the scope of my research. Epistemic governance therefore offers a promising way of conceptualising how structural relations of power interact with moral phenomena in a way that is more subtle than a wholly instrumental or strategic interpretation of the accounts of research participants.

Before applying this concept to the Moving on Up programme, I will first demonstrate the compatibility of epistemic governance with my multi-level moral economy framework through a closer examination of the concept. According to Alasuutari and Qadir (2014) there are three ever-present aspects of this epistemic work:

- Ontology of the environment – This refers to 'the shared view of what is a truthful and accurate picture of the situation at hand' (p.73).

- Actors and identifications – This refers to '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' (p.75).

- Norms and ideals - This refers to 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 (p.76).

There are clear linkages here with the moral background. For instance, 'ontology of the environment' and 'actors and identifications' has clear overlaps with the metaphysics aspect of the moral background, which can include specific assumptions about reality and about human beings (Abend 2014: 50-1). Equally, 'norms and ideals' overlap with both groundings and objects of evaluation. It can help in understanding the role of power relations in influencing why certain moral concepts (such as ideals) are considered as valid, convincing justifications (groundings) in certain circumstances. It can also help show the role of power in determining what things are considered valid to morally evaluate within a certain social context in the first place (objects of evaluation). The concept of epistemic governance therefore offers a route via which these background elements may be influenced by day to day processes of governance. In addition to this, Alasuutari and Qadir explicitly note the importance of considering the deeply held commitments of individual actors when analysing the role of epistemic governance. This therefore also makes it compatible with the concept of lay morality. They argue that:

> governance that acts upon people's understandings not only consists in daily political framing contests of meaning; epistemic governance speaks to and evokes actors' deep-seated values and beliefs, and we argue that success in epistemic governance is based on those paradigmatic assumptions. (p.68)

As a result, and in addition to influencing moral background elements, this perspective also allows for a focus on the ways in which governance can work to channel existing held ethical (i.e. lay moral) commitments in ways that support hegemonic views.

Overall then, the concept of epistemic governance can show how structural relations of power are entwined with moral phenomena in a way consistent with the data I have collected for this research. It offers a mechanism that links constitutive rules with both the moral background (containing meso and macro-levels of morality) and micro-level lay morality. It also promises to explain why some of participants' beliefs are inaccurate, specifically regarding the certainty provided by evidence and the unimportance of finances, without resorting to a wholly instrumentalist perspective that would be inconsistent with the accounts of participants. As such, it offers both a way of adding the final layer to my analysis, while also offering novel insights into the interface of structural power relations with individual values and beliefs.

7.2 Applying epistemic governance to Moving on Up

I will dedicate the remainder of this chapter to exploring the two major ways in which epistemic governance can elucidate the interaction between moral and economic (i.e. relational structural) phenomena as part of the Moving on Up programme. Firstly, I will consider the direct influence of constitutive rules on shaping the objects of evaluation and metaphysical assumptions of participants. That is, how the structure of both the programme and organisations within it shaped the implicit belief that finances are not an object of evaluation and the metaphysical belief in a predictable, plannable world. Secondly, I will explore how constitutive rules indirectly impacted on moral background elements. Here I will focus on the way in which the grounding of the legitimate authority of *clinical opinion* was mobilised through the structure of the programme in a way which is consistent with the government's austerity agenda. In both cases, I will primarily explore how participants were objects of epistemic work carried out by the constitutive rules of the NHS. However, it is important to note that participants were also engaged in epistemic work, particularly in communicating the changes with the public – something I touch upon but that is not the focus of this section.

Direct influence

The constitutive rules that structure performance regulation in the NHS work to separate most issues from financial considerations, while also placing responsibility for addressing them with local organisations and commissioners. As discussed in the previous analysis chapters, in interviews participants presented the safety issues of the Acute Trust as a moral concern which they, as a programme, are responsible for addressing. However, they expressed no accompanying moral concern about the national financial crisis within the NHS, or a belief that the government has a responsibility to address this. The lack of attention participants gave to such issues reflects the accountability relationships they operate within. These tend to bracket off financial considerations from safety issues, while framing the latter as a matter of organisational performance. This is evident from the way regulatory responsibilities are split between the Care Quality Commission (CQC) and NHS Improvement (NHSI). With respect to the former, this centres on carrying out regular inspections of health and social care providers to ensure basic standards of safety and quality are met (CQC 2017: 2). Standards are represented by a traffic light style rating system that appraises organisations as 'outstanding', 'good', 'requires improvement' or 'inadequate' (CQC 2018b). This relates to five dimensions: whether services are safe, effective, caring, responsive and well-led (CQC 2018c). NHS Improvement[30], on the other hand, has several responsibilities in areas such as quality, operational performance, strategic change, and leadership capability (NHS Improvement 2017a: 4), some of which overlap with the CQC. However, unlike the CQC, it has specific responsibilities for finances and the use of resources. This includes regulation of tariffs and pricing (p.12) and the power to place trusts in special measures for financial reasons (NHS Improvement 2018). They do also have the power to place a trust in special measures for quality reasons, but this is done on the recommendation of the CQC (NHS Improvement 2017b: 3). As a result of these

[30] This was formed in 2016, largely as a combination of NHS Trust Development Authority (TDA) and Monitor.

governance structures, safety ratings do not present to those within provider organisations and their commissioners as being related to financial factors. Instead they are treated as a separate area of performance that organisations have a moral and legal obligation to meet, regardless of the broader financial context within which they operate.

The effects of this governance structure were evident in the perception of participants regarding what is and is not an appropriate object of evaluation. During the time of the programme the Acute Trust experienced concerns over both safety and finances. However, it was on the safety side that performance was flagged up as particularly bad, and this came across strongly in the interviews. As I discussed in the Methodology chapter, at the time of data collection the CQC had longstanding concerns regarding the Acute Trust. Indeed, in their most recent inspection at the time of the interviews the CQC had rated the Acute Trust inadequate for safety (CQC 2018a). The report gave nearly eighty 'actions' the Trust must take. All follow a similar pattern of stating the Acute Trust must rectify an area of concern, without speaking to any of the underlying causes of the area of concern. For example, common areas of recommendation included: ensuring medical and nursing staffing is adequate to keep patients safe; ensuring that appropriate training is provided; ensuring that equipment is used safely; and ensuring that guidance is followed. This strongly reinforces the idea that such issues are a matter of poor systems, organisation and management on the part of the Acute Trust. It leaves little room for a consideration of the underlying causes associated with national policy making and decisions. The responsibility to address safety concerns clearly weighed heavily on the minds of several participants, and this concern was only exacerbated when the Trust was taken into special measures for quality reasons soon after this rating. This made it more likely that participants would perceive the difficulties of the Acute Trust purely in terms of the local health economy's failure to arrange safe care, and their responsibility to rectify this. In this context, the question was never raised as to whether long term funding decisions made by the government had contributed to these difficulties. Indeed, participants tended to see the programme as an opportunity for

investment into the local healthcare economy to finally tackle these intractable issues. This demonstrates how the epistemic work carried out by the constitutive rules regarding safety and financial regulation acted to obscure the national funding situation as an object of moral evaluation with respect to participants' understanding of why the programme is needed.

Epistemic governance also worked to remove government funding as an object of evaluation when it came to how the preferred option was selected. This is specifically related to how the options appraisal system works, which separates out financial and non-financial considerations. It also works to ensure that most of the moral deliberation and decision making is focused on the non-financial side, with the financial appraisal largely carried out by accounting professionals. The non-financial appraisal was carried out by a panel consisting of a range of NHS and other stakeholder organisations from several different managerial and clinical roles. They reviewed a range of evidence on accessibility, quality, workforce and deliverability and then decided what weighting should be given to these different factors, before attributing a score. This process was therefore a relatively open and inclusive one. However, the financial appraisal was much more closed and specific. Here the appraisal seems to have been primarily carried out by finance and accounting teams in line with Department of Health and Treasury guidance. As Eli reflected:

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

This process 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 of the way the constitutive rules of the programme made them the sole concern of financial professionals. As such, finances were presented to participants as something that was 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 can therefore help account for *why* finances were not considered an object of evaluation for participants and therefore why these issues were not more prominent in their interviews.

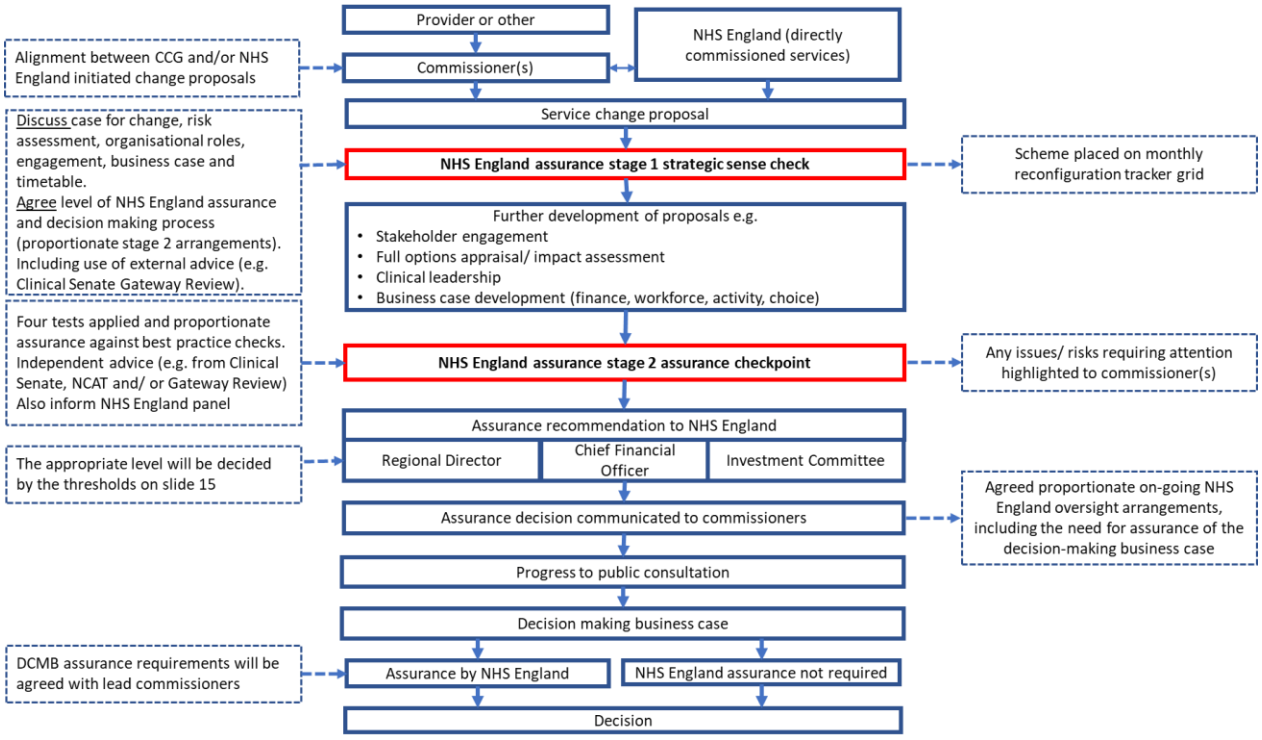
Epistemic governance can also be used to understand the participants' metaphysical assumption that the world is predictable and plannable, particularly in the way it shapes the ontology of the environment. This assumption shaped how participants viewed the role of evidence, as they believed this could clearly show what benefits would be realised by the programme. The way the programme is governed encourages a large degree of confidence in this evidence. One way this was achieved was by the sheer weight of evidence that the programme needed to provide to NHS England. As discussed in the previous analysis chapters, the constitutive rules 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 requirements placed on commissioners for the provision of evidence. The process is demonstrated by the flow chart in Figure 7.1, taken from the service change guidelines (NHS England 2018: 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 and distance
- Evidence of how the service change will address health inequalities
- Details of how the reconfiguration will impact local government services

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

Figure 7.1 – The NHS England (2018) Assurance Process



The documents generated by the Moving on 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 service change is likely to 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. In addition to this, there is a clear implication within the NHS England guidance that such evidence can provide confidence that proposed changes will lead to benefits to patient care, thus creating an ontological 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: 9) reinforces the idea that such levels of certainty can be attained. This notion is further reinforced by the idea that those leading service change can 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) [my emphasis]

Here NHS England draw on the authority provided by this clinical body to further reinforce the idea that evidence can show, with a high level of certainty, that improvements will be obtained - a point I will expand on in the next sub-section. Therefore, when the regulatory requirements participants are subject to are taken into account, their belief in a predictable, plannable world begins to look like a more understandable perspective.

The epistemic governance of both certainty around evidence, and finances as a non-object of evaluation, therefore show how participants came to view the programme as predominantly driven by what is best for patients, despite its clear links to the politics of austerity. This was done by channelling all effort and attention towards issues of safety and evidencing improvements, and away from the financial drivers of performance issues and the financial constraints on the programme. As a result, the lay normative commitment

expressed by participants to improving services for their population can be treated as genuine. However, the constitutive rules of the programme carried out epistemic work to channel this commitment so that it did not threaten the underlying policy priority for fiscal restraint. This, in turn, helps demonstrate how participants' understanding of evidence as transparent and free of bias, and their view that the programme is not driven by financial considerations, while highly disputable, need not be interpreted in wholly instrumental or strategic terms. Instead, it reflects an entirely reasonable response to an institutional context wherein:

1. The performance issues of the Acute Trust were presented by regulators predominantly as safety issues that are separate from underlying financial drivers and are the responsibility of local organisations to resolve.

2. Financial matters were largely structured as a fixed part of the governance process outside of participants' control and involvement.

3. To obtain the capital investment they believed necessary to address the safety concerns of the Acute Trust, they had to present a level of certainty around the benefits of future service models.

The constitutive rules of the programme therefore form a regime of epistemic governance that creates a tendency to see the programme as objectively based on evidence, and not driven by financial concerns, even if alternative interpretations are more plausible.

This interpretation resonates and adds to existing literature on the role of bias in strategic management and evidence-based policy. I use the term 'bias' in the broad sense to refer to 'the adoption of a particular perspective from which some things become salient and others merge into the background', rather than a form of 'systemic error' (Hammersley and Gomm

1997). Such bias is recognised to influence managerial decisions. For example, Das and Teng (1999) state that cognitive biases are 'are an ever-present ingredient of strategic decision making' (p.757). Indeed, they hypothesise that rational decision-making processes are often characterised by a bias similar to the one found by this study: what they refer to as 'an illusion of manageability' (p.765). That is to say, decisions, such as that followed by Moving on Up, which follow a systematic process are often accompanied by a cognitive bias in which 'managers tend to overestimate the extent to which an outcome is under their control' (pp.762-3). The concept of epistemic governance helps to reveal the relational-structural origins of such biases, and how these can influence decision making via the moral background. As such, it builds links between more behavioural and psychological perspectives and sociological ones. This is by showing how biases toward particular outcomes can arise 'through practices and norms that routinely privilege particular types of evidence' while also obscuring the political nature of decision making, even to those intricately involved (Pankhurst 2017: 42-43). It can therefore be linked with Bachrach and Baratz's (1970, cited in Pankhurst 2017: 43) seminal account of the 'mobilisation of bias'. This refers to the way in which power can be mobilised through:

> [a] set of predominant values, beliefs, rituals, and institutional procedures ("rules of the game") that operate systematically and consistently to the benefit of certain persons and groups at the expense of others' (Bachrach and Baratz 1970: 40. Cited in Pankhurst 2017: 43).

This therefore further underlines the value of the concept of epistemic governance to the moral economy framework I have used in this thesis. The perspective helps show how institutional arrangements can condition people within them to take a certain perspective on what constitutes evidence, as part of often unquestioned practices and routines. This will often benefit the perspectives of powerful groups, but in ways that are not necessarily fully perceptible to the social actors involved.

This discussion therefore shows one way in which the moral economy framework developed by my research can highlight the entwinement of moral phenomena with structural relations of power. Participants came to the service change with a micro-level lay normative commitment to improving health for their populations in a fair way. The constitutive rules of the programme (particularly the options appraisal and approval process) directly shaped and influenced meso-level moral background elements to refract this lay normative commitment, in ways which allowed participants to act in accordance with their beliefs *and* central government priorities. This was done by the epistemic work carried out by the constitutive rules that governed the programme. These framed the situation in a way that relegated the importance of finances in the consciousness of most of those involved, whilst enhancing the perspective that evidence can transparently show the benefits that will be accrued from the various options. As a result, the moral economy approach proposed here allows for a more sophisticated view on how managers can be subtly biased in certain ways by structural relations. It also allows for a consideration of how this bias is related to their own normative commitments and the moral background of the programme to influence first order moral beliefs and judgements.

Indirect influence

The constitutive rules of the programme also carried out epistemic work indirectly by channelling the thick moral concept of 'clinical' and the grounding of clinical opinion, alongside the moral authority they evoke, in a way which is consistent with the government's policy agenda. This was done through how the constitutive rules of the programme both bestowed legitimate authority on the Clinical Senate and the independent clinicians on the JGB, but also limited the scope of this authority. This means that it was only ever harnessed in a way that did not come into conflict with the policy objectives of the government. In this sub-section I will explore this process in depth. I will begin by recapping how the concept 'clinical' exists in the programme as both a meso-level and macro-level phenomenon. I will

do this by re-examining the way the Clinical Senate and independent clinicians were able to draw on both moral authority *and* legitimate authority (bestowed by regulations) when resolving disputes during the programme. I will then expand on this by showing how the constitutive rules of the programme bestowed a particular type of legitimate authority: substantive rational authority (Guzmán 2015). This represents a mode of entwinement between moral and economic phenomena it its own right, through the way official validation boosted the pre-existing moral authority of clinicians. However, I will then go on to explore how this legitimate authority is itself subject to epistemic governance, where the power bestowed to clinical bodies and individuals within the programme was also highly constrained by the way the NHS England service change process is structured. I will finish the section by discussing how this reflects longstanding conflicts between clinical and state power within NHS organisations.

The moral authority of individuals, roles and objects designated as clinical was a prominent part of participants' account of the service change. As I established in the last chapter, this authority seemed to emanate through a range of meso-level understandings held by participants, including the thick moral concept of clinical, the expert ethos and the grounding of clinical opinion. However, this authority also had additional normative force, particularly at times of conflict and disagreement in the programme. Here clinicians in certain roles were bestowed a legitimate authority which strengthened their ability to influence decision making. Morgan's (Bloughton CCG) account of how the initial impasse over the location of the Women and Children's Unit was overcome provides a useful example of this:

> So a full…Impact assessment was completed, and that clearly showed that the demographic need was highest in Bloughton. I think Bloughton PCT had fought long and hard for the Women and Children's centre to be here, based on that evidence. The review findings that were done subsequently were really linked into the Clinical Senate saying that Women and Children's needed to be aligned with the emergency centre, and I think that body of the clinical expertise

> strongly saying that was a real challenge then for our system to disagree with. And whether we would've got it through the approval processes, if we'd gone against a body of clinical support [is doubtful].

Here Morgan indicates that previous evidence had justified the location of the Women and Children's unit in Bloughton. However, for the Moving on Up programme the Clinical Senate had subsequently decided that it must be moved to Whitdon for the sake of alignment with the emergency centre. This acceptance by Morgan was not explicitly based on an agreement with this assessment, but rather an acceptance of the Clinical Senate's legitimate authority in determining what is best for patients. This authority is enshrined in the NHS England (2018) service change process, which strongly implies that authorisation will not be granted unless plans have been checked and approved by the Clinical Senate (p.17). A similar authority was also bestowed upon the 'independent clinicians' who were appointed onto the JGB. This step was taken when Bloughton and Whitdon CCG were deadlocked over what the preferred option should be, particularly in terms of which site emergency care should be located. Once these individuals were appointed, they were effectively given the authority to arbitrate on which option best met the clinical needs of patients. This eventually resulted in both sides accepting the preferred option of having emergency care in Whitdon, despite Bloughton's initial opposition. This again shows how the moral authority clinical opinion had over decision making was not just limited to meso-level understandings. It was also given additional normative force by being enshrined in regulations, and thus also existed on the macro level of morality. This represents a form of entwinement between moral and structural relational phenomena in itself via the legitimate authority bestowed by the constitutive rules of the programme.

It is important to note that this mode of entwinement is slightly different from the forms of legitimate authority discussed in the Theory chapter, in that it does not *just* constitute a form of legal rational authority, but also *substantive rational authority* (Guzmán 2015). This

indicates a subtly different relationship between macro, meso and micro level moral phenomena than I originally speculated in the Theory chapter. Namely, macro (regulatory) morality here was effectively used to help 'boost' the power of certain clinicians to interpret the micro-level, lay moral, commitment to improving services for patients. As discussed in the last chapter, this moral authority was already to some extent established by meso level understandings, particularly the grounding of clinical opinion and the thick moral concept of clinical. However, here formal rules enhanced this authority so that certain clinical bodies and individuals had the power to arbitrate specific disputes. This therefore still has an element of legal rational authority as the source of legitimacy, as discussed in the Theory chapter. That is, individuals accepted this authority because of a belief that those in certain formal positions have the right to make decisions. However, it also contains a strong element of *substantive-rational authority* (Guzmán 2015). This holds that legitimate authority is not just limited to the three types outlined in Weber's original work: traditional, charismatic and legal (p.73). Instead, a fourth type might be added, that of 'substantive-rational authority' (p.73). This refers to two variations of one ideal type:

> (a) legitimacy based on the belief that an authority is a correct mediator between abstract ultimate values and concrete practical norms and (b) and legitimacy based on the belief that an authority is a correct mediator between ultimate goals and concrete means. (p.80)

This legitimacy is one often held by professionals. It is generally backed up by official credentials and authorisation but does not wholly emanate from them in the same way as rational legal authority (p.80). However, as with all ideal types, it never appears in its pure form in the real world. In the case of the Clinical Senate and the independent clinicians, much of their legitimacy seems to have come from the pre-existing, meso level understandings (such as the thick moral concept of clinical) which were independent from formal rules and regulations. This generally gave them the legitimacy to interpret what is best for patients. However, in the case of Bloughton Women and Children's services, this

legitimacy was not enough to settle the dispute. As a result, the formal, constitutive rules that set out which specific clinical bodies and individuals are the right arbitrators of patient interests became more important. This therefore represents a less 'top down' form of legitimacy than is represented by legal rational authority. Here, the constitutive rules only subtly reinforce an existing form of clinical authority that is already established in participants' meso-level understandings**.** This represents a more subtle interaction of structural relations of power and moral phenomena that I originally anticipated when I presented macro morality and legal-rational authority as a possible entwinement mechanism in the Theory chapter.

While this form of legitimate authority on the surface appears relatively 'bottom-up' (i.e. derived from pre-existing meso-level understandings), the constitutive rules of the programme still exerted a subtle but strong influence to ensure this authority was channelled in a way that did not conflict with central government priorities. This is best demonstrated through an examination of the role of the Clinical Senate in the service change process. While the involvement of the Clinical Senate may have reinforced the view that the preferred option of the Moving on Up programme is supported by 'independent' clinical opinion, the advice of this body was structured within the process in a way which was highly specific and somewhat limited. Clinical senates are designed as a supporting body which respond to requests for advice from commissioners and providers of healthcare. As the original guidance states:

> Clinical Senates will bring together a range of professionals to take an overview of health and healthcare for local populations and provide a source of strategic, independent advice and leadership on how services should be designed to provide the best overall care and outcomes for patients…They will provide a clinically led and strategically focussed space for commissioners and providers to come together and determine the most clinically appropriate way to configure services for the future. (NHS Commissioning Board 2013: 2)

Clinical senates do not have statutory duties themselves, but only the ability to provide advice to bodies such as CCGs, especially as part of NHS England's service change process. For example, the Terms of Reference for the Clinical Senate (2017) involved in Moving on Up states that it will respond to requests made by organisations such as CCGs, Local Authorities and Health and Wellbeing Boards. This is to provide 'formal clinical advice' in support of decision making, particularly with respect to 'complex clinical issues'. With respect to the Clinical Senate's involvement in the Moving on Up programme, this involved a committee of people of various clinical backgrounds providing advice on the invitation of the Bloughton and Whitdon CCGs. They met several times to review documentary and verbal evidence provided by the programme on the three options deemed feasible by the JGB. This included Option 1 and Option 2, which ultimately went to consultation, and the option discussed in Morgan's interview where emergency services would be moved to Whitdon, but Women and Children's would remain in Bloughton. They reviewed these options to assess their 'clinical quality, safety and sustainability' (Clinical Senate 2016). As discussed, the Clinical Senate discounted the third option listed above due to issues of clinical interdependencies.

A closer look at the process by which the Clinical Senate intervened in the programme shows how its power, via epistemic governance, was largely channelled in a way which was bracketed off from financial considerations. This is clear from the sequencing of when NHS organisations are required to seek clinical senate advice as part NHS England's service change process. A detailed review by a clinical senate is typically required for large scale service changes at the stage two gateway. This is the same stage at which the financial feasibility of the programme is also assessed. According to the NHS England (2018) guidance:

> Before public consultation is launched, proposals should be tested to ensure there is a high degree of confidence that all options would be capable of being

> delivered as proposed and do not imply an unsustainable level of capital expenditure or revenue funding. NHS England will review this as part of the assurance process. Service change schemes which require capital financing will require the support of NHS England and NHS Improvement (in writing) before public consultation on options requiring capital commences. (p.21)

As such, it only makes sense for CCGs to request a review of proposals that have already gone through a financial appraisal. Indeed, this was implicit within the stage one informal advice provided by the Clinical Senate (2015) on the provisional proposal provided by the programme. This report states that it does not allow financial constraints or political considerations to influence its response. However, it goes on to express concerns about whether the model 'could be clinically and financially sustainable' and makes it clear that more detail is needed on these points. This shows how the advice the Clinical Senate provided regarding the NHS England (2018) test of 'a clear clinical evidence base' (p.9) was largely restricted to proposals that had already been deemed 'financially sustainable'. This system therefore works in a similar way to the options appraisal process by separating out financial and non-financial elements and limiting the input non-financial professionals can have on the former. As a result, while the Clinical Senate's ability to exert regulatory authority over the programme was an outworking of clinicians' own moral authority within the NHS, the extent of this power was also shaped by wider constitutive rules regarding the way service change in the NHS is governed.

The independent clinicians on the Joint Governing Board were given a similar role in deciding whether the preferred option of Moving on Up should have the A&E in Whitdon (Option 1) or Bloughton (Option 2). Again, much of their legitimacy was of a substantive rational kind and emanated from the same meso-level understandings discussed earlier. However, this was reinforced by the power granted to them through their place on the JGB to arbitrate between two specific options which, again, had already been appraised as financially acceptable. What is different about the introduction of independent clinicians is

that this intervention was, ostensibly at least, a decision made by the JGB itself, rather than imposed upon it by NHS England. In this sense then, it can be described as an example of participants applying epistemic governance to themselves to make it possible to come to a decision. It is hard to draw definitive conclusions about the process by which this happened as it was only briefly touched upon by participants in their interviews. However, it does potentially help to underline the subtlety of epistemic governance as a form of power that is often exercised with the consent of those who are subject to it.

The way clinical legitimacy was mobilised by the constitutive rules of the programme both reflects and elucidates the long-term tension between the power of medical professionals and the power of the state within the NHS. This helps to further illustrate how the moral and para-moral phenomena present in the programme were connected to broader power relations within NHS policy. An implicit feature of the original structure of the NHS was a compromise between state and medical professions, wherein the former decided on the budget, and the latter decided what was done with this budget (Klein 2010: 61). While the nature of this compromise has undergone significant change over the years, the fundamental tension between these two forms of power remains. As Hunter (2016) notes, despite several attempts to challenge medical hegemony within the NHS in recent years, this seems to remain a major force within the institution (p.100). Indeed, clinicians continue to hold ‘public jurisdiction’ over the NHS, wherein they maintain ‘the right to define certain problems… culturally and to dominate the problem-solving structure’ (Thorne 2002: 15). As such, they have a high level of cultural authority wherein ‘medical definitions of reality and medical judgements are accepted as valid and true’ (p.16). At the same time, successive reforms from the 1980s onwards have meant that the organisation of medical work is increasingly subject to managerial prerogatives (Harrison and Ahmad 2000. Cited in Waring 2014: 692). This has mostly been an outworking of the influential New Public Management perspective, which typically views public services as inefficient, unresponsive, ineffective, and run in the interests of providers, in this case clinicians (Hunter 2016: 48). The public

sector is therefore seen as needing to emulate private sector management practices and 'the NHS has been subjected to more of this type of thinking than any other public service' (p.48). This has manifested in, among other things, an increased focus on performance management, and 'the promotion of discipline and parsimony in resource allocation' (p.46). As part of this endeavour, clinical power has become increasingly mixed with managerial forms of control. Doctors are more and more integrated into the managerial structure and the boundary between professions and organisations has become increasing blurred (Fitzgerald 1994. Cited in Thorne 2002: 17). This trend has been interpreted in various ways, including the idea that clinicians are being co-opted to support managerial priorities and visa-versa (Waring 2014: 693). However, regardless of this, the two forms of power are clearly intricately interrelated, and this changing relationship has been one of the central themes of healthcare reform over the past 30 years (Hunter 2016: 51).

The way the legitimate authority of clinicians manifested within the Moving on Up programme provides an example of the way these power dynamics 'play-out' when it comes to concrete decision-making in NHS service change. Participants within my research predominantly held a lay moral commitment to patient care, and an implicit understanding that clinicians should have the final say as to how to realise this commitment. Added to this, they also believed the public were more likely to accept a decision if it was seen as backed by clinicians. This understanding is also contained within the NHS England (2018) guidance, which states:

> It is important that front-line clinicians affected by the proposed changes are involved. Clinicians are powerful advocates and play an important role in communicating the benefits of change to a wider community. (p.13)

Clinicians therefore held a great deal of moral authority over the service change, and it is clear from both participants' accounts and the national guidance that their ostensive support is seen as crucial for making a service change possible. This authority can perhaps account

for why clinical bodies and individuals are also given extra formal legitimacy within the NHS England service change process. They are the only group that would feasibly be able to wield this legitimacy to mediate disagreements over concrete decision making. At the same time, the power granted to clinicians is also subject to a form of epistemic governance, via the constitutive rules of the service change process, which channel this power in a way which is broadly in keeping with the prerogatives of a New Public Management perspective, particularly the focus on constraint in public spending. As a result, the authority of clinical bodies and individuals, such as the Clinical Senate, is only ever drawn upon in isolation from financial matters. As such, this demonstrates how state/ managerial power and clinical power are enmeshed within the service change process. While the latter may be more obvious and visible, the former still takes overriding precedence in decision making around resources.

Conclusion to chapter

In this chapter I have demonstrated how the forms of morality discussed in the first two analysis chapters are entwined with structural relations of power within the Moving on Up programme (summarised in figure 7.2). To do this, I began by drawing attention to two particularly problematic aspects of the moral background. The first was the tendency to not view finances as an object of moral evaluation. The second was the metaphysical assumption that the world is plannable and predictable, which lay behind participants' approach to using evidence to plan future service provision. These assumptions are key to the first order moral belief that the programme is the right thing to do for patients. However, they are also problematic because:

1. Their accuracy is highly questionable when scrutinised using recent research and academic commentary.

2. They also work to bring the programme in line with central government prerogatives, particularly the desire to constrain spending (i.e. austerity policies).

I then sought to explain how structural relations of power may influence these erroneous background assumptions. I did this by exploring two possible interpretations. The first is an *instrumental* perspective. This holds that managers strategically draw on certain understandings, such as the belief in value free, transparent evidence, to reinforce existing power relations. The second interpretation is epistemic governance. This holds that social actors' assumptions about the world can be subtly influenced by power relations via processes of governance. I argued that an instrumental perspective is not wholly adequate, as the accounts of participants strongly suggest both a *genuine* belief in the credibility of the evidence behind the reconfiguration, and a lay moral commitment to improving services for patients. I then argued that the concept of *epistemic governance* represents the best way of understanding how the power of central government influenced the perspectives of those involved in planning and implementing the Moving on Up programme. This operated subtly via the constitutive rules by which the programme and the organisations within it were structured to shape certain aspects of the moral background, and therefore also the first order moral beliefs of participants.

I then explored two broad ways by which this happened within the Moving on Up programme: direct and indirect epistemic governance. The direct form operated by acting on the objects of evaluation and the metaphysical assumptions of participants. With respect to objects of evaluation, programme and regulatory structures largely removed issues relating to the national funding settlement of the NHS out of view. This was achieved through the way performance regulation divides safety (the responsibility of the CQC) and finances (the responsibility of NHS Improvement). This worked to create the impression that all safety issues were the responsibility of the Acute Trust and had little to do with funding issues. Direct epistemic governance on objects of evaluation also occurred through the way the

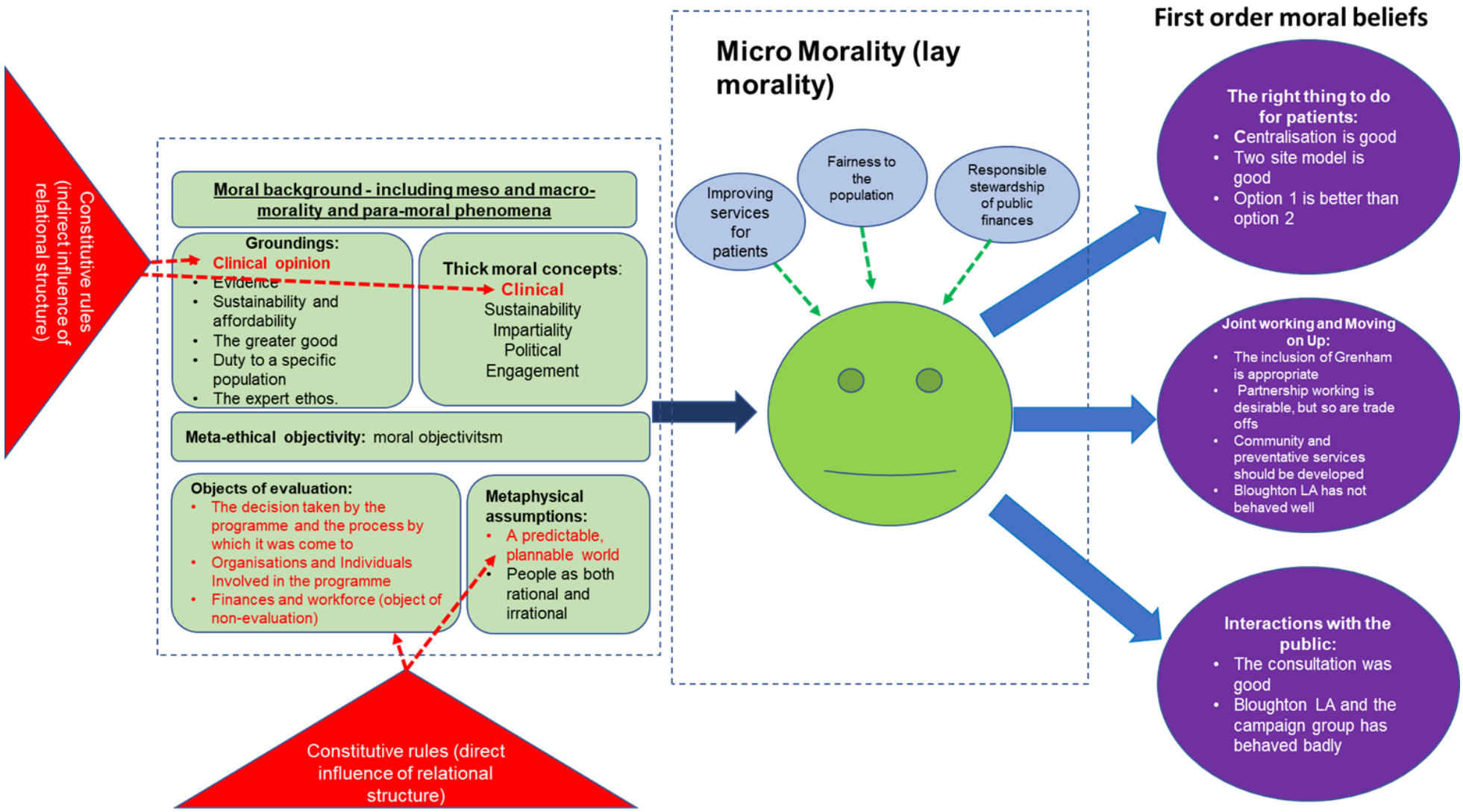
options appraisal of the programme was structured. This separated out the financial and non-financial appraisals, with the former carried out largely by financial professionals away from the view of participants. This meant the financial review was experienced as a fixed part of the process, and therefore was not seen as a relevant object of moral evaluation. Direct epistemic governance also worked on participants' basic metaphysical assumptions about the nature of evidence. The NHS England approval process is based on the need to pass five tests, including having a 'clear, clinical evidence base' (p.9). The Moving on Up programme was therefore required to generate and submit a high volume of evidence about the potential impacts of the service reconfiguration. This process created the impression amongst participants that the programme is strongly evidenced to improve patient outcomes. This is despite the doubtful status of the core assumptions behind these views: that centralisation of acute services improves outcomes, and acute demand can be managed through community provision. When taken together, these two forms of direct epistemic governance – on objects of evaluation and metaphysical assumptions – created the impression that the programme is predominantly based on concrete evidence of improved patient outcomes and has little to do with finances. As a result, it worked, via the moral background, to channel participants' micro-level lay moral commitment to improving patient outcomes in a way which was also in line with the government's wider austerity agenda.

The constitutive rules by which the programme was structured also carried out what I refer to as *indirect* epistemic governance. This form of epistemic governance did not work by directly shaping elements of the moral background, but instead by the way it controlled *when* certain elements became relevant during the service change process. To illustrate this, I drew on the specific example of the way the grounding of the moral and legitimate authority of clinicians was channelled by the programme structure so that it never came into conflict with the government priority of containing spending. I showed how the rules of the programme gave certain clinicians - the Clinical Senate and independent clinicians on the JGB - increased legitimacy to decide how to apply the abstract value of improving patient

outcomes. However, this was only granted at specific points in the overall approval decision-making process. As such, this legitimate authority was subject to a form of epistemic governance through the way the programme was structured. That is, such authority only 'came into play' after financial considerations had already significantly narrowed down the options being chosen from. As a result, it was never able to conflict with the broader government objective of controlling spending. I finished the chapter by arguing that this serves as an example of the complex relationship between clinical and state power within the NHS, which has been a fundamental point of conflict since its inception.

Overall, in this chapter I have demonstrated how the entwinement of economic and moral phenomena can be conceived with respect to the Moving on Up programme. In doing so, I have shown how, through a process of epistemic governance, constitutive rules can influence first order moral beliefs via the moral background. Such an understanding allows for an appreciation of the subtle workings of power within the Moving on Up programme, wherein participants' lay moral beliefs were channelled through this moral background in a way which is also consistent with the government's overarching austerity agenda. This potentially has a variety of wider theoretical and substantive implications which I will explore further in the Conclusion.

Figure 7.2 - Summary of findings



Conclusion

In this final chapter I will summarise the line of argument I have taken in this thesis, highlight my original contribution, and discuss possible limitations of my study to be taken account of in future research. I will finish the chapter by pulling all these insights together to explicitly answer Research Question 6, thus highlighting the implications of this study for the use of moral economy as a means of understanding service reconfiguration processes.

In this thesis I have sought to fulfil two aims: to apply the concept of moral economy to gain an improved understanding of the process of service reconfiguration in the NHS, and develop the concept itself so that it can be used to explore similar contexts in future research. I have achieved both these aims by constructing and applying a multi-level moral economy framework to a qualitative case study of a service change in the NHS (the Moving on Up programme), and refining said theoretical model in light of this study. This has illuminated how moral beliefs within NHS organisations are underpinned by complex, interdependent webs of meanings, ethical commitments, regulations, and power structures. In so doing, I have provided a sociologically informed theoretical tool which can be applied to understanding similar contexts in the future.

I began the thesis with the Background chapter (Chapter 1), where I argued that the current dearth of sociological perspectives on large scale service change in healthcare makes moral economy a timely and relevant theoretical perspective for this kind of empirical setting. This is especially the case given recent scholarly interest in the impact of policy change in the NHS on the normative commitments and ethical decision-making of those who work within it. However, I also highlighted that there is a large breadth of uses for the term, making it unclear how it should be conceptualised and applied. I then presented the Literature Review (Chapter 2), in which I examined several existing empirical studies which apply the concept to work and organisations to appraise the suitability of their approach to moral economy for

my study. From this, I concluded that the most rigorous and coherent approaches are those that conceptualised morality as existing on micro, meso and macro levels, and which conceptualise the relationship between moral and economic phenomena as one of *entwinement*. However, I also found two unresolved questions. The first relates to how a multi-level understanding of morality can be applied to understand organisations, especially NHS organisations involved in service reconfiguration. The second relates to how the economic and moral dimensions can best be conceptualised to differentiate them when exploring the process of entwinement.

I sought to address these questions in the Theory chapter (Chapter 3). Here I drew extensively on critical realist meta-theory, and a range of sociological perspectives (such as Durkheim, Weber, and March and Olsen), to characterise multi-level morality and economic phenomena. I conceptualised the economic dimension of moral economy as relational structures, particularly hierarchical relational structures, formed by constitutive rules. I also argued that micro-level morality can be conceptualised as lay morality; the meso-level as shared ideals, duties, and thick moral concepts; and the macro-level in terms of duties, obligations and moral rules that are endorsed by hierarchical constitutive rules. I then argued that Abend's (2014) moral background provides a useful concept to integrate these various phenomena in a way which is also consistent with a critical realist understanding of the relationship between structure and agency. This is particularly so regarding the way it separates out first order and second order (background) morality, which allows for a focus on how concrete moral beliefs and judgments are influenced by a range of contextual phenomena. The framework is well suited for studying the process of service change in the NHS, which actively requires individuals involved to form opinions and make decisions. The moral background also provides a range of para-moral cultural phenomena that influence individual moral beliefs, thus further deepening my multi-level moral economy framework. In the Theory chapter I also began to explore different ways economic (i.e. structural relational) phenomena and moral phenomena are entwined with one another. Here I focused on the

way those in power can formalise moral understandings into regulations, thus giving them legitimate authority. I also speculated that constitutive rules may allow those in power to shape certain aspects of the moral background. In the Methodology chapter I then set out how I operationalised this theory into an empirical study of service change in the NHS. Here I again drew on a critical realist meta-theory to design a qualitative case study into one service reconfiguration in the NHS; and I used abductive and retroductive inferential strategies to inform data analysis.

In Chapters 5, 6 and 7 I then presented the results from the analysis of the data I collected in the case study. In Chapter 5 I identified the most prominent constitutive rules relating to the Moving on Up programme, the most common first order moral beliefs participants expressed, and their lay moral commitments. With respect to constitutive rules, these included the various accountability structures that CCGs are subject to and the NHS service change process for authorising service reconfiguration. I also identified three sets of first order moral beliefs relating to: the belief that the preferred option of the programme is the right thing to do for patients; the perceived desirability of joint working; and interactions with the public. In addition to this, I identified three lay moral commitments: a commitment to improving services for patients; a commitment to fairness to the population; and a belief in the need for responsible stewardship of public finances. In the second analysis chapter (Chapter 6), I went on to characterise the moral background of Moving on Up and its relationship to lay morality and first order moral beliefs. In this chapter I explored several meso and macro-level moral and para-moral phenomena existing in the moral background. This included the shared ideal that clinicians have a high degree of moral authority in deciding what is best for patients; a shared commitment to evidence-based decision making; and a shared belief in the importance of affordability. All acted as groundings for the first order moral belief that the programme is the right thing to do for patients, whilst also allowing participants to apply their lay moral commitment - to improving services for patients in a fair way which uses resources responsibly - to concrete decision making. With respect to the

clinical ideal, this was also reinforced by macro-level morality (i.e. regulations), which often gave clinicians enhanced legitimacy in decision making in addition to the moral authority they already held. This therefore indicated a potentially fruitful area for examining the entwinement of economic and moral phenomena.

Two other notable background elements were objects of evaluation, particularly the belief that finances are not an object of evaluation, and metaphysical assumptions, particularly the belief in a predictable and plannable world (which had a big influence on how evidence was used in the programme). Both these beliefs seemed problematic, the first because finances were clearly an issue for the Acute Trust, and the second because recent research suggests that participants' beliefs regarding what evidence can predict are wrong. I therefore identified these two moral background elements, alongside the legitimate authority given to clinical opinion, as potential areas of entwinement. In the final analysis chapter, I went on to explore these in more detail, and suggested two modes of entwinement between economic and moral phenomena. The first was *direct epistemic work* which, via the constitutive rules of the programme and the NHS in general, created the impression of both a predictable, plannable world, and the sense that finances are not an object of evaluation. Both these elements worked together to enhance the influence of central government priorities on decision making within the programme. The second mode of entwinement was *indirect epistemic work*, wherein the constitutive rules that structure the service change process controlled *when* clinicians' moral authority was reinforced with legitimate authority. Here I showed how this was largely done in a way that did not interfere with central resource considerations, thus apparently advancing – knowingly or unknowingly – the interests of central policy makers. Overall then, I have provided a detailed and layered exploration of how moral economy can be applied to service reconfiguration in the NHS, whilst also developing the concept itself.

Through fulfilling the aims of my research, I have made two original contributions to existing academic literature. The first is to provide a precise definition of the concept of moral economy that is suitable for the study of organisations involved in service reconfiguration. That is, I have used critical realist meta-theory to develop a multi-level approach to moral economy that is specific about what moral and economic phenomena *are* and *how* they interact with one another. I have done this by drawing on sociological theory to characterise morality as existing on macro, meso and micro levels, and economy as equating to relational structures formed by constitutive rules. Furthermore, I have shown how these phenomena interact to influence individual moral beliefs and judgements by using a critical realist approach to structure, culture and agency (i.e. the morphogenetic approach) to reimagine Abend's (2014) moral background. In so doing, I have filled the gap I identified in the literature review regarding empirical applications of a multi-level moral economy framework to the study of organisations. By critically assessing the underlying theoretical foundations of the term moral economy, I also hope to have contributed to recent debates regarding its usefulness at a time where it is being used in an increasingly broad and diffuse way (Simeant 2015, Palomera and Vetta 2016, Carrier 2018).

My second contribution is to have provided an original, *sociologically* informed perspective on large scale service change involving healthcare organisations. I have done this by analysing the beliefs and decisions of individuals involved in service change with respect to two foundational sociological concerns. The first is the interaction of structure, culture and agency which, as discussed above, has formed the bases of the moral economy framework I have developed. The second is the operation of social power, which I have explored in a novel way by drawing upon the concepts of *moral background* and *epistemic governance*. Here I have elucidated how the moral background can act as a distinctive site of the workings of social power through the epistemic work carried out by constitutive rules. The influence this has on the moral background can, in turn, channel the lay moral commitments of social actors in ways which prevent the decisions they make from conflicting with

overarching power interests. As such, my account shows how individual subjectivity and decision making can be influenced in subtle ways by hierarchical systems of governance. These insights can, in turn, have important implications for both policy and practice. This is particularly in encouraging more critical reflection on how evidence is used, and the way clinical opinion and financial considerations are included in the structure of the service change process.

There are some limitations to my study, and these can provide insights into ways the moral economy framework I have set out in this thesis can be developed and refined in future research. Firstly, as I explored in the methodology chapter, I only interviewed individuals who were involved in planning and implementing Moving on Up, and who were predominantly strongly supportive of the programme. This allowed me to develop an in-depth understanding of the moral background and lay moral commitments of those on the Programme Board and the Joint Governing Body. However, it also means that my study has not been able to include the perspective of groups who may be more hostile to the programme, such as Bloughton Local Authority. This could have yielded interesting comparative insights by showing how the differing structural, cultural and regulatory contexts of those working in different sectors can encourage different moral beliefs and judgements. Another fruitful area of enquiry would have been to explore the perspectives of 'front-line' clinicians, as this would have allowed me to examine whether there were significant differences in perspective between them and those in hybrid managerial roles.

The second limitation is the restricted number of background phenomena I was able to scrutinise in terms of their entwinement with hierarchical relational structures. In Chapter 7 I only explored the influence of relational structure upon those background beliefs that seemed particularly problematic: the metaphysical belief in a predictable plannable world and finances as a non-object of evaluation. While this decision was necessary given the space constraints of the thesis, there is future scope within the data I have collected and

analysed to explore the influence of relational structure on other elements of the moral background of Moving on Up. For example, I could give more consideration to the implicit power imbalance that is created by the expert ethos with respect to public consultation, particularly in terms of privileging the opinions of managers and clinical managers over the public.

All the insights I have provided above allow me to directly answer Research Question 6, this being:

6. What are the implications of the findings of this study for the use of moral economy as a means of understanding service reconfiguration processes?

    a) What modifications can be made to the moral economy approach to make it better suited for studies into the normative dimension of service reconfiguration in the NHS?

The implications of this study for the understanding of service reconfiguration are to show the complex cultural, structural, and agential dynamics that inform the beliefs and judgements of those charged with planning and implementing these changes. I have therefore demonstrated how moral economy can be used to provide a sociologically informed lens for understanding the influence of these often unseen and unacknowledged factors.

I have also identified several modifications that can be made to the moral economy framework to make it better suited for studying similar contexts in the future. As I noted in the Introduction, the relationship between theory development and empirical enquiry is necessarily complex and non-linear. My development and modification of the concept moral economy for explaining service reconfiguration processes can therefore be split into two

parts. The first took place prior and during data collection and in the early stages of data analysis, and relates to:

1. The need for moral economy studies to focus on a multi-level conceptualisation of morality which is entwined with economic phenomena in various way.
2. The need to modify such an understanding of moral economy – using existing sociological theory, a critical realist approach to structure and agency, and Abend's moral background – to make it more suitable for use in the study of organisations.

The second set of modifications relate to the output of my analysis, and involve acknowledging:

1. The relevance of epistemic governance as a way of conceptualising the entwinement of moral and economic phenomena, particularly in terms of how constitutive rules can interact with the moral background to subtly influence perceptions of social actors.
2. The way this entwinement can work in both direct and indirect ways.

Through this thesis I have therefore developed – through the rigorous theoretical deconstruction, reconstruction and empirical application of moral economy – a theoretical approach that can shed valuable insights on the process of service reconfiguration in the NHS. In so doing, I hope to have provided a conceptual tool that can be used and refined by other researchers studying similar contexts, and beyond.

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Appendices

Appendix A – Papers included in Literature Review

Author(s)	Title
Bailey, J., Macdonald, F. and Whitehouse, G. (2011)	'No leg to stand on': The moral economy of Australian industrial relations changes'
Banks, M. (2006)	Moral Economy and Cultural Work
Baur, P., Getz, C. and Sowerwine, J. (2017)	Contradictions, consequences and the human toll of food safety culture
Bolton, S.C., Houlihan, M. and Laaser, K. (2012)	Contingent Work and Its Contradictions: Towards a Moral Economy Framework
Bolton, S.C. and Laasar, K. (2013)	Work, employment and society through the lens of moral economy
Bolton, S.C. and Laaser, K. (2020)	The Moral Economy of Solidarity: A Longitudinal Study of Special Needs Teachers
Bolton, S. Laaser, K. and Mcguire, D. (2016)	Quality Work and the Moral Economy of European Employment Policy
Bonizzoni, P. (2017)	The shifting boundaries of (un)documentedness: a gendered understanding of migrants' employment-based legalization pathways in Italy
Bryand, L. and Garnham, B. (2014)	Economies, ethics and emotions: farmer distress within the moral economy of agribusiness
Curely, A. (2017)	T'áá hwó ají t'éego and the Moral Economy of Navajo Coal Workers
Dodson, L. (2007)	Wage-Poor Mothers and Moral Economy
Galam, R.G. (2019)	Utility Manning: Young Filipino Men, Servitude and the Moral Economy of Becoming a Seafarer and Attaining Adulthood
Hiah, J. and Staring, R. (2016)	But the Dutch would call it exploitation'. Crimmigration and the moral economy of the Chinese catering industry in the Netherlands
Irwin, S. and Bottero, W. (2000)	Market returns? Gender and theories of change in employment relations

Khurana, S. (2017)	Resisting labour control and optimizing social ties: experiences of women construction workers in Delhi
Kofti, D. (2016)	Moral economy of flexible production: Fabricating precarity between the conveyor belt and the household
Laaser, K. (2016)	'If you are having a go at me, I am going to have a go at you': the changing nature of social relationships of bank work under performance management
Mulinari, P. (2019)	Weapons of the poor: Tipping and resistance in precarious times
Nara, L. (2011)	The Moral Economy of Domestic and Care Labour: Migrant Workers in Naples, Italy
Noronha, E., Chakraborty, S. and D'Cruz, P. (2020)	'Doing Dignity Work': Indian Security Guards' Interface with Precariousness
Palomera, J. and Vetta, T. (2016)	Moral economy: Rethinking a radical concept
Sanghera, B. and Satybaldieva, E. (2009)	Moral sentiments and economic practices in Kyrgyzstan: the internal embeddedness of a moral economy
Sayer, A (2008)	Moral Economic Regulation in Organizations: A University Example
Stenbacka, S (2019)	Responsibilities, Caring Practices and Agriculture: Farmers
Umney, C. (2017)	Moral economy, intermediaries and intensified competition in the labour market for function musicians
Vallejo, M.C. and Langa, D. (2010)	Effects of family socialization in the organizational commitment of the family firm from the moral economy perspective
van Doorn and Velthuis's (2018)	A good hustle: the moral economy of market competition in adult webcam modelling
Wheeler, K. (2018)	The moral economy of ready-made food
Wheeler, K. (2019)	Moral economies of consumption

Appendix B – Proof of University of Birmingham ethical approval (front page of sponsorship letter)

UNIVERSITY OF BIRMINGHAM

FINANCE OFFICE

Mr Christopher Q Smith
Postgraduate Researcher
University of Birmingham
Health Services Management Centre
40 Edgbaston Park Road
Birmingham
B15 2RT

Tuesday, 7 August 2018

Dear Mr Smith

Project Title:	Moral economy and the NHS: How does service reconfiguration affect the normative character of NHS organisations?
Sponsor Reference:	RG_18-102
ERN reference:	ERN_17-1167

Under the requirements of Department of Health Research Governance Framework for Health and Community Care, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable HRA opinion and NHS R&D management approval where appropriate.

As Chief Investigator, you must ensure that local study recruitment does not commence until all applicable approvals have been obtained. Where a study is or becomes multi-site you are responsible for ensuring that recruitment at external sites does not commence until local approvals have been obtained.

Following receipt of all relevant approvals, you should ensure that any subsequent amendments are notified to the Sponsor, University Ethic's and relevant NHS R&D Office(s), and that an annual progress report is submitted to the Sponsor, REC and NHS R&D departments where requested.

Please ensure you are familiar with the University of Birmingham Code of Practice for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) and any appropriate College or School guidelines.

Finally please contact researchgovernance@contacts.bham.ac.uk should you have any queries.

You may show this letter to external organisations.

Yours sincerely

Dr Sean Jennings
Head of Research Governance and Ethics
Research Support Group

cc Dr Iestyn Williams

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom
w: www.finance.bham.ac.uk

Appendix C – Proof of NHS HRA ethical approval (front page of approval letter)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Christopher Smith
Health Services Management Centre
40 Edgbaston Park Rd
Birmingham
B15 2RT

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

12 September 2018

Dear Mr Smith

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Moral economy and the NHS: How does service reconfiguration affect the normative character of NHS organisations?**
IRAS project ID:	**248873**
Protocol number:	**RG_18-102**
REC reference:	**19/HRA/0324**
Sponsor	**University of Birmingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

UNIVERSITY OF BIRMINGHAM

Research Briefing – Moral Economy and the NHS: How does service reconfiguration affect the normative character of NHS organisations?

1. Introduction

The University of Birmingham has obtained funding from the Economic and Social Research Council (ESRC) to undertake a doctoral research project into cultural change within health and social care organisations. This document provides information on this project for organisations considering participating in the study. It begins by giving an overview of the aims of the project, before describing what questions it seeks to address and how this will be done. It then goes on to describe the conceptual framework being used by the study (moral economy), the ethical procedures the research will follow, and the expected outputs (including what participating organisations can gain from taking part in the study).

2. Background/ aims

The NHS is facing well documented challenges due to budgetary pressures, shifting patient needs and changes in technology (NHS England 2014, 2017). Financial pressures in particular have been identified as one of the main drivers of reconfiguration (House of Commons Library 2017). Large budgetary pressures therefore mean many services are likely to experience a significant degree of change in the coming years. Such large scale change can create a range of implementation issues, particularly in terms of relationships between different groups within the NHS (such as professional groups, departments, and organisations).

This research aims to explore these relationships, particularly in terms of the ways in which organisational change affects the shared moral/ethical understandings which exist within and between different groups working in the NHS.

3. Data Collection

Data collection will focus on discerning how service change affects the shared moral understandings which exist within NHS organisations about what is considered good and bad, right and wrong, and appropriate and inappropriate. It will aim to do this by examining the process by which different groups draw on shared moral understandings when formulating and implementing responses to local and national policy imperatives. Data collection will seek to address questions such as:

1) What are the key shared moral understandings within and between organisations regarding issue such as:
    - What is considered fair?
    - The responsibilities of different groups and individuals?
    - Concerns about the wellbeing being of others?

2) How do challenges associated with the current policy context impact upon these shared understandings?

3) What strategies do different groups and individuals use to promote, accommodate or resist any changes to these understandings?

4) What insights can these findings provide on the impact of service reconfiguration on the shared moral understandings held within organisations, as well as how these understandings influence the implementation of local or national policy?

The research will involve the in-depth study of the implementation of one service change or reconfiguration linked to a national or local policy initiative. It will use a qualitative case study methodology in order to achieve this. This type of research typically involves intensive study whereby detailed information is gathered on the case (Hammersley 2007) using a variety of data collection methods. Any participating organisations will therefore be asked to allow the researcher to immerse himself in the life of the organisation during a time of service change or transformation. This will likely include observing meetings, workshops, project planning activities and other relevant events. It will also involve informal conversations with staff members, analysis of guidance documents and semi-structured interviews. The research aims to carry out data collection for approximately 6 months, starting in summer 2018.

4. Conceptual Framework

A moral economy framework states that all organisations rely on shared cultural understandings about what is good and bad, right and wrong, and appropriate and inappropriate when carrying out their day-to-day functions. However, this framework also acknowledges that these understandings are adaptable and can change in response to internal and external pressures (Sayer 2007). According to the moral economy approach being used by this research, shared beliefs about what constitutes the five “moral foundations” (fairness, harm, accountability, respect and loyalty) (Haidt and Kesebir 2010) are a core part of organisational culture – defined as the set of shared, taken for granted assumptions held by a group (Schein 2004). Such shared moral understandings are important for achieving most types of organised activity (Wilmott 2011) and influence everything from day to day interaction between staff to large scale decision making. They act as a key resource in helping individuals make sense of the challenging situations and competing demands that are part and parcel of everyday life in complex organisations. Shared values and beliefs also serve a binding function and can act as a glue that holds an organisation together (Smircich 1983).

Cultural factors such as shared moral beliefs are important in determining how national or local policy is received by organisations. However, this dimension is often not explicitly considered by those formulating such policy. This is problematic for two reasons. Firstly, not having a good understanding of the cultures of the organisations that are the target of reform increases the chance of policy failure. At the same time, poorly considered policy changes might also have a negative effect on organisational culture itself, leading to increased difficulties in delivering their day-to-day functions. Externally imposed policy can therefore disrupt internal organisational coherence, leading to unintended adverse consequences.

5. Research Outputs

Organisational culture plays a vital role in determining the success of change programmes, but it can also be difficult to identify and understand (Heracheous 2001). The research will provide participating organisations with important insights into the ethical dimension of their

organisational culture from the point of view of several different groups. The research will also provide an in-depth, qualitative account of the implementation of a service reconfiguration. This could dovetail with any formal evaluation activity which takes place as part of the service change.

Further to this, the research aims to make key contributions to both health policy and sociological literature. With respect to the former, there is a growing literature which seeks to assess the impact of recent policy changes to the NHS. This explores topics such as integration (Miller and Glasby 2016), productivity (Bojke et al 2016) and public health (Hunter 2016). This research will add to this literature by exploring how recent reforms are impacting on the moral aspect of the culture of NHS organisations.

6. Ethics

All research projects at the University of Birmingham must go through the University's ethics review process before data collection is carried out. Therefore data collection will not begin until the project is approved.

Informed consent will be sought from anyone who is interviewed as part of this research and no findings from interviews will be used without this consent. To maintain the confidentiality of research participants and the organisation(s) in general, the data collected from all research activities will be kept secure (either on an encrypted disk and/or a locked cabinet). The researcher will also take steps protect the anonymity of all those who take part in the research. With this in mind, pseudonyms will be used both for individuals and organisations in the typing up of notes, transcription of interviews and the writing up of the research findings.

Please note, the research may request access to organisational documents (such as business cases, minutes of meetings, internal policies etc.) for the purposes of the research. The researcher will not access these documents without permission from a member of the management team. Documents deemed sensitive and/ or confidential by the organisation will never be taken off site. However, the researcher may ask permission to take less sensitive documents offsite (such as guidance documents, project communications etc.) for the purposes of analysis. If documents are taken offsite, they will be stored in a locked cabinet. Once analysis is complete, documents will either be returned to the organisation or destroyed by shredding (depending on the preferences of the organisation(s).

If you require any more information of the ethical procedures being followed as part of this research (e.g. data management, confidentiality etc.) please do not hesitate to ask the researcher (contact details below).

7. Further Project Information

Doctoral researcher - Christopher Q Smith

Research supervisor - Dr Iestyn Williams (Director of Research, Health Services Management Centre)

Ethical Review Number - ERN_17-1167

Contact details - If you have any questions about this research, please contact Christopher Q Smith by email at

Appendix A: Additional Information for those being asked for consent to carry out research in their organisation

If you are being asked for consent to carry out this research in your organisation, please note that this consent means that you agree that the researcher can do the following:

- Spend time with staff members in the course of their day to day work.
- Make, write up and store notes on insights from observations and conversations during the course of data collection.
- Write up and store findings from observations and conversations held as part of this research. These findings will be written up and published as part of the researcher's doctoral thesis and may also be used in other publications (such as journal articles). Please note, real names, job titles and the names of organisations will not be used in the write up of findings.
- Approach employees of the organisation for interviews (the researcher will also obtain individual consent from employees before carrying out interviews).

If you require any more information, please do not hesitate to ask the researcher.

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UNIVERSITY OF BIRMINGHAM

Participant Information Leaflet for Individual Consent

Doctoral Research Project Title - Moral economy and the NHS: How does service reconfiguration affect the normative character of NHS organisations?

Primary Researcher – Christopher Q Smith

Introduction

You are invited to take part in this study. This is being carried out by a doctoral researcher (Christopher Q Smith) on behalf of the Department of Social Policy, Sociology and Criminology in the University of Birmingham. Before you decide, you need to understand why the study is being carried out and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

Part 1 tells you about the purpose of the study and what will happen if you take part. Part 2 gives you more detailed information about the conduct of the study.

If you have any questions please do not hesitate to ask. Contact details for the primary researcher are at the end of this information sheet.

Part 1

What is the study about?

This study seeks to use a moral economy framework to analyse the impact of service change on the shared moral understandings of those who work in healthcare organisations. A moral economy framework states that organised economic activities depend on shared moral understandings about what is good and bad, right and wrong, and appropriate and inappropriate. However, this framework also holds that these understandings are adaptable and can change in response to external pressures. This study will therefore examine the process by which shared moral understandings are renegotiated in response to policy change and financial constraint.

The research is using a case study research design to study the implementation of one service change or reconfiguration. This will aim to gain a detailed understanding of a service change through emersion in people's day to day contexts. One way the research will learn about different moral understandings is through interviews with people who work within the organisation(s) involved in the service change.

Do I have to take part?

Participation in the study is entirely voluntary and you are under no obligation to take part.

What will happen if I take part?

The researcher will contact you to arrange an interview to be undertaken face-to-face at a location which is convenient for you. During this interview, the researcher will ask you questions about your views on the shared moral understandings (regarding issues such as what is considered fair, what responsibilities different groups hold etc.) of the organisation(s) involved in the service change. The researcher may also ask you about your own moral values.

What are the possible benefits of taking part in this study?

The study will provide your organisation with important insights into the ethical dimension of its culture from the point of view of several different groups. This could be valuable, as organisational culture is an important aspect of organisations but can also be difficult to identify and understand. It will also generate original insights into the relevance of a moral economy framework to studying organisations more generally.

What are the possible disadvantages, side effects, risks, and/or discomforts of taking part in this study?

There are very few risks in taking part in this study, as all you are required to do is share your thoughts and experiences. There is a small chance you may find some questions about your own moral values or commitments to be personal. Therefore please feel free to say if you are not comfortable answering these questions.

Expenses and payments

No expenses will be incurred by you beyond the time taken to complete the interview. The researcher is not able to offer remuneration to interviewees.

What will happen when the study ends?

You will be given the opportunity to hear about the results of the study and will receive a summary of the final thesis if you request this.

How will data collected as part of this research be managed?

All typed up field notes, audio recordings and interview transcripts will be stored on an encrypted password protected disk that will only be accessible to the doctoral researcher. Data will be backed up on University of Birmingham (UoB) severs in a password controlled area only accessible to the researcher. Data held on disks will be stored for ten years and then destroyed in accordance with UoB code of practice for research. For data stored on disks, the researcher will delete this data himself after the 10 years have elapsed. For data stored at UoB, IT services will be asked to ensure a complete and timely removal of this data on request of the researcher once the final PhD has been submitted.

Any paper notes created as part of the interview will be typed up as soon as practically possible and then destroyed. Whilst these notes are waiting to be typed up and not under the direct supervision of the researcher they will be stored in a locked cabinet that only the researcher has access to.

Will my taking part be confidential?

Yes. Strict procedures will be followed to ensure all information about you will be handled in confidence. More information about this is given in part 2.

<u>This concludes Part 1. If the information in Part 1 has interested you and you are considering participating, please read the additional information in Part 2 before making any decision.</u>

Part 2

What am I consenting to by signing the consent form?

By signing the consent form provided with this information leaflet, you are agreeing that the primary researcher can:

- Make and store an audio recording of any interview that takes place as part of this research (the researcher will let you know when the recording starts and stops).
- Make and store notes from any interview that takes place as part of this research. Pseudonyms will be used for both you and your organisation when typing up these notes. Your job title will also not be used when typing up notes to help make sure that you are not identifiable.
- Transcribe and store transcriptions of any interviews that take place as part of this research. Pseudonyms will be used for both you and your organisation in writing up these transcripts. Your job title will also not be used when transcribing to help make sure that you are not identifiable.
- Use insights and quotes gained from audio recordings, transcripts and notes taken from interviews as part of his data analysis and final write up of findings. These findings will be written up and published as part of the researcher's doctoral thesis, and may also be used in other publications (such as journal articles). Pseudonyms will be used when referring to you and your organisation in research findings. Your job title will also not be used in any write up to help make sure that you are not identifiable.
- Store your name, alongside the pseudonym that has been applied to you in the typing up of notes/ data analysis and findings, in a table for the purposes of ensuring the researcher can attribute pseudonyms to the correct individual. This table will be stored on a separate encrypted disk from other documents created as part of this research (such as typed-up notes, findings etc.).

Who is organising and funding the study

This is a doctoral research project (PhD) being undertaken by Christopher Q Smith, who is a PhD student at the University of Birmingham. The study is being supervised by Dr Iestyn Williams, who is the Director of Research within the Health Services Management Centre at the University of Birmingham.

This doctoral research project is funded by a studentship which has been granted by the Economic and Social Research Council (ESRC) Midlands Doctoral Training Partnership.

Does my organisation know about this study?

Consent has been gained from your organisation to carry out this research. This consent includes permission to approach employees of the organisation for interviews. If you require more information on the consent that has been given by your organisation, please ask the researcher.

Will what I say be confidential?

Procedures are in place to ensure *as far as is possible* that all research data remains confidential between you and the researcher in the typing up of notes, transcripts and writing up/ publication of research findings. Pseudonyms will be used (both for individuals and organisations) and job titles will not be referenced so that individuals and organisations are not readily identifiable in transcripts, typed field notes or the final write-up.

Every reasonable effort will be made to ensure individuals and organisations who take part in the research are not identifiable to anyone except the researcher. However, there is a small possibility that individuals will be identifiable after pseudonyms have been applied. For example, people who are particularly familiar with the situation within the organisation (such as those who work within the organisation) may be able to make “educated guesses” to attribute comments/ actions to particular individuals, or to identify the organisation(s) involved.

The University of Birmingham will keep your name, contact details and signed informed consent form confidential and will not pass this information to any third parties. The University of Birmingham will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Certain individuals from the University of Birmingham and regulatory authorities may look at the research records to check the accuracy of the research study. The Chief Investigator will collect and analyse the information under the supervision of his academic supervisor.

How will information collected about me be managed?

The University of Birmingham (UoB) is the sponsor for this study based in the United Kingdom. UoB will be using information from you in order to undertake this study and will act as the data controller for this study. This means that UoB is responsible for looking after your information and using it properly. The University of Birmingham will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as UoB needs to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, UoB will keep the information about you that it has already obtained. To safeguard your rights, UoB will use the minimum personally-identifiable information possible.

You can find out more about how UoB use your information by contacting Legal Services at University of Birmingham, Edgbaston, Birmingham B15 2TT.

Can I withdraw from the study?

You are free to withdraw at any time during the research. However, it is important to note that it will not be possible to withdraw from the research after the researcher has submitted his thesis. This is because the researcher is planning on using insights and quotes gained from interviews in his thesis, and once this is submitted it will no longer be within his power to change it. The researcher is currently planning on submitting his thesis by September 2019.

If you wish to withdraw, please contact the primary researcher (Christopher Q Smith – details below) to do so.

What will happen to the findings of the study?

The researcher intends to write up the findings of the study for his doctoral thesis, which will be publically available on completion. Furthermore, the findings might also be used in other publications (such as journal articles, conference papers etc.). The research will supply a copy of his thesis (once this is completed) if requested.

Who has reviewed the study?

This research has obtained approval from the University of Birmingham's Ethical Review Process.

Further Project Information

Doctoral researcher - Christopher Q Smith

Research supervisor - Dr Iestyn Williams (Director of Research, Health Services Management Centre)

Ethical Review Number - ERN_17-1167

Contact details - If you have any questions about this research, please contact Christopher Q Smith by email at [redacted].

Appendix F – Consent Form

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Individual Consent Form

Project title - Moral Economy and the NHS: How does service reconfiguration affect the normative character of NHS organisations?

Name of Researcher – Christopher Q Smith

Statements of understanding/ consent

- I confirm that I have read and understand the Participant Information Leaflet for Individual Consent for this study. I have had the opportunity to ask questions if necessary and have had these answered satisfactorily.
- Based on the above, I agree to take part in this study.

Name, signature and date

Name of participant:	……
Signature	……
Date	……

Name of Researcher/ individual obtaining consent:	……
Signature	……
Date	……

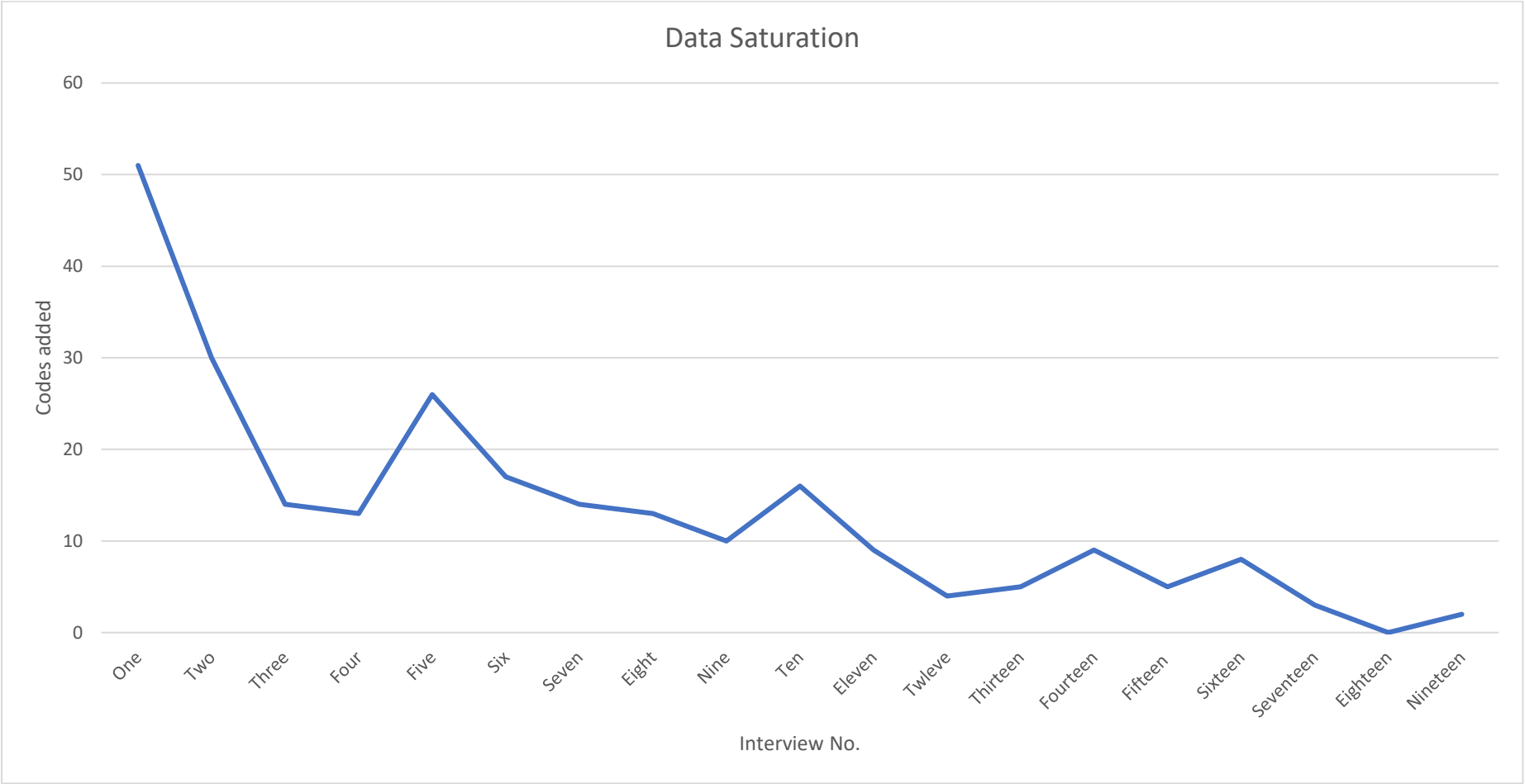
Appendix G – Individuals approached for interview (anonymised)

No.	Pseudonym[31]	Role Type	Group Affiliation	Interviewed?[32]	Programme Board (PB) or Joint Governing Body (JGB)?
1	Al	Senior manager	Bloughton Community Representative Organisation	Yes	PB
2	Alex	Senior manager	Community Trust	Yes	PB
3	Andy	Programme team member	Programme Team	Yes	PB
4	Ashley	Programme team member	Programme team	Yes	PB
5	Bobby	Senior manager	Acute Trust	Yes	PB
6	Charlie	Senior clinical manager	Whitdon CCG	Yes	JGB
7	Danny	Non-clinical Governing Body member	Whitdon CCG	Yes	JGB
8	Dylan	Senior clinical manager	Bloughton CCG	Yes	JGB
9	Eli	Senior manager	Bloughton CCG	Yes	PB
10	Elliott	Non-clinical Governing Body member	Whitdon CCG	Yes	JGB
11	Fred	Manager	Grenham Commissioner	Yes	PB
12	Kit	Senior manager	Whitdon Community Representative Organisation	Yes	PB
13	Leslie	Senior manager	Grenham Commissioner	Yes	PB
14	Manny	Non-clinical Governing Body member	Bloughton CCG	Yes	JGB
15	Riley	Programme team member	Programme Team	Yes	PB
16	Rowan	Senior clinical manager	Bloughton CCG	Yes	JGB

[31] I have only applied pseudonyms to those who agreed to participate in the research. I have marked the Pseudonym field N/A for those who I attempted to recruit but did not participate.
[32] Please note, if someone was not interviewed this does not necessarily mean they refused. They may have not replied to an invitation and/ or indirect approach via another member of the programme team. For some potential interviewees, like the independent clinicians, I failed to find someone willing to broker an introduction.

17	Ryan	Strategic Governing Body member	Whitdon CCG	Yes	PB
18	Terry	Senior manager	Whitdon CCG	Yes	PB
19	Morgan	Senior clinical manager	Bloughton CCG	Yes	JGB
20	N/A	Clinical Governing Body member	Bloughton CCG	No	JGB
21	N/A	Clinical Governing Body member	Whitdon CCG	No	JGB
22	N/A	Finance manager	Whitdon CCG	No	JGB
23	N/A	Finance manager	Bloughton CCG	No	JGB
24	N/A	Independent chair	N/A	No	JGB
25	N/A	Independent clinician	N/A	No	JGB
26	N/A	Independent clinician	N/A	No	JGB
27	N/A	Independent clinician	N/A	No	JGB
28	N/A	Programme team member	Programme Team	No	PB
29	N/A	Non-clinical Governing Body member	Bloughton CCG	No	JGB
30	N/A	Senior clinical manager	Acute Trust	No	PB
31	N/A	Strategic Governing Body member	Bloughton CCG	No	PB
32	N/A	Finance manager	Acute trust	No	PB
33	N/A	Patient rep	N/A	No	PB

Appendix H – Code saturation diagram



Appendix I – Interview schedule

Introduction (5 minutes)

- Give option of explaining the objectives of interview with relation to the research. These are to:
  - Find out more about their role within the organisation and the service change
  - Collect personal reflections on the shared moral values (regarding issues such as what is considered fair, what responsibilities different groups hold etc.) of the organisation(s) involved in the service change.
- Check they are happy with being recorded
- Check interviewee has received participant information sheet
- Ask if participant has any questions/ concerns arising from the participant information sheet
- Check that participant is happy to continue (also double check whether they have any questions).
- Remind the participant that they do not have to answer any questions they are uncomfortable with. Also remind the participant that they should ask for clarification if they do not understand a question, and that they can leave the interview at any time.

Explain structure of questions:
- There will be four sections
- The first will ask about your duties, responsibilities and accountabilities, both with respect to your organisation and the MoU programme.
- The second will ask for your perspective on the aims and vision of the MoU programme
- The third will ask your perspective on how the programme has been carried out and delivered
- The fourth will ask for your perspective on the engagement side of the programme (e.g. engagement with the public)

1. Background (5 minutes) (organisational context, role, responsibilities etc.)

Role and Organisation - General

- What are your responsibilities/ duties?
  - Are financial duties included in this?
  - What could you get blamed for?

- Who are you accountable to?
  - Internal and external (regulators)
- Do you consider yourself a member of a professional group?

Role and organisation: MoU

- What is your role within MoU?
  - What are your responsibilities/ duties?

- What are your accountabilities?
  - Internal and external (regulators)
  - What could you get blamed for?

- Is anyone on the programme accountable to you?
  - What are your expectations of them?

2. Vision of Moving on Up (MoU) (30 minutes)

The aim of this section is to ascertain the interviewee's evaluations of the vision of MoU and what it is trying to achieve in the local healthcare economy.

- What is MoU and why is it happening?
    - What do you think is the main driving force behind it?
    - Is "doing nothing" an option? If so, why not?
    - How do you know that action needs to be taken?

- What values, if any, do you believe MoU is based on?

- How do you feel about the option that has been decided on?
    - Is it the right thing to do?
    - Why? How will you know?

- Who are the 'main players' in MoU?

- Is there consensus on the overall aim or vision of MoU between the main groups involved? (e.g. providers and CCGs)

- Is there any conflict on the overall aim or vision of MoU between the main groups involved? (e.g. providers and CCGs)

    - Do you anticipate any future conflict?

3. Professional moralities – Conduct (5 minutes) (*the way* MoU has been carried out).

- How have you found working with other organisations involved in the MoU process?
    - Has the process of working together changed how you feel about other organisations?

- Do you feel the r*ight* approach has been taken to working together as part of MoU?

4. Public (5 minutes)

The aim of this section is to gain reflections on how MoU has been presented to the public, as well as how this has been received.

- How have you found the engagement side of MoU?
    - How has the programme been presented to the public?

- Have there been any big sources of controversy?
    - If so, why have the area(s) you have listed been particularly controversial?

Optional questions (if there is time)

- Who else should I talk to?

Appendix J – Codes

Economic and Structural Phenomena	Funding and resources	Balancing activity and outcomes		
		Demand management		
		Improving efficiency		
		Physical environment		
		Capital funding for programme		
		Workforce		
		Renumeration systems	Commissioning relationship	
		Increasing unsustainability	Of community trust	
			Of acute trust	
			Of NHS in general	
			Caused by changing population profile and demographics	
	Inter-organisational structure	Accountability	Clinical model	
			Complexity	
			Consultation	
			Informal	
			Judicial review	
			Legal	Finance
				Safety
			Member GPs	
			Multiple	
			Regulators	To CQC
				To NHS England
				To NHS Improvement
		CCG leadership		

		Changing commissioning landscape		
		Clinical model		
		Clinical representation		
		Elections		
		Geographical and organisational boundaries		
		Local authority		
		Merger		
		Past reconfigurations		
		Public meetings		
		Regulators		
		Sponsor organisations		
		STP and ICS		
		Transfer of responsibilities		
		Reconfiguration	Alternative models	
			Appraisal process	
			Emergency services	
			Implementation	
			Planned services	
			Process requirements	
			Separation of community and acute	
			Women and Children's	
		Programme Board	Vote	
		Inclusion of Grenham		
		JGB	Independent members	
		Complexity	Regulators	
			Moving services to acute	
	Inter-role structures	Accountable officer		
		Working across organisations		
		CCG Chair		
		Changing role		

		Line management		
		Primary and Acute		
		Programme Board		
		Rotas		
		Tension		
		Within CCG Governing Body		
		Within Organisation		

Moral phenomena	Moral beliefs	Legitimacy	Sanctions	
		Appropriateness	Engagement	
		Moral Conflict	Over model	
		Duties and obligations	To chairperson	
			To government	
			To local authority	
			To Organisation Board	
			To patients	
			To professional body	
			To secretary of state	
			To Sustainable Transformation Partnership	
			To the programme	To programme manager
				To whole population
			To deliver performance metrics	
			To carry out engagement	Seldom heard groups
			To establish governance	Consultation
			For service change to be clinically led	

			To provide leadership and management	
			To represent organisation	
			Stakeholder management	
			To support CCGs	
			Support Partnership working	
			To decide/ act/ deliver	
			To follow NHS England recommendations	
			To involve local authority and HOSC	
			To specific population	
			To support programme	
			To whole population	
		Ideals	Evidence	
			Fairness	Representing whole county
			Clinical	Clinical Senate
				Royal College Guidance
			Democratic	
			Engagement	Consultation institute
				Hard to reach groups
			Equitable care	
			Improved services/ outcomes/ safety	For patients
				For whole population
			Moving services into community/ prevention	
			Professionalism	Auditing standards
				Managerial
			Sustainability	
			Transparency	Working together
			Integration and partnership	
			Trust	

			Us and them	
	Moral emotions	Frustration		
		Anger		
		Sympathy	For position of Bloughton	
		Blame		
		Empathy		
	Thick moral concepts	Being done to		
		Cooperation (lack of)		
		Courage		
		Dishonesty		
		Emotional		
		Incompetence		
		Integrity		
		Inferiority		
		Naivety, ignorance or misunderstanding		
		Objectivity	Bias	
		Parochialism		
		Political		
		Reasonable		
		Respect (and lack of)		
		Responsibility		
		Robustness		