



## CIMA Executive Summary Report

# Discharging democratic accountability: The role of strategy and performance information in local authority Health and Wellbeing Boards

Stuart Cooper (University of Bristol)  
and Suzana Grubnic (Loughborough University)



# Key conclusions

The Health and Social Care Act (2012) required the creation of Health and Wellbeing Boards (HWBs) to provide strategic leadership for health outcomes for localities across England. It was suggested that HWBs would enhance democratic accountability and provide a forum for key leaders to come together from across the health and social care systems. This research explores the extent to which HWBs have, or have not, enhanced democratic accountability through the use of strategic planning and performance information. The study is informed by a total of 39 interviews with experts and members of two HWBs and has resulted in the following key conclusions:

- ▶ Understanding of what is meant by democratic accountability was variable across the interviewees. Many interviewees felt that their key obligation was directly to their local public rather than being held accountable through the political process. The low level of public engagement with HWBs also suggests that democratic accountability is indirect and limited.
- ▶ Many members of the HWBs also recognised that they felt they had multiple accountabilities. There appeared to be a tension between an interviewee's perceived accountability for local health outcomes as a member of the HWB and their accountability for their own organisation's operations in long-established accountability relationships. For instance interviewees representing organisations operating within the health service have long been accountable to NHS England and the Department of Health.
- ▶ HWBs have been required to develop a Joint Health and Wellbeing Strategy, but doing so effectively has proved challenging. Our evidence suggests that important lessons have been learnt about the potential scope of HWBs as reflected in their strategy. Our interviewees point to how there has been a need to 'refresh' strategies and to reduce the number and scope of priorities. In particular emphasis has shifted to priorities where there is the potential for joint working from the different members of the HWBs.
- ▶ We find that there is some level of agreement that, whilst the use of performance information in our two HWBs has been limited, it may become more important into the future. It is suggested that performance information accompanied by associated narratives could be used as a way to further improve the work plans and structure of HWB meetings.
- ▶ HWBs are strengthened by the developing relationships between the key leaders from across the health and social care systems. Their potential to improve health outcomes, however, is inhibited by a lack of financial and human resources and a lack of integration and system leadership. Policy initiatives such as sustainability and transformation partnerships (STPs) also contribute to uncertainty that can hinder the progress of HWBs.

# Contents

2	Introduction
3	Research methodology
4	Main findings and their implications for practice
11	Conclusion
12	References
13	Glossary



## Introduction

Health inequality has long been a subject of interest to politicians. A key message from the Marmot Review (2010: p.15) was that “reducing health inequalities is a matter of fairness and social justice” and that reduced health inequalities would bring both economic and social benefits. To help address health inequalities, the Marmot Review identified the need to empower local communities and recommended local partnerships between primary care, local authorities, the third and private sectors and community groups. Partly in response to this, the UK government passed the Health and Social Care Act in 2012. One of the key elements of the Act was the introduction of Health and Wellbeing Boards (HWBs) in local government and it was argued that this would “promote integration and partnership working ... and improve democratic accountability” (Department of Health & Communities and Local Government, 2010: p. 8). It is now an appropriate time to consider the extent to which HWBs have, or have not, been able to improve democratic accountability.

Existing research relating to accountability for public services has found the issue to be especially problematic as there are often multiple objectives that are by their nature ambiguous, conflicting and long-term, that are often associated with issues of equity and fairness (Christensen and Lægreid, 2015; Parker and Gould, 1999; Sinclair, 1995). There is a need, therefore, for multiple accountabilities of different types for public services. It is also recognised that accountability arrangements for public services continue to shift as they are subject to frequent reform (Bracci et al., 2015: p. 2) and that such reforms have the potential to create tensions and “involve trade-off between different accountability types” (Byrkjeflot et al., 2014: p. 171). As such, democratic accountability is one type of accountability, but there are others such as legal, administrative, and managerial accountabilities that will form a complex web of relationships (see for example Bovens, 2007; Byrkjeflot et al., 2014; and Sinclair, 1995).

This research investigates how public health and social care leaders construct and discharge accountability through their membership of and roles in HWBs. Statutory guidance issued by Government (Department of Health, 2012), together with a parliamentary note (Heath, 2014), sets out numerous ways for accountability to be discharged, with the use of strategic planning (feeding into a Joint Health and Wellbeing Strategy) and performance measurement (in the form of information on local health outcomes) featuring prominently. A study by the King's Fund pointed to 'overwhelming support' for HWBs, but simultaneously raised concerns relating to their operation (Humphries et al, 2012: p1). For example, their study suggested that determining a joint health and wellbeing strategy would be a 'formidable test' (ibid. p. 22) for boards. More generally, there is a concern that it is “easier to measure ... and less costly to monitor” (Christensen and Lægreid, 2015: p. 4) activities and outputs, but such metrics have been criticised for their ability to only partially and imprecisely reflect outcomes (Dambrin and Robson, 2011; Justesen and Mouritsen, 2011).

This research addresses these issues through interviews with 'experts' and members of two HWBs. The findings provide deeper insights into how these new accountability and partnership working arrangements have been enacted in practice. The findings will further understanding of the complexities and tensions associated with these relative new accountability arrangements such that any potential “accountability overload and accountability deficits” (Byrkjeflot et al. 2014: p. 171) can be identified. In addition, the findings increase awareness of the challenges faced in determining a joint health and wellbeing strategy and measuring progress towards improved health outcomes and reduced health inequalities.

## Research methodology

### Objectives

The aim of this study is to investigate how public health and social care leaders construct and discharge accountability through their membership of and roles in Health and Wellbeing Boards (HWBs) which have been established 'to improve democratic accountability' for health outcomes

Our four broad research questions are:

- ▶ How do members of HWBs view their accountability in a new context of integrated care?
- ▶ What factors are important when constructing the strategy for the health and wellbeing of the local population?
- ▶ How do the case HWBs construct and use performance information to assess progress against their health and wellbeing strategy?
- ▶ What factors facilitate and inhibit the case HWBs in discharging their accountability?

Given the exploratory nature of this research a qualitative case study approach was adopted. Two HWBs agreed to participate and we explored issues related to our research questions primarily through interviews with both 'experts' and members of the two HWBs.

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 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. To further inform our study a total of six interviews (seven interviewees) were conducted with interested 'experts' identified through our reading of the above documents. This groundwork informed our interview guide for the members of our case HWBs.

Two HWBs agreed to participate with our research. In one case (Metro) the Local Authority Area is a Metropolitan Borough Council whilst the other (City) is a City Council. According to the Public Health England Health Profile Information, the Local Authority Areas to which our case HWBs relate both have issues with health inequalities with marked differences in life expectancy between the most and least deprived areas.

The Chairperson of both HWBs was from the Local Authority with a co-chair being a representative of the Clinical Commissioning Group (CCG). Both HWBs had also recently refreshed their Joint Health and Wellbeing Strategies (JHWS). There were also differences, however, with, for example, City having a rising child population whilst Metro has an ageing population. Another difference was noted in the size of the HWB membership with Metro being larger (with 19 members compared to 16 members at City) and including, for example, representatives from the police and fire services.

A total of 33 interviews (fifteen with City and eighteen with Metro) were conducted with 35 interviewees. This represented the vast majority of HWB members and, in addition, includes a small number of interviews with individuals who had roles such that they had significant interaction with and knowledge of the workings of the HWB. The interviews were structured such that interviewees were first asked about their experience and background, but then moved on to questions relating to their perceptions of accountability, strategy construction and performance information. In addition to interview data, the web pages, agenda, minutes, Joint Strategic Needs Assessment (JSNA) and JHWS of each HWB provided further valuable information. We believe this provides us with a rich source of data relating to these two cases. The interviews were analysed thematically and the key findings are presented in the following section. So as to preserve anonymity each interviewee is identified by a code (Expert A-F, City A-O and Metro A-R) when quoted in our findings.

## Main findings and their implications for practice

The findings presented below draw upon the evidence from our interviews and are themed around our key areas of interest: accountability, strategy and performance. In addition, our interviews provided insights into factors that inhibit and facilitate the HWBs as they operate and look to discharge their accountability.

### 1. Accountability in a Context of Integrated Care

#### Health and Wellbeing Boards

As noted in the Introduction, it has been suggested that HWBs will increase democratic accountability for health and wellbeing outcomes for a locality. This appears, at least in part, to be in response to a perceived insufficient level of *"local democratic legitimacy in health"* (Department of Health & Communities and Local Government, 2010: p. 1). The same report argues that an enhanced role for local government through elected representatives would address this issue. To this end the Health and Social Care Act 2012 states that a HWB is a *"committee of the local authority"* and must have at least one member that is a councillor of the local authority. It was envisaged that local authorities provide a broader perspective on health and wellbeing in a locality by being best placed to *"promote integration of local services across the boundaries between the NHS, social care and public health"* (Department of Health & Communities and Local Government, 2010: p. 1).

#### Democratic accountability

Bovens (2007) and Bovens et al. (2008) suggest that the democratic perspective on accountability relates to the ability of citizens to hold to account and control those in public office. As such, they argue that from this perspective there is a *"democratic chain of delegation"* from, at one end the electorate, to their elected representatives and onto public servants. From this perspective, it is ultimately the local citizens who have the power to reward or sanction as they *"indicate their (dis) pleasure at the ballot box"* (Bovens et al., 2008: p. 231). To do so the public should be provided with the information they need to make a judgement upon the effectiveness of the government's conduct.

Recognition of the democratic accountability perspective was prevalent throughout our interviews. Members of both HWBs expressed that they felt accountability directly to the local population and this was irrespective of whether or not they were from the local authority. It is clear that in both of our cases information is provided by the HWB to local citizens. HWB meetings are open to the public and the agenda and minutes are made publically available through dedicated web pages. As such the HWB

has *"brought some of the Health discussions into a more public arena"* (Metro, I). The public nature of these meetings, however, did raise some concerns as it was felt that some members *"do not like to have difficult conversations in public"* (Metro, N).

There was less confidence in the extent to which the public were engaged in debate around the information provided by the HWBs. Public attendance at HWB meetings was very limited with one interviewee noting that *"the same old couple of people always pitching up to the Board is not public engagement"* (Metro, N). There was a general consensus that the vast majority of citizens were not engaged with these debates with some interviewees suggesting that most citizens would be not even be aware of the HWB's existence.

It was argued by some interviewees that this lack of direct public engagement may be compensated in two ways. First, it was noted that some HWB members regularly interact with the public. For instance, local councillors, GPs, and representative from both the voluntary sector and Healthwatch all interact frequently with members of the public and so can present their views as part of HWB meetings. In particular, a representative of the local Healthwatch organisation is a statutory member of the HWB and acts as a voice for users of health and social care services. As such, it is argued, citizens' views are informing the debates held by the HWB. Second, some interviewees pointed out that the HWB was also accountable up the democratic chain of delegation by reporting to Full Council and through the Local Authority's Scrutiny Committee. For instance, the joint chairs of City HWB *"have gone to the OSC [Overview and Scrutiny Committee] to explain our strategy... And I quite enjoyed that and it was a really open and helpful discussion"* (City, M).

#### Multiple accountabilities

Accountability types, other than the democratic accountability discussed above, were also referred to by our interviewees. Most prominent was that members of the HWB felt accountable to each other. This was most clearly expressed, as *"there's an accountability to each other and that's a very human thing rather than a statutory you must..."* (City, C). As such the evidence from our interviews is that the members of these HWBs felt a

horizontal accountability to fellow board members. This 'partnership accountability' appears to be further developed at Metro and there was a view that this horizontal form of accountability is more appropriate than a more vertical, upward accountability:

*And for me, going back to that culture stuff is that if everybody gets it and everybody's working towards the best, do you need the scrutiny under the light, the finger-pointing? No you don't. And you just don't get well how do we make this better and that supportive and collaborative approach, that's a much better way of working in my mind. However, if somebody's falling short of what they need to and really aren't engaging in that approach, then yes that's your fall back plan. (Metro, G)*

There was also a sense that the members of the HWBs have a 'collective accountability' (Bovens, 2007) for the conduct and performance of the board. In addition to and alongside this collective accountability, however, it was apparent that the members of the HWB felt a responsibility for the department or group or organisation that they were representing. In some cases this was realised by the member providing their own 'feedback' to their organisations. This may be verbally at meetings or in some instances producing their own 'user-friendly' version of the minutes and 'information sheets' for sharing.

What was also very apparent was that certain statutory members of the HWB faced significant accountabilities for health and wellbeing issues through relationships at their own organisation. For instance, the directors of adult social services, children services and public health are statutory members of the board, but have significant responsibilities and accountabilities already associated with the performance of their directorates within the local authority. Similarly, a representative of the local clinical commissioning group (CCG) is a statutory member of the HWB, but the CCG faces an established accountability regime through NHS England and the Department of Health. Certainly for some interviewees these other accountability requirements were more challenging than those related to the HWB.

### **An emphasis on information sharing**

In order to consider the extent to which HWBs have been able to enhance democratic accountability we draw upon Bovens et al. (2008). They argue that three elements (information provision, debate, and consequences) are essential in assessing accountability. Our evidence suggests that the HWB has become a useful forum where information is shared between the different members of the board. In addition, a lot of information is provided to each HWB in the form of reports presented at the meetings from board members and other stakeholders with interests relating to the health and wellbeing of the local population. In fact, a concern was raised that too much information is presented to the Board with papers for meetings often being so long as to be difficult for members to fully consider all of them.

The HWB itself does provide a forum for discussion and debate of key issues. As noted above, however, it is challenging to get the public engaged in these discussions. The role of Healthwatch and other members who are regularly in contact with citizens may act as a conduit for the public's voice to be heard. The public nature of the meetings may also stifle debate. There was certainly some concern expressed as to whether 'difficult conversations' would happen in public. On the whole, however, there was a sense that the information provided was often accepted by the HWB and there was rarely disagreement with regard to the importance of the issues raised. More challenging was for the HWB to then know what was being asked of it and how best to proceed. For example, whilst observing HWB meetings we heard the question posed to presenters 'and what is it you want from us?'

The extent to which the HWB faces consequences if it were to be perceived to be failing in its duty is yet to be tested in our two cases. What consequences are there for a HWB if health outcomes and health inequalities worsen? Similarly, the HWB itself appears to have very limited powers (or 'teeth') to hold others to account. It does have the statutory power to request that members of the board and the local authority supply information to it, but appears to have no formal power of sanction. Given this, we find that any increase in democratic accountability has been indirect and limited.

## 2. Constructing strategy

HWBs have a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) for their local population. The purpose of the JSNA and JHWS is to inform the commissioning plans of the local authority, CCG and NHS England.

### Multiple inputs and multiple players

The original strategies of our case study HWBs were constructed with numerous inputs from a range of players. Inputs included broad consultations, JSNA, Marmot Review (2010) and matters of concern both nationally and locally. The initial construction of the strategy was not controversial and seemed not to involve significant conflict. In both cases, the statutory members were active in considering inputs and deciding upon priorities. As an exception, members of the boards noted irregular attendance by the representative from NHS England at HWB, with some members speculating that this was perhaps due to time pressures and work duplication:

*...it's a crowded territory because my own organisation writes documents that are a five-year forward view and tells everyone what problems they've got to solve and how.* (City, L)

The HWB at Metro has an expanded membership compared to City and therefore there seemed to be broader input into the strategic process. A key differentiating factor appeared to be the interpretation of the Health and Social Care Act 2012, and supplementary guidance, by the Chair and Co-Chair of the respective boards. While City did not invite providers as members "because this is a commissioning piece" (City, M), the HWB at Metro included representatives from the two main hospitals. It was reasoned that "there's far more commissioners on the Health and Wellbeing board than there are providers. And therefore any votes, should we take one, would be overwhelmed" (Metro, A).

### Public Health lead

Respondents at both Metro and City acknowledged the critical role of the Director of Public Health in assembling and finalising the JHSA and JHWS. The members from Public Health at our respective cases felt that they had a key role in engaging members with the JSNA, identifying priorities, and assessing what intervention might be warranted to address issues.

There were two main advantages in public health leading on the strategic process. Firstly, the public health lead had credibility with the local authority members and members of the CCG, and therefore was well placed to facilitate integrated care. Secondly, the members of the HWBs appeared to appreciate the rigour brought to the process by the public health colleagues:

*We felt that [strategy] should not be directed by what our current feeling is or public outcry, target headlines, A&E four hours or whatever is coming up through the media.* (Metro, A)

The influence of the Public Health lead on strategy was impacted upon by the positioning of public health in the local authority. At Metro, for example, the importance of a separate public health directorate, accountable to the Chief Executive Officer for the execution of duties by public health was commented upon. In contrast, the position of Director of Public Health at City has been downgraded to a second-tier role, affecting the role holder's scope to engage in, and be aware of, debates at corporate level.

### Manageable, evidence-based priorities

In both cases, it was recognised that there was a need to revisit the strategy, and to reduce the number of priorities from nine or ten to about half that number. The members of the HWB Boards acknowledged that the priorities were not sufficiently focused upon local needs and, also, not manageable given the existing duties of board members. A member of Metro explained the predicament as follows:

*You can have an agenda that is so wide you can't actually do any of it. Let's just focus on a few things that we can change. I think the fewer and sharper [the priorities], the better.* (Metro, O).

The process of refreshing the strategy was less inclusive than had been the case in formulating the initial strategies in that it involved minimal external consultation. The members of the boards reasoned that it was too soon after the previous consultation and, consequently, there would not be sufficient public appetite to provide input. Instead, the Directors of Public Health devised a set of guiding principles that would help 'shortlist' key priorities and both recognised the importance of the need for joint working. For Metro it was explained that: "we agreed it should be around step change which should not just be what individual agencies could do by themselves" (Metro, P).



### 3. The role of performance information

There is a very large number of indicators relating particularly to health that are available at both national and local levels. As noted in the previous section HWBs are required to produce a JSNA and in both localities these are lengthy reports that are rich with data at both the local authority level and at ward level. A wide range of measures are reported from information on the wider determinants of health outcomes to data on current life expectancy. Some of these measures are consistent with national initiatives such as the Public Health Outcomes Framework whilst others have been developed more locally. Overall our interviewees suggest that there is a relatively high level of confidence that the measures and indicators provide a useful reflection of health (and perhaps to a lesser extent wellbeing) for the population of a locality. There are, however, a very large number of indicators reflecting the complexity inherent in understanding the health and wellbeing of a locality.

[The approaches taken to making use of this extensive data set have varied.](#) The JSNA itself is brought to the HWB and so members will have an opportunity to see the report and underlying data. The JSNA is perceived to be an important and helpful tool, but both boards have recently looked to develop new ways of reporting performance. For City this has taken the form of steps to develop JSNA chapters that provide a more detailed, in-depth exploration of priority issues. For Metro, in an attempt to focus more upon performance in priority areas, this has seen the creation of a Performance Scorecard aligned with the priorities identified in the refreshed strategy. This is at least in part an acknowledgement of the 'huge' number of measures and indicators available and the inability of the HWBs to consider all of them.

#### Activities, outputs and outcomes

[As noted in the Introduction, it is particularly difficult to measure outcomes and this is certainly true in the case of health and wellbeing.](#) For instance, health outcomes relating to inequalities in life expectancy are complex as they may be influenced by very many determinants and may take many years to change. As such interviewees pointed to the need to measure and monitor activities and outputs:

*I think the things that you need to measure in Public Health is maybe not so much the kind of weight of the children ... you know, you're not maybe going to get that but personally what I think you want to know is for example how many schools are engaging with your campaign? How many schools have set up their extra sports clubs for physical activity? Or how many are signed up to Healthy Eating and ...? I think those are better indicators perhaps (City, F)*

*So I think there are some things that we could do much more, there are some outputs, even if you don't get the outcome shifts maybe for three, five, seven, ten, 15 years. Actually what are the output shifts or the outputs that you're going to look at that will reflect that you are moving in the right direction and more likely therefore to deliver those outcomes? (Metro, N)*

At Metro there was also a decision that, for the purposes of strategic oversight, there was a need for their Performance Scorecard to include key measures relating to outcomes even where more short-term changes are unlikely to be apparent. In addition, however, it was agreed that a key criteria for priorities is that "we want to see some measurable difference in the next two years" (Metro, P). As such, we see that there is a tendency for the HWBs to be drawn towards measuring more immediate and short-term activities and outputs.

#### Performance measures and narrative

[There was a strong view from both HWBs that it was very important for performance measures to be accompanied by a narrative.](#) In City the JSNA data profiles is complemented by 'a lot of narrative' and the move towards presenting Chapters "is all about narrative and some data" (City, N). Similarly, the new Performance Scorecard at Metro includes a 'commentary', which is seen as very important in terms of enabling discussion and understanding. The 'commentary' provides context and "can add value and actually help unblock some of the issues" (Metro, P). The Metro Scorecard also employs a RAG (Red Amber Green) notation against measures and so the narrative is recognised as being particularly valuable where performance may be "red" and the HWB looks for potential responses.

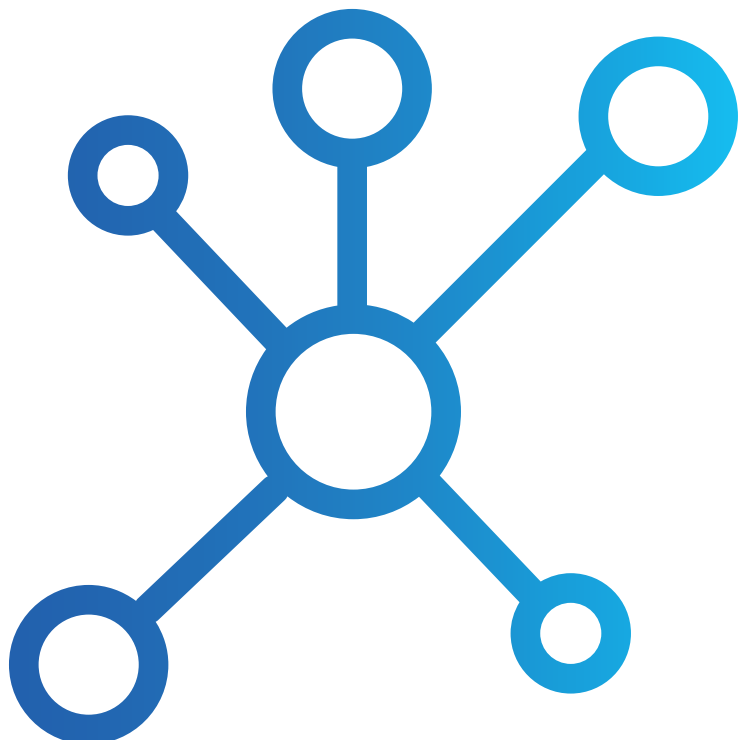
Underlying this recognition of the importance of the

narrative is an acceptance that the measures themselves can be flawed. It appears to be accepted that a greater understanding of why reported performance has changed or is different to key targets or benchmarks requires narrative explanation.

### **Looking to the future and putting performance on the agenda**

Both HWBs recognise a greater role for performance information / scorecards as the Boards evolve and mature. In particular there is scope for structuring the HWBs' work plans and agenda around themes with associated performance information. This is most advanced at Metro HWB who now have a performance scorecard in place. A concern was raised, however, that the Scorecard may get *"tagged onto the end of the meeting"* (Metro, N) and so is given little time and attention.

In contrast, there was hope that the scorecard could become *"a very significant core element of the agenda"* (Metro, O). One suggestion voiced at an observation of Metro HWB was that the scorecard be presented at meetings with a front sheet identifying issues of concern (reds or a worsening in performance). Alternatively it was suggested that meetings could be themed around priorities where the scorecard is used to provide an insight into performance trends.



## 4. Facilitators and Inhibitors

### Facilitators

The membership of HWBs includes, as a statutory requirement, key players and leaders in health and social care within a locality. It is recognised that these members are very experienced, hold significant influence on health and wellbeing in the local area, and are responsible for very significant budgets. As an expert interviewee clarified:

*...the clinical, political and professional leadership of the place in one board. And particularly the strength of having the elected member and the GP together as either co-chairs, or chair and vice-chair, in that role because those two have got so much in common in terms of knowing that community and the needs of that community. And they probably have been there a long time. (Expert, A)*

The members of both boards recognised that the HWBs have enabled relationships to form, or further develop, across the different organisations. Partnership working was aided by two further factors at Metro HWB. The statutory and non-statutory members referred to a history of partnership working prior to the establishment of the HWB, with a few members citing continuation of partnership working between organisations as an ongoing feature. Several of the members offered that, due to the location of organisations, it was more straightforward to arrange face-to-face meetings. For instance, local authority members, interim Healthwatch, and fire and police services were within walking distance of each other.

### Inhibitors

Members of Metro and City HWB invariably spoke of a lack of time and financial resource as inhibiting the discharge of accountability. On the former, interviewees noted that they are leaders, with key organisational responsibilities, in their respective organisations and so time to attend formal and supplementary meetings was sometimes tight. Policy initiatives such as Sustainability and Transformation

Partnerships (STPs), and Combined Authorities, served to draw attention away from the work of the HWB and were, therefore, deemed a distraction. On the latter, financial austerity and, in particular, NHS funding, remained a core limitation. There was restricted sharing of financial information and no sharing of budgets.

In addition to resource constraints, interviewees revealed issues associated with role fulfilment. Firstly, new members at both Metro and City recounted difficulties in becoming familiar with the activities of the Boards, especially given limited formal induction, while existing members, markedly at City HWB, felt that a turnover in board membership was disruptive to partnership working. Secondly, non-statutory members, at times, felt overwhelmed with the complexity and jargon of the health and wellbeing agenda. There is a danger that these members lack knowledge and influence within the Board. Thirdly, at the time of research, Metro HWB was in the process of recommissioning a replacement Healthwatch organisation. The original organisation was viewed by members as under-performing on their statutory duties due to a lack of focus and clarity.

As a final substantive inhibitor in discharging accountability, members of the HWBs referred to the need to discharge individual organisational responsibilities prior to delivering on collective priorities as set out in the JHWS. In order to help surmount this issue at City HWB, a series of workshops have been initiated to explore ways to strengthen health and wellbeing system leadership. However, as articulated by an expert respondent, the challenge is "creating a health and wellbeing board approach where all partners prioritise the need to work together collectively. And see that joint work on the areas of health and wellbeing as their principle focus rather than the success or not of their individual organisation" (Expert, F).

An overall summary of the similarities and differences between the two cases is provided in Table 1 below:

Table 1: Similarities and differences between Metro and City

Similarities	
Marked differences in life expectancy between the most and least deprived areas	
Chair is drawn from the local authority and the Co-Chair is a representative from the CCG	
Director of Public Health has a critical role	
Irregular attendance by NHS England representative	
Members expressed that they felt accountable directly to the local population	
Initial construction of strategy uncontroversial	
Lack of time and financial resources	
No sharing of budgets	
Differences	
Metro	City
Lower percentage of children living in poverty compared to the national average	Higher percentage of children living in low income families compared to the national average
Percentage of inhabitants on a state pension higher than the England average	Percentage of inhabitants on a state pension lower than the England average
HWB comprised of statutory and non-statutory members (19 members in total)	HWB comprised of statutory members only (16 members in total)
HWB chaired by Elected Leader of the Local Authority	HWB chaired by the Major of the Local Authority
Recommissioning of Healthwatch organisation	No change in Healthwatch organisation
Partnership accountability in evidence	Partnership accountability in emergence
<ul style="list-style-type: none"> <li>▶ history of partnership working prior to establishment of HWB</li> <li>▶ most HWB members within walking distance of each other</li> </ul>	<ul style="list-style-type: none"> <li>▶ high turnover of HWB members, including Director of Public Health</li> <li>▶ workshops held to strengthen systems leadership</li> </ul>
Director of Public Health directly accountable to Chief Executive Officer (first-tier post)	Director of Public Health directly accountable to a Strategic director (second-tier post)
Refresh of strategy involved performing a priority exercise against a number of criteria such as achievability within 24 months	Refresh of strategy involved Board deliberation of a number of questions including evidence of need and potential impact
Performance reported in a Performance Scorecard which is aligned to priorities, and includes key measures relating to outcomes	Performance reported through development of JSNA chapters which focus on specific issues (for example, alcohol misuse)

## Conclusions

The health and wellbeing outcomes for a locality are complex and depend on a great number of wider determinants and factors. It is recognised, however, that improvements in health outcomes and reduced health inequalities have the potential to provide significant social and economic benefits. HWBs have been tasked with bringing together key leaders from across the health and social care systems to help address these issues, but being held accountable for such a 'wicked' problem is, to put it mildly, challenging.

Accountability regimes in public services (and in particular health and social care) are multiple. There is a complex web of accountability relationships, which have the potential to result in accountability deficits, overloads and tensions. As accountability arrangements change, so issues can fall between the cracks or can become replicated in more than one arena. We find that over time our case HWBs have focused on a smaller number of priorities where they can work together to make a difference. This should reduce the potential for accountability overload on issues that are predominantly the concern of a single organisation. HWBs provide a new accountability forum which may complement existing arrangements, but there does continue to be tensions between the many different accountability relationships.

It was originally hoped that HWBs would improve democratic accountability, but it appears that there is only limited public engagement and very limited threat of consequences at the 'ballot box'. Bovens (2007) and Bovens et al. (2008) distinguish the democratic accountability perspective from both the constitutional and learning perspectives on accountability. Looking forward, we suggest that accountability from a learning perspective may offer the greatest potential for HWBs. As a starting point, the learning perspective requires that

"information gathering and provision routines yield an accurate, timely and clear diagnosis of important performance dimensions" (Bovens et al., p. 238). This would suggest an important role for the JSNA, Strategy and performance scorecards. It would also require 'substantial' debate and discussion of this performance both within the HWB and also with broader stakeholders. A challenge would be that there is a need for "sufficiently strong outside actors" to hold the HWB to account, but at the same time a "sufficiently 'safe' culture of sanctioning to minimize defensive routines" (Bovens et al., 2008, p. 238).

Finally, we return to the government's aspirations in terms of HWBs leading to significant integrated working across the health and social care systems. We find that there are significant financial and time constraints that inhibit the potential for greater integration. Our evidence suggests that key organisations have tended to "cling on to what we have" (City, A) and that there has been very little move towards the pooling of budgets or even the sharing of financial information. In the future, it is hoped that these same organisations "must break out of the silos ... [and that] everybody's got to be thinking about the big picture" (City, G). Essentially there is a call for greater 'system leadership', which requires much greater integration. In this regard, we note more recent moves towards "accountable care systems" for localities and suggest that these may provide an appropriate framework. We recognise, however, that this will, yet again, present a further period of policy uncertainty and change which can also be a distraction.

## References

- ▶ Bovens, M. (2007) 'Analysing and Assessing Public Accountability: A Conceptual Framework', *European Law Journal*, 13 (4), pp. 447-468.
- ▶ Bovens, M., Schillemans, T. and 'T Hart, P. (2008) 'Does Public Accountability Work? An Assessment Tool', *Public Administration*, 86 (1), pp. 225-242.
- ▶ Bracci, E., Humphrey, C., Moll, J. and Steccolini, I. (2015) 'Public sector accounting, accountability and austerity: more than balancing the books?', *Accounting, Auditing and Accountability Journal*, 28(6), pp. 878-908.
- ▶ Byrkjeflot, H., Christensen, T. and Lægreid, P. (2014) 'The Many Faces of Accountability: Comparing Reforms in Welfare, Hospitals and Migration', *Scandinavian Political Studies*, 37 (2), pp. 171-195.
- ▶ Christensen T. and Lægreid, P. (2015) 'Performance and accountability – A theoretical discussion and empirical assessment', *Public Organization Review*, 15 (2), pp. 207-225.
- ▶ Dambrin C. and Robson K. (2011) 'Tracing performance in the pharmaceutical industry: Ambivalence, opacity and the performativity of flawed measures', *Accounting, Organizations and Society*, 36, pp. 428-455.
- ▶ Department of Health (2012) 'Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies', London: Department of Health.
- ▶ Department of Health & Communities and Local Government (2010) 'Liberating the NHS: Local Democratic Legitimacy in Health: A consultation on proposals'. London: Department of Health & Communities and Local Government.
- ▶ Heath, S. (2014) Parliamentary Note: Health and Wellbeing Boards (England), London: House of Commons.
- ▶ Humphries, R., and Galea, A. (2013) 'Health and Wellbeing Boards: One Year On', London: The King's Fund.
- ▶ Humphries, R., Galea, A., Sonola, L. and Mundle, C. (2012) 'Health and Wellbeing Boards: System Leaders or Talking Shops', London: The Kings Fund.
- ▶ Justesen, L. and Mouritsen, J. (2011) 'Effects of actor-network theory in accounting research', *Accounting, Auditing and Accountability Journal*, 24 (2), pp. 161-193.
- ▶ Marmot, M. (2010) 'Fair Society, Healthy Lives: A Strategic Review of Inequalities in England'. London: University College London.
- ▶ Parker, L. and Gould, G. (1999) 'Changing public sector accountability: critiquing new directions', *Accounting Forum*, 23 (2), pp. 109-135.
- ▶ Sinclair, A. (1995) 'The chameleon of accountability: forms and discourses', *Accounting, Organizations and Society*, 20 (2/3), pp. 219-237.

## Glossary

**CCG** – Clinical Commissioning Group

**HWB** – Health and Wellbeing Board

**JHWS** – Joint Health and Wellbeing Strategy

**JSNA** – Joint Strategic Needs Assessment

**OSC** – Overview and Scrutiny Committee

**STP** – Sustainability and Transformation Partnership

## Acknowledgements

The authors would like to thank CIMA's General Charitable Trust for funding this project. In addition, they thank the interviewees for their willingness to contribute their time to our research project.

## Researchers

Prof Stuart Cooper

Department of Accounting and Finance

University of Bristol

Dr Suzanna Grubnic

School of Business and Economics

Loughborough University



[aicpa.org](http://aicpa.org)  
[aicpa-cima.com](http://aicpa-cima.com)  
[cgma.org](http://cgma.org)  
[cimaglobal.com](http://cimaglobal.com)

June 2018