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Enhancing democratic accountability in health and social care: The role of reform and performance information in Health and Wellbeing Boards

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ABSTRACT

The UK government passed the Health and Social Care Act in 2012 and a key element of this legislation was the introduction of Health and Wellbeing Boards (HWBs) in local government. HWBs were argued to have the potential to both improve democratic accountability and give greater autonomy to health and social care leaders to strengthen local health outcomes. This paper explores how members of HWBs construct and discharge accountability for better health outcomes to a local population. We find that there are multiple types of accountability present and that democratic accountability can be complemented by and compete with other types of accountability.

Keywords: Accountability, Health and Wellbeing Boards, New Public Governance, Performance, Reforms

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1 INTRODUCTION

The mission and objectives of organisations responsible for providing public services are multiple and ambiguous, conflicting and imprecise, contradictory and confusing and are often associated with issues of equity and fairness (Christensen and Lægreid, 2015; Parker and Gould, 1999; Sinclair, 1995). Public services, therefore, require multi-dimensional and multiple accountabilities that are ‘continually being constructed’ (Sinclair, 1995: 231) and shift with frequent reforms (Bracci et al., 2015).

The increasing multiplicity and complexity of public service provision has led governments to replace New Public Management (NPM) with New Public Governance arrangements, which involve broader societal actors and partners to achieve their desired outcomes (Klijn, 2008; Osborne, 2006). In their conceptual paper, Virtanen et al. (2018) consider how accountability arrangements differ between the more hierarchical structure and efficiency focus within NPM to a more processual “flow within an integrated local service system” (p. 2) within New Public Governance. A change to New Public Governance emphasises integrating and coordinating networks of actors (Christensen and Lægreid, 2015: 213) and results in new accountability arrangements (Valentinov, 2011; Virtanen et al., 2018), which are in addition to those that were already in place (Benish and Levi-Faur 2012). There is a danger that these new arrangements will lead to shared accountabilities and tangled accountability arrangements (Christensen and Lægreid, 2015).

Within this context, the study explores the creation of Health and Wellbeing Boards (HWBs) in local government in England. The introduction of HWBs was a key element of the UK Government’s Health and Social Care Act in 2012, which places a statutory requirement on all upper-tier and unitary local authorities in England to establish a board, and treat the board as if appointed under section 102 of the Local Government Act 1972 (Local Government Association, 2013). It was argued that implementing the Act would improve democratic accountability and give greater autonomy to health and social care leaders to strengthen local health outcomes. It is an example of the coalition government’s attempts to “replace the old system of bureaucratic accountability with a new system of democratic accountability – accountability to the people, not the government machine” (Cameron, 2010). A key element of Cameron’s democratic accountability was to provide transparency to the people through publishing full information, giving people choice and democratic control through local elections and local referenda (Cameron, 2010).

HWBs were expected to bring together key players (as a statutory minimum, membership of the boards is comprised of elected councillors, senior local government officers representing adult social care and children's services, public health officials, clinical commissioners and Healthwatch, as a body representing the local community) with a range of insights into the care and safeguarding of the local population. HWBs also have the option of co-opting additional members such as the police, fire brigade and universities if it is felt that the key post-holders could help co-develop new solutions. In order to work toward better outcomes for the public, the Local Government Association (2013) clarified a number of principles underlying the creation of the boards, including shared leadership of a strategic approach, shared ownership, and parity between board members on deliberations, strategies and activities.

Improving the health and wellbeing of people in a given area, and reducing inequalities, is aided by the statutory duties of the boards. Specifically, the Health and Social Care Act 2012 requires local authorities and clinical commissioning groups (who have replaced Primary Care Trusts) to develop a Joint Strategic Needs Assessment (JSNA) (assessing the needs of the local population) and a Joint Health and Wellbeing Strategy (JHWS) (an overarching strategy). In developing their strategies, HWBs are required to consider the role of wider social determinants such as housing, education and transport on health, wellbeing and quality of life. In order to fulfil the requirements of openness and transparency, the preparation of the JSNA and JHWS is to involve members of the local public and for the finalised documents to be published. The HWBs are accountable to both Full Council and the local public, and could be called to account by the local authority's Overview and Scrutiny Function (OSF). In addition to the JSNA and JHWS, HWBs should also provide clear measures of progress on priorities that have been agreed by board members.

There is very limited research that explores accountability relationships in the context of a recent shift towards New Public Governance. More specifically a gap remains regarding how this shift effects the types of accountability experienced in the various relationships between the network of New Public Governance actors. This paper contributes to the accountability literature by exploring how members of HWBs construct and discharge accountability and how the members perceive interactions between different accountability types. The significance of this contribution is due to the broad range of accountability types and relationships that are present and interact within our case HWBs. Specifically, our paper contributes further insight into how different accountabilities may compete with and complement each other. We also explore how the UK Government's Health and Social Care reform has changed accountability arrangements, both accountability relationships

and types, and how performance measurement informs the practices in our case HWBs. As such our paper responds to Christensen and Lægreid's (2015: 223) call for research that studies:

“the dynamic relationships between reforms, performance and accountability and how multiple and hybrid accountability relations interact and change over time”

The remainder of this paper is structured as follows. Next, we provide a review of the literature relating to the multiple types of accountability, and the relationship between accountability and performance within a public sector context. We then introduce our case study HWBs and describe the research methods adopted before presenting an analysis of our findings. We conclude with further discussion of our findings regarding reform and accountability.

2 MULTIPLE ACCOUNTABILITY TYPES AND RELATIONS

Multiple definitions of accountability exist, but at its most basic, accountability could be understood as a relational phenomenon. There exists a relationship between those required to provide an account (the accountor) and those to whom the account is given (the accountee) (Bovens, 2007; Byrkjeflot et al., 2014). Byrkjeflot et al. (2014) suggest that it is taken for granted that there are many accountability relationships within the public sector and this adds to the complexity within this setting. Accountability relations could be hierarchical, horizontal or downwards (see Roberts, 1991; Caker and Nyland, 2017; and Cordery and Sim, 2018), and to a broad range of stakeholders with different interests and resources.

Not all relationships require accountability. An accountability relationship is one where there is an option to ask questions, require explanations, and make judgments resulting, potentially, in consequences being faced (Bovens, 2007). This suggests, therefore, that an accountability relationship is one where there is 'answerability', a holding to account, and an 'enforcement' which may result in negative consequences (Stirton and Lodge, 2001). In public services, Stirton and Lodge (2001) propose four mechanisms of 'transparency', which are voice, representation, choice and information. We note here that the concepts of accountability and transparency are closely related (Stirton and Lodge, 2001), but are not the same. Despite this, and for the purposes of our paper, we find these 'transparency' mechanisms to be a useful 'toolbox', as they appear aligned with David Cameron's view of democratic accountability as introduced earlier.

Providing the public with information, giving them opportunities to make choices over service providers and elected representatives, and providing a forum through which they are able to voice concerns were key elements of Cameron's democratic accountability. This conception of democratic accountability includes both a direct link to the electorate through choices made at the ballot box

and a less formal, but more direct relationship with the public. Sinclair (1995) would term these two elements as political accountability, which she equates with democratic accountability, and public accountability respectively.

Sinclair's public accountability resembles what Bovens (2007) calls social accountability and relates to a feeling of obligation to provide an account directly to the public. Social accountability could be established through public meetings or panels and the giving of accounts in public (Bovens, 2007; Byrkjeflot et al., 2014; and Fowler and Cordery, 2015), with Bovens (2007) noting the potential role for the internet as an appropriate communication medium. It is assumed that this more direct account will empower stakeholders and citizens and so enhance democracy (Pestoff, 2011). Such social accountability is also recognised as an increasingly important practice in non-profit organisations (see for instance Costa and Goulart da Silva, 2018), but it is noteworthy that this accountability mechanism may be weakened if recipients lack the ability to sanction the accountor (Bovens, 2007).

Alongside the political and public accountability introduced above, Sinclair (1995: 224-5) identifies three further forms of accountability: "managerial (or financial), professional and personal accountability". Managerial accountability relates to the accountor being held to account for their inputs and the associated outputs and outcomes. Sinclair (1995) makes a distinction here with a sixth form of administrative accountability, which is concerned with the procedures by which inputs are transformed. With professional accountability the accountor's affiliation to a profession or standing as an expert invokes a sense of duty to professional values and calls upon their expertise and integrity. Finally, personal accountability is more psychological and relates to the accountor's internal ethical and moral values.

More recently Bovens (2007) produced a map of accountability types on the basis of four dimensions each related to an important accountability question. The first question is to whom the account is rendered. This question distinguishes five types of accountability, namely political accountability, legal accountability, administrative accountability, professional accountability and social accountability. Clearly these five types bear a strong resemblance to Sinclair's (1995) forms of accountability especially given, as noted above, the similarity between Boven's social accountability and Sinclair's public accountability. Also, Sinclair (1995) refers to administrative accountability in discussing managerial accountability. Similarly, Byrkjeflot et al. (2014) recognise the distinction between these two forms as accountability for process or procedures (administrative accountability) and accountability for outputs and results (managerial accountability).

The second important question asked by Bovens (2007) relates to who is required to provide the account. This is termed the “problem of many hands” as each policy is handled to some extent by a multitude of different potential accountors. Four accountability types are mapped in response to this question: corporate accountability; hierarchical accountability; collective accountability; and, individual accountability. Of particular relevance to our paper is corporate accountability and the distinction between collective and individual accountability. Corporate accountability recognises that public organisations “operate as unitary actors and can be held accountable accordingly” (Bovens, 2007: 458). Collective accountability is where each member (of an organisation, partnership or board say) could be held accountable for the conduct and performance of the group. In contrast individual accountability suggests that each member of a group or organisation is held to account in proportion to their own contribution to the overall conduct.

Boven’s third question relates to what the accountor is accountable for. The answer to this question is complicated as organisations face multiple, conflicting and ambiguous objectives (Parker and Gould, 1999; Christensen and Laegreid, 2015). Functional accountability for short-term and operational issues can be contrasted with strategic accountability for long-term objectives (Cordery and Sim, 2018). In public services, these longer-term objectives are often associated with issues of equity and fairness that are not easily resolved. In response to this question, Bovens (2007) identifies three types of accountability: financial accountability, procedural accountability and product accountability. The first two of these are relevant here. Sinclair (1995) views financial accountability as part of managerial accountability, and there is also a clear relation between procedural accountability and administrative accountability. For the purposes of this paper, we subsume financial accountability and procedural accountability into managerial accountability and administrative accountability respectively. Boven’s fourth question relates to why the accountor is compelled to provide an account and falls outside the scope and interest of this paper.

Multiple types of accountability have been identified and described within the academic literature. It is also the case that in some instances alternative names are used for similar types of accountability and definitions vary and overlap. Drawing primarily on Sinclair (1995), Bovens (2007) and Byrkjeflot et al. (2014), we identify and define the following accountability types:

INSERT TABLE 1 HERE

As can be discerned from this discussion, there are a multitude of accountability relations and types of relevance to the public sector. This multiplicity results in a complex web of accountabilities. As reforms are introduced, by necessity, they impact upon and change these accountability

arrangements (Bracci et al., 2015). Public sector reforms have the potential to create tensions in accountability relationships (Byrkjeflot et al., 2014) and may require actors to reconfigure and balance these relations in new ways. Moreover, reforms may result in a greater emphasis upon a specific accountability type, increase or reduce overall accountability and “produce both accountability overload and accountability deficits” (Byrkjeflot et al., 2014: 171). For instance, Sinclair (1995: 219) suggests that moves towards greater managerial accountability have “either replaced or augmented traditional norms of democratic accountability”. More recent reforms in the UK have, arguably, enhanced democratic (through political and / or social) accountability, but it is unclear how these changes interact with other forms of accountability. We suggest that the impacts of reforms upon the interrelationships and entanglements between the different accountability types is under-researched and our paper aims to address this gap.

Arnaboldi et al. (2015) suggest that the ‘inherent complexity’ and repeated reforms make for complicated accountabilities in the public sector, but they argue that “performance management is **the** challenge confronting public service managers” (p. 1, emphasis in original). Added to this, they note the perceived necessity for even more performance management in the current period of austerity, but there is a danger that such systems may lose sight of equity and justice issues. Relatedly, Dubnick (2005, p. 378) refers to the ‘powerful’ and ‘unchallenged’ rhetoric, which assumes that performance will be improved if accountability is enhanced. He suggests, however, that this relationship is unproven and that accountability requirements may divert attention and resources away from actions that improve performance. Dubnick (2005: 376) suggests that the relationship between performance and accountability is “paradoxical and either spurious or so contingent as to raise questions regarding administrative reforms based on it”. This potential ‘accountability paradox’ leads Christensen and Lægreid (2015: 212) to suggest that the relationship between “accountability and performance is characterized by tensions, ambiguities and contradictions”.

Despite this, Christensen and Lægreid (2011; 2015) argue that NPM reforms were often justified on the basis of managerial accountability and a rhetoric based on improving performance (particularly efficiency) and enhancing responsiveness to users. NPM focussed on managers having responsibility and accountability for performance criteria and results. The shift to managerial accountability within the public sector noted above has also been associated with a need for quantitative/financial measures and targets that aim to improve performance, enhance efficiency and provide greater effectiveness and responsiveness (Christensen and Lægreid, 2015). There is a concern, however, that there may be a tendency in practice for performance measurement to focus upon outputs that are

“easier to measure ... and less costly to monitor” (Christensen and Lægreid, 2015, p. 210). The technical problems and costs involved in measuring the multiple and subjective outcomes for public services has been recognised (Brignall and Modell, 2000; Cavalluzzo and Ittner, 2004; Justesen and Mouritsen, 2011). The problems are not only technical, but also conceptual as defining good performance within public services is far from easy (Fryer et al., 2009; Van de Walle, 2008). Subsequent critique suggests, however, that in practice, the challenges in identifying measures that reflect outcomes, and NPM’s emphasis upon efficiency, comes at a cost in terms of effectiveness (Pollitt and Bouckaert, 2011). Measuring effectiveness and outcomes is not only more difficult, but accountability for them is problematic due to issues of attribution and timing. Effectiveness and outcomes are more likely to be co-determined and longer-term and hence it is much more difficult to be held accountable for these.

Finally, it is worth recognising that performance management systems are not necessarily neutral and objective in design (Brignall and Modell, 2000). Rather than rational, they may be influenced by political interests and aim to inform the public about the success and legitimacy of reforms (Chang, 2015). Despite this Johnsen (2005) concludes that, whilst from a political theory perspective, performance measures seem “subjective, uncertain and ambiguous” (p. 14), they can play an important role in terms of democratic accountability as they may enable scrutiny and challenge by stakeholders. In our study, therefore, we consider the role played by performance measurement in the accountability arrangements of HWBs. The next section briefly articulates the research methods employed to address these challenges.

3 RESEARCH METHODS

This study adopts a qualitative case-study approach with the intention of gaining in-depth insights into the discharge of accountability, inter-relationship between accountability types, and role of performance measurement in leaders of HWBs providing an account and being held to account by the public. At the outset of the study, a review was undertaken of documents related to the reforms in the Health and Social Care Act 2012 that resulted in the creation of Health and Wellbeing Boards (HWBs). Of particular relevance were the Marmot Review (2010), statutory guidance issued by the Government (Department of Health, 2012) together with a parliamentary note (Heath, 2014), the work of the King’s Fund (see for instance Humphries et al, 2012; and, Humphries and Galea, 2013) and the annual reports produced by the Local Government Association. HWBs in England are aligned with the Local Authority Areas.

We selected two cases for the research:

1. Metro: a Metropolitan Borough Council with a population in excess of 200,000.
2. City: a City Council inhabited by approximately 450,000 people.

There are three key similarities between the two cases. First, as revealed by the respective Health Profiles published by Public Health England, both Metro and City have stark health inequalities in the male population. There are marked differences in the life expectancy of males taking into account the most and least deprived areas served. At approximately 10 years, the difference in life expectancy for men was higher than the England average, and exceeded the regional average where the HWBs are located (please see Table2).

INSERT TABLE 2 HERE

Second, from a management / governance perspective, both HWBs have similar organisational arrangements in that the Chair is drawn from the local authority and the Co-Chair is a representative from the clinical commissioning group. Third, the HWBs have recently refreshed their strategy and , as a result, substantially reduced the number of priorities in the JHWS (please see figures 1 and 2 respectively). Specifically, Metro has narrowed the number of priorities from 8 to 4, while City has decided to focus on 3 key priorities from an original set of 10 included in the JHWS 2013.

INSERT FIGURES 1 AND 2 HERE

There are, however, some significant differences between the two cases. Drawing upon information provided in the Health Profile fact sheets the difference in female life expectancy in Metro is higher and in City is lower than the national average (6.9 years). City has: a higher percentage of children living in low income families, a rising child population, and a below average percentage of people from ethnic minorities. In contrast, Metro has: a lower percentage of children living in poverty and an ageing population. The composition, local influences and stability of the two Boards is also different (please see figures 3 and 4).

INSERT FIGURES 3 AND 4 HERE

City's Board is mostly restricted to statutory members based on an agreement by Board members to maintain the split between commissioning services and providing services. Accordingly, representatives from the major health care providers have been excluded from the Board. Given the membership, major health care providers are prevented from influencing decision-making on local health and social care priorities and, following on, the expansion and/or withdrawal of services. Metro's Board, however, is comprised of both statutory and non-statutory members and,

accordingly, has representation from the Mental Health Trust, police and fire, and schools. Finally, there is a difference in terms of the priorities pursued, with Metro drawing three priorities directly from the objectives in the Marmot framework, and adding a fourth priority to reflect the Borough's ageing population, and City focusing on the more narrow health risks identified in the Marmot Report (2010), rather than objectives in the Marmot framework.

Each Board member of the two case HWBs was approached with a request for an interview. In both cases the request had the support of a key player on the HWB, in City the Director of Public Health and in Metro the Chair of the HWB. A total of fourteen interviews were conducted in City. Eleven of the interviewees were members of the HWB (in total there were fifteen members of the Board, but four declined our request for an interview due to time availability). The other three interviewees had roles such that they had significant interaction with and knowledge of the workings of the Board. In Metro a total of eighteen interviews were conducted with twenty interviewees. Seventeen (from a total of nineteen) members of the HWB were interviewed and, again, the other three interviewees had significant interactions with and knowledge of the Board. On average the interviews were slightly longer than one-hour in duration, and semi-structured in nature. Wherever possible interviews were conducted face to face, but three interviews were undertaken by telephone. Almost all of the interviews were undertaken with both researchers present, with one researcher leading on asking questions and the other researcher ensuring that all major topic areas were covered. In line with our research aims, our interview topics focused upon strategy construction, performance information and, in particular, attended to accountability and the factors perceived to facilitate and inhibit the discharge of accountability.

In total 32 interviews (fourteen with City and eighteen with Metro) were conducted with 34 interviewees. This, alongside documentary evidence, provided a rich and deep source of data for our study. Each interview was coded by accountability type (as shown in Table 1), performance (e.g. construction of measures and use of information), and facilitators and inhibitors in the discharge of accountability. Both researchers undertook independent coding of the interview transcripts and instances of ambiguity were discussed before final coding decisions agreed. The coding allowed the researchers to generate themes, and to consider the relationship between the accountability types. The latter was cross-checked through discussions between the authors, and involved a more systematic reading of the publicly available documentation issued by the respective HWBs.

The following section presents the findings and analysis emerging from the data collected.

4 FINDINGS

Given that a key goal of the Health and Social Care Act 2012 was to allow greater autonomy to health and social care leaders to strengthen health outcomes, and to improve democratic accountability, the findings consider the inter-relationships between democratic accountability and other accountability types. It is important to note here that our interviewees, consistent with the views of David Cameron, conceived social (or public) accountability to be part of democratic accountability and so in our findings below we distinguish between democratic (political) and democratic (social) accountability. For each case study organisation, we present our findings under complementary and competing accountabilities, thus denoting instances where different accountabilities serve to strengthen or weaken the discharge of democratic accountability respectively.

4.1 Metro

Complementary accountabilities

(a) Performance Scorecard

The Director of Public Health was among a few HWB members who articulated a clear sense of democratic (political) accountability in contrast to democratic (social) accountability:

“Well I think we’d say we’re accountable to the local population and that is through Scrutiny. We’re on the annual work plans for Scrutiny to go and talk to them to give them a summary of the year’s progress of the Health and Wellbeing Board and to talk about any issue they may have. And certainly in the last couple of years that we’ve been together, they [the Board] have challenged , ‘Well you said you would do this, how much progress do you think you’ve actually made?’”

He perceived the compilation of, and continual work on, the performance scorecard as aiding the democratic (political) accountability process as it was used to provide an account to the OSF. The scorecard is structured around the four priorities of the HWB, contains 34 performance indicators (PI) and, for each PI, shows results against a target, a trend chart, a red-amber-green (RAG) status and a brief narrative commentary (please see table 3 for an extract of the measures used). In part, the Director of Public Health giving an account to members of the OSF on health outputs and outcomes had some overlap with him answering to the Chief Executive Officer of the Borough as his line manager (individual and managerial accountability), although involved different audiences.

In contrast to the above, the performance scorecard was not used within or outside of public HWB meetings to provide an account to members of the public. Most members of the HWB acknowledged that very few, if any, local residents attended the public meetings where results were

presented and no member of the public had asked for an explanation on the weaker results in writing or otherwise. Moreover some members of the HWB questioned the extent of the public's awareness of the Board, speculating that such awareness is rare. It was a matter of professional and personal integrity (professional and personal accountability), however, that Board members sought explanations for and discussed the poorer results. To this end, a number of respondents remarked that they had found the commentaries accompanying the metrics useful in providing a more contextual understanding of performance.

(b) Healthwatch

The Board included the voice of the local public through Healthwatch in what could be viewed as the discharge of democratic (social) accountability. At local level, the organisation is responsible for understanding the needs and experiences of patients, service users, carers and the public, and feeding this into decision-making. However, Board members perceived Healthwatch as failing to discharge duties, claiming that it was not a "household name" in the locality, and therefore not perceived to be acting on behalf of the public.

As an action of first resort, and as revealed by the OSF minutes in addition to interview responses, the commissioners of Healthwatch (i.e. the local authority) sought to determine the extent of poor performance, understand the reasons for poor performance, and to provide support in a spirit of partnership (partnership accountability). The local authority instigated further enquiries on account of a number of factors including discrepancies between what was reported by Healthwatch and what was communicated by local people through alternative means. A spirit of partnership was underpinned by a strong tradition of partnership working by the local authority, and an acknowledgement that Healthwatch, as a young organisation, most likely required support to work effectively. However, tolerance of poor performance such as poor visibility and engagement with the local community meant that Healthwatch was not regarded as a 'consumer champion', and was perceived to neglect 'hard to reach' groups.

As the next action, the partners sought advice from the Local Government Association and Healthwatch England (administrative accountability) and, finally, requested Metro Borough Council to remove Healthwatch from the Board (legal accountability). Metro Borough Council justified not renewing the contract with Healthwatch on grounds that the organisation did not meet important terms. Notably, the Council highlighted specific terms where Healthwatch fell short of expectations to:

“Ensure systematic and on-going engagement with all sections of the local population so that a wide cross-section of views are represented in respect of local health and social care.”

“Make reports and recommendations, based on robust evidence, about how services could or should be improved.”

(Health and Adult Social Care Scrutiny Board, 2016).

In order to help ensure the more effective discharge of democratic (social) accountability in the future, Metro HWB decided upon two courses, both orientated toward strengthening administrative accountability. Firstly, the Board opted to enter into interim arrangements with an alternative Healthwatch team prior to re-commissioning an organisation for the longer term. The local authority as commissioner maintained close oversight over the interim Healthwatch organisation. Secondly, the HWB Board sought to pre-empt the delivery of better performance by Healthwatch in the future by investigating different models of delivery of the Healthwatch function. This included considering options such as working with a neighbouring organisation, or splitting the function between two or three local organisations governed by a steering board.

(c) Health and Wellbeing Board, Scrutiny Board and Healthwatch

Soon after the establishment of the Health and Wellbeing Board (2013), a protocol outlining the roles and responsibilities of the Council’s Health Scrutiny, Local Healthwatch and Health and Wellbeing Board was constructed, and signed by representatives of the three respective organisations. The protocol served to strengthen democratic (political) accountability by demarcating responsibilities between the three bodies. The Director of Public Health explained that members of the HWB Board were clear that they did not want “scrutiny people” at the Board owing to a potential conflict of interest. He felt that Scrutiny members had a duty to *evaluate* decisions and therefore had no role in actually *making* decisions. This was corroborated by the Deputy Chair of the HWB :

“But our feeling was that the membership of the Board should reflect what needs to be done in a sense, and what we can do and get on and do, whereas Scrutiny should be [a] different membership. And so opposition members sit on Scrutiny and can challenge that way.”

By clarifying the distinctive roles of the three bodies in a written document (administrative accountability), the discharge of democratic (political) accountability was protected.

(d) Partnership relations

A close partnership between members of the HWB Board, accountable to one another (collective accountability) could be viewed as helping democratic (social) accountability and democratic (political) accountability as it is the collective rather than an individual organisation that provides an account and is held to account. Collective accountability was strengthened by the Public Health team in leading on the strategic refresh in 2016. As explained in the Health and Wellbeing Strategy 2016-2019:

“...you will not find single agency priorities within the strategy, but instead those priorities where a combined effort across agencies is needed to make an impact on improving health outcomes and reducing health inequalities.”

Our interviews with the HWB members revealed a number of factors that facilitated collective accountability, and administrative accountability, in the setting of parameters for the priorities. Firstly, partners were located in offices mostly within walking distance of each other, and therefore benefited from an ease in arranging face-to-face meetings. Secondly, the Board was comprised of one council and one clinical care commissioning group (CCG), reducing potential friction if more than one CCG was involved. Thirdly, the Public Health Team, by virtue of position in the Council, had representation in the Directorates of Adult Social Care and Children’s Services. Moreover, the team were proactive in forging links with other partners such as the police and fire services, and voluntary sector.

Competing accountabilities

(a) Better Care Fund

Political pressure, coupled with administrative requirements, relating to the Better Care Fund had an impact on perceived accountabilities and the discharge of democratic (political) accountability. The Better Care Fund was first announced in the Government’s Spending review 2013 and established in the Care Act 2014. In order to benefit from the Better Care Fund, HWBs were required to satisfy conditions set by NHS England that, in 2015/16, included a CCG minimum contribution to social care funding.

Meeting the conditions led to protracted negotiations between the CCG and Council, and between the HWB and senior officials of NHS England, who acted on the policy framework agreed between the Department of Health and the Department for Communities and Local Government. Due to the precarious financial status of the CCG, the Council entered into discussions with the CCG on a way forward, and the HWB then submitted and justified a Better Care Fund Plan to Central Government.

“So the 16/17 plan [Better Care Fund], the proposals only just got endorsed about a month ago, ‘the national sign-off’. And that is a culmination of a story which is one of disagreement I think between the Council and the CCG in terms of what the mutual investment should look like and what’s a fair balance of investment into social care should look like from health.”

(Director of Adult Social Care)

While the CCG maintained a sense of partnership working, this was over-ridden by a responsibility for the financial viability of the CCG. The CCG member of the Board admitted that he was firstly accountable for delivering a turnaround in the financial position of the CCG (corporate accountability) and, in the short-term, avoiding the threat of sanctions by NHS England in the form of formal intervention (managerial accountability). Due to the CCG’s significant financial deficit, it was the Council, and not the CCG, who contributed the CCG’s share to the Better Care Fund.

Over the course of the year for this particular Better Care Funding round, members of the HWB were required to present the local agreement to the Health and Adult Social Care Scrutiny Board, and to write to and meet with Senior Executives for the Better Care Fund. This had the consequence of deflecting Scrutiny’s attention from more fully evaluating the Board’s impact and progress that is more in keeping with democratic (political) accountability. Moreover, as the Chair of the Board conceded, continual attention to the Better Care Fund served to distract members from providing more complete attention to the health and wellbeing of residents in the Borough.

(b) Partnership relationships

Most members of the HWB cited strong partnership relationships as facilitating efforts toward reducing inequalities and improving health outcomes (collective accountability). As partnership working between some members predated the existence of the formation of the HWB, it was felt that there was some common understanding of local issues. Contrary to expectation, the members did not recall voicing major disagreements in arriving at the original Joint Health and Wellbeing Strategy, or on selecting priorities to focus upon in the Strategy refresh.

However, there was a tension between collective accountability and individual/managerial accountability and, ultimately, democratic (social) accountability and democratic (political) accountability. The tension was expressed by a medical member of the Board, for example:

“... I’m not sure we hold each other to account quite as tough as we should. We have great respect for each other. I think we probably like each other individually, I think that’s been good for relationships and enablement because we have been able to fashion solutions

without it becoming bitter or personal. The downside of that is that you know, at times you feel like saying oi, come on, you should have stepped up to the mark on this one.”

(Vice Chair of HWB)

Although considered a mature partnership, there was still some way to go before partners felt able to hold each other to account for performance (managerial accountability). There was a perceived need to defend partnership working even if, in the short-term, this meant that the individual effort of Board members was not questioned.

(c) Corporate parenting

The potential for democratic (social) accountability was somewhat compromised by the expert knowledge of members of the Board (professional accountability) and also the pre-disposition to do the right thing (personal accountability). ‘Corporate parenting’ was most evident in the interviews with the Chair and Vice-Chair of the HWB :

“So, you know, we will do things because it’s the right thing to do, even if it’s uncomfortable. And then go out and justify why we’ve done it. And I know from personal experience that occasionally you can go out on a limb and back something that the public are not very happy about. But if you explain to them the reasons why, very often they will come round.”

(Chair of HWB)

“When we changed [health service provision], which in many areas of the country would have been a placard, strike-type approach...we transformed that through really strong public engagement, through sponsorship of the Health and Wellbeing Board, getting the public on Board.”

(Vice-Chair of HWB)

While the examples provided relate to pre and post decision-making, both the Chair and Vice-Chair alluded to the rationality of citizens when provided with information. The Chair was confident in the answerability dimension of accountability on account of his long-service as leader in the Council, broader viewpoint and extensive knowledge of decision-making processes. The Chair’s sense of personal accountability served to drive his decisions on the health and social care of children and the mentally ill more so than the views of the local population at large. From our interviews, it was clear that – foremost – he felt answerable to his conscience, and that this could then be justified to parents, carers and residents in the area.

4.2 City

Complementary accountabilities

(a) Personal Commitments

Interviews with the Director of Public Health and representative from local Healthwatch, in particular, revealed strong personal accountability to the local population. In the case of the former, the Director of Public Health shared that, in contrast to her predecessor, she occupied a second-tier rather than a first-tier post in the local authority. As such, she did not occupy a Strategic Director post and, therefore, was not directly answerable to the CEO. However, pragmatically, she reasoned that this allowed her to address the health and social care needs of the local population:

“...because my personal view is I am the Director of Public Health for the City, employed by the Council but my responsibility is to the community of City, to the population of City.”

“So I would say ideally the Director of Public Health should be sitting at the corporate level to be able to influence across the organisation. But in doing so, you also get taken into a lot of management time that actually sometimes is not relevant.”

On the latter, the representative from local Healthwatch spoke of personal efforts in bringing the Board to the public rather than relying on members of the public to attend the Board meetings:

“...when I get the papers I do my utmost to produce a very brief summary of the papers, which then goes on our website and out to our volunteers and people that we’ve got contacts with, to ask for any feedback that they have before the meeting on the agenda item. And then after the meeting, I do a summary of what was discussed in the meeting....”

(b) Joint Strategic Needs Assessment and Chapters

Unlike Metro, City did not produce and publish a performance scorecard, but did up-date the JSNA on an annual basis and, as explained by the Director of Public Health, supplemented the JSNA with ‘chapters’ on priority areas. While the JSNA provided a sense of the variety of local health and social care needs, the chapters offer an in-depth mapping of specific priority areas (e.g. domestic violence and abuse, and cancer). It was argued by the Director of Public Health that the production of greater intelligence on selected topics was primarily intended to better drive planning and commissioning.

Given the relative newness of the chapters, the link between the discharge of administrative accountability and democratic (social) accountability was, in the main, conveyed by the Director of Public Health and the Strategic Intelligence and Performance Manager. The Performance Manager, for example, shared that the Council had recently procured an Open Data Platform with the intention to generate more real-time data. The availability of more current on-line information, he believed, would help in the discharge of democratic (social) accountability:

"I think if we can get it as much more of an online data dashboard linked into automated data updates, so that it feels more live, I think that would help."

Competing accountabilities

(a) Sustainability and Transformation Plans

Sustainability and Transformation Plans (STPs), announced in NHS planning guidance published in December 2015, was raised by all HWB members interviewed without prompting by the authors. As STPs consider the wellbeing of the public over a larger geographical footprint, members questioned the standing of 'localism', which was viewed as a key underpinning of the operation of HWBs. There were two inter-related concerns. Firstly, it would be more challenging to consider the wider determinants of health and social care of a larger population given the diversity of health and social care needs. Secondly, given different health profiles in adjacent areas, actions on health and social care could potentially resort to addressing the lowest common denominator of concerns. As a consequence, STPs were viewed as compromising on both democratic (social) accountability and democratic (political) accountability.

On democratic (political) accountability, the Director of Public Health observed that a move to STPs would mean that local actions and outcomes would no longer be subject to the OSF as the new STP Boards would not be formed as a sub-committee of the local authority. However, contrary to the concerns of the other Board members, the NHS England member welcomed STPs, and the reorganisation of health and social care that this entailed:

"...it's become the health version of the Health and Wellbeing Board and that's where decisions really get [made]...that's got more power and less democratic legitimacy than the Health and Wellbeing Board. Its meetings aren't held in public."

The reference to power corresponded to political diktat working for the benefit of the population without necessarily involving the public directly in decisions. While she had no criticisms of the process of the local Health and Wellbeing Board, she deemed the HWB largely ineffectual due to lack of resources. On the Better Care Fund, she commented:

“That’s just a little tiny bit sliced off and put in a pool with somebody else’s to try and do magic with.”

Resourcing issues were compounded in what she saw as a “crowded territory” on improving health and social care needs. Specifically, alongside the JHWS, NHS England produced a five-year forward view containing views on intentions for solving pressing health and care issues.

Whether expressing concerns on STPs or welcoming STPs, members of the HWB perceived political accountability in implementing the reform as a priority and as having the potential to demote democratic (social) accountability to a lower ranking.

(b) Managed public responses

The meetings of the HWB were tightly managed in that each agenda item was assigned a time allowance that, the authors observed, was strictly enforced. While responses to public queries received beforehand were answered at the beginning of meetings, public comments raised during meetings were not encouraged and kept to a minimum in order to keep to time.. Accordingly, the HWB Co-Chairs, arguably, prioritised administrative accountability over democratic (social) accountability.

In turn, administrative accountability contributed toward collective accountability in that the Co-Chairs sought to focus joint efforts on the priorities set in the JHWS. There were no public forum questions posed in four of the eight public meetings held between January 2017 and January 2018, and two of the meetings contained questions from the same individual.

(c) Political/personal aspirations

The personal aspirations (personal accountability) of the Mayor, and Co-Chair of the Board, had a direct and indirect impact on the discharge of democratic (political) accountability and democratic (social) accountability.

According to our interviewees, the Mayor's strong vision dominated over the findings presented in the JSNA, and the information contained in the Public Health England Health Profile fact sheet, in decision-making on local health and social care needs. He was dismayed by the lack of data available on issues relevant to his vision:

"...there were some question marks in the JSNA last time in that there's no ethnic breakdown of it. Because it's based on GP data which apparently doesn't have ethnic breakdown, not all GPs have an ethnicity element to their database... And you know this is something the Mayor got very upset about"

(Cabinet Member of City Health and Wellbeing)

In response to a lack of data at equality group level (relative to geographic and socioeconomic levels), the Mayor empowered the performance team to create and analyse bespoke data sets on ethnicity. As a consequence, it could be argued that prioritising one group of the population could lead to over-representation of that group relative to other groups.

Indirectly, the Mayor's aspirations had an impact on perceptions of collective accountability by some Board members. As an example, there appeared to be some friction between the Mayor and a statutory member of the HWB. During an interview, the statutory member maintained that some decisions were not collectively made, and alluded to a less than harmonious relationship.

There was a sense that the Mayor was motivated by his own political ambitions when pursuing projects which extended beyond the local inhabitants of the city. As another example, a Cabinet Member of City HWB responded as follows when asked who she felt accountable to:

"I was there to deliver the Mayor's manifesto, was pretty much my sense of it."

She described herself as a *"smaller fry politician"*, rather than as a Board member with equal opportunity to contribute to the Board's deliberations on improving local health and social care services and outcomes.

4.3 Postscript – performance

Comparing key measures from the time HWBs were fully operational in 2013, both Metro and City show deepening health inequalities in both males and females. According to the Health Profile fact sheet published by Public Health England the life expectancy gap, has increased by 0.2 years in males in the two authorities, and 0.8 years and 1.2 years in females in the respective authorities, between 2013 and 2016. This compares to an average increase of 0.2 years for males and 0.4 years for

females, between 2012-2014 and 2014-2016 in England, and average increases of 0.3 years and 0.4 years for females in the respective regions that Metro and City belong (Public Health England, 2018). At regional level, the inequality in life expectancy increased by 0.6 years for males in the region where Metro is located, and decreased by 0.2 years in the region where City is situated (*ibid.*, 2018).

The widening inequalities in life expectancy shown for Metro and City HWBs need to be treated very cautiously. On the one hand, given worsening results at national level, it could be argued that the gap in health outcomes as experienced by the richest and poorest is due to changing demographics and government policy. Figures produced by the Office for National Statistics (July 2017, p.2) reveal an ageing population, with higher percentages of people aged over 65 and 85, while The Institute for Fiscal Studies (2018, p.5) show a reduction in spending on adult social care. As argued by Marmot (2018), funding cuts in a time of austerity is likely to lead to unmet needs in the elderly and, therefore, is a cause for concern. On the other hand, some of the interventions of HWBs are long-term in nature and hence impacts on results are unlikely to show in a limited time frame. The narrative in the Metro scorecard states that inter-related strategic plans address health inequalities across different target groups, which could be masked in the reporting of average figures across the local population. Given the above, we tentatively suggest that the effect of the shift in accountability relationships on performance is complex and ambiguous.

5 DISCUSSION AND CONCLUSIONS

The aim of this paper is to contribute to the accountability literature by exploring how members of HWBs construct and discharge accountability and how the members perceive interactions between different accountability types. Our findings provide evidence that there are multiple types of accountability experienced within HWBs. One of the key arguments for introducing HWBs was that they would enhance democratic accountability. In our HWBs, democratic accountability is conceived of as encapsulating both political accountability and social accountability. The HWBs are chaired by an elected representative and so, to some extent, it could be argued that they are held accountable by their electorate at the ballot box. This was not previously the case, but this is weakened as the performance of the HWB is likely to be one of many factors considered by the electorate when casting their vote. We also found that members of HWBs feel accountable to their local population through a form of social accountability. This was achieved through a variety of mechanisms. First, information was made available as the HWB meetings are held in public and minutes made available on the internet. Our findings also suggest that public representation is institutionalised via Healthwatch being a statutory member of the HWB. There is also some scope for voice as members of the public have the option of raising questions at HWB meetings, although, as evidenced, at City

HWB these are carefully managed. Our reflection would be that given weak democratic political accountability and limited direct public engagement (democratic social accountability), the role of representation by Healthwatch and other members becomes an essential accountability mechanism in the two cases.

Our discussion thus far, however, only presents a partial understanding of the complex accountability relationships at play. We find that other types of accountability are also present and that these interact with democratic accountability. As well as feeling accountable to the electorate and local population (democratic political and social accountability), our findings suggest that members of HWBs also feel personally accountable to a host of parties, including their own organisation (corporate accountability), their profession (professional accountability) and each other (collective accountability) in what is perceived as a joint endeavour. Further, the members may feel accountable for statutory duties (legal accountability), processes and procedures (administrative accountability) and performance (managerial accountability). We suggest that these other types of accountability both complement and compete with democratic accountability. As such we contribute by providing evidence of a broader range of accountability relationships in the context of New Public Governance and the complexity of interactions between different accountability types (Christensen and Lægreid, 2015).

In terms of complementary accountability interactions, we found that in both cases HWB members felt a personal accountability to their local populations, which further strengthened their desire to engage with stakeholders and interest groups (democratic social accountability). Administrative accountability arrangements (e.g. demarcation between different organisations) could also complement both democratic political (Metro) and democratic social (City) accountability. We also found that, in the case of Metro, proactive steps to strengthen partnership relations created a sense of collective accountability that complemented democratic (social) accountability and democratic (political) accountability.

In our cases, attempts to enhance democratic accountability were also complemented by development of a performance scorecard (in Metro) and JSNA chapters (in City). Whilst not perfect, the performance scorecard was deemed to be useful in that it was felt to provide information on the health and wellbeing in the locality and was a useful tool for discussion. In particular, the qualitative commentaries were recognised as being helpful in enabling HWB members to gain a more in-depth contextual understanding of the performance. Even in this case, however, it was suggested that this practice required further development as it was felt that greater use could have been made of the performance scorecard as a tool for the structuring of the agenda for future meetings by themes.

We find, therefore, that despite the widespread critique of performance measurement in the literature (Christensen and Laegreid, 2015; Dambrin and Robson, 2011; Johnsen; 2005; Justesen and Mouritsen, 2011), there is a potential for it to play a role in this accountability forum. What appears important is how the performance information is contextualised and used in practice. In our cases, performance information was deemed an appropriate tool to enable discussion and retain focus upon the priorities for which the HWB is accountable.

We also find evidence of some competing accountability relationships. An important aspect of HWBs is that they bring together representatives from within the National Health Service, local councillors and employees, and broader stakeholders (for instance from the voluntary sector). There was a sense that health service representatives felt that they were already held accountable, at a corporate level, for their performance by NHS England (managerial accountability). This corporate level managerial accountability was primary in that this relationship was where it was felt that there would be consequences if appropriate standards were not met (Bovens, 2007). This presents an interesting example of how multiple accountability relationships exist alongside each other. To some extent this is a complementary accountability in that it relates to the health and wellbeing in the locality, but it is not discharged through the HWB. It is also competing, however, in that if this is the primary accountability, then this may be prioritised for resources at the expense of the more integrated and coordinated actions desired by the more democratic HWB for broader wellbeing and social care issues.

A further threat to the potential positive effect of HWBs is the changing policy context in which the health and social care services operate. Since the government passed the Health and Social Care Act in 2012, policy has continued to evolve such as to require the development of STPs for larger geographical footprints. It seems likely that STP Boards are to be given greater powers and so this has the potential to further weaken the role of HWBs, as health leaders are faced with a further competing accountability relationship.

Our study, potentially, has implications for re-considering accountability in New Public Governance models that unite local government, general practice and community organisations in improving health and reducing health inequalities. Our evidence suggests that there is potentially an important role for performance information, but it is recognised that the multiplicity and complexity of the issues would require numerous measures and that this makes understanding performance challenging for HWB members. It is accepted that the performance measures are, to some extent, flawed and so contextual commentaries have an important role in aiding understanding. Further understanding of the dynamics of and interactions between accountability types within a specific

context could help in designing future accountability arrangements which, in turn, could provide better incentives for improving health outcomes. In more general terms, we suggest that prior literature has not paid sufficient attention to changes in the interrelationships between different types of accountability. Our paper contributes in this regard, but we call for further research into the complex web of accountability types and relations particularly in the context of New Public Governance reforms.

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Table 1: Accountability types

Accountability types	Sources
Political accountability is where a public servant is held accountable via a direct chain to elected representatives who are held accountable by the electorate.	Sinclair (1995), Bovens (2007) and Byrkjeflot et al. (2014).
Social (or public) accountability relates to a feeling of obligation to provide an account directly to the public, stakeholders or interest groups.	Sinclair (1995), Bovens (2007), Byrkjeflot et al. (2014).
Legal accountability “will usually be based on specific responsibilities, formally or legally conferred upon authorities”	Bovens (2007: 456) and see also Stewart (1984)
Administrative accountability “concentrates on monitoring the process or procedures whereby inputs are transformed”	Byrkjeflot et al. (2014: 174) and see also Sinclair (1995)
Managerial (or financial) accountability focusses upon the inputs and outputs and outcomes according to agreed performance criteria.	Sinclair (1995), Byrkjeflot et al. (2014), but see also Stewart’s (1984) performance and programme accountability.
Personal accountability “is fidelity to personal conscience ... driven by adherence to internalised moral and ethical values”	Sinclair (1995: 230)
Corporate accountability is where a public organisation operates as a unitary actor and can be held accountable accordingly.	Bovens (2007)
Collective accountability is where each member can be held accountable for the conduct and performance of the collective.	Bovens (2007)
Individual accountability suggests that each member of a collective or organisation is held to account in proportion to their own individual contribution to the overall conduct.	Bovens (2007)

Table 2: Inequality in life expectancy at birth in England and by region (in years)

	2011-13		2012-14		2013-15		2014-16	
	Male	Female	Male	Female	Male	Female	Male	Female
England	9.0	6.9	9.1	6.9	9.2	7.1	9.3	7.3
East Midlands region	8.5	6.6	8.4	6.7	8.6	7.1	8.9	7.2
East of England region	7.1	5.3	7.1	5.4	7.2	5.3	7.6	5.6
London region	7.4	5.0	7.5	4.8	7.4	4.9	7.4	4.8
North East region	10.7	8.3	10.6	8.5	10.9	9.2	11.0	9.2
North West region	11.2	8.8	11.3	9.1	11.2	9.3	11.5	9.6
South East region	7.6	5.4	7.5	5.5	7.7	5.5	7.8	5.7
South West region	7.3	5.1	7.7	5.0	7.7	5.1	7.5	5.4
West Midlands region	9.0	6.8	9.1	7.0	9.4	7.3	9.7	7.3
Yorkshire and Humber	9.7	7.8	9.7	7.7	10.0	8.0	10.2	8.1

(Source: <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/>)

Table 3 City HWB: Excerpt of Performance Measures used in the Performance Scorecard

Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England - males
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England - females
Number of people living beyond 75 years of age
Mortality from causes considered preventable
Number of people whose life satisfaction is rated medium or high
Proportion of people who use services who reported that they have as much social contact as they would like
Overall satisfaction of people who use services with their care and support
Proportion of people who die in hospitals
Proportion of children aged 10-11 classified as overweight or obese
Percentage of adult population with a healthy weight
Proportion of the population meeting the recommended '5 a day'
Percentage of physically active adults
Rate of alcohol-related hospital admissions
Community dementia diagnosis rate
Number of cases of homelessness prevented or relieved

Figure 1 Metro HWB: Timeline of strategy formation and strategy refresh

Figure 2 City HWB: Timeline of strategy formation and strategy refresh

Figure 3 Metro HWB: Organisation Chart, National Drivers and Local Influences

Figure 4 City HWB: Organisation Chart, National Drivers and Local Influences