University of Birmingham

Public Health in English Local Authorities

Accounting, performativity, & practice

James Brackley

27 October 2021

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Acknowledgements

After close to eight years, this thesis feels like it has been a long time in the making. In 2012, I had the idea that I would like to apply for a qualitative PhD but had little idea of where to start, being fresh out of professional practice and only a rough understanding that there was such a thing as 'critical accounting'. I would therefore like to thank Prof. Tuck for taking sympathy on me at this time – without your generous guidance and the lengthy reading list you gave me one afternoon that year I would not have been able to begin this journey.

I would also like to thank Prof. Exworthy for his time, guidance, and thoughtful feedback throughout my study at the University of Birmingham, and to the many other colleagues and staff who kindly read over my work, helped me secure places at conferences, and helped me progress through a few too many annual reviews.

As a student of both the University of Birmingham's Business School and Health Services Management Centre I have benefited greatly from School seminars, doctoral conferences, and colloquia across both Schools, so I would also acknowledge the excellent set up and support they have provided over the years.

I would similarly thank all participants to this project, both those who provided interviews and the many more who offered their time to help me learn more about the Public Health profession.

And lastly, I would like to thank the many friends, family, and comrades who have given me their support and kindness during this time. Particularly Ioana Chis, who has always been there for me, and through our activism and the Contemporary Philosophy of Technology group has contributed many important ideas for this thesis.

Preface

This PhD thesis is structured as a somewhat traditional 'seven-chapter' thesis or monograph. I it the product of a part-time PhD project that was commenced in January of 2014 and was largely written-up between 2016 and 2020, with the primary data collected in 2015, 2016, and 2017. This period also included a short leave of absence for medical reasons in 2017.

I published two blogs in the early stages of the analysis via the University of Birmingham's 21st Century Public Servant site, listed below:

> Brackley, J., (2015) 'The public health professional: Finding a voice', The 21st Century Public Servant, April. Available at: https://21stcenturypublicservant.wordpress.com/2015/04/22/the-public-health-professional-finding-a-voice/
>
> Brackley, J. (2016c) 'Everything is public health: opportunity or threat for local public health professionals?', *The 21st Century Public Servant*, May. Available at: http:// https://21stcenturypublicservant.wordpress.com/2016/05/24/everything-is-public-health-opportunity-or-threat-for-local-public-health-professionals/

Before presenting the project at the 2018 IPA at Edinburgh where an early draft paper was published in the proceedings. With the support of my supervisors, a revised version of this paper was later submitted to the Auditing, Accounting, and Accountability Journal, in 2019, before being accepted for publication in 2021:

> Brackley, J. (2018) 'Public Health intervention in English Local Authorities: Constructing the facts, (re)imagining the future', *12th Interdisciplinary Perspectives on Accounting*. University of Edinburgh, July 2018.
>
> Brackley, J., Tuck, P., and Exworthy, M. (2021) 'Public health interventions in English local authorities: constructing the facts, (re)imagining the future', *Accounting, Auditing and Accountability Journal*, 34(7), pp.1664-1691.

Adapted and abbreviated wording from some sections of Chapters 1 and 3 were used in framing this paper (see 3.3 subsection 'STS in the critical accounting literature: introducing the performative'), together with some of the data presented in Chapter 5 and wording developed from the discussion in Chapters 6 and 7 (see 6.2 subsection 'discussion: performativity and the mobilisation of material-discursive inscriptions'; 7.1 subsections 'From new public management to intelligent accountability?' and 'Intelligent accountability and austerity').

To preserve the coherent structure of this thesis I have not separated it into separate papers. A second empirical paper drawing on the professions literatures presented in Chapter 2, section 2.2, and the discussion in Chapter 6, section 6.1, is also in its early stages.

Please also note that the data collection and the large proportion of the write-up of this project were completed prior to the Covid-19 pandemic. The outcomes described in the concluding Chapter 7 therefore inform, to some extent, lessons to be learnt post pandemic, particularly in relation to the impact of austerity cuts on service delivery, but these questions were not within the scope of the original data collection or analysis.

Table of Contents

Acknowledgements 1

Preface 2

Extended abstract 6

Table of acronyms used in this thesis 7

List of Figures 8

Chapter 1: Introduction 9

1.1 What is Public Health? An overview of recent reforms in England 14

1.2 Outline of the thesis 18

Chapter 2: Background literature review 23

2.1 A historical review of Public Health reforms in the United Kingdom 23

2.2 Emerging empirical literature on the new Public Health system in the United Kingdom 31

Public Health in local Government: 'Democratising' Public Health? 32

Reflecting on practice: Findings from academic literature on the transfer of Public Health into Local Government 34

Evidence in context: stating the facts or telling the story? 36

Austerity: the increasing cuts to budgets and the focus on 'disinvestment' 39

2.3 Public sector accounting and 'post'-New Public Management 43

The nature of accounting information and New Public Management in the public sector 43

On the public sector accounting literature 50

Speaking the truth? Accounting as *parrhesia* and accounting as *maieutica* 56

2.4 Professions and the 'Public Health Professional' 58

On professions and professionals 59

The reflexive construction of professional identity 64

2.5 Summary and conclusions 67

Chapter 3: Theoretical and conceptual framework 72

3.1 Introducing the paradox of objectivity 73

3.2 The paradox of objectivity: lessons from science and technology studies 75

Background: Science and Technology Studies (STS) 75

A brief introduction to Performativity: from speech acts to distributed agency 79

Posthuman performativity and agential realism 83

Resolving the paradox: diffraction, indeterminacy and anti-essentialism 89

Resolving the paradox: Implications and conclusions for objectivity 91

3.3 Paradox in practice: Untangling critical accounting's contribution 93

STS in the critical accounting literature: The emergence of Actor-network theory 94
STS in the critical accounting literature: Introducing the 'performative' 100
(Re)theorising performativity: Leaving behind the performativity thesis 108
3.4 Summary and conclusions 111
Chapter 4: Methodology and methods 114
4.1 An agential realist approach to research design and research methods 116
Agential realism: implications for the research design 117
Agential realism: implications for the research methods 120
4.2 Research design and research methods 124
Initial design and construction of research objectives 124
A multimethod, qualitative, and longitudinal design 130
Summary of documentary analysis 136
Constructing the facts: A detailed look at Drug and Alcohol interventions 139
Research Ethics 141
4.3 Cutting together-apart: the construction of diffractive codes 142
Chapter 5 Part 1: The transfer of Public Health activities into local government 148
5.1 Analysis and review of the Public health reforms in England and associated government and industry level guidance 149
The government's vision for Public Health 150
Local 'leadership' and the role of the Directors of Public Health (DsPH) 153
Evidence and value for money (VfM) in the new system 155
5.2 The cases, the spaces, and the initial transfer of Public Health to Local Government 159
On the initial transfer from the outgoing Primary Care Trusts (PCTs) 160
The right place to be? Bringing health into all policies 164
On the role of the new Health and Wellbeing Boards 171
On building networks: Directors of Public Health (DsPH) and the Public Health England (PHE) regional office 181
Chapter 5 Part 2: From health in all policies to austerity 185
5.3 Dysfunctionality and fragmentation 187
The removal of the ring-fenced public health grant and the proposed business rate retention scheme 194
5.4 Multiagency work and regional collaborations 198
Making the case: evidence of multi-agency work and regional collaborations towards a public health agenda 201
5.5 Summary and concluding remarks 206

Chapter 6: (Re)constructing Public Health: identities and evidence 209
6.1 (Re)constructing the Public Health discipline 211
The reconstruction of 'Public Health' 213
Discussion: Performativity, 'identity work', and the 'hybrid professional' 224
6.2 (Re)constructing interventions: making the case for Public Health 231
Mobilising the evidence: inscription devices and calculations across the case authorities 234
The case example of drug and alcohol interventions 243
Discussion: Performativity and the mobilisation of material-discursive inscriptions 250
Chapter 7: Discussion and concluding remarks 256
7.1 From New Public Management to intelligent accountability? 261
Intelligent accountability and austerity 266
7.2 Performativity and ethico-onto-epistemology 270
(Re)constructing the valuable in an ethico-onto-epistemological framework 274
7.3 Recent developments and opportunities for further research 276
List of References 279
Appendix 1: Timeline of primary data collection 299
Appendix 2: Primary and case authority documents 301

Extended abstract

By following Public Health activities through a historic transfer from the UK National Health Service into local government in the aftermath of the Health and Social Care Act 2012, this project draws together several crucial discussions in the critical accounting literature. Namely, the growing STS inspired accounting literature on the role of accounting representations in making accounting objects both knowable and valuable, together with the public sector accounting literature exploring the role of accounting in constructing value, identity, and ethically informed alternative accounts in times of austerity.

In following the transfer of Public Health activities the project focuses on two case localities, both of which had lost over half of their managed expenditure, together with the newly created statutory body Public Health England, through a series of interviews, observations and document analysis between 2015 and 2018. The project explores how professionals in this new organisational environment construct their 'evidence base' in making the case for Public Health, re-establish their professional legitimacy and identity, and work towards 'intelligent accountabilities' in the most difficult of times. Data was collected across a range of settings involving senior Public Health consultants, health economists, finance professionals, and Directors of Public Health, together with observations of workshops, group meetings, and the newly established Health and Wellbeing Boards. To date accounting practices of naming, measuring and reporting have been largely absent from initial studies of the transfer of Public Health activities into local government, but are found to play a crucial role. The study follows the successes and challenges as these strategies are put into practice, but also reflects on the reconstruction of 'Public health' itself, as a discipline, as professionals navigate new and conflicting accountability arrangements, budgetary structures, and funding cuts.

In following these practices, the study applies a science and technology studies (STS) inspired methodology, and Karen Barad's *agential realism*, in its exploration of the active, iterative, and ethical knowledge construction processes applied by Public Health professionals. In so doing, it demonstrates that such processes are far from politically or ethically neutral, arguing that organisational activities that seek to construct the 'facts' in establishing what is made valuable are by their nature dynamic, iterative, and networked. Public Health professionals are found to be rigorously trained in scientific and mixed methods, but increasingly needed to learn how to make use of this evidence in mobilising change in a highly politicised austerity context. This in turn drove new calculative and discursive practices, constructed to better suit the new organisational context. It was in this sense that giving 'account' of the 'facts' became an active, political, and entangled affair.

Table of acronyms used in this thesis

Acronym	Meaning
ANT	Actor-Network Theory
CCGs	Clinical Commissioning Groups
DCLG	Department for Communities and Local Government
DsPH	Directors of Public Health
FRC	Financial Reporting Council
HSC	Health Select Committee
HSCA 2012	Health & Social Care Act 2012
HWBs	Health and Wellbeing Boards
Las	Local Authorities
LGA	Local Government Association
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPM	New Public Management
PCTs	Primary Care Trusts
PH	Public Health
PHE	Public Health England
SROI	Social Return on Investment
STS	Science and Technology Studies

List of Figures

Figure 1.	**Public health grant net expenditure change in spend 2014/15 to 2018/19 (Health Foundation, 2018)**	p. 25
Figure 2.	**Title and abstract key word search: 'performativity' in critical accounting research**	p. 63
Figure 3.	**Timeline of primary data collection**	p. 81
Figure 4.	**Summary of primary and case documents analysed**	p. 85
Figure 5.	**Primary data collected in relation to Drug and Alcohol interventions**	p. 86
Figure 6.	**Overall coding structure for interviews, observations, and parliamentary enquiry**	p.91
Figure 7.	**Summary of third layer coding, with number of sources and references by code**	p.92
Figure 8.	**Overarching indicators Midland City 2017 (PHE 011, 2017)**	p. 146
Figure 9.	**Midland City Charity KPIs 2016/17 (MC 018, 2016)**	p. 149
Figure 10.	**Extract from Midland City PHE Outcomes Framework 2017 (PHE 011, 2017)**	p. 149
Figure 11.	**Extract from SROI tool showing the cost of one incidence of domestic violence**	p. 154
Figure 12.	**NPM, austerity, and 'post'-NPM following HSCA 2012**	p. 165

Chapter 1: Introduction

The question of what is valued in society goes to the heart of how resources are produced and distributed, our provision for want and need, how we educate and re-educate each other, and ourselves, how we indulge our excesses or, yet, demand the frugality of others. And all the while these value induced processes in turn unfold into new value constructions, from generation to generation or, even, from one day to the next. Accounting practices of naming, categorising, and reporting play a crucial role in the articulation and reproduction of concepts such as 'financial sustainability', 'value for money', 'costliness', and 'accountability' at the core of what is made valuable, and, in so doing, are far from politically or ethically neutral. In exploring these processes, this project conducts a critical investigation of how Public Health activities are made valuable in their new organisational environment of local government in England following a major and historic reorganisation. The project investigates the processes of counting-up and constructing the 'Public Health agenda', and addresses the dynamic, iterative and entangled nature of the frameworks capable of establishing value systems without essentialising the processes at play in which we all hold a stake. The contested value(s) of healthy life and wellbeing presented in this project must, in this sense, be understood as knowledge networks that are inherently ethical-political.

The construction of value and of the valuable through the accounting devices, rankings, standardisation, and categorisations that commensurate organisational and social life has come under renewed focus in critical accounting research in recent times (Kornberger et al., 2015). In particular, there is a rich and developing discussion of the role of accounting in the making of markets and the *performativity* of accounting instruments on the back of a renewed interest in the social studies of finance and economics (Miller, 2008; Vollmer et al., 2009; Justesen and Mouritsen, 2011; Kornberger et al. 2015), with a growing empirical

literature emerging in this area. However, to take the 'performativity' of accounting devices to be their e*ffect(s)*, in cause-and-effect relationships, with the 'performativity thesis' to be proven or disproven is problematic (Butler, 2010; Callon, 2010; Vosselman, 2014), and, just as crucially, despite the hegemony of exchange values in both the discourses and materialities of advanced capitalist economies – *monetary* values, via constructed market exchange mechanisms, do not represent the only means through which the value of objects and practices are contested. Areas of the public sector, especially, present fertile ground for the study of valuation practices that arise through and with accountability and budgetary reforms, creating new spaces in which ethical commitments to 'intelligent accountabilities' (Roberts, 2009) or 'alternative accounts' (Bracci et al., 2015) come to intersect with knowledge construction processes that establish 'what counts' and for whom in the wider public interest.

Towards this end, this thesis follows the reforms of the Health and Social Care Act (HSCA) 2012 in England, under which Public Health activities underwent a historically significant reorganisation. From April 2013, local Public Health teams were transferred from the NHS, along with the abolition of 152 Primary Care Trusts (PCTs), to Local Authorities (LAs). An initial £2.7 billion ring fenced grant fund was set up and distributed to LAs via a newly created statutory body, Public Health England (PHE). Prior to the transfer, a national baselining exercise was carried out by the Department of Health to establish specifically the 'Public Health' spend, as distinguished from the broader primary care budgets, in anticipation of the transfer. Teams of Public Health professionals across the country were physically transferred to offices in LA estates, and were required to rebuild, almost from scratch, previously taken for granted legitimacy, professional identity, and working vocabularies in a context itself being redefined by austerity. Challenges that finally crystallised in 2020 as the

underfunded and fragmented national response to the Covid-19 pandemic was widely criticised (BMJ, 2020; The Lancet, 2020), with the government then abolishing PHE in response, the body they had created just seven years earlier.

Public Health activities speak to contemporary concerns over valuation practices, particularly since 2013, because they are often multi-agency and cross-profession activities that address 'wicked problems' (Pedersen et al., 2017) that, nonetheless, represent huge potential for improved quality of life and the financial sustainability of health care systems and local government (Davies, 2015; Buck, 2017). They typically have long time horizons, needing to be strategically planned along the 'entire life course' (Marmot, 2010), and are enmeshed with localised issues of health and economic inequality. Public Health professionals meanwhile pursue the double role of scientist, committed to rigorous methods and establishing their evidence base, and of advocate of Public Health initiatives and the Public Health profession itself. Since 2013 the social and economic benefits of Public Health activities have come into increasing conflict with austerity measures that have disproportionately hit the deprived communities that would benefit most directly from improvements in Public Health (Hastings et al., 2015). This throws into contradistinction the short-term cost based valuations and 'cashable savings' under austerity in local government (Ahrens and Ferry, 2015) and the longer term, holistic, outcome based (re)valuations advocated by the Public Health profession as they advocate for these activities.

Given this context, the study follows the socio-material assemblages that (re)construct 'Public Health' through its ongoing contestation via a range of interviews in two local case study authorities 'Metro Town' and 'Midland City', PHE, private sector consultants, charitable organisations, and former Public Health professionals; observations of health and

wellbeing boards; and documentary analysis. The thesis contributes to the growing 'post'-NPM public sector accounting (Bracci et al., 2015) and performance measurement (Julnes and Steccolini, 2015) research both empirically, by following contested discourses and practices of private sector management styles encountered by public sector experts in a context of deep austerity, and theoretically by drawing greater emphasis on the role of the knowledge production process itself. In particular, the discussion links the process of knowledge construction to the growing theoretical debate around the concept of 'value' in science and technology (STS) inspired studies, and builds on similar findings in the literature claiming accounting inscriptions and practices should be understood as inherently and ontologically political (Vosselman, 2014), entangled, as they are, in unfolding knowledge making processes. Finally, broadening out the analytical vocabulary in the discussion of accounting and value construction, the thesis draws particularly upon Karen Barad's 'agential realism' (2003, 2007), together with other STS scholars, to demonstrate that such processes necessarily deal in iterative performative agential interventions throughout organisational life, and across organisational boundaries, that are inseparable from material discursive understandings of ethics and identity formation.

Overall Research Aim:

This project seeks to understand how the 'value' of Public Health is (re)constructed as a shared understanding of what matters and what counts. This leads to the broader understanding of how it is that value(s) are constructed in organisational contexts, and how constructing what is valued is deeply tied up with the iterative reconstruction of what is held to be true. The thesis addresses this overall aim by reviewing the emerging empirical and theoretical literature relevant to the study of Public Health activities (Chapter 2), introducing

the key conceptual terms of reference and the *agential realist* theoretical framework (Chapter 3), applying this framework to the empirical study of Public Health activities by introducing the research design and methods used (Chapter 4), before moving on to the analysis of the empirical data and discussion of results (Chapter 5 and Chapter 6), followed by concluding remarks (Chapter 7).

Research Objectives:

- To explore how the case for Public Health activities is contested and made valuable in local authorities (LAs) in England in the aftermath of the HSCA 2012.

  ↳ To explore the evolution of new Public Health **identities** since the move to local authorities, and to describe the **performative processes** that construct these new identities.

  ↳ To explore how the emerging **accounts of** Public Health activities are (re)constructed towards a 'Public Health agenda', and to describe the **performative processes** that (re)construct these accounts.

  ↳ To discuss the **ethical** and **political** dimensions of these valuation practices, with reference to critical public sector accounting literatures on 'post'-New Public Management, 'intelligent accountability', and austerity.

These are presented as an overarching objective to explore the valuation practices implicit as Public Health professionals, and others, make or contest the case for Public Health activities, followed by subsidiary objectives exploring the emergent accounts, group structures and identities, through and with their ethical and political consequences. These objectives are further discussed in light of the theoretical and methodology framework in Chapter 4 (section 4.2).

1.1 What is Public Health? An overview of recent reforms in England

The initial inspiration for this project was an interest in the intersections between different areas of the public sector, and between health and local government in particular. The HSCA 2012 had recently established a range of deep reforms to the structure of healthcare in England, including the abolition of PCTs and their replacement with GP led Clinical Commissioning Groups (CCGs), but also included a proposal to transfer 'Public Health' from the National Health Service to local government. This transfer reversed a historical change in 1974 that had coincided with establishment the modern Public Health profession via the Faculty of Public Health (Faculty of Public Health, 2014), and represented a major re-organisation for the profession. This empirical area was therefore chosen for investigation as it provided a timely example of both organisational 'controversy' (Latour, 2005 pg.21) and an example of knowledge (re)construction through and with material and discursive practices in an extremely challenging environment of deepening austerity.

The Government narrative driving these reforms drew on this history in describing the 2013 transfer as 'returning public health home' (Department of Health, 2011) and pointed out that LAs would be 'democratically accountable' with a 'greater understanding' of the wider social drivers of health inequalities such as crime, place, age demographics, employment etcetera (Ibid.). The Local Government Association (LGA) also describe the reforms as having returned Public Health 'home', putting Public Health 'back at the heart of local government', and as 'democratising' Public Health (LGA, 2014a and 2014b) while providing Public Health professionals a more integrated working space to 'bring health into all policies'. Under the new system, the newly created autonomous body, PHE, would provide LAs with a ring fenced Public Health grant, and monitor performance against a new national

Public Health outcomes framework. At the local level, Health and Wellbeing Boards (HWBs) would be set up in the LAs through which collaboration across the council would be facilitated, and through which a statutory duty to produce a Joint Strategic Needs Assessment in collaboration with local CCGs would be executed (King's Fund, 2016a). LAs would prepare a Public Health annual report and report their expenditure to the Department of Health via a Revenue Outturn form, which was to be signed-off by the Director of Public Health (Department of Health, 2016). Across this new structure, PHE was to play the double role of advocacy for, and an 'authoritative voice' on, Public Health issues at the national level (NAO, 2014), while simultaneously playing a support and coordination role at local and regional levels.

In this sense, one could argue that 'Public Health' is defined by its policy context. In the UK, Public Health legislation can be traced back at least as far as the first Public Health Acts, starting with the United Kingdom Public Health Act 1848 that first legislated for basic improvements to sanitation and housing, through to the more progressive Public Health Acts that gradually broadened the scope of public health by increasing the requirements of LAs to protecting their citizens, through to the creation of the NHS and the establishment of Public Health as a medicalised profession. The history of Public Health in the UK is summarised in Chapter 2 (2.1), which explores the establishment of the modern profession from the late 1960s that sought to place Public Health interventions in environmental engineering, education, mass media, leisure, and mental health services at a 'new frontier' of medicine (Morris, 1969). Calls which were to be repeated through subsequent decades in the Black review (1980) and more recently in the influential Marmot review (2010).

Drawing on the data collected in this project, there has, more recently, been a growth in the discourse around 'wellbeing' following the establishment of Health and Wellbeing Boards as the primary local accountability mechanism following the HSCA 2012. This was a theme picked up throughout the data analysis as Public Health professionals stressed the need to embed what they do across all activities in creating a 'Public Health Ethos' as opposed to a 'Public Health service'. In this context, PHE (2018) define Public Health as follows:

> Public health is about helping people to stay healthy, and protecting them from threats to their health. The government wants everyone to be able to make healthier choices, regardless of their circumstances, and to minimize the risk and impact of illness.

While the Faculty of Public Health (2014) define Public Health as:

> Public health is the science and art of preventing disease, prolonging life and promoting health through organised efforts of society.

Public Health as 'science' and as 'art' touch on key themes of the discussion in Chapters 6 and 7 as Public Health professionals seek to mobilise their scientific training to legitimise and advocate for Public health activities in their new context. Public Health professionals themselves acknowledge the difficulty in defining their discipline, with no clear or precise boundaries having been widely agreed upon and a clear shift in emphasis over time (Hunter et al., 2016). Plsek and Greenhalgh (2001), for example, describe Public Health as a system that is 'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents', so that it must be understood in its historical and social context rather than in the abstract.

In describing the history of Public Health, the Director of Public Health in Midland City (the larger of the two case authorities under investigation in this study) put this in the context of the ancient history of population health:

> So it's back to the future stuff. If you look at what the Romans did around Public Health… if you look at the big aqueducts coming into Rome [...] They recognised water was important, sewage was important. They recognised that housing was important. It may have been called something else, but the ethos was there. They recognised without those things you die. Food is another good example. If you don't have a good, clean food supply, your city dies. In Rome they built Ostia, fed a million people everyday. Without that, the city dies. 85% of the transport [from Ostia] was food. Food is a public health issue. It's like water. If you don't have the food, in a famine, what happens? Everyone dies.' **Alan, Midland City DPH, Dec 2016**

This points to the practical economic and social necessities underlying the discipline; that for millennia ensuring the physical health of the population has important economic and social consequences that impact on public policy. The idea of a pluralistic Public Health agenda or ethos able to enrol a wide network of actors, however, comes into controversy with the strategic essentialism of the term itself as a marker of professional identity in more recent times as budgets are squeezed and resources reduced – thus, in addressing the research questions, the projects asks to what extent are practitioners redefining 'Public Health' as a discipline and in what ways are they doing so?

The regional director of PHE points to this controversy as Public Health professionals look to embed themselves in their new organisational environment, bringing 'Public Health' into all LA functions rather than coming across as a standalone function or cost centre.

> 'When we talk about public health, we're often talking about the public's health whereas it can be construed that we're talking about the profession and the specialty and actually that can be unhelpful in some of the conversations with local government. [the CEO of PHE] often jokes about the fact that one of the key things he's done is introduced the

'apostrophe S' into the language. So we're talking about the public's health.' **Rosanna, PHE Regional Director, Nov 2016**

Backgrounding this statement, there are wide ranging institutional and cultural arrangements that variously lead to the establishment of Public Health as a discipline and as a professional identity. The identity constructed through and with the Faculty of Public Health and associated expert status, professional qualifications and programs of continued professional development, PHE and regional Public Health knowledge sharing activities, formal accountability mechanisms, and the ring-fenced grant conditions all serve to protect the essentialism of the discipline. In a context of deep austerity, protecting the discipline, jobs and activities, potentially comes into collision with the pluralistic and embedded view of Public Health as professionals find new ways of valuing what they do in the eyes of a LA audience. This project therefore does not try to answer the question 'what is Public Health?' in the abstract, instead, drawing on a contemporary and historical literature review, makes this question one of the key empirical and theoretical aims of the project itself as professionals reconstruct their evidence base and identity through and with their new organisational context.

1.2 Outline of the thesis

This project is structured around the exploration of value construction, in its multiple forms, as it is constructed and contested in making the case for Public Health activities. It draws on multiple case examples and engages with actors in a variety of settings via an *agential realist* (Barad, 2007) philosophy and methodology. A task made all the more challenging as this approaches refuses to allow the researcher to step outside the socio-material world under investigation (Hollin et al., 2017), embracing instead a 'strong reflexivity' (Harding, 1991) in

which context and a critical appreciation of the ethical and political dimensions of the processes under investigation are crucial.

Chapter 2 begins with an in depth review of the history of Public Health activities in the UK (2.1) before exploring literatures across critical Public Health, critical Accounting, Organisational studies. The chapter reviews emerging enquiries into the experiences of Public Health practitioners following the HSCA 2012 reforms (2.2) by focusing on studies investigating the key challenges facing professionals in their new organisational environment, the implications for Public Health evidence and advocacy, and more recently reductions to Public Health funding. The chapter progresses to the existing Public Sector accounting literature (2.3) with a particular focus on empirical studies of accounting in health and local government settings, but also a conceptual consideration of the nature of accounting information, New Public Management (NPM) and austerity in a public sector context. Finally, the chapter explores the professions literature across organisational studies, again with a particular focus on studies in healthcare and local government settings, to explore the role of accounting practices, and NPM and post-NPM style reforms, to contemporary medical professions and professionals. While a range of important theoretical concepts are introduced in this chapter, its objective is to explore the broad literatures that are implied in the research objectives so as to relate the findings to extant literature in the subsequent discussion. It will be noted in this Chapter that few studies adopt STS inspired methodologies when investigating Public Health reforms and none apply an agential realist framework.

Chapter 3 introduces the central theoretical and methodological framework of the thesis, following Karen Barad's agential realism. This framework is introduced to address the 'paradox of objectivity' (3.1) in standard approaches to social science research between

interpretivism and positivism, with each in turn criticised as being based on a priori subjectivism or objectivism that each split the world into irreconcilable realms, and each failing to address the knowledge claims of the other. Agential realism presents a framework that instead considers knowledge claims as arising out of entangled material discursive apparatus via performative agential intra-action (3.1). Consequences of this approach include the inseparability of ethics and politics from knowledge in any emergent value claims under investigation, the inseparability of the observer from the observed, and a sensitivity to the variety of human and non-human actors via both material and discursive entanglements. The chapter begins with an overview of key lessons from STS before introducing central concepts of a generalised posthuman *performativity*, *diffraction* and *diffractive methodologies,* as well as concepts such as *translation*, *inscriptions*, and *mediation*. The remainder of the chapter (3.2) explores how STS has inspired theoretical development in the critical accounting literature and proposes agential realism as an extension of current applications of the performativity concept to a more fully developed method for interrogating the iteration, failure, and negotiation of knowledge practices in organisational life. This section argues that a re-engagement with the post-structural turn in applications of performativity allow us to open up our analysis to both discursive and material practice, and realise the ethical, political, and ultimately ontological consequences of a performative methodology.

Chapter 4 then moves on to describe the implications of agential realism for the research design and methods (4.1) before providing a detailed overview of the research process, the design used, and the methods applied (4.2). This thesis does not present a traditional comparative case study and it does not apply typical social science methodologies so this chapter is crucial in setting out the consequences of the atypical methodology proposed and describes the points of departure from more familiar social science methods.

This is particularly true of the breadth of data collection and the need for a multimethod design involving the triangulation of traditional semi-structured interviews, observations and document analysis beyond organisational and professional boundaries. The chapter closes with a discussion of the implications of the diffractive methodology for data analysis and coding (4.3) concurring with critiques from the Actor-Network Theory (ANT) literature of grounded theory and (post)positivist approaches to coding but proposing a solution via more open coding techniques rather than outright rejection of coded data.

Chapter 5 then overviews the main empirical findings and analysis of this project. It is presented in two parts: the first gives an overview of the cases, the physical spaces, and the challenges and opportunities faced by Public Health professionals in the two case locations in the immediate aftermath of the transfer to Local Government. Part 2 then presents the second round of data, with a particular focus on the impact of austerity on the newly established networks, the dysfunctional consequences of fragmentation, and emergent collaborative responses to deepening cuts across the system. The presentation of this chapter addresses the overarching research objective in exploring how Public Health professionals 'made the case' for Public Health activities and is presented via the key themes reported by participants as they emerged from the diffractive coding process.

Chapter 6 then applies the analysis presented in chapter 5 in two parts: to a discussion of the (re)construction of the Public Health profession through and with the new structural arrangements, performances, inscriptions, and discourses (6.1) with reference to the professions literatures. This is followed by an analysis and discussion of the role of accounting devices, calculative techniques, and contested knowledge making observed as Public Health professionals, and others, make the case for Public Health (6.2) with reference to the critical

accounting literature. The concluding Chapter 7 then explores the implications of Chapters 5 and 6 for our understanding of 'post'-NPM, austerity, and 'intelligent accountability' (7.1) with reference to the critical public sector accounting literature, before reflecting on the theoretical contribution of the thesis (7.2). Chapter 7 then closes with a brief review of the latest reforms and the opportunities for further research that these reforms present for critical accounting scholars and those interested in exploring how things are made valuable in organisational life in non-market settings.

Chapter 2: Background literature review

This Chapter aims to provide both historical background, policy context, and an introduction to the academic literatures relevant to the empirical and theoretical contributions of this thesis. The literatures selected give a technical grounding in the nature of the recent policy reforms to Public Health and their consequences, and then link these back to current discussions in critical accounting and organisational studies. These 'literatures' are far from mutually exclusive, and the papers discussed here do not give an entirely comprehensive or systemic selection. The discussion is instead intended to give a grounding to main themes discussed later in the thesis. The main theoretical and conceptual contributions in light of the broader critical accounting discipline is then discussed in Chapter 3.

The Chapter begins with a brief history of Public Health in England and the UK (2.1); it then sets out the recent empirical literature on the recent Public Health reforms in the context of the Health and Social Care Act 2012 (2.2); before laying out the relevant literature from public sector accounting (2.3) and professions (2.4) research with reference to the research objectives.

2.1 A historical review of Public Health reforms in the United Kingdom

The first Public Health Act in the United Kingdom was The Public Health Act 1848, which was in part pioneered by Edwin Chadwick, one of the key architects of the preceding 1834 Poor Law (Susser and Stein, 2009, pg.50). In his role as secretary to the Poor Law Commissioners he led the well-known report 'The Sanitary Condition of the Labouring Population of Great Britain', which made the economic case that, to reduce pay outs of poor relief, improved sanitation would be cost effective in the long term (Ibid.). In 1848 the political impetus provided by a major cholera epidemic was the catalyst for some of these recommendations

being brought into statute. The main features of the Act included the creation of a Central Board of Health and the devolution of responsibility for adequate drainage and water supplies to LAs (*Public Health Act 1848*). In addition, finance was made available for Public Health infrastructure via central government loans, and where death rates were above 23 per 1000 there was now a requirement for local Boards of Health to be set up (*Public Health Act 1848*).

More widely, the 19th century was the first century in which there was no major country wide epidemic, while death rates per 1000 per year in England and Wales dropped from 21.9 from 1848–54 to 17 in 1901 (by comparison, the rate was 5.4 in 1971) (Szreter, 1988). Very high mortality rates in some urban areas by the middle of the century due to the growth in industrialization and the lack of basic sanitation were gradually counteracted through the Public Health Acts 1848, 1866, and 1875 (*Public Health Act 1848*; *The Sanitary Act 1866*; *Public Health Act 1875*), the introduction of the London sewage system in 1858, and advances in medicine, such as improved medical procedures around childbirth and the growing use of antiseptics (Szreter, 1988).

The Public Health Act 1866 further legislated for improved sanitation in urban areas, and enabled LAs to create linked drainage districts to counteract flood risks and made allowances for improved household drainage (*The Sanitary Act 1866*). The Public Health Act 1875 made specific recommendations that all new residential buildings must have facilities for running water and an internal drainage system (*Public Health Act* 1875), and required that every local Public Health authority employ a medical officer and a sanitary inspector to ensure that new laws on food, housing, water and hygiene were enforced (*Public Health Act 1875*).

The Public Health Acts of 1907, 1925, and 1936 gradually widened the powers of LAs regarding Public Health matters, and greatly increased the scope of centrally mandated

standards. These Acts included the provision of public toilets; drinking fountains; extensive legislation on drainage and sewerage provision; through to wider environmental requirements over water pollution and sewage (*Public Health Act 1907*; *Public Health Act 1925*; *Public Health Act 1936*). The 1907 Act in particular legislates extensively on infectious diseases as well as sanitation and housing, with new powers and obligations delegated to LAs on disease identification and confinement (*Public Health Act 1907*).

All of which reflects a gradual shift across successive governments coinciding with advances in the medical understanding of the links between such measures and the health of the overall population. A range of moral, economic, and even militaristic arguments were deployed through this period, Lee (1996) notes for example that:

> In 1902 General J.F. Maurice lifted the Rowntree figure of people unfit for military service to 60%. This was confirmed by the director-general of the Army Medical Service. As a consequence, the Balfour government set up the ominously named Inter-Departmental Committee on Physical Deterioration (1903-04). From this came suggestions for regular medical inspections of children and the feeding of the hungry ones by the local authorities.

Following this the Liberal government, under Asquith and with the support of 29 MPs from the newly formed Labour Party, put forward the 'People's Budget' of 1908 that proposed radical reforms to fight poverty and raise the standard of living for the poorest classes (Ibid.).

The growing emphasis on regulating LAs with a view to improving the health of the wider population took on an entirely new character in the post war period, with the National Health Service being created and largely established by 1948. Beyond simply allowing or mandating LAs to deliver good sanitation, modern building regulations, access to fresh water, and disease control, the state was now actively providing acute health care for the entire population. In particular, this development now meant that there were two separate arms of the state with responsibilities over an individual's health; LAs with the traditional Public

Health powers and duties, and the NHS with the new duties covering primary treatment and after care.

Inevitably, the size and scale of the NHS gradually altered the position for LAs, and the Public Health Act 1968 enacted a sizeable bill to set this into statute (*Health Services and Public Health Act 1968*). This Act systematically laid out the division between local government and the NHS for the first time in law, specifying which specialist services would remain under the statutory duty of LAs and which preventative services were to fall under the remit of the NHS (*Health Services and Public Health Act 1968*). In the same period, two of the UKs largest charities that operate on the border between local government and the NHS were also founded in Mind (formerly the National Association for Mental Health) in 1946 and Marie Curie in 1948 (Marie Curie, 2021; Mind, 2021).

These boundaries were to continue to evolve over the subsequent decades, and relatively soon after the introduction of the Public Health Act 1968 the lines were re-drawn in an order from the newly elected Labour government (per the *National Health Service Re-organization Act 1973*). The order created Regional, District and Area Health Authorities and brought the overall management of Public Health into the NHS for the first time (Cooper, 1974). This order was in part following the recommendations of the Todd report (Royal Commission on Medical Education, 1968) on the future of medical education, which cites the growing need to bring Public Health services into the formal remit of medical practitioners. Among the recommendations of the Todd report was the creation of a specialist Public Health body, which in 1972 led to the founding of the Faculty of Public Health to oversee the future training and professional development of Public Health practitioners (Faculty of Public Health, 2014).

These changes were fully introduced by 1974, and would greatly reduce the role of LAs, with dedicated health professionals taking over roles that were previously carried out by civil servants and administrators. Commenting on the importance of these changes, Cooper (1974) argued that 'uniformity' had taken precedence over 'expediency' in local government, and that there had been a disincentive for professionals to rock the boat within 'monopolistic' LAs. The re-organization was designed to incorporate management structures, performance monitoring and strategic thinking into the NHS, in what might retrospectively be described as the first tentative steps towards a NPM approach (Hood, 1991). However, unlike the 2013 transfer, which involved the TUPE transfer of Public Health professionals on existing terms and conditions, it was noted by Cooper (1974) that the 1974 re-organization was 'traumatic', with all professionals taken on by the newly created authorities having to re-apply for their positions, with the new authorities 'being no respecters of persons or seniority in rejecting candidates for the more senior posts'.

Anticipating the formalisation and medicalisation of Public Health at this time, Morris (1969) traces the improvements in mortality rates from the early 20th century through to relative stagnation in the late 50s and 60s and called for environmental engineering, education, mass media, leisure, and mental health services to become the new frontiers in medicine. This 'Public Health' agenda of wider preventative measures, he argued, must become the key focus of the health profession if it were to continue to progress. A call that is taken up in the subsequent Black review (1980) and, more recently, the Marmot (2010) review.

The rising cost of health care, cited as justification for the 1974 transfer of Public Health into the NHS (Cooper, 1974), was to become a recurring theme in the decades to come.

In 1977, the Labour government of the day commissioned a wide-ranging report into health inequality, resulting in the Black Report (1980). The key findings of the report were that there persisted serious and preventable health inequalities that could be addressed through a well funded Public Health program, and that the major contributor to health inequality was entrenched economic inequality (The Lancet, 1997). The report recommended investment in child health, elderly people's services, primary care, nutritional advice, anti-smoking campaigns, and better housing.

In an editorial feature of The Lancet (1997) the authors looked retrospectively at the NHS over the preceding 20 years at what they saw as successive failures to invest, update, and implement the recommendations of the Black report (1980). They argued that the findings of The Black Report had largely been ignored by the then Conservative government, stating that 'The political cowardice of this decision was unforgivable', and go on to note that none of the major parties in the 1997 elections were addressing the issues raised by The Black Report in their manifestos. After 25 years in the NHS there was a sense of frustration from the medical community at the lack of progress on key Public Health priorities and the general lack of investment, with health spend in the UK of 6.9% GDP well below the average of 10.4% for OECD nations (The Lancet, 1997).

By the 1990s the relatively stable NHS of the 1960s and 1970s was facing increasingly turbulent reforms (Salauroo and Burnes, 1998), particularly in the aftermath of the NHS and Community Care Act 1990, which first established the internal market within the NHS through the separation of 'purchasers' (such as District Health Authorities and GP Fundholders) and 'providers' (such as NHS Hospital Trusts) (Ibid.). In their summary of the market-based

reforms, Salauroo and Burnes (1998) cite Flynn and Williams (1997, pg.3) in concluding on the legislative agenda of the previous two decades:

> The new watchwords for the public sector became competitiveness, efficiency, consumer choice and value-for-money, while other values embedded in the history of the welfare state - access, equity, need and universalism - were ideologically discredited.

This highlights a new and growing tension in the medical profession with the introduction of market mechanisms; standard costing; payment by results; reporting of key performance indicators; and growth in audit practices, all of which can be understood as part of the implementation of neoliberal or NPM style reforms (Hood, 1991; Hood, 1995; and Power, 1997; Gebreiter, 2017). But such reforms did little to address the concerns of chronic under investment and a lack of focus on the wider determinants of health by the late 1990s (The Lancet, 1997), and coincided with a growing managerialism and financial 'hybridisation' of the medical professions (Miller et al., 2008).

When Public Health responsibilities were initially brought into the remit of the NHS in 1974 there had been 14 regional Health Authorities and 90 area Health Authorities that were responsible for implementing the Public Health agenda through the UK. Continuing the intensity of reform, an order from central government in 1994 then cut this number to 8 District authorities supported by a similar number of area health authorities (Nuffield Trust, 2021). Then, in 2001, in an attempt to create more 'transparency' and leadership at the local level the Labour government created Primary Care Trusts (PCTs) to act as the exclusive purchasers of health care services (LGA, 2013), taking over from District Health Authorities. This led to a drastic increase in accountable bodies, with over 300 PCTs (Nuffield Trust, 2021), all with detailed disclosure requirements in their annual accounts subject to statutory audit. Further large scale reorganization was soon to follow with the reduction in the number of

PCTs in 2006, from 303 to 152 (Nuffield Trust, 2021), and then their abolition in March 2013 leading to the full transfer of their public health roles, with a combined value of £2.7 billion for 2013/14 (LGA, 2013), back to LAs.

This brings the overall history of Public Health reforms up to the point at which this study undertakes its investigation. By tracing Public Health activities, calculations, and identities in English LAs this study is investigating a historically and geographically specific set of material-discursive arrangements in their unique social context[1]. The study begins with interviews in 2015 through to 2017 and draws on a range of documentary evidence on the new arrangements.

The vision driving the current reforms put forward by government sources, particularly the Department of Health, drew on this history in describing the 2013 transfer as 'returning public health home' (Department of Health, 2011) and points out that LAs are 'democratically accountable' with a 'greater understanding' of the wider social drivers of health inequalities such as crime, place, age demographics, employment etc. Similarly, the LGA describe the reforms as having returned Public Health 'home', put Public Health 'back at the heart of local government', and 'democratised' Public Health (LGA, 2014a and 2014b) while providing Public Health professionals a more integrated working space to 'bring health into all policies'. The current discursive framework will be analysed through and with interview data, observations, and further documentary analysis, which is fully detailed in Chapter 4. The remainder of this Chapter introduces the reader to the emerging empirical

[1] It should also be noted that as a result of devolution in the United Kingdom through The Scotland Act 1998, the Government of Wales Act 1998, and the Good Friday Agreement, since 1998, health services have been separately administered in each of the devolved nations of the United Kingdom and Northern Ireland, so that the transfer of Public Health activities through the Health and Social Care Act 2012 and the creation of Public Health England was exclusive to *England*. Public Health activities currently remain within the NHS in each of the other devolved nations.

literature on the efficacy of the 2012 Public Health reforms, and then to the relevant critical public sector accounting and professions literatures. These will provide a basis for the empirical contribution of the thesis as discussed in Chapters form the basis of the findings presented in the discussion (see Chapters 6 and 7).

2.2 Emerging empirical literature on the new Public Health system in the United Kingdom

The initial inspiration for this project began in 2014 with an interest in the intersections between health and local government, from a critical accounting perspective, and the resulting funding, organisational, and professional boundary problems that would emerge in reconstructing the 'Public Health agenda'. The HSCA 2012 and the subsequent transfer of Public Health activities from the NHS into local government in 2013, with a specific ring fenced grant, therefore seemed an ideal empirical opportunity. However, beginning an investigation into the consequences of very contemporary policy reforms brings the immediate challenge of a lack of empirical literature on which to draw. On the other hand, a common challenge faced by part time students is keeping up with a developing literature over the extended time it takes to complete, typically at least six years from registration. The background literature presented in this section therefore consists of a range of studies that emerged during the project itself, some of which informed the initial research questions (from 2014 to 2016) and data collection (2015 to 2018) while some only became available during the analysis and final write up (2018 to 2020). This section summarises this literature at the time of writing, up to 2020 and the preparation of the final draft of the thesis.

Public Health in local Government: 'Democratising' Public Health?

Immediately after the 2012 reforms the only published material specifically on Public Health in local government were fact sheets and guidance notes issued by the Department of Health (2011, 2013), the LGA (2014a, 2014b), and the newly established PHE (2013). These variously laid out the details of the statutory arrangements, describing the duties and expected responsibilities of Directors of Public Health, Health and Wellbeing Boards, PHE itself, and the new reporting and accountability arrangements associated with the new ring fenced Public Health grant and associated grant conditions. Together with the original white paper that preceded the HSCA 2012, entitled 'Healthy lives, healthy people' (HM Government, 2010), the Department of Health (2011) outline the vision for Public Health in local government, which was described variously as bringing Public Health 'home', 'democratising Public Health', 'putting local communities at the heart of Public Health', and providing local government with the 'freedom to innovate' within the context of newly provided local funding.

Increased aspects of democracy were, initially, welcomed as Public Health commentators described the reforms as an opportunity for bringing 'health into all policies' (Buck and Gregory, 2013; LGA, 2014a; LGA, 2014b; Peckham et al., 2017) and emphasising the full 'life course approach' (Nuffield Trust, 2011). 'Health in all policies' was a key plank of the Marmot review (Marmot, 2010) and became a recurring theme in the argument for the transfer of Public Health activities into local government, with Sir Michael Marmot later writing the preface for the LGA's 'Health in all policies: a manual for local government' (LGA, 2016). In short, his influential report argued that the majority of health issues faced by the health care sector are highly complex and integrated, and that we live in a time of increasingly decentralised governance; therefore, in order to tackle these problems, health responses must be highly collaborative and work hand in hand with all parts of the public sector.

Decision makers across the public sector should be informed of the consequences for health, equity, and sustainability, and there ought to be an increasing role for health professionals in Public Health advocacy (LGA, 2016).

However, concerns were also raised, with the Nuffield Trust emphasising the need for robust accounting and strong governance of the Public Health grant in a context of local government austerity (Nuffield Trust, 2011). The King's Fund went further in their response to the White Paper consultation, questioning the logic of the transfer at a time of 'severe budgetary pressure' in local government and major organisational change in the NHS (The King's Fund, 2011). They go on to question the apparently fragmented accountability arrangements that were service driven rather than 'outcomes focused' (Ibid.).

Finally, a technical consequence of the creation of a specific ring fenced Public Health grant for LAs was the completion of a full 'baselining exercise' in which the outgoing PCTS were surveyed to establish the level of their Public Health spend, which was then used as a guide for the initial grant allocations (NAO, 2014). This exercise highlighted significant inequity in allocation across the country. While the initial funding formula and annualised grant increases were designed to narrow this gap, by 2014/15 the government had scrapped their commitment to increasing the grant, instead announcing a series of year on year cuts (The King's Fund, 2017b), consequently also scrapping the roadmap towards the narrowing of funding inequalities across the country.

As a result of the reforms, Public Health was also moved outside of the government's nationally protected healthcare budget, and has continued to receive year on year cuts since 2015, amounting to an 5% overall cut in Public Health funding between 2014/15 and 2017/18 for a population that has increased by 3% (Buck, 2018). The future prospects for the Public

Health grant remain unclear as the government's initial proposals to remove the ring fence from April 2016 were put on hold, with the further proposals being made to fully replace the Public Health grant with a local business rate retention scheme from April 2020 (Department of Health and Social Care, 2018).

Reflecting on practice: Findings from academic literature on the transfer of Public Health into Local Government

A range of academic journals have begun to publish research on the organisational, professional, and practical implications of the transfer of Public Health into LAs. In the Public Health literature investigations have been undertaken in the journals *Public health, Social Science and Medicine,* and *Critical Public Health* among others looking at questions of leadership (Day et al., 2014), Public Health advocacy and evidence in the new context (Brown et al., 2014; Phillips and Green, 2015; Smith and Stewart, 2017; Sanders et al., 2017; Reynolds et al., 2018), and strategic delivery and partnership working (Caron et al., 2014; Van Der Graaf, 2017; Chantler et al., 2019), with some studies in the local government literature having taken up similar questions (Peckham et al., 2017; McGivern et al., 2017). While enough output is now available for this to be described as an emerging body of literature, this review omits the much broader body of knowledge from the disciplines of evidence based epidemiology and health economics, in which Public Health professionals themselves are trained. The studies selected here draw broadly critical perspectives on how evidence is constructed and used, the efficacy of the new policy landscape for improving the public's health and wellbeing, and a reflective view on what this new landscape means for Public Health as a discipline largely via qualitative or mixed methods approaches.

In one of the first such studies to be published Phillips and Green (2015) conduct a cross sectional qualitative study of health and wellbeing boards in three metropolitan and

three district councils. They find that the system introduces a new mix of stakeholders, with a range of sometimes competing accountabilities to the local population, to management, and to politicians (Ibid.). In particular, financial accountabilities are powerful, but depend crucially on where funding comes from; with external grants being subject to more prescriptive evaluations and audits. They also find evidence of contrasting 'epistemologies of practice'; comparing locally formed experiential and qualitative forms of knowledge traditional in LAs, while more scientific 'evidence' based, standardised forms of knowledge that were observed among Public Health professionals, particularly those at PHE (Phillips and Green, 2015; Brown et al., 2014).

In the aftermath of the reforms industry commentary and academic research suggests an initial 'culture shock' (Peckham et al., 2017), and a sense that the reforms created a more 'fragmented' environment of performance measurement and reporting (Brown et al., 2014; Phillips and Green, 2015; Chantler et al., 2019). The new statutory reporting arrangements, through which Public Health activities are reported and negotiated through Health and Wellbeing Boards, in particular, was noted as an example of complex and multiple accountability (Brown et al., 2014; Phillips and Green, 2015). The NAO (2014) in their initial value for money review of the new system cite this as a concern, criticising the lack of standardisation and the likely variability they expect to result from PHE's relatively limited statutory control. Weakened links between PHE and the NHS, with a loss of links between CCGs and the new Public Health teams, in particular, were similarly reported by Brown et al. (2014) in their review of cancer care, while Chantler et al. (2019) report a lack of clarity in the allocation of roles between LA Public Health and NHS England in commissioning of immunisation services.

However, there were also clearly positive aspects to the transfer cited with, perhaps surprisingly, occurrences of 'scope creep', with existing Council services being brought into Public Health control, being seen as a 'freedom' to more broadly embed Public Health Activities and, in some cases, to use the new found evidence base to resist austerity cuts (Brown et al., 2014). The new environment also brings Public Health professionals closer to the 'wider determinants of health' (Gorsky et al., 2014) and allows them to work more closely across local services, for example in alcohol licensing (Reynolds et al., 2018) and local commissioning (Sanders et al., 2017). In so doing Public Health professionals were indeed, at least initially and despite the challenges created by a more fragmented system, able to realise some of the ambitions behind the HSCA 2012 reforms in 'returning Public Health home' and 'bringing health into all policies' (Department of Health, 2011; LGA, 2016).

However, in making the transfer a 'success' Public Health professionals needed to not only proactively build new working relationships, but learn to present their evidence base to new audiences, and to take on new roles as budget holders and commissioners (Milton et al., 2014). The reforms created Health and Wellbeing boards as an accountability mechanism of sorts, in which Public Health professionals presented their work, but also created a forum for collaborative working to be established and for the 'Public health agenda' to be made (Phillips and Greene, 2015). The reforms therefore placed particular focus on the role of the Director of Public Health (DPH) as a key advocate and powerful actor in an increasingly politicised context (Day et al., 2014; Hunter et al., 2016; Peckham et al., 2017).

Evidence in context: stating the facts or telling the story?

Several studies have found that 'evidence' alone can sometimes be peripheral in the local government context, particularly when compared to the NHS (Hunter et al., 2016; Sanders et al., 2017), with performance indicators in particular often being ad-hoc, varied, and forming,

for the most part, a legitimising role within a political context of negotiation and justification (Phillips and Green, 2015). Public Health professionals are seen in this context as bringing a rigorous scientific 'evidence based' approach (Sanders et al., 2017) and a contrasting epistemology of practice (Phillips and Green, 2015). Brown et al. (2014) describe the resulting dynamic as Public Health professionals look to learn a new 'language' and to 'tell the story' of Public Health interventions, particularly when dealing with elected members and short-term political cycles. Milton et al. (2014), however, point out that these apparent epistemological differences do not typically prevent successful collaborative working relationships and Hunter et al. (2016) evidence in their study the multiple strategies through which Public Health professionals are able to successfully influence decisions.

The 'value' of Public Health professionals was discussed in the context of their influence and ability to make use of evidence to direct strategic decision making around investment and intervention, and, increasingly, around disinvestment (Marks et al., 2015). Drawing on three case study authorities and interviewing members of the newly created Health and Wellbeing boards, Marks et al. (2015) highlight the organisational and boundary issues of such calculations as they run into different understandings of both 'Public Health' and 'evidence'. In particular, they point to the economic utility calculations inherent in the guidance tools issued by National Institutions for Health and Care Excellence (NICE) and the development of competing valuation practices of PHE based on 'optional appraisal' that more broadly monetise financial savings, social benefits, and environmental costs. In a follow up study drawing on some of the same data, Hunter et al. (2016) go on to theorise an action based understanding of successful Public Health interventions as a coincidence of evidence, policy opportunity, and political support, so that the 'evidence' of what works underlying

valuation practices becomes contingent on organisational, professional, and political networks.

Writing in *Organisational Studies*, McGivern et al. (2017) investigate a management consultancy project commissioned by the Department of Health to redesign Public Health with a view to delivering an initial savings plan for the new coalition government prior to the 2012 reforms. They emphasise the importance of backstage 'silent politics' and the temporal work of boundary objects in the negotiation of Public Health before the project was abandoned in the run up to the much deeper reforms of the HSCA 2012. In their study, silent politics was observed in the disengagement and puzzlement of Public Health professionals not being openly expressed; instead, they resigned themselves to the project knowing both that it was necessary at the national level to be able to legitimise initial savings targets, while, at the same time, believing that the proposed changes could not actually be implemented. Their study emphasises the importance of temporality, time horizons, and boundary construction in Public Health decisions.

McGill et al. (2015) cite the trade-off between relevance and quality of Public Health evidence while several other studies cite the crucial importance of not only establishing the facts but being able to mobilise actors in the new organisational context (Reynolds et al., 2018; Sanders et al., 2017). In an analysis of a social return on investment based commissioning tool, Sanders et al. (2017) in particular note both the political subjectivity inherent in calculative practices and, at the same time, the need for measures to have sufficient rigor that they could convince a questioning audience. In so doing, Public Health commissioners were found to be skilled in finding the evidence to support their case, but they also note that the majority of academic literature professionals draw upon fails to recognise

the 'messy' reality of constructing evidence in practice and in context (Ibid.). Interventions must be aligned with key corporate documents, be able to enrol key actors both inside and outside of the organisation, and align with what they note as a 'transactional' business ethic focused on cost effectiveness and value for money in order to not only be effective but to be possible (Ibid.).

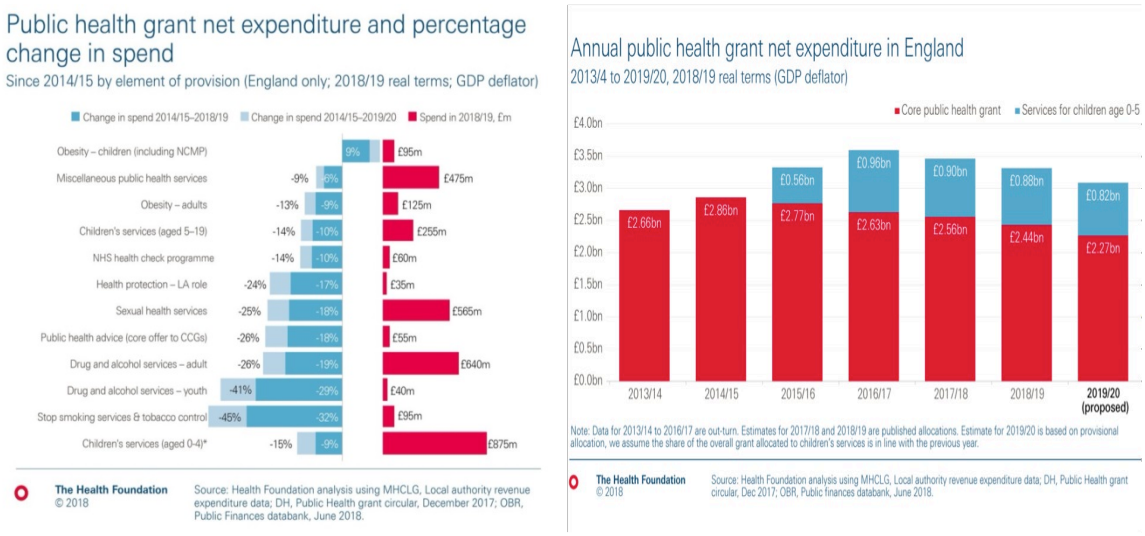
This use of the evidence to make the case, however, itself throws up new ethical questions and issues around how Public Health professionals and Public Health academics understand the knowledge that they construct. Participants in Smith and Stewart (2017), for example, ask just how ethical can it be to manipulate the evidence or to choose priorities based on how 'winnable' an intervention might be? They go on to highlight the apparent contradiction between forms of Public Health knowledge that are on the one hand based on 'ivory tower' academic studies that ignore how interventions can be implemented, while on the other, acknowledging the practical limitations of local, bottom up, contextual forms of knowledge that may be more subjectively driven (Ibid.). Ultimately, they suggest, Public Health professionals in local government will need to learn how to be both ethical advocates and rigorous scientists in the local government context; that is, they must learn to understand both the objective and the subjective in conversation, through and with one another, in the construction of their evidence base.

Austerity: the increasing cuts to budgets and the focus on 'disinvestment'.

More recent findings and commentary suggest that by 2016 the initial 'culture shock' of the transfer itself has begun to pass (Peckham et al., 2017), and that funding cuts to the core Public Health grant had started to impact on delivery. This resulted in reductions to specialist consultancy posts and cuts to a range of core Public Health areas (Peckham et al., 2017; Buck, 2017; Buck, 2018) (see figure 1). Indeed, the latest government announcements in 2017

amount to real terms cuts in the region of 4% to 5% in the Public Health grant annually for a population that has increased by 3% (Buck, 2018), leading to strong criticism from the LGA (2017) who had, previously, expressed clear support for the Public Health reforms (LGA, 2014a and 2014b).

Figure 1. Public health grant net expenditure change in spend 2014/15 t0 2018/19 (Health Foundation, 2018)



Source: Finch et al. (2018)

The consequences of these budgetary cuts are highly variable across the different areas of Public Health spend nationally, with all areas besides childhood obesity showing varying levels of cuts. There is, however, little evidence that these changes are being coordinated at the national level. Indeed, part of the consequence of the 2012 reforms has been to create a localised system with few national levers (Department of Health, 2011). Therefore the implementation of the grant reductions has depended upon local strategic priorities, the ability of Public Health professionals to make the case, and their ability to develop strong local partnerships. Nonetheless, the overall allocation of Public Health budgets locally has moved from growth to disinvestment since the transfer to local government.

Chantler et al. (2019) note that successful partnership working is rarely a cost neutral activity and that lack of coterminous budgets between departments and organisations is a major challenge in a context of resource constraint. Similarly, Sanders et al. (2017) note the significance of budgetary boundaries in commissioning decisions due to overall budget constraints, so that austerity begins to come into conflict with the 'public service ethos' among health professionals across LAs and the NHS. Hunter et al. (2016) similarly note the increasing importance of Public Health professionals making the 'economic' case due to the depth of austerity measures and the importance of this becoming part of the narrative in influencing political decisions locally. Meanwhile, in the public sector accounting literature, studies have shown how austerity in local government has placed an increasingly short-term focus on financial decision due to the annual budgetary cycle and the statutory duty to produce a balanced budget (Ahrens and Ferry, 2015).

Meanwhile, some of the most strongly worded arguments in relation to austerity have come from Public Health commentators and the profession itself. Paddison (2017) writing for the Nuffield Trust cites the multi-billion pound costs to the NHS of smoking, alcohol, and unhealthy life styles and suggest that, on average, the monetary value of preventative Public Health measures averages at around £14 return for every £1 spent. Such measures, they argue, are central to ensuring the financial sustainability of the NHS but have instead been seen as 'soft targets' for cuts due to the relatively long time horizons for these benefits to be achieved (Ibid.). Buck (2017 and 2018) writing for The King's Fund analyses the initial in year £200m cut to the Public Health grant in 2015 and the subsequent cuts of approximately 4% per year against the areas of spend based on revenue outturn reports, concluding on the folly of central government policy as 'death by a thousand cuts'. In a joint paper, the Nuffield Trust, the King's Fund, and the Health Foundation responded to the cuts to the Public Health grant

in the November budget of 2017 stating that the cuts were a 'false economy' that were putting 'people's health at risk and storing up problems for the future' (Nuffield Trust et al., 2017).

In the following section (2.3) the austerity context is found to be an important theme across the critical public sector accounting literature as it explores the consequences of austerity in a 'post'-NPM era (Steccolini, 2019). Austerity is characterised not only by budgetary restraint, but by a fundamental shift in how accounting numbers are mobilised, how organisational practice is reshaped, and how new valuation practices are put to the test in the always contested action of 'making things count'. In the context of Public Health in local government, knowledge construction practices in general and valuation practices in particular are complex, multiple, and, have become increasingly localised and pluralistic. The new arrangements have placed Public Health activities and Public Health professionals within an entirely new set of accountability relationships, during which time there was a major policy shift from initially increasing Public Health spending during the first two years to considerably reducing it thereafter. These points will be further explored in Chapter 5 with reference to the primary data, and particularly in Chapter 5 part 2: 'From health in all policies to austerity'.

In the following section (2.3) the broader discussions in the Public Sector accounting literature around performance measurement, budgetary practices, accountability, austerity, and value for money are introduced. Then in the final section of this chapter (2.4), the literature on the professions, particularly in the context of the health sector, are explored with reference to the critical accounting and organisational literatures.

2.3 Public sector accounting and 'post'-New Public Management

As demonstrated in the previous section, across the emerging empirical literature on the transfer of Public Health into local government very little attention has been given to the financial arrangements and practices, and no studies have analysed the transfer of Public Health activities in light of existing Public Sector accounting literature. By analysing the reforms from this angle, this thesis draws on a body of existing knowledge of budgetary and measurement practices, accountability relationships, and reporting. All of which are seen in subsequent chapters to play a major role in the reconstruction of Public Health practices and identities in their new context and in the making of the case for a Public Health agenda. This section begins with a brief overview of what we understand as 'accounting' and 'accountability', and then summarises current themes in the public sector accounting literature relevant to this project. Finally, it goes on to draw links to the theoretical framework (Chapter 3) on the active role of accounting practice in 'making things valuable', and the double aspect of such relations as both active and mobile, on the one hand, and as subjectivising and coercive on the other.

The nature of accounting information and New Public Management in the public sector

Following the recent House of Lords Select Committee report (Parliament. House of Lords, 2011) into the role of audit market competition during the credit crisis the Financial Reporting Council (FRC) recently announced their review of the 'true and fair' concept together with associated legal advice (FRC, 2014). They reaffirm the centrality of accounting information in 'reflect[ing] economic reality' in any published financial reports in both UK GAAP and IFRS, stating that in their view this represents the 'whole essence' of recognition, measurement and disclosure. This is certainly familiar ground for accounting scholars and demonstrates the

overwhelming view among regulators that accounting information is primarily concerned with providing 'relevant information for decision makers' and the maintenance of 'accountability', 'transparency', and 'stewardship' (Burchell et al., 1980). Critical accounting scholars, however, have long questioned this hegemony of neutrality, noting that accounting practices themselves often define the pre-given economic ends they are supposedly to describe and that, at the organisational level, accounting devices may just as often act as *post hoc* rationalizations of already made decisions (Burchell et al., 1980). Accounting has been described as 'constructing' organisational and social reality (Hines, 1988), and as a programmatic, active constituent of the social world it produces and reproduces in its own image (Miller, 1994). Indeed, accounting is powerful precisely because it purports to reveal and represent an economic reality while also consisting of the body of experts and expertise who prescribe and diffuse norms of best practice (Miller, 1994; Miller and Power, 2013).

This, nonetheless, leaves rather open the question of what accounting information and accounting practices actually are, if not neutral representations, beyond information produced by people practicing accounting. This question will be returned to in the final subsection, below: 'Speaking the truth? Accounting as *parrhesia* and accounting as *maieutica*'. For the time being accounting information is introduced as the 'naming and counting' of what 'ought' to be evaluated (Bassnett et al., 2019) that form the basis of calculative practices so central to the governance of modern economic life (Miller and Rose, 1990). Such naming and counting typically occurs within more less formalised accountability relationships both within and outside of the organisation[2].

[2] Accounting performed inside organisations in the performation of management control is typically referred to as *management accounting*, while accounting information involving external reporting is typically referred to as *financial accounting*. This distinction, however, is not one made in this thesis as Public Health professionals mobilise accounting techniques within and across organisational boundaries.

In the context of the Public Sector there is, arguably, a very precise difference in the nature of accounting information due to the fact that it is not drawn up in the interests of invested capital. This affects both the nature of internal management information and external reporting to a wider variety of stakeholders, politicians and the public. Drury (2015, pg.390) for example describe management accounting in not for profit organisations as focused primarily on costing inputs and controlling the use of resources due to the difficulty of measuring in monetary terms the precise objectives of the organisation. This distinction, however, is doubly problematic. On the one hand, the importance of non-financial outputs on long-term financial sustainability has long been recognised in an increasingly complex and globalised private sector, most obviously in the popularity of the balanced scorecard and its iterations. While, on the other hand, there has been a prolific growth in measurement practices, output and outcome controls, and markets for monetary exchange across the public and not for profit contexts in recent decades. The latter having become a particular focus of critical scholars in their critique of what Hood (1991 and 1995) describes as New Public Management (NPM).

NPM is broadly defined as a global trend within the public sector that is used to characterise a wide range of reforms in recent decades. Under this characterisation, a guiding principle of such reforms has been that the public sector would be more efficient and better run if it were able to appropriate private sector management techniques and ideas (Lapsley and Pallot, 2000; Lapsley, 2009). Governments across developed economies have systematically sought to disaggregate publicly owned institutions, introduce market and quasi-market competition, quantify outputs and outcomes, and introduce private sector style management and remuneration practices (Hood, 1991; Hood, 1995). These reforms were assumed to increase efficiency and reduce costs, remaking the public sector bureaucrat into

a proactive and results orientated rational manager with more flexibility over spending and investment decisions (Parker and Gould, 1999).

There is, however, considerable empirical evidence that the ambitions of the NPM generation have not always been achieved in practice (Justesen and Skærbæk, 2010), or indeed that such reforms can actually be counter-productive and costly in both healthcare and local government (Lapsley, 2009; Arnaboldi and Lapsley, 2008). Lapsley (2009), for example, finds that management consultancy, risk management, and e-governance reforms in healthcare have all been cruel disappointments, NHS market mechanisms dysfunctional, and the outsourcing of expertise through consultancy highly costly. There has similarly been widespread criticism of private finance initiatives and public private partnerships due to the failure to properly account for the risk to the public purse (Hodges and Mellett, 2012), and critique of the proliferation of private sector style risk management techniques (Power, 2004; Fischer and Ferlie, 2013).

A further conceptual difficulty in the context of public sector is typically the complexity of the 'accountability' arrangements through which accounting practices represent the giving of account (Parker and Gould, 1999). A range of studies in the public sector literatures approach the question of accountability by mapping its various taxonomies; for example, Sinclair (1995), noting the wide range of definitions, draw on qualitative empirical data to map out shifting accountabilities of the political, public, managerial, professional and personal. Alternatively, Stewart (1984) defines his 'levels' of accountability in the public sector context as Probity, Process, Performance, Programme, Policy; starting with the low level transactional accountability through to the high level public accountability at the policy level.

Sinclair (1995) notes that accountability can be both 'personal' and interpersonal or 'structural', but that in either case there is a relationship of explaining ones actions and being 'held to account'. Bandy (2011, pg.191) defines accountability relations in the public sector context as one of 'scrutiny' with a potential for reprisal or consequence, while Mulgan (2003, pg.6) notes the extent to which it has come to prominence as a term of reference in recent times over the more traditional concepts of 'representation', 'democracy' and 'responsibility'. There have been growing calls for 'accountability' across the public sector, which have been concurrent with the growth in NPM through the 1980s and 1990s (Hood, 1991; Hood 1995; Power, 1997, pg.42; Lapsley, 2009); however, Mulgan (2003, pg.151) notes the ambivalent relationship between the two. In particular, the tension between 'political' accountability on the one hand, and the quasi-autonomy of organisations operating at a distance from political centres in constructed and regulated markets on the other. Following this outline, NPM could be at least partially characterised as a process of transfer from political accountabilities to managerial accountabilities, and an increased reliance on arm's length agency relationships.

But such characterisations are never straight forward. In the context of the HSCA 2012 reforms we see Public Health practitioners 'giving account' to elected members through the newly established health and wellbeing boards as, to some extent at least, returning an element if 'political' accountability (Mulgan, 2003). However, on the other, recent reforms of Public Health were also a result of 'disaggregating' (Hood, 1991) Public health activities from wider budgets for primary care within a newly reframed context of commissioned services, local autonomy, and professional independence.

While 'accountability' has crept beyond, and gained legitimacy from, its roots in financial reporting in a public sector context, for a first principles definition Bryer (2006) traces

the etymology of the 'giving of account' back to inspection practices of receipts and expenses. Giving account is a process of reckoning that makes an agent answerable for their actions in a principle-agent relationship that only later becomes crystallised in arrangements of formal reporting. Subsequent *financial* accountability is then conceptualised as a calculation or reckoning designed to explain activity or to be made answerable for ones actions in a principle agent relationship. Bryer (2006) notes the central role of accountability in the notion of 'control' in tracing the word back to the ancient French word *contre-roller* and the medieval English word *counter-rollour* as one who inspected registers of receipts and payments via a *counter-roll* or account, but is critical of the capacity of agency theory to fully explain the organisational dynamics of accountabilities in practice. Bryer (2006) resists presenting accounting as inherently subjective, socially created, and as simply one form of control among many others, critiquing such characterisations in the accounting literature (for example Hopwood, 1989, and Burchell et al., 1980). Financial accountability instead becomes a central relation through which capitalism institutionalises the subordination of labour and it is through accounting and monetary accountability that capital is able to objectively control the capitalist enterprise. Extending this argument to the public sector, the move towards financial and managerial accountabilities through NPM style reforms can therefore be framed as a territorialisation of a particular form of structural relations under capitalism.

Extending this discussion towards the realm of social rather than structural relations, Roberts (2009) gives a theoretically rich and somewhat contrasting overview of how we can conceptualise accountability. He draws on Butler (1997) and also on Freudian analysis to suggest that accountability is both an interpersonal process (how we relate to others) and an intrapersonal one (how we relate to ourselves). In this analysis, accountability is instead presented as inherently subjectifying and deeply socially and psychologically constructed;

accountability becomes largely a fantasy used to legitimise decisions, construct a certain kind of transparency with a 'self-fulfilling life of its own' based on ideals that can never quite be lived up to. But at the centre of the concept is a socio-material arrangement in which ones actions are, at least potentially, subject to review, translation, scrutiny, and ultimately consequence of reprisal that goes beyond 'responsibility' or 'authority' (Bandy, 2011, pg.191). Following Lacan, Roberts (2009) points towards the 'mirror image' of the self that accountabilities produce in the giving of an account; in so doing we disassociate ourselves from the account, which brings us some sense of solidity and self by forcing us into competition and comparison with others. The intrapersonal question of the self is then presented as one which is intimately wrapped up with the social; with the Freudian concept of 'recognition' and the powerful 'other' used to explore how our own narcissistically produced ideal 'self' is constructed through the internalisation of performance evaluation.

Concluding with a critique of neoliberal accountability practices, Roberts (2009) argues that traditionally constructed accountabilities have driven self-interest over the collective good; that accountability practices drive the people 'performing' in these systems towards avoiding blame in ways that can become dysfunctional and erode trust. Drawing on Butler (2005, pg.83), he offers instead a new direction; arguing that a more 'intelligent accountability' would be a more reflexive, qualitative, personal, and compassionate accountability that is not the violent pursuit of an ideal and acknowledges the impossibility of a 'self fully transparent to itself'.

Relatively few studies have explored the construction of intelligent accountabilities in practice, and none have explored in detail how ethics are embedded in, and reproduced through, measurement and accounting practices themselves. Empirical examples of

intelligent accountability emphasise the contested and difficult nature of maintaining more forgiving and collaborative alternatives to hierarchal regimes of transparency (English, 2013; Yates et al., 2019), with English (2013), in particular, providing a convincing account of how more intelligent governance founded on intelligent accountability can improve performance of large public interest institutions. Intelligent accountability is also, arguably, an extension of a number of similar concurrent themes in the critical accounting literature; for example, reflecting on the social and environmental accounting literature Bebbington et al. (2017) envision alternative accounts and accountability relationships that are transformative and emancipatory in answer to grudging partial disclosures of big corporations and governments. Similarly, Bracci et al. (2015) call for public sector accounting scholars to explore the performativity of accounting technologies in relation to austerity narratives and to consider alternative accounts that break down myths, stereotypes, and bias on which such supposedly value neutral economic arguments rest.

In conceptualising accountability relations and following them through the data, this project considers both structural principle-agent relationships (Bryer, 2006), together with the personal and subjective experience of accountability relations in practice (Roberts, 2009). To explore accountability relationships, therefore, is to explore particular forms of power relations in which what is named and counted through particular statement types matters (Bassnett et al., 2019), and through which subjects are constructed as subjects both materially and discursively (Roberts, 2009; Foucault, 1982) in a manner that is often punitive and yet holds the potential for more forgiving, collaborative and 'intelligent' alternatives.

On the public sector accounting literature

In exploring these concepts empirically, a wide range of studies have followed the various tracks of accounting and accountability in the public sector; some laying out critiques of NPM

style reforms (Arnaboldi and Lapsley, 2008; Lapsley, 2009) and some, more recently, investigating accounting practices in the context of austerity based reforms (Ahrens and Ferry, 2015; Bracci et al., 2015). Many such studies have taken place in healthcare (Chua and Preston, 1994; Llewellyn and Northcott, 2005; Kurunmaki, 2004; Kurunmaki and Miller, 2008; Lapsley, 2009; Frandsen, 2009; Fischer and Ferlie, 2013), while a smaller minority of studies have investigated such practices in local government settings (Llewellyn, 1998; Goddard 2004 and 2005; Arnaboldi and Lapsley, 2008; Ahrens and Ferry 2015); variously reviewing the role of accounting practices such as budgeting (Goddard, 2004; Goddard, 2005; Ahrens and Ferry, 2015; Anessi-Pessina et al., 2016), costing (Chua and Preston, 1994; Llewellyn, 1998; Llewellyn and Northcott, 2005; Jarvinen, 2009), performance management and value for money (Arnaboldi and Lapsley, 2008), and some on the active role of accounting in (re)constructing or mobilising knowledge frameworks (Frandsen, 2009; Christensen and Skærbæk, 2007) and professional identities (Kurunmaki, 2004; Fischer and Ferlie, 2013; Vinnari and Skærbæk, 2014).

In the public sector and in local government in particular, budgetary cycles represent important means of allocation, control, and accountability (Jones and Pendlebury, 2010, Pg.62; Goddard, 2004). Prior to the implementation of post crisis austerity, Goddard (2004) conduct a detailed study of four LAs to find that the budget cycles were a key source of tension and point of accountability; centralising power in overall resource allocation while providing limited freedom to manage within directorates once allocations were made. Austerity, one would expect, would increase such pressures and tensions. Bracci et al. (2015), for example, note that LAs in England lost an average of 37 percent of their budgets in the period of 2010 to 2016 while at the same time experiencing strict limits on their ability to increase revenues through local taxation. Ahrens and Ferry (2015) cite the statutory arrangements in LAs that

requires them to make savings on a short term annual basis to report 'balanced budgets', forcing a short term 'temporal politics' (McGivern et al., 2017) into decision making processes. Both Goddard (2004 and 2005) and Ahrens and Ferry (2015) find a strong emphasis on financial accountability and see the finance director as a powerful actor in the local government context.

More broadly, Anessi-Pessina et al. (2016) find that budgeting remains relatively under researched across the public sector literature, despite the clear consensus of the importance of budgetary practices. While a number of studies have linked the use of budgetary practices to the growth of NPM techniques in intra-organisational practices, studies remain under theorised and relatively little attention has been paid to inter-organisational budgetary practices between public sector bodies. Similarly, more research is needed into the intersections of budgetary practices, performance management, professional identity, and political accountability (Ibid.).

A number of important studies in the literature have explored the consequences of standard costing and the proliferation of calculative performance and risk management practices, especially in the healthcare context (Chua and Preston, 1994; Llewellyn, 1998; Kurunmaki, 2004; Kurunmaki and Miller, 2008; Frandsen, 2009; Fischer and Ferlie, 2013). These studies associate NPM reforms with both processes of standardisation in healthcare and, relatedly, with the 'hybrid professional' who learns to mobilise calculative practices (Kurunmaki, 2004; Frandsen, 2009). Llewellyn (1998) similarly investigates costing and value for money practices in the local government context of social services, finding that costing and performance management becomes entangled with discursive boundary drawing practices revising the concept of 'care'. In particular, Llewellyn (1998) notes practitioners as

seeking to align public sector accounting concepts of 'efficiency', 'effectiveness' and 'accountability' with some of the core valued categories of the care profession such as 'equity', 'rights' and 'dignity'. In some cases such proliferation of costing and other accounting practices such as performance measurement and risk management lead to an evolution towards the hybrid professional (Kurunmaki, 2004) as calculative practices became active in redefining organisational spaces (Frandsen, 2009), while in others this led to fundamental challenges to professional identity, breakdown in trust, and even organisational failure (Fischer and Ferlie, 2013).

Furthermore, the growth in performance management practices under a regime of NPM was also associated with a growth in a Value for Money (VfM) discourse (Arnaboldi and Lapsley, 2008) and associated growth in VfM audit practices (Power, 1997), explicit performance measurement, and 'making management auditable' (Arnaboldi and Lapsley, 2008). Power (1997, pg.44), in particular, is critical of the inherent vagaries of value for money as a concept due to the centrality of 'effectiveness' in the efficiency-economy-effectiveness model of VFM; he points out that it is very difficult to question effectiveness without critiquing politicians and policy, which is at odds with the supposed independence and neutrality of audit. Similarly, Lapsley and Pong (2000, pg.563) conclude that there remain serious difficulties in establishing what constitutes best practice in the public sector, and with matching the stated aims of VfM audits to the practice of institutions like the NAO. Similarly, a major difficulty with the concept of 'value' in the context of VfM is the ambiguity about what outcomes ought to be measured and if so in what way. Julnes and Steccolini (2015) highlight, for example, the increasingly complex and hybridised public sector as a major reason for the failure of NPM style reforms and call for a plurality of performance practices that encourage partnership working and are flexible and contextual. In the local government

context the government's 'localism' agenda led to the coalition government of 2010 abolishing the Audit Commission, leaving LAs with responsibility for appointing auditors who would provide a VfM opinion (Ellwood, 2014). LAs were therefore granted an 'earned autonomy' status rather late in the NPM cycle, similar to preceding 'New Public Governance' style reforms governance reforms that had established Foundation Trusts in the NHS and Academies in secondary education (Ellwood, 2014; Steccolini, 2019).

The increased questioning NPM style solutions in an increasingly hybridised public sector seeking complex and often non-financial outcomes (Julnes and Steccolini, 2015) has also been more recently extended to a questioning of the continued relevance of the NPM thesis itself when describing the reforms we see in an austerity climate (Bracci et al., 2015; Steccolini, 2019). While it was pointed out in the discussion of accountability that recent Public health reforms do not neatly fit into a NPM characterisation, Bracci et al. (2015) go further and suggest that post crisis austerity now represents a new context that alters the role and implications of accounting practices fundamentally. Where once the NPM advocates were 'promoting the principles of the market, encouraging competition, results-oriented behaviour, the quantification of performance and an emphasis on value-for-money – all wrapped up in a commitment to, and belief, in managerialism' policy is now more focused on national debt reduction, supranational institutions, and localised fiscal tightening (ibid.). In this environment, short term budgetary cycles in LAs in England, which were already influential in the NPM discourse (Goddard 2004 and 2005), become overpowering and begin to drive exclusively short-term decisions (Ahrens and Ferry, 2015). Others argue that social impacts and equality are now even further left out of the discussion in favour of financial savings through new and distinct accountability arrangements, or, alternatively, that NPM

reforms themselves pave the way for a shrinking state via a negative 'evaluation trap' (Olson et al., 2001, and Sapir et al., 2014; cited by Bracci et al., 2015).

In sum, the Public Sector accounting literature provides a broad and rich set of themes for further investigation in the new empirical context of Public Health activities in local government. These literatures provide a strong basis for understanding accountability relationships (Mulgan, 2003; Bryer, 2006; Roberts, 2009), the discursive and coercive strength of calculative and budgetary practices (Goddard, 2004; Ahrens and Ferry, 2015), costing and performance management techniques (Kurunmaki, 2004; Llewellyn and Northcott, 2005; Frandsen, 2009), and VfM techniques (Llewellyn, 1998; Lapsley and Pong, 2000; Arnaboldi and Lapsley, 2008) in redefining organisation practice and professional identity. More recently, the literature suggests that austerity, partnership working, and 'hybrid professions' are breaking down and moving beyond the classic NPM agenda in austerity environments (Julnes and Steccolini, 2015; Bracci et al., 2015; Steccolini, 2019). Steccolini (2019), in particular, points out that NPM remains relevant, but calls for more research into how accounting practices can contribute to understandings of 'public value' and how accounting practices are mobilised in 'making austerity visible'. Bracci et al. (2015) similarly call for more research into ethically informed 'alternative accounts' echoing the call by Roberts (2009) for the development of 'intelligent accountabilities'.

However, a number of gaps across the literature remain – the literature remains relatively under theorised (Anessi-Pessina et al., 2016; Steccolini, 2019) with the main theoretical frameworks applied being either institutional theory or governmentality approaches, or, in many cases little theorisation at all (Steccolini, 2019). New empirical opportunities to investigate inter-organisational budgetary practices such as pooled

budgeting (for example, pooled budgets between the NHS and local government through the Better Care Fund) and partnership working (for example, through Sustainability and Transformation Plans and combined authorities) are opening up in the UK context, and more specifically in the context of the Public Health activities explored in this thesis. Meanwhile, theoretical developments in the broader critical accounting literature, particularly in theorising accounting practices through STS inspired understandings of knowledge construction and value creation are yet to be fully drawn upon. The following subsection touches on such opportunities to develop a critical public sector accounting perspective and links through to the following chapter on the theoretical and conceptual framework (Chapter 3).

Speaking the truth? Accounting as *parrhesia* and accounting as *maieutica*

Throughout the debates discussed above, and across the critical accounting field more generally, the role of accounting information in the structure-agency dialectic remains controversial and contradictory. Does accounting information have the capacity to shine a light of truth, offer up liberation, and speak the truth to power by offering 'alternative accounts'? Or is it inevitably bound up in coercive and disciplinary practices of contemporary globalised capitalism? Do the monetary and financial accountabilities that are the very power relations through which accounting information flows constitute global capital's 'objective control' of modern life (Bryer, 2006) or are they coercive 'fantas[ies]', subjective social constructs with a 'self-fulfilling life of their own' (Roberts, 2009)?

In presenting these contrasting conceptualisations this project points to the iterative *duality* that often characterises accounting in practice. The following chapter presents a theoretical framework (Chapter 3) based on Karen Barad's *agential realism* and her generalised concept of *posthuman performativity,* extending the post-structuralist analysis of

discourse into the realm of material-discursive entanglements. Under this theorisation, social structures are always under renegotiation, and objectivities are constructed through embedded material-discursive settings. Rather than taking polemical positions *a priori* the analysis begins instead with the exploration of how subjects and objects are made up, in this case public health professionals and the public health agenda, through and with an assemblage of material-discursive organisational practices.

Accounting information in the context of the HSCA 2012 is found in subsequent chapters to be both a mobilising actor with coercive influence on the non-Public Health 'other' and as holding to account the Public Health professional themselves. This is seen both structurally; as local Public Health teams are provided with a newly 'ring-fenced' grant that provides a certain level of autonomy to manage their own activities and commissioned services; discursively, as they then have to 'justify' why they are 'different' or 'special' by constructing a language of 'spend to save' in health and wellbeing boards where they are confronted by other budget holders facing major cuts; and, finally, as a cite of resistance to austerity cuts. As a result, both the public health professional and the new spaces they enter into are remade, iteratively, through and with one another in the context of dynamic material arrangements and discursive and calculative practices.

In Foucault's lectures at the College De France of 1983 he outlines the concept of *parrhesia* in contrast to the Austinian *performative utterance* as the binding of one's self to the utterance of truth to power; parrhesia is a practice of truth that is ethical, personal, disruptive, and a marker of change (Foucault, 2011). Butler (2010) draws a similar emphasis in their analysis when they argue that organisational scholars who wish to follow organisational knowledge practices may be best served by following the iterations, failures,

and (re)negotiations that are characteristic of perlocutionary performativities rather than the all too special case of illocutionary performativity in which statements are seen as 'self-fulfilling prophesies'. Meanwhile, Quattrone (2015) argues that accounting information should not in fact be treated as telling the truth at all, but as a *maieutic* machine that provides users with doubt, context, and the opportunity to ask the right questions. By outlining a new materialist approach via Karen Barad's agential realism, Chapter 3 attempts to demonstrate how accounting information can be understood as both disruptive and coercive in its (re)construction of the facts; as accounting both disciplines and mobilises. In (re)constructing the facts, and by consequence what is made valuable, such practices of establishing the truth are seen as highly politically and ethically emotive.

Accounting practices, at their most fundamental, are understood as performative agential cuts that redraw boundaries, disrupt, coerce, and work to redefine both subjects and objects in organisationally contextualised dialectical negotiation. They speak the truth, or at least a partial truth, about (re)named categories that are (re)measured and reported through institutionally defined accountability relationships, which in turn offer up new questions and new accounts. Accounting is therefore understood as both *maieutic* and *parrhesiastic* in the iterations of organisational truth making.

2.4 Professions and the 'Public Health Professional'

One of the central themes of this thesis is to understand the iterative dialectical processes that emerge from the transfer of Public Health activities into LAs, and, in so doing, understanding how both calculations and identities are reconstructed through and with one another. Calculative and, more specifically, accounting practices that develop through a variety of modes of accountability are seen as shaping and re-shaping those who put them

into practice. Understanding the reconstruction of Public Health activities and the Public Health professional in this new organisational context therefore speaks in several ways to the broader literatures exploring the sociology of the medical profession(al); the role of accounting devices and practices in influencing professional practices and professional identities; and the emergence of new hybrid professional identities out of complex organisational dynamics. This section briefly reviews some of the key sources in this field and relates them back to the Public Health profession, in particular, and to the distinctive theoretical lens presented in the following Chapter (3).

On professions and professionals

'Professions' and can variously be described as the singularity of 'expertise' or domain of 'juristiction' (Abbott, 1988 and 1991), access to which is restricted and highly selective, with the 'professional' constructed via a set of 'occupational values' that are forged through training, ethical frameworks and codes of conduct (Evetts, 2011, pg.406). Understanding the profession as the monopoly of a defined area of expertise (Abbott, 1991) helps us explain both the unique labour value and the corresponding social status that often accompanies the professional at the individual subjective level. Abbott (1991) does not seek an exclusively functionalist understanding, however, arguing that the emergence of distinct professions is an empirical question that can occur through a variety of dynamics and in more or less regularised ways. In an analysis of the history of the medical profession he argues that professional identity arose through the creation of medical associations, shared interests in learning and professional education, the furthering of professional knowledge frameworks, and shared working environments (Ibid.). While the 'profession' might therefore be subject to various attempts at abstract definition, both the collective and the individual subject

remain in tension, with Abbott (1988) noting that typically professions will seek to expand their domains of jurisdiction by appropriating bodies of knowledge and expertise as their own.

Much has been written in the critical accounting and medical sociology literatures of the various attempts to standardise, discipline, and rationalise the traditional autonomy of the medical professional in the UK context (Bourn and Ezzamel, 1986; Kurunmaki, 2004; McGivern et al., 2015). This intersects both with discussions of NPM in which health professionals are seen to adopt managerial tasks subject to performance measurement and risk management (Fischer and Ferlie, 2013; McGivern et al., 2015), and with the critical accounting literature that explores the ways in which medical professionals are subject to accounting techniques of control (Bourn and Ezzamel, 1986; Kurunmaki, 2004; Llewellyn and Northcott, 2005; Samuel et al., 2005; Jarvinen, 2009; Kurunmaki and Miller, 2008). Samuel et al. (2005), for example, follow Abbott's (1988) conceptualisation of the professional 'jurisdiction' to find that accounting has enveloped the medical profession to become *the* essential profession in healthcare decision making.

In the accounting literature Jarvinen (2009) also takes up the question of how management accounting techniques influence and shape the practice of medical professionals through a shifting NPM agenda and the implementation of standard and activity based costing systems. Jarvinen (2009) also sees the expanding NPM agenda as an encroachment of the accounting profession into areas typically occupied by other professionals (such as medical professionals), and finds that the sense of occupational identity can strongly influence the successful implementation of new accounting systems where this dynamic is seen as rivalrous. While Llewellyn (1998), investigating social care, demonstrates the cross-organizational realignment of discursive categories of 'costing' and 'caring', with

public sector accounting categories of 'efficiency', 'effectiveness' and 'accountability' coming to replace traditionally valued categories in the care sector of 'equity', 'rights' and 'dignity'. Costing and value for money practices became conduits 'through which caring discourses must pass', influencing and coercing the social care profession.

Research into how professionals in general adapt to new or changing environments is substantial. In a study of the legal profession, Wallace (1995) suggests that the literature on professions in general can be classified into either 'proletarianization' or 'adaptive' theories. Proletarianization is described as the top down erosion of professional values resulting from overly mechanical or specialized roles within a bureaucratic system, while adaptive theories suggest that professionals are able to maintain their professionalism even within large bureaucratic systems by protecting themselves from overly prescriptive organizational controls. Several studies in the healthcare context, however, challenge this binary view. Kurunmaki (2004), for example, points out that such processes are perhaps not best understood as a contest between contested professional jurisdictions (Abbott, 1988), but rather that professionals in fact develop 'hybrid' identities borrowed from different professional disciplines. In the context of medical professions this did not occur through a contest of abstract knowledge frameworks but practical adoption of budgetary practices, costing techniques, and pricing mechanisms. The modern 'hybrid professional' is therefore someone who adopts a variety of skills in an increasingly inter-professional environment, and that such processes are not always contested or controversial. McGivern et al. (2015) further develop the concept of the hybrid medical professional noting how Medical Directors in the NHS emerged as a new elite, combining clinical expertise with managerial responsibilities over budgets, line management, and performance measurement. Via an institutional theory framework they identify 'incidental' hybrids who adopt certain temporary hybrid roles while

preserving traditional professional identities, and 'willing' hybrids who develop new and lasting hybrid identities (Ibid.). Their analysis suggests that the developing institutional context driving the emergence of new willing hybrids in turn drives lasting change in the medical profession as a collective.

On the other hand, Fischer and Ferlie (2013) demonstrate how processes of hybridisation can be highly contested and controversial. In their longitudinal study of a Mental Health Trust following a major organisational scandal, rules based risk management techniques are seen to lead to challenges to professional identity, a breakdown in trust, and ultimately organisational failure. They cite Power (2004) in noting that risk management, as a form of control through calculation and surveillance, has colonised terrains formerly occupied by less formal controls such as professional self-regulation. Through a Foucauldian governmentality framework Fischer and Ferlie (2013) conclude that professionalism, ethics, and personal moral frameworks have the potential to bring professionals into open conflict with standardised evaluative modes of control. Indeed, by focusing on an extreme case of 'intractable conflict' they are able to explore a situation in which accounting devices did not lead to ready hybridisation, but were rather exposed as morally laden devices for attributing blame and punishment.

In recent times, contemporary public organisations are increasingly characterised by such hybridised spaces in which the traditional professions are weakened, particularly where expert practice brings together competing forms of control and mixed occupations (Noordegraaf, 2007). In a post austerity climate, in particular, public organisations are seeking increasingly complex non-financial outcomes and organising via a range of disciplines in cross-organisational collaboration (Julnes and Steccolini, 2015). In such hybrid contexts,

Noordegraaf (2007) emphasises the importance of reflexive forms of control, suggesting that we ought to move from a traditional model of the profession as control over an occupation towards control over the process of network building, collaboration, and shared working. Control over the process of control itself. The extent to which this will be welcomed or resisted by professionals remains controversial and is likely to be highly context dependent (Fischer and Ferlie, 2013).

On the theme of control Exworthy (2015) investigates two empirical examples from the medical profession; namely, performance measurement and financial incentives. With regard to performance measurement practices, the paper notes both the intensification of the 'cage' of bureaucratic controls due both to cultures of managerialism and medical scandals eroding professional autonomy and the 'gaze' of Foucauldian self-regulation as measures are made public and activities are made calculable. Similarly, Waring and Currie (2009) note the influence of NPM style managerial reforms in driving an intensification of bureaucracies that challenge professional autonomy and argue that such reforms are not simply top down impositions, but dynamic iterations that redefine professional identities themselves. Drawing on an ethnographic study of the introduction of patient safety systems they detail how knowledge practices are central to dynamics of identity work as medical managers codify the knowledge and experience of clinicians, which results in both realignment of working practices and new forms of professional resistance (Waring and Currie, 2009). Control is played out through iterations of top down and bottom up contestations of the facts.

Professional identity work in organisational contexts in general, and in healthcare in particular, is therefore a contested topic. Structure agency dialectics in which processes of

management control mediate the image [external] and the identity [internal] are perhaps best understood as entangled, iterative, or performative processes (Alvesson and Willmott, 2002; Roberts, 2009) that are never completely settled. Identity work is dynamic in general (Skærbæk and Thorbjørnsen, 2007) and in a healthcare setting has shifted in recent times (Waring and Currie, 2009; Exworthy, 2015); with differing views on the extent to which managerialism dominates or is co-produced through professional autonomy, and differing views on the extent to which performance measurement and risk management practices are seen as coercive and dysfunctional, or as part of a 'willing' processes of hybridisation that can help link up a more collaborative public sector (McGivern et al., 2015).

The reflexive construction of professional identity

The above discussion of the 'professions' and the 'professional' drew largely on literature from organizational and critical accounting studies, and focused particularly on examples from the healthcare sector that drew on concepts of professional identity and identity work. Healthcare professionals were variously seen as willingly adopting accounting techniques and adopting new 'hybrid' identities in a regime of NPM, or as resisting such processes as they erode their professional autonomy, but in either case the pervasiveness of calculative practices was clear. Relatively little in this literature, however, has been written explicitly on the Public Health professional, and it should be noted that the Public Health profession is a distinct healthcare profession in its own right, with its own qualifications[3]; its own professional body[4]; and its own networking associations and organizational spaces[5].

[3] MSc programmes in Public Health and the UK Public Health Register of Public Health consultants.
[4] The Faculty of Public Health.
[5] For example, the Association of Directors of Public Health, Public Health England, and professional development programmes led by University providers.

In addition, while there is extensive discussion of how healthcare professions have changed and adapted in recent times, and how professional identities have correspondingly developed through processes of 'professionalization' (Abbott, 1991), 'de-professionalization' (Noordegraaf, 2007), or 'identity work' (McGivern et al., 2015), there is relatively less technical discussion of *how* the construction of the facts and professional epistemologies have developed from a STS perspective. Furthermore, while there is some empirical literature on moments of professional resistance among health professionals (for example Waring and Currie, 2009; Fischer and Ferlie, 2013), there remain relatively few studies across the organization studies literature exploring how the performativity of material-discursive practices leads to dynamic (re)iterations of institutional and professional knowledge frameworks (Gond et al., 2016). One study to provide such a framework for the use of discursive practices is Hodgson (2005), who draw on Butler (1990 and 1993) to argue that it is through moments of subversion, satire, and parody that disciplinary norms and discursive practices are continually re-worked and re-framed in the iteration of professional identity. Professions do not simply product docile subjects, but constantly reconstruct professional education and ways of knowing through and with professional subjects themselves.

The abstract knowledge base described by Abbott (1988) can therefore be seen as being, in fact, highly localized, practical, and dynamic; both in a theoretical sense in its performative reconstruction (Hodgson, 2005) and through several empirical papers exploring how professional identities are continually (re)constructed in practice (Kurunmaki, 2004; Waring and Currie, 2009). Such discussions also lead towards questions of how professional 'expert' status (Carolan, 2006; Noordegraaf, 2007; Waring and Currie, 2009) must therefore be capable of reflexively engaging with its ever changing social purpose in order to remain

relevant. In the case of the Public Health professional following the HSCA 2012 reforms this is especially apparent.

Through the literature on Public Health activities following the 2012 reforms several studies identified the complex and fragmented environment consisting of multiple accountability arrangements (Phillips and Greene, 2015; Chantler, 2019) as Public Health professionals sought to bring their activities closer to the 'wider determinants of health' (Gorsky et al., 2014). This led to a reappraisal of the role of Public Health advocacy (Smith and Stewart, 2017) and a challenge to the traditional 'representational' view of the scientific evidence base underlying Public Health domain of expertise as professionals must learn to embed their knowledge base more closely with the ethical political issues facing LAs. Smith and Stewart (2017) argue that this requires the Public Health profession at large to better understand how 'representational' knowledge works through and with 'facilitational' knowledge, and the role of Public Health professionals is increasingly to reflexively build coalitions of different types of actors behind a Public Health agenda. This echoes what Carolan (2006) describe in their review of different forms of professional 'expertise'; arguing that technical expertise must, crucially, be supplemented by both 'interactional expertise', in which experts are able to interact in an interdisciplinary space, and 'public expertise', through which professionals are able to explicitly incorporate values into their decision making processes. They argue that this is especially important in the field of environmental sustainability, but one can easily see how a similar argument could be made in Public Health population health decisions.

In sum, the professions literature across organizational studies has variously reviewed the nature of the 'profession' (Abbott, 1988; Abbott 1991), professional 'identity' (McGivern,

2015), and the role and nature of professional 'expertise' in professional practice (Carolan, 2006), but also in the evolving and changing nature of the professions themselves (Abbott, 1991; Kurunmaki, 2004; Exworthy, 2015) and in realizing a reflexive agency through which professionals can continue to exert a degree of professional autonomy (Noordegraaf, 2007; McGivern et al., 2015). This gives an apparently contradictory picture, but on closer inspection one sees that this is due to the wide variety of contexts and disciplines that fall under 'professional' umbrella across the organizational studies literature, even when attempting to look more specifically at 'medical' or 'healthcare' professions in particular. What unites the definition of the 'professional' may be a unique area of expertise, a well defined identity, and a given community of norms and practices (Abbott, 1991), but in each case there are a wide range of social, geographical, and institutional contexts depending on exactly which professionals we are studying (Fischer and Ferlie, 2013). The particular characteristics of the Public Health professional, and the importance of their (evolving) profession and professional identity, on making the case for Public Health in their new organizational context will be explored in this thesis.

2.5 Summary and conclusions

This chapter has provided an overview of the historical reforms to the Public Health system in the UK and, following devolution, in England (2.1); explored the contemporary academic literature on the new Public Health arrangements following the HSCA 2012 (2.2); and provided an overview of the critical public sector accounting (2.3) and professions (2.4) literatures relevant to this study. These literatures demonstrate that Public health activities, and the Public Health profession, are experiencing a unique period in their history as they encounter an entirely new set of policy and accountability arrangements in a more

collaborative inter-organisational LA space. Public Health professionals have increasingly had to learn how their evidence can be mobilised (Reynolds et al., 2018; Sanders et al., 2017) and navigate the increasingly ethical and political entanglements of 'advocacy' with 'evidence' (Smith and Stewart, 2017) in learning to 'tell the story' to non-specialist audiences (Brown et al., 2014). Initially, the transfer to local government received some positive reaction from industry commentators who welcomed the opportunity to embed the Marmot (2010) principle of 'health in all policies' across grass roots service delivery (Buck and Gregory, 2013; LGA, 2014a; LGA, 2014b; Peckham et al., 2017), but increasingly the dysfunctionality of austerity measures across local government and cuts to the Public Health grant in particular came in for heavy criticism (Buck, 2018; Nuffield Trust et al., 2017).

Across the public sector, and particularly in healthcare, calculative practices of control such as standard costing (Llewellyn, 1998) and budgeting (Goddard, 2004); discursive regimes linked to value for money, audit, and risk management (Llewellyn, 1998; Kurunmaki, 2004; Kurunmaki and Miller, 2008; Fischer and Ferlie, 2013); and an emphasis on the measurability of efficiency and effectiveness (Arnaboldi and Lapsley, 2008) have all been shown to have reshaped the public sector in recent decades in the context of NPM reforms and management techniques. In the local government context, budget structures and boundaries played a crucial role (Goddard, 2004; Ahrens and Ferry, 2015) but remained relatively under researched and under theorised across the literature in an increasingly collaborative and hybridised public sector space (Anessi-Pessina et al., 2016; Julnes and Steccolini, 2015).

In more recent times the intersection of austerity measures with NPM style reforms has become a point of debate with some arguing that austerity has refocused efforts away from disaggregation, competition, and output controls, back towards short term cost

reductions and a scaling down of the public sector (Ahrens and Ferry, 2015; Bracci et al., 2015) to the extent that we are now in a 'post'-NPM environment (Bracci et al., 2015). The extent to which this is true is contested (Hyndman and Lapsley, 2016), but certainly, in the context of reforms to Public Health delivery, elements of both NPM style disaggregation, measurement, and evidence based policy play out through and with increased political accountability in a highly contested austerity environment.

In the professions literature, medical professionals are seen to adopt 'hybrid' identities (Kurunmaki, 2004; McGivern et al., 2015) as they adopt accounting practices and NPM style management techniques, particularly in leadership roles. Hybrid identities develop particularly out of hybrid spaces in which multiple professions work in inter-disciplinary and multi-agency contexts. Such hybridised contexts are increasingly common in the public sector in austerity contexts and are a major contributing factor in the repeated failure of NPM style reforms where, instead, a plurality of performance practices that encourage partnership working needs to be developed (Julnes and Steccolini, 2015).

In line with the broader literature tracing the growth in NPM reforms, the professions literature demonstrates how accounting techniques of control and managerial discourses have influenced and, in turn, become internalised by medical professionals (Exworthy, 2015) thus restricting traditional understandings of professional autonomy. A number of studies, however, emphasis that such processes are dynamic and often involve resistance and interplay between differing forms of agency, self-discipline, and bureaucratic control (Hodgson, 2005; Waring and Currie, 2009; Exworthy, 2015). Professional 'experts' must therefore learn to navigate this dynamic, pluralistic world reflexively; mobilising evidence in public contexts that incorporate a sense of publicness and ethics (Carolan, 2006; Noordegraaf,

2007). Such themes resonate with the emerging Public health literature as professionals encounter complex and multiple accountability relationships (Phillips and Greene, 2015), are required to make the case to politicised non-medical audiences (Hunter et al., 2016; Sanders et al., 2017; Smith and Stewart, 2017) that embodies both the evidence base and the ethos of the Public Health profession.

Several gaps were also identified throughout these discussions. Firstly, there was relatively little cross over between the sociological investigations of Public health activities in local government and the critical accounting field, with the latter potentially being well placed to introduce a critical analysis of calculative practices, budgetary structures, and accountability arrangements in the new context. In the public sector accounting literature, several areas for further development were identified. Overall, there was relatively little discussion of the process of knowledge construction in the public sector context through an STS lens, which could add significant insight on *how* accounting devices help construct what is made valuable via contested truth claims in complex settings. There was also limited research on accounting practices in a contemporary local government setting following the major HSCA 2012 reforms, and even less on the cross agency spaces between local government and the NHS. Such spaces now exist in the shape of Health and Wellbeing Boards that contain a range of stakeholders from CCGs, LAs, and other agencies; and, increasingly, in new collaborative spaces created via Sustainability and Transformation Plans, Better Care Fund pooled budgets, and combined authorities. Not all of which will fall within the scope of this thesis. Finally, in the professions literature, the majority of studies reviewed looked at medical or other healthcare professionals, such as nurses or social workers, but very few professions papers have been written in the organisation studies space drawing on Public Health professionals. Public Health professionals have their own unique identity, and are of

particular interest as they advocate inherently hard to measure, long term, preventative interventions in a context of deep austerity.

In the discussion presented in this Chapter the background literatures relevant to the investigation of Public Health activities have been explored. These were introduced in section 2.3 in light of a conceptual definition of accountability relations as socio-material power relations in which ones actions were 'held to account' (Sinclair, 1995) via a process of 'scrutiny' or 'reprisal' (Bandy, 2011, pg.191). Such relations were seen as iterations of 'objective control' (Bryer, 2006) and 'self-fulfilling fantasy' (Roberts, 2009) via two contrasting theoretical perspectives. Accounting was then defined as the practice of 'naming and counting' (Bassnett et al., 2019) that takes place in the context of accountability relations. Again, such practices demonstrate a double aspect; the disruptive parrhesia of unexpected truth and the maieutica of uncertainty, doubt, and the opportunity to ask new questions that may not have been asked before. In each case, we move beyond accounting as a strictly disciplinary practice, towards an extension of what Hodgson (2005) introduces as the iterative re-working and re-framing of human discursive practices through the *performativity* of language. This extension takes us radically beyond the realm of the human, towards an understanding of performativity of posthuman material-discursive assemblages of both discursive, calculative, and material practice. Towards what is introduced in the following Chapter (3) as a posthumanist *agential realism*.

Chapter 3: Theoretical and conceptual framework

This chapter presents the central theoretical framework (3.2) and theoretical contribution (3.3) of this thesis. It is presented in several key sections: in section 3.1 I provide an overview of the 'paradox of objectivity', which outlines what will become a recurring conceptual theme underlying many of the ideas presented in this thesis – namely, that there can be no essentialised or a priori separation of the natural and the social, and that both interpretivism and positivism fail to account for the respective truth claims of the other. Recognising subjective experience and objective truth as distinct and yet entangled phenomena, section 3.2 turns to Karen's Barad's generalised posthuman performativity, and her agential realist framework as a possible solution to this paradox. Section 3.2 outlines the wider STS theoretical literature before further exploring the agential realist framework, its characteristics, its concepts, and the genealogy of some of its terms, which may not be familiar to critical accounting scholars. In section 3.3, I then conduct a review of the STS inspired critical accounting literature and, in particular, present a (re)reading of the concept of performativity in this literature that draws on insights from the agential realist approach. In the concluding section (3.4) I call for a performative questioning of both accounting objects and practices, in their iterative intra-active becoming, through their continually dynamic, vibrant, and agential processes of realisation, that are capable of establishing cause and effect arguments and frameworks of objectivity. I also discuss how such frameworks of objectivity have ethical, political, and ontological consequences, and how both the ethical, iterative, and the subjective have been neglected in much of the STS inspired accounting literature, while the material, active, and agential are equally left out of other interpretative or relativist frameworks.

3.1 Introducing the paradox of objectivity

The story told by many social science text books is that social science research falls into two distinct camps – the positivists and self-styled pragmatists on the on hand, and then variously the interpretivists, relativists, and the social constructivists on the other (Laudan, 1996; Ransome, 2010). The former group might be typified by a commitment to objectivity or 'realism' (Robson, 2011, p.22); maintaining a philosophical framework with roots in enlightenment thinking and the scientific method (Kuhn and Hacking, 2012; Laudan, 1996), often with an implicit debt to the legacy of August Comte and then Emile Durkheim (Latour, 2005, pg.13; Thomas, 2013, pg.107). Such research is often characterised by its reference to the 'scientific method', typically involving isolating variables to test hypothesis in a deductive manner (Thomas, 2013, pg.108). The interpretivists, on the other hand, draw more heavily or exclusively on qualitative data, preserving a commitment to subjectivity and productive analysis of difference in their data (Thomas, 2013, pg.108). It is common in text books on social science research to introduce interpretative approaches as helping to sensitize the researcher to people's individual experiences and perceptions; interpretivism, it is argued, recognizes at the epistemological level the importance of observation and interpretation in an often subtle and dynamic social world, and, at the ontological level, that reality is an inter-subjective social construct (Hennink et al., 2011, pg.15; Snape and Spencer, 2003, pg.7). This chapter begins by framing what we mean by realism and objectivity, and by asking the difficult questions that arise when we bring these concepts into social constructivism, and into the same frame as our own subjective perspectives as understanding, acting, ethical subjects in a complex material world.

By exploring the ground laid by STS, economic sociology, and feminist new materialisms, this chapter goes on to develop a theoretical framework that allows us to break down what I introduce as the 'paradox of objectivity' – a paradox that arises when we insist that reality exists in the two irreconcilable domains of the natural and the social. This project chooses neither of the well-worn theoretical paths rooted in either the subjective or the objective, of interpretivism or positivism; arguing that either choice leaves us falling back into the paradox that is created by an essentialist separation of subject and object from the outset. Instead, by tracing ideas and concepts from the STS, economic sociology, and critical feminist literatures I argue that we can overcome this emergent dichotomy to establish ourselves more securely at the ontological level. With reference to Karen Barad this chapter builds towards an *agential realist* framework that takes seriously both the objective validity of much of modern science, but also the very valid critiques of simplistic applications of scientific methods and *positivistic* ways of thinking to social research – this is an approach that applies the central concept of *generalised performativity* to reject not just the subject-object dichotomy, but many of the common dualisms of social research such as nature-culture; structure-agency; human-nonhuman; and material-discursive, to give a firm foundation to the analysis.

I begin by introducing the broader STS literature, the important lessons for organisational research, and the potential for resolving the paradox of objectivity (3.2). This section introduces the key concept of *performativity*; briefly tracing the concept from applied linguistics, through to critical feminist research and into the STS literature. This second section leads to a discussion of the important ontological implications for a generalised performative understanding of reality and introduces concepts of *diffraction, entanglement* and *intra-action* following Barad's agential realist framework. In the following section (3.3) I go on to

focus more specifically on the economic sociology and accounting literature that draws on STS, particularly the work of Michael Callon and Bruno Latour's work on Actor Network Theory (ANT), in applied organisational research. This section will introduce the key concepts of *translation*, *framing* and *inscriptions*, *calculative spaces* and *calculative practices*, *action at a distance* and *centres of calculation*, *actors* and *agency*, and the *assemblage*. I go on to link this to binaries of power and agency, and build towards a framework that is concerned both with the grounded *how* and the ethico-political *why* of social research. In particular, this section addresses the separation in Accounting studies between Foucauldian conceptualisations of *power* and Latour's conceptualisation of *agency*. The chapter ends with a summary of the key developments and the methodological implications for the empirical data collection in the following chapter of the thesis.

3.2 The paradox of objectivity: lessons from science and technology studies

> *How can a discourse be outside of the reality that it describes and simultaneously participate in the construction of that reality as an object by acting on it? To this paradoxical question the concept of performativity provides a convincing and general answer.*
>
> Michael Callon, *What does it mean to say that economics is performative?*

Background: Science and Technology Studies (STS)

In their 1979 book *Laboratory* Life Latour and Woolgar (1979) set out one of the important texts for subsequent STS work, and, in particular, the later development of ANT. The work is a detailed ethnographic investigation of the process of knowledge production in a laboratory setting conducted at the Salk institute for biological studies between 1975 and 1977, and reveals the complex mobilisations of material and social forces necessary for the construction of scientific 'facts'. The motivation for the book is to reveal the everyday practices of scientific

endeavour; rather than seeking to debunk by focusing on moments of scandal or intrigue the work is seeking to understand *how* it is that facts come to be facts. Indeed, in the 1986 second edition of the book the subtext of the title is corrected from *The Social Construction of Scientific Facts* to simply *The Construction of Scientific Facts* (Latour and Woolgar, 1986) to emphasise that the work is not an attempt to dismiss science as 'socially constructed'. Instead, it is by understanding the processes through which scientific knowledge comes to be established that we are able to understand its apparent strength and solidity. Ideas do not come from nowhere in inspired moments of discovery, but come out of complex assemblages of circumstance, social context, and material conditions. In particular, it becomes apparent to the researchers in their observations that the scientists in the laboratory are constantly recording and narrating their results in documents, charts, graphs, and databases, constantly codifying and correcting previous observations.

In their account, Latour and Woolgar (1979) show that physical laboratory equipment are devices of *translation* by which physical phenomena are converted into numbers and representations, and it is these representations that are central to the construction of verifiable and comparable information. Importantly, the analysis goes on to incorporate not just the practices themselves, but the socio-economic environment in which they are embedded, where, for example, the production of scientific papers to enhance the funding opportunities and reputations of the scientists is also important. To the observers the production of a fact is not the pure revelation of absolute truth, but the application of material, technical, and human resources to narrow the field of possibilities that can be verified deductively. What 'counter-facts' can be produced depends intimately on the social and material context so that, in their analysis, it is 'the set of statements considered too costly to modify constitute what is referred to as reality' (ibid., pg.243).

Ian Hacking (Kuhn and Hacking, 2012), meanwhile, traces the discipline of STS back two decades earlier; to Thomas Kuhn's 1962 book *The Structure of Scientific Revolutions*, a book that challenges the universality of truth through concepts such as the incommensurability of scientific endeavour between paradigms. The book itself represents a fundamental and resounding shift in science's conception of itself, seeming to suggest that science hangs together not as a rationalist progressive but as a set of community dependent ways of knowing and practicing. Hacking (Kuhn and Hacking, 2012) somewhat revises its scope, if not its significance; he suggests in his retrospective that Kuhn's work maintained a commitment to some of the objectivism and the superiority of theory present in the positivism of the Vienna School. But, he argues, Kuhn nonetheless makes a centrally important contribution to the development of what I am here referring to as STS in that he popularises the sociological investigation of scientific practice, and the embeddedness of the humble scientific *exemplar* within a wider community. Kuhn's overall framework suggests scientific knowledge moves from puzzle solving, to crisis, to revolution, and it his notion that science moves away from crisis rather than towards truth that is an important break from the unifying omniscience of western enlightenment thinking and previous positivist thought (Kuhn and Hacking, 2012).

STS was, therefore, a well established and vibrant community of research by the release of Latour's now well known 1987 book *Science in Action* (Latour, 1987); however, it was this book that had the biggest impact on accounting research (Justesen and Mouritsen, 2011) and helped bring ANT into main stream organisational research (Chiapello and Baker, 2011). The immediate cross over came through the use of *translation*, *mediation* and *mediators*, *centres of calculation*, *and action at a distance* into Foucauldian studies as developments of the governmentality approach (Miller, 1990; Miller, 1992; Miller and Rose,

1990), and similarly into some neo-institutional theory studies (Robson, 1992). By the early 2000s papers were regularly being published in the top critical accounting journals with ANT frameworks referencing, overwhelmingly, *Science in Action* (Justesen and Mouritsen, 2011). The unique appeal of the STS literature, and *Science in Action* in particular, alongside other early ANT works such as Callon (1986), was that they presented a framework for analysing chains of translation that led to organisational and social change in a grounded or 'flat' ontology (Latour, 1999; Latour, 2005). The researcher no longer privileges a priori assumptions about the social, the human, or the structural, which might obfuscate their findings, they instead look at assemblages of actors who come together in materially specific circumstances (Latour, 2005). In the case of Callon (1986), this alignment follows the distinct phases of problematisation; interessment; enrolment; and mobilisation.

Latour's (2005) book *Reassembling the Social* develops the idea of linear chains of translation into more complex networks that are the result of constantly unfolding controversies. The macro exists only as an assemblage of social links, sitting neither above nor below the micro, and sociologists must learn to follow 'the painful and costly longhand of associations' over the convenient shorthand of the social (Latour, 2005, pg.11). This later work is cited by Justesen and Mouritsen (2011) as apposite for the further development of the empirical ANT inspired accounting literature. Fuller (2012), however, sees Latour's approach and emphasis on the material and nonhuman, his 'flat ontology', as a reductionist flattening of reality. Arguing that there ought to be an ethical case made for scientists to be scientists, not to mention for human subjects to be human subjects, and that the classic Latourian conclusion that science is the effect rather than the cause of scientific endeavour results in the dismissal of the autonomy of science as a discipline. There is some important ground to be covered in extending these criticisms of Latour to a lack of appreciation for the human (in

our ongoing construction), for the discursive, and for a lack of attention to power relations, which will be taken up below.

A brief introduction to Performativity: from speech acts to distributed agency

ANT has, following the previous discussion, grown out of a wider discussion in the field of STS. One central and often challenging concept in this wider STS literature is that of *performativity*. Drawing on a range of STS thinkers, and following the rout this concept has followed in finding its way into the critical accounting literature, I introduce performativity as the quality of a thing that simultaneously represents reality *and* changes reality; it is not simply a 'performance', nor is it solely the quality of display or representation, rather it is the mutual unfolding or *becoming* of objects, bodies, and discourses as they encounter a complex and dynamic material world.

In the same year as Kuhn's famous *The Structure of Scientific Revolutions* is released, Austin (1962) coins the word performativity, or, more precisely, 'performative utterances', as statements that cannot be said to be true or false because they themselves perform actions. Some statements, in certain contexts, do not only describe but 'perform'. From there the concept moves through a number of theorisations via linguistics (Searle), critical theory (Derrida), post-structuralism (Foucault), gender studies (Butler), STS (Latour, Barad), and more recently economic sociology (Callon, MacKenzie). With reference to Foucault (2011), in particular, he suggests performative utterances are at their most interesting when they are *parrhesiastic,* the act of speaking the truth to power. Through this analysis, speech acts sit at the nexus of our personal obligation to speak the truth, procedures of governmentality, and the construction of identity, which are at the heart of his analysis of the subject, ethics, and politics. Parrhesia involves risk, as the speech act binds ourselves to the spoken, even the risk of death at the hands of the tyrant in the case of Plato at the court of Dionysius (Ibid.); it is

genuine expression of oneself and ones own compulsion to truth telling; and crucially, as an expression of the self it becomes a truth that binds and brings into being. Such statements are necessarily political; understood through what Foucault refers to as an 'ontology of the present' as the statement brings oneself into the world anew (Foucault, 2011).

In the gender studies literature Butler (1990) takes this concept rather further; influenced by Foucault, she goes beyond the explicit utterance and the analysis of language towards discourse and ways of knowing. Butler's body of work has a huge influence on critical feminist studies (Sönser Breen and Blumenfeld, 2005; and Lloyd, 2007), on critical and queer phenomenology (Ahmed, 2006), and arguably her coining of the phrase 'gender performativity' plays a significant role in the rise of a more generalised concept of performativity in the STS literature through the 1990s (Callon, 2007; Licoppe, 2010). Butler's (Ibid.) use of performativity in the analysis of gendered discourse and gendered social performances is important here because she uses the two-way iterative nature of performativity to challenge positivist scientific understandings of gender as a stable and fixed category. For Butler (Ibid.), these assumptions are built into the hypothesis of scientific argument from the outset, which leads their processes of knowledge production towards a reproduction of socially constructed gender binaries, and, importantly, gendered oppressions. Similarly, Donna Haraway's (1991, pg.19) feminist analysis of field experiments on primates in the 1930s and 1940s shows how essentialist assumptions in science re-inscribe modes of dominance. Her analysis concludes:

> [The] sciences will have liberating functions in so far as we build them on social relations not based on domination. A corollary of that requirement is the rejection of all forms of the ideological claims for pure objectivity rooted in the subject-object split that has legitimated our logics of domination of nature and ourselves. If our experience is of domination, we will theorize our lives according to principles of dominance.

For Haraway previous radical feminist thought had fallen back into this trap and re-inscribed the essentialist division of male-female to protect their own movement of liberation (1991, pg.132). For Butler (1990), much like Haraway's broader call for an emancipatory knowledge framework that acknowledges our part in the construction of systems of thought, we need to understand the fluid coproduction of gendered subjectivity to have any workable understanding of empowerment and agency. Butler's work on the processes of gendered subjectification through performative repetitions brings out the two-way nature of these 'performances', and, alongside Haraway, shows that such a performative understanding has ethical and political consequences.

There have been critiques of the legacy of Butler and other post-structuralist thinkers, in critical feminist studies. Barad (2003), for example, suggests the post-structuralist turn led to a privileging of discourse over materiality and a re-inscription of the nature-culture binary – Butler's own use of the word (Butler, 1990; 1993), however, at least remains true to a non-binary view of performativity as a concept. She describes performativity as 'that reiterative power of discourse to produce the phenomena that it regulates and constrains' (Butler, 1993, pg.236). Specifically on gender performativity, gender is a *doing*, it is both materially and socially constructed in complex and contingent ways (Butler, 1990); this does not imply an agency that is equivalent to liberal ideas of free will or choice, nor does this suggest that gender is objectively determined by the body we are born with. In short, a performative understanding of gender is necessarily a rejection of a priori inscriptions of nature-culture and ultimately material-discursive binaries. Instead gender, as a social category, is an ongoing interaction of bodies, discursive practices, and agency.

The concept of performativity has therefore been crucial in understanding the nature of the human, in the case of Donna Haraway's *Cyborg Manifesto* (1991, pg.149), and of gender (Butler, 1990) in the gender studies literature. It is perhaps a somewhat smaller task to apply performativity to, for example, our use of assets, liabilities and equity on a company's balance sheet, to management accounting devices, or to organisational inscription devices. The accounting conventions in Ruth Hine's (1988) parable of financial accounting can, retrospectively, be described as applying a performative understanding – particularly her titular phrase 'in communicating reality, we construct reality'. Our choices for financial accounting principles and practices have profound implications for the environment, for biodiversity, and for human wellbeing (Hines, 1988). Similarly, Smith's (1984) analysis of organisational texts as detached from the speaker, using the example of the job application, becoming 'active' in organisational life *both* through the reproduction of power relations and through creative and localised interpretations can be described as applying a performative understanding.

There are also a great many more recent examples that draw more explicitly on the concept in the critical accounting literature. These are discussed further in section 3.3, and it is noted that while there are some peripheral references to Butler and earlier works by Latour in the accounting field, the concept of performativity really takes off as scholars apply the ideas of Michel Callon (1998 and 2007), Donald MacKenzie's (MacKenzie, 2006; MacKenzie, 2009; Hardie and MacKenzie, 2007) work in economic sociology. Callon (2007 and 2010), however, does draw directly on Butler's use of performativity, together with Mol's (2002, pg.31-32) extensions of the term more broadly to the material in addition to the discursive, in extending his previous work on framing and overflowing (Callon, 1998). In his influencial work in economic sociology, Callon (2007) applies performativity in particular to both

economics, as a discipline that produces the world it seeks to understand, and to both human and non-human actors in the construction of actor-networks that bring economic theory into reality. In extending the application of performativity beyond speech acts, to objects and material inscriptions in the construction of 'calculative agency' (Callon and Muniesa, 2005), Callon is drawing on an already rich discussion in the STS field in which knowledge production practices are understood as having both a social context and history via networks of distributed technological and material agencies.

Vollmer et al. (2009), in particular, draw on Callon (2007) and MacKenzie's (2006) conceptions of performativity and their contributions to the social studies of finance literature in their agenda setting paper, calling for greater cross-fertilisation between the critical finance and accounting literatures. By this point, from around 2010 onwards, the concept of performativity has very much leaked across into critical accounting, as well as the wider organisational studies literatures (see Gond et al., 2016), as a useful and propitious conceptual tool that augments existing constructivist trends in these fields.

Before further exploring applications of the performativity concept, and other key terms drawn from STS, have entered and proliferated through the critical accounting discipline the remainder of this section (3.2) will discuss performativity as it is understood from an *agential realist* perspective. This will help both establish a secure methodlogy for the remainder of this thesis and also help elaborate the particular theoretical contribution suggested in the closing sections of this Chapter.

Posthuman performativity and agential realism

Barad (2007), similarly to Callon (2007), further extends the concept of performativity beyond the discursive and the representational to what they call a unified *material-discursive* account

of performativity. Her account is highly important as it rigorously grounds the STS literature, and the concept of performativity itself, at the ontological level rather than merely the epistemological level. Ian Hacking's (2002) notion of dynamic nominalism has nature and society developing through history, each egging the other on in a process of naming and constituting, in a kind of scale that ranges from the relatively stable actions of bacterial microbes that are mostly independent of their description through to the socially constituted roles of, say, the waiter in Jean-Paul Satre's analysis of the Parisian Café. But Hacking is criticised by Barad (2007), in particular for his stance of experimenting as being separable to theory. His distinction between intervening and representing is, for Barad (Ibid), problematic, who argues that the material and the discursive are always in a performative co-relation. For Barad (Ibid.), naming is *itself* a material act. This is a useful point that goes to the heart of Barad's agential realist philosophy; in this framework every boundary is constructed and every boundary, including the inherent essentialism of language itself, is an unfolding material-discursive construction. Matter and meaning are here 'performed' together, through and with one another, in the same agential dance in the most generalised sense.

In her book *Meeting the Universe Half Way*, Barad (2007) roots this philosophy in a comprehensive discussion of the critical feminist and STS literature, and while she had developed these ideas in previous articles (for example; Barad, 2003) it is this book that fully grounds and develops her thought. Their notion of generalised performativity has several important starting points, which need to be considered if her framework is to be properly understood. The book begins with an analysis of the philosophical implications of early 20th century developments in quantum physics; in particular, what is referred to as the problem of wave-particle duality. This was a problem first recognised in the paradoxical duality of the very nature of light itself – as discovered in the early 20th century, light exhibits the unusual

property that in some experimental set-ups it can behave like a wave, and yet in other set-ups it could act like a particle[6]. A problem compounded when experimental physicists began to find the same property of wave-particle duality in other particles of non-zero mass such as electrons. This leads to what is known as the Copenhagen interpretation of quantum physics, but in the discussion Barad (2007, pg.97) draws particular emphasis to physicist Niels Bohr's understanding of the Copenhagen interpretation as implying that reality itself is fundamentally indeterminate. For Barad, this has profound consequences for the STS literature that had previously focused largely on processes of knowledge production as an epistemological matter. Barad (ibid.) goes on to discuss several well-known Nobel prize winning experiments in physics and concludes that theorisation is a material practice, and that our process of knowledge production is fundamentally *both* material and discursive. An important consequence of this is that our discursive methods of constructing theoretical frameworks are, in fact, inseparable from what a scientist may consider their *apparatus.* This leads to the generalised concept of the material-discursive *apparatus*, which is to be understood as the complex material and social circumstances by which *phenomena* can be produced and observed. It is the material-discursive contextual understanding of the phenomena that allows us to be objective, recognising at the same time the embeddedness and contingency of our objectivity. Building on the ideas of Donna Haraway, knowledge production, for Barad, becomes an inseparable or *entangled* combination of the ethical, ontological, and the epistemological in what she describes as ethico-onto-epistemology (2007, pg.185). These thoughts are further developed in her discussion of theorising as

[6] First proposed in Albert Einstein's 1905 paper on the photoelectric effect, in which he theorises how experimental data could be explained by modelling light as a particle or 'photon', which leads to his award of the Nobel prize for Physics in 1921. Classical light phenomena, such as diffraction, had previously been understood as demonstrating the unique property of light as a wave.

touching (Barad, 2012), and the observation that acts of knowing or feeling depend as much on difference, space, and absence, as they do on unity, touch, and inclusion. This is a radically post-human position that places the human, knowledge, and essence within a material intra-acting space. For Barad (2007, 2012) knowledge can only ever be understood as reality attempting to (performatively) understand itself.

The discussion of Niels Bohr's position in *Meeting the Universe Half Way* is described as a 'proto-performative' account, and Barad is critical of Bohr for not fully exploring or making explicit the ontological implications of his philosophy physics (2007, pg.67-69). In addressing this issue, Barad's discussion of performativity turns to Butler's notion of gender performativity, which in turn draws on Foucault's (1978) seminal study of the history of sexuality. Butler's (1990) analysis demonstrates that the scientific study of sex is problematized by the observation that gendered meanings and assumptions are built into the very hypothesis that are used to test or establish 'sex', supposedly prior to cultural or social understanding of gender. As discussed earlier, Donna Harraway (1991) makes similar observations in her well-known analysis of the study of primates, in which sexual determinism and evolutionary functionalism has been used by scientific communities to project their own patriarchal patterns of dominance onto their subjects. But Barad's critique of Butler, similarly to Mol's (2002) criticism that there is an unbalanced emphasis on the discursive, is that they do not take this concept of performativity all the way to its necessary material-discursive conclusions (Barad, 2007, pg.66). Ultimately, the work of Butler in *Gender trouble* (Butler, 1990) and arguably Foucault (for example Foucault, 1978, pg.151-152, cited by Barad, 2007) themselves re-inscribe anthropocentric assumptions by only applying performative understandings to human bodily subjectivity. Her framework therefore seeks to bring

together Neil's Bhor's proto-performative account of materiality with Butler's humanist account of discursive and bodily performativity.

This has important consequences for how we reappraise cause and effect relationships if we are to take this framework seriously and avoid falling back into assumed essentialisms. In understanding the relationship between cause and effect under agential realism we need to introduce the concept of *entanglement.* Starting with entanglement, this concept draws on the phenomena of quantum entanglement, a phenomenon that occurs when the properties or 'states' of particles in 'entangled systems' cannot be described separately, but rather the system must be understood as a whole. The properties of individual particles in an entangled system are inherently indeterminate until measured, at which point the measurement determines the states of the entire system. In Donna Haraway's (1991 and 2008) works interconnectedness, diffractive understandings, and post-humanism are central to her thought in which we are to be understood as ethical subjects intimately ensconced in material, biological, and technoscientific systems. Barad draws on these ideas with her use of the word 'entanglement' in the broader sense, using it to break down subject-object binaries and disrupting atomised understanding of cause and effect:

> If what is implied by 'consequences' is a chain of events that follow one upon the next, the effects of our actions rippling outward from their point of origin well after a given action is completed, then to say that there are consequences to our actions is to miss the full extent of the interconnectedness of being. Future moments don't follow present ones like beads on a string. Effect does not follow cause hand over fist, transferring the momentum of our actions from one individual to the next like the balls on a billiard table. There is no discrete 'I' that precedes its actions. Our (intra) actions matter– each one reconfigures the world in its becoming– Causality is an entangled affair. (Barad, 2007, pg.394)

This is not to say we cannot talk about cause and effect or objectivity, on the contrary, her framework is a 'realist' framework that draws heavily on examples of scientific experiment. The consequence is that our understanding of the world around us is the construction of an objectivity that exists as far as the stability of the material-discursive apparatus that frame our vision and our thought can be said to hold true. *Entanglement*, *generalised performativity*, and the embeddedness of *intra-action* (which is the understanding of all actions as action that determine outcomes within an entangled systems, not between a priori separable or atomised elements) therefore provide us with a method for a critical engagement with the world rather than a set of theories to be tested. Agential realism is an approach that recognises the dialectical binary thinking of subject-object, natural-social, human-nonhuman, structure-agency, and so on as historical material constructions and performative agential cuts.

Performativity, as a concept, has therefore travelled considerably. The concept I draw on in the subsequent chapters will employ this most generalised agential realist interpretation. I will look at performativity of objects, accounting devices, discursive practices and identity across the Public Health system, and I will recognise that the objective knowledge production process Public Health professionals engage in – within and across LA organisational boundaries – is performative, intra-active, and entangled. It is a system that requires critical engagement as opposed to neutral observation. The entangled and contextual nature of knowledge production in the new Public Health system and the difficult task of stabilising useful objectivities are therefore brought centre stage in this analysis. The empirical and technical implications of a generalised concept of performativity will be discussed further in Chapter 4.

Resolving the paradox: diffraction, indeterminacy and anti-essentialism

In resolving the paradoxes of positivist essentialism Barad draws heavily on Donna Haraway's notion of *diffraction* and diffractive methodologies as an alternative to reflection and to representationalist accounts in social research. Diffractive methodologies draw on the metaphor of diffraction as a classical property of waves. Waves spread out when they pass through a narrow gap or space, and where you have several waves interacting you get wave *interference*. So, when Francesco Grimaldi first noticed diffraction patterns created by sunlight passing through a narrow slit, and noticed patterns of interferences from light passing through two adjacent pinholes, light was established by classical physicists as a wave (Barad, 2014). Haraway (1992) has the diffraction metaphor as disrupting essentialised social categories and taxonomies, and uses the example to draw attention to effects that are as much the result of difference and absence as they are by presence and inclusion:

> Diffraction does not produce 'the same' displaced, as reflection and refraction do. Diffraction is a mapping of interference, not of replication, reflection, or reproduction. A diffraction pattern does not map where differences appear, but rather maps where the *effects* of difference appear. (Haraway, 1992, pg.304)

If Barad takes this further it is by suggesting that this is not really a metaphor at all. Drawing on Bohr's philosophy physics she argues that the property of diffraction is a result of the inherent *indeterminacy* of all matter[7], and this understanding of indeterminacy should therefore be central to our 'diffractive' understanding of all forms of knowledge produced by specific material-discursive apparatuses (Barad, 2007). In the two-slit electron experiment, in which electrons are fired at two open slits and their scatter pattern is then measured on a

[7] The quality of diffraction demonstrated when electrons and other particles are introduced to the two slit apparatus is a result, under the Copenhagen interpretation, of their wave function. The wave function only applies until the matter interacts with a physical apparatus, at which point the wave function 'collapses' and the property of the particle results. This is a fundamental property of matter as we know it.

receiving screen in a similar set up to Grimaldi's two pinhole observations of light, traditional understandings of matter are 'queered' (Barad, 2014). Just as with the queering of gender identity, the electron 'performs' a certain position only if there is introduced into the apparatus a measuring device at one of the slits, otherwise it remains indeterminate and produces a wave-like interference pattern on the screen. For Barad, a diffractive understanding of gender identity in which identities are indeterminate until iteratively (re)performed, depending on agency and context, is ontologically the same as the electron that is either a particle or an indeterminate distribution capable of being in two places at once, depending on the material-theoretical set up. In Barad's 'diffractive' piece *Diffracting diffraction,* she gives a literature review of sorts in which she maps the emergence of diffraction as a concept in physics and the leaking across of the concept into critical feminist studies. While running over some familiar ground the article introduces the narrative consequences for diffractive understandings, similarly to Czarniawska's (2004) concepts of kairotic time a diffractive understanding of narrative is one of creating anew, rereading memories and histories through and with subsequent experiences. A diffractive understanding of organisations and professions therefore requires us to construct objectivities that are embedded, decentred, alive to potentiality, and alive to dynamic agential intra-actions.

Barad's (2007) diffractive methodology as an attempt to resolve paradoxes of objectivity also has strong parallels in the 'strong objectivity' and 'strong reflexivity' suggested by Harding (1991) in previous feminist science studies literature. In acknowledging this paradox, Harding (1991) notes the need for a more sophisticated alternative to positivism that doesn't simply fall into epistemological or judgemental relativism. While it seems increasingly 'arrogant' for defenders of the Western intellectual tradition to dismiss

alternative epistemological paradigms, embracing 'diversity, pluralism, relativism, and difference', while politically and intellectually useful resolves these differences to nobody's satisfaction. Instead Harding (1991) calls for a 'strong objectivity' that critically engages with context and background assumptions through which hypothesis might arise, putting the 'subject' in the same causal plane as the object of enquiry in a reciprocal relationship. Similarly, 'strong reflexivity' becomes the counter call to the weak reflexivity of the scientific method, rather than simply 'reflecting' one critically engages with the political, ethical and social entanglements of scientific research. Barad, arguably, provides a strong foundational basis for a 'strong objectivity' and a 'strong reflexivity', and while there is some difference of terminology Hollin et al. (2017) note that Barad's diffractive methodology is largely consistent with the strong reflexivity proposed by previous STS scholars as a resolution to the limitations of positivism and interpretivism.

Resolving the paradox: Implications and conclusions for objectivity

Through this section so far I have traced the broad STS literature towards a conceptualisation of *performativity*, in the generalised posthuman sense, introduced the concepts of *entanglement, indeterminacy,* the *material-discursive* and then *diffraction*. I began by suggesting that many introductory social science textbooks introduce early career researchers to two, often competing theoretical paradigms of positivism and interpretivism, and argued that, taken on merit, these two competing theories of knowledge presented us with a paradox. With the right exemplars both approaches appear reasonable, however, taken together they split the world irreconcilably into two. Donna Haraway (1978) summarises this dichotomy well in her critique of positivism whose roots lie, she argues, in liberal individualism:

> We have allowed our distance from science and technology to lead us to misunderstand the status and function of natural knowledge. We have accepted at face value the traditional liberal ideology of social scientists in the twentieth century that maintains a deep and necessary split between nature and culture and between forms of knowledge relating to these two putatively irreconcilable realms.

Latour (2005) makes similar criticisms of positivism as re-inscribing an essential split between the natural and the social. Latour (Ibid.) argues that social scientists appeal too often and too quickly to the 'social' for quick explanations when this ought to be the beginning of their painful exploration. But, as Haraway suggests, the solution to this is to reappraise the nature of scientific knowledge, to disrupt boundaries, to recognise systems of knowledge as having potential for both emancipation and for domination. My discussion of generalised performativity and the agential realist framework, as put forward by Barad, has sought to ground these STS discussion on a rigorous ontological foundation that enables us to address the political, ethical, and social dimensions of knowledge construction processes.

This section has therefore introduced the important conceptual tools of agential realism, and has attempted to place this within the broader context of the STS and STS inspired social science literature. Importantly, the concepts elaborated in this literature aid us in breaking out of commonly constructed dichotomies and dualisms that underpin separations of social science research into interpretivist and positivist camps. In so doing, we are able to break away from common theoretical difficulties and narrowness of scope of some social science research. Performativity, in this theorisation, is key – defined as the iterative material-discursive process through which knowledge is co-produced in entangled, intra-active networks or assemblages. This definition escapes characterisation of performativity as the 'action' or 'effect' of a material-discursive interventions, while similarly breaks down structuralist or deterministic readings of power relations, as we understand that such power

relations observed in any moment are being reproduced in a continual processes of making and re-making, translated and re-translated. So that, where one researcher sees structural power relations manifest in their data, and yet another sees agency and translation, the agential realist sees both, each through and with the other. In the following section, I explore the these ideas further with reference to the critical accounting context before introducing their implications for the data collection and analysis in Chapter 4.

3.3 Paradox in practice: Untangling critical accounting's contribution

This chapter began with a discussion of the 'paradox of objectivity'. I concluded this paradox through a review of the STS literature and by tracing concepts of performativity through to Karen Barad's generalised performativity as a framework for knowledge production with solid foundations at the ontological level. I ended this discussion with an introduction to the concepts of *entanglement, indeterminacy* and *diffraction*, as the creative process of reading 'through and with' in a strongly reflexive framework. The following section applies an agential realist framework and a diffractive reading to our understanding of processes of mobilisation and control in the accounting, organisational, and economic sociology literatures. I build towards a (re)reading of performativity as a concept in these literatures and its relationship to existing modes of enquiry into accounting objects and practices. I review the uses and potentialities of performativity for understanding processes of knowledge construction in organisational life, and its potential usefulness in reconciling dichotomies of agency and control, the material and discursive, and the human and the nonhuman, as they have emerged in this literature. In covering this ground I will first introduce some of the concepts coming out of the classical ANT literature, such as *translation*, *mediation* and *mediators*, *centres of calculation*, and *action at a distance,* which provide common ground to the critical accounting

reader, before building towards a framework in which these concepts can be applied in a non-reductiist sense that preserves an attentiveness to questions of power, politics, and ethics.

STS in the critical accounting literature: The emergence of Actor-network theory

The first and still largely the predominant STS influence in the critical accounting field comes from ANT, with works by Latour (1987), Callon (1986), and Law (1986) making an early impact, notably in works developing post-Foucauldian governmentality (Miller, 1990 and 1992; Miller and Rose 1990) or neo-institutional (Robson, 1992) frameworks. This following an already active discussion of the implications of Foucault and governmentality for Accounting research, and the construction of the disciplined liberal capitalist subject under accounting technologies of control (Hoskin and Macve, 1986; Miller and O'Leary, 1987; and Hopwood, 1987). Particular focus was drawn to the disciplinary power of numbers in their analysis of 'subjectification', in the Foucauldian sense, and the construction of the 'calculable self' within a 'calculable space' (Miller, 1992), thus developing Foucault's (1977 and 1978) concepts of discursive practices and technologies of power. The key contribution of Latour (1987) in this literature can be seen in the renewed emphasis on material objects and physical devices in the establishment of 'action at a distance'. Numbers, 'calculative practices', and the means by which they can be communicated immutably and without distortion, then becomes central in the establishment of centres of power that can 'act' on internalising calculating subjects (Miller, 1990 and 1992; Miller and Rose, 1990). Just as the maps, charts, and instruments of navigation, along with a whole assemblage of human and nonhuman actors, enabled centres of colonial power to establish networks of control across the world from the 16th century (Law, 1986; Latour, 1987), similarly discounted cash flows, standard costing, and innumerable accounting reports allow for the governance at a distance of economic life (Miller and Rose, 1990). In his seminal contribution to the accounting literature at this time, Robson (1992) argues that rather than

treating language as a 'window' to the world, we have to understand that our only access to reality is through modes of representation; in understanding that the correspondence between 'explanation' and 'object' is only a problem for those that 'wish to act at a distance' then problems of representationalism do not arise to the same extent (Robson, 1992, pg.691).

The concept of *translation* is introduced in this literature in two ways; firstly, language itself is translated, and power relations are reproduced in the Foucauldian sense, through the proliferation of 'inscription devices' that fix language, and detach it from the speaker for ready reinterpretation by subjects under discursive regimes of control (see Smith, 1984). Miller and Rose (1990) draw on this conception of discursive practices and power relations, but they also introduce the second discussion of translation, drawing on Callon and Latour, as the mobilisation of networks who may variously come to share a common interest. What Callon (1986) refers to as the 'obligatory passage point'. Latour (2005, pg.179), provides a useful definition of 'translation' to the actor-network theorist as follows: '[Translations] mean displacement, drift, invention, mediation, the creation of a [social] link that did not exist before'.

Placing the two uses of the word besides one another, we begin to see the potential for contradiction and the reintroduction of binary thinking across the literature. On the one had we have scholars trained in the analysis of subjectification under Foucault who see translations arising out of disciplinary regimes of discursive and calculative knowledge practices, what Miller (1992, pg.63) refers to as 'exercises of power' in the construction of the 'calculable self'. In contradistinction, we have the Latourian emphasis on the material over and above the discursive (see for example Latour, 2005, pg.69) and the rise of subsequent studies, relying on ANT as a methodological framework in its own right, moving away from

'programmatic' conceptions of discourse or power, and towards the analysis of agency, change, mobilisation, or controversy (Justesen and Mouritsen, 2011). This section contends that this becomes a division in the critical accounting literature, one that arises out of a structure-agency binary with its roots in Foucauldian applications of power as 'acting on' (see McKinlay, 2008), on the one hand, and a Latourian conception of agency as 'creation, drift and invention' on the other.

A second theoretical distinction should also be drawn out here. In the early applications of *Science in Action* through a governmentality lens (Miller, 1990 and 1992; Miller and Rose 1990) there is a departure from the construction of reliable and objective knowledge in the Latourian sense. When Latour and Woolgar (1979) discuss objective knowledge production in the scientific laboratory, or when Latour (1999) approaches the question of objectivity through reversible 'chains' of translation, there remains a commitment, albeit a contingent and reflexive commitment, to the existence of objective reality. For Miller (1992), on the other hand, the 'objectivity' of accounting is always programmatic and very much part of the necessary illusion that accountancy is required to maintain in order to remain effective in organising economic life. In his piece 'Accounting and Objectivity', Accounting devices are 'complex machines' for actively intervening in society, and the focus for us as researchers ought to remain on the processes of subjectivity under which accounting creates 'responsibilized autonomy' (Miller, 1992).

Justesen and Mouritsen's (2011) summary of the ANT literature shows that ANT became a significant methodological framework in its own right by the early 2000s, with works drawing more exclusively on the seminal contributions of Callon (1986), Latour (1987) and Law (1986). Many of the ANT papers at this time focused on qualitative investigations of

organisational change, emphasising the active role of technologies and accounting devices as nonhuman actors in the production of knowledge, strategic or other networks (Briers and Chua, 2001; Lowe, 2001; Mouritsen and Thrane, 2006; Gendron et al., 2007; Alcouffe et al., 2008; Justesen and Skærbæk, 2010; Vinnari and Skærbæk, 2014). Some within this literature, in particular, develop the work of Callon (1998) and Latour (1999 and 2005) towards an analysis of the construction of narratives and identity (Skærbæk, 2009; Justesen and Skærbæk, 2010; Vinnari and Skærbæk, 2014).

In their review, Justesen and Mouritsen (2011) cite some of the more recent writings of Latour and later iterations of ANT as having potential for the further development of the empirical ANT inspired accounting literature. In particular, Latour's (2005) *Reassembling the Social* opens up the previous conceptions of chains or stages of translation to a more dynamic, fluid, circulating set of unfolding controversies. The macro exists only as an assemblage of social links, sitting neither above nor below the micro; sociologists must learn to follow 'the painful and costly longhand of associations' over the 'convenient shorthand of the social' (Latour, 2005: pg.11). Turning on its head what Latour sees as the traditional positivist social science research, in the tradition of Durkheim, in which social scientists end their investigations where they ought to begin them by citing the Social or Power, with a capital S or P, as explanations for the phenomena they observe. The 'Social' is not an abstract domain, and it is up to the researcher to hear and follow their actors, both human and nonhuman, rather than by translating their data to fit preconceived hypotheses.

Latour's (2005) *Reassembling the Social* provides further useful methodological insight into *how* one goes about grounded social research that is attentive to an open conceptualisation of 'agency', in which an actor is simply anything that can empirically be said

to act upon the action of others. Latour (ibid.) takes us through a list of controversies that can be said to continually unfold, one upon the other. The first controversy is groups and group formations, that groups are constantly (re)formed and maintained. To see this process it is often easier to focus on initial formation or shock. At such moments of dynamism the 'spokes persons', the large retinue of group makers and group talkers become more visible as they have not yet been taken for granted. Under such an approach, boundaries, objects, and social formations should not be taken for granted and are dependent upon material objects and technologies for their stability. For Latour (ibid.) the *intermediary* transports meaning without transformation, while, crucially, the *mediator* transforms and translates. Thus it is essential to distinguish between the more neutral and the more active in the construction of objects and collectives – 'we', like 'I', is a 'wasps nest' (Latour, 2005, pg.45). The *Centre of calculation*, in this discussion, is then a star like formation, with the actor situated always at the loci of analysis, and the network being the unfolding collective (Latour, 2005, pg.181). The centre of calculation is described physically as the place where actual calculations are made, with the researcher prompted to ask 'which office?', 'which building?', 'what communication flows?'.

Latour's (ibid.) concept of the *oligopticon*, used in the accounting literature by Boll (2014a) in her analysis of the tax inspector's practices of investigation of small businesses, is described as the sturdy but extremely narrow view of the constructed 'whole'. Along with the concepts of *scale*, what material actors achieve by spacing and contextualizing one another, and *panoramas*, which is the act of contextualising and framing (Callon, 1998); these concepts give a grounded framework for the analysis of emergent macro structures. The emphasis throughout is on the construction; that it is through such processes of translation that stable groups, frames, and scale can be observed and foregrounded for investigation, rather than appealed to for explanations.

Further developing this methodological debate in the accounting literature are several contributions demonstrating the occurrence of multiple centres (Quattrone and Hopper, 2001 and 2005; Czarniawska, 2004), multiple competing calculations (Hansen and Mouritsen, 1999; Kurunmaki and Miller, 2008; Skærbæk and Tryggestad, 2010), and a renewed emphasis on the formation of the 'actor' in their potentiality – what Czarniawska (2004) calls the 'action net'. Scholars have also pointed out that accounting devices are special actors as they shape and define the very spaces over which they are capable of exerting control at a distance (Frandsen, 2009; Corvellec et al., 2016). Christner (2015), in exploring this literature, notes the division between Foucauldian conceptions of control through the disciplinary power of numbers on the one hand and ANT inspired studies that demonstrate control through the mobilisation of networks of alliances on the other, but also makes the important observation that both streams in the literature often take for their starting point an implied centre of control. Christner (2015) challenges the presumption that control is necessarily operationalised through coherent centres and calls for accounting scholars to refocus on the question of *how* control is practiced.

In addressing the apparent limitations of both the Foucauldian and classical ANT inspired literatures of implied centres of control Christner (2015) suggest a turn towards the conceptual vocabulary of the technological turn in economic sociology following Callon (2007) and MacKenzie (2009). In particular, the concepts of calculative agency and processes of framing, both of which will be discussed in the following section. Similarly, the increasing focus on the 'performativity' of accounting devices; on theorising the role of accounting in processes of knowledge production and valuation; and on the role of accounting in the making of new markets and social practices beyond the organization have become a major set of concerns for STS inspired accounting scholars (Vollmer et al, 2009; Justesen and Mouritsen, 2011;

Kornberger et al., 2015). The following section explores recent empirical developments in the critical accounting domain, builds towards a (re)reading of performativity in this literature, and finally sets out an agential realist contribution to this theoretical landscape that adapts mutually compatible conceptions of power and agency.

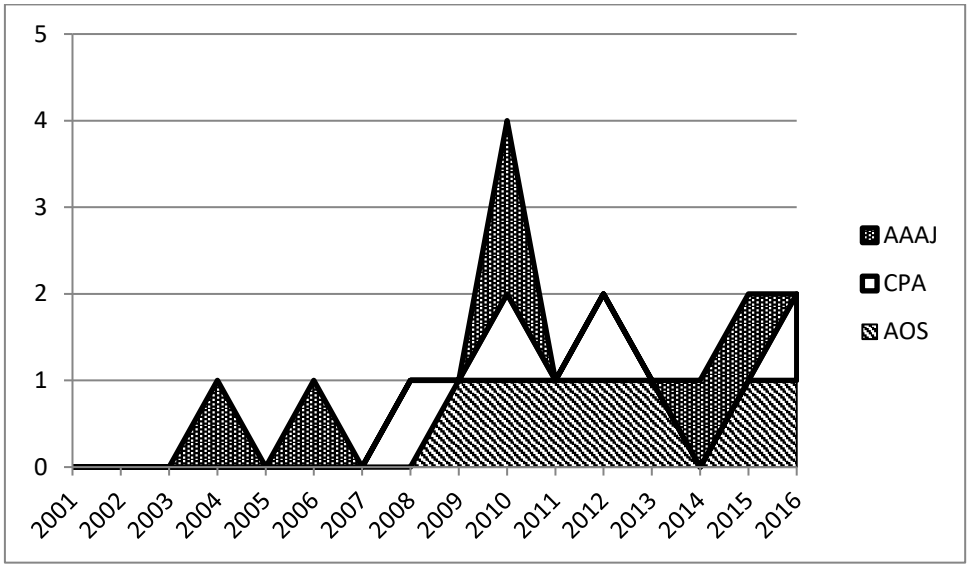
STS in the critical accounting literature: Introducing the 'performative'

The previous section demonstrates that ANT, and the work of Bruno Latour in particular, has been a major influence in the framing of critical accounting research, and through its focus on translation has provided a major contribution to what Quattrone (2015) describes more generally as the growth of constructivist approaches to accounting research. In this section I briefly trace the recent emergence of the concept of performativity in the critical accounting literature with a view to contextualising the application of my own agential realist framework. To narrow the scope of this review I have performed a keyword search of all articles published online by the three main critical accounting journals AOS, CPA, and AAAJ since their foundation for uses of the word 'performative' or 'performativity' in titles, abstracts, and contents. Figure 1. Shows the time series distribution of the 17 publications containing the keywords in either titles or abstracts. In total 34 articles across AOS, CPA, and AAAJ were reviewed as part of the wider literature review together with a number of important contributions from outside of these journals (for example, Miller, 2008; Keevers et al., 2012; Vosselman, 2014; Boll, 2014b; Revellino and Mouritsen, 2015; Kornberger et al. 2015; Quattrone, 2015), together with the primary theoretical readings.

Based on this review, it was noted that a second, STS inspired stream had entered the literature that was somewhat distinct from the classic ANT, which, while holding many commonalities with self-styled ANT studies, can be held as distinct from that body of literature. This has increasingly been the case over the past two decades as studies

increasingly draw on the work of Michael Callon (1998 and 2007), Donald MacKenzie (MacKenzie, 2006; MacKenzie, 2009; Hardie and MacKenzie, 2007) in economic sociology. One feature of this body of work in particular is their mobilisation of the concept of *performativity*. Some accounting scholars applying this concept and citing Callon and MacKenzie, also linked their conceptualisation to wider discussions of performativity (for example, to Hacking, 2002) on representing and intervening, or to Butler (1993, 2010), but on careful review, references directly to Callon and MacKenzie, or references to performativity in passing that clearly resemble their theorisation, were clearly predominant. Particularly since 2010 (see Figure 2.).

Figure 2. Title and abstract key word search: 'performativity' in critical accounting research



Focusing on a title-abstract keyword search in just three journals necessarily gives a narrow field of view, but nonetheless it is striking that, within this specific framework, there were no uses of the keywords until Lowe (2004) and Mouritsen (2006) in AAAJ. Then, by 2008, the concept of the 'performative' had become sufficiently common currency for at least one title-abstract reference every year since.

In the sample literature references to the work of Michael Callon and Donald MacKenzie are the most common citations, but several nuances to this picture can be seen. Indeed, due to the complex genealogy of the word itself, and the varying degrees to which its path through post-structuralist influences, the picture is a somewhat messy one. The following section reviews the uses the word is put to, and elaborates on potential issues in the current conceptualisations. I then conclude this section by suggesting new directions in a generalised, iterative, non-binary use of the word that can be applied within a framework that is sensitive to the ethical-ontological and political consequences of accounting practices, theorised as processes of (performative) knowledge construction.

Performativity enters the literature

Without making overly strong claims about the exact point at which the concept of performativity enters the critical accounting lexicon, it is important to analyse the two earliest uses of the concept in the title-abstract sample. The paper by Lowe (2004) draws on the STS literature to discuss the role of technology in the formation of 'postsocial relations' and the performative construction of knowledge cultures; and then Mouritsen (2006), who suggests a performative theorisation of intellectual capital research as an alternative to the positivistic 'ostensive' theorisations that have previously been applied by scholars. Indeed, these papers were also two of the earliest papers picked up in the wider literature review of the critical accounting and organisational studies journals.

Lowe (2004) reviews the STS literature and draws valuable parallels for management accounting research through an emphasis on practice, 'epistemic cultures' (Knorr Cetina, 1999, cited by Lowe, 2004), and the role of technology and nonhuman actors in knowledge producing networks. The paper does not advocate an ANT approach but does draw on Latour

(1987) in drawing attention to the linkages between humans and the knowledge objects they produce, and then Latour (1988) and Law (1999 and 2002) (cited by Lowe, 2004) in emphasising the importance of performative understandings, defined as:

> Actants whether human or non-human 'acquire the attributes' through the idea of 'performativity'. Actants are human or non-human entities that achieve their form as a consequence of the relations in which they are located. The idea of performativity refers to the dynamics through which actants become defined through the performance of network relations. (Lowe, 2004)

Similarly, Mouritsen (2006) draws on Latour's (1986) conception of performativity in suggesting that accounting scholars would be better served by treating intellectual capital as a process of theorising rather than as a fundamental or 'ostensive' property or essence. Intellectual capital then becomes a 'boundary object' that performatively shapes, and is shaped by, practice. Such an approach yields potentially more interesting research questions that open up the 'black box' of intellectual capital.

Two important observations at this point are the *iterative* and the *epistemic* conceptualisation of performativity as it is introduced at this stage. The iterative is in line with the poststructuralist uses of the word, as acknowledged by Lowe (2004) who places his use of the word within a poststructuralist perspective, while the epistemic focus is in line with the STS literature at this time (see Barad, 2007, pg.42). Additionally, both papers cite Latour's use of the concept in the 1980s in literature that would have been familiar to accounting scholars from at least the early 1990s. While not expressing this purpose explicitly, both papers can been read as attempts to widen the STS inspired theoretical discussion beyond strictly or exclusively ANT framed studies, with a particular focus on the question of *how* knowledge networks are produced in practice.

Influences from economic sociology: Callonistics and the performativity thesis

While much of the ANT inspired accounting research drew on Latour (Justesen and Mouritsen, 2011), the renewed focus on performativity is often more closely linked to the writings of Michael Callon (Callon, 1998; Callon and Muniesa, 2005; Callon, 2007; Callon, 2010) and Donald MacKenzie (MacKenzie and Millo, 2003; MacKenzie, 2006; MacKenzie, 2009) in what is sometime referred to as 'Callonistics' (Vosselman, 2014) or, more broadly, the social studies of finance (Vollmer et al., 2009). The commonly referred to 'performativity thesis' in this literature can be characterised specifically as the claim that economics produces the very assumptions on which it relies (Santos and Rodrigues, 2009). In particular, economics, as a discipline, itself produces Homo Economicus.

Influential and agenda setting contributions in the accounting literature that attribute the growing use of performative understandings directly to the emerging discussions in the social studies of finance, and to what Callon and Muniesa (2005) refer to as 'calculative agency' in market operations, include Miller (2008) in the Journal of Cultural Economy, Vollmer et al. (2009) in AOS, and Justesen and Mouritsen (2011) in AAAJ. A number of empirical contributions in the critical accounting literature then take up Vollmer et al. (2009) and Justesen and Mouritsen's (2011) calls for greater focus on the role of accounting in the making of markets (for example, Cushen, 2013; Williams, 2013; Vesty et al., 2015; Mouritsen and Kreiner, 2016), or respond to the call for renewed focus on the performativity of accounting practices with reference to these developments in the social studies of finance or STS (for example, Boll, 2014a; or Corvellec et al., 2016). There were many empirical studies noting the active 'performative' consequences of accounting practices as knowledge-producing, framing, representing, or boundary-drawing practices (Skærbæk and Tryggestad, 2010; Dambrin and Robson, 2011; Cushen, 2013; Williams, 2013; Boll, 2014a; Vesty et al., 2015; Ravellino and Mouritsen, 2015; Corvellec et al. 2016), and in some studies evidence of

performativity 'failing' to produce action at a distance (Asdal, 2011), or producing what Donald MacKenzie terms 'counter-performative' consequences in studies of management accounting devices (Cushen, 2013).

Other authors in the review draw on the work of Michael Callon (1998 and 2007) and Quattrone and Hopper (2005), particularly their work on the concepts of 'framing' and 'overflowing', in applying the concept of performativity as a further development of the ANT approach, or as the property of accounting that iteratively stabilises socio-material networks (Vollmer, 2007; Skærbæk and Tryggestad, 2010; Vinnari and Skærbæk, 2014). Skærbæk and Tryggestad (2010) in their case study investigation of processes of corporate strategy, see 'overflowing', where the performation of strategy creates the conditions for its own failure, as the norm and find that accounting devices are intimately involved in the ongoing framing and re-framing processes. Vinnari and Skærbæk (2014) develop the discussion of framing and overflowing in the ANT literature by looking at a case of risk management in a local government setting; their contribution is to show that risk management practices such as the COSO cube (the frame) can in themselves lead to uncertainties (the overflows), but also that multiple frames continually interact in a dynamic process. For Vinnari and Skærbæk (2014), the 'performativity thesis' in which economic models can 'become self-fulfilling prophecies' is seen as relatively peripheral. Dambrin and Robson (2011), on the other hand, apply performativity in an ANT framework to show that technologies of performance measurement of sales representatives in a large drugs company performatively enrol actors into an already stable actor-network. They show, in particular, that steps in chains of translation need not be strong and objective, as suggested by Latour (1999), but rather that the opacity of the network serves to strengthen it by allowing otherwise incompatible organisational and institutional tensions to remain unresolved.

In other theoretical contributions Ezzamel (2008) invokes the ritualistic iterations of inscription devices in a study of the New Kingdom, ancient Egypt, in his conception of performativity; citing performative repetitions as central to the question of *how* accounting creates fragile heavenly order our of chaos, within visual, linguistic, numerical and material assemblages. While Mouritsen and Kreiner (2016) theorise the performativity of accounting decisions in constructing markets and economies as a 'memory device' in a 'promisory economy', drawing on Butler (2010) and Callon (2007) to emphasise that it is the iterative nature of performation as forgiving, forgetting, and re-formulating that makes this hope in the future possible.

All of this makes for a rich and developing theoretical conversation across the critical accounting literature, with conceptualisations of performativity being applied to studies of organisational control through management accounting techniques (Ravellino and Mouritsen, 2015; Dambrin and Robson, 2011; Corvellec et al., 2016); audit and regulatory practices (Asdal, 2011; Vinnari and Skærbæk, 2014); standard setting and intellectual capital (Baker et al., 2010; Mouritsen et al., 2001; Mouritsen, 2006); corporate strategy (Skærbæk and Tryggestad, 2010; Cushen, 2013; Carter et al., 2010; Boedker, 2010); tax practices (Boll, 2014a); social and environmental accounting (Vesty et al., 2015); and to the newly developing empirical questions of how markets are operationalised (Cushen, 2013; Williams, 2013; Vesty et al., 2015; Mouritsen and Kreiner, 2016). The majority of these studies make use of the concept of performativity to continue the critical accounting research tradition of qualitatively investigating and theorising the 'active' role of accounting in performing, or in some cases counter-performing, organisational life; continuing the conceptualisation of accounting, in various ways, as a 'rationalisation machine' rather than as an answer machine (Burchell et al., 1980).

While the majority of these studies reference the work Callon and MacKenzie, a minority of studies also refer directly to the poststructuralist conception of performativity in the construction of the subject, particularly the work of Michel Foucault and Judith Butler. Roberts (2009 and 2015) draws on the work of both Butler and Foucault in theorising ethical subjectivity in relation to accounting, accountability, and transparency (Roberts, 2009), and in relation to corruption (Roberts, 2015). Roberts (2009), in particular, understands the construction of the quantified self as an iterative and performative process of identity building, and, with reference to psychoanalysis, theorises accountability as an ongoing negotiation between the constructed self and the constructed other. In an investigation of web 2.0 technologies on small businesses, in which rankings systems become 'power-charged', Scott and Orlikowski (2012) draw on Roberts (2009), but also on Butler (1993) and Barad (2007), to investigate the redistributed accountability relations and the performativity of digital rankings. This paper is of particular interest as it combines poststructuralist conceptualisations of performative identity construction of Butler, with the posthumanist work of Barad in STS.

However, work drawing directly on the poststructuralist turn, through which the concept of performativity has travelled, remain outliers in this theoretical literature. The focus instead remains firmly on theorising the 'active' role of accounting devices, the performativity of material and calculative devices in socio-material arrangements, rather than on the performativity of discourse, identity, or accountability. In the following section I relate the current influences in the critical accounting literature to my own agential realist conceptual framework, and to ongoing controversies over how the concept of performativity, and the process of knowledge construction, can and ought to be theorised.

(Re)theorising performativity: Leaving behind the performativity thesis

Following Barad (2014) every moment of theorising is both a material and political act. So in theorising performativity we must recognise that this is a diffractive re-engagement with the apparatus through which we see ourselves, each other, and the word, and that, furthermore, it is not about establishing the rights and wrongs of the matter, but rather it is about addressing certain questions. What are the possibilities and potentialities for a generalised posthuman performativity? How does a re-theorising contribute to the critical accounting context? How does it help us look for and interpret our data as social scientists? Does it help us to come to better and deeper understandings of our data? Returning to the structure-agency controversy, it is the contention of this chapter that there are tendencies in the accounting literature to fall into a binary of approaches. Applications of Foucault, on the one hand, focus on regimes of disciplinary control (McKinlay, 2008), and applications of Latour, and more latterly, Callon and MacKenzie, focus on questions of agency. As analysed above, this binary can be drawn more sharply through analysis of applications of the concept of *translation*.

Of course, both Foucauldian scholars and STS inspired scholars would argue that this claim is wrong on both counts. There are many ongoing attempts to enrich the Foucauldian genealogical method with renewed emphasis on the material dynamism and the concepts of the *dispositive* or *assemblage* (see for example Power, 2013). While on the other there are good examples within the STS inspired accounting literature that resist structure-agency binaries and scope within the theoretical sources to address the big questions of power and politics (Callon, 2010). But nonetheless there are emergent tensions, and focusing specifically on the use of the concept of *performativity* it is evident that the most commonly emerging understanding in the accounting literature is that the concept refers to the 'active' agential

role accounting plays in creating reality and to a direct application of 'the performativity thesis' of socio economics. This was particularly evident in many papers in the wider literature review in which the concept was only briefly referred to or mentioned in passing. Against this background, see how Chiapello (2017) characterises 'performativity' in her review of the concept of neoliberalism in the critical accounting research:

> The ***use*** of accounting techniques by actors (pragmatic dimension), conventions have the effect of: ***performativity:*** because the actor's action is informed by the analysis framework and models, the world increasingly comes to resemble the theory actors have of it, and predictions tend to come true. [emphasis added]

This reinforces Butler's (2010) observation, in her paper for the Journal of Cultural Economy's special issue on Performativity, Economics, and Politics, that 'performativity' is often taken to mean the 'effect' of the actor, human or otherwise, endowed with calculative agency. As Callon (2010) acknowledges, in the same special issue, this is problematic. Performativity is more than simply the 'effect' in an assumed cause and effect relationship that can be proven or disproven as a hypothesis through deductive reasoning; it is, or ought to be, the concept through which we understand how dualisms such as subject-object, structure-agency, nature-culture, and so on, come to be constructed. Performativity is the iterative coming and becoming through which boundaries, frames, and material-discursive apparatus are continually made and re-made. Butler's contribution here remains important as her work keeps the focus precisely on the ethical political consequences of knowledge producing practices, and provides a firm and direct link to the post-structuralist Foucauldian tradition, without which it can be all too easy to wander into a narrow empiricism or even yet, a re-inscription of the paradoxes of positivism and representationalism.

Examples in the critical accounting literature that demonstrate the potential of an iterative, material-discursive conceptualisation of performativity, enriched both by post-Foucauldian sensitivities to processes of accountability and subjectification, and, simultaneously, to occurrences of agency were Scott and Orlikowski (2012) and Boll (2014a, 2014b). These empirical applications offer non-binary, material-discursive, performative understandings; applications that resist falling into assumed subject-object, material-discursive, structure-agency binary oppositions. Scott and Orlikowski (2012) apply Barad's (2007) concept of *intra*-action and Donna Harraway's (2008) concept of entanglement to demonstrate the unfolding performative drift as users become aware of web 2.0 technologies to engage with ranking systems of regional hotel businesses, and how, in turn, the business owners, and the hotel staff are iteratively transformed through and with their customers and the developments in technology. Boll (2014a) apply the performative understanding they sketch out in Boll (2014b) to give a striking theorisation of the structure-agency dialectic as it plays out in HMRC inspections of small businesses. Here, they invert the concepts of the Panopticon (Foucault, 1977) and the Oligopticon (Latour, 2005) in their ethnography, demonstrating that structures of surveillance, discipline, and internalisation, on the one hand, and processes of inspection, translation, and interpretation, on the other, iteratively play out in practice, each through and with the other.

Barad's agential realist framework in itself does much of this work; preserving the iterative and ontological consequences of performative understandings of reality while extending the implicit humanist focus of Foucault and Butler to STS inspired knowledge networks of dynamic socio-material agency. But, useful as this approach is, her analysis of scientific experimentation as objectivity construction through material-discursive apparatus within an inherently indeterminate entangled world grounds this discussion, I argue, more

firmly upon a first principles approach. Furthermore, this framework allows us to tackle head on the ongoing controversies of objectivity – we take both Miller's (1992 and 2008) central point that claims to the neutral objectivity of accounting form part of its strength in reproducing power relations, what Haraway (1978) calls 'systems of domination', along with our instinctive desire to analyse the 'effects' of accounting devices in coming to rational and objective conclusions that can be clearly communicated outside of academia. Being careful to recognise such effects as iterative and dynamic, constructed via apparatuses that produce and reproduce both the effects we see, through all of our devices of translation, and ourselves as we see these effects.

3.4 Summary and conclusions

In presenting this chapter I aimed at a (re)reading of the concept of performativity in the context of a wider foundational questioning of knowledge production practices. How was it that objectivities of hard minded science, became so hard and fast while the objectivities of the heart – ethics, politics, and hope, so transient? And if such a divide must hold true is accounting an objectivity of the heart or an objectivity of the mind? Particularly, through the framework provided by Karen Barad's agential realism, and then through readings of knowledge production practices in the STS in section 3.2, I sought to outline a non-essentialist philosophy in which no such divisions are taken to hold true prior to all else. As Mouritsen and Kreiner (2016) hint towards; if hope in a future guided by a rational understanding of past and present is possible, then it is possible through our iterative forgiving, forgetting, and re-formulating – knowing always that such frameworks of objectivity hold only so far as the material-discursive apparatus that we have constructed can be said to hold true. In this sense, the generalised performativity put forward in this chapter is defined by co-production and

iteration – rather than a thesis that can be strong or weak, or true or false, 'performative' or 'counter-performative', it is itself the perpetuity of doing, acting and becoming that makes manifest our material-discursive knowledge frameworks. As Barad (2014) clarifies – it is only by touching and interacting with (or more precisely intra-acting in) the world that we know the world, and in this moment both ourselves and the world are made anew.

It is therefore through and with this framework that I begin the 'performative' questioning of the accounting objects and practices in the following chapters of this thesis – in their 'iterative intra-active becoming; through their continually dynamic, vibrant, and agential processes of realisation' (Barad, 2007, pg.170). This has a number of conceptual consequences. In section 3.2 I introduced Barad's concept of *diffraction*, and, following Donna Harraway, *indeterminacy*, and *entanglement*; and then in section 3.3 I introduced some of the concepts borrowed directly from the ANT literature, and the work of Bruno Latour in particular, such as *translation*, *mediation*, *centres of calculation*, and *action at a distance.* Then, further to this, my (re)reading of the concept of performativity in the critical accounting literature demonstrated the potential for iterative material-discursive sensitivities in the analysis of inspection practices, technological change, and accountability relationships (Roberts, 2009; Scott and Orlikowski, 2012; Boll, 2014a), all of which have the potential to become part of a broader methodological program that refuses to separate out disciplinary processes of subjectification from processes of drift, translation, and agency. Bringing together the sociology of translation as the socio-discursive reproduction of *power* relations*,* on the one hand the *acting-on,* with the sociology of translation as the socio-material, agential, and creative consequences of networks of actors, the *action-of*. In this sense, unlike Callon (2007), rather than seeing the calculative agency as a consequence of socio-material framing and then seeing performativity of calculations as the consequence of calculative

agency, we are reversing the logic – we argue that it is through the iterative framing and reframing process that calculative agency is *performatively* constructed, and that each iteration in the construct is a dialectic of agency and structure, both of which can be simultaneously analysed by the researcher. And, importantly, that analysis of such constructs is not just an epistemological matter, it has ontological consequences (Barad, 2007) that are inseparably ethical and political in nature (Barad, 2007; Vosselman, 2014).

Chapter 4: Methodology and methods

In the previous chapters this thesis set out the research objectives relating to the transfer of public health activities into LAs in the aftermath of the HSCA 2012 (Chapter 1); the empirical 'gap' in the public sector accounting and organisations literature (Chapter 2); and then the theoretical and conceptual framework for the project (Chapter 3). The theoretical framework presented in Chapter 3 itself addressed a gap in the critical accounting theoretical literature by bringing together notions of subjectifying practices (Foucault, 1982) with notions of translation, drift, materiality, and agency (Latour, 2005), via an 'agential realist' framework suggested by Karen Barad (2007). In particular, this was through the focus on a generalised or posthumanist performativity in which material and discursive practices iterates new knowledge of newly constructed realities. This chapter aims to establish how such a framework can be put into practice and sets out the detailed design for the research project.

Agential realism, as discussed in Chapter 3, is not a theory of the world as it is, but rather a methodology through which we understand how the world is constructed through emergent processes, the properties of such processes, and how we then engage with the world through performative knowledge claims. The linkage of methodology with method, the abstract with the particular, is therefore of crucial importance in mobilising such a framework. One important implication is the rejection of either overt or implicit liberal positivist assumptions; rather than making neutral observations of the 'facts' as they are, we seek to understand, through intra-action, how such facts are produced, and what these facts, so established, 'do' in context. A variety of authors point to the conclusion that fully embedding ourselves in the assemblages of 'fact' construction, what Barad (2007) calls the material discursive apparatus, necessarily becomes an ethical, political (Butler, 2010; Vosselman,

2014), and ultimately ontological matter (Barad, 2007, pg.137). It is a task that requires the application of what Barad (2003, 2007, 2014) describes as a 'diffractive methodology'; a methodology in which reality is always (re)constructed 'through and with', and in which our analysis is always a *re*-engagement or *intra*-action with the phenomena or process under observation.

The practical consequences of this approach for the research design, choice of methods, and data analysis are several-fold. Firstly, there is added emphasis on the potential variety of material and discursive modes of enquiry into a range of human and non-human actors. Related to this, throughout the analysis of Public Health the movement of actors and the construction of the facts is regularly seen to transcend organisational boundaries. This produced an exploratory emphasis on 'following the actors' (Latour, 2005) so as to understand the fact construction process on its own terms rather than through preconceived taxonomies or categories (for example, with given organisational or professional boundaries), although these categories often also arise empirically from the data. Second, an emphasis on the performative iterations of discursive practices through and with material inscriptions, organisational context, legal frameworks, and so on. The 'facts', or the calculations or arguments that sought to establish the facts, were therefore followed in the back-and-forth of organisational life as far as possible. This drew the research towards specific examples that were then followed up through interviews, document analysis, and observations. Thirdly, following the data collection the agential realist framework demands a recognition that data analysis is a *re*-engagement rather than a neutral observation of reality 'as it is'. This required a re-assessment of coding as a practice, and a self-consciousness that the findings produced are produced through specific angles of analysis. As is the case with all scientific experiment,

different material-conceptual set-ups constructed to observe the same phenomena may well generate very different results.

This project therefore looks at how the 'value' of Public Health is constructed as a shared understanding of what matters, iteratively produced and reproduced through discursive, calculative, and material means. This leads to the broader understanding of how it is that value(s) are constructed in organisational contexts, and how constructing what is valued is deeply tied up with the iterative reconstruction of what is held to be true, taken for granted, or accepted. The reconstruction of values in organisational life through truth claims is therefore uncovered as the ethical-ontological basis of organisational knowledge practice in the case of Public Health activities. This is observed across much of the data generated in the context of Public Health activities in LAs in England, where Public Health professionals are seen as active knowledge makers; but also, iteratively, this is also true of the project itself, in which the researcher employs a material discursive apparatus to produce new findings that must themselves be understood in the context of the methodology employed. The question of coding and diffractive analysis is picked up in section 4.3, 'Cutting together-apart', and the together with the importance of a 'strong' reflexivity.

4.1 An agential realist approach to research design and research methods

In drawing on an agential realist framework Chpater 2 demonstrated how 'diffractive methodologies' could be mobilised in response to the paradoxes of positivist essentialism. Haraway's (1992, pg.304) notion of diffraction drew on the metaphor of diffraction as a classical property of waves in order to disrupt often essentialised social categories such as gender or race. This approach draws an emphasis towards the investigation of differences and interactions in often dynamic social and material spaces. Barad's articulation of

diffraction (Barad, 2014) and diffractive methodologies (Barad, 2007, pg.71) extend this discussion beyond metaphor to argue that all representations and associated knowledge claims are indeed diffractively produced, that truth claims are always produced through re-readings and difference, whether it be the physical image, inscriptions, or more complex material-discursive reproductions of ideas. In the overview to this chapter the duel consequence of this was suggested – firstly, in the analysis of Public Health practitioners as producers of knowledge, and second, at a further level of abstraction, for the researcher themselves as a re-producer of knowledge. This approach introduces the challenge of ensuring that the proposed methods are consistent with the broader framework, and do not re-introduce issues common in some social science text books that would imply the very presumptions under critique.

Under this framework interventions are seen as 'agential cuts' (Barad, 2007) that produce objectivities that hold true within the material-discursive apparatus of the experiment. The agential cuts made by Public Health practitioners include their methods, their theories, but as the analysis unfolds are seen to also depend on their social, material, and institutional surroundings. Similarly, the agential cuts of the project itself range from the multi-methods approach outlined in this chapter to the theoretical and conceptual framework outlined in Chapter 2; and, ultimately, arise out of the highly institutionalised context of a part time post graduate PhD project in the scholarly field of critical accounting.

Agential realism: implications for the research design

Chapter 2 discussed how Barad's agential realist framework was an extension to existing Foucauldian analysis (Barad, 2003; Barad, 2007), and to Butler's (1990) theorisation of performativity. It also introduced broader perspectives from the STS literature, and from feminist science studies, to place agential realism in context of debates over the materiality

of knowledge production in those fields. The conclusion reached was that the agential realist framework allowed for a sophisticated methodology, in which we were sensitive to arrangements of discursive practices through and with their material contexts across networks of human and nonhuman actors. The necessary consequences of this approach are such that the researcher must open the researched to key documents, texts, and reports; discursive and calculative practices; data collected beyond the traditional interview setting, such as observation and document analysis; awareness of physical location; and to the budgetary, legal, and institutional contexts in which knowledge practices are embedded.

In analysing the variety of such diverse data we borrow the concept of translation, which was introduced in Chapter 2 as having the double characteristic of translation as the reproduction of power relations and the alignment of networks of actors (Miller and Rose, 1990). In mapping out the material-discursive apparatus through which Public Health activities become established, and new knowledge forms are contested, the documents produced by Public Health professionals such as Public Health annual reports, strategic needs assessments, power points presentations, guidance documents, fact sheets, and many more, must be considered through these alternative perspectives.

This can be done by following the material-discursive strands of the Public Health agenda, as it unfolds, through the employment of several qualitative methods and the comparison of different sources. This is what is broadly described by Saunders et al. (2016, pg.166) as a 'multimethods' design that draws on multiple qualitative sources for its data. For example, the LA Public Health annual report may be discussed with the Director of Public Health in a semi-structured interview, the public presentation of the document at a Health and Wellbeing board meeting observed, and the document itself analysed. In the rest of the

chapter this will be referred to as 'triangulation', however, unlike some research methods text books for business and social science students this will not be with a view to improving the 'accuracy' of results by ensuring the convergence of difference sources (for example, Ghauri and Gronhaug, 2010, pg.212). A diffractive reading does not produce 'the same displaced' but rather reads alternative views through and with one another (Barad, 2014) so that we are not looking to establish the rights and wrongs of the data, but instead seek to critically understand how various perspectives contest the truth. Berg (2007, pg.8) reviews the methods literature and concludes that triangulation is good practice when seeking to establish the wider spheres of influence acting on those observed that can never be fully captured by one single method, while Saunders et al. (2016, pg.207) point out that rather than seeking to establish a single story interpretive researchers instead refer to triangulation as a means of adding depth and complexity to their findings. A diffractive methodology differs from interpretative applications of the term to the extent that it rejects the subject-object dualism from the outset. Similarly, drawing on the STS literature, while we reject a positivist view of the world 'as it is' that can be observed through neutral observer independent measurement, we remain interested in how objective statements are constructed in context, for whom, and for how long. To this extent, while positivist approaches fall short in essentialising and fetishizing objectivity, interpretative analysis that focus exclusively on the social construction can also fall short in explaining the strength or fragility of such knowledge claims in action. This dialectic was introduced in Chapter 2 as the 'paradox of objectivity', to which the diffractive methodology was presented as a synthesis.

Thus diffractive translation, as a re-reading 'through and with', together with an emphasis on 'following the actors' through the construction of the 'material-discursive apparatus' through which knowledge, and subsequent value claims, are produced leads the researcher towards

a multimethod design. The particular emphasis on the 'construction' and the 'following' of the actors also suggests an element of longitudinal design, where possible, and the triangulation of inscriptions through their creation and application, with reference to interview and observational data.

Agential realism: implications for the research methods

The following section (4.2) details the research design, and explains the particular lines drawn in defining the boundaries of the project. The design addresses the challenge of linking sufficient detail of the micro in the technical construction of the facts to the broader policy and organisational environment, the budgetary and calculative practices, and the discursive, ethical, and professional context. In doing so, the design draws on three main methods: semi-structured interviews, observations, and primary and secondary document analysis. These were supplemented through off the record discussions, feedback on initial findings from participants, and broader secondary research.

Much of the detailed data collection follows recognised qualitative research practice, particularly when conducting the primary interviews and observations. The interviews were semi-structured in nature, drawing on a detailed interview questionnaire that was designed following careful review of the relevant literatures (detailed in chapter 2) and consideration of the research questions. Following Saunders et al. (2016) these interviews varied in the order of the questioning, were informal in nature, and emphasised different elements or angles of interest depending on the interviewee's relative experience.

For a more in depth guide to doing interviews the project also drew on Kvale (1996 and 2007). The researcher needed to build a relationship with the participants, and, in particular, a legitimacy that the project was of value in framing the interview (Kvale, 1996,

pg.128). This was established early in the interview process, and drew on a detailed knowledge of Public Health reforms and the latest developments in the industry. Familiarity with the latest developments, mutual contacts, and understanding of local context also helped the conversations flow more smoothly. It was also important with many participants to emphasise that the project did not seek to establish the 'right' answers, but was more interested in the views and experiences of the participants with all data generated being anonymous in the final write up. This often helped generate richer data as participants then opened up in the more informal back and forth of the conversation. The questions were brief and simple, and encouraged the participants to explore the answer on their own terms (Kvale, 1996, pg.132). The quality of the interviews necessarily varied, but overall was rich and led to a high density of coded data.

A range of observations of different types were conducted, but again these drew, to varying degrees, on standard qualitative research methods. For the most part the observations detailed in section 4.2 were unstructured natural observations (Saunders et al., 2016, pg.354), particularly the observations of the public Health and Wellbeing boards. In some cases these observations were recorded, however, a number of unrecorded unstructured observations were also conducted which relied on field notes and supporting documents (such as agendas, reports, and so on). Notes were also made as far as possible on informal conversations, and on any feedback received from Public Health professionals when presenting findings at a number of conferences and networking events. One structured observation was also conducted as part of a conference on the future of Public Health hosted by the University of Birmingham in February 2016. This allowed the researcher to make specific prompts on the key issues faced by Public Health professionals and their expectations

for the future in relation to the key funding challenges laid out by the researcher and to then facilitate a discussion.

A crucial element in the diffractive methodology is in not separating the researcher from the researched, and in ensuring that view points are triangulated 'through and with' as far as possible. The combination of structured and unstructured observations, together with follow up interviews and documentary analysis therefore provided the starting point for a 'diffractive reading'. Central to this approach was to understand the embeddedness of the data in physical material context, and the networks of translation through and with material 'inscriptions'.

Inscription devices in this sense are documents, charts, webpages, or emails/letters (physically printed, visually presented, or shared electronically). They are viewed in these arrangements as 'mediators' (Latour, 2005, pg.38), and are, to varying degrees, products of professional discourses and disciplines that reproduce ways of knowing, framing, and categorising. These in turn become internalised and reproduced by other professionals, colleagues, and collaborators in arrangements of 'distributed governance' (Miller and Rose, 1990). But, equally, are assessed in their physicality as objects that make solid social links (Latour, 2005, pg.70), mobilise networks of interests, and actively re-shape LA activity towards the 'Public Health agenda'.

On textual data, Prior (2002, pg.39) explores the text as artefact detached from the 'meaning' intended by the author, made solid as an object ready for investigation. Both the product of discourses with their own history and genealogy, arising out of socially produced categorisations that establish a set of 'facts', and as moments of change as the inscription becomes a re-working, re-ordering, and re-naming emerging from new social situations. Thus,

Prior (2002) argues, documents are to be treated as objects of study in their own right, and we as researcher should seek to trace both the genealogy of the document as an object and the agency of the object as actor. Drawing on Foucault, Smith (1984) similarly emphasises the active nature of texts in her analysis of the job description as both arising from a broader discursive apparatus and as active mediator that becomes translated and internalised by users.

As well as understanding the disciplinary nature of texts as arising out of discursive practices, particular emphasis is also placed on the role of *calculations* that take on the particular property of driving change and new practice by re-interpreting broader frames in solving specific contextual problems (Vollmer, 2007). Indeed, the role of accounting, calculative practices, and inscriptions as enabling action at a distance (Miller and Rose 1990; Robson 1992), performative (Revellino and Mouritsen, 2015) or counter-performative (Asdal, 2011) effects, framing and re-framing (Skærbæk and Tryggestad, 2010; Vinnari and Skærbæk, 2014), across time and space have become a distinct theme in the critical accounting literature. The methodological focus in this project develops that trend by emphasising the iterative performativity of the material-discursive in which the disciplinary and reproductive powers of discourse are read through and with the performativity of objects, numbers, and public performances.

Thus, in researching *how* Public Health is re-constructed as an iteration of evaluations and identity it is necessary to cross reference or triangulate the data generated through different qualitative methods. The agential realist approach draws on a range of well known qualitative methods, but differs particularly in the combination of these methods and their analysis through and with one another on an equal footing in the analysis of objectivity

construction. In this case, this was the construction of the Public Health agenda and the contested *value* of the public's health and wellbeing. The following section details the research design in full (4.2) before moving on to further considerations for data analysis under the agential realist framework.

4.2 Research design and research methods

Initial design and construction of research objectives

During the initial design phase of the project, background research of historic public health reforms and previous public health acts were reviewed together with the HSCA 2012 and associated white paper (HM Government, 2010); government fact sheets from the Department of Health (2011 and 2013); along with briefing papers from the LGA (2014a and 2014b); the Nuffield Trust (2011); The King's Fund (2011), and PHE (Department of Health et al., 2013). An initial pilot interview was then conducted at a mid-sized unitary city council in the midlands in March 2015, with reference to an initial draft research questionnaire, which focused on the challenges faced by public health professionals in their new context, the construction of the 'facts' in their new organisational environment, and associated accountability mechanisms. The town was given the pseudonym 'Metro Town' in order to protect the identity of the participants involved. The initial interview was exploratory in nature and successfully led to further contacts within Metro Town.

Metro Town itself was selected as an interesting authority for study due to the particularly severe experiences of austerity that disproportionately affect city councils and metropolitan boroughs (Hastings et al., 2015). It was expected that the challenging environment would more profoundly bring out tensions of identity and organisational change as Public Health professionals sought to establish the 'Public Health agenda'. Such councils,

while facing disproportionately more severe austerity cuts to their managed budgets also experience disproportionately greater health, wealth, and educational inequality (Hastings et al., 2015). Thus the 'gap' between funding and need, and the associated challenge faced by public health professionals entering this environment, was especially pronounced. This choice reflects what Callon (1998) refers to as 'hot' situations in which investigators study knowledge frameworks in moments of change, and Latour's emphasis on studying moments of 'controversy' so as to understand how new social links are formed (Latour, 2005).

The initial pilot interview highlighted a range of interesting tensions faced by Public Health professionals between scientific or 'evidence based' knowledge practices against more experiential practices across the rest of the authority. It also brought out 'language' and 'cultural' issues; challenges created by the new budgetary structures and the initial ring fencing of the Public Health grant; and, particularly, evidence that Public Health networks extended well beyond any one organisation. Indeed, this first interview remained one of the richer interviews right through to the final analysis presented in Chapter 5 and gave good guidance as to what issues would be of interest for further study.

Access for the initial pilot interview itself came via a recommendation from a colleague at the University's of Birmingham's HSMC, and after completing the initial interview and discussing the project with the Public Health Consultant (pseudonym 'Emily') they gave a recommendation to the Director of Public Health at the authority, 'Joanna'. After an initial conversation and discussion of the research questions and ethical approvals for the project Joanna invited key members of her core team to provide further interviews, in what Saunders et al. (2019, pg.318) describe as 'snowballing'. While this approach does not generally give representative samples, in this case it led to a number of the core Public Health team being

interviewed along with the PHE advisor to the authority, all of whom were relatively senior consultants. This approach, together with primary observations of the HWBs, gave a strong indication of the core issues as they affected the case authority following the initial transfer.

Following these initial interviews and observations in Metro Town, building on existing links within the University of Birmingham's HSMC, the decision was taken to extend the project to a second authority, 'Midland City', a larger city authority in the same region. This second authority shared many of the same regional networking spaces as Metro Town, and PHE as the newly established national regulator. This triangulation between three differing contexts gave the study an overview of the intersections between national, regional, and local, together with depth in two specific localities of profound health inequality experiencing deep austerity cuts. It also allowed for the observation of certain spaces where these different contexts intersected, such as regional briefings, workshops, and conferences. This was thought to give a better overview of the multi-agency construction of value than could have been achieve via a case study of Metro Town alone.

Across the initial empirical literature the variability possible within and across the new Public Health system was noted, particularly due to the renewed emphasis on 'localism' underlying the HSCA 2012 (Brown et al. 2014; Phillips and Green, 2015) and the lack of 'statutory levers' available to regulators (NAO, 2014). In this study, it is the similarities between the case examples, together with the regional intersections through the PHE regional office, which made them of interest. Both case locations held clear Labour Party majorities among elected members, and while Midland City was significantly larger than Metro Town in terms of total revenue and expenditure, both had similar demographics and health challenges facing the broader population.

Drawing on this idea of micro similarities within and across a larger macro system, a further decision was made to build upon links with a large national accountancy firm. This provided some valuable data on the reforms, local government finance, and multi-agency work across the sector, as well as some interesting insights into the particular discourses employed by financial advisors to the industry. Contacts at PHE were recruited in a similar manner, with initial positive references from Metro Town and also via contacts made at the HSMC's thought leadership seminars. This led to a range of interviews with actors directly linked to my case authorities, for example the case authority advisors, to Health Economists in the PHE national office and other regional Directors of Public Health (see Figure 3., below).

Following the agential realist philosophy, and the extended conceptual vocabulary of STS discussed in Chapter 3, this was a highly explorative design that sought to follow the assemblage of actors; both discursive and material, human and non-human, in order to address the research objectives detailed below. At times this was 'opportunistic' while at other times there was scope for more strategic targeting of participants (for example the focus on non-Public Health actors in the second round of data collection; the follow up interviews with PHE health economists; and the focus on interviews with commissioners of Drug and Alcohol interventions in both case authorities).

The objectives detailed in Chapter 1. were refined following the initial pilot interview, and are presented below:

Research Objectives:

- To explore how the case for Public Health activities is contested and established in local authorities in England in the aftermath of the HSCA 2012.



To explore the evolution of new Public Health **identities** since the move to local authorities, and to describe the **performative processes** that construct these new identities.



To explore how the emerging **accounts of** Public Health activities are (re)constructed towards a 'Public Health agenda', and to describe the **performative processes** that construct these accounts.



To discuss the **ethical** and **political** dimensions of these valuation practices, with reference to critical public sector accounting literatures on 'post' New Public Management, 'intelligent accountability', and austerity.

These are constructed as one overarching research objective, with three specific subsidiary objectives. The three subsidiary objectives can in fact be seen as constructing 'Public Health' interventions in the broader sense through and with one another. That is – group structures, boundaries, and identities played a significant role in structuring the calculations, but, in turn, calculations were also seen to be influencing identities, boundaries, and legitimacies. In formulating these objectives, the link was made between broader knowledge making practices of the STS inspired theoretical literature and valuation practices implicit in mobilisation of the Public Health agenda as a specific knowledge framework via the coding (see section 4.3). There was therefore no 'research object' or 'unit of analysis', instead the objectives relate to the *emergence* of particular forms of valuation from broader networks. These practices established the value of 'Public Health' as a discipline and 'the public's health and wellbeing' as a domain of ethical-political consequence.

Similarly, no a priori assumptions were introduced as to whether certain element of the network 'came first', so that others followed in terms of the identities, accountabilities, calculations, inscriptions, or discursive practices, thus distinguishing the methodology from

contingency or (post)positivist approaches. Instead the focus was on the iterative emergence of new forms of valuation which were implied by, and themselves active in, the networks from which they emerged in an unfolding process with no identifiable beginning or end points. In the language of Latour, the study draws the map but does not confuse the map drawn with the landscape walked (Latour, 2005, pg.133).

Consequently, in interpreting these objectives an attempt was made to follow interesting examples of value construction through various methods that shared some similarities with traditional qualitative case study design, but also some important differences. On the one hand, the focus on two case authorities and PHE was certainly an example of a 'case study' design in the sense of 'in-depth, qualitative study of one or few illustrative examples' (Hagan, 2006, pg.240), however, the design did not fit well with the commonly accepted understanding that a case study design establishes the 'case' itself as the unit of analysis (Yin, 2003, Pg.21). It is not the intention of this study to put either of the two case authorities or PHE front and centre of the investigation as 'cases of', but rather to use them as context for the investigation of practices and processes that re-established public health activities following the HSCA 2012 reforms. Explicitly Public Health funded activities made up a relatively small proportion of the two case authorities, while the regional activities of PHE under investigation made up a small proportion of the activities of that organisation nationally, but taken together they make up an important part of a broader network that sought to establish Public Health activities.

The study therefore chooses the less contentious phrase 'case examples' to refer to the organisations from which the bulk of the interviews are drawn, but notes that some interviews draw beyond these organsations so as to gather alternative perspectives of

interest, while the observations of health and wellbeing boards were made up of participants from a wide range organisations, and in some cases the general public.

A multimethod, qualitative, and longitudinal design

Following the initial pilot interview in March 2015 a first round of interviews with consultants in Public Health within the Public Health teams in the two case authorities was planned; interviews with the local directors of Public Health within the two authorities; consultants working for the regional PHE office in an advisory capacity to the case authorities; and interviews with private sector financial consultants in the NHS and local government practice of a large national accounting firm. These were then supplemented by follow up observations, documentary access, and a second round of interviews through 2016 and 2017 that sought to both triangulate key themes and controversies, to gather more in depth data on calculative practices, and to gather perspectives from outside of the core Public Health functions within the two authorities.

In total, 27 semi-structured interviews (Kvale, 2007, pg.10) with 25 participants, including a follow-up interview with the Directors of Public Health in each of the case study locations were carried out, transcribed, and then coded in Nvivo. Following the outline laid out by Kvale (2007, pg.10) the semi-structured approach to interviewing allowed for both flexibility in exploring new angles of analysis while maintaining a certain level of consistency that allowed for depth and comparison at the analysis phase. These interviews lasted on average around 45 to 60 minutes each. 5 observations of Health and Wellbeing boards were conducted with detailed field notes and cross referencing to document packs circulated by the authorities. Both observations at MT were recorded following an announcement from the chair, although the quality of the recording only allowed for the first of the two meetings (July 2015) to be fully transcribed and coded. At MC the chair did not initially allow for the meeting

to be recorded, however, the third meeting (February 2017) was webcast online and access was granted to the recording, which was then subsequently transcribed and coded. The public Health and Wellbeing board meetings typically last 3 hours each.

Four sessions of the 2016 parliamentary inquiry were observed, with two of these sessions fully transcribed and coded. This was done following the observations of the video streams available from the Health and Social Care Committee website with a view to including the most relevant data. The interviews selected for coding made up a further 10 public contributions covering 154 questions of the inquiry, and included a number of key figures in the field who had been referenced in the data collection by participants, and several contacts including one of the Directors of Public Health who was also interviewed for this study. Off the record discussions were also health with senior PHE executives who contributed to this inquiry, providing further opportunity to contextualise the data of the inquiry.

Finally, document analysis of a range of primary and secondary documents, reports, and calculative devices was conducted including, for example, local survey results, social return on investment calculations, commissioning guidelines and reports was conducted. Notes were taken at one regional PHE workshop launching some of their calculative commissioning tools in the first round of data collection, then later in the study findings were fed back to participants via a regional conference, at a regional Directors of Public Health network meeting, and via a video conference with contacts in PHE.

Following the post-humanist approach, particular attention was paid to the active role of inscription devices, discursive practices, physical space, material resources, and accountability arrangements as an assemblage through which actors navigated and constituted themselves and each other. The detail of calculative practices was also crucial in

establishing how 'facts' and valuation practices were constructed, which allowed for a *triangulation of difference* between these constructions and the ethical-political dimensions explored in interviews and other empirical methods. Observations were then also important in order to observe how actors mobilised one another through interaction and performance, and so that power relations could more easily be observed. This gave the researcher useful insights into the real world activities of Public Health professionals, which in turn helped in developing interesting and relevant questions. Detailed notes on the physical locations contextualising the various interactions were made, and a questioning of the physical and material nature of agency alongside interview and documentary analysis was included throughout.

Figure 3. Timeline of primary data collection

Event / method	Participant pseudonym	Date	Employer / Role
Transfer of PH teams from PCTs to local authorities		**01/04/2013**	
Fully coded *pilot* interview	Emily	31/03/2015	PH Consultant / MT
PHE regional Alcohol & Drugs Value for Money workshop / observation		03/06/2015	PHE
Midland City HWB / Observation		30/06/2015	MC
Metro Town HWB / Observation		29/07/2015	MT
Fully coded interview	Mike	06/08/2015	Partner / AF
Fully coded interview	Harvey	06/08/2015	Partner / AF
Fully coded interview	Paula	26/08/2015	PH Advisor / PHE
Fully coded interview	Steven	01/09/2015	Partner / AF
Fully coded interview	Elizabeth	02/09/2015	PH Advisor / PHE
Fully coded interview	John	04/09/2015	Partner /AF
Fully coded interview	Alan	12/11/2015	DPH / MC

Fully coded interview	Jane	24/11/2015	50:50 PH & EH / MC
Fully coded interview	Joanna	03/12/2015	DPH / MT
Fully coded interview	Matthew	03/12/2015	PH Consultant / MC
Fully coded interview	Adam	11/12/2015	PH Consultant / MC
Fully coded interview	Rodrigo	08/01/2016	PH Consultant / MC
First session of parliamentary inquiry / observation		09/02/2016	
Public Health workshop / feedback on findings		11/02/2016	University of Birmingham
Second session of parliamentary inquiry / *fully coded* observation		01/03/2016	All contributions from 6 witnesses were fully coded, which included the DPH from MT
Third session of parliamentary inquiry / observation		24/05/2016	
Fully coded interview	Penelope	01/06/2016	PH Consultant / MT
Fully coded interview	Janet	01/06/2016	Commissioner / MT
Fourth session of parliamentary inquiry / *fully coded* observation		07/06/2016	All 4 contributions from the first sitting were fully coded which included senior executives of PHE
Video conference with PHE executives / observation and field notes		19/09/2016	PHE
Metro Town HWB / Observation		19/10/2016	MT
Fully coded interview	Barbara	20/10/2016	CEO / Local Charity
Fully coded interview	Suzanna	03/11/2016	PHE Economist
Fully coded interview	Rosanna	04/11/2016	PHE Regional Director
Fully coded interview	Leon	11/11/2016	Policy Director / MC
Fully coded interview	Mandy	25/11/2016	PHE Regional Director
Midland City HWB / Observation		29/11/2016	MC
Fully coded interview	Joanna	06/12/2016	DPH / MT
Fully coded interview	Gerry	06/12/2016	Strategic Finance MT
Fully coded interview	Paul	08/12/2016	Finance Team / MC
Fully coded interview	Vicky	13/12/2016	PHE Economist

Fully coded interview	Alan	13/12/2016	DPH /MC
Regional meeting of DPHs / feedback on findings		17/02/2017	PHE
Midland City HWB / Observation		31/02/2017	MC
Fully coded interview	Aanika	21/06/2017	Lecturer, Occupational Health, Safety and Environment, University
Fully coded interview	Frank	27/07/2017	Deputy Programme Director for MPH (IAHR), Research Fellow in Public Health, University

The above timeline also documents some of the difficulties and challenges encountered along the way. Following the initial pilot interview in March 2015 access was a major challenge and a level of trust and legitimacy needed to be established in the eyes of the participants. This was a somewhat slower process in Metro Town (MT), where, following a pilot interview that was secured via a mutual contact, an interview with the Director of Public Health (DPH) was secured several months later after attending a Health and Wellbeing public meeting. In MT the initial gateway contact, following the pilot interview and the public meeting, was the elected member for Health and Wellbeing who did not themselves agree to be interviewed, but instead spoke to the researcher off the record to understand the scope of the project. By contrast, in Midland City (MC), the DPH was approached as a University alumnus and quickly agreed to circulate an invite across his team. The contacts at MT and MC also led to the two PHE consultant advisors supporting the two authorities agreeing to contribute to the project, which then opened further avenues for distribution of initial results and participant feedback. This first round of data collection also included four interviews with senior partners in a national accountancy firm with expertise in their public sector advisory practice, particularly NHS and local government. These advisors were recruited in a similar manner, with an

exploratory email being sent to an existing contact who again helped recruit other potential volunteers within that organisation, with a particular focus on senior volunteers from their advisory and consultancy service. These interviews generated interesting early phase data on the importance of value for money, budgetary practices, and austerity in the public sector, and contextualised some of the key challenges facing Public Health professionals following the reforms of the HSCA 2012.

In mid-2016, following the results of the parliamentary inquiry into the Public Health Reforms and the publication of their report in July, the decision was taken to conduct a second round of data collection with a view to broadening out beyond the core team of Public Health consultants and PHE advisors. This was in order to understand the perception of the Public Health activities from the perspective of participants outside the discipline itself with whom Public Health practitioners worked with across the authorities; for example, the interviews with strategic finance and policy contacts in each authority and the CEO of a local charity. The second round interviews also included two interviews with PHE health economists, which were conducted in order to trace the calculative practices back to their source and to triangulate against the discussions observed in the regional PHE workshop in 2015.

Lastly, in 2017, in order to link to education and reproduction of the profession itself two interviews with educators at a local University were conducted, both of whom had strong links with the case authorities through graduate employment schemes. The interviews with educators in particular was supplemented at that point by interviews with more senior directors in PHE and notes taken from the regional meeting of DPHs. These interviews in the latter part of the data collection period gave a strong insight on the changing nature of Public Health as a discipline and a high level reflection on the transfer to the LA context in light of

the findings of the parliamentary inquiry. Two further off the record discussions were also held with a chief operating officer at PHE during and following the second round of data collection, the second in July 2018, together with analysis of briefing notes and power point slides obtained following the discussions with the PHE executives. In particular, detailed feedback on a 14,000 word conference draft of the paper 'Public Health in English local authorities; Constructing the facts, (re)imagining the future' was received from one of the chief operating officers of PHE in these follow up discussions, which fed into the final discussion chapter of the thesis.

This design gave the project a significant longitudinal dimension. The intention was to 'follow' the 'emergence' of Public Health activities in their new context, and observe the aftermath of a major 'shock', after which new social links can be formed (Latour, 2005, pg.21). In December 2016 two follow up interviews were also conducted with the DPHs in each authority, which allowed the researcher to ask explicit questions on the change and development in the organisations since the first round of interviews. In total, the primary data collection spanned more than two and a half years, with discussion and feedback continuing three years on from the initial pilot interview and HWB observations.

Summary of documentary analysis

Across the study a range of crucial documents were gathered, usually via direct reference either in interviews or observations. In particular it was possible to obtain the minutes and document packs for all Health and Wellbeing boards observed, and indeed, the packs for the meetings not observed in the interim. These minutes provided a useful timeline for events at the two case authorities. A second source of documentary data was through the PHE contacts, starting with the slides and commissioning tools presented during the PHE regional workshop on the value of drug and alcohol interventions. These were followed up subsequently with

interviews with the health economists who had put the tools together and the local drug and alcohol commissioners at the case authorities, with some further commissioning documents obtained from MT. Finally, several useful documents were obtained at PHE presentations at regional conferences and at a video conference held with the PHE executive, which gave insights into the high level challenges facing PHE as the regulatory body.

Secondary analysis of publically available documentation was also useful in providing context for the case authorities, and for cross referencing to the primary data collection. Some of the most useful secondary documents included the annual reports for the case authorities; the Public Health annual reports produced by the Public Health teams and presented to the Health and Wellbeing Boards; statutory Joint Strategic Needs Assessments; PHE outcomes frameworks; and other strategic reports and business plans. In total, more than 50 secondary documents were reviewed and are detailed in the appendix.

Figure 4. Summary of primary and case documents analysed

Summary of primary documents (not in the public domain)	Date	Author	Document citation reference
001 MT Signed core offer document	01-Jun-14	MT DPH (Joanna), CCG Chief clinical offer, MT Strategic director	(MT 001, 2014)
002 Alcohol & drug VFM programme update (signed letter)	04-Feb-15	PHE (Alcohol, Drugs and tobacco division)	(PHE 002, 2015)
003 Cost calculator presentation (power point)	01-Jun-15	PHE (Vicky)	(PHE 003, 2015)
004 Intelligence briefing: Personal Social Services Survey of Adult Carer's 2014/15	30-Dec-15	MT PH intelligence team	(MT 004, 2015)
005 MT Commissioning peer review self-assessment	01-Jan-16	MT	(MT 005, 2016)
006 Being in local government 2020 (power point)	29-Feb-16	PHE Deputy chief operating officer	(PHE 006, 2016)

007 Interpretation of the ring fenced grant conditions (confidential)	31-Aug-16	PHE and the Association of Directors of Public Health	(PHE 007, 2016)
008 Addressing wicked problems (power point)	01-Sep-16	PHE (Deputy director for health improvement)	(PHE 008, 2016)
009 Sharing Learning: University of Birmingham and PHE	19-Sep-16	PHE	(PHE 009, 2016)
010 Drugs and Alcohol Peer Challenge Session	21-Oct-16	PHE, Learning for Public Health, & Association of Directors of PH	(PHE 010, 2016)
011 Public health outcomes MC	May-17	PHE	(PHE 011, 2017)
012 Public Health outcomes MT	May-17	PHE	(PHE 012, 2017)
013 WORKING DRAFT FOR DISCUSSION: Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups	No date	DH	(DH 013, n.d.)
014 Drugs and Alcohol Peer Challenge Session self-assessment	No date	MT	(MT 014, n.d.)
015 MT PH Effective Commissioning Strategy 2014-2019	No date	MT	(MT 015, n.d.)
016 MT guidance on qualitative research methods	No date	MT PH intelligence team	(MT 016, n.d.)
017 Families drug and alcohol SROI tool	2016/17	PHE	(PHE 017, 2016)
018 Midland City Charity - KPIs on commissioned services	2016/17	MC Charity and PH in MC	(MC 018, 2016)

*A summary of the anonymised primary and secondary case authority documents is summarised in 'Appendix 2: Primary and case authority documents'.

In order to address the objective of analysing the performative nature of knowledge construction and valuation practices around the Public Health agenda it was important to follow the process of calculation and inscription and to link these documents to the interview and observation data so as to understand them in their *intra-action* in the network. PHE's national outcomes framework, for example, contained well over 200 separate indicators,

disaggregated at the LA level, which were then discussed with participants and coded when discussed as part of the parliamentary inquiry. Similarly, locally produced survey data, commissioning documents, and strategic documents were often cross referenced to their presentation in Health and Wellbeing boards and in some cases discussed in follow up interviews. This was the case, for example, with the MT Public Health Annual report presented at the Health and Wellbeing board observed on the 29 July 2015.

Constructing the facts: A detailed look at Drug and Alcohol interventions

Given the exploratory nature of the study and the breadth of the Public Health remit, covering 6 prescribed areas of Public Health as a condition of grant, and a further 12 non-prescribed areas of discretionary spend, the further decision was taken to pay particular attention to drug and alcohol throughout the data collection period. This provided for greater depth of analysis through cross referencing between observations, interviews with drug and alcohol specialists, and specific commissioning processes and calculative devices.

In part this was due to early leads, which included noting that both case authorities had undergone a major re-tender of their drug and alcohol commissioned services after the transfer in 2013, and early access to PHE's drug and alcohol value for money workshop in June 2015. It was also chosen as it represented one of the most significant areas of Public Health spend nationally, with drug and alcohol interventions, according to the DCLG's revenue account statistics for 2017/18 (King's Fund, 2017b), accounting for £716m of the total spend in England. This meant that it was a sufficiently large area for triangulation between national and local participants, and that the researcher was able to conduct interviews with drug and alcohol specialists in each authority and in PHE.

The above design gave the opportunity to analyse a network at many different levels by tracing interactions between micro and macro elements; by tracing the dialectic of accountability and agency; and by triangulating the data gathered from observation, interview, document analysis, and other secondary sources. This was especially important in the context of the agential realist methodology that sought to move beyond anthropocentric qualitative techniques, but, on the other hand, created serious challenges as to where to draw the boundaries around the project. One solution to this had been the initial selection of two 'case example' authorities so as to give specific context to the overall analysis, but even this risked generating far more data than could have been processed. A further decision was therefore taken to focus in on Drug and Alcohol interventions in more depth in order to follow specific calculations through their construction. This was facilitated by attendance at PHE's regional Drug and Alcohol Value for Money Workshop early in the project.

This created a specific sub set in the data collected with contacts working primarily as commissioners of drug and alcohol services, or professionals working in PHE on the national drug and alcohol agenda. This angle was also cross referenced in interviews with the DPHs and in Health and Wellbeing boards and other documents such as the overarching PHE outcomes frameworks or Public Health annual reports.

Figure 5. Primary data collected in relation to Drug and Alcohol interventions

Event / method	Participant pseudonym	Date	Employer / Role
PHE regional Alcohol & Drugs Value for Money workshop / observation	Led by Vicky from PHE	03/06/2015	PHE workshop
Fully coded interview	Rodrigo	08/01/2016	PH Consultant – drug and alcohol commissioner / MC
Fully coded interview	Janet	01/06/2016	PH Consultant – drug and alcohol commissioner / MT

Fully coded interview	Suzanna	03/11/2016	PHE Economist
Fully coded interview	Vicky	13/12/2016	PHE Economist
Summary of primary documents (not in the public domain)	**Date**	**Author**	**Summary of primary documents (not in the public domain)**
002 Alcohol & drug VFM programme update (signed letter)	04-Feb-15	PHE (Alcohol, Drugs and tobacco division)	Alcohol & drug VFM programme update (signed letter)
003 Cost calculator presentation (power point)	01-Jun-15	PHE (Vicky)	Cost calculator presentation (power point)
005 MT Commissioning peer review self-assessment	01-Jan-16	MT	MT Commissioning peer review self-assessment
010 Drugs and Alcohol Peer Challenge Session	21-Oct-16	PHE	Learning for Public Health, & Association of Directors of PH
014 Drugs and Alcohol Peer Challenge Session self-assessment	No date	MT	Learning for Public Health, & Association of Directors of PH
017 Families drug and alcohol SROI tool	2016/17	PHE	SROI tool for commissioners

Research Ethics

In line with the University of Birmingham's ethical guidelines all primary data will be securely held, with participant names coded as per Figure 3. and references that could identify individuals or their institutions removed from the thesis and any publications arising from this project. The project is considered relatively low risk, with participants all professionals, senior managers, consultants, or other experienced public servants. The majority of participants were also themselves familiar with qualitative research methods as part of their professional training.

The main ethical consideration was in ensuring that all data remained confidential and that no references that could identify individuals to line managers are included in materials

published or shared with third parties (for example with reviewers). Similarly, no disclosure was made to participants about who other participants in the project were with the exception of one interview with two participants, which was agreed in advance, and the HWB observations. On this basis, informed consent was obtained prior to the interviews using a signed informed consent form that included a full outline of the project, an outline of how data would be stored, and detail on how to withdraw from the study as per the University of Birmingham and the ESRCs ethical framework. For the observations of the Metro Town HWB public meetings the chair of the meeting read out the ethical considerations and the option to withdraw at the start of the meeting, while at Midland City I was invited to attend and then make use of the public recording of the session that was subsequently released online. No participants have withdrawn at the time of writing.

4.3 Cutting together-apart: the construction of diffractive codes

The particular challenge presented by the diffractive methodology is in the double resistance to each side of the often taken for granted subject-object dualism. We must resist the simple explanation of 'reality as it is' that resolves to deductively prove or disprove hypothesis, or, alternatively, that builds up theory inductively out of codes like so many Lego bricks, while also resisting an unsatisfactory ontological relativism of the subjective that holds the social, human, or the discursive apart from the natural, the solid, or the scientific. This impacts on the analysis and coding process as it becomes crucial that coding is not the imposition of categories, or an attempt to explain the data through the presentation of categories as if they were fixed and absolute. In this spirit an attempt at 'diffractive coding' was used in which the coding categories were not as mutually exclusive boundaries but instead lenses of

observation – a sorting of the data into subsets that would be of particular interest from particular analytical perspectives.

The decision was to systematically code all of the interviews and recorded observations using Nvivo, which differs from a number of ANT inspired studies in the accounting literature (for example, Justesen and Skærbæk, 2010; Vinnari and Skærbæk, 2014). In the ANT literature the controversy over 'symmetry' and 'inclusion' (McLean and Hassard, 2004) often leads to conclusions that representational accounts, through coding, are inherently problematic; that to ensure that practice precedes reality (Law, 2004) or that researchers are not indulging in an obfuscation of their own data, in which we replace the language of our participants with our own preconceived theories (Latour, 2005, pg.49) it may be better not to code at all. While this study has chosen to code its qualitative data, the diffractive approach tries to resist these critiques. Codes in which hypothesis are proved or disproved, or, then again, following grounded theory, separable codes that reveal underlying social mechanisms that are iteratively revealed (Glaser and Strauss, 1967) are likewise resisted. The diffractive approach follows Barad's (2012) notion of theorising through touching, with coding therefore seen as a material engagement through which directions of analysis are entangled, and through which conclusions are drawn that are themselves ethical-political (re)engagements in ongoing processes of knowledge construction. This in turn emphasises the importance of a strong practice of reflexivity and discussion of the embeddedness of one's own engagement with the data.

The codes themselves were thus constructed on three levels; the first produced the double analysis of power relations and specific accountabilities on the one hand, and then the agency, mobilisation, translation, and drift on the other. Within the primary power-agency

codes specific practices, discursive strategies, material and calculative devices, etcetera, were drawn out of the data, creating a very broad cross section of interest for further in depth analysis. Two further rounds of analysis then created further subsets of data that were of interest from more particular angles of analysis, for example, power relations were divided specific accountability practices, budgetary arrangements, statutory levers, professional identity, and so on. With each of these specific themes were then generated such as the strong emphasis among Public Health professionals on the 'evidence base', the commitment to 'statutory' accountabilities in the LA, the importance of maintaining the ring fenced Public Health grant, and so on. All the time recognising that each angle of analysis would be entangled with others in the final analysis, and ensuring that where the data showed relevance to multiple angles of analysis the coding was 'thick' (Saunders et al., 2019, pg.196) across multiple codes.

Once constructed, in analysing the codes it was then crucial to remain true to Barad's (2014) fluid understanding of diffraction as a re-construction or re-making through particular material-discursive apparatus. This was taken to mean a strong approach to reflexivity in which multiple angles of analysis are read through and with one another. A summary of this coding as per the Nvivo file is provided below (Figures). Within the third 'layer' of codes there remain a significant amount of data, partly because of the diffractive approach that allowed data to bleed across categories – within this third layer themes were pulled out manually as part of the initial write up Chapter 5, particularly in relation to the construction of groups and establishing of the public health function in their new context, and then re-examined for Chapter 6 in relation to professional identity and constructing the facts. It was also possible to annotate the files within each of the codes and to include tags in relation to specific sub-themes, for example Drug and Alcohol interventions. As can be seen, a further high level code

was created for the initial transfer from the NHS, which helps set the scene in the opening part of Chapter 5:

Figure 6. Overall coding structure for interviews, observations, and parliamentary enquiry

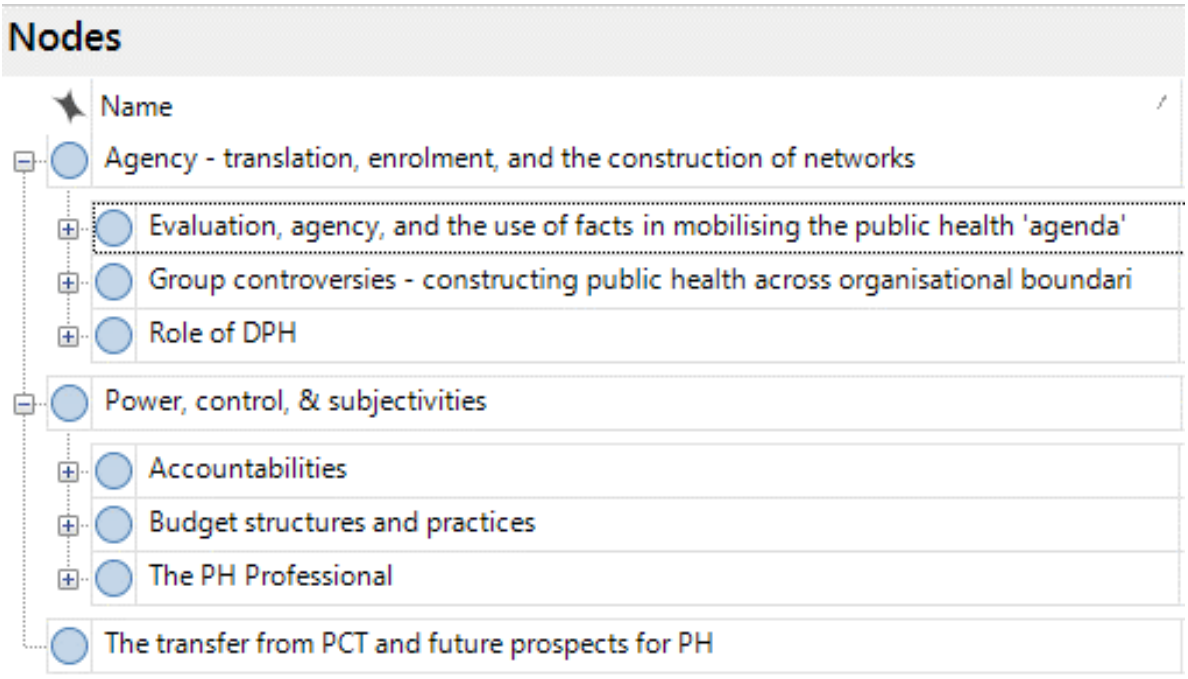


Figure 7. Summary of third layer coding, with number of sources and references by code

Nodes

Name	Files	References
Agency - translation, enrolment, and the construction of networks	0	0
Evaluation, agency, and the use of facts in mobilising the public health 'agenda'	0	0
Agency, mobilisation, and construction of narratives	29	311
Case example - drug and alcohol	13	34
Constructing the 'facts'	30	289
HWB mobilising key actors	20	60
Inscription devices and specific calculations	23	96
Group controversies - constructing public health across organisational boundar	0	0
Networks across (other) boundaries (inc STPs & CAs)	25	206
Networks across CCG boundaries	24	87
Networks across directorate boundaries	23	130
Networks across NHS England & NHS provider boundaries	19	70
Networks across Public Health England boundaries	24	173
Role of DPH	0	0
Character dynamics - Identity, egoism, and personality	8	16
DPH as a key actor	24	88
Mobilisation of inscription devices, calculations, and 'the facts'	8	19
Social skills, social links, and language used	14	31

Name	Files	References
Power, control, & subjectivities	0	0
Accountabilities	0	0
HWB holding PH to account	19	41
Internal accountability and appraisal PHE	5	15
Internal accountability and appriasal LAs	9	19
Localism and devolution	19	73
Political (and public) accountability	0	0
Purchaser provider accountability and scrutiny	26	146
Statutory powers and statutory accountability	28	94
Budget structures and practices	0	0
Austerity and funding formula	27	231
Boundary drawing and removal of ring fence	28	145
Budgets coming directly into PH control	20	52
Time horizons	19	57
The PH Professional	0	0
(Re)defining public health	26	195
Ethics and identity	25	223
Fragmentation and difference within the profession	13	60
Skill sets and expertise	25	93

While Barad (2007, pg.86-88) argues against 'reflexivity' as being itself opposed to diffractive methodologies, drawing on metaphors of reflection and 'stepping out of ones self', this project agrees with Hollin et al.'s (2017) analysis that Barad's critique of reflexivity does not do justice to the heterogeneous uses of the term across the STS literature. Barad's critique of reflexivity is perhaps best characterised as a critique of what Harding (1991) refers to as 'weak' reflexivity in which the practice is used in the (post)positivist sense of removing bias, standing at a critical distance, and removing oneself from the data as much as possible. However, referring instead to a 'strong' notion of reflexivity as the extension of what Harding refers to as 'strong objectivity' (Harding, 1991) is very much in line with the approach suggested by Barad's (2007) diffractive methodology.

For Harding (1991) all knowledge is situated, including scientific knowledge, but this can be understood without embracing epistemological relativism. Similarly, a sort of judgemental relativism is not the only alternative. She argues that a stronger objectivity is possible by grounding research in people's lives and lived experiences, and a critical analysis of context, background, discourse, and all the social variables through which scientific knowledge arises. Her notion of strong objectivity, similarly to Barad (2007), thus puts the subject in the same causal plane as the object of their enquiry in a reciprocal dynamic relationship. Strong reflexivity, by extension, is then the reflective analysis of one's own social, theoretical, and ethical stand point when constructing and interpreting the data. It is therefore in this sense that the diffractive methodology is described as 'reflexive', which is picked up in the closing chapter of the thesis.

Chapter 5 Part 1: The transfer of Public Health activities into local government

This chapter gives an overview of the two case authorities, Metro Town and Midland City, and the stories and challenges facing Public Health professionals and practitioners in the years immediately following the transfer of Public Health into local government in April 2013. The chapter presents an outline of the HSCA 2012 reforms and key guidance documents before moving on to an analysis of the key intersections of accountabilities, inscriptions, and networked practices in 'making the case' for Public Health. These stories introduce a number of themes around the role of discursive and calculative practices in constructing a shared public health agenda; the importance of statutory and budgetary arrangements; and the challenges to professional and ethical identity in the face of deepening austerity. These themes, and how they play out through and with accounting and budgetary practices, are then further explored with reference to the literature review and conceptual framework in Chapters 6 and 7.

Part 1 of the chapter details the reforms and key national documents (5.1) from the Department of Health, Public Health England (PHE), Local Government Association (LGA), the Faculty of Public Health and others in order to identify material-discursive signifiers and practices, and to set the context of the subsequent analysis. It moves on to a review of the case authorities, spaces, and evolving networks (5.2), then presents the main themes emerging from the interviews and observations immediately after the transfer as Public Health professionals encountered a drastically new organisational and statutory environment. In Part 2, the chapter develops this discussion through the second round of data collection and builds towards an analysis of the growing austerity measures in relation to public health (5.3), highlighting future developments and controversies that remain

unresolved in the system. Finally, the chapter presents an overview of multi-agency practices that have developed since the HSCA 2012 in response to system fragmentation and austerity, in particular the Better Care fund, Sustainability and Transformation Plans, and the regional combined authority.

5.1 Analysis and review of the Public health reforms in England and associated government and industry level guidance

During the initial design phase of the project, background research of historic public health reforms and the previous public health acts were reviewed, together with the HSCA 2012 and the associated government White Paper (HM Government, 2010). Responses to the government's consultation on the new Public Health arrangements from industry bodies were reviewed (Nuffield Trust , 2011; The King's Fund, 2011), together with initial government fact sheets from the Department of Health (2011 and 2013), and briefing papers from PHE (Department of Health et al., 2013) and the LGA (2014a and 2014b). These were briefly summarised in the opening sections of the literature review presented in Chapter 2 (section 2.2) as laying out the statutory arrangements, the duties and responsibilities of Directors of Public Health, the new arrangements for Health and Wellbeing Boards, the establishment of PHE, and the new reporting and accountability arrangements associated with the new ring fenced Public Health grant. The purpose of this section is to review these documents with a view to highlighting key discursive practices and the important structural arrangements relevant to the analysis of public health activities as practitioners 'make the case' in subsequent sections of the analysis. The themes from these documents are then triangulated (Berg, 2007, pg.8; Saunders et al., 2016, pg.207) with primary data through the remaining analysis.

The government's vision for Public Health

The foreword to the 'Healthy Lives, Healthy people' White Paper, written by the Secretary of State for Health (HM Government, 2010), outlines the wider political vision that contextualised the HSCA 2012 legislation. The 'freedom' to innovate without 'Whitehall diktat and nannying' are indicative of references to 'localism' and 'the big society' throughout the White Paper (Ibid.) and other documents issued by the Department of Health (Department of Health, 2011 and 2013). In the case of local Public Health activities, this was to be achieved by bringing 'well resourced' and ring-fenced Public Health budgets into LAs who would then have the 'freedom' to choose how to spend the grant locally in order to achieve outcomes against a new national outcomes framework to be drafted by PHE in consultation with the profession. The new freedoms were to allow greater control over commissioning and third sector engagement (HM Government, 2010), while the government guidance notes (Department of Health, 2011 and 2013) lay out the areas of Public Health that will be mandated by statute along with a new duty to provide expert support to CCGs in their commissioning decisions. The White Paper outlines how a baselining exercise to establish existing spend in PCTs will be used as the basis for spend in LAs and suggests that the independent Advisory Committee on Resource Allocation (ACRA) will then be tasked with reviewing the fairness of these initial allocations in subsequent years. The White Paper initially estimates this spend as £4 billion per annum (HM Government, 2010), although the actual transfer following the 2011 baselining exercise came to a final figure of £2.7 billion for the 2013/14 financial year (NAO, 2014). The government documents emphasise the cost effectiveness of preventative investment and propose that positive improvement against

outcomes will be rewarded via a new 'Health Premium' scheme, which is to be managed by a new Health Premium advisory group[8].

The scale and importance of Public Health intervention was further emphasised in the Government's 'Localising the Public Health responsibility deal' document (Department of Health et al., 2013), in which the detailed costs to the public purse, together with statistics on premature deaths, and avoidable hospital appointments, are mobilised to encourage LAs to take local 'responsibility' and 'leadership' for health and wellbeing. Similarly, the 'Wellbeing – why it matters' briefing paper (Department of Health, 2014) develops the Marmot (2010) arguments in a highly visual slide show format to demonstrate how acute problems are embedded in wider issues of social inequality and wellbeing. All of these initial documents from the government and the Department of Health can be seen as attempts to enrol and mobilise LAs towards taking ownership of the 'problem' of poor health and to adopt the latest thinking from the Public Health profession detailed in the Marmot review (2010).

The White Paper and initial factsheets (HM Government, 2010; Department of Health, 2011) do indeed draw heavily on the Marmot review (2010) in stating the case for preventative action through integrated partnership working, 'making every contact count', and taking a 'full life course approach' following the 'starting well', 'developing well', 'living

[8] Following the 2012/13 baselining exercise, a funding formula for the ring-fenced Public health grant was developed so that funding could be linked on a per capita basis to indices of mortality (Department of Health, 2015). The HSCA 2012 reforms tasked ACRA with reviewing the basis of the grant allocation and transitioning from the baseline spend to a national funding formula. The initial ACRA formula proposed a weighting towards areas of deprivation via a standardised mortality ratio and adjusted for other available data on market forces, gender, and lifestyle, with the formula put out to consultation and revised in 2016/17 (Department of Health, 2015). However the use of a simple standardised mortality ratio rather than a more comprehensive index of multiple deprivation was criticised by participants in the health select committee (HSC, 01/03/2016) as benefiting wealthier councils at the expense of those with greater need. As a result the proposed transition in 2015/16 did not take place and the cuts to the national public health grant were applied as a % reduction to pre-existing spend. Similarly, the lack of investment in the Health Premium scheme proposed in the HSCA 2012 reforms meant it had little practical effect in 'incentivising' local health improvement. When discussed with participants they pointed to the very low level of funding available through the scheme, which came to just £5m for England, less than 0.2% of the national budget (Department of Health and PHE, 2014).

well', 'working well', and 'aging well' framework. The analysis of the White Paper follows the Marmot review (2010) in drawing attention to broader 'wellbeing' as well as 'health' in a key discursive shift. This continues into the terms of reference of 'Health and Wellbeing Boards' and many of PHE's outcomes under their new outcomes framework. In referencing wellbeing, the documents also draw on Marmot's (2010) concept of 'proportionate universalism', under which we recognise the significant health inequality across income deprivation levels for both life expectancy and disability free life years. 'Health in all policies' and the Marmot recommendations continue to be important reference points in the new system with Sir Michael Marmot later writing the preface for the LGA's 'Health in all policies: a manual for local government' (LGA, 2016) and being invited to give evidence at the opening session of the 2016 inquiry into the new Public Health system. Marmot (2010) is therefore very much at the centre of the rhetoric of these reforms within a wider political narrative of bringing Public Health 'home', 'democratising Public Health', 'putting local communities at the heart of Public Health', and providing local government with the 'freedom to innovate' (HM Government, 2010; Department of Health, 2011).

Some concerns were raised in the initial consultations to the White Paper by the Nuffield Trust on the need for robust accounting and governance arrangements to cover the new Public Health grant in a context of local government austerity (Nuffield Trust, 2011), while the King's Fund questioned the logic of the transfer at a time of 'severe budgetary pressure' and major organisational change in the NHS (The King's Fund, 2011). They also highlight what would become a key theme in the initial data collection that the new system creates an entirely new set of fragmented accountability arrangements for practitioners to navigate, and that these arrangements could continue to drive a service based rather than 'outcomes focused' approach to Public Health (Ibid.). Broadly, however, the increased aspects

of democracy were welcomed at the initial consultation stage (Nuffield Trust, 2011; The King's Fund, 2011), as was the opportunity to bring in Marmot principles of 'health in all policies' (Buck and Gregory, 2013; LGA, 2014a; LGA, 2014b) and the full 'life course approach' (Nuffield Trust, 2011) into local government.

Local 'leadership' and the role of the Directors of Public Health (DsPH)

In outlining the new 'freedoms' provided to local government the HSCA 2012 reforms place particular emphasis on the role of DsPH as a key leader and advocate within the new system (HM Government, 2010). The Department of Health (2011) go on to describe how the new system will 'rely heavily' on DsPH who will be responsible for overall progress against PHE's outcomes framework, will be required to produce a Public Health annual report, and should be a leading officer in the authority who reports directly to the authority Chief Executive. The DsPH will have budgetary responsibility for the new ring fenced Public Health grant and will be required to sign off annual expenditure, confirming that the conditions of the grant have been fulfilled so that mandatory service requirements over sexual health, the national child measurement program, NHS health checks, and core offer to CCGs have been met, and that remaining monies have been spent in line with PHE's objectives. They will also oversee the 'scrutiny and challenge' function requiring them to ensure that services commissioned back to the NHS are delivering value for money (HM Government, 2010).

The statutory guidance on the responsibilities of DsPH are further laid out in the Department of Health's 'Roles, responsibilities, and context' document (Department of Health, 2013), which outlines the role of the DsPH as an active member of the new Health and Wellbeing 'partnership' Boards (HWBs) and as contributing to the development of annual Joint Strategic Needs Assessments and Joint Health and Wellbeing strategies. This places them in an important strategic role in the authority that extends beyond their core budgetary

and line management responsibility. The new HWBs were set up as partnership boards through which the strategic priorities for the council would be worked out in collaboration with CCGs, representatives from across the local health and care system, and key decision makers within the council, and would be chaired by a senior elected member (Department of Health, 2012).

In addition to the new statutory landscape, and the important emphasis these place on the DsPH, the government's White Paper (HM Government, 2010), briefing notes (Department of Health, 2011 [9]and 2013), and subsequent advice from PHE (PHE et al., 2013) also provide useful information on the new skills needed by DsPH and Public Health practitioners in their new context, along with extensive guidance on how to appoint DsPH. The 'leadership' role of the DPH in particular was linked to the wider 'localism' agenda with the introduction to the guidance note on appointments emphasising that it was not the job of government to 'look over the shoulders' of LAs (Department of Health, 2013). The DPH must be a registered Public Health professional, be qualified with the Faculty of Public Health, and hold a registration with the General Medical Council, General Dental Council, or UK Public Health Register (Department of Health, 2013; PHE et al., 2013). PHE will be responsible, via the regional director of Public Health, for reviewing and guiding the recruitment process, and drafting the job description in consultation with the Faculty of Public Health to ensure it complies with the latest professional requirements (PHE et al., 2013). PHE et al. (2013) also outline the requirements for all Public Health practitioners to follow an appropriate program of continuous professional development (CPD) documented in an annual return submitted to and ratified by the Faculty of Public Health. The DPH post is politically restricted[10] with a

[9] PHE also act as the revalidation body for any Public Health professional holding a medical qualification.
[10] i.e. the post holder cannot be a member or supporter of a political party.

requirement to take strategic leadership of the Public Health annual report and contribute to authority strategy and leadership at the highest level (PHE et al., 2013). According to the Department of Health (2013), the DPH should be someone authorities look to for 'leadership', 'expert knowledge', 'objective advice', know how to improve population health, and know how to 'change behaviour and promote health and wellbeing'. It is this advocacy, broader focus on wellbeing, and partnership work that characterises the key change for Public Health professionals in the new system. The DPH has been made a visible front person for a broader and more outward looking brief, while PHE and the Faculty of Public Health have been given an important role in defining job descriptions and ongoing CPD requirements in practice.

Evidence and value for money (VfM) in the new system

The documents introducing the role of the DPH in the new system are informative for their discussion of the evidence base and the new multi-disciplinary nature of the role of the DPH, but also, by extension, the skills required by public health practitioners in their new LA context. The profession is to be outcomes focused, embedded in the wider determinants of health, and to drive both evidence and advocacy, while at the same time existing within a more clearly bounded Public Health budget granted by the newly established body PHE. The construction of the 'value' of Public Health activities is central to this analysis, and the construction is found to be embedded within and across multiple accountabilities and epistemic practices. One particularly crucial set of accountabilities are financial accountabilities, and it is notable that briefing documents from the LGA strongly emphasise both specific localised examples of return on investment calculations and the general cost effectiveness of Public Health interventions based on national data (LGA, 2013; Department of Health et al., 2013; PHE and LGA, 2015). This is indicative of themes that arise through the later interview data, observations, and primary document analysis presented in Chapter 6

(section 6.2 '(Re)constructing interventions'), and the shift in calculative and disciplinary practice away from largely medicalised assessments towards appraisals targeted at LA audiences. This process is found to be a two way dialectic through which both the Public Health profession and their new local government environment are reconstructed though one another (Chapter 7).

The 'Local leadership, new approaches' document circulated by PHE and the LGA (PHE and LGA, 2015) provides several early examples of multi-method analysis by Public Health professionals designed for a LA audience. The document summarises a series of seven case studies, drawing on local interviews with Public Health practitioners, of effective and convincing partnership working and integration. The case studies explore examples of good practice in which Public Health professionals collaborate with GPs, school teachers, citizen's advice services, housing associations and others. The evidence mobilised in each case varies from qualitative evidence, quotes, and anecdotal examples through to 'before and after' quasi-experimental designs. In some cases this is monetised in the discussion of the outcomes in return on investment style appraisals; in Blackburn, for example, a new referral service that pooled funds from Public Health and the local CCG saw an increase in call volumes of 28% through the local referral service. Another partnership program was found to improve dementia diagnosis based on GP data, while another described a healthy living initiative that led to 45% of parents self-reporting that their families were eating more fruit and veg in a follow up survey. In Derbyshire, £10m of additional income was secured for low income people while £4.5m in debts were restructured or written-off in a collaborative intervention with GPs and the Citizen's Advice Bureaux, so that £1 invested by the Council secured £12.53 in income for service users. The various cases presented are highly contextual so that medicalised 'randomised controlled trial' would have been impractical, but they also

demonstrate how useful and convincing evidence can, nonetheless, be generated via localised mixed methods designs. Indeed the localised rather than generalised nature of the evidence may be all the more useful for advocacy in a local context.

Many documents on the 2013 reforms outline the strongly cost effective nature of Public Health activity at the macro level, however, the LGA's (2013) 'Money well spent?' document introduces some of the basic methodology for return on investment appraisal of activity in a local context. They begin by outlining the basic principles of cost-utility (also referred to as economic utility) analysis based on quality adjusted life years (QUALYs)[11]. Again, the LGA (2013) document provides several case examples of cost-utility return on investment appraisals such as a NICE study that demonstrated how a smoking cessation intervention returns 63p per £1 in year 1, £1.46 per £1 over five years, £2.82 per £1 over ten years and so on. A second case example draws on a study from a Midland City prior to the reforms into obesity intervention that was found to return £23 per £1 invested in total health benefits over the entire life course. The methodology in such studies requires practitioners to assess the health outcomes of an intervention drawing on prior epidemiology and local data, and then to monetise these health outcomes at a rate of £20,000 per QUALY[12]. This approach would

[11] This is later developed into 'optional appraisal' methodology developed by PHE so as to include a range of 'optional' cost savings and monetised social benefits that can be included or excluded from the analysis, only some of which are based on QUALYs.

[12] The history of the QUALY is summarised by the Department of Health (2010) while the Cabinet Office (2009) present the first full government guidance document in the UK on how to produce bespoke social return on investment calculations. The purpose of the QUALY is to quantify both life years lost and quality of life in a single measure, which can then become a single 'currency' in assessing the effectiveness of health interventions and comparing to alternative treatments (Department of Health, 2010). One case example in the Department of Health document (2010) demonstrates the generalising effect of this commensuration process: a heart by-pass operation to treat angina was noted as having a 67% success rate with a corresponding extension to average life expectancy of 6 years and close to 100% quality of life compared to the control group. The operation would prove fatal in 3% of cases, which understandably corresponds to 0% quality of life. Therefore the QUALY benefit of the intervention is 6 years x 64% (67% 'success' minus 3% 'failure') = 3.84 QUALYs. This is an example of generalised as opposed to contextualised knowledge and one can see the benefit for policy when one then attempts to cost the outcomes, but equally the downside, that the intervention would knowingly kill 3% of

later be criticised by practitioners in this study as they point out the over emphasis on short-term health rather than broader wellbeing and other social and cost benefits such calculations produce (Chapter 6.2).

The guidance provided by the Department of Health (2010) advises on the inclusion of marginal and opportunity costs weighed against health outcomes that are monetised and discounted to present values based on their QUALY values. A necessary step therefore is to arrive at a standard cost per QUALY. The amount is based on a 'willingness to pay' methodology (hence 'cost-utility') first developed by the department for transport in 2008 and is set at a level of £60,000 for public sector interventions[13]. This has been the standard government advice on the cost per QUALY for over ten years (Cabinet Office, 2009), with ten years of inflation effectively reducing the 'willing to pay' of the public sector for health outcomes. However, as the LGA (2013) outline, due to resource constraints in the NHS when assessing new drugs and treatments NICE use the still lower figure of £20,000, so that interventions must achieve health outcomes at this lower cost bar. Both of these figures continue to be eroded by inflation so that the same health outcomes need to be met at a reduced real terms cost year on year.

patients! Nonetheless, if the QUALY 'gain' compares favourably to the acceptable cost per QUALY then the method suggests that the intervention is a success and should be recommended. 'Failure' and 'success' become commensurable and a threshold for decision making can be set.

[13] This figure is derived from a 2008 Department for Transport study estimated the value of a prevented fatality in a typical road traffic accident based the value of pain, grief, suffering, lost output, and medical costs as £1.637m (2009 prices), while the average life expectancy at the time of death was 45.2 years for men and 39.1 for women. This information is then averaged based on a man-female weighted average and discounted based on self-reported survey data on quality of life. This gives a final average of 26.7 QUALYs lost per road traffic accident. The Department of Health (2010) conclude: 'When £1,637,420 is divided by 26.7 QALYs, the result is £61,346 per QALY. This figure conveys a spurious impression of accuracy. Thus an estimate rounded to £60,000 is used'.

All of this outlines a very specific context for a particular set of 'facts' that produce objectivities with strongly ethical (or unethical) assumptions that then become the basis for a rhetoric of affordability and cost effectiveness (see 5.3 and chapter 6). As will be introduced in Chapter 6 (6.2) Public Health professionals continually re-work and contest the construction of these 'facts' in practice, with a particular tension noted between the short term more easily measured service based intervention, and longer term more holistic preventative interventions that address a broader range of outcomes.

5.2 The cases, the spaces, and the initial transfer of Public Health to Local Government

Both case examples in this study, Metro Town and Midland City, are unitary city councils in the Midlands of England, and their Public Health teams were found to share many of the same networking spaces, particularly those facilitated by the regional PHE office. The significant cuts to LA budgets nationally was highlighted as coming to approximately 37 percent of managed expenditure for councils in England between 2010 and 2016 (Bracci et al., 2015), but such effects are known to have a disproportionate effect on more deprived areas with greater health, wealth, and educational inequality (Hastings et al., 2015). Both case authorities selected in the study reflect this. Both were highly populated unitary authorities, and analysis of PHE's outcomes show that for 2015/16 both Metro Town and Midland City were rated as 'red' for all 8 benchmarked overarching indicators on a green-amber-red system that split councils equally in three thirds by their individual score on each indicator (PHE, 2016). At the level below the overarching indicators, the more detailed benchmarked indicators in the PHE outcomes framework for 'healthcare and premature mortality', showed that both Metro Town and Midland City were rated in the bottom third for more than half of

the 66 indicators, with Metro Town being rated in the top third in just 1 of the indicators and Midland City just 4 (Ibid.).

In their 2014/15 budget consultation (MC 024, 2013) Midland City identify that they would lose more than 66% of their managed expenditure by 2017/18, while Metro Town identified that they had already lost 52% of their central block grant by 2015/16 (equivalent to £126m) with just an extra £9m being generated from other sources and further reductions to come (MT 019, 2016). Due to the ring-fencing of the Public Health grant and initial uplift in funding for 2013/14 there was a certain degree of protection and freedom to manage noted through the interview data collected in 2015; however, throughout 2016 and 2017 participants, and both DPHs at the case authorities, reported the significant negative consequences of cuts to both the core Public Health grant and wider authority budgets. These consequences and the impact of austerity in subsequent years are explored further in section 5.3.

On the initial transfer from the outgoing Primary Care Trusts (PCTs)

Following the transfer in April 2013 and the abolition of the outgoing PCTs, Public Health professionals at both case authorities physically transferred to new LA premises. One consultant at Metro Town who stayed with Public Health through the change described the 'terrible' atmosphere in the PCT building prior to the move, while the Metro Town DPH summarised the atmosphere prior to the move as follows:

> I covered the last part of the transition from PCT through to local government, which was a very odd time – very odd. I mean, I've never been part of an organisation, and I mean the PCT at this stage, that just felt desolate... it was like the last people to leave the ship. **Joanna, Metro Town DPH, Dec 2015**

Joanna described how she had transferred some of the staff and activities prior to the move to help establish a presence and reviewing the HWB board minutes it was noted that an initial

'shadow' HWB was set up in March 2013 ([MT002], 2013) just prior to the change. The staff at the Council were said to have been extremely accommodating, and despite a significant reduction in the size of the team to just 17 staff, due to early retirements and attractive severance packages, consultants in the team spoke positively of the protection to their contracts and terms and conditions under TUPE[14]. The Public Health professionals who moved to Metro Town were placed in the council's main post war civic centre located in the city centre, in the same building as many of the core Council services and most Council committees and subcommittees.

Midland City's Public Health team, meanwhile, moved to a large newly built building on the edge of the Midland City University with an expansive open plan layout, but separate from the main council building in which the Health and Wellbeing and other council meetings took place. Midland City saw a much larger and more complex transfer with close to 100 staff coming from three PCTs into the single city authority:

> Three NHS departments into one. The second piece was to lead the transition from the NHS into the council, where there was another public health department, so actually assimilate those on transfer… Just under 100 staff being pulled in from three departments into one. Then also there were three different successive bodies: there was Public Health England; some were going to NHS England; and then council. **Alan, Midland City DPH, Nov 2015**

But the biggest change was said to be the new budgetary arrangements with £18m coming directly under the DPH in Midland City (Alan, Nov 2015) within a larger budget of £79.6m for 2013/14 including commissioned contracts (MC 025, 2014). This was compared to a personal budget of only £0.5m as DPH and deputy chief executive officer of the outgoing PCT.

[14] Transfer of Undertakings Protection of Employment, see HM Government (2019a).

The first major challenge at both authorities, after the initial transfer, was a consequence of the Public Health budget being separately identified and ring-fenced for the first time following the national baselining exercise to identify Public Health specific spend within the outgoing PCTs. This exercise and the resultant transfer of funds resulted in Public Health teams, and DPHs in particular as budget holders, inheriting large numbers of NHS contracts in the new authorities. In the case of Midland City this was more than 400 separate contracts at the time of transfer, all of which needed to be recommissioned with new LA contracts drawn up (Rodrigo, Assistant Director of Commissioning, Midland City, Jan 2016). In both cases, Public Health teams took the opportunity to do a ground up reassessment of spend to ensure it was in line with their strategic objectives and the new PHE national outcomes framework. Joanna, DPH at Metro Town, described the efficiency and financial savings this process realised:

> Although the pain was immense at the time, you get through the other end and then you have local authority contracts, rather than NHS contracts that are within your gift to manage in a much better way... And that's been shown definitely through the efficiency savings that we've made out of our NHS contracts – unbelievable. We've been slightly more hardnosed about how we commission… And that's very outcome focused. But if you can drive efficiencies out of that, then that gives you some slack in terms of where you can invest any savings that you have from taking that approach.
>
> About 75–80% of our entire budget is on commissioned services, so if there's going to be any slack, it's got to be out of them. So in terms of once you've got a workforce that's slick and able to be agile and respond to new evidence and emerging threats, balance the services effectively that you commission, horizon scan in terms of new ways of working, good practice in other areas. You've got to be on top of your game to be able to do that. **Joanna, Metro Town DPH, Dec 2015**

The above, and other similar quotes from participants, provide a crucial insight into the work done following the 2013 transfer. Public Health professionals were taking direct control and responsibility of Public Health money for the first time, as opposed to making the case within a larger primary care budget, and were therefore able to use this budgetary and contractual

power to reassess activity against outcomes. Both authorities reported substantial savings as a result of this re-tendering activity, with the Assistant Director of Commissioning at Midland City (Rodrigo, Jan 2016) describing a saving of £16m over 5 years out of a £37m total spend on substance misuse contracts by bringing together 28 separate commissioned contracts, while at the same time delivering better outcomes through closer scrutiny. Metro Town saw similarly significant re-tending activity across drug, alcohol and sexual health services, also resulting in significant savings. These reviews allowed Public Health professionals to re-draw the service level key performance indicators, through discussion with users, volunteers, and presentations to prospective providers, and to align them against PHE's new outcomes framework.

However, in managing these commissioned contracts, and providing what is referred to as the 'core offer' to CCGs, Public Health practitioners encountered a number of problems accessing data at a level sufficient for their local population level analysis. A joint guidance note from PHE, the Association of Directors of Public Health, and the Faculty of Public Health describes the core offer as providing 'professionally credible input to commissioning and, if required, to clinical and public engagement' so that CCGs can properly consider the wider determinant of health in their commissioning decisions (PHE et al., 2017). Other participants also pointed to the large staff turnovers around the time of the transfer, as well as the shifting boundaries in the case of Midland City, so that existing working relationships had been disrupted. To address these issues, the Public Health commissioning manager at Metro Town (Janet, June 2016) described how the Public Health team were looking to appoint a number of staff in joint roles, especially around commissioning with CCGs so as to rebuild those lost links and to help with data access and analysis, while others also pointed to the growth in 'job

share' style appointments and jointly funded projects. A Metro Town Public Health consultant put this as follows:

> Where possible, teams that would sit comfortably within Public Health are being moved into the Public Health department so that they can pick up some of the Public Health funding, and savings are therefore made elsewhere within the council, so its an interesting strategy but it also means that Public Health teams are growing often, around the country, but sometimes with odd (laughs) kind of teams in them. So we've expanded now to between about 40 and 50 [from 17 at the time of transfer] and we're still growing… It's easily taken us a couple of years for us to really hit the ground running with activity. **Emily, Metro Town Consultant in PH, Mar 2015**

In the initial years after the transfer, Metro Town saw a particularly large increase in staff to make up for those lost prior to 2013, while both authorities reported bringing some existing Council services facing closure into the new Public Health departments. This was described positively by Public Health consultants and both DPHs interviewed, so that the 'scope creep' (Phillips and Green, 2015) noted in some prior literature was being driven by Public Health teams and DsPH proactively looking to build links and embed activities.

While a number of these findings appear to have been typical across the new system; such as the significant retendering activity, the loss of staff prior to the transfer, and the opportunity to more closely engage with the wider determinants of health, the extent to which Public Health teams were able to drive their agenda remained highly context specific. A great deal depended on the DPH as a key actor, political support within the authority, mobilisation of convincing narratives, and, latterly, the impact of cuts to the Public Health grant. Bringing health into all policies was not something Public health professionals could do alone.

The right place to be? Bringing health into all policies

When asked directly whether or not local government was the right place to be, or more broadly whether the reforms of the HSCA 2012 had been a success for Public Health

participants responded positively to the new opportunities to influence 'health in all policies' and to more deeply embed Public Health activities across the new local government context. Several expressed scepticism at the motivations behind the reforms while others points to the practical problems following the transfer that did not appear to have been anticipated in the initial reforms. Increasingly through the second round of data collection participants also pointed to the dysfunctionalities of austerity measures, their counterproductive consequences, and the need for increased collaborative working to join up the public sector around a Public Health agenda. Following the initial physical transfer, several participants commented on the important role of the LGA and PHE in hosting sessions and providing working papers that helped raise the profile of Public Health activities and provide a certain level of legitimacy to a LA audience. In his preface to the LGA's 'Health in all policies' (2016) manual for LAs, for example, Michael Marmot describes the key role LAs have to play in bringing health and health equity into all aspects of council activity and the need to see beyond short term budget cuts.

Similarly, the Association of Directors of Public Health and the LGA (2014) wrote in 2014 that 'there is an overwhelming sense… that the transfer of public health has gone well across all 152 areas, and that all HWBs have made a strong and enthusiastic start'. The ethos of 'health in all policies' was found to have gained discursive traction among Public Health practitioners across the study, and was particularly emphasised by the DPH at Midland City (Alan, Nov 2015 and Dec 2016), reflecting a broad consensus that, in principle, local government was the right place for Public health to be. Despite the pre-existing austerity environment outside of the protected Public Health grant the democratic accountability, access to decision makers across the council, ability to influence commissioning, and local population engagement were all cited as positives immediately following the move. This was supported by several

contributions to the Health Select Committee's inquiry into Public health activities in 2016, including Joanna, the DPH at Metro Town:

> We would say—and the consensus is—that public health in local authorities is working well and getting better all the time. Obviously, a transition period is a difficult point for public health teams and overall, but in local authorities you have massive opportunities to work with colleagues, with public health teams working in an integrated way… It was the right thing to do for us to get some traction in terms of those efforts we wanted to put into facts across the social determinants of health, trying to get into the mix around educational attainment and housing standards, and trying to get into the conversation around skills and employability to try to improve getting people into work. It was the right place to be. **Joanna, Metro Town DPH, HSC, Mar 2016**

Elaborating on these points in the data, participants emphasised that being able to influence areas outside of traditional NHS primary care, such as the built environment, education, housing, and employment were crucial to Public Health activities being able to influence the wider determinants of health in the community. PCTs were not seen as having the same traction or influence prior to the transfer, and were instead largely service driven, focusing on acute activity rather than prevention.

But these very opportunities presented their own challenges, not least to those Public Health practitioners with little experience in LAs or to those with highly specialised medical backgrounds who had to learn and develop new skills. Learning to speak a 'new language' was a point made repeatedly across the data and in the prior literature (Brown et al., 2014; Phillips and Green, 2015), referring to the contrasting discourses and evidence bases used across local government and the NHS and the need to report to elected members in the new system. Participants reported that the scientific terms of reference, so familiar across the NHS, no longer carried the same weight, instead noting that it was experience and the personal 'story' that would carry greater resonance. The regional PHE 'place based' Consultant for Metro Town put this as follows:

> I think one of the most valuable things I've ever done is spent a few days with some local elected members. Because, you know, at the end of the day local authorities are part of the democratic process. And it's local elected members who they need to justify their value added to. And it's really caused me to have a shift in my thinking around the use of narrative and stories. When you talk to local elected member it's story, story, story. I saw somebody who came to my office and complained about X. I met Mrs so-and-so who complained about Y. I experienced this. So if we produce them a lovely, shiny, glossy report saying we've evaluated this and we had X number of people through it, you're talking just different *languages* [emphasis added]. **Paula, PHE Consultant in PH, Aug 2015**

Participants spoke about not being overly 'precious' about prior ways of working within the NHS and the need to think about how to be effective in influencing decisions in order to take advantage of the potential opportunities in the new system. Increasingly, this extended beyond the directly controlled Public Health budget and became an agenda for influencing strategy and decision making across all council services. One Public health consultant in Midland City put this as follows:

> The wider determinants and that early prevention… is much more embedded in a social and municipal environment. And the social environment includes not only the relationships we have with our families and/or communities, the places we live in and the housing itself and its quality and safety, and the sort of employment that you may be involved with, whether you've got a job or not, so the financial environment… We have a greater opportunity to influence those, or to ensure that development policies, strategies, initiatives don't undermine that as well as promote them and enhance them. **Adam, Midland City Consultant in PH and lead Commissioner, Dec 2015**

Public Health needed a 'strong narrative' to justify their spend and to gain legitimacy, which was further observed in the HWB observations, particularly at Metro Town, in which Public Health professionals mobilised clear messages around childhood obesity in presenting their third Public health annual report (HWB, July 2015). This need to drive a 'narrative', together with the large scale re-commissioning of NHS contracts, presented the context for outcomes focused program budgeting across both case authorities, instead of incremental budgeting in which service driven contracts rolled forward from year to year. On justifying 'Public health

spend' and engaging with new 'languages' following the transfer one consultant at Midland City gave a key quote on the value driven activity in the new environment:

> There's a sense in which it's easier because you can talk the language of value, you can talk the language of equity and you can talk about meeting need in a much more direct way. To be honest, most of my times in the PCT/NHS world was certainly marginal change of funding that had been set by activity in the past. So actually, it was institutionally-based accounting, as opposed to programme budgeting. Nobody ever went to prove the budgeting because the institutions made it difficult for people to.
>
> There is a sense in which, talking with politicians, with councils, they are much more in touch with it, that softer idea of need and context. And they get that sort of conversation, that sort of idea quite quickly. Some of them are much more accountable and much more accounting friendly and they do understand also some of the budgetary constraints, so they will be hard-nosed in terms of the financial resource that you may well have. **Adam, Midland City Consultant in PH and lead Commissioner, Dec 2015**

Adam links the scrutiny created by the austerity context to the receptiveness of politicians and budget holders across council services to a program based approach to budgetary planning. This was because councils had already had to fundamentally reassess service level activity and by 2015 both authorities had had to conduct zero based budgets under their medium term financial plans (MT 019, 2016; MC 024, 2013). This allowed Public Health professionals to make the case for the value of their activity in financial terms and make the argument that their interventions would benefit other areas of the public sector in the longer term.

Another Public Health consultant stressed that LAs understand early intervention 'more than people in the NHS ever did' (Emily, Metro Town Consultant in PH, Mar 2015), while others also linked an emphasis on quality over service delivery to developments in the sector following the Francis report into the failures at the Mid Staffordshire NHS Foundation

Trust[15]. While some participants referred to frustrations among the Public Health profession with the lack of medical or scientific training within and across local government, others pointed out that many of the common complaints about evidence and money were not necessarily new. Life in PCTs was often a 'battle' for funding and a struggle for investment in prevention rather than treatment and aftercare. One Public Health educator with a background as a consultant in Public health in the NHS linked this to a professional hierarchy among medical professions that often had Public health professionals as the 'junior partner' to medicalised and acute services prior to 2013 (Frank, Jul 2017).

Despite the overall positivity towards local government being the right place for local Public Health activity to be there were also a number of issues created by the nature of the reforms and general scepticism about the politicised nature of the cycles of reform across health and social care. Several participants discussed their fears that there would be major re-oraganisations further down the line and uncertainty over the future of PHE, CCGs, the social care system, and NHS England, all of which could be subject to future reorganisation. Frank, the former Midland City Public Health Consultant, put this down to political pressure and public accountability:

> It is far more difficult to say we are not going to make any changes, we are just going to make everything work 10% better. And that would be far better for the population for the professionals, for everyone. **Frank, former Midland City Consultant in PH and PH educator, Jul 2017**

Suggesting that it is actually much harder to engage constructively with the real challenges of delivering multiagency work than it is to re-organise the system and create 'change for change's sake'. This was repeated by Steven (Sep 2015), one of the private sector consultants,

[15] The Francis report was discussed extensively at the first HWB observation at Metro Town (29/07/2015) with the key themes for action being 'preventing problems, detecting problems quickly, taking prompt action, having robust accountability, staff training and motivation, and a culture of safety and openness'.

who emphasised the overall lack of planning and the need to allow the current reforms to play out and to take stock, describing the aftermath of the HSCA 2012 as a 'rabbit in the headlights' moment.

Several such issues emerged in relation to the Public Health transfer. These were primarily around the loss of access to data and loss of links within the NHS that were crucial in understanding local population level health and reduced influence over commissioning that had remained within the NHS. On loss of data, consultants pointed out that they could no longer access the StEIS dataset[16], which had been used to log and report clinical incidents across, for example, drug and alcohol or sexual health services. Public Health professionals did not need patient level data, but data protection legislation made it difficult for them to access even aggregated information and were left needing to arrange multiple 'data sharing agreements', which took several years to establish. Data sharing issues also made some of the new statutory duties extremely difficult to carry out, in particular, the scrutiny and challenge function of services commissioned back to the NHS.

In sum, while the new Public Health system provides the space for Public Health professionals to engage new audiences and make the case for prevention among a wider set of local actors than was possible in the NHS, there remain serious challenges to further embedding Public Health around language, culture, evidence base, influence, and organisational boundary problems. There was particular emphasis among external observers, such as PHE consultants and private sector advisors, on the variation across the system with reporting structures, political support, and so on, being highly variable by authority. It was also suggested that the relative success of embedding Public Health was highly dependent on

[16] The NHS Strategic Executive Information System

the DPH as a key actor and advocate. In the cases observed, the Midland City DPH was seen as influential across the council at a strategy level and sought to embed a 'Public Health ethos' outside of the Public Health function, while the Metro Town DPH was seen as a highly motivating character who had successfully gained support from a range of actors behind an explicitly 'Public Health' agenda. Other authorities were referred to as having a more 'difficult' time and Public Health as being much more 'marginal'. The new Health and Wellbeing Boards (HWBs) facilitated this integration to some extent by bringing together actors and decision makers from several organisations, but their effectiveness was disputed, and their success was, again, highly variable and context specific.

In the years following the initial reforms the challenge of embedding Public Health activities across the wider determinants of health was increasingly found to be exacerbated and entrenched by deepening austerity measures. Both from the wider cuts to LA block grants, and, from 2015 onwards, cuts to the Public Health ring fenced grant. As one Public Health consultant observed in their feedback on this projects at the first Public Health workshop (Feb 2016): 'it was the right reform, but at the wrong time'. The following sections of this chapter further explore the immediate transfer post 2013 (5.2) before moving on to the specific issues created by austerity measures (5.3) followed by a review of the coded data (5.4). The new 'language', 'ethos', and associated calculative techniques and other strategies of Public Health professionals discussed above are explored further with reference to the reconstruction of the Public Health professional and disciplinary identity in Chapter 6 (section 6.1) and with reference to the reconstruction of evidence in Chapter 6 (section 6.2).

On the role of the new Health and Wellbeing Boards

In a number of the early interviews participants reported that it was not initially clear how the new Health and Wellbeing Boards (HWBs) would work out, to what extent they would

have statutory 'teeth', and whether or not they would be effective in linking up the new CCGs with LAs and other stakeholders. Ironically, medics appeared to find them to be too much like Council committees, while non-medics and other stakeholders reflected on them as being too technical or too 'medic dominated'. Clearly, they were bringing together audiences who had not been used to working closely together prior to the transfer. At the Health Select Committee's (HSC) public inquiry, one DPH reflected on this clash of cultures as an initial 'learning curve' that had already been overcome:

> CCGs saw them as a threat initially because they were very much a council-focused committee. While I was on a learning curve in terms of a new culture, so was the CCG. I think we have moved on from that considerably. **DPH at HSC, Mar 2016**

On the other hand, one former environmental health officer at Midland City described the boards in the early days after the transfer as being too medic dominated with not enough buy in from the broader council, suggesting that boards were not following discussion through to action in the community. When asked whether HWBs were an effective forum the officer replied:

> No, I don't think so because you don't have the doers on the board (laughter). None of the doing people have any place there really… it's quite medic dominated in some ways because you've got all the CCGs haven't you? CCGs have got statutory plays and then you've got public health… Then we have head of social services and kind of those sorts of things but you are lacking, I didn't see many representatives of housing services or environmental health or planners or any of those kind of professions in the health and wellbeing boards. I don't think the health and wellbeing boards is a forum who are successful in drawing things up, from what I saw... it was all very remote. **Anika, former Midland City Environmental Health Officer and PH educator, Jun 2017**

The cultural difference and an initial sense of inertia were similarly articulated by one elected Chair of a London based Authority in the oral evidence presented to the HSC (Feb 2016) who pointed out that because it was 'legally' a council committee it reproduced bureaucratic structures that NHS practitioners were not used to. Working GPs were often sitting through

'declarations of interests', 'minutes of the previous meeting', and 'actions arising' which would lead to visible frustration among CCG representatives. There was also wider uncertainty about how HWBs could draw up effective action plans following the transfer, with one partner in a private advisory firm describing numerous 'open doors' as council would buy in a bit of advisory work as a 'comfort blanket' in 2013 (Mike, Partner in consultancy firm, Aug 2015). This was due to uncertainty about how to mobilise action beyond the initial joint strategic needs assessments – HWBs were able to identify were problems lay but found it more difficult to agree on a strategy that could affect health and wellbeing outcomes.

In total, five full HWBs were observed across the two case authorities, three at Midland City and two at Metro Town, while the remaining board minutes and documents (for example Public Health annual reports, Joint Strategic Needs Assessments, Health and Wellbeing strategy documents, and so on) were reviewed. This gave an overview of how the boards had developed in the years following the transfer, and in the case of the observations, gave an insight into the dynamics of the boards and allowed the researcher to observe how key documents, power point presentations, various fact constructions and discursive practices were mobilised.

At Midland City, an initial Health and Wellbeing strategy was drawn up in 2013 focusing on infant mortality, healthy children, hospital admissions, and wider determinants under employment and housing. These five strategic priorities were then mapped against ten indicators in the following Joint Strategic Needs assessment of 2014 (MC 030, 2014). On review of the HWB minutes, a review of the public health outcomes framework indicators was also performed in 2014 and presented to the HWB. Overall, this strategy was described by the DPH as focusing efforts and limited resources on the most vulnerable groups, on

children, and on the 'resilience' of the system. This was used to mobilise consensus across a range of council services so that Public Health activities would be fully integrated. The HWB, in the observations attended, was observed to be a forum to drive this strategy and provide legitimacy for Public Health practitioners to take their targeted evidence base into other boards of the council, for example housing, planning, and commissioning. Meanwhile other key public health areas were leveraged into these strategic objectives, for example Drug and Alcohol was linked to both the employment objective and the healthy children objective, which fed into the 2013/14 Drugs and Alcohol Needs Assessment document (MC 031, 2013).

The presentation of a newly revised Health and Wellbeing Strategy was observed and analysed in the final HWB observation in Jan 2017, along with the presentation of a new Mental Health briefing paper and a Midland City clean air strategy. This followed the pervious HWB in Nov 2016 at which the objectives for the revised strategy were first discussed. The new strategy was presented 'on a single page of A4' in order to provide greater focus with even fewer priorities and outcomes that would 'focus Board work and make best use of limited resources' (Alan, Dec 2016; MC 032, 2017). The focus remained on the most vulnerable, but stressed a longer term 'asset building' approach over short term disinvestment, and would focus on communication and collaboration between agencies; emphasising a 'change in culture' promoting independence and resilience rather than dependence on service driven approaches (MC 032, 2017). The new strategy included improving the wellbeing of children; improving the independence of adults; improving the wellbeing of the most disadvantaged; and making Midland City a healthy city (MC HWB, Jan 2017). The last of these referred to a detailed call to action on air pollution in Midland City with a power point presentation (MC HWB, Jan 2017) introduced by the DPH as a separate

item to the board along with the introduction of a joint mental health strategy linked to improving the wellbeing of the most vulnerable.

Notable in the DPHs presentation of the revised Health and Wellbeing strategy was the lack of detailed evidence based argument or technical language, instead the DPH focused on integrating Public Health priorities into a wider strategy conversation. It was the regional PHE director, at the same meeting, who suggested PHE assistance in drawing up detailed indicators to tie in with the PHE outcomes framework for the next JSNA:

> We are simply there to advise and hopefully influence some of the work at local level. And we do that on the basis of the evidence, so our stock in trade is the evidence. Trying to make sure that it is there to help the decision making, that it's there in a form that colleagues can use. And there is a huge amount of synergy between these things, all of the things that we are talking about today are reflected in national priorities as well as local priorities. We have a named consultant, for [Case B] it's [Elizabeth] who is there, whose role really is to make sure that as PHE we understand the priorities and to work with [Alan] and his team so that we are involved in the right conversations. **Rosanna, PHE Regional Director to the HWB, Jan 2017**

Here the PHE regional director can be seen to be supporting and legitimising the role of public health and public health evidence in particular, as well as the role of the DPH. The two interventions can be seen as supporting one another, which was confirmed when interviewing the PHE link consultant named in the above quote from the regional director, who emphasised the important personal nature of interactions at the HWBs:

> Well, the expertise, you can buy it in. But what we've got is a lot of technical people, which worked in an NHS dominated world because it was technical and it's about technical skills, abilities, solving the problem, whatever. But… We're in a situation where technical skills, well, you need to have good understanding, awareness, knowledge; you need to know when it's wrong. But more than that, actually, you need to be able to come across really well and engage with the politicians and, you know, do the schmoozing. And there's just that something about making the connection and becoming that slightly larger than life character. **Elizabeth, PHE consultant, Sep 2015**

The personal nature of these interactions, supplementing the technical expertise of the public health professionals, was also observed once the HWBs were formally closed. Particularly at the larger Midland City which spanned several CCGs and a large population, as board members, observers, and wider stakeholders broke into smaller groups and would stay on and discuss items and actions for up to an hour after the meetings.

The DPH of Midland City, Alan, described the boards as a useful and important forum for aligning strategy, but also emphasised that it was crucial to work alongside the senior decision makers of the Council and to sit on key boards so as to have a strong influence on the senior leadership. In the following, he explains this need for collaborative working, public health leadership, and an outcomes focus:

> Everybody wants to put stuff on, 'This is important. That's important.' And actually, fine, but what comes off? So that's really our strategy, and just… What's been useful now is a recognition that the health and wellbeing board isn't a standalone board – it works with other departments and other boards. So the thing they've done about housing and homelessness, we can actually delegate that to the housing board, with being clear, 'This is what we want. Can you deliver that?', 'Yes? No?', 'What can you deliver?' And then actually delegate it to them… Everyone comes along expecting things to happen, but not everyone's prepared to do something. **Alan, Midland City DPH, Dec 2016**

One conspicuous absence from the Midland City HWBs were presentations of Public Health annual reports by the DPH as outlined in the government's framework for the new system (HM Government, 2010). Alan described the annual reports as useful but potentially a distraction, advertising public health budget for the 'vultures':

> Annual reports are useful. They're useful documents but by themselves I don't think they engender change. They're more about talking points to get other things through, rather than the end report itself, is my view. The money has been a big distraction because everybody wants it. Everybody wants the 80 million quid to sort out their problems, so that has been a real distraction. **Alan, Midland City DPH, Dec 2016**

However, at Metro Town, the public health annual reports and their presentation to the HWB were considered a key part of the Public Health agenda and strategy, and while many similar themes were noted in terms of the importance of the DPH as a key actor, the importance of social links, some differences were noted in style and strategic priorities. The Metro Town DPH sought to mobilise support around the Public Health annual report for an explicitly Public Health agenda, rather than a broader strategic of influence.

In her evidence to the HSC the importance of collaboration and emphasis on the HWB as the primary vehicle for mobilisation was evident. The board was emphasised as a 'partnership board' rather than a traditional LA committee, and was seen as crucial to developing the local system:

> They have huge potential in trying to lead a local system. There is a level of maturity that probably varies across the country as to how developed health and wellbeing boards are in making progress and outcomes against their agendas and their priorities. Again, personally speaking, there is a strong sense of wanting to do the right thing across our local partnership, and that is what it is. It is not a local authority committee; it is a local partnership for the health and social care system in trying to do the right thing. **Joanna, Metro Town DPH to the HSC, Mar 2016**

Joanna was interviewed both before and after her intervention at the HSC and reflected on the importance of the ethics of public health in building a shared agenda, which can been seen in her quote above when she repeatedly refers to collaboration on a shared agenda as coming together 'to do the right thing'. In her follow up interview she particularly extends this to influencing STPs and the combined authority, and the importance of the HWB for influencing these wider forums as well.

The emphasis on building the ethical arguments for public health were observed at the first full HWB observation at Metro Town at which the DPH launched her third Public Health annual report. This built on the previous two annual reports: the first, the 2013/14

report, was entitled 'Weight? We can't wait' (MT 021, 2014) and was a focused call to action on childhood obesity. The DPH described how this was introduced in order to make public health visible in the council and included a public drive among local politicians and community leaders to take on the weight loss challenge. At the Jul 2015 HWB observation the DPH reported that since the launch of the first annual report an 'obesity summit' had been called, an elected 'member champion' had been established, a community call to action was launched and the City Council had implemented a series of workplace health interventions. The second public health annual report focused on 'prevention' and the importance of healthy lifestyles on a range of preventable diseases (MT 022, 2015), while the third report, launched at the first HWB observation, gave a history of public health in the city and identified six 'big killers': heart disease, infant mortality, lung cancer, strokes, alcohol, and suicide (MT 023, 2016). Throughout the focus was on the entire life course approach (Marmot, 2010) and early intervention. The DPH described this as an educational process, first establishing public health through a single issue initiative and then broadening out the number of priorities around the same themes of healthy lifestyles and childhood intervention.

In her presentation of the 'big six killers' Joanna mobilised local descriptive data to emphasis the scale of the problem and drew on ethical arguments to build consensus. Still drawing on childhood obesity:

> On obesity, I've already given you those killer stats… I gave you the figures for obese reception class, but it's 26.4% if you bring in overweight and obese. That's 12.5% obese and 26.4% [obese or overweight], so that's over a quarter of our four year olds who are already starting school. That's the issue we've really got to get in early, and that is why we're constantly talking about this life course approach, that we are starting right at the beginning and getting them with prevention work right from the start – pre-conception and during pregnancy, right the way through.
>
> [Then] you can see there, that scary statistic – over 40% of our 10 and 11 year olds are overweight or obese. 26.2% of those children are obese. That's really robust data, because our school nurses

> take the height and weight measurements of our reception classes and year 6 classes and we get about 91% uptake. That's really, really accurate data. **Joanna, Metro Town DPH to the HWB, Jul 2015**

The associated slides gave a highly visual representation of the data through charts and graphs that were cross referenced to the annual report itself. It was also notable that there was a strong emphasis on the robustness of the data around an issue that was perceived to be emotionally important. In this case the Director was able to mobilise the relatively strong descriptive statistics based on primary local survey and demographic data, together with national data, to drive a detailed list of recommendations. In the analysis of the 2015/16 Public Health annual report referred to in the above quote, it was noted that the evidence was presented and constructed in terms of health and wellbeing; with the economic argument only introduced in broad terms in the introduction rather than by each recommended intervention.

Similarly to Midland City, the Metro Town DPH also strongly encouraged partners to step up and take responsibility and ownership of the public health agenda.

> One of the questions that I'd ask partners today to reflect on the nominations that they've put forward in terms of that strategic route, that needs to have senior representatives from agencies across the city that have got the authority to make decisions and actually commit resources to this programme.
>
> You know where I am. You've got my email address and you've also got my telephone number. Please can you just get back to me in terms of, I've got an invitation sitting waiting in the wings to go out for the inaugural meeting of that programme board. If we've got to move from a starter for 10 and the action plan that you've got presented today, we really do need to drive through some of the contributions and ideas from partners. **Joanna, Metro Town DPH to the HWB, Jul 2015**

This clearly had the strong support from the elected member chairing the board who remarked after the presentation:

> Just looking at the figures for Metro Town – alcohol, smoking, infant mortality and obesity. We've got a ticking time bomb here, and it means that as health, for me, as health stakeholders around the table, we have to do something about it. **Chair of Metro Town HWB, Jul 2015**

In the presentations to the board, the Metro Town DPH appeared to be particularly effective in mobilising convincing evidence together with moral argument to encourage targeted action. In the final observation, she presented the 2016 annual healthy lifestyles survey, which allowed the HWB to understand the detailed primary data underpinning the public health strategy when mapped against the PHE outcomes framework, which was then linked to the Marmot (2010) agenda and rhetoric in ensuring a targeted early intervention approach. As with many of the public health briefing documents introduced in section 5.1 the Metro Town presentations drew strongly on the wider health and economic statistics without, for the most part, detailed cost benefit analysis of each proposed strategy.

The HWBs were therefore highly dynamic and performative spaces in which new agendas were set, facts contested and established, and new networks formed. One point that was noted across the data was a move from narrower definitions of 'health' or 'public health' towards 'health and wellbeing' or 'wellbeing'. In section 5.1 this was traced to the influence of the Marmot (2010) review and to the broader emphasis in the reforms on healthy life and wellbeing beyond service based NHS model. This could particularly be seen in the development of the new mental health strategy and the centrality of mental health in the revised 2017 health and wellbeing strategy at Midland City. This was confirmed by several public health consultants, but also other non-public health participants such as the health educators and the CEO of a local Midland City charity. The HWBs were helping broaden the discussion and by integrating public health interventions served to blur the boundaries of public health activity.

On building networks: Directors of Public Health (DsPH) and the Public Health England (PHE) regional office

Due to their statutory role as the public health representative at the HWBs, together with their role as budget holder for the ring fenced public health grant, the new system placed the DPH in a key role for the mobilisation of networks around a shared public health agenda. Their ability to be successful depended on a wide range of factors, from building a strong team of public health professionals who could develop the evidence base and work across the council, to their personal ability to engage stakeholders, their relationships with the PHE regional office, their relationship with the elected member for Health and Wellbeing, to the geography and history of the LA area. HWBs were highly performative spaces in which facts were established and strategic decisions made, and through which disciplinary practices of the public health profession; their evidence base, their ethics, and their discursive practices, were able to influence what mattered. However, across this structure any one actor in the network is still dependent on a broad arrangement of other actors, inscriptions, and calculations, as well as the political circumstance of the authority. In the case of the DsPH they worked especially closely with the PHE regional office who provided a dedicated lead consultant, ran knowledge sharing workshops and events, and facilitated monthly regional meetings of all 14 local DsPH.

Exploring the role of PHE and other networks further, it was found that prior to the time of the change PHE had relocated much of their activity to a building a short walk from the Midland City team, closer to the Midland City centre, which was also roughly central in the wider geographical region, with Metro Town to the north. The regional PHE director described the physical aspect of the relocation in the context of their regional footprint as follows:

> We work with 14 of the tiers, that's the big [footprint], there's at least three incarnations of the region that we're working with… In 2004, the Health Protection Agency[17] had 13 bases. [Prior to the change] I'd managed to rationalise our estate to three sites, this one, one in X, one in Y, and so we decided to use this one as the base for our [regional] centre. It's central and we all shuffled up a bit and redesigned the building a bit. Actually, it's been hugely helpful because fairly early on we were able to bring all of the bits of PHE into essentially the same place. **Rosanna, PHE Regional Director, Nov 2016**

While there was a significant emphasis on local independence of Public Health delivery, and variation in areas of Public Health spend, PHE were noted as playing an important role in establishing a support network for knowledge sharing and advice. Their location, at the centre of the largest city in the region, with good transport links, helped them to facilitate the regional DPH monthly meetings, knowledge sharing seminars, and allowed their place based leads to more efficiently access the localities they worked with on an advisory and consultancy basis. Perhaps because of the autonomy of the new system, described by the NAO as representing PHE's 'loose statutory levers' (NAO, 2014); social links, facilitated by physical geography and infrastructure, became particularly crucial. This was observed as PHE staff worked with LA consultants to develop and refine various calculative interventions and return on investment tools such as the 'Families drug and alcohol SROI tool' (PHE 017, 2016), collaborated on a joint interpretation of ring fenced grant conditions (PHE 007, 2016), local interpretations of the 'core offer' to CCGs, and a range of other evaluation and value for money tools.

This dynamic was observed in an observation of one of the regional DsPH monthly meetings (Feb, 2017) and across a number of interviews with PHE staff and consultants. On describing the role of the PHE regional team, the regional director of the PHE office explained

[17] The Health Protection Agency was set up in 2003 and their functions were laid out in the Health Protection Agency Act 2004. It was abolished as of April 2013 with many of their staff being transferred across to the newly established Public Health England.

how they work through the DsPH on a network basis. This was to act as a link between the national and local strategies and to support both the technical analysis and legitimacy of local public health teams:

> Less so with the political members because we don't have a seat on health and wellbeing boards, although… I will have a seat on the combined authority wellbeing board. A lot of that influences is through and with the DPH. I certainly wouldn't go over the top of the DPH to have conversations with local government. Within our networks, our people are involved with all sorts of other parts of the councils, but we do it on a network basis. **Rosanna, PHE Regional Director, Nov 2016**

In her presentation to the Midland City HWB (Jan 2017), Rosanna described the linking role of PHE with the phrase 'we are aiming to be the most local of the national organisations', which was consistent both with the loose statutory control of PHE but also the 'localism' agenda introduced in the government's briefing documents on the new system (HM Government, 2010; Department of Health, 2011). The nature of this work implied a significant variation across the system and a dependence on context, personal relationships, and convincing narratives to be successful. Another senior PHE director described how this had been a major learning curve for the PHE staff following the transfer as the new PHE office 'had virtually no HR' and 'people couldn't work out who was doing what', describing how authorities across the regional were all at different stages of readiness following the initial transfer (Mandy, PHE Regional Director, Nov 2016).

This was mirrored in the relationship with the new CCGs as the separation of public health from the NHS had weakened links, while ambiguity over the 'core offer' of public health advice led some CCGs to employ their own in house public health professionals (Adam, Midland City Consultant in PH, Dec 2015). One of the key tasks of the regional PHE office was in pulling together this multi-agency work. One such example was PHE's 'interpretation' of the statutory 'core offer' (MT 001, 2014; PHE et al., 2017), which recommended that DsPH

produce local service level agreements between LAs and CCGs. On the relationship with CCGs, one PHE regional director went on to conclude.

> It's really different in different places… I could see some areas where you know, they just don't get on at all. And it's really difficult and providing the Public Health advisor is really hard. I suppose what we've got is a system that's developing in really different ways in different parts. **Mandy, PHE Regional Director, Nov 2016**

Similarly, a wide range of networking activities were noted as taking place below the level of the DsPH, either through LA networking events or the professional CPD activity. The researcher presented preliminary findings at two such knowledge sharing events and sought feedback on initial findings. The first event was a one day conference organised by the researcher at the University of Birmingham's HSMC and was entitled 'Public health in local government: healthy lives out of austerity' (Feb 2016), the second was a poster presentation organised by Midland City entitled 'Rising to the challenge of collaborative research' (Nov 2017). In both cases, the public health profession was noted as being an active research community with close links to both academia and professional practice that worked across organisational and professional boundaries. These dynamics and the development of the public health profession in this new context are further explored in Chapter 6.

Chapter 5 Part 2: From health in all policies to austerity

In the background literature review (section 2.2) the shift from an initially increasing Public Health grant through the first two years following the transfer, to considerable reductions thereafter was summarised. The reforms left Public Health outside of the government's nationally protected healthcare budget, in a wider context itself being redefined by austerity. Between 2010/11 and 2016/17 LA budgets were reduced by 49% in real terms (NAO, 2018) with disproportionate effects on more deprived areas (Hastings et al., 2015). Both case authorities in this study, Metro Town and Midland City, reflected this due to the demographics of their local populations, with both having already lost over half of their managed expenditure by 2015.

The initial transfer of Public Health activities into local government saw an increase in funds on the baseline PCT level funding of 5.5% for 2013/14 (NAO, 2014) to £2.7bn nationally, though this was still less than the initial estimate of £4bn laid out in the Public Health White Paper of 2010 (HM Government, 2010). In the aftermath of the transfer, section 5.2 described how both case authorities in this study generated savings through large scale re-commissioning of services as the full Public Health budgets came under the direct control of DsPH for the first time. However, by the Autumn statement of 2014 the chancellor announced a £200m cut from the following year's (2015/16) Public Health grant, which was to be followed by further reductions of 3.9% per year through to 2020/21 (The King's Fund, 2017a). Between 2013/14 and 2017/18 the King's Fund (2017b) identify that in real terms the like-for-like Public Health grant to LAs had fallen by 5.2%.

These cuts were heavily criticised by industry commentators (Buck, 2017 and 2018) and the LGA (2017) who had previously supported the reforms (LGA, 2014a and 2014b).

Writing for The King's Fund, Buck (2017 and 2018) describes the folly of central government policy on the Public Health grant as 'death by a thousand cuts', while the Nuffield Trust, The King's Fund, and the Health Foundation described them as a 'false economy' that were putting 'people's health at risk and storing up problems for the future' (Nuffield Trust et al., 2017). They also appear to contradict and undermine the proposals put by the government in the original reforms, in which they acknowledge the importance and cost effectiveness of a well-resourced public health system (HM Government, 2010). Furthermore, the integration of public health with the wider determinants of health and the ambitions of the Healthy Lives, Healthy People white paper to relieve pressure on the NHS were initially recognised as needing investment via an uplift in grant allocations (HM Government, 2010; NAO, 2014). Thus the change in stance from 2014/15 onwards can be seen as a reversal in government policy away from progressive investment in a 'well-funded' ring-fenced public health grant, towards disinvestment and austerity. This trend continued with further announcements that the ring-fencing of the grant itself was to be scrapped and replaced with a business rate retention scheme under which public health funding would instead be linked to the local business tax base (Department of Health and Social Care, 2018)[18].

In section 5.1 and 5.2 I described how the 'big society' and elements of localism were built into the HSCA 2012 reforms, together with the 'freedom' to manage public health locally and take 'ownership' of the problem of health inequality. However, as noted by Ahrens and Ferry (2015), localism in the context of austerity also localises the implementation of wider

[18] Initial government proposals put the full transfer to a business rate retention scheme at April 2016. This was then delayed to April 2020 in subsequent announcements. Several pilot schemes were introduced from 2017 onwards. However, by 2020 major delays to the legislative program due to Brexit appear to have delayed the transfer further, with additional pilots being announced by the newly created Ministry of Housing, Communities, and Local Government through 2019 and 2020. As of April 2020 the public health remains a specific ring-fenced grant from PHE to local authorities.

budget cuts; with LAs on the one hand blaming central government for the cuts to the main block grant, while, on the other, attempting to justify their implementation and pass responsibility on to citizens through the budget consultation process. This was noted on review of the wider budget consultation in Midland City as various cuts to services were described as 'empowering people and communities' (MC 026, 2016; MC 027, 2017; MC 028, 2017) and as driving 'resilience' in the local population (MC 028, 2017). Metro Town similarly describe their financial plans as 'empowering people and communities', the same phrase noted at Midland City, and typically describe proposed reductions in pre-existing services positively as delivering 'efficiencies' (MT 019, 2016).

Having set the scene for the wider shift from 'health in all policies' to 'austerity', Part 2 of this Chapter summarises the primary data on the effects of austerity on public health activities through and with accounting techniques, budgetary practices, and professional ethics and motivations. This covers both the specific cuts to the public health ring-fenced grant, wider cuts to council services, and broader fragmentation created by year on year reductions to public budgets. This shines a particular light on how statutory budget structures and cycles impact on activity in particular ways; the short-term dysfunctionality of annualised budget cuts in times of austerity; and, latterly, the importance of collaboration around a shared health and social care agenda as practitioners seek to respond to the changing landscape.

5.3 Dysfunctionality and fragmentation

Asked about the potential for 'scope creep' (Brown et al., 2014), with other departments transferring their activity into the newly transferred Public Health budget, participants described this positively as an opportunity to more closely integrate Public Health across the

case authorities, citing the DPH's statutory duty in signing off the Public Health grant declaration as protection against abuse of the grant. Nonetheless, progressive cuts to the grant did begin to come through more strongly in the second round of data collection. The announcement in 2014 had an immediate impact on Metro Town as it resulted in the loss of allocated reserves that had been rolled over from 2013/14 into 2014/15, and which had been generated through re-commissioning of contracts and closer scrutiny of service level activity. The DPH at Metro Town expressed her frustration at the lack of notice:

> We got huge savings out of certain contracts in particular, but huge savings and with a view to being able to reinvest that money for services that we needed to do because of our health needs. And this is where I'm uber disappointed because the government then turns around and penalises us for what I think is sound financial management and actually with an ambition to invest in preventative services in the areas that we needed to for [Metro Town]. And of course, what the government's done now is taken away £1.3 million out of our budget in-year.
>
> The rules of the ring-fence meant that your underspend can't be tampered with; it needs to be earmarked. So I'd earmarked all our underspend against future projects against our priorities for obesity, for infant mortality, for smoking cessation, for alcohol harm reduction. 'We'll invest in this. We'll do a pilot in this.' It was energising… And no. 'Local authorities, you've got underspend in your Public Health budget, i.e. you don't need it, so we're going to take it away from you.' **Joanna, Metro Town DPH, Dec 2016**

Here we see the 'freedom' to manage the local public health budget and plan ahead being directly undermined as earmarked reserves were retrospectively removed. The Strategic Finance officer at Metro Town commented on the impact this had on the medium term financial plans as they had to be re-written, leading to 'very tricky' variation to tender negotiations. For many existing contracts, however, the authority were simply 'locked in' to commitments they could no longer afford. This was described as being the situation the 'length and breadth of the country' (Gerry, Strategic Finance Metro Town, 06/12/2016).

Similarly, wider council cuts were also increasingly impacting public health directly. By the follow up interview, the DPH at Midland City was expressing his frustration at being faced with conversations 'every single day' requesting money from the Public Health budget.

> But all the time […] every single day I would imagine I'm faced with somebody who's either coming to see me for cash, or is trying to weasel their way into money. **Alan, Midland City DPH, Dec 2016**

As the cuts to the public health specific budget began to bite at Midland City, they were being passed on to non-statutory commissioned services with the public health team reviewing contracts for disinvestment based on the newly narrowed objectives set out at the HWB. Following the 2016 budget consultation, the CEO of a local Midland City charity was interviewed after hearing that two of their largest commissioned services, funded by the Public Health grant, were to be cut:

> When I last saw you, James, it was February, wasn't it? We'd heard rumblings… We knew that things were really bad in terms of the council's budget, and we knew that they were going to have a significant cut, but we hadn't had any discussion with them. We were invited to a meeting, and then following that meeting in February, we got a letter to say that two of our services were going to be decommissioned.
>
> At that point, that was just enormous. I think three quarters of our income […] came from [Midland City]. So they informed us that two of our services for them would be decommissioned, which really in broad terms was about half of our income as an organisation, which was devastating. My response to that had to be a practical one, and I put all my staff at risk [of redundancy], because I knew that if those two services went half of our workforce had to go, and we'd have to look at our viability as an organisation. So that was my immediate response, which was something that I was very angry about having to do, to stand and explain to my staff that I was putting them all at risk of redundancy. It's not a pleasant thing. A couple of members of staff burst into tears. **Barbara, CEO of Midland City Charity, Oct 2016**

In the above, the CEO was reflecting on a February 2016 decision on the back of the 2016 Midland City budget consultation. The charity provides a range of services to vulnerable people in the community to bring them back into employment and to improve lifestyles,

particularly working with young families. As of February 2016, she was given less than two months' notice of the loss of half of the entire income of her organisation. She went on to describe how pressure was put on public health by GPs as the local CCG who did not want to see one of the services, health trainers, go; so that within a month of the initial decision that service was saved. However, their other service, weight management, was discontinued.

On investigation of the annual accounts of the charity, overall income reduced from £1.8m in 2014/15 to £0.6m in 2017/18 while the number of employees dropped from 67 to 31 in the same period (MC Charity 033, 2015; MC Charity 034, 2018). The CEO went on to describe the need for compulsory redundancies, the associated loss of skills, and the demoralisation of the workforce. She also summarises how disinvestment had become part of the business model of the charity:

> We're used to that upheaval every spring, because we're on fixed term contracts. None of our contracts are for more than 12 months, so we have that sort of horrible stomach churning feeling of what's going to happen, and it's very rare that we get a definite decision before maybe February. So staff get over sort of Christmastime and they're like, 'What's going to happen?' And I'm not able to tell them. **Barbara, CEO of Midland City Charity, Oct 2016**

Similar issues were said to be facing many other third sector organisations with 'four or five' other organisations having had to restructure in the same way in the local region. Meanwhile, some of the most striking data on the impact of austerity within the authorities came from those working outside of the core ring-fenced public health grant. One joint Public Health and Environmental Health officer in Midland City described the cuts across the rest of the council, and to environmental health in particular, as follows:

> At the moment, I would say we're [Environmental Health] reduced almost 50% than what we were in 2008. Management has definitely reduced by almost 80%, but the workload hasn't, so actually, we're still doing the same amount of work that we did, in fact, more work. It's exceptionally pressurised work. You don't stop at all. It is absolutely constant. And the demand for the service has

> grown as well. People have become intolerant to the public sector, so people are getting abused and shouted at by the public a lot more.
>
> A lot of our work is working with other agencies and what's happened is we've reduced and everyone else has and so people have completely disappeared. And what's been quite difficult is they've disappeared and we didn't even know. Physical people and then physical agencies have just gone. One day they're there and the next minute they're gone and you don't even know. It's the inefficiency: it's not necessarily that we're inefficient; it's just that we don't know what is happening to every other agency…
>
> It just feels very, very scary on where all this is going because the problem being is you don't know what the end result is going to be. You don't know what the endgame is. **Jane, Midland City Environmental Health Officer, Nov 2015**

In this quote we can see many of the wider issues that austerity causes, and the consequent difficulty to manage and coordinate services. Ad hoc approaches to disinvestment due to annualised budget cycles were disrupting existing networks, losing skills from the workforce and demoralising staff. As with the Midland City charity, these longer term effects were typically left unaccounted for. On discussion of the relationship between Environmental Health and Public Health with the officer, who was in a split 50:50 role between the two departments, she described how the cuts were both 'everybody's problem' but also 'nobody's problem' at the same time. Authorities would seek to adjust their financial plans, but year after year those plans would become redundant as new rounds of cuts were announced. This was described as a 'salami slicing' approach to disinvestment:

> If someone is going to disappear, if an agency is going to disappear in this endgame, then actually you might have all your plans including this agency, but not knowing that they might be gone in three years' time. **Jane, Midland City Environmental Health Officer, Nov 2015**

The wider fragmentation caused by austerity decisions and the HSCA 2012 reforms were a theme across much of the data, as were an increasing pressure on short-term delivery, mandated services, and increasingly 'cashable' returns on investments. System fragmentation was noted as a key theme in the 2016 Public Health enquiry into the post-2013 reforms with

one committee member citing cuts to sexual health services in particular as both counterproductive and as causing confusion across the system:

> You mentioned sexual health. That is an area where we have picked up a lot of concern from patients' groups, professionals and from organisations that are commissioned to deliver services, about not only the impact of cuts but the impact of the fragmentation of the services, with whole HIV services being decommissioned, for example. It does not seem to be a very sensible approach when you say that indicators are going in the wrong direction. **Bradshaw, HSC, June 2016**

This contradiction between the short termism of austerity measures, and both the public health evidence base and the wider public health ethos of prevention, came through in interviews time and again. One PHE consultant described the impact of the cuts to the public health specific grant as 'cutting off your nose to spit your face' (Elizabeth, PHE consultant, Sep 2015) while others pointed to the return on investment figures quoted both by the profession and by many of the government's own factsheets circulated prior to the transfer to local government. Others also pointed to the difficulty in achieving the government's vision to embed public health across the wider determinants of health if the core budget was continually cut away. One former public health Consultant described how public health activities were not just about 'counting beans', but that they needed to have the resources to actually get out and improve the situation in communities (Frank, Jul 2017), suggesting that public health should be more than simply monitoring the commissioning of mandated services.

Similarly, senior financial advisors interviewed described how most finance directors across local government had already cut away the 'low hanging fruit' in the years after 2010. One senior advisor argued that the case for longer term investment needed to be a strong one, with a clear focus on outcomes that are linked to the strategic objectives of the council in order to influence the difficult financial decisions being faced sector wide in order for public

health to survive (Harvey, Aug 2015). He was also critical of the failure to realise the 'Big Society' vision, which conflicted with the longer term sustainability of resources, and emphasised the difficulty councils were facing in committing to longer term preventative expenditure with future resources so uncertain. On the 'big society':

> I haven't really seen that come through at all. It's that sustainability of the resource that I think is the thing that is really exercising finance directors at the moment. How do you plan over the medium-term when you may not yet have a clear idea of what services are going to be like in three years' time? **Harvey, Partner in private consultancy firm, Aug 2015**

In this context, the PHE regional office grappled with the difficult task of mobilising the national PHE outcomes framework as their LAs were experiencing ever deepening austerity. As several participants pointed out, if public health professionals could mobilise the argument that preventative measures could save authorities money and free up resources elsewhere then this could be an attractive proposition. The regional PHE lead consultant for Midland City, Elizabeth, emphasised this point:

> The current economic climate forces us to monetise everything and certainly, I think, where councils are at the moment, they're looking for cashable savings, like, today. **Elizabeth, PHE consultant, Sep 2015**

However, several participants also problematised this dynamic as potentially detracting from a wider public service ethos in which all parts of the public sector were seen as being 'in the same boat' (Emily, Metro Town Consultant in PH, Mar 2015) and as counterproductive due to a bias towards more easily measureable short term service based interventions. Therefore a balance was sought between making the case for public health interventions based on their return on investment, and also ensuring that those return on investment calculations included wider social benefits and returns to the wider public sector and local economy.

The removal of the ring-fenced public health grant and the proposed business rate retention scheme

Despite repeated delays in its implementation, first to April 2016 and then to April 2020 (Department of Health and Social Care, 2018), the proposed removal of the ring-fencing from the public health specific grant and the transfer to a business rate retention scheme offered up interesting data on the strength and embeddedness of public health activities in local government. The acid test for integration would be whether or not councils continued to prioritise public health spend once ring-fencing was removed. The proposals themselves, to replace central funding with funding derived from the local business tax base, were heavily criticised as entrenching social inequality and running counter to Michael Marmot's 'proportionate universalism' under which resources should be targeted towards greatest need.

Asked what would happen should the ring-fence be removed, despite a reasonably successful integration the DPH at Midland City was not optimistic:

> Okay, so if you spoke to me two years ago, I'd have been really hopeful. I think in [Midland City] we are the biggest local authority with some of the largest cuts. And everyone's trying to mitigate their cuts by using someone else's money, and that's true for the public health allocation. And the council is fixed on balancing the budget, and it's very difficult in that scenario to seize opportunities. We're trying to. **Alan, Midland City DPH, Dec 2016**

Similarly, at Metro Town the scale of the challenge that would face the public health function should the ring-fence be removed was recognised. With reference to the risk of services becoming unstable due to exposure to salami slicing cuts, in this case described as 'creaming off', one Metro Town consultant described how non-mandated activities that were either in house or whose contracts were expiring would be at greatest risk:

> It will vary dependent on, potentially how much you've already agreed that you will commit to some existing local authority types of functions. I think we have got a battle on our hands to really

> demonstrate what we must spend our money on what we are absolutely mandated to provide, and we are mandated to provide a number of key services like drug and alcohol and sexual health, so you know, undoubtedly there's only so much creaming-off of those services that you can do before they become completely unstable services. So, we absolutely need to keep fighting our corner, demonstrating the needs for some of those services. But… there's no doubt, if the ring fence comes off next year or the year after or whenever, we will take our hit in terms of savings, there's just no doubt about it. **Emily, Metro Town Consultant in PH, Mar 2015**

The above quote was taken following initial proposals to remove the ring-fencing as of April 2016, with this cut-off acting as a focus and motivation for the local team to strongly establish themselves in the authority. The fear was that following such a move, public health would be seen as a 'soft' or 'fluffy' target for cuts, so that actors within authorities needed to be convinced of the savings that preventative action could realise, and of the real and valuable impact on health and wellbeing outcomes. This dynamic framed much of the observations of the HWBs described in section 5.2.

Given the local government context and the harsh austerity environment several participants commented on the importance of zero-based or programme based budgeting, building up activity around council strategy from the ground up. Adam, consultant and lead commissioner at Midland City (Dec 2015) made this point; pointing out that interrogating the value of activities and proving the budget had never been a priority in the NHS where budgets had been set incrementally. Similarly, in response to the threat of the removal of the ring-fence, the DPH at Metro Town described the importance of proving the budget based on 'need':

> What we've been deciding to do internally is financially plan from the bottom so you literally set a budget at nothing and you build up layers of actually what do we need in terms of investment in public health services, bringing in a lot of different things. It's need in terms of the population need and the evidence base in terms of what works, mandated services that are still in statute so they won't be changing even though the ring-fence is removed. **Joanna, Metro Town DPH, Dec 2016**

This approach put statutory services at the heart of the strategy on the basis that these would continue to be mandated even after any removal of the ring-fence, but also gave the activities a solid base in evidence and in institutional strategy. However, this focus on mandated services, particularly those commissioned back to the NHS such as immunisation, the NHS health check programme, and sexual health, risked reducing public health activities to a 'service' with the remaining 'public health advice' and non-mandated preventative activities around obesity, families, smoking cessation, and wider preventative action on sexual health and drug and alcohol becoming 'unsustainable' or 'unaffordable'. One public health educator and former environmental health officer at Midland City summarised this point:

> When times are tough and when you have austerity, the nice to do, real proactive stuff often goes out the window because there isn't the funding and people are focusing on the statutory stuff and that's where I think the gap starts happening more because you get this mentality of right, I've got to bang out X number of food hygiene inspections. **Anika, former Midland City Environmental Health Officer and PH educator, Jun 2017**

Several participants made similar points on the 'tension' between short and long term activity with the removal of the ring-fence putting the public health budget under greater external scrutiny. Fears were raised that public health would be reduced to 'box ticking' or that the portfolios of public health consultants would be increased dramatically. One regional PHE consultant summarised this as being somewhat inevitable should the ring-fence be removed, with the direct impact being on staff in public health teams:

> Their biggest costs, at the end of the day – they do have commissioning budgets – but the biggest cost, at the end of the day, is their staff. Which is back to my, well, they're going to strip the staff. (Laughs) And I think we're going to see more directors of social care in health, or directors of children and wellbeing… They'll be looking to strip out the staffing costs or increase people's portfolios or, basically… I mean, I don't think I'm being negative. (Laughs) I think I'm being honest, really. **Elizabeth, PHE consultant, Sep 2015**

The DPH at Midland City suggested in the 2016 follow up interview that 'if I go out three years, I've got very little apart from mandated services' and described how he had moved to crowd funding of childhood obesity services as an example (Alan, Dec 2016). He went on to conclude on the wider point that the fate of public health activities in LAs might be tied to the viability of the organisations themselves:

> I think we are on the cusp of either succeeding or failing. We're right on the edge. The next – well, it's the two year budget – is absolutely critical to the council. If the council succeeds, Public Health succeeds; if the council fails, it will be a nightmare. **Alan, Midland City DPH, Dec 2016**

Meanwhile, the Metro Town MP posed questions on the current level of public health spend and on the impact of transferring to business rate funding to Michael Marmot at the 2016 public health enquiry. His response drew attention to the wider social issues associated with entrenched health and wealth inequality, the dangers of linking ability to spend with a tax base that is inversely proportionate to need, and the danger of allowing authorities to 'fail':

> I am very concerned at cuts to the public health budget and cuts to the budget for the areas that I think impact on the health of the public. I am very concerned. I do not know what the right mechanism is for funding it, but something that resulted in those sorts of cuts— and we know that, in general, areas with higher mortality rates, that is, more deprived areas, have had steeper cuts to local government funding—other things being equal, will have an adverse impact on health inequalities […] Think about the US, where local services are funded from property tax [...] When Baltimore erupted, with civil unrest, after a black man was killed in police custody, it was the poor area, with a male life expectancy of 63, that erupted, and that area spends very little because the property tax is so low—the tax base. If we move to something like that, which enshrines these economic inequalities in the poor areas that have greater need, it is my proportionate universalism upside down. It is not spending proportionate to need. **Prof. Marmot, HSC, Mar 2016**

Participants locally expressed scepticism in the politics of further reforms to public health, suggesting that there appeared to be very little planning or consultation. However, it was also notable at the public health enquiry that public health leaders were reticent to engage directly in a political critique of the government. This was especially so in the discussion of whether

HIV prevention through pre-exposure prophylaxis (PrEP) should be funded by the NHS (HSC, Jul 2016). Fears were raised over the loss of momentum and that the 'good work' and 'enthusiasm' following the transfer of public health to local government would be lost as a result of austerity measures (HSC, Mar 2016). While locally, participants in PHE and both DsPH talked about linking in with the shared health and social care agenda and influencing what was increasingly being seen as a funding crisis in the NHS. Shared budgets and regional collaboration on broader geographical footprints through the better care fund, sustainability and transformation plans (STPs), and the newly created regional combined authority all emerged as possible responses to the fragmentation of public health and the erosion of funds as organisations realised they would not be in a position to tackle entrenched health inequality in isolation.

5.4 Multiagency work and regional collaborations

Through section 5.2, this chapter explored both the fragmentation that resulted from the HSCA 2012 reforms as multiple new accountabilities were created, access to data was disrupted, and commissioning split across Councils and CCGs; and then the ongoing attempts to build networks, particularly through the PHE regional office and professional spaces. The dysfunctionality and fragmentation resulting from austerity, particularly form 2015 onwards, was then further explored in section 5.3. Through the follow up interviews and second round of data collection, participants increasingly discussed the evolving agenda and proposals around devolution and pooled budgets. Three major developments included the introduction of the Better Care Fund, pooling social care costs between LAs and CCGs (HM Government, 2019b); the introduction of mandatory NHS Sustainability and Transformation Plans (STPs), which include LA representation in finding funding solutions to the projected budgetary

shortfalls across the local NHS and primary care footprints (NHS England, 2016); and a wider regional combined authority, which, in 2017 elected its first mayor. An emphasis across much of these reforms was on increasing multi-agency collaboration in response to the ongoing fragmentation of public health and the wider health and social care system, particularly with a view to addressing a growing funding crisis in the NHS.

From the literature review presented in Chapter 2, Chantler et al. (2019) note that successful partnership working between LAs and the NHS requires positive investment and that the lack of coterminous budgets between departments and organisations is a major challenge in a context of immunisation services. Similarly, Sanders et al. (2017) note the significance of budgetary boundaries in commissioning decisions due to overall budget constraints, so that austerity begins to conflict with the 'public service ethos' among health professionals across LAs and the NHS. This was supported by participants in this study, both with reference to issues of accountability and data access immediately after the 2013 transfer of public health activities and to more recent issues created by austerity cuts that disrupted existing networks and undermined long-term strategic planning.

Combined Authorities grew out of devolution plans laid out by the previous Labour government in the Local Democracy, Economic Development and Construction Act, 2009. This act sought to establish voluntary partnerships that would focus on developing transport links and incentivising local economic development and regeneration. A combined authority was set up in the midlands region in 2016, which included both case authorities, and went on to elect its first mayor in 2017. Better Care Fund, meanwhile, was introduced in 2014/15 as a pooled budget between the NHS, via CCGs, and LAs to deliver 'integrated care' with a view to reducing emergency hospital admissions and plug the shortfall in social care funding that had

arisen since 2010 (NAO, 2017). Following the Marmot (2010) principle of making every contact count and aligning complex care pathways, the Better Care Fund was to be overseen by HWBs and would seek to create a budgetary arrangement that would better align adult care services.

The introduction of the Better Care Fund did not appear to have had the desired effect of reducing demand for NHS services. In 2017, the National Audit Office (NAO, 2017) found that there had in fact been an 87,000 increase in emergency admissions against a forecast 106,000 reduction, as reported in Better Care Fund metrics, between 2014/15 and 2015/16. They go on to conclude that there was no evidence that the new arrangements would deliver sustainable financial savings or reduce demand long term, leaving a £900m budget gap in the NHS by 2020. This, together with rising costs and an aging population led to record deficits across NHS hospital trusts, with Foundation Trusts alone reporting a total deficit of £2.4 billion in 2015/16 (The King's Fund, 2017c). It was against this backdrop that NHS England announced in 2016 a £2.1 billion Sustainability and Transformation Fund[19], which were to be accompanied by Sustainability and Transformation Plans (STPs) that would implement the Five Year Forward View (The King's Fund, 2016b). These plans would cover 44 geographical areas across England, to be agreed between NHS trusts, LAs and CCGs, with a lead appointed by these bodies, typically from the CCG. Among the many objectives of the new STPs were ambitious proposals to reduce hospital capacity, streamline provision of acute services, redesign primary and community care, and strengthen prevention and early intervention (The King's Fund, 2016c), with a view to withdrawing the £1.8bn emergency deficit element of the funding from the NHS by 2020.

[19] £1.8bn of which would be used to plus NHS deficits, the 'sustainability' element, with the further £0.3bn for various 'transformation' funding streams.

All of these reforms were cited by participants in this project as providing opportunities for public health practitioners to pursue their agenda: to make the case that prevention and the public's health and wellbeing must be central to any systemic redesign of the health and social care system. In particular, public health professionals were able to mobilise existing networks through their DsPH regional meetings and through PHE to ensure they had a coordinated 'pitch' that they could use to include themselves in these developments. Given the wider funding crisis, these reforms also made the financial and economic framings of public health interventions all the more powerful as austerity in LAs continued to deepen.

Making the case: evidence of multi-agency work and regional collaborations towards a public health agenda

During the second round of data collection professionals in both case authorities had established Public Health working groups within the newly formed Sustainability and Transformation Plans (STPs). They sought to bring together actors across both of their geographical regions to address upstream pressure on the NHS; had established joint commissioning roles with other budget holders within their authorities; and in the case of both Metro Town and Midland City, had been working closely with the wider regional combined authority to ensure Public Health objectives were central to regional planning. Across the data, an ethos of prevention and an ethics of population health and wellbeing, that drew on more pluralistic evidence based understandings of what ought to count, continued to play out in contradiction with the ever increasing short-term pressures of austerity. A key role of public health professionals in this context was in resisting this short-termism and using their networks to address the difficult boundary problems that would arise as multiple different groups worked to differing geographical footprints.

The regional PHE director explained how working on a broader footprint was potentially a major opportunity for public health, particularly in relation to the regional combined authority. She described how existing networks were being mobilised as professionals sought to embed the language of public health into what was initially an arrangement focused around economic development and transport:

> To some extent it was built on quite a lot of work that had gone on in the West Midlands before that, around making every contact count, [Elizabeth] has probably spoken about that. This region had a very strong history of not just working with the NHS but also working with the fire service and the police[...] Of course in the final analysis we don't know, but we're viewing it as a huge opportunity. Obviously the initial devo deal was predominantly around transport skills, infrastructure, those areas. Increasingly, and this is driven locally through the Mental Health Commission, increasingly there's a social element to that[…] and that's where we can see the huge opportunity because as far as we're concerned, health and wealth are two sides of the same coin.
>
> **Rosanna, PHE Regional Director, Nov 2016**

She goes on to describe how they had established a 'health planning group' as part of the Combined authority that fed into public health networks involved in planning decisions within LAs, through which professionals have already been working for some time to develop a 'common language'. We can also see in the quote above the emphasis on bringing the 'social' into the economic and the understanding of 'health' and 'wealth' as interrelated and interdependent.

The work of PHE regional in facilitating these networks was recognised by the DPH at Metro Town, who described how the work of feeding public health ideas into the Combined Authority grew out of the PHE facilitated regional DsPH meetings. When asked what their involvement with PHE had been in relation to the Combined Authority the DPH replied:

> Hand in hand. So going back nearly a year now, we meet as an association of directors of public health and the Public Health England centre director regionally sits on that. We started talking about some of the opportunities[...] Some really exciting things could happen as a result of the combined

> authority working on that sort of footprint and that's been recognised in our STP plan, actually, as a work stream.
>
> We organised ourselves as seven mets initially, so directors of public health from those seven areas[…] all came together with some bits from PHE and we started to organise ourselves into like a combined authority group and we developed a 'pitch' in terms of an offer of the conversation and the work streams we'd really like to get involved in and we made that pitch to the programme board and the combined authority together[…]
>
> The programme board of the combined authority in the summer warmly received us and we're taking the offer forward. **Joanna, Metro Town DPH, Dec 2016**

However, there was also some scepticism expressed in relation to the 'rediscovery' of the importance of regional working, with some participants pointing out that the HSCA 2012 had only recently abolished Regional Health Authorities which would have addressed this gap before the latest round of reforms. Frank, a public health educator and former public health professional in Midland City put this as follows, linked the growth in combined authorities to attempts to reduce overheads as well as creating better collaboration, which could be at the expense of local responsiveness:

> CCGs are seen as maybe too small. And councils in a way are seen as too small. And the positives from places like Greater Manchester, is they're pooling resources over a larger area[...] So if you have those social care needs or health needs or whatever needs we have, then you have got that pot of money where you can spend it as efficiently and effectively as possible to improve that individual's life course.
>
> Yeah, so that seems to be the way. So that they have got the combined authority, that sort of larger scale area, but it seems if you look at the last 50 years, that is the way it goes it moves more and more and more towards larger scale. And then in 10 years they will be saying all these combined authorities to unyielding and where is the local responsiveness?
>
> So the regional assembly, where I used to work, and the regional health authorities [were] too big, and get rid of all those just go down to the area. And now it seems to be back to the regional area. You can imagine in 10 years' time thinking, well actually it's just too big a budget. **Frank, former Midland City Consultant in PH and PH educator, Jul 2017**

In this sense we can see that public health professionals were being pragmatic and adaptable in responding to the constantly changing organisational and regulatory landscape. Austerity and the HSCA 2012 had driven fragmentation of the system, but the need to further reduce costs and respond to the crisis NHS caused by a lack of a coordinated systemic approach to prevention were also driving greater centralisation of resources at the regional level. The attempt to link the funding crisis in the NHS to a more joined up approach to prevention, reduction of demand, and to adult social care in particular, were taken up in the newly mandated Sustainability and Transformation Plans (STPs).

At the second Health and Wellbeing Board attended at Midland City the local CCG lead introduced the first Midland City STP, in collaboration with the board and the Public Health team, which was the first such presentation at any public facing meeting (Midland City HWB, Nov 2016). The STP had been aligned with the Council's HWB strategy (MC 036, 2016), with a focus on mental health, infant health and maternity, as well as the wider determinants of health as identified in the plan (MC 035, 2016). However, at the follow up interview when asked about the STP the DPH at Midland City was not optimistic that it would lead to the ambitious systemic transformation required, describing how it had become a patchwork document that was trying to incorporate too many political 'agendas' that undermine local responsiveness:

> Each iteration has [come with] more rules and more control, and it means the flexibility locally becomes increasingly limited. But also the ownership that we had from the very outset, in our process has suddenly got lost. I started off being extremely hopeful around the STP, but increasingly, as the weeks and months have gone by, I have become more and more disillusioned with it, that it will lead to real change. Not because it doesn't allow that, it's just [that] there are other agendas being played out, which have been botched in as the STP, but actually they're not a system transformation. They're bits of the system, but they're not a system transformation. **Alan, Midland City DPH, Dec 2016**

Meanwhile, the Metro Town DPH described the STP as an opportunity to drive the Public Health agenda into future collaboration and planning, with the document also including a Public Health work stream as a central element. The DPH particularly emphasised the difficult public accountability issues as the documents were seen as outlining major cuts to services and reductions to NHS capacity, so that it was a relief to finally have the detail made public after 10 to 12 months of 'talking about it' without having the detail. On the geographical boundary issues these were described as 'robust' in the Metro Town STP as there were coterminous boundaries with the local CCG, with whom the public health team had already built a good working relationship over several years. This was, however, described as more problematic and more complex at Midland City which spanned three separate CCGs so that embedding the core strategic priorities across multiple STPs became more challenging.

In addressing whether STPs effectively brought key actors together to solve boundary issues and align objectives a second regional PHE director, Mandy, described how they were dependent on the pre-existing networks that PHE had managed to develop, and, to some extent, an element of chance as to whether the boundaries determined by the STPs matched up well with existing networks and the parallel processes relating to devolution:

> I think after the initial concept where they talked about place-based plans, I can buy into that totally. Where we struggle more is where that plan is not coherent and consistent with other sort of plans and grouping. So, to give you an example. For the north west [combined authority] is working really well because of the devo plan, the STP and their devo plan are as one. So, it operates, same boundaries, same people, proper strategic partnership board. They're really clear what they're doing.
>
> In [another authority region] it's been much more difficult because the boundaries of the STPs and then the complexity of the local delivery plans underneath those have got different boundaries to the [local] city region and their devolution proposal and the proposals around [the authority region]. So, it's been really hard to galvanise people into that side of footprint because it hasn't really fit with other teams and some of the early conversations from the CCGs were we can only do so many things,

we can do the STP and we can do our own plan but we can't cope with the devo stuff as well, the devo boundaries. **Mandy, PHE Regional Director, Nov 2016**

Across all of these plans it was notable that public health voices were prominent, and that the case for preventative planning was well aligned with the ambitions for more collaborative working and transformative systemic change. What was less clear was how such change was to be achieved in light of funding reductions. The plans essentially sought to both reduce capacity in the NHS by reducing demands, while also seeking to reduce investment in the activities that could achieve those ends. Thus the strategy of public health professionals was increasingly one of influence outside of the core ring-fenced public health budget – to steer ongoing strategic planning across transport, adult social care, and local economic development to include public health considerations. Perhaps counter intuitively, while annualised budget cuts increased pressures to deliver short term and 'cashable' savings they also created a climate in which integration and collaboration across the remaining services became increasingly vital to their future viability.

5.5 Summary and concluding remarks

This Chapter has sought to outline the key developments since the transfer of public health activities to LAs, following the HSCA 2012, in order to address the overarching research question:

- How has the case for Public Health activities been contested and established in local authorities in England?

This has been done in an intentionally broad way; following the key actors, from the broader documents, factsheets and inscription devices associated with the HSCA 2012 (for example, HM Government 2010; Department of Health 2010 and 2011), through to the primary

interviews, observations, and documentary analysis across two unitary metropolitan city councils and the regional PHE office. This was supplemented with interview data from public health professionals at the PHE head office in London, interviews with private sector consultancy advisors, public health educators, and data from the publicly available parliamentary enquiry. This was in order to capture the interrelation of the macro with the micro across organisational settings; linking the wider policy context with specific case examples. This Chapter is therefore intended to familiarise the reader with the data and the core controversies as they developed since the transfer of public health activities to local government, and as they were observed through this particular longitudinal study. Throughout, reference has been made to the financial context, and specific examples of budgetary arrangements, calculative techniques, and, through part 2 in particular, to the impact of austerity.

The evidence has been gathered using the agential realist approach described in Chapter 4, which led the researcher to diversify the range of evidence considered, follow the actors, and to consider the non-human, material, and the calculative through and with discursive, the human, and the subjective. However, it is the following Chapter 6 that seeks to explore what this story tells us in relation to the literatures introduced in Chapter 2 in the reconstruction of professional identity (6.1) through and with a reconstruction of the evidence (6.2), and ultimately to conclude on what public health can tell us about the ethical, performative construction of contested value claims and accounts (6.4).

Across all of the reforms summarised in this Chapter, and in the particular context of the primary data, public health professionals were seen to mobilise an abstract 'public health agenda' that was itself iteratively being redefined towards a broader understanding of

'wellbeing' over the more medicalised 'health', and by austerity towards arguments and narratives framed in increasingly explicit economic and financial terms. This was a two way dialectal process in which professional identity and evidence were continually redefined through and with an evolving multi-agency space, and across geographical and organisational boundaries that varied from the LA and CCG boundaries to wider regional or even nation-wide spaces. Chapter 6 explores how the public health professional identity (6.1) developed through and with new ways of constructing evidence and narrative (6.2) in this complex and dynamic environment. It goes on to reflect on the lessons for understanding these reforms and calculative techniques as (post)NPM developments that operationalise 'intelligent accountability' (6.3), before making the case that in investigating how accounting objects and practices construct value(s) and value claims we must engage with the complex and dynamic material-discursive apparatus that frame and reproduce them (6.4).

Chapter 6: (Re)constructing Public Health: identities and evidence

Through Chapter 5 we saw that following the transfer of Public Health activities into LAs, Public Health teams sought to mobilise their professional expertise as applied medical scientists to enrol budget holders, city planners, politicians, charities, CCGs, and many others in an increasingly broad understanding of health and wellbeing. 'Bringing Public Health into everything we do' (Marmot, 2010) while maintaining a ring-fenced Public Health budget through deepening austerity. The disaggregation and fragmentation of Public Health activities under the HSC Act 2012 subsequently led to reductions in the scope of direct interventions as budgets were reduced from 2014 onwards, but also coincided with increased multi-agency and cross-profession collaborations. The calculative and discursive valuation practices employed by Public Health practitioners sought to embed the value of a Public Health agenda through iterative and performative intervention across an increasingly diverse organisational sphere. These performative intra-actions (Barad, 2007, pg.184) demonstrated the cyclical nature of valuation practices in the day to day back-and-forth of organisational life that were variously economic, calculative, and discursive in nature. In this Chapter we will discuss how this constituted a reconstruction 'Public Health' towards a new, more pluralistic and collaborative professional identity, and how this played out through performative calculative and discursive practices that established what 'ought' to be accounted for in terms of time horizons, outcomes, and economisation.

Chapter 5 provided a narrative for how ethical and social values were contested through the construction of a shared Public Health 'agenda' in the context of the HSCA 2012 reforms. In so doing, it sought to address the overarching research objective:

- To explore how the case for Public Health activities is contested and established in local authorities in England in the aftermath of the HSCA 2012.

This Chapter extends the empirical investigation presented in Chapter 5, to examine the emergence of a new Public Health professional identity through and with calculative and discursive practices, evidence, politics, and austerity. The chapter begins by exploring the data on the 'reconstruction' of Public Health, before outlining how this story contributes to the growing Public Health (see 2.2), Local Government (see 2.2), and health professions (see 2.4) literatures (6.1). The chapter then discusses the reconstruction of evidence in the data (6.2), and explores how both calculative practices in general, and accounting and accountability practices in particular, are shaped and reshaped by the new multi-agency network, drawing particularly on the case example of Drug and Alcohol interventions. Reflecting on Chapters 5 and 6, the thesis then moves on to discuss the specific contributions to the critical public sector accounting literature (7.1); developing our understandings of 'New Public Management' (Hood, 1991; Hood, 1995; Power, 1997, pg.42; Lapsley, 2009; Hyndman and Lapsley, 2016), 'intelligent accountability' (Roberts, 2009), 'alternative accounts' (Bracci et al., 2015; Bebbington et al., 2017), and austerity (Bracci et al., 2015; Hyndman and Lapsley, 2016; Steccolini, 2019). The discussion concludes with a review of how this study can contribute to our understanding of how *value* is performatively constructed in organisational life (with particular reference to Barad's (2007) Agential Realism) through the ethical-political iterations of subjective experience through and with the reconstruction of the objective 'facts'.

In presenting the following two sections, 6.1 and 6.2, this chapter addresses the specific sub-objectives introduced in Chapter 1 that make reference to the performative reconstruction of identity (6.1) through and with the performative reconstruction of the emerging 'accounts' and calculative practices that seek to establish the value of Public Health activities (6.2):

- To explore the evolution of new Public Health **identities** since the move to local authorities, and to discuss the **performative processes** that construct these new identities. (6.1)

- To explore how the emerging **accounts of** Public Health activities are (re)constructed towards a 'Public Health agenda', and to discuss the **performative processes** that construct these accounts. (6.2)

Chapter 7 then addresses the final research question when reflecting on the contribution to the critical accounting literature, together with the concluding remarks that give particular attention to the theoretical contribution of the thesis. In particular, the bearing the agential realist methodology has had on the project and how this theoretical framework has helped shaped the results, before reflecting on opportunities for further research.

- To discuss the **ethical** and **political** dimensions of these valuation practices, with reference to critical public sector accounting literatures on 'post' New Public Management, 'intelligent accountability', and austerity. (7)

6.1 (Re)constructing the Public Health discipline

In the opening sections of this thesis, the question of 'What is Public Health?' was posed by way of introduction to the empirical context of the project. While broad definitions referencing protecting population health and empowering healthy lifestyle choices (for example PHE, 2018) were provided, it was observed that the definition had itself shifted over time and that 'Public Health' was a complex network of reflexive practitioners (Plsek and Greenhalgh, 2001) with a long statutory, professional, and institutional history. The question of 'What is Public health?' therefore was not one to be established at the outset, but rather one to be foregrounded as an empirical question. This section takes up this task.

In Chapter 2 (section 2.4) we saw that 'identity work' is dynamic (Skærbæk and Thorbjørnsen, 2007), with differing views on the extent to which managerialism dominates professional autonomy in healthcare settings (Waring and Currie, 2009; Exworthy, 2015), and differing views on the extent to which performance measurement practices are coercive or dysfunctional, or part of 'willing' processes of hybridisation (McGivern et al., 2015). McGivern et al. (2015) in particular argue that it is through 'willing' processes that more permanent reforms become established and a more collaborative, interdisciplinary public sector can be achieved. It was noted that a significant body of empirical literature has explored processes of 'hybridisation' of medical professions via adoption of accounting, budgetary, performance measurement, and risk management practices, and how medical professions have adopted accounting techniques of control (for example Bourn and Ezzamel, 1986; Kurunmaki, 2004; Llewellyn and Northcott, 2005; Samuel et al., 2005; Kurunmaki and Miller, 2008; Jarvinen, 2009; Fischer and Ferlie, 2013). The literature sees this process of hybridisation as coinciding with the proliferation of NPM style reforms across the public sector and explores the how such reforms reconstitute discursive categories and calculative practices (Llewellyn, 1998; Kurunmaki, 2004). The modern 'hybrid professional' is someone who adopts a variety of skills in an increasingly interdisciplinary and inter-professional environment. Noordegraaf (2007) in particular emphasised the move away from traditional controls over the profession as a 'body of expertise', towards control over the process of network building, collaboration, and shared working. Similarly, Waring and Currie (2009) detail how knowledge practices are central to dynamics of identity work as medical managers codify knowledge and experience through iterations of top down and bottom up contestations of the facts.

Building on this review, Chapter 2 noted that while there had been extensive discussion of how professional identities have developed through processes of

'professionalization' (Abbott, 1991), 'de-professionalization' (Noordegraaf, 2007), or 'identity work' (McGivern et al., 2015), there was much less discussion of *how* the construction of facts and professional epistemologies have developed from a STS perspective. Furthermore, few studies had explored how the *performativity* of material-discursive practices leads to dynamic (re)iterations of institutional and professional knowledge frameworks (Gond et al., 2016). The literature review demonstrated that the abstract knowledge base described by Abbott (1988) was, in fact, highly localized, contextual, and dynamic, with several empirical papers showing how professional identities are continually (re)constructed in healthcare settings (Kurunmaki, 2004; Waring and Currie, 2009; McGivern et al., 2015). The studies reviewed in Chapter 2 also lead towards questions of how professional 'expert' status (Carolan, 2006; Noordegraaf, 2007; Waring and Currie, 2009) must be capable of reflexively engaging with its ever changing social purpose in order to remain relevant. This sets the scene for the analysis of 'identity work', often framed via Governmentality or institutional theory lenses, through an STS theoretical framing. In particular, the application of an agential realist framework (Barad, 2007) draws the analysis towards 'material-discursive' performative practices, and sensitizes the researcher to the ethical and political dimensions of identity reconstruction.

The reconstruction of 'Public Health'

In addition to the limited literature on identity construction and identity work from an STS perspective, it was also noted in Chapter 2 that few studies in the professions literature had looked at Public Health professionals, in particular, among health professionals in general. The Public Health profession is a distinct body of experts and expertise with unique organizational spaces, its own professional body, its own professional qualification, and its own professional development requirements. Furthermore, it had just undergone a major shift in institutional environment, from the NHS to Local Government under the HSCA 2012.

Several studies in the Public Health literature had begun to explore the impact the transfer to Local Government was having on practice, with several studies noting the complex and fragmented accountability arrangements (Phillips and Greene, 2015; Chantler, 2019). One important point in the literature was the increasingly double role of the Public Health professional as both 'advocate' and 'expert' (Smith and Stewart, 2017). This challenged the traditional positivist 'representational' view of the scientific evidence base underlying Public Health as practitioners moved closer to the core ethical and political issues facing LAs. Both Smith and Stewart (2017) and Carolan (2006) emphasized the importance of Public Health professionals to develop both 'facilitational' or 'interactional' expertise. This echoes both the call made by Noordegraaf (2007) in the wider health professions literature to understand professional knowledge frameworks as 'reflexive', and at the more fundamental level the concepts presented in the theoretical framework of 'diffractive methodologies' (Barad, 2007 and 2014) and 'strong reflexivity' (Harding, 1991).

In the initial phases of the project, through the pilot interview and background review of the professional pathway provided by the Faculty of Public Health, it was noted that Public Health professionals came from a range of both medical and non-medical backgrounds. They could qualify by either exam or portfolio with the Faculty, with many professionals moving into Public Health after having already established their careers elsewhere. Following the transfer into LAs, the way in which they interacted with local populations, were able to build their evidence base, and the accountability arrangements through which they engaged with key actors all changed dramatically in a short period of time. Participants described how coming into local government required them to 'speak a different language' (also noted by Brown et al., 2014, and Phillips and Green, 2015). Describing this as an issue of how they understood and communicated 'evidence' across the authorities and when working with

elected members. They often referenced the idea that the 'scientific' terms of reference, familiar in the NHS, no longer carried the same weight. Instead, noting that experience and the personal 'story' would carry greater resonance. The regional PHE 'place based' consultant for Metro Town put this as follows:

> I think one of the most valuable things I've ever done is spent a few days with some local elected members. Because, you know, at the end of the day local authorities are part of the democratic process. And it's local elected members who they need to justify their value added to. And it's really caused me to have a shift in my thinking around the use of narrative and stories. When you talk to local elected member it's story, story, story. **Paula, PHE Consultant in PH, Aug 2015**

This change in how evidence was to be communicated, however, extended beyond direct interaction with elected council members. There were contrasting epistemologies at play across the range of interactions that were not linked directly to political accountability. This came as Public Health professionals increasingly began working with colleagues across the council on joint commissioning, evaluating existing activities, and supporting planning decisions. At Midland City, a senior Public Health consultant and former DPH who held the joint post of 'Consultant in Public Health' and 'Director of Commissioning' in the authority, when asked if LAs 'do enough of that kind of evidence base in a more scientific sense?', responded:

> No, they don't at all. No. So you have to, from a training point of view, and you have to do that yourself and create the environment[…] which helps you at work to change some of the culture. But no, it's very much that that isn't the driver for a lot of the work and that's essentially what our role is, a lot of what our role is, I say 'our' in terms of Public Health […], [in asking] 'Where's the evidence of what you're doing' [and] 'what are you trying to achieve?' You know, what are we actually trying to do?
>
> And this is helpful working with [Midland City DPH], that we always go, 'What was the outcome here?' as opposed to putting a service in place. If you're really strict in that, it really does stop people in their tracks. **Rodrigo, Midland City Consultant in PH and lead Commissioner, Jan 2016**

This was one of many examples of a distinct organisational and professional 'approach' to evidence based evaluation and outcomes focused intervention. Of interest in drawing out the contrast between Public Health and other health professions is the particular emphasis on *outcome*, in addition to evidence and accountability. This was a point of distinction made repeatedly between the Public Health profession and other health professionals in NHS, with the latter being considered to be overly 'service' driven rather than outcome focused.

The focus on outcome was also emphasised as a collaborative endeavour. For Public Health to 'thrive' in LAs they needed to integrate Public Health thinking into every decision across the council, and, indeed across all interagency and regional collaborations. The regional director of PHE joked in one interview (Rosanna, PHE Regional Director, Nov 2016) that one of the most important steps taken by the profession in recent years had been the introduction of the apostrophe in moving from 'Public Health', capital 'P' capital 'H', to 'the public's health'. This coincided with many of the Marmot (2010) recommendations that have developed wide linguistic traction across the system including bringing 'Public Health into everything we do', 'making every contact count', and integrating Public Health activities along the 'life course' across multiple agencies. Some participants, particularly the private sector consultants and health economists interviewed, argued that there was an organisational 'reality' that the Public Health budget that needed to be 'protected', defining Public health as well-defined identity with a community of norms and practices that needed to be maintained (Abbott, 1991). However, there was a clear sense of conflict or tension between the idea of 'protecting' Public Health, particularly in the face of austerity, and the underlying aim of bringing Public Health into every decision and influencing every outcome.

This conflict came across particularly strongly in response to the possible removal of the ring fence from the Public Health local grant allocation. One participant in Midland City described this conflict; of treating Public Health as a traditional stand-alone budgetary department, as being analogous to the conflict between service based health provision in the NHS and the preventative Public Health 'ethos' of Public health in local government:

> I think if you say Public Health, it seems to hark back to its traditional sense of a Public Health department delivering Public Health stuff, so I'd say, well, you know, how can you truly reframe that and say – is health and wellbeing just a key value for this council? […] You think, well, yeah, that's good. Public Health is embedded, it's there. But if we leave with 'Public Health', it seems like it's an entity, it's a tradition. It's almost comparable with the bricks and mortar approach: it's an institution or a department or whatever. And I find that unhelpful…
>
> I'd like to say I've seen the light. I think in the NHS around Public Health it was very service-focused and that's because of my upbringing, we call it upbringing, in the National Health Service. 'Service', that's the key thing in there. It's based on services. It's service provision. It's service driven. **Rodrigo, Midland City Consultant in PH and lead Commissioner, Jan 2016**

The move from the NHS had 'opened up' Public Health and shifted discourses from narrower definitions of 'health' to broader definitions of 'health and wellbeing' and 'prevention'. This was a clear theme that came up across the case authorities, in interviews with the PHE health economists, and was noted in the HWB observations, for example in the move towards a joint strategy on mental health in Midland City (MC 037, 2017) and community engagement at Metro Town (MT 038, 2016). The transfer from the NHS, therefore, changed not just the formal accountability and reporting arrangements, as described in Chapter 5, but also began to change the very meaning and scope of Public Health itself. Meanwhile, the focus on Public Health outcomes was a way of codifying the Public Health professional ethics and 'agenda' into a broader sense of the collective; combining the objective independent rigour of the 'scientist' who applies the 'evidence' with an ethically informed position on what outcomes ought to matter. This ethical emphasis on a broadened set of outcomes was summed up with

by the DPH of a south England County Council at the March 2016 meeting of the health Select Committee's inquiry into Public Health in Local Government referencing repeatedly how the national PHE outcomes framework 'is really important to us' and is what 'really matters to us' (HSC, Mar 2016).

In exploring further the question of identity and ethics, participants were asked in each interview about how they were held accountable for their work; particularly given the long time horizons and the difficulties in establishing causal links between their immediate work and the indicators in the PHE outcomes framework. There were three parallel appraisal processes in place depending on whether the consultants were LA based or PHE staff. These were the internal organisational appraisals (either within the LA or PHE); an annual Public Health professional appraisal overseen by the PHE regional office; and a five yearly revalidation process with the Faculty of Public Health for non-medical doctors (or a similar five year revalidation with the General Medical Council for medical doctors)[20].

The internal appraisals at the authorities were described as relatively informal, recognising the difficulty in linking broader outcomes to the activities of individual practitioners. As a result they were described as activity driven, evidenced by meetings attended or documents prepared such as the Joint Strategic Needs Assessment or Public Health annual report. At PHE the internal appraisal was linked to the strategic objectives and the director of the regional office emphasised the importance of being able to trace individual

[20] The five year revalidation appeared to have pre-existed for medical doctors, and was underpinned by statute, while the similar five year revalidation for non-medical Public Health practitioners had come to align and mirror that process. This also coincided with the creation of the 'consultant' in Public Health role, which was an attempt to give a comparable professional 'status' to medical consultants.

objectives through to the organisational 'business plan'. Indeed the emphasis on 'business' activity was prominent in PHE when discussing appraisal, for example:

> We've got the management appraisals and increasingly what we try to do there is to make sure that our business plan, we've put quite a lot of energy into creating a business plan that is smart and deliverable, and then we follow that through into people's objectives. If I was somebody in the health protection team, I could see which of the objectives in the centre business plan I was contributing to. **Rosanna, PHE Regional Director, Nov 2016**

This and other such examples supported the view of Hyndman and Lapsley (2016) that the fundamentals of NPM, in the adoption of private sector management techniques, measurement practices, and a certain discourse that privileges 'business' activity in a public sector context, remained deeply embedded. However, the 'professional' appraisals that ran in parallel to these were somewhat different. For the Public Health appraisal, the process was independently 'audited' to ensure that activities were genuinely linked to fitness to practice, and included elements of reflective writing in which professionals discussed how their CPD activity kept their knowledge relevant and up to date. This process appeared to be more strongly and explicitly linked to how the professionals identified with their sense of self, and also helped them maintain a distinct identity within the authority. The PHE regional office, and 'place based consultants' for the two case authorities (each of whom where interviewed for this project Elisabeth and Paula), were crucial in this 'identity work' (McGivern et al., 2015) via their role in conducting the professional elements of the appraisal. The PHE office also had a role in drafting job descriptions and overseeing the recruitment process for new LA consultants.

It was these latter professional appraisals, both the annual process via the PHE regional office and the Faculty of Public Health 5 year revalidation, that were found to be much more strongly implicated in the construction and maintenance of identity. In particular,

the separation from the authority and the 'external' element to the regulation and oversight gave legitimacy and also, in a more practical sense, helped develop a distinct but coherent 'voice' of the profession. The PHE place based consultants, for example, worked directly with local consultants in an advisory capacity so that the professional appraisal almost amounted to a parallel line management in which actions were judged against a professional set of standards external to the institution. Similarly, the observations of PHE regional workshops, for example on drug and alcohol interventions, observations of DsPH regional meetings, and 'CPD events' such as the conference held at the University of Birmingham (see Figure 3. Timeline of primary data collection) all showed a positive and self-reinforcing space in which Public health professionals discussed common problems and came to common solutions.

However, this process was not entirely harmonious. One point of contention was in the internal division between Public Health consultants from either medical or non-medical backgrounds. Medical professionals, despite a long history of regulation and reform of how their profession is controlled through both measurement and bureaucratic practices, come from a tradition of professional autonomy and as a result well institutionalised sense of professional identity (see for example, Exworthy, 2015). On the other hand, non-medical Public Health practitioners who qualified via the 'portfolio' rather than exam rout into the profession had often come from a variety of non-medical backgrounds and reported feeling somewhat second class within the 'hierarchy' of identities. This split of professional hierarchies has been seen before in the literature, for example Ferguson et al. (2021) in finding that temporary employed doctors or 'locums' reported feeling inferior and as having a lower place in the medical hierarchy than permanently employed colleagues. With respect to the performance appraisal process in this project, one non-medical public health

professional described how there was an entirely separate professional appraisal system in place, which contributed to this perceived hierarchy:

> There's GMC registered Public Health professionals and UK Public Health registered professionals. And we came together. And I think there's some tension there still. Public Health England have set up an appraisal process for their own staff and for all the medically registered ones. Non-medically registered ones, like myself, who aren't members of Public Health England, can't use their system. We've got to use a separate system. We've got to use separate documentation. And the reason for that is they've not let us use it. They've just not let us use their appraisal system. So that immediately makes me feel I'm separate. **Matthew, Midland City Consultant in PH, Dec 2015**

On review of the staffing at the regional PHE office it was noted that all of the place based consultants carrying out the professional appraisals were medical doctors, while in both case authorities there was more of a mix of medics and non-medics, with the DPH at Metro Town, in particular, being a non-medic. It did appear to be the opinion of at least some of the participants that PHE were in part responsible for continuing a perceived historical hierarchy and emphasis on the medical side of the Public Health profession. This tension also created the interesting hybrid category among Public Health professionals who came into Public Health with a strong pre-existing professional identity. Again in the PHE regional office, one consultant with a medical background described herself as a 'Public Health Doctor' and emphasised the importance of this to her NHS facing role:

> Interviewer: So would you see yourself both as a medical doctor professional and also a public health professional? Do you see those as separate things?
>
> Respondent: No, I see it as one and the same. It's interesting. I see myself as a public health doctor. We have consultants in Public Health who aren't doctors. For my role, I think it is important to have the medical background because of the role I'm undertaking. I'm very much NHS facing. I work a lot on patient safety agenda. **Paula, PHE Consultant in PH, Aug 2015**

Similarly, further evidence of the growing 'hybrid' status of the Public Health professional was noted in an interview with a Public Health consultant in Midland City with a medical background. Their role involved working across both the council and the new CCG, and they describe how they have grown out of a deeply embedded NHS 'brand' to become the link or the 'glue' between the NHS and local government:

> My role has very much developed to being a bridge between the local authority and the NHS. And that's, kind of, the rebranding of public health consultants. You know, you speak both languages. It sounds odd maybe, but you do. You have the ability to bring and be a bit of a glue between the two parts of the sector. So that's been really helpful in terms of being in the best position. I was 20 years in the NHS. And, certainly, when I moved over I was horrified. It was, kind of like, cut me and I'll bleed blue sort of thing. But you get to realise that, actually, the local authority you can[…] engage with the population using that route. **Rodrigo, Midland City Consultant in PH and lead Commissioner, Jan 2016**

Drawing on both of these examples, the medical–hybrid Public Health professional could be described as a sub-set within Public Health, in the context of a perceived hierarchy within the Public Health discipline. This contributed positively to the plurality of the Public Health profession, allowing professionals to draw on a range of skills and speak to a range of audiences across an inter-disciplinary and multi-agency space. Across these tensions was also a strong unity of purpose – when questioned about what brought the professionals into Public Health and what defines Public Health professionals, for example, participants responded overwhelmingly with their ethical commitment to the public and with their 'accountability' to local populations. The DPH at Metro Town put this as follows when reflecting on the increasing challenges posted by austerity:

> From a professional accountability, I've absolutely got a duty to improve the health of the residents of the city of [Metro Town]: to protect them from harm. And I also need to be reducing health inequalities. And that is absolutely my driving principle. I come and remind myself of this every day. So whether I have flak and worries around that money, flak and worries around doing politically the

> right thing, ultimately, my main accountability is to those 252,000 people out there in terms of me continually striving professionally to do my best. And that is absolutely what I hold probably the most dear. **Joanna, Metro Town DPH, Dec 2016**

Public Health in Local Government was therefore a combination of evidence and advocacy, with a range of individuals from a variety of backgrounds brought together through an underlying ethic that drew heavily on a sense of professional identity, constructed across organisational boundaries and between medical and non-medical health experts. In the above quote, the DPH at Metro Town was reflecting in particular on her accountability to the public, and her relationship with political actors in the council via the newly created HWBs, in a manner that would have been hard to imagine in the context of PCTs. The reforms had both freed up Public Health to take control of their own pitch, and put them closer to the grass roots community services and activities that they wanted to influence. The challenge, however, was that this had come as wider council budgets, and then the Public Health budget itself, were facing unprecedented cuts to their resources.

Drawing particularly on the interviews with the two Public Health educators and on the parliamentary enquiry this point leads to one final reflection on the Public Health profession more broadly, and how it was perceived as a career in its new LA context. Drawing on HSC data several contributors cited anecdotally that posts had been lost in the transfer, while others discussed the broader role for specialist consultant in their new context. Cramer CBE, Chief Executive, Royal Society for Public Health, addresses the issue of the role becoming increasingly 'undervalued' due to ongoing cuts to budgets:

> People feel that the progression routes within the core public health workforce are quite opaque and sometimes it is not very clear where you might go next or what your career might look like. In order to encourage people—younger people and people coming out of university and others into these professions—we need to have a very clear pathway and career route. At the moment, that is not the case[...] Another frustration is around the funding — that if you are having to cut back on

> services you have set up or been involved with, it can feel that it is an undervalued role. **Cramer, HSC, Mar 2016**

Both Public Health educators interviewed (Frank, Jul 2017; Anika, Jun 2017) repeated this point, suggesting that it is becoming much harder to encourage young people into the PH profession due to austerity and the environment that created. Reflecting on the reputation of Midland City, Frank, a former Public Health practitioner for the council noted that:

> All the cuts and if you see a newspaper articles at the council it's all about problems with children's service, problems with this. It is very rarely a positive story about the councils. Yeah so, in the past it was a fantastic organisation and massive positive force for change across the cities. One of the hard sells is that now it's not seen as the council which is seen as a horrible… When I have been going round trying to sell public health as a career, as something to do for the rest of your life, that is one negative issue that some people come up with. They say that sounds interesting [but] 'The council, not sure I want to work there.' **Frank, former Midland City Consultant in PH and PH educator, Jul 2017**

This was a point made towards the end of the data collection and seemed to be linked to the deepening austerity measures being imposed on both Council budgets and on the ring-fenced Public Health grant, but also broader social discourses around the Public Sector and Local Government in particular. There was perhaps a sense that Local Government was not as desirable or as respected an employer as the NHS in the minds of the public or young people entering the profession. There was relatively limited opportunity to put this point back to PHE or to senior Public Health practitioners but it does suggest an added dimension to the challenges being faced due to austerity – challenges that were not just immediate and practical but ones that affected future recruitment and entry into the profession.

Discussion: Performativity, 'identity work', and the 'hybrid professional'

This section provides a discussion of the reconstruction of Public Health professional identity in LAs in England in the aftermath of the HSCA 2012, summarising and further discussing what

the analysis presented so far contributes to the literature introduced in Chapter 2 and Chapter 3. The discussion begins with a brief comment on the applied Public Health and Local Government literatures (2.2) before focusing the remainder of the discussion on the contribution to the broader health professions literature across organisational studies and critical accounting (2.4). This is in part to highlight important empirical gaps that are addressed by this thesis, but also to discuss what the Agential Realist theoretical framing adds to our understanding, together with the broader potential for STS and feminist science studies inspired research can contribute to future studies of professions and professionals in practice.

Early qualitative research across applied Public Health and Local Government studies does a great deal to highlight some of the key challenges facing Public Health practitioners in their new context (see for example Day et al., 2014; Phillips and Green, 2015; Hunter et al., 2016; Peckham et al., 2017; Sanders et al., 2017; Reynolds et al., 2018; Chantler et al., 2019), but have, so far, only begun to address how austerity is changing this landscape or how calculative practices, accounting, and accountability play important roles in mobilising a Public Health agenda. There is therefore scope for interdisciplinary conversations between Public Health (for example journals such as *Critical Public Health, Public Health,* or *Local Government Studies*), organisational studies, and critical accounting on the intersections of the profession, the institution, and public sector austerity in relation to Public health reforms in England. Furthermore, as will be discussed below, there is relatively limited theorisation in the Public Health literature, and even in the health professions literature more broadly little theorisation from an STS perspective. The empirical narrative outlined in Chapter 5 detailing the growing impact of austerity and fragmentation (5.3); the response by Public Health professionals to move to more integrated multi-agency and cross-profession working (5.4); and the contradictions between the ambitions of the reforms and the consequences of

austerity all provide potentially valuable empirical insights to the study of applied Public Health. Similarly, the iteration of professional identity with context, the reconstruction of evidence through discourse, inscription, and calculation, discussed in the remainder of this Chapter (6.2), together with the wider contradictions between the initial ambitions of the reforms, characterised as 'classic NPM', and the later moves to 'post'-NPM and austerity (7.1), could all add valuable theoretical weight to these interdisciplinary debates.

Developing this point, the analysis so far has shown that 'Public Health', as a professional discipline and a shared identity, was itself reconstructed in a new and increasingly multi-agency context. Practitioners engaged with new stakeholders and began to rethink both their understanding of Public Health and how they mobilise their shared agenda. The transfer from the NHS had 'opened up' Public Health to new non-medical audiences and widened the scope of interventions from 'health' to 'health and wellbeing', while practitioners had learnt to speak a 'new language', 'tell the story', and engage more closely with the local population. The data showed that this took place across a range of spaces, from the HWBs to regional PHE workshops, DsPH monthly meetings, CPD and academic events, via a range of performances, positions on committees, informal social links, and the construction of inscription devices designed to align strategy (see 6.2). This echoes what Sanders et al. (2017) refers to as the 'messy' reality of constructing evidence in practice, which they argue remains under researched. While authors in the Public Health literature such as Hunter et al. (2016) and Smith and Stewart (2017) note the importance of aligning good evidence with opportunity, advocacy and political support.

All of this speaks to concerns in the wider professions literature, which has increasingly explored how the abstract 'expertise' that helps define the profession (Abbott, 1988) must

be capable of reflexivity in order to engage with dynamic social circumstance and purpose (Noordegraaf, 2007; Waring and Currie, 2009). It is then in precisely such changeable contexts that 'identity work' takes place as professionals seek to form and reform their sense of coherence and self in the face of changing organisation, institutional, and social circumstances (Sveningsson and Alvesson, 2003). Waring and Currie (2009), for example, frame this as a mediation between top-down and bottom up forms of control, while McGivern et al. (2015) describe how medical professionals form lasting hybrid identities through continual identity work that unfolds in the face of institutional tension and renewal. The role of 'Public Health Doctor' described by one participant (Paula, PHE Consultant in PH, Aug 2015) could be described as one such 'willing hybrid' (McGivern et al., 2015), particularly as the Public Health Doctors had established an elite status within the Public health profession and, particularly through the PHE regional offices, took on active mentoring roles. Similarly, the analysis demonstrates the importance of 'external' forms of monitoring and cross-organisational spaces in maintaining and developing hybrid identities via what could be described as 'hybrid identity work' through which Public health professionals were seen to reconstruct their identity with reference to the new skills required to engage and mobilise in their new context. Several observations, for example the PHE regional Alcohol & Drugs Value for Money workshop, the regional DsPH monthly meeting, and the University of Birmingham Public Health conference, focused heavily on the question of how Public Health professionals needed to adopt new skills in order to provide the 'glue' across and between other actors and organisations. In particular, by working across local government and the NHS through HWBs, and wider initiatives such as STPs and the regional Combined Authority. Part of this hybrid identity work involved adopting management accounting and performance management techniques, such as modified SROI tools (see 6.2), but a major part also consisted of adapting

their use of discourse, narrative, and evidence towards to 'personal story' to new non-medical audiences.

The Public Health profession is therefore an interesting and important case as it provides us with a profession that actively fosters plurality and actively seeks out willing hybrids so as to further their core ethos of 'health in all policies' in order to influence the 'wider determinants of health' (Marmot, 2010). Professionals were found to be highly reflexive and actively tailored both their communication styles and their evidence base towards effective advocacy, a point that was also well studied in the Public Health literature (Plsek and Greenhalgh, 2001; Carolan, 2006; Smith and Stewart, 2017). This project, however, adds that this was more than simply a difficult trade-off between subjectivity and objectivity (Smith and Stewart, 2017); indeed, the ethics of constructing a shared 'public health agenda' were inevitably *entangled* with the discursive strategies, calculative techniques, and networked knowledge construction that iteratively and performatively established the facts. Evidence and advocacy were therefore part of the same phenomena, which was the contested 'value' of the public's health and wellbeing as objectivity was continually (re)constructed and contested.

In making this point, this project is heavily indebted to the Agential Realist methodology, and in particular the rejection of the subject-object dualism that was seen to lead to the 'paradox of objectivity' (3.1). Drawing on this methodology, instead of trying to understand knowledge as separate from questions of ethics and politics, these are brought into the material-discursive apparatus under investigation, which together served to construct objectivity within the network. This removes concerns about which came 'first' – the facts or the political agenda, identity or institution, but instead allows us to analyse how

each play out through and with one another. The facts are (re)constructed to fit the circumstance and the circumstance are embedded in the facts. This fundamentally informs how we think of 'identity work', which then becomes part of the entanglement of matter and meaning that is to be understood not just as the performative iteration between the individual (identity work) and the institution (institutional work), but as the material-discursive iteration of everyday life as phenomena are produced and reproduced. Barad's (2003, 2007) concept of diffractive methodologies that has the reproduction of knowledge as a material-discursive entanglement of ethics, ontology and epistemology, together with similar concepts in the feminist science studies literature, for example Haraway's (1991) emancipatory knowledge frameworks and Harding's (1991) strong reflexivity, all therefore have a crucial contribution. If professionals rely on a shared body and status of expert and 'expertise' (Abbott, 1988), and if that expertise must be highly reflexive in order to engage with dynamic social purpose (Sveningsson and Alvesson, 2003; Noordegraaf, 2007; Waring and Currie, 2009), then the theoretical apparatus of how knowledge is produced and reproduce has a direct bearing upon how we study and theorise the profession.

This approach seems especially suitable for the study of 'hybrid' identities. Rather than seeing these as discrete elements that can be consolidated, for example Public Health + Medical Doctor = Public Health Doctor, identities are seen as a 'doing' (Barad, 2007, pg.240). With reference to intersectionality (see Crenshaw, 1991) Barad continues that identity formation is a "contingent and contested ongoing material process; 'identities' are mutually constituted and (re)configured through and with one another in dynamic intra-relationship with the iterative (re)configuring of relations of power" (Ibid.). In this project we took up this call by analysing the dynamics within the Public Health profession such as the status between medics and non-medics, the role of the PHE regional office, the role of the various

performance appraisal mechanisms, and the LA context, with particular reference to austerity and how Public Health professionals were able to influence decisions. Identity was found to be no fixed thing for abstract study, and similarly hybrid identities were not discrete blocks to the be added to together; identity was instead a shared 'doing' that involved attempts to enroll actors across local government and the wider region in a shared understanding of what counts and what ought to be accounted for. Hybrid identities in this context therefore refers to attempts to pluralise the Public Health profession to better influence across an increasingly multi-agency and cross-profession spaces in which the traditional medical profession, and the traditional Public Health evidence base, no longer provided the tools for the job at hand.

In applying an Agential Realist framework in this project, and in taking inspiration from other STS and feminist science studies scholars, we focused not just on discourse and interview when studying identity as a 'doing', but sought to triangulate this against documentary evidence, observation, and then, in section 6.2, an in depth review of how facts were produced and reproduced. In this sense, sections 6.1 and 6.2 should be read diffractively (Barad, 2014) through and with one another as we see professional identity (6.1) produced through and with interaction and contestation (6.2), in particular as attempt to build shared knowledge and consensus are contested and (re)produced. As we will see in the following sections, the ethical commitments observed in this chapter towards a shared Public Health agenda are actively inscribed into, for example, the PHE national outcomes framework, locally commissioned contracts, Public Health annual reports, strategy documents, and economic valuations. Finally, the politics and short-termism of austerity becomes increasingly central, and what was described in this section by some Public Health educators above as having a negative affect on recruitment to the profession is seen to be shifting the landscape away from provision and towards further collaboration over diminishing resources (7.1).

6.2 (Re)constructing interventions: making the case for Public Health

In section 6.1 we saw how the Public Health professionals developed through and with their new context, and how pluralistic 'hybrid identities' developed to better embed Public Health activities and make links across organisational boundaries. These identities were not uniform or static, either within the Public Health discipline or over time, as professionals reacted to a new political, statutory, and cultural environment, and to growing austerity cuts. Instead, they grew and developed through iterations of discourse and practices, in conversation with their new surroundings. This section takes up this dynamic by looking at how these identities developed through and with inscription devices, performances, and calculations. The section then concludes with a discussion of what the case of Public Health activities in LAs in England adds to the ongoing analysis of the *performativity* of inscriptions and calculations in the critical accounting literature, and how this in turn contributes to our understanding of the reconstruction of *value* in organisational life.

In Chapter 2 (2.3), having introduced the background literature on the Public Health reforms the thesis introduced the critical accounting literature and reviewed the uses and impacts of accounting devices, inscriptions, and calculative practices in healthcare and local government. We noted the 'active' role ascribed to accounting and its power as it seeks to 'reveal' or 'represent' economic reality while also consisting of the body of experts and expertise who prescribe and diffuse norms of best practice (Miller, 1994; Miller and Power, 2013). We then introduced the literature on NPM (Hood, 1991, Hood, 1995) and noted both the link between measurement practices and the proliferation of accounting techniques of control and their potentially counter-productive or dysfunctional consequences (Arnaboldi and Lapsley, 2008; Lapsley, 2009; Justesen and Skærbæk, 2010). The growth of NPM style

reforms, in particular, saw the growth of calculative practices and standardisation across healthcare through the 1990s and 2000s, which had an active role in reconstructing professional identity and organisational spaces (Kurunmaki, 2004; Frandsen, 2009). Discursive practices associated with value for money, particularly 'efficiency', 'effectiveness' and 'accountability', were seen to increasingly intersect with core professional values, such as 'equity', 'rights' and 'dignity' in a social care setting (Llewellyn, 1998). NPM reforms were also associated with growing calls for 'accountability' across the public sector, (Power, 1997); however, we also noted that classic NPM could, drawing on Mulgan (2003, pg.151), be characterised as a process of transfer from political accountabilities to managerial accountabilities involving greater reliance on measureable 'arm's length' agency relationships. We noted the difficulty and ambiguity of such characterisations with reference to the reforms to Public Health under the HSCA 2012, which introduced elements of both NPM, such as disaggregation of budgets and managerial autonomy with greater political accountability, for example via HWBs in the LA setting.

In Chapter 5 (5.1), we noted that financial accountabilities were crucial in the current system and were strongly emphasised in the initial national documents associated with the reforms. The LGA, for example, emphasise return on investment calculations and the general cost effectiveness of Public Health interventions (LGA, 2013; Department of Health et al., 2013; PHE and LGA, 2015). While in section 5.3 we noted the increasing prevalence of financial justifications, short-termism, and fragmentation associated with increasing austerity across the sector and across the case authorities in particular.

Further theorising these accountability relationships, the thesis introduced the concept of 'intelligent accountability' (Roberts, 2009) in Chapter 2 (2.3). Intelligent accountability could,

it was argued, provide a more reflexive, qualitative, personal, and compassionate accountability that is not the violent pursuit of an ideal, and instead acknowledges the impossibility of a 'self fully transparent to itself'. This was developed through the discussion in Chapter 3 where we explored 'posthuman' subjectivity, knowledge construction, and performativity via Barad's (2007) Agential Realist framework. Importantly, we saw that any analysis of knowledge construction in general, or of calculative practices in particular, was more than a material or epistemological matter; we saw that it became, inevitably, the analysis of entangled material-discursive assemblages with ontologically political consequences (Barad, 2007, Vosselman, 2014).

This wider theoretical discussion in the first half of Chapter 3 (3.1 and 3.2) was then linked to the growing critical accounting literature mobilising STS inspired theorisations and their use of *performativity*. We noted many empirical studies drawing on the active performative consequences of accounting practices as knowledge-producing, framing, representing, or boundary-drawing practices (Skærbæk and Tryggestad, 2010; Dambrin and Robson, 2011; Williams, 2013; Boll, 2014a; Vesty et al., 2015; Ravellino and Mouritsen, 2015; Corvellec et al. 2016), and in some studies evidence of performativity 'failing' to produce action at a distance or producing 'counter-performative' consequences (Asdal, 2011; Cushen, 2013). We saw studies that explored how inscription devices and calculative techniques re-drew spaces and boundaries (Frandsen, 2009), stabilised complex networks by institutionalising opaque chains of translation (Dambrin and Robson, 2011), or alternatively, how inscriptions and organisational models might contain the conditions for their own contradiction in an ongoing process of framing and re-framing (Skærbæk and Tryggestad, 2010). All of which made for a rich and developing theoretical conversation across the critical

accounting literature in which the active role of accounting devices in socio-material arrangements was emphasised.

This discussion concluded by proposing a re-reading of *performativity* in the critical accounting literature, making the case for iterative material-discursive sensitivities in the analysis of inspection practices, technological change, and accountability relationships. Using Barad's (2007) Agential Realism to bring together the sociology of translation as the socio-discursive reproduction of *power* relations and *subjectivity* (Foucault, 1982) with the sociology of translation as the socio-material, agential, and creative consequences of networks of actors (Latour, 2005). I argued that this was a reversal of the Callonistic logic (Callon, 2007): instead of seeing the calculative agency as a consequence of socio-material framing and then seeing performativity of calculations as the consequence of calculative agency, we analyse calculative agency through and with the iterative framing and reframing processes through which agency is *performatively* (re)constructed.

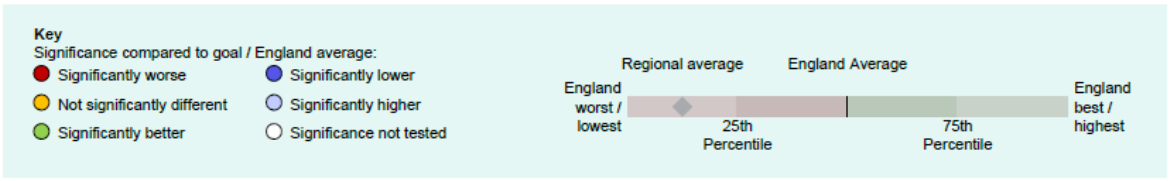
Mobilising the evidence: inscription devices and calculations across the case authorities

Across the two case study authorities, and PHE, Public Health professionals stress their commitment to detailed construction of facts, objectivity, and scientific methods, which was noted in 6.1 as being rooted in their professional training and sense of identity. A number of broad tensions were noted throughout the documentary analysis, observations, and interviews when considering the particular question of how Public Health professionals reconstructed the 'facts' and mobilised evidence. Broadly speaking, conflicts were noted between tools based on nationally aggregated data and locally produced analysis; between longer term upstream preventative interventions and acute service based interventions; and, finally, whether interventions released cash savings and where such savings would fall across

organisational and budgetary boundaries. At the root of all of these tensions was a trade-off between harder to measure ethically informed accounts versus narrower but easier to measure alternatives. For example longer term, locally specific health and wellbeing measures across a range of outcome measures, as opposed to narrower or acute 'health' outcomes, or outcomes that could make more clearly identifiable cash savings.

Starting with the overall PHE outcomes framework, these were updated annually, and fed directly into the Joint Strategic Needs Assessments (JSNAs) at each authority. For Midland City the JSNA for 2014 (MC 030, 2014) was reviewed prior to the interviews and observations, and this was cross-referenced to the 2013/14 financial plan (MC 024, 2013), the 2013/14 Drug and Alcohol Needs Assessment (MC 031, 2013), and the 2013/14 Childhood Obesity Strategy (MC 029, 2013). These formed the background to the primary data collection collected through 2015 to 2017. The JSNA and PHE outcomes framework for 2017 (MC 032, 2017) were then reviewed following the second round of primary data collection along with the 2017 and 2018 financial plans (MC 027, 2017; MC 028, 2018). In addition to the PHE outcomes for the City and the various strategy documents and financial plans, we also obtained the KPIs for a key commissioned contract with third sector provider of family support services (MC 018, 2016) commissioned from the Public Health budget. These documents were cross-referenced to interviews with commissioners, the Midland City DPH, and the CEO of the commissioned charity. The Summary table below shows the six overarching PHE outcomes from the framework for Midland City, along with the key, and gives an indication of the visual presentation of this information (as well as the poor outcomes for the city):

Figure 8. Overarching indicators Midland City 2017 (PHE 011, 2017)



Overarching indicators

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
0.1i - Healthy life expectancy at birth (Male)	2013 - 15	58.4	63.4	54.0		71.1
0.1i - Healthy life expectancy at birth (Female)	2013 - 15	59.4	64.1	52.4		71.1
0.1ii - Life expectancy at birth (Male)	2013 - 15	77.1	79.5	74.3		83.4
0.1ii - Life expectancy at birth (Female)	2013 - 15	81.9	83.1	79.4		86.4
0.1ii - Life expectancy at 65 (Male)	2013 - 15	17.6	18.7	15.8		21.4
0.1ii - Life expectancy at 65 (Female)	2013 - 15	20.7	21.1	18.8		23.9

Similarly, at Metro Town the Joint Strategic Needs Assessment 2017 (MT 039, 2017) was obtained following the primary data collection, together with Financial Plan 2016 (MT 019, 2016), the locally produced Health Lifestyles survey 2016 (MT 038, 2016), the Health and Wellbeing Strategy 2013-2018 (MT 040, 2013), the Metro Town Shortlisted Outcomes chart (MT 041, 2017) (which drew on the PHE outcomes framework), the Metro Town Effective Commissioning strategy 2014-2019 (MT 042, 2014), together with the Public Health Annual Reports for 2013/14, 2014/15, 2015/16, and 2016/17 (MT 021, 2014; MT 022, 2015; MT 023, 2016). These were triangulated with interviews and observations as far as possible, with the launch of the 2014/15 Public Health annual report, in particular, being observed at the July 2015 HWB.

HWBs were a key space in which the tensions and contestations over the facts played out and in which many of the above documents were presented and discussed. Through the observations, they were found to be important sites of translation and mobilisation between the Public Health team and their key contacts among CCGs, elected councillors, and other budget holders and service directors. The following quote came during the Observation of the launch of the Metro Town 2015/16 Public Health annual report, and the introduction by the

DPH to the new childhood obesity strategy using data from the recently completed Healthy Lifestyles survey 2016. Introducing the report, via a power point presentation, she began:

> To move onto obesity, I've already given you those killer stats… I gave you the figures for obese reception class, but it's 26.4% if you bring in overweight and obese. That's 12.5% obese and 26.4% [obese or overweight] [...] [Then] you can see there, that scary statistic – over 40% of our 10 and 11 year olds are overweight or obese. 26.2% of those children are obese. That's really robust data, because our school nurses take the height and weight measurements of our reception classes and year 6 classes and we get about 91% uptake. That's really, really accurate data. **Joanne, Metro Town DPH to the HWB, Jul 2015**

This was the first presentation of the second annual Public Health annual report since the transfer, made to the Metro Town Health and Wellbeing Board in July 2015. The presentation, while ostensibly about holding Public Health to account, allowed the Public Health team, and the DPH in particular, to mobilise contacts among CCGs, elected councillors, and other budget holders and service directors. The associated slides gave a highly visual representation of the data through pie charts and graphs that were drawn from the annual report document itself. There was also a clear emphasis on the robustness of the data around an issue that was perceived to be emotionally important when discussed later with the DPH. In the presentation, the DPH was able to mobilise the relatively strong descriptive statistics based on primary local investigation with secondary national data to drive a detailed list of recommendations. In the analysis of the 2015/16 Public Health annual report referred to in the above quote, it was noted that the evidence was presented and constructed in terms of health and wellbeing outcome measures adapted from the PHE framework; with the economic argument only very briefly introduced in broad terms in the introduction rather than by each recommended intervention.

Evidence of tension between the localised approached exemplified in the above, with a clear emphasis on mobilisation of actors in areas of stark emotive need, against a more

systematic economic argument was noted in the interviews with the health economists in PHE's national head office and participants from the private sector consultancy firms. Following the DPH's presentation, above, the childhood obesity situation in Metro Town was described by the elected member for Health and Wellbeing as a 'ticking time bomb' and she called for the stakeholders around the table to come together to 'do something about it'. However, PHE's lead health economist for their health and social services network problematised the 'political' influence on Public Health evaluations as follows:

> But politics has a massive influence[21]; there are certain things that you have in your Public Health grant that you'd want to cut but you can't – so some things are mandatory. There are certain ones that you don't think in your area that this is a priority, but for political reasons you can't cut it. Childhood obesity is an area where we have very little evidence – very little evidence of anything being effective, yet it's a massive priority to change it. And public opinion, public sensitivity and political influences are that we need to invest in it. So that's fair enough, because, in some places, there are whatever, 50%, 60% of children who are obese – overweight or obese. But if there are no effective interventions…'. **Suzanna, PHE Health Economist, Nov 2016**

Following this, when questioned on whether this was a conflict between being 'objective' or making the political case she responded:

> But saying that, when you look at the evidence, the vast majority of Public Health interventions are incredibly cost effective. And in a world where the NHS, the sort of NICE thresholds and things, if you're looking at life quality things, I mean there's an incredible amount of evidence that suggests lots of alcohol / smoking interventions are cost effective. So it's making the case where there is a case to make. **Suzanna, PHE Health Economist, Nov 2016**

Other participants highlighted the general cost effectiveness of Public Health interventions, but also the relative difficulty in establishing this clearly, in a localised context in a manner that could justify 'spending to save' given specifically localised cuts to authority budgets. Indeed, a great deal of the work of Public Health analysts employed in LAs consisted of

[21] Note that 'politics' in this quotation from the health economist was reserved for the politicians, while the evidence based analysis of Public Health interventions was described through a rationalist objective perspective.

establishing the positive case and monitoring existing interventions. Looking specifically at the 'scrutiny and challenge' function of Public Health, several Public Health commissioners were interviewed and at Midland City the CEO of a local Charity supporting deprived families through community education programmes was interviewed. Following the interview with the local charity CEO the set of KPIs attached to their commissioned contracts was also obtained (MC 018, 2016; Figure 4.), which had been re-drawn as part of the re-tendering activity following the transfer of Public Health into local government in 2013.

Note that in the following figure the majority of the KPIs related to measureable *outputs* linked to service level activity, while the two highlighted in green related to their desired Public Health *outcomes* that matched through to the PHE outcomes framework. This was consistent with the interviews with Public Health commissioners at both case authorities who reported significant savings through the re-tendering process as a result of much closer monitoring of activity levels against spend:

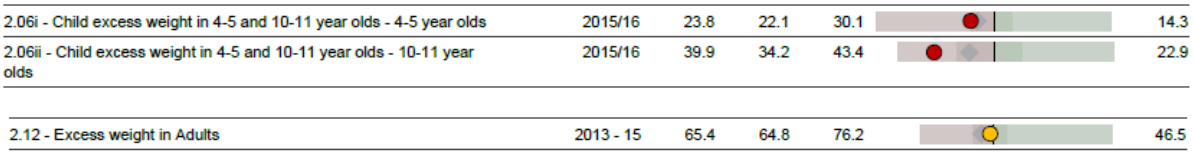
Figure 9. Midland City Charity KPIs 2016/17 (MC 018, 2016)

Conversion rate of referrals to attendance at first appointment
Number attending 1st appointment/log on with commercial weight management provider (online)
% of completers based on each **commercial** provider
% of completers based on **online** providers
Number of completers from IMD1 (National deprivation score)
Weight recorded for all service users. To include; start weight and weight at last intervention and/or programme completion
% of completers based that have lost ≥ 5% of weight – **Commercial**
% of completers based that have lost ≥ 5% of weight – **Online**
Proportion of service users who complete evaluation questionnaire/app
Proportion of service users who complete evaluation questionnaire/app and report to be satisfied or more than satisfied with the service (score ≥ 7/10 via the app)
Number of Child Safeguarding referrals made

Number of Vulnerable Adult Safeguarding referrals made
Number of complaints received relating to service

Note also, in the following figure, that for Midland city the two outcome indicators relating to child excess weight were significantly behind the national average, while the indicator for adult excess weight was slightly below the average:

Figure 10. Extract from Midland City PHE Outcomes Framework 2017 (PHE 011, 2017)



In section 5.3, we noted that the Midland City charity had lost their two biggest contracts amounting over around half their workforce and the short notice that they were given at that time. On investigating the performance against the above KPIs it was noted that the charity had achieve their agreed performance targets, and that the discussions with Midland City's Public Health commissioners and DPH had not raised any performance issues. It was simply a matter of non-statutory services having become 'unaffordable', with them having fallen outside of the HWB's newly narrowed health and wellbeing strategy for 2016. Again, this cut appeared to contradict both the government's 'big society' vision, which, in theory, saw a greater role for the third sector in the provision of Public Health activities (HM Government, 2010), and Midland City's own initial focus on Childhood Obesity outlined in their 2013/14 Health and Wellbeing Strategy (MC 029, 2013) and their 'fit for the future' childhood obesity strategy (MC 029, 2013). The CEO concluded this point with reference to the cut as a 'business decision', linking the rhetoric of NPM (Hyndman and Lapsley, 2016) to the austerity measures being imposed:

> They've been very clear with us that it was nothing to do with our performance. It was nothing to do with our reputation. It's nothing to do with what they felt about us. It was just purely a business decision. **Barbara, CEO of Midland City Charity, Oct 2016**

The key point to note here is that there appeared to have emerged a significant break between the rhetoric of the initial reforms, the outcome measures and strategy documents that sought to operationalise those ambitions in light of the initial funding settlement, and the difficult 'economic reality' of austerity. This apparent dysfunctionality was similarly noted on investigation of the 'payment by results' funding formula written into the Charity's commissioned contract: which was set up so that the funding was granted on condition that they met the targets in the contract on an ongoing basis but where these targets were *exceeded* no additional funding was made available so that the incentive was 'one-way'. Again, the ambitions of the initial Health and Social Care White Paper (HM Government, 2010) to 'incentivise' improvement were not being realised in practice.

In the interview with the Charity CEO their ethical commitment also came through strongly, and it was interesting that despite the cost pressures there were certain things that she 'would not compromise on' in terms of quality of delivery, to the point that the entire service faced closure. One such example was visiting service users in their own homes, which they felt was central to delivering the commissioned outcomes, despite the costliness of the activity. The ethical commitment to the outcome measures, at various levels of the system, and the emerging contradiction between achieving the outcomes and achieving financial 'sustainability' was a recurrent theme and was noted particularly in the interviews with the DsPH and the 2016 parliamentary enquiry. On insisting on the outcomes, and resisting pressures to narrow the scope of measurement to more easily prove financial returns, one lead commissioner at Midland City put this as follows:

> My approach is that I recognise that these are potential savings you could make. And I'm not sure that actually putting a pound sign on it, a cost, is what you really ought to be arguing. It is about what is the *value* [emphasis added] of what you are investing. **Adam, Midland City Consultant in PH and lead Commissioner, Dec 2015**.

Despite this, and other similar quotes across the data, practitioners across both local cases made strategic decisions to narrow the focus on more specific outcomes with a view to maximising the impact of diminishing resources. In Metro Town this was specifically through an initial 'action on obesity' and a particular emphasis on childhood obesity in the first observation of their Health and Wellbeing board in July 2015. Similarly, the Midland City DPH described this narrowing down of the focus as a pragmatic issue of enrolment and mobilisation in which the inscription devices played a crucial role – translating the wide ranging outcomes framework into workable local priorities:

> So it goes back to when I first arrived here, there was a 75 page document… And what I said was you can't do that. And we had a useful informal board meeting, where people reluctantly agreed that we needed a much tighter [document], certainly than 75 pages. So then there was a discussion which was around what goes on to our strategy. So that's where I came up with this thing about a plan on an A4 page – if you can't fit it on one page, then actually… you can only have one page. So it was being pragmatic: if you want to put something on there, you've got to take something else off. **Alan, Midland City DPH, Nov 2015**

In triangulating the above quote to the supporting documentation it was noted that the full 'Public Health strategy' in Midland City, formalised in the statutory Joint Strategic Needs Assessment, does in fact list out all indicators per the national Public Health outcomes framework (and runs over 11 pages). However, the more specific focus described in the above remained an internal document not for wider circulation, focusing more specifically on children, homelessness, and collaboration with the local CCGs around health protection. A similar document was obtained for Metro Town for their 'shortlisted outcomes' (MT 041, 2017) marking the end-point of a chain of translation from the initial ambitions of the reforms, through to the widely consulted on national outcomes framework, to the locally agreed strategic priorities and performance monitoring the remaining commissioned contracts.

Inscription devices, performances via organisational spaces, professional ethics, and formal and informal social links all therefore played their part in mobilising the evidence, enrolling local actors, and finally narrowing the Public Health focus. This narrowing was in part necessity as resources reduced and clearly in the case of Midland City involved local 'losers' as 'difficult decisions' on 'financial sustainability' were made. But throughout this process it was clear that the commensuration of priorities through convincing local and national data, and the giving and receiving of account to actors outside of the Public health function, was key in establishing and re-establishing organisational priorities and 'influence' outside of the core public health function.

The case example of drug and alcohol interventions

As introduced in Chapter 4, given the breadth of the Public Health remit, covering 6 prescribed areas of Public Health as a condition of grant, and a further 12 non-prescribed areas of discretionary spend, the decision was taken to pay particular attention to drug and alcohol interventions and activities throughout the data collection period. This provided for greater depth of analysis by cross-referencing between observations, interviews with drug and alcohol specialists, and specific commissioning documents and calculative devices. Building on early leads from the data collection and early access to PHE's drug and alcohol value for money workshop in June 2015, interviews were targeted towards the lead commissioners for Drug and Alcohol at both authorities, and the workshops followed up with further interviews with the PHE health economists responsible for the newly redesigned Drug and Alcohol commissioning tools. These interviews were also triangulated with documentary evidence such as the associated slides for the Drug and Alcohol workshop (PHE 003, 2015), the joint Alcohol & drug VFM programme update (signed letter) (PHE 002, 2015), and the Families Drug and Alcohol Social Return on Investment tool (PHE 017, 2016).

Drug and alcohol interventions were a major area of Public Health spend; according to the DCLG's revenue account statistics for 2017/18 they accounted for £716m of the total spend in England (The King's Fund, 2017b). Both case locations had undergone major re-tendering of their various drug and alcohol programs following the re-organisation in 2013, following the disaggregation of Public Health from wider PCT budgets. Participants commented on the number of previous contracts and the lack of scrutiny of activity prior to the transfer to LAs. In Midland City the lead commissioner described saving £16m over 5 years while at the same time delivering better outcomes through closer scrutiny, bringing together 28 separate contracts for substance misuse. Similarly, in Metro Town, significant re-tending activity took place across drug, alcohol and sexual health services, resulting in significant savings. On investigating the processes and calculations, it was also observed that these processes were particular points at which professionals could re-draw the service level key performance indicators, through discussion with users, volunteers, and presentations to prospective providers. The following was taken from the tender documentation at Metro Town, completed by the lead commissioning consultant, under the section entitled 'Good commissioning promotes a diverse and sustainable market' in the standardised commissioning assessment form:

> Public Health has done a number of procurement exercises with different experiences of market responses… Since the transfer of Public Health departments to local government the market has been subject to a plethora of tenders across the country around the Public Health service areas, sexual health, drugs and alcohol, healthy lifestyles school nursing and health visiting etc. There is a noticeable gap in terms of the provider markets' ability to respond to service change and redesign in new, innovative and cheaper ways. In other areas some of these programmes have failed and alternatives; in house provision or new ways of working with existing providers have been implemented. (MT 042, 2014)

This shows that re-tendering was encouraged across the new system, noting particularly the emphasis on the 'market' and on the purchaser-provider model so strongly associated with NPM reforms more generally (Lapsley, 2009). Significant savings were reported following this activity in both cases in this study, despite the supply side issues noted above, which was reported positively by the Public Health commissioners in both councils. Commissioners were able to re-inscribe more comprehensive Public Health outcomes into the new contracts, aligning these outcomes with the new PHE outcomes framework, while also more carefully monitoring activity. One major reason for the savings that came up several times was that in the previous NHS environment there had been poor monitoring of contracts with Public Health activities getting lost in the much broader primary care remit of the PCTs.

Following these initial re-tendering activities, PHE developed calculative tools to assess newly re-commissioned contracts for 'social value' added for the different types of drug and alcohol interventions. This was through the development of first a Drug and Alcohol 'Cost Calculator' and 'Commissioning Tool', and then, building on these, a Drug and Alcohol 'Social Return on Investment tool' (SROI tool) (PHE 017, 2016). The first two were related to cost identification to facilitate more accurate returns to the DCLG, then the latter tool was rolled out in 2016 to help articulate the 'social return' on specific commissioned services based on national data sets and academic research adjusted for local variables.

In developing these tools, a member of PHE's health economics team organised knowledge sharing workshops in each of PHE's regional offices. In observing the initial presentation of these tools and the revised SROI tool in the PHE regional office, I was able to obtain some of the detail behind the calculations and organise a follow up interview with PHE's presenter, particularly focusing on the iterations and negotiation as the tools were

developed in conversation with practitioners across the country. She described the 'tricky' balance of developing the tools based on accurate standardised data whilst also getting the input of those who would ultimately be using these tools in a local context:

> So it's really quite tricky, and for us to be able to provide commissioners with accurate tools about their cost effectiveness, then they need to work a bit harder to try and disaggregate exactly where the spend is and what groups they're spending it on. And that's obviously massively complicated and that's why we've done the cost calculator to try and help them to do that. We've also got another tool called the commissioning tool, which has a cost calculator embedded into it and then it also looks at the different types of treatment pathways that different types of clients can be accessing and what the cost effectiveness is. So, by cost effectiveness there, we are defining it as spend over successful completions of treatment. And again, that was out last year and we've received a lot of feedback on that and made amendments to try and improve, make it more user-friendly. **Vicky, PHE Health Economist, Dec 2016**

Here we can see the basic economic definition of return, starting with cost effectiveness, which is then used to establish social return based on the direct and indirect cost savings together with other social value added of a successful completion of the activity. But this calculation was not simply dictated in a top down fashion to drive commissioning strategies, but was a two-way process so as to help develop the tools in the most relevant and most useful direction for practitioners. For the tools to work they also needed strong input data which was the point of the commissioning tool and cost calculator.

One of the results of this project was the 'Families Drug and Alcohol tool', a tool for 'estimating the benefits of treating substance misusing parents' (PHE 017, 2016). This tool settles on a detailed set of calculations based on the locality, known output data across social care, education, employment, housing and crime, and allows the user to adjust for their preferred time horizons and length of service across each of the outputs. These are then converted into pound-sterling (£) figures in three categories: 'fiscal' defined as cost savings to

the public sector; 'economic' defined as wider benefit to the local economy, and 'social' defined as wider gains to society.

The Families tool is a highly detailed piece of work that took PHE's health economists many months to refine and complete, and undergoes constant review. Within the document detailed methodologies are explained to the user, enrolling them in the nature and relative robustness of the data. There is an emphasis through the document on 'fiscal' savings, although also an emphasis in the introductory page that these savings may not be cash releasing or 'cashable', and gives examples of how some savings listed may release cash in other areas of the public sector beyond LAs. One of the few measures where all three elements of the model come together; Fiscal, economic, and social, is in domestic violence interventions. Here the calculation draws on a range of pieces of academic and governmental research to estimate the various costs and qualities associated with issues of domestic violence, and draws on 'QUALYs' or quality adjusted life years in the conversion to social values.

Figure 11. Extract from SROI tool showing the cost of one incidence of domestic violence

Outcome detail	Cost / saving detail	Fiscal Cost	Economic cost	Social Cost	source
Domestic Violence	Domestic violence average cost per incident (fiscal, economic and social values)	£ 2,797	£ 1,668	£ 7,695	Sylvia Walby - The Cost of Domestic violence, update (2009), p.8

With regards to health based outcomes and QUALYs, the chief health economist at PHE describes how the conversation (and, in turn, the emphasis within the associated calculations) has changed over time:

> So we're operating in a completely different environment now, where what the local authority needs is to *balance the books* [emphasis added] every year. And they need to understand what they're going to benefit from investing in Public Health. And what we find hardest is that all of the

> literature is based around cost per QUALY – because… used to be NHS; in the NHS where that was the outcome – the outcome measure was health.
>
> Now the outcome measure is less and less health, which is quite depressing really because Public Health literature has been around to do that. So taking alcohol for example, we used to say alcohol treatment is cost effective, it has a low cost per QUALY, you'll get lots of health outcomes. Now we're changing the argument to say, 'The impact on families is X, therefore in a local authority you'll need to spend less on your children's social service side. And the impact on crime is Y, and therefore the criminal and justice system, and the police in your area will have to spend less time and money on Y.' So it's trying to change the dialogue to influence local authority decision making, rather than NHS decisions. **Suzanna, PHE Health Economist, Nov 2016**

The QUALY has an interesting construction in its own right, drawing on a Department of Transport study in which the collective value of pain, grief, suffering, lost output, and medical costs of one life lost was assessed and then scaled up to reflect current prices (Department of Health, 2010) (see 5.1, pg.100). However, the above quote was also supported by the analysis of the Families tool itself. The vast majority of returns were calculated in 'fiscal' and/or economic terms, with only 1 of the 17 elements drawing on social values (see example in figure 1.), and this with the option that it could be left out by the user. In this sense, the reconstruction of the calculation reflected not just the changing communication of Public Health outcomes, but of *relative* value of the outcomes themselves when commensurated into a single economic outcome measure.

Through the reconstruction of such interventions it was noticeable that there was a clear commitment to 'evidence' and 'objectivity' from the professionals involved in constructing the calculations, but equally, that part of the purpose of such calculations was to 'make the case' for Public Health by determining what *ought* to matter within a new set of calculations. Going back to one of the lead commissioners in Midland City, responsible for Drug and Alcohol interventions, when asked about SROI and the changing nature of Public

Health evaluations, he came back to the core ethical argument in making the case for Public Health on its own non-monetary terms based on a plurality of outcome measures:

> My own approach is that I recognise that these are potential savings you could make. And I'm not sure that actually putting a pound sign on it, a cost, is what you really ought to be arguing. It is about what is the *value* of what you are investing. So if people don't commit as much crime, or certainly don't need specialist residential care, but can live at home, it isn't the difference in the costs, but actually the value to the person that actually ought to be what we're trying to work a because that's a good in itself. **Adam, Midland City Consultant in PH and lead Commissioner, Dec 2015**

This cuts directly to the contestation of processes of *economisation* (Çalışkan and Callon, 2010) at play in the commensuration of 'values', plural, to 'value' defined in economic terms, and whether or not this changes fundamentally the ethics and epistemology implicit in the broader set of outcomes articulated by the PHE outcomes framework. This contestation remained unresolved, with the key source of tension being the increasing focus on short-term cuts to budgets and wider austerity measures. Public Health professionals, when asked about PHE's SROI tools around Drug and Alcohol and other similar tools questioned the focus on service level activity rather than prevention and highlighted the tension between the narrowing of focus inherent in such calculations. In short, while such acute activities were potentially easier to measure precisely, and therefore economise, they were also somewhat behind recent developments in the changing nature of 'Public Health' itself as an integrated ethos of health and wellbeing across all activities that could not be readily reduced to a single measure. The calculations themselves therefore became the battleground between the more integrated Public Health profession of the Marmot review (Marmot, 2010) which envisioned 'bringing Public Health into everything we do' via a diversity of qualitative and quantitative evidence and the pressure to 'prove' that interventions could deliver 'value', and, increasingly, 'cashable savings'.

Discussion: Performativity and the mobilisation of material-discursive inscriptions

With reference to the literature summarised in the opening paragraphs of this section, there are several lessons that can be drawn from the above analysis of Public Health inscriptions, evidence and calculative practices. Noting particularly that the practices analysed in this case unfolded across a complex multi-agency network over several years of observation. There was clear evidence for the 'active' and 'mediating' role of accounting (Miller, 1994; Miller and O'Leary, 2007), in its various forms, as an actant in this network. The narrative account provided in the 2016 Metro Town Public Health annual report (and the associated HWB presentation); the choice of measures in the national PHE outcomes framework (and the online dashboard presentation); the behaviours and negotiations those outcomes then induced as they were written into KPIs of newly commissioned contracts; and the relative (re)valuing of Public Health outcomes via the SROI calculations designed to justify expenditure with potentially difficult disinvestment decisions in mind all supported this thesis. More precisely, it was not just that such accounts endowed human actors, for example DsPH, with agency, but that the naming, categorising, and commensuration processes inherent in statements, inscriptions, reports, and presentations themselves shaped how both Public Health and non-Public Health actors understood their shared problem and formulated strategies to respond. This was especially notable both in the early stages of the reforms as 'Public Health' morphed from primarily 'health' based outcomes to broader 'health and wellbeing' outcomes, and then again in the years thereafter as austerity measures became more acute and practitioners were forced to translate the pluralistic PHE outcomes into narrower strategic objectives with more clearly defined cashable returns. In both cases it was insufficient to analyse these processes as either the result of human agency, discourse, or any

individual model or report, but instead the 'Public Health agenda' was continually and iteratively rearticulated via material-discursive exchanges across multiple settings.

Across the scope of the study, we can see the pragmatic necessity of translation as a means of mobilising action as (human) actors are left with an inevitably partial, localised, and context specific perspective on 'the Public Health agenda', and examples of how translation both reinforces hierarchal control (Dambrin and Robson, 2011) and creates unexpected outcomes, overflows, and the conditions of its own contradiction (Skærbæk and Tryggestad, 2010). We can also observe that it is precisely out of this incompleteness, and the inevitable oligoptic vision provided by individual representations (Latour, 2005, pg.181), that human actors become so reliant on multiplicities of reports, calculations, and visual representations that in turn commensurate the general into the specific; national strategies into local outcomes, broad ambition into practical action. This echoes Mouritsen and Kreiner's (2016) analysis as 'human action', decision making, and control are seen as performatively mediated through and with accounting statements as 'promisory'; that is, representations make real by envisioning and bringing into the present the future they purport to describe. Similarly, drawing on authors in the accounting (Boll 2014b, Scott and Orlikowski, 2012) and organisational studies (Keevers et al., 2012) literatures who apply elements of Barad's agential realist approach, we can see that human subjectivity, 'distributed' agency (Latour, 2005, pg.46), and more broadly knowledge making processes of accounting and accountability play out iteratively through *material-discursive* networks of human and non-human actors.

This finding calls back to the discussion in Chapter 3 (3.3) in which it was argued that translation through accounting statements and accountability relationships necessarily

involved the iteration of subjectifying practices (for example Miller, 1992), through and with the realisation of agency through mediating material devices. We noted in particular the divergence in the literature in which performativity was applied as either the performativity of discourse, drawing on Foucault and Butler, or the performativity of material or calculative statements or models in many ANT studies (see Justesen and Mouritsen, 2011) but rarely both. In avoiding this regression into dualism, characterised in Chapter 3 as a 'paradox of objectivity', this study turns to Barad's (2007, pg.134-137) posthuman conception of performativity in order to resist polemical understandings of material-discursive dialectical processes. Processes of translation are neither exclusively or primarily material processes, nor exclusively or primarily discursive or linguistic processes; following Barad, processes of understanding are necessarily 'intra-active' agential processes that work through and with material-discursive 'entanglements'. Drawing on the example of Drug and Alcohol SROI calculations (PHE 017, 2016), the entanglement of discourse and narrative with the calculations was unavoidable as the reader was enrolled into the robustness of the methodology in the introduction to the document, as references were drawn to discursive signifiers in the Public Health professional discourse, and as the document was then presented and refined through discussion with practitioners. The calculative 'truth' of the social benefit of any given Drug and Alcohol intervention in the model was the phenomena produced by a material-discursive, physical-theoretical, apparatus (Barad, 2007, pg.206).

In particular, drawing on Barad (2003, 2007) and feminist science studies scholars more broadly (Haraway, 1991 and 1992; Harding, 1991; and others) allows us to more diretly address the 'lack of critical stance' identified in the ANT literature (Vosselman, 2014). In his review Vosselman (2014) cites Roberts (2012) who is critical of 'Callonistics' as it 'pay[s] no attention to underlying virtual powers of the socio-historical formation of capitalism and

related neoliberalism' and goes on to suggest that in moving the analytical framework provided by STS we must understand management accounting as not only 'ontologically relational' but also 'ontologically political'. In their seminal contributions the concepts of 'emancipatory knowledge frameworks' (Haraway, 1991), 'strong reflexivity' (Harding, 1991), and latterly 'diffractive methodologies' (Barad, 2007; 2014) have all recognised this implication for some time and have provided the frameworks and conceptual vocabularies for just such an analysis. In following discourse, complex and heterogeneous networks, material-discursive inscriptions, through and with one another through documentary analysis, interviews and observations, this project has greatly benefited from these approaches. In particular, the inherently ethical-political dimensions of knowledge production processes (Barad, 2007, pg.59) drew the analysis towards the politics of austerity, the ethical assumptions drawn into and reproduced by calculative practices, and then the consequences of those emergent practices on how a shared 'Public health agenda' was produced. The example of domestic violence interventions including elements of social return were an example of attempting to construct 'value' via calculative practice into difficult local disinvestment decisions. Conversely, the example of the local charity losing their funding despite meeting and exceeding their KPIs was an example of the real practical and politicised consequences of a shift from broader outcome measures to narrower, and more short-term, objectives under a regime of austerity. These 'political' points are picked up further in Chapter 7 in the discussion of Intelligent accountability and austerity' (7.1) and more broadly in the discussion of how 'value' is reconstructed in organisational life (7.2).

In developing the above analysis, we are also able to move the discussion of 'performativity' in organisational life beyond the narrow (and arguably less interesting) 'special case' of the 'performativity thesis' (Callon, 2007; Vosselman, 2014), in which

calculative models are seen to create the realities they represent, towards an understanding of performativity in a more generalised sense. In particular, performativity is not simply the 'success' or otherwise of a given model (i.e. is the model performative in the illuctionary sense), but, with reference to Butler (2010), applies to organisational knowledge practices in their iterations, failures, and (re)negotiations (i.e. we follow the more interesting general case of performativity in the perlocutionary sense). Again, this was highly evident, and profoundly useful as an approach, in following knowledge making processes in the case of Public Health. Rather than foregrounding the question of whether or not any given model or calculation 'worked' or 'failed' we followed the tensions, iterations, negotiations and mediations across organisational and professional boundaries to understand how the case was made for Public Health and the role accounting and accountability played in this network. In sum, the distributed agency implied in the phrase 'making the case' for a shared or constructed 'Public Health agenda' was not, as Callon (2007) suggests, a consequence of socio-material framing, with the performativity of calculations a consequence of this calculative agency. Instead, calculative agency was itself performatively constructed and reconstructed through and with discursive practices as political controversy and ethical concerns were contested in, and reproduced by, new calculations and new representations.

In concluding this discussion, it is also important to point to the potentiality of the concepts of 'intra-action' and 'entanglement' introduced in Chapter 3 (3.2) to the claimed lack of critical stance (Vosselman, 2014) or 'flat' empiricism (Fuller, 2012) of STS inspired approaches in the critical accounting literature. Barad (2007, pg.139) uses this term 'intra'-action, as opposed to the more obvious 'inter'-action, to emphasise that there can never be action between discrete objects or independent variables; only 'intra'-action through which objects and practices (re)constitute and (re)define one another within entangled systems.

Entanglement (Barad, 2007, pg.309) is then an extention of Haraway's (1991) use of the term to emphasise that there is an ontological inseparability between the object and the agencies of observation[22]. These concepts serve a crucial purpose in foregrounding in the political in our analysis as they prevent us from falling back into neutral or omniscient observation of networks. If the phenomena under investigation, such as the knowledge claims and value statements that accounting and accountability reproduce, are ontologically entangled with any observer then we are always part of the network of study. This can be seen on at least two levels of abstraction – contrary to the assumptions made by some participants, Public Health experts do not produce neutral observer independent facts, the facts are iteratively produced as Public Health experts act as advocates for intervention. Thus the case they make is inherently and ontologically entangled with their own ethics, subjectivity, and the material-discursive network out of which their findings are produced. At a further level of abstraction, the analysis presented in this thesis, and more generally of the manifold uses and abuses of accounting documented in any empirical research, is similarly ontologically inseparable from our own context, ethics, subjectivity, discipline, and generally speaking, our socio-materiality as researchers. This reminds us as researchers to not only to embed the analysis of politics and ethics into our observations of accountants in practice, but to similarly engage in a strong reflexivity (Harding, 1991) with respect to the knowledge claims we produce as academics.

[22] Noting that 'agencies of observation' need not be human agencies.

Chapter 7: Discussion and concluding remarks

Using the empirical context of the HSCA 2012 and the transfer of Public Health activities into local government, this project has drawn together several crucial debates in the critical accounting and organisational studies literatures. It has also provided an interdisciplinary view on the Public Health reforms, with a focus on public finance, accountability, and the mobilisation of accounting practices as public health professionals make the case for a shared public health agenda in a radically new organisational context. Chapter 2 provided a historical background review, before introducing the emerging empirical literature on the experiences of public health professionals in their new environment, with a particular focus on austerity and the controversies over evidence and advocacy in the critical public health literature. The Chapter went on to introduce key themes from the critical public sector accounting literature, including NPM and 'post'-NPM, a conceptual discussion of accounting and accountability in a public sector context, and a review of the literature exploring accounting and measurement practices in healthcare settings. The Chapter concluded with a discussion of the health professions literature, and the interrelation of evidence and identity in the reflexive (re)construction of professions and professionals. We noted the limited use of STS inspired theoretical frameworks in all of these discussions, and the limited consideration of public health, in particular, among the health professions and public sector accounting literatures.

Chapter 3 then introduced the reader to the conceptual vocabulary of STS and Karen Barad's agential realism as a framework for this project, with a view to providing a foundational framework for exploring the iterations of evidence and identity through and with accounting inscriptions and representation. Accounting, it was argued, both make things knowable and valuable through iterative dialectic relationships in which both the giver and receiver of account are made continuously remade in the heterogeneous back and forth of

organisational truth making. This approach avoids common issues of representationalism, characterised as 'paradoxes of objectivity', in which the world is split into irreconcilable realms – for example, the natural and the social, the subjective and the objective, and the material and the discursive. Barad's (2003, 2007) agential realist framework, addressed this in a manner that avoids re-inscribing binaries and avoids lurching from discursive to materialist explanations by suggesting a generalised post-humanist performativity through which knowledge is always (re)produced via material-discursive exchange and intra-action within entangled systems. This framework extends both the sociology of translation (Latour, 2005) and the post-structuralist analysis of the ethical subject (Butler, 1990; Foucault, 1978 and 1982) by applying a performativity to both objects and subjects, via material-discursive exchange. It also extended the discussion of performativity in the critical accounting literature from the 'special case' of the performativity thesis to the general case perlecutionary performativities that are characterised by iteration, failure, and the behind the scenes back and forth as opposed to the relative 'success' or 'failure' of the statement, the model, the report, or the calculation.

This theorisation laid the groundwork for the methodology and methods chapter (4), which suggested an application of the methodological framework to the data collection and analysis. In particular, an emphasis on the diffractive triangulation of observations, interviews, workshops and documentary analysis to understand the production of the public health agenda through a diverse material-discursive apparatus (Barad, 2007, pg.206) and open coding techniques sensitise the analysis to both material and discursive practices and, crucially, the ethical-political dimensions of knowledge construction. Akin to a series of scientific experiments, Public Health practitioners reconstructed both their material apparatus (for example, by circulating new local surveys and data collection) and their

theoretical apparatus (for example, by shifting the focus from 'health outcomes' in terms of QUALYs to broader health and wellbeing outcomes, and, increasingly, towards financial outcomes) to produce objective arguments to fit their circumstances.

The two case authorities, Metro Town and Midland City, and the newly formed national body, PHE, were initially introduced in Chapter 4. Chapter 5 Part 1 then provided a narrative for the experiences reported by Public Health professionals in the immediate aftermath of the transfer in 2013. Chapter 5 Part 2 then explored the growing impact of austerity as practitioners sought to adapt their discursive and calculative techniques to the changing organisational landscape. Chapter 5 (5.2) demonstrated that both the value of Public Health interventions were iteratively established via the reconstruction of new knowledge networks that ran between and across traditional organisational boundaries and explored the techniques by which public health professionals sought to embed their ethics into the LA context and strategy. In Part 2, short-term annualised budgetary practices and austerity were found to play increasingly negative and dysfunctional roles in this reconstruction (5.3), but were countered, to some extent, by practitioners seeking to more deeply embed a Public health ethos into all decisions across the LAs and, latterly, to begin to build networked practices and collaborative budgetary regimes across wider regional footprints (5.4). These inter-organisational practices included the new Sustainability and Transformation Plans (STPs) designed to put NHS funding on a 'sustainable' footing (NHS England, 2016), the introduction of the Better Care Fund in aligning the interests of LAs and CCGs in the commissioning of social care and community interventions (HM Government, 2019b), and the newly formed regional Combined Authority.

Drawing on both Barad (2003 and 2007) and Haraway (1978) it is no surprise to discover that such a processes did not produce abstract 'truth' about the state of the public's health, but instead (re)inscribed and (re)produced an ethical and political 'Public Health agenda', which was itself always in flux. Public Health practitioners were found to be highly reflexive agents in this network, and from the PHE national outcomes framework, which created a dashboard for each authority, down to the service level agreements on commissioned contracts they sought to embed their ethics through measurement and reporting arrangements within the newly ring-fenced Public Health grant. The professional identity and discursive understanding of Public health, as a discipline, was seen to be reconstructed through and with a drastically new organisational and institutional environment (6.1) as professionals learnt to 'tell the story' of Public Health to new non-medical audiences. While inscription devices, calculations and accounts of Public Health were observed 'in action' and through their reconstruction (6.2), with a particular focus on the contested reconstruction of outcome measures and valuation techniques, such as social return on investment tools and KPIs, between PHE, LA practitioners, and commissioned services. With reference to the critical accounting literature (6.2), we saw that these naming, measuring, and reporting practices were not neutral, but instead implied the active reproduction of ethics and discourses through debate, discussion, presentation, and disclosure in various 'accountability' settings. In particular, via the newly established HWBs, but also via the regional DsPH monthly meetings, informal networking spaces, workshops and CPD activities. This demonstrated what Barad describes as the *entangled* (2007, pg.394) (3.2) nature of knowledge construction as Public Health professionals worked to make Public Health activities valuable and embed Public Health thinking into wider decision making.

The remaining sections of this chapter will begin by discussing what Chapters 5 and 6 tell us about the final research objective, namely the contribution in relation to 'post'-NPM (Julnes and Steccolini, 2015; Steccolini, 2019), 'intelligent accountability' (Roberts, 2009), and austerity (Bracci et el., 2015) in the critical public sector accounting literature (7.1). It will explore how making things 'valuable' in organisational life (Kornberger et al., 2015) in the public interest involves the performative contestation of alternative accounts through an ethically informed, more 'intelligent' alternatives, and the extent to which such efforts are contradicted by austerity measures that re-impose 'violent' top-down hierarchal control. It will go on to reflect on the overall theoretical contribution of the thesis (7.2), discussing how the generalised post-human performativity (Barad, 2003, and 2007, pg.134-137) and agential realist framework suggested in Chapter 3 contribute to our understanding of the construction of value(s) in organisational life. In particular, this section calls on the reader to diffractively re-read sections 6.1 and 6.2 in the previous chapter 'through and with' one another. In practice it was not the case that the concerns of section 6.2 followed those of 6.1 in a linear manner, instead the reconstruction of the 'evidence' was reciprocally reconstructed through and with identity and subjectivity. The phenomena discussed in sections 6.1 and 6.2 ought to be understood as entangled and co-productive of new collective understandings of the public's health and wellbeing.

Finally, section 7.3 concludes with a brief discussion of opportunities for further research by accounting scholars into Public Health activities. In particular, the considerable empirical opportunities opening up for the study of organisational value construction, intelligent accountabilities and alternative accounting, multi-organisational performance management and budgetary practices, and the mobilisation of accounting in complex interdisciplinary settings.

7.1 From New Public Management to intelligent accountability?

The focus on two case authorities and the newly formed national body, PHE, in this study demonstrated that both the mobilisation of evidence and enrolment in the value of Public Health interventions were central to the reconstruction of new knowledge networks. In this setting, short-term annualised budgetary practices and austerity were found to play an increasingly negative and dysfunctional role in this reconstruction. Public Health practitioners were divided as they sought to resist the 'opportunism' of embedding an increasingly short-term measureable focus into their evidence base, while, on the other hand and particularly through PHE, they sought to demonstrate the social, financial, and, increasingly, 'cashable' value of their interventions (6.2). Participants across the project spoke of their frustration as systems fragmented under 'salami-slicing' cuts to national budgets, and of the counterproductive consequences for health, wellbeing, and longer-term financial viability of the health and social care system (5.3).

The story of Public Health activities in England during this period provides good ground for critical accounting scholars looking to investigate accounting under austerity, and the possibility of counter or 'alternative' accounts in a post-NPM environment (Bracci et al., 2015; Steccolini, 2019), but also presents a note of caution against easy characterisations. Many elements of the initial government White Paper (HM Government, 2010), preceding the HSCA 2012, could be said to 'fit' a classic NPM story (Hood, 1991 and 1995; Power, 1997, pg.44) – Public Health activities were 'disaggregated' from wider primary care budgets and a national outcomes framework was developed through an arm's length body, PHE, to ensure the system provided value for money. Similarly, the emphasis in the reforms on the 'freedom to innovate', and the political rhetoric of 'localism' and the 'big society', together with

subsequent cuts to funding were, arguably, consistent with early stage NPM reforms designed to shrink the state (Ferlie et al., 1996; Hyndman and Lapsley, 2016). However, the shift from investment in a 'well resourced' ring-fenced Public Health grant (HM Government, 2010; Department of Health, 2011), with an initial uplift in funding, to annualised cuts from 2014 onwards began to directly undermine the initial ambitions of the HSCA 2012 and led to the cutting of services whose value for money was never contested. This ironic twist in the NPM logic was illustrated in the case of the local charity in Midland City, who lost half of their income in the 2016 budget, when they were told that the cut 'was nothing to do with [their] performance[…] it was just purely a business decision' (6.2, pg.152).

As articulated in previous literature (Bracci et al., 2015; Julnes and Steccolini, 2015; Steccolini, 2019) the austerity context of recent years is opening new avenues for critical public sector accounting research across complex inter-organisational collaborations. Public Health activities were and are a good example of this developing dynamic as they sought to embed longer time horizons and a broadening out of 'what counts' in decision making across increasingly multi-agency networks. In response to the fragmentation of services under the HSCA 2012 and progressive rounds of budget cuts, regional collaborations between the NHS and Local Government in England emerged. During the second round of data collection practitioners in both case authorities had established Public Health working groups within the newly formed regional Sustainability and Transformation Plans (STPs); joint commissioning roles within the case authorities; and in the case of Midland City had been working closely with the regional combined authority to ensure Public Health objectives were central to wider regional planning. Similarly, budgetary collaboration with the NHS developed through HWBs under the Better Care Fund (HM Government, 2019b). Perhaps counter intuitively, while annualised budget cuts increased pressures to deliver short term and 'cashable' savings they

also created a climate in which remaining services such as Public Health saw integration and collaboration as increasingly vital to their future viability.

With reference to a growing austerity climate, Bracci et al. (2015) and Steccolini (2019) suggested that post-crisis austerity represents a new context that alters the role and implications of accounting practices fundamentally, so that policy focuses ever more on national debt reduction, supranational institutions, and localised budget tightening. Meanwhile the fragmentation of the public sector under regimes of NPM has, arguably, promulgated a 'paradigm shift' from NPM to 'New Public Governance', under which there is greater emphasis on horizontal collaboration, hybridization, and inter-organisational working (Almquist et al., 2013; Julnes and Steccolini, 2015). The multiagency and cross-profession examples discussed in section 5.4 certainly provide evidence for the latter, from the HWBs themselves to the growing emphasis on influencing the new STPs, the Better Care Fund, and the regional Combined Authority. Others, however, argue that while practices develop and change over time, much of the traditional thrust of NPM, particularly the focus on 'business like' practices, remain deeply entrenched in the UK context (Hyndman and Lapsley, 2016). A key conclusion of this thesis is that while these networked practices were growing in prominence they were not so much a shift in an epistemological paradigm, but instead rose out of wider attempts to redress the dysfunctionalities caused by austerity practices and better manage dwindling resources.

Multi-agency and cross profession collaboration were certainly prominent in a 'Public Health ethos' that sought to embed what Marmot (2010) described as the 'health in all policies' approach, particularly as a result of their multi-methods training and increasingly pluralistic identity as the profession of the public's health and wellbeing (6.1). So that as

networked governance practices grew they were well placed to influence the new spaces that emerged. This was perhaps a result of what one Public Health consultant observed in their feedback on this project when they described the HSCA 2012 reforms, and the transfer from the NHS to Local Government as 'the right reform, but at the wrong time' (Public Health workshop, Feb 2016). In essence, Public Health budgets had transferred just as LAs, and latterly the Public Health function itself, were losing the funding to really take advantage of being 'closer' the local populations. Better collaboration with other agencies and actors outside of the core Public Health function was, therefore, the product of difficult necessity and crisis as the initial ambitions of the HSCA 2012 were gradually abandoned, and were not part of the initial reforms. This was exemplified on inspection of the STPs, which sought to reduce demand in the NHS, using much of the same rhetoric of the HSCA 2012 reforms, while also seeking to reduce investment in the very activities that might achieve those ends (MC 035, 2016; MT 043, 2016). The strategy of Public Health professionals was therefore increasingly one of influence outside of a reducing Public Health budget – to steer ongoing strategic planning across transport, adult social care, and local economic development via these new initiatives as they emerged in the face of austerity. In some senses, this could be described as evidence of a 'post'-NPM (Julnes and Steccolini, 2015; Steccolini, 2019), but it might better be understood as a continuation of an underlying business ethic in a context that forced practitioners towards collaboration over dwindling funds in the face of increasingly contradictory, short term, and economised (Çalışkan and Callon, 2010) measurement practices.

As these events developed somewhat chronologically across the new Public Health and wider health and social care system, the three 'phases' of NPM could be seen as linked, and all part of a wider neoliberal programme. The initial HSCA 2012 and the emphasis on

outcome measures, a well resourced and ring-fenced Public Health grant, disaggregated budgets with the DsPH 'free' to manage their own commissioning could all be described as 'classic' NPM. However, as Hyndman and Lapsley (2016) argue, the move towards austerity, increased focus on balancing budgets and reducing costly inputs regardless of the possible 'value' of the intended outcomes are all reminiscent of early 'Thatcherite' reforms. In this project, austerity was quite clearly considered by participants, both those who embraced it and those who sought to resist, as being part of a discourse of 'financial sustainability' 'economic reality' and 'business decisions', the very same rationale that led to 'classic NPM' in the UK in the 1980s and 1990s (Ibid.). Similarly, the evidence of 'post'-NPM, 'new public governance', and increasingly hybrid or networked practices did not represent a call for re-investment in activity as a public good, but again simply involved practitioners accepting the 'business like' 'reality' of austerity and then doing what they could to prevent 'salami-slicing' cuts from destabilising the system. Public Health practitioners acted pragmatically to use these spaces to better influence new and emerging conversations while remaining sceptical of reforms that did little more than attempt to patch together a system that was buckling under years of austerity.

Figure 12. NPM, austerity, and 'post'-NPM following HSCA 2012

Literature		
Evidence of 'classic' NPM (Hood, 1991, 1995) in HSCA 2012	**'Early stage' NPM (see Ferlie et al., 1996; Hyndman and Lapsley, 2016) and austerity**	**'post'-NPM (Julnes and Steccolini, 2015; Steccolini, 2019) strategies to address contradiction between classic NPM and austerity**
Timeline		
2010 – 2013	2010 – (annualised cuts to Local Government) 2014 – (annualised cuts to Public Health)	2013 – present (Better Care Fund) 2016 – 2018 (STPs)

		2017 – first regional mayor of Combined Authority elected
Evidence		
Budgets 'disaggregated' from wider PCTs	'Localism' agenda	Regional collaborations via STPs to address financial deficits in the NHS
'Freedom to manage' new ring-fenced Public health grant	'Big society' and emphasis on third sector delivery	Increasing use of job shares and joint-commissioning within Local Government
Quasi-autonomous governmental body created in Public Health England	Annualised cuts to budgets and increasing focus on inputs rather than outputs or outcomes	Longer-term 'joined up' financial planning
Standardised performance measurement via the PHE national outcomes framework	Contradiction with classic NPM as services demonstrating measureable value for money are cut away	Attempts to embed Public Health priorities into new regional Combined Authority

Intelligent accountability and austerity

Following this broader characterisation of the post HSCA 2012 reforms, this project asks to what extent did the knowledge production and accountability practices observed in this project constitute 'intelligent accountability' (Roberts, 2009) in practice and in a context increasingly dominated by austerity measures? In Chapter 2 (2.3), 'intelligent accountability' was introduced with reference to Roberts (2009) as a possible alternative to the 'fantasy' of accountancy as transparency, through which Public Health practitioners reconstructed both their identity and the collective value of their activities. Instead of the 'violent' imposition of measures, intelligent accountabilities ought to offer a more compassionate exchange between the giver and receiver of account that would be capable of incorporating a reflexive ethics. It was suggested that this rejection of transparency, and the call for ethical (and more effective) alternatives, mirrors similar calls across the accounting literature for 'emancipatory' 'alternative' or 'counter' accounts that challenge corporate greed and politicised austerity

narratives in which harmful cuts to services are argued as necessity (Bracci et al., 2015; Bebbington et al., 2017). This study contributes to the limited empirical literature on intelligent accountability in practice (see English, 2013; Yates, 2019) by demonstrating that attempts towards intelligent accountabilities gradually came under pressure as short-term austerity measures that sought to 'balance the books' (Bracci et al., 2015) shifted calculative and discursive practices, fragmented existing services, and re-imposed short-term hierarchal control.

In the early years, following the HSCA 2012 reforms, Public Health teams were found to be mobilising their expertise and identity as applied medical scientists to enrol city planners, politicians, charities, CCGs, and others in an increasingly broad understanding of 'health and wellbeing' (5.2). This involved a necessary shift as the 'rigorous' scientific terms of reference, so familiar in the NHS, no longer carried the same weight. To enrol and mobilise in this new context Public Health professionals instead needed to learn to 'speak a different language' (Brown et al., 2014; Phillips and Green, 2015), linking their data on population wide health and wellbeing to the personal and individual. Faced with this new environment, Public Health professionals sought to adapt their calculative techniques to include *emotive* localised information on need, deprivation and health inequality in order to influence the authority towards more evidence based policy decisions. The emphasis on more pluralistic health and wellbeing outcomes, following the HSCA 2012, was also seen by participants as a move away from a 'service' culture in the NHS (6.1). All of this reshaped the giving and receiving of account through the newly formed HWBs and through newly re-commissioned contracts. The move from the NHS environment therefore not only involved reforming the budgetary, accountability and reporting arrangements, it began to change the very idea of Public Health itself as a discipline (6.1).

To some extent, therefore, we can see Public Health professionals as embedding themselves in their new LA context through a network of *intelligent accountabilities*, negotiating their ethical agenda with colleagues, service providers, and politicians towards collective action on a shared problem. The process of compromise and iteration was evident throughout the data, and was exemplified in the new calculative drug and alcohol tools as PHE health economists sought to work with local practitioners to develop a system of measuring SROI that built consensus on 'what worked' and 'what mattered' in their new context (6.2). It was also clear that these outcomes, in turn, (re)shaped the ethical commitment and motivations of professionals who worked towards these ends.

Public Health professionals were themselves acutely aware of the limitations of traditional accountability as transparency, which in turn had crucial methodological implications as accountability ceased to be a top-down form of control and instead was revealed as a two-way process of *translation* (Latour, 2005, pg.179). Public Health professionals were not simply 'held to account', but used established mechanisms of calculating, communicating, and reporting to influence and engage. They were skilled and largely successful in mobilising Public Health annual reports; joint strategic needs assessments; and the forum of the HWB to convince various professional stakeholders of their objectives and interventions (5.2) (6.2). In actively mobilising forums of accountability they not only transformed themselves through new calculative and discursive practices, they successfully convinced others of the importance of 'spending to save', 'bringing Public Health into all policies', and the 'whole life course approach'. The relative *value* of the public's health and wellbeing had therefore been iteratively (re)articulated and (re)defined. By reflexively building their ethical agenda into their accounts, and constructing their accounts through an openly two-way iterative process that involved mixed methods approaches, the attempt to

mobilise the PHE outcomes framework could be described as a practice of intelligent accountability[23].

However, this does not tell the full story. As described above, the disaggregation and fragmentation of Public Health activities under the HSCA 2012 subsequently led to reductions in the scope of direct interventions as budgets were reduced from 2014 onwards, which coincided with increased multi-agency and cross-profession collaborations. The holistic, mixed-method, 'Public Health agenda' came into increasing conflict with the language of 'financial' and 'economic' 'security' and 'sustainability', often referenced specifically to annualised budget processes, which were found to be pushing some calculations towards 'fiscal' or even specifically 'cashable' outcomes. While this continued to be contested and resisted, the fiscal and budgetary 'reality' of cuts from central government broke up pre-existing contracts, and re-imposed the hierarchal 'violence' of austerity. This was seen in two of the examples presented in section 5. as one charity CEO described how her staff 'burst into tears' as they lost half of their budget while another financial advisor coldly talked of euthanizing those no long 'economically viable'. This speaks profoundly to not only the continually contested nature of intelligent accountabilities in practice, but also of the highly ethical-political consequences intelligent accountability in times of austerity. It would appear that one conclusion must be that 'intelligent accountability' cannot exist entirely within and yet apart from a wider system of neoliberalism.

[23] The use of the PHE outcomes framework could also be described as non-violent in so much as it was not used as the basis for performance management or performance appraisal within the Public Health function. However, this violence is effectively re-imposed as the outcomes are embedded into commissioned contracts and linked to punative performance incentives. See 6.2 pg.151-152.

7.2 Performativity and ethico-onto-epistemology

Throughout this analysis, an understanding of knowledge construction as a messy, heterogeneous, performative process was central (Barad, 2003, and 2007, pg.134-137). Inscription devices were sometimes decoupled from actual strategic direction, as in the case of the Joint Strategic Needs Assessments in Midland City, with backstage documents aligning actors behind more focused objectives. Or, at other times they were crucial to the translation and mobilisation of networks, as in the case of the Public Health annual reports, power point presentations, and handouts observed in action in Metro Town. Throughout, the ethics of a public sector assemblage that delivered against health, wealth, and economic inequality drove actors towards an 'intelligent accountability' (Roberts, 2009) that was, itself, in the midst of continual material and discursive upheaval. This was never a settled matter. What constituted intelligent measurement, through which one could be made accountable for what ought to be valued, was always in a state of flux. The giving of account, in this sense, to the 'self' and to the powerful 'other', in the construction of rational and emotive 'truth' was an intractably entangled affair, dependent always on what futures could plausibly be imagined and whose collective interests those imagined futures best served.

To some extent, parts of this story could have been analysed through more conventional theoretical frameworks. A classical ANT framework would have provided many of the methodological tools for following networks of human and nonhuman actors, while the DsPH could well have been described as 'spokes people' for the network, and no doubt examples of the four stages of translation, as described by Callon (1986) could have been traced. Or, drawing on more recent iterations of ANT, more heterogeneous assemblages could have been mapped across organisational boundaries by following moments of

controversy (Latour, 2005). Indeed, many of the tools provided by Latour (2005) and others are mobilised in this project, and the transfer of Public Health activities to local government was in part chosen as it provided a 'hot' situation (Callon, 1998) in which framework overflowed and were redrawn and new group structures emerged (Latour, 2005, pg.27). Such a framework would have been especially apposite for the analysis provided in section 6.1 in light of the more recent interest, inspired by economic sociology (see Miller, 2008; Vollmer et al., 2009), in the performativity of accounting and accounting inscriptions, with reference to the performativity of economics and economic models as laid out by, for example, MacKenzie (2006).

On the other hand, drawing more directly on the post-structuralist tradition, and on governmentality in particular (see Dean, 2009), the project could have explored the distributed assemblages of power relations in the governance of Public Health activities. This may have been especially suitable for the analysis in section 6.2 as Public health professionals reconstructed their self-disciplining ethics and identity in a new organisational and institutional environment. Neither framework would entirely have neglected the other; in *The Subject and Power* for example, Foucault (1982) explores how subjectivisation is achieved in modern society. In education, for example, it might be the result of a vast arrangement of power relations that proliferate through technologies of communication, surveillance, physical setting, coded signs of obedience and so on. Power becomes the ensemble of actions which induce action in others. These points are taken up in the critical accounting literature, for example by Miller (1990) who takes up the crucial question of how accounting practice, in particular, play a crucial role in mediation modern governance as organisational life is made calculable and therefore governable in the modern sense.

Similarly, several contemporary ANT studies take up the question of narratives and identity (for example Skærbæk and Thorbjørnsen, 2007; Justesen and Skærbæk, 2010), and Latour's definition of agency bears a striking resemblance to the definition of power relations provided by Foucault when he describes the actor as "An actor is what is made to act by many others" (Latour, 2005, pg.46). Elements of early ANT are also incorporated into early governmentality frameworks in critical accounting and economics, see for example how Miller and Rose (1990) cite Latour (1987) in their discussion of 'centres of calculation' that allow for 'government at a distance' and both Callon and Latour's analysis of translation as network's of actors come to share a common interest.

In Chapter 3, however, (3.4) I argued that Barad, and more widely feminist science studies, contributes to a post governmentality-ANT discussion In the critical accounting field in several important ways, and make the case that there has more recently been several clear points of divergence in the literature. Firstly, and perhaps foremost, the agential realist framework was introduced as providing a foundational framework, at the ontological level, for a posthumanist performativity that both addresses and extends the performative construction of subjectivity and identity, through and with material-discursive intra-action. Post-Foucauldian approaches can be criticised for remaining primarily humanist in their philosophy and, ultimately, reinscribing the uncritical essentialism in relation to human subjectivity that they seek to address. This was explored particularly with reference to bodily and gender performativity as described by Butler (1990). Again, conversely, while ANT and other STS scholars have attempted to de-center the human, they had typically not done so at the ontological level (Barad, 2007), instead arguing for an epistemological decentering that addressed ways of knowing without fully considering the entanglement of ways of knowing with reality itself. The result can be a depoliticised 'flat ontology' that lacks critical depth

(Fuller, 2012; Gond et al., 2016). More recent attempts towards 'relational ontologies' (Vosselman, 2014) similarly call for a reappraisal of the inherently political and ethical dimensions of accounting statements and practices, but the theorisation of how this can be achieved within classic ANT or more recent 'Callonistics' remains somewhat tentative and unconvincing. Barad (2007), on the other hand, provides an account of the inherent indeterminacy of matter and meaning as they explore how reality itself emerges through performative material-discursive intra-action with reference to our understanding of the laws of nature. The result is a unified ethico-onto-epistemology; that is to say a theory of ethics, being, and knowing.

Further to this, Chapter 3 made the case that there was indeed evidence ofcontradictory tensions in the accounting literature and that the theorisation of performativity, as a proposed solution to paradoxes of representationalism or objectivity, typically fell back into either primarily or exclusively performativity of material objects, inscriptions, or statements, with the special case of the illuctionary 'performativity thesis' (Callon, 2010) to be proven or disproven, on the one hand, or, on the other, some relatively peripheral papers in the review who drew on performativity via post-structuralist analysis of subjectivity and discourse (for example Roberts, 2009). Latour, in particular, seems to be especially guilty of privileging the agency of objects over, above, and in contradistinction to, discourse and theory (see for example 2005, pg.69-72), rather than recognising their ontological inseparability. That is not to say dualisms do not emerge, and that human-nonhuman, nature-culture, theory-practice distinctions are not necessary to articulate, but that we must be able to analyse them in performative co-relation. Objects, statements, and inscriptions are constituted through performative processes just as are discursive signifiers, human subjects, and social institutions.

(Re)constructing the valuable in an ethico-onto-epistemological framework

It was argued in Chapter 2 of this thesis that there was a need to explore empirical examples of how activities are made valuable in organisational life beyond the special case of monetary value via constructed market exchange mechanisms, and that few studies had considered such concerns in public sector settings. In addressing this gap, this paper has sought to follow the performativity of accounting and budgetary techniques through and with the material-discursive regulatory regimes they encounter, moving beyond the 'special case' of the 'performativity thesis' (Vosselman, 2014) towards performativity understood as translation and iteration through which knowledge networks are continually (re)constructed. Barad's agential realism (2007) has been put forward as an overarching methodology for doing just that; following the translations in organisational activity through the subjective and discursive, together with the material and the calculative, in investigating the physical-theoretical apparatus for truth claims about the public's health that were deeply ethical and political in nature.

Valuation was, in this project, found to be a two-way process that played out through performative intra-actions (Barad, 2007, pg.184) and 'intelligent accountabilities' (Roberts, 2009) in the day to day back-and-forth of organisational truth making in which what counts is always contested. Public Health activities, in particular, were and continue to provide an interesting empirical setting for such questions as they offer up huge potential for improved quality of life and the financial sustainability of health care systems and local government (Davies, 2015; Buck, 2017) while at the same time being inherently difficult to measure. They typically have long time horizons, needing to be strategically planned along the 'entire life course' (Marmot, 2010), and are enmeshed with 'wicked' (Pedersen et al., 2017) issues of health and economic inequality. Public Health professionals meanwhile pursue the double

role of scientist and of advocate in relation to Public Health interventions. Similarly, austerity measures that have disproportionately hit the deprived authorities (Hastings et al., 2015) throw up difficult ethical-political problems. Two stark examples of this presented were seen Chapter 6 as one charity CEO described how her staff 'burst into tears' as they lost half of their budget while another financial advisor coldly talked of euthanizing those no long 'economically viable'. This speaks to the highly ethical-political consequences intelligent accountability in times of austerity and the need for a theoretical framing that puts ethics and politics at the heart of the knowledge construction process.

The data presented in this thesis that saw Public Health activities being valued and revalued over time has demonstrated that the construction of the 'facts', in organisational settings, is deeply entangled with what 'ought' to be accounted for in terms of time horizons, outcomes, and economisation, which consequently affected crucial investment and disinvestment decisions. Drawing reference to feminist science studies, in particular, among the broader field of STS, we see that the radical de-centering of the human can form the basis for an analysis of the posthuman ethical subject through and with matter, discourse, bodies and practices across assumed organisational boundaries. Barad (2007) provides a strong framework for doing just that, as does the work of Harding (1991), Haraway (1991 and 2008), and potentially other feminist new materialist scholars (see for example Coole and Frost, 2010).

Thus, the question of what is valued in society put forward in the opening lines of this thesis, in which accounting practices of naming, categorising, and reporting are so central, is never a politically or ethically neutral one, and, furthermore, in developing critical perspectives on accounting we equally need a critical perspective on the ethics and politics of

accounting. Making things valuable (Kornberger et al., 2015) travels far beyond the special case of making markets for exchange, and becomes, ultimately, a dual task of making things knowable while at the same time constructing and mobilising a shared agenda for action around an agreed set of problems. Making things valuable in the public interest, across the traditional public sector and beyond, is a shared, pluralistic and hybrid endeavour in which human subjects and public perceptions are constantly reconstructed through social and material relations that are always in flux and in which we all hold a stake.

7.3 Recent developments and opportunities for further research

During the second round of data collection professionals in both case authorities had established Public Health working groups within the newly formed STPs. They sought to bring together actors across both of their geographical regions to address upstream pressure on the NHS; established joint commissioning roles with other budget holders within their authorities; and in the case of Midland City practitioners had been working closely with the wider regional Combined Authority to ensure Public Health objectives were central to regional planning. Across the data, an ethos of prevention and an ethics of population health and wellbeing, that drew on more pluralistic evidence based understandings of what ought to count, played out in contradiction with the ever increasing pressures of austerity. Perhaps counter intuitively, while annualised budget cuts increased pressures to deliver short term and 'cashable' savings they also created a climate in which remaining services such as Public Health saw integration and collaboration as increasingly vital to their future viability. This was particularly visible in their engagement with regional devolution and pooled budgets; for example, the pooling of social care costs between LAs and CCGs under the Better Care Fund (HM Government, 2019b).

As articulated in previous literature (Bracci et al., 2015; Julnes and Steccolini, 2015) the current context of austerity is opening new avenues for critical public sector accounting research, particularly with regard to budgeting and performance measurement across complex inter-organisational collaborations. The emerging regional collaborations between the NHS and Local Government in England, which are being designed to more rationally address issues of primary care previously fragmented under the HSC Act 2012, and a Public Health ethos of 'health in all policies', can be framed as attempts to move beyond short term planning and disaggregation. All of which open up new avenues for greater collaboration, hybridization, and inter-organisational working through networked governance practices (Almquist et al., 2013) that seek to construct public value via pooled budgets and multi-agency work. Three examples briefly explored in Chapter 5 included the introduction of the Better Care Fund, pooling social care costs between LAs and CCGs (HM Government, 2019b); the introduction of Sustainability and Transformation Plans (STPs), which include LA representation in finding funding solutions to the budgetary shortfalls across the local NHS and primary care (NHS England, 2016); and a wider regional combined authority. The common thread across these reforms was the increasing multi-agency collaboration in response to the perceived fragmentation of the wider health and social care system, particularly with a view to addressing a growing funding crisis in the NHS.

However, on this being an 'opportunity' for Public Health, austerity was described, ironically, taking away many of the opportunities and possibilities increased collaboration might have brought if Public Health had been transferred in times of growth and investment. This dynamic did not stop in 2017 and no doubt continues to throw up interesting new conflicts and accounts. More recently, the fragmentation of the Public Health system is strongly criticised in the context of the Covid-19 pandemic (BMJ, 2020; The Lancet, 2020), and

as a result the government announces the dissolution of PHE, the body they had created just 7 years earlier. This, perhaps more than any other development, demonstrates the conflict inherent in the various NPM, Public Health, and austerity agendas. There is a call to develop the most cost effective interventions, yet at the same time pressure to cut the inputs that make those cost effective (and often cash generating) outcomes possible. There is a push for a more collaborative and joined up health and social care sector, but the scale and pace of reform creates fragmentation and dysfunctionality. An interesting follow up to this project would be to extend the data collection to include questions on how the reforms of the HSCA 2012 set the scene for the failures during the Covid-19 pandemic and the political pressures faced by PHE prior to its dissolution.

More widely, Public Health activities themselves sit at several interesting intersections for critical accounting researchers. They address inherently difficult to measure problems that involve valuing health, wellbeing, and sometimes life itself, and which run across two very different areas of the public sector in healthcare and local government. Geographical footprints also present a range of interesting problems a local councils, STPs, PHE regional offices, and combined authorities all operate across different boundaries. All of which presents multiple possibilities to explore multi-agency budgetary practices, complex and pluralistic performance measurement practices, austerity, and the construction of public value in non-market settings (Bracci et al., 2015; Anessi-Pessina et al., 2016; Julnes and Steccolini, 2015; Steccolini, 2019).

List of References

Abbott, A. (1988) *The system of professions.* Chicago: University of Chicago Press.

Abbott, A. (1991) 'The order of professionalization: an empirical analysis', *work and Occupations,* 18(4), pp.335-384.

Ahmed, S. (2006) *Queer Phenomenology: Orientations, Objects, Others,* Durham: Duke University Press.

Ahrens, T., and Ferry, L. (2015) 'Newcastle City Council and the grassroots: accountability and budgeting under austerity', *Accounting, Auditing & Accountability Journal*, 28(6), pp.909-933.

Almquist, R., Grossi, G., van Helden, J.G. and Reichard, C. (2013) 'Public sector governance and accountability', *Critical Perspectives on Accounting*, 24(7-8), pp.479-487.

Alvesson, M., and Willmott, H. (2002) 'Identity Regulation as Organizational Control: Producing the Appropriate Individual', *Journal of Management Studies*, 39(5), pp.619-644.

Anessi-Pessina, E., Barbera, C., Sicilia, M., and Steccolini, I. (2016) 'Public sector budgeting: a European review of accounting and public management journals', *Accounting, Auditing and Accountability Journal*, 29(3), pp.491-519.

Arnaboldi, M., and Lapsley, I. (2008) 'Making Management Auditable: The Implementation of Best Value in Local Government', *Abacus*, 44(1), pp.22-47.

Asdal, K. (2011) 'The office: The weakness of numbers and the production of non-authority', *Accounting, Organizations and Society*, 36(1), pp.1-9.

Association of Directors of Public Health, and the LGA (2014) *The Health and Wellbeing System Improvement Programme*, the LGA website. Available at: https://local.gov.uk/publications/health-and-wellbeing-system-improvement-programme-june-2014 (Accessed 24 October 2021).

Austin, J.L (1962) *How to Do Things with Words*. Cambridge: Harvard University Press.

Bandy, G. (2011) *Financial Management and Accounting in the Public Sector,* London: Routledge.

Barad, K. (2003) **'**Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter**',** *Signs: Journal of Women in Culture and Society*, 28 (3), pp.801-831**.**

Barad, K. (2007) *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*, Durham: Duke University Press.

Barad, K. (2012) 'On touching – The inhuman that therefore I am', *Differences*, 23 (3), pp.206-223.

Barad, K. (2014) 'Diffracting Diffraction: Cutting Together-Apart', *Parallax*, 20 (3), pp.168-187.

Bassnett, S., Frandsen, AC, and Hoskin, K. (2019) 'The unspeakable truth of accounting On the genesis and consequences of the first 'non-glottographic' statement form', *Accounting, Auditing and Accountability Journal,* 31 (7), pp.2083-2107.

Bebbington, J., Russell, S. and Thomson, I. (2017) 'Accounting and sustainable development: reflections and propositions', *Critical Perspectives on Accounting*, 48(1), pp.21-34.

Berg, B. (2007) *Qualitative Research Methods for the Social Sciences,* Pearson/Allyn & Bacon: London.

Black, D. (1980) 'Inequalities in Health: Report of a research working group'. *The Socialist Health Association website.* Available at: https://www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/black-report-foreword/ (Accessed 18 October 2021).

BMJ (2020) 'The UK's public health response to covid-19'. *The BMJ website*, 15 May 2020. Available at: https://www.bmj.com/content/369/bmj.m1932 (Accessed 22 October 2020).

Boedker, C. (2010) 'Ostensive versus performative approaches for theorising accounting-strategy research', *Accounting, Auditing, & Accountability*, 23(5), pp.595-625.

Boll, K. (2014a) 'Shady car dealings and taxing work practices: An ethnography of a tax audit process', *Accounting, Organizations & Society*, 39 (1), pp.1-20.

Boll, K. (2014b) 'Representing and Performing Businesses: A segmentation model in action', *Journal of Cultural Economy*, 7(2), pp.226-244.

Bourn, M., and Ezzamel, M. (1986) 'Costing and budgeting in the National Health Service', *Financial Accountability & Management*, 2(1), pp.53-71.

Bracci, E., Humphrey, C., Moll, J., and Steccolini, I. (2015) 'Public sector accounting, accountability and austerity: more than balancing the books?', *Accounting, Auditing & Accountability Journal*, 28 (6), pp.878-908.

Briers, M., and Chua, W. (2001) 'The Role of Actor-Networks and Boundary Objects in Management Accounting Change: A Field Study of An Implementation of Activity-Based Costing', *Accounting Organizations and Society*, 26(3), pp.237-269.

Brown, H, Ellins, J, Kearney, J, Singh, K, Jackson, O, Krelle, H and Snelling, I (2014) 'Measuring Up? The Health of NHS Cancer Services', A report for Cancer Research UK by the Health Services Management Centre at the University of Birmingham and ICF International.

Bryer, R.A. (2006) 'Accounting and control of the labour process', *Critical perspectives on accounting*, 17 (5), pp. 551-598.

Buck, D., and Gregory, S. (2013) 'Improving the public's health: A resource for local authorities', *The Kings Fund.* Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf (Accessed 12 Jan 2018).

Buck, D. (2017) 'Chickens coming home to roost: local government public health budgets for 2017/18', *The Kings Fund.* Available at: https://www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18 (Accessed 12 Jan 2019).

Buck, D. (2018) 'Local government spending on public health: death by a thousand cuts', *The Kings Fund.* Available at: https://www.kingsfund.org.uk/blog/2018/01/local-government-spending-public-health-cuts (Accessed 12 Jan 2019).

Burchell, S., Clubb, C., Hopwood, A., Hughes, J., and Nahapiet, J. (1980) 'The roles of accounting in organizations and society', *Accounting, Organizations and Society*, 5(1), pp.5-27.

Butler, J. (1990) *Gender Trouble*, London: Routledge.

Butler, J. (1993) *Bodies that matter*, London: Routledge.

Butler, J. (1997) *The psychic life of power; theories in subjection,* Stamford: Stamford University Press.

Butler, J. (2005) *Giving an account of oneself*, New York: Fordham University Press.

Butler, J. (2010) 'Performative agency', *Journal of Cultural Economy*, 3(2), pp.147-161.

Cabinet Office (2009) *A guide to social return on investment.* Available at: https://neweconomics.org/uploads/files/aff3779953c5b88d53_cpm6v3v71.pdf (Accessed 3 March 2020).

Çalışkan and Callon (2010) 'Economization, part 2: a research programme for the study of markets', *Economy and Society*, 39 (1), pp.1-32.

Callon, M. (1986) 'Some Elements of a Sociology of Translation: Domestication of the Scallops and Fishermen of St. Brieuc Bay'. In Law, J. (ed.) *Power, Action and Belief: A New Sociology of Knowledge?* London: Routledge. pp. 196-233.

Callon, M. (1998) 'An essay on framing and overflowing: economic externalities revisited by sociology', *The Sociological Review*, 46(1), pp.244-269.

Callon, M. (2007) 'What does it mean to say that economics is performative?', in MacKenzie, D., Muniesa, F., and Siu, L. (Eds.) *Do Economists Make Markets? On the Performativity of Economics*, Princeton: Princeton University Press, pp. 225–244.

Callon, M. (2010) 'Performativity, misfires and politics', *Journal of Cultural Economy*, 3 (2), pp.163-169.

Callon, M., and Muniesa, F. (2005) 'Economic Markets as Calculative Collective Devices', Organization Studies, 26(8), pp.1229–1250.

Carolan, M.S. (2006) 'Sustainable agriculture, science and the co-production of 'expert' knowledge: The value of interactional expertise', *Local Environment*, 11(4), pp.421-431.

Caron, R., Hiller, M., and Wyman, W. (2014) 'Public health system partnerships: role for local boards of health in preparing the future public health workforce', Journal of Community Health, 39, pp.29-34.

Carter, C., Clegg, S., and Kornberger, M. (2010) 'Re-framing strategy: power, politics and accounting', *Accounting, Auditing & Accountability,* 23(5), pp.573-594.

Chantler, T., Bell, S., Saliba, V., Heffernan, C., Ramsay, M., and Mounier-Jack, S. (2019) 'Is partnership the answer? Delivering the national immunisation programme in the new English health system: a mixed methods study', BMC Public Health, 19(1), pp.1-12.

Chiapello, E. (2017) 'Critical accounting research and neoliberalism', *Critical Perspectives on Accounting*, 43, pp.47-64.

Chiapello, E., and Baker, R. (2011) 'The introduction of French theory into English language accounting research', *Accounting, Auditing, & Accountability*, 24(2), pp.140-160.

Christensen, M., and Skærbæk, P. (2007) 'Framing and overflowing of public sector accountability innovations : A comparative study of reporting practices', *Accounting Auditing and Accountability Journal*, 20(1), pp.101-132.

Christner (2015) 'The Valuable Organisation. A study of how activities are calculated, controlled and made valuable', PhD Thesis. Stockholm Schyool of Economics. Available at:https://www.hhs.se/contentassets/95137c26e7cf44818b9abd03314cf885/fulltext_christner_thesis_final_2015maj11.pdf (Accessed 24 October 2021).

Chua, W., and Preston, A. (1994) 'Worrying about accounting in health care', *Accounting, Auditing & Accountability Journal*, 7(3), pp.4-19.

Coole, D., and Frost, S. (2010) *New Materialisms: Ontology, Agency, and Politics*, Durham: Duke University Press.

Cooper, P. (1974) 'What will reorganisation do for the patient?', *The Lancet,* 1(7859), pp.670-671.

Corvellec, H., Ek, R., Zapata, P., and Zapata Campos, M.J. (2016) 'Acting on distances: A topology of accounting inscriptions', *Accounting, Organizations and Society*, (Forthcoming).

Crenshaw, K. (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color', *Stanford Law Review*, 43(6), pp.1241-1299.

Cushen, J. (2013) 'Financialization in the workplace: Hegemonic narratives, performative interventions and the angry knowledge worker', *Accounting, Organizations and Society,* 38(4), pp.314-331.

Czarniawska, B. (2004) 'On Time, Space, and Action Nets', *Organization*, 11(6), pp.773-791.

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(7), pp.428-455.

Davies, A. (2015), "£200m cuts to Public Health: the situation is getting serious", *The Nuffield Trust*. Available at: https://www.nuffieldtrust.org.uk/news-item/200m-cuts-topublic-health-the-situation-is-getting-serious (Accessed 21 April 2018).

Day, M.; Shickle, D.; Smith, K.; Zakariasen, K.; Moskol, J.; Oliver, T. (2014) 'Training public health superheroes: five talents for public health leadership', *Journal of Public Health*, 36(4), p.552-561.

Department of Health (2010) *Quantifying health impacts of government policies*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216003/dh_120108.pdf (Accessed 21 February 2020).

Department of Health (2011) *Public health in Local Government.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216708/dh_131904.pdf (Accessed 24 April 2019).

Department of Health (2012) *The general duties and powers relating to health and wellbeing boards.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144020/General-health-and-wellbeing-board-duties-and-powers.pdf (Accessed 16 February 2020).

Department of Health (2013) *Directors of Public Health in Local Government: Roles, Responsibilities and Context.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213007/DsPH-in-local-government-i-roles-and-responsibilities.pdf (Accessed 24 April 2019).

Department of Health (2014) *Wellbeing: why it matters to health policy.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative_January_2014_.pdf (Accessed 16 February 2020).

Department of Health (2015) *Public health grant: proposed target allocation formula for 2016/17*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/468964/1_Public_Health_Grant_-_Proposed_Target_Allocation_Formula_2016-17_-_amended.pdf (Accessed 24 October 2021).

Department of Health (2016) *Public health ring-fenced grant 2017/18.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/578906/LAC_DH_2016_3_v2.pdf (Accessed 16 December 2017).

Department of Health and Social Care (2018) *Call for evidence: Local authority public health prescribed activity.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/674840/local-authority-public-health-prescribed-acitivity-call-for-evidence.pdf (Accessed 24 April 2019).

Department of Health and Public Health England (2014) *Health premium incentive scheme 2014/15 and public health allocations.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/352511/Consultation_Document.pdf (Accessed: 5 May 2020).

Department of Health, Public Health England, and the Local Government Association (2013) *Localising the Public Health responsibility deal – a toolkit for local authorities.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/193106/130408-RD-Toolkit-Web-version.pdf (Accessed 29 January 2020).

Drury, C. (2015) *Management and cost accounting*, 9th Ed., Hampshire: Cengage.

Ellwood, S. (2014) 'Debate: Autonomy, governance, accountability and a new audit regime', *Public Money & Management*, 34(2), pp.139-141.

English, L. (2013) 'The impact of an independent inspectorate on penal governance, performance and accountability: pressure points and conflict 'in the pursuit of an ideal of perfection'', *Critical Perspectives on Accounting*, 24(7-8), pp.532-549.

Evetts, J. (2011) 'A new professionalism? Challenges and opportunities', *Current Sociology,* 59 (4), pp.406–422.

Exworthy, M. (2015) 'The Iron Cage and the Gaze: Interpreting Medical Control in the English Health System', *Professions and Professionalism*, 5(1), pp.1-14.

Ezzamel, M. (2008) 'Order and accounting as a performative ritual: Evidence from ancient Egypt', *Accounting, Organizations and Society*, 34(3–4), pp.348-380.

Faculty of Public Health (2014) *Standing orders*. Available at: https://www.fph.org.uk/media/1460/standing-orders.pdf (Accessed: 29 January 2020).

Ferguson, J., Tazzyman, A., Walshe, K., Bryce, M., Boyd, A., Archer, J., and Price, T. (2021) ''You're just a locum': professional identity and temporary workers in the medical profession', *Sociology of health & illness*, 43(1), pp.149-166.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996) *The New Public Management in Action*, Oxford University Press, Oxford.

Flynn, R. and Williams, G. (1997) 'Contracting for health', in Flynn, R. and Williams, G. (Eds) (1997), *Contracting for Health: Quasi-Markets and the National Health Service*, Oxford University Press: Oxford.

FRC (2014) *True and fair.* Available at: https://www.frc.org.uk/accountants/accounting-and-reporting-policy/true-and-fair-concept (Accessed: 28 April 2019).

Finch, D., Bibby, J., and Elwell-Sutton, T. (2018) *Briefing: Taking our health for granted. Plugging the public health grant funding gap*. Available at: https://www.health.org.uk/sites/default/files/upload/publications/2018/Taking%20our%20health%20for%20granted_for%20web.pdf (Accessed: 14 April 2019).

Fischer, MD., and Ferlie, E. (2013) 'Resisting hybridisation between modes of clinical risk management: Contradiction, contest, and the production of intractable conflict', *Accounting, Organizations and Society*, 38(1), pp.30–49.

Foucault, M. (1977) *Discipline and Punish*, London: Allen Lane.

Foucault, M. (1978) *The History of Sexuality, Vol. I: An Introduction*, Trans. Robert Hurley. NewYork: Vintage Books.

Foucault, M. (1982) 'The subject and power', *Critical Inquiry,* 8 (4), pp. 777-795.

Foucault, M. (2011) *The government of self and others: lectures at the Collège de France, 1982-1983.* Translated by G. Burchell. Basingstoke: Palgrave Macmillan.

Frandsen, AC. (2009) 'From psoriasis to a number and back', *Information and Organization*, 19(2), pp. 103-128.

Fuller, S. (2012) 'CSI: Kuhn and Latour', *Social Studies of Science*, 42(3), pp.429–434.

Gebreiter, F (2017) 'Accounting and the emergence of care pathways in the National Health Service', *Financial Accountability & Management*, 33(3), pp. 299-310.

Ghauri, P., and Gronhaug, K. (2010) *Research methods in business studies*, 4th Ed., Edinburgh: Pearson.

Glaser, B.G, and Strauss, A.L (1967) *The Discovery of Grounded Theory. Strategies for Qualitative Research*. Chicago: Aldine.

Goddard, A. (2004) 'Budgetary practices and accountability habitus A grounded theory', *Accounting, Auditing & Accountability Journal*, 17 (4), pp.543-577.

Goddard, A. (2005) 'Reform as regulation—accounting, governance and accountability in UK local government', *Journal of Accounting & Organisational Change,* 1(1), pp.27-44.

Gond, JP, Cabantous, L., Harding, N., and Learmonth, M. (2016) 'What Do We Mean by Performativity in Organizational and Management Theory? The Uses and Abuses of Performativity', *International Journal of Management Reviews*, 18 (4), pp.440-464.

Gorsky, M., Lock, K., Hogarth, S. (2014) 'Public health and English local government: historical perspectives on the impact of 'returning home'', *Journal of Public Health*, 36(4), pp.546–551.

Hacking, I. (2002). 'Making up people'. In Hacking (Ed.), *Historical Ontology*, Cambridge: Harvard University Press.

Hagan, F. (2006) *Essentials of Research Methods in Criminal Justice and Criminology*, 2nd Ed. New York: Pearson.

Hansen, A., and Mouritsen, J. (1999) 'Managerial Technology and Netted Networks. `Competitiveness' in Action: The Work of Translating Performance in a High-Tech Firm', *Organization*, 6(3), pp.451-471.

Haraway, D. J. (1978) 'Animal Sociology and a Natural Economy of the Body Politic, Part I: A Political Physiology of Dominance', *Signs*, 4 (1), pp. 21-36.

Haraway, D. J. (1991) *Simians, cyborgs and women: the reinvention of nature*, London: Free Association.

Haraway, D. (1992) 'The Promises of Monsters: A Regenerative Politics for Inappropriate/d Others', in L.C. Grossberg, C. Nelson, C and P.A. Treichler. (Eds.), *Cultural Studies,* New York: Routledge. pp.295–337.

Haraway, D. J. (2008) *When species meet*, Minneapolis: University of Minnesota Press.

Hardie, I., and Mackenzie, D. (2007) 'Assembling an Economic Actor: The Agencement of a Hedge Fund', *The Sociological Review*, 55(1), pp.57-80.

Harding, S. (1991) *Whose science? Whose knowledge?*, Buckingham: Open University Press.

Hastings, A., Bailey, N., Bramley, G., Gannon, M., and Watkins, D. (2015) The cost of the cuts: the impact on local government and poorer communities. York: Joseph Rowntree Foundation.

Health and Social Care Act 2012, Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (Accessed: 24 April 2019).

Health Services and Public Health Act 1968. Available at: https://www.legislation.gov.uk/ukpga/1968/46/contents (Accessed: 24 October 2021).

Hennink, M., Hutter, I., and Bailey, A. (2011) *Qualitative research methods*, London: Sage.

Hines, R. (1988) 'Financial accounting: In communicating reality, we construct reality', *Accounting, Organizations and Society,* 13(3), pp.251-261.

HM Government (2010) *Healthy lives, healthy people: our strategy for public health in England,* Available at: https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england (Accessed 29 January 2020).

HM Government (2019) *Business transfers, takeovers and TUPE*, Available at: https://www.gov.uk/transfers-takeovers (Accessed: 20 December 2019).

HM Government (2019b) *2019-20 Better Care Fund: policy framework,* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachm

ent_data/file/821676/Better_Care_Fund_2019-20_Policy_Framework.pdf (Accessed: 17 May 2020).

Hodges, R., and Mellett, H. (2012) 'The U.K. private finance initiative: An accounting retrospective', *The British Accounting Review*, 44(4), pp.235-247.

Hodgson, D. (2005) ''Putting on a Professional Performance': Performativity, Subversion and Project Management', *Organization,* 12(1), pp.51-68.

Hollin, G., Forsyth, I, Giraud, E, and Potts, T. (2017) '(Dis)entangling Barad: Materialisms and ethics', *Social Studies of Science*, 47(6), pp.918-941.

Hood, C. (1991) 'A public management for all seasons?', *Public Administration*, 69 (1), pp. 3-19.

Hood, C. (1995) 'The 'New Public Management' in the 1980s: Variations on a Theme' *Accounting, Organizations and Society*, 20 (2/3), pp. 93-109.

Hopwood, A.G. (1989) 'Accounting and the pursuit of social interests', in W.F. Chua, T. Lowe, A. Puxty (Eds.), *Critical perspectives in management control*, London: Macmillan.

Hoskin, K., and Macve, R. (1986) 'Accounting and the examination: a genealogy of disciplinary power' *Accounting Organizations and Society*, Vol. 1 1, No. 2, pp.105-136.

Hunter, D., Marks, L., Brown, J., Scalabrini, S., Salway, S., Vale, L., Gray, J. and Payne, N. (2016) 'The potential value of priority-setting methods in public health investment decisions: qualitative findings from three English local authorities', *Critical Public Health*, 26, pp.578-587.

Hyndman, N., and Lapsley, I. (2016) 'New Public Management: The Story Continues', *Financial Accountability & Management*, 32(4), pp. 385-408.

Jarvinen, J. (2009) 'Shifting NPM agendas and management accountants' occupational identities', *Accounting, Auditing & Accountability Journal*, 22 (8), pp.1187-1211.

Jones, R., and Pendlebury, M. (2010) *Public sector accounting,* London: Pearson.

Julnes, P., and Steccolini, I. (2015) 'Introduction to Symposium: Performance and accountability in complex settings—Metrics, methods, and politics', *Public Administration*, 20(4), pp.329-334.

Justesen, L., and Mouritsen, J. (2011) 'Effects of actor network theory in accounting research' *Accounting, Auditing & Accountability Journal,* 24 (2), pp.161-193.

Justesen, L.; and Skærbæk, P. (2010) 'Performance auditing and the narrating of a new auditee identity', *Financial Accountability & Management*, 26 (3), pp. 325-344.

Keevers, L., Treleaven, L., Sykes, C., and Darcy, M., (2012) 'Made to measure: taming practices with results-based accountability', *Organization Studies*, 33 (1), pp.97–120.

The King's Fund (2011) *Consultation response: Healthy lives, healthy people.* Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/consultation-response-healthy-lives-healthy-people-public-health-mar11.pdf (Accessed 24 April 2019).

The King's Fund (2016a) *Health and Wellbeing Boards (HWBs) Explained.* Available at: https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained (Accessed 16 December 2017).

The King's Fund (2016b) *How will services access the new Sustainability and Transformation Fund?.* Available at: https://www.kingsfund.org.uk/blog/2016/01/sustainability-and-transformation-fund (Accessed 27 August 2020).

The King's Fund (2016c) *Delivering sustainability and transformation plans: From ambitious proposals to credible plans.* Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf (Accessed 27 August 2020).

The King's Fund (2017a) *Spending on public health.* Available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health (Accessed 14 January 2018).

The King's Fund (2017b) *Big cuts planned to public health budgets.* Available at: https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets (Accessed 14 January 2018).

The King's Fund (2017c) *Nine things we learnt about provider finances in 2016/17.* Available at: https://www.kingsfund.org.uk/publications/nine-things-NHS-provider-finances-2016-17. (Accessed 27 August 2020).

Knorr Cetina, K. (1999) *Epistemic Cultures*, Cambridge: Harvard University Press.

Kornberger, M., Jusesen, L., Moursitsen, J. and Madsen, A. K. (2015) *Making Things Valuable*, Oxford: Oxford University Press.

Kuhn, T.S., and Hacking, I. (2012) *The structure of scientific revolutions*, Chicago: The University of Chicago Press.

Kurunmaki, L. (2004) 'A hybrid profession - The acquisition of management accounting expertise by medical professionals', *Accounting, Organizations and Society*, 29 (3), pp.327-347.

Kurunmaki, L., and Miller, P. (2008) 'Counting the costs: The risks of regulating and accounting for health care provision', *Health Risk & Society*, 10(1), pp.9-21.

Kvale, S. (1996) *InterViews : an introduction to qualitative research interviewing,* California: SAGE.

Kvale, S. (2007) *Doing interviews,* London: Sage.

The Lancet (1997) 'Health inequality: the UK's biggest issue. *The Lancet,* 26 April 1997. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(97)21017-2/fulltext

The Lancet (2020) 'Building a resilient NHS, for COVID-19 and beyond'. *The Lancet*, 3 October 2020. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32035-3/fulltext (Accessed 22 October 2020).

Lapsley, I. (2009) 'New Public Management: The Cruellest Invention of the Human Spirit?' ABACUS, 45(1), pp.1-21.

Lapsley, I., and Pallot, J. (2000) 'Accounting, management and organizational change: A comparative study of local government', *Management Accounting Research*, 11, pp.213-229.

Lapsley, I., and Pong, CKM. (2000) 'Modernization versus problematization: value-for-money audit in public services', *European Accounting Review*, 9(4), pp.541-567.

Latour, B. (1986) *The Powers of Association*, in Law, J. (Ed.), Power, Actions and Belief: A New Sociology of Knowledge, Routledge and Kegan Paul: London, pp.264-80.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*, Cambridge: Harvard University Press.

Latour, B. (1988) *The Pasteurization of France*, Cambridge: Harvard University Press.

Latour, B. (1999) 'On Recalling Ant', in Law, J. and Hassard, J. (Eds.), *Actor network theory and after* (pp. 15– 25). Oxford: Blackwell.

Latour, B. (2005) *Reassembling the social: An introduction to actor-network theory*, New York: Oxford University Press.

Latour, B., and Woolgar, S. (1979). *Laboratory life: The construction of scientific facts*, London: Sage.

Latour, B., and Woolgar, S. (1986). *Laboratory life: The social construction of scientific facts*, 2nd Ed., London: Sage.

Laudan, L. (1996) *Beyond positivism and relativism: Theory, method, and evidence,* Oxford: Westview Press.

Law, J. (1986), *On the Methods of Long Distance Control: Vessels, Navigation and the Portuguese Route to India*, pages 234-263, in Law, J. (Ed.). Power, Action and Belief: a new Sociology of Knowledge? London: Routledge.

Law, J. (1999) 'After ANT: complexity, naming and topology', in Law, J. and Hassard, J. (Eds.), *Actor Network Theory: and After*, Oxford: Blackwell. pp. 1-14.

Law, J. (2002), 'Objects and spaces', *Theory, Culture and Society*, 19(5/6), pp.91-105.

Law, J. (2004) *After method: mess in social science research*, London: Routledge.

Lee, G. (1996) *The People's Budget: An Edwardian Tragedy.* London: Shepheard-Walwyn.

LGA (2013) *Money well spent? Assessing the cost effectiveness and return on investment of public health interventions.* Available at: file:///C:/Users/bracklej/Downloads/Money-well-spent-assessing-the-cost-effectiveness-and-return-on-investment-of-public-health-interventions.pdf (Accessed 24 October 2021).

LGA (2014a) *Public health transformation nine months on: bedding in and reaching out.* Available at: https://www.local.gov.uk/sites/default/files/documents/public-health-transformat-88b.pdf (Accessed 11 December 2017).

LGA (2014b) *Public health in local government – one year on.* Available at: https://www.local.gov.uk/sites/default/files/documents/public-health-local-gover-ad1.pdf (Accessed 11 December 2017).

LGA (2016) *Health in all policies: a manual for local government*. Available at: https://www.local.gov.uk/publications/health-all-policies-manual-local-government (Accessed 24 October 2021).

LGA (2017) *Councils respond to cuts in Public Health grants allocation*. Available at: https://www.local.gov.uk/about/news/councils-respond-cuts-public-health-grants-allocation (Accessed: 24 October 2021).

Licoppe, C. (2010) 'The 'performative turn' in science and technology studies: Towards a linguistic anthropology of 'technology in action'', *Journal of Cultural Economy*, 3 (2), pp. 181-188.

Llewellyn, S. (1998) 'Boundary work: Costing and caring in the social services', *Accounting, Organizations and Society*, 23(1), pp.23-47.

Llewellyn, S., and Northcott, D. (2005) 'The average hospital', *Accounting, Organizations and Society*, 30(6), pp.555-583.

Lloyd, M. (2007) *Judith Butler: From Norms to Politics*. Cambridge: Polity Press.

Local Democracy, Economic Development and Construction Act 2009. Available at: https://www.legislation.gov.uk/ukpga/2009/20/contents (Accessed 11 August 2020).

Lowe, A. (2001) 'Accounting information systems as knowledge-objects: some effects of objectualization', *Management Accounting Research*, 12(1), pp.75-100.

Lowe, A. (2004), 'Postsocial relations: Toward a performative view of accounting knowledge', *Accounting, Auditing & Accountability Journal*, 17(4), pp.604-628.

MacKenzie, D. (2006) *An Engine, Not a Camera: How Financial Models Shape Markets*, Cambridge: MIT Press.

MacKenzie, D. (2009) *Material Markets: How Economic Agents are Constructed*, Oxford: Oxford University Press.

MacKenzie, D., and Millo, Y. (2003) 'Constructing a Market, Performing Theory: The Historical Sociology of a Financial Derivatives Exchange', *The American journal of sociology*, 109(1), pp.107-145.

Marie Curie (2021) *Our History*. Available at: https://www.mariecurie.org.uk/who/our-history (Accessed 24 October 2021).

Marks, L., Hunter, D., Scalabrini, S., Gray, J., McCafferty, S., Payne, N., (2015) 'The return of public health to local government in England: changing the parameters of the public health prioritization debate?', *Public Health*, 129(9), pp.1194–203.

Marmot, M. (2010) *The Marmot Review: Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post-2010*, London: University College London.

McGill, E.; Egan, M.; Petticrew, M.; Mountford, L.; Milton, S.; Whitehead, M.; and Lock, K. (2015) 'Trading quality for relevance: non-health decision-makers' use of evidence on the social determinants of health', *BMJ*, 2015-04, 5(4), pp.1-8.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., and Waring, J. (2015) 'Hybrid manager-professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts', *Public Administration*, 93(2), pp.412-433.

McGivern, G., Dopson, S., Ferlie, E., Fischer, M., Fitzgerald, L., Ledger, J., and Bennett, C. (2017) 'The Silent Politics of Temporal Work: A Case Study of a Management Consultancy Project to Redesign Public Health Care', *Organisational Studies*, (Forthcoming).

McKinlay, A. (2008) 'Performativity and the politics of identity: Putting Butler to work', *Critical Perspectives on Accounting*, 21(3), pp.232-242.

McLean, C., and Hassard, J. (2004) 'Symmetrical Absence/Symmetrical Absurdity: Critical Notes on the Production of Actor-Network Accounts', *Journal of Management Studies,* 41(3), pp.493–519.

Miller, P. (1990). 'On the interrelations between accounting and the state', *Accounting, organizations and Society*, 15(4), pp.315-338.

Miller, P. (1992) 'Accounting and Objectivity: The Invention of Calculating Selves and Calculable Spaces', *Annals of Scholarship*, 9, pp. 61-86.

Miller, P. (1994) 'Accounting as social and institutional practice: an introduction', in Hopwood, A., and Miller, P. (Eds.), *Accounting as social and institutional practice*, Cambridge: Cambridge University Press.

Miller, P. (2008) 'Calculating economic life', *Journal of Cultural Economy*, 1(1), pp.51-64.

Miller, P., Kurunmaki, L., and O'Leary, T. (2008) 'Accounting, hybrids and the management of risk', *Accounting, organizations and Society,* 33, pp.942-967.

Miller and O'Leary (1987) 'Accounting and the construction of the governable person', *Accounting Organizations and Society*, 12(3), pp. 235-265.

Miller, P. and O'Leary, T. (2007) 'Mediating instruments and making markets: capital budgeting, science and the economy', *Accounting, Organizations and Society*, 32 (7–8), pp.701–734.

Miller, P., and Power, M. (2013). 'Accounting, Organizing, and Economizing: Connecting Accounting Research and Organization Theory', *Academy of Management Annals*, 7(1), pp.557–605.

Miller, P., and Rose, N. (1990) 'Governing economic life', *Economy and Society*, 19, pp. 1-31.

Milton, S., Petticrew, M., and Green, J. (2014) 'Why do local authorities undertake controlled evaluations of health impact? A qualitative case study of interventions in housing', Public Health, 128(12), pp.1112-1117.

Mind (2021) *Our Achievements*. Available at: https://www.mind.org.uk/about-us/our-achievements/ (Accessed 24 October 2021).

Mol, A (2002) *The body multiple: ontology in medical practice.* Durham: Duke University Press.

Morris, J.N (1969) 'Tomorrow's community physician', *The Lancet*, 294(7625), pp.811-816.

Mouritsen, J., Larsen, H.T., and Bukh, P.N.D. (2001) 'Intellectual capital and the 'capable firm': narrating, visualising and numbering for managing knowledge', *Accounting, Organizations and Society*, 26(7), pp.735-762.

Mouritsen (2006) 'Problematising intellectual capital research: ostensive versus performative IC', *Accounting, Auditing & Accountability Journal*, 19(6), pp.820-841.

Mouritsen, J. and Thrane, S. (2006) 'Accounting, network complementarities and the development of inter-organisational relations', *Accounting, Organizations and Society*, (31)3, pp.241-275.

Mouritsen, J., and Kreiner, K. (2016) 'Accounting, decisions and promises', *Accounting, Organizations and Society,* 49, pp. 21-31.

Mulgan, R. (2003) *Holding power to account – Accountability in Modern Democracies,* Basingstoke: Palgrave Macmillan.

NAO (2014) *Public Health England's grant to local authorities.* Available at: https://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england's-grant-to-local-authorities.pdf (Accessed: 11 December 2017).

NAO (2017) *Health and social care integration.* Available at: https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf (Accessed 27 August 2020).

NAO (2018) *Financial sustainability of local authorities*. Available at: https://www.nao.org.uk/wp-content/uploads/2018/03/Financial-sustainabilty-of-local-authorites-2018.pdf (Accessed on 5 May 2020).

National Health Service Re-organization Act 1973. Available at: https://www.legislation.gov.uk/ukpga/1973/32/1993-08-01 (Accessed: 24 October 2021).

NHS England (2016) *Sustainability and Transformation Plan footprints.* Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf (Accessed 5 May 2020).

Noordegraaf, M. (2007) 'From 'Pure' to 'Hybrid' Professionalism Present-Day Professionalism in Ambiguous Public Domains', *Administration & Society*, 39 (6), pp.761-786.

Nuffield Trust (2011) *Public Health White Paper 'Healthy Lives, Healthy People': our consultation response*. Available at: https://www.nuffieldtrust.org.uk/resource/public-health-white-paper-healthy-lives-healthy-people-our-consultation-response (Accessed 24 April 2019).

Nuffield Trust (2021) *Health and social care explained.* Available at: https://www.nuffieldtrust.org.uk/health-and-social-care-explained/nhs-reform-timeline (Accessed: 24 October 2021).

Nuffield Trust, The Kings Fund, and The Health Foundation (2017) *The Autumn Budget: Joint statement on health and social care*. Available at: https://www.kingsfund.org.uk/sites/default/files/2017-11/The%20Autumn%20Budget%20-%20joint%20statement%20on%20health%20and%20social%20care%2C%20Nov%202017.pdf (Accessed 24 April 2019).

Olson, O., Humphrey, C., and Guthrie, J. (2001) 'Caught in an evaluatory trap: a dilemma for public services under NPFM', *European Accounting Review*, 10(3), pp. 505-522.

Paddison, C. (2017) 'Cuts to public health: why spending less will cost the NHS more'. *Nuffield Trust*. Available at: www.nuffieldtrust.org.uk/news-item/cuts-to-public-health-why-spending-less-will-cost-the-nhs-more (Accessed 24 April 2019).

Parker, L., and Gould, G. (1999) 'Changing public sector accountability: critiquing new directions', *Accounting forum*, 23(2), pp.109-135.

Parliament. House of Lords (2011) Auditors: market concentration and their role. The second report. (HL 2010-2011 (119)). London: The Stationary Office.

Peckham, S., Gadsby, E., Jenkins, L., Coleman, A., Bramwell, D., and Perkins, N. (2017) 'Views of public health leaders in English local authorities – changing perspectives following the transfer of responsibilities from the National Health Service to local government', *Local Government Studies,* 43(5), pp.842-863.

Pedersen, P., Hjelmar, U., Høybye, M., and Rod, M. (2017) 'Can inequality be tamed through boundary work? A qualitative study of health promotion aimed at reducing health inequalities', *Social Science & Medicine*, 185, pp.1-8.

PHE (2013) *Health and Care Integration Making the case from a public health perspective*. *Available at:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/268181/Health_and_care_integration.pdf (Accessed 24 October 2021).

PHE (2016) *Public Health Outcomes Framework*, Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework (Accessed: 18 January 2016).

PHE (2018) 'Public Health England: About us', Available at: https://charterforcompassion.org/healthcare-partners/public-health-england (Accessed 1 September 2018).

PHE, Association of Directors of Public Health, and the Faculty of Public Health (2017) *Core Offer: The Healthcare Public Health Advice Service to Clinical Commissioning Groups*, Available at: https://www.adph.org.uk/wp-content/uploads/2017/08/Healthcare-Advice-Service-Briefing.pdf (Accessed: 18 January 2020).

PHE, The Faculty of Public Health, and the Local Government Association (2013) *Directors of Public Health in Local Government,* Available at: https://www.fph.org.uk/media/1706/dsph_in_lg_guidance_on_appointments-2013.pdf (Accessed 16 February 2020).

PHE and LGA (2015) *Local leadership, new approaches,* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407060/2014712_Local_leadership.pdf (Accessed: 24 October 2021).

Phillips, G., and Green, J. (2015) 'Working for the public health: politics, localism, and epistemologies of practice', *Sociology of Health & Illness*, 37 (4), pp.491-505.

Plsek and Greenhalgh (2001) 'Complexity science - the challenge of complexity in health care', *BMJ*, 323(7313), pp.625–8.

Power, M. (1997) *The audit society: rituals of verification,* Oxford: Oxford University Press.

Power, M. (2004) 'The risk management of everything', *Journal of Risk Finance*, 5(3), pp.58-66.

Power, M. (2013) 'The apparatus of fraud risk', *Accounting, Organizations, and Society*, 38 (6–7), pp.525-543.

Prior, L. (2002) *Using documents in social research,* London: Sage.

Public Health Act 1848. Available at: https://www.legislation.gov.uk/ukpga/Vict/11-12/63/enacted (Accessed: 24 October 2021).

Public Health Act 1875. Available at: https://www.legislation.gov.uk/ukpga/Vict/38-39/55/contents (Accessed: 24 October 2021).

Public Health Act 1907. Available at: https://www.legislation.gov.uk/ukpga/Edw7/7/53/body (Accessed: 24 October 2021).

Public Health Act 1925. Available at: https://www.legislation.gov.uk/ukpga/Geo5/15-16/71 (Accessed: 24 October 2021).

Public Health Act 1936. Available at: https://www.legislation.gov.uk/ukpga/Geo5and1Edw8/26/49/contents (Accessed: 24 October 2021).

Quattrone, P. (2015) 'Value in the age of doubt: Accounting as a maieutic machine', in Kornberger, M., Jusesen, L., Moursitsen, J. and Madsen, A. K. (Eds.), *Making Things Valuable*, Oxford: Oxford University Press.

Quattrone and Hopper (2005) 'A 'time' space odyssey': Management control systems in two multinational organisations', *Accounting Organizations and Society*, 30(7), pp.735-764.

Ransome, P. (2010) 'Social theory for beginners', Bristol: Policy Press.

Revellino, S., and Mouritsen, J. (2015) 'Accounting as an engine: The performativity of calculative practices and the dynamics of innovation', *Management Accounting Research*, 28, pp.31-49.

Reynolds, J., McGrath, M., Engen, J., Pashmi, G., Andrews, M., Lim, J., and Lock, K. (2018) 'Processes, practices and influence: a mixed methods study of public health contributions to alcohol licensing in local government', BMC Public Health, 18(1), pp.1-13.

Roberts, J. (2009) 'No one is perfect: The limits of transparency and an ethic for 'intelligent' accountability', *Accounting, Organizations and Society*, 34 (8), pp. 957-80.

Roberts, J. (2012) 'Poststructuralism against poststructuralism: actor-network theory, organizations and economic markets', *European Journal of Social Theory*, 15(1), pp.35 – 53.

Roberts, J. (2015) 'The 'subject' of corruption', *Critical Perspectives On Accounting*, 28(C), pp.82-88.

Robson, K. (1992) 'Accounting numbers as 'inspcription': action at a distanceand the development of accounting', *Accounting, Organizations and Society*, 17(7), pp.685-708.

Robson, C. (2011) *Real world research: A resource for users of social research methods in applied settings*, 3rd Ed. Chichester: Wiley.

Royal Commission on Medical Education (1968) *Todd Report 1968.* (MH 149, Cmnd 3569). London: The National Archives.

Salauroo, M. and Burnes, B. (1998) 'The impact of a market system on the public sector: a study of organizational change in the NHS', *International Journal of Public Sector Management*, 11(6), pp.451-467.

Samuel, S., Dirsmith, M., and Mcelroy, B. (2005) 'Monetized medicine: from the physical to the fiscal', *Accounting, Organizations and Society*, 30(3), pp.249-278.

Sanders, T., Grove, A., Salway, S., Hampshaw, S., and Goyder, E., (2017) 'Incorporation of a health economic modelling tool into public health commissioning: Evidence use in a politicised context', Social Science & Medicine, 186 (1), pp.122-129.

The Sanitary Act 1866. Available at: https://www.legislation.gov.uk/ukpga/Vict/29-30/90/enacted (Accessed: 24 October 2021).

Santos, A., and Rodrigues, J. (2009) 'Economics as social engineering? Questioning the performativity thesis', *Cambridge Journal of Economics*, 33, pp.985-1000.

Sapir, A., Wolff, G.B., de Sousa, C., Terzi, A. (2014) 'The Troika and financial assistance in the Euro Area: successes and failures', Study on the Request of the Economic and Monetary Affairs Committee, Economic Governance Support Unit. Available at: www.europarl.europa.eu/ECON.

Saunders, M., Lewis, P., and Thornhill, A. (2016) *Research methods for business students*, 7th Ed., Edinburgh: Pearson.

Saunders, M., Lewis, P., and Thornhill, A. (2019) *Research methods for business students,* 8th Ed., Edinburgh: Pearson.

Scott, S., and Orlikowski, W. (2012) 'Reconfiguring relations of accountability: Materialization of social media in the travel sector', *Accounting, Organizations and Society*, 37(1), pp.26-41.

Sinclair, A. (1995) 'The chameleon of accountability: Forms and discourses', *Accounting, organizations and society*, 20(2), pp.219-237.

Skærbæk, P. (2009) Public sector auditor identities in making efficiency auditable: The National Audit Office of Denmark as independent auditor and modernizer', *Accounting, Organizations and Society*, 34(8), pp.971-987.

Skærbæk, P., and Thorbjørnsen, S. (2007) 'The commodification of the danish defence forces and the troubled identities of its officers', *Financial Accountability & Management*, 23(3), pp.243-269.

Skærbæk, P., and Tryggestad, K. (2010) 'The role of accounting devices in performing corporate strategy', *Accounting, Organizations and Society*, 35(1), pp.108-124.

Smith, D. E. (1984) 'Textually mediating social organization', *International Social Science Journal*, 36, pp.59-75.

Smith, K.E. and Stewart, E.A. (2017) 'Academic advocacy in public health: Disciplinary 'duty' or political 'propaganda'?', Social Science & Medicine, 189, pp.35-43.

Snape, D., and Spencer, L. (2003) 'The Foundations of Qualitative Research', in Ritchie, J. and Lewis, J. (Eds.), *Qualitative Research Practice: A Guide for Social Science Students and Researchers,* London: Sage, pp.1-23.

Sönser Breen, M. and Blumenfeld, W. J. (2005) *Butler Matters: Judith Butler's Impact on Feminist and Queer Studies*, Aldershot: Ashgate.

Steccolini, I. (2019) 'Accounting and the post-new public management Re-considering publicness in accounting research', *Accounting, Auditing and Accountability Journal,* 32(1), pp.255-279.

Stewart, J. (1984) 'The Role of Information in Public Accountability', in Hopwood, A., and Tomkins, C. (Eds) *Issues in Public Sector Accounting*. Oxford: Philip Allan, pp.13-34.

Szreter, S. (1988) 'The Importance of Social Intervention in Britain's Mortality Decline c.1850–1914: a Re-interpretation of the Role of Public Health', *The Society for the Social History of Medicine*, 1 (1), pp.1-38.

Susser, M., and Stein, Z. (2009) 'The British Sanitary Movement: Edwin Chadwick', in Susser, M., and Stein, Z., (Eds.), *Eras in Epidemiology: The Evolution of Ideas,* Oxford: Oxford University, pp. 51-63.

Sveningsson, S. and M. Alvesson (2003) ' Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle ', *Human Relations*, 56(10), pp.1163-94.

Thomas, G. (2013) *How to do your research project*, 2nd Ed., London: SAGE.

Van Der Graaf, P., Forrest, L.F., Adams, J., Shucksmith, J., and White, M. (2017) 'How do public health professionals view and engage with research? A qualitative interview study and stakeholder workshop engaging public health professionals and researchers', BMC Public Health, 17(1), pp.1-10.

Vesty, G.M., Telgenkamp, A., and Roscoe, P.J. (2015) 'Creating numbers: carbon and capital investment', *Accounting, Auditing & Accountability Journal,* (28)3, 302-324.

Vinnari, E. & Skærbæk, P. (2014) 'The uncertainties of risk management: A field study on risk management internal audit practices in a Finnish municipality', *Accounting, Auditing & Accountability Journal*, 27(3), pp. 489 - 526.

Vollmer, H. (2007) 'How to do more with numbers: Elementary stakes, framing, keying, and the three-dimensional character of numerical signs', *Accounting, Organizations and Society*, 32(6), pp.577-600.

Vollmer, H., Mennicken, A., Preda, A. (2009) 'Tracking the numbers: Across accounting and finance, organizations and markets', *Accounting, Organizations and Society*, 34(5), pp.619-637.

Vosselman, E. (2014) 'The 'performativity thesis' and its critics: Towards a relational ontology of management accounting', *Accounting and Business Research*, 44(2), pp.181-203.

Wallace, J. (1995) 'Organizational and professional commitment in professional and nonprofessional organizations', *Administrative Science Quarterly*, 40(2), pp.228.

Waring, J., and Currie, G. (2009) 'Managing Expert Knowledge: Organizational Challenges and Managerial Futures for the UK Medical Profession', *Organization Studies,* 30(7), pp.755-778.

Williams, J. (2013) 'Regulatory technologies, risky subjects, and financial boundaries: Governing 'fraud' in the financial markets', *Accounting, Organizations and Society*, 38(6-7), pp.544-558.

Yates, D., Gebreiter, F. and Lowe, A. (2019) 'The internal accountability dynamic of UK service clubs: towards (more) intelligent accountability?', *Accounting Forum*, 43(1), pp.161-192.

Yin, R. (2003) *Case study research: design and methods*, 2nd Ed., London: SAGE.

Appendix 1: Timeline of primary data collection

Event / method	Participant pseudonym	Date	Employer / Role
Transfer of PH teams from PCTs to local authorities		***01/04/2013***	
Fully coded *pilot* interview	Emily	31/03/2015	PH Consultant / MT
PHE regional Alcohol & Drugs Value for Money workshop / observation		03/06/2015	PHE
Midland City HWB / Observation		30/06/2015	MC
Metro Town HWB / Observation		29/07/2015	MT
Fully coded interview	Mike	06/08/2015	Partner / AF
Fully coded interview	Harvey	06/08/2015	Partner / AF
Fully coded interview	Paula	26/08/2015	PH Advisor / PHE
Fully coded interview	Steven	01/09/2015	Partner / AF
Fully coded interview	Elizabeth	02/09/2015	PH Advisor / PHE
Fully coded interview	John	04/09/2015	Partner /AF
Fully coded interview	Alan	12/11/2015	DPH / MC
Fully coded interview	Jane	24/11/2015	50:50 PH & EH / MC
Fully coded interview	Joanna	03/12/2015	DPH / MT
Fully coded interview	Matthew	03/12/2015	PH Consultant / MC
Fully coded interview	Adam	11/12/2015	PH Consultant / MC
Fully coded interview	Rodrigo	08/01/2016	PH Consultant / MC
First session of parliamentary inquiry / observation		09/02/2016	
Public Health workshop / feedback on findings		11/02/2016	University of Birmingham
Second session of parliamentary inquiry / *fully coded* observation		01/03/2016	All contributions from 6 witnesses were fully coded, which included the DPH from MT
Third session of parliamentary inquiry / observation		24/05/2016	

Fully coded interview	Penelope	01/06/2016	PH Consultant / MT
Fully coded interview	Janet	01/06/2016	Commissioner / MT
Fourth session of parliamentary inquiry / *fully coded* observation		07/06/2016	All 4 contributions from the first sitting were fully coded which included senior executives of PHE
Video conference with PHE executives / observation and field notes		19/09/2016	PHE
Metro Town HWB / Observation		19/10/2016	MT
Fully coded interview	Barbara	20/10/2016	CEO / Local Charity
Fully coded interview	Suzanna	03/11/2016	PHE Economist
Fully coded interview	Rosanna	04/11/2016	PHE Regional Director
Fully coded interview	Leon	11/11/2016	Policy Director / MC
Fully coded interview	Mandy	25/11/2016	PHE Regional Director
Midland City HWB / Observation		29/11/2016	MC
Fully coded interview	Joanna	06/12/2016	DPH / MT
Fully coded interview	Gerry	06/12/2016	Strategic Finance MT
Fully coded interview	Paul	08/12/2016	Finance Team / MC
Fully coded interview	Vicky	13/12/2016	PHE Economist
Fully coded interview	Alan	13/12/2016	DPH /MC
Midland City HWB / Observation		31/01/2017	MC
Regional meeting of DPHs / feedback on findings		17/02/2017	PHE
Fully coded interview	Aanika	21/06/2017	Lecturer, Occupational Health, Safety and Environment, University
Fully coded interview	Frank	27/07/2017	Deputy Programme Director for MPH (IAHR), Research Fellow in Public Health, University

Appendix 2: Primary and case authority documents

Summary of primary documents (not in the public domain)	Date	Author	
001 MT Signed core offer document	01-Jun-14	MT DPH (Joanna), CCG Chief clinical offer, MT Strategic director	(MT 001, 2014)
002 Alcohol & drug VFM programme update (signed letter)	04-Feb-15	PHE (Alcohol, Drugs and tobacco division)	(PHE 002, 2015)
003 Cost calculator presentation (power point)	01-Jun-15	PHE (Vicky)	(PHE 003, 2015)
004 Intelligence briefing: Personal Social Services Survey of Adult Carer's 2014/15	30-Dec-15	MT PH intelligence team	(MT 004, 2015)
005 MT Commissioning peer review self-assessment	01-Jan-16	MT	(MT 005, 2016)
006 Being in local government 2020 (power point)	29-Feb-16	PHE Deputy chief operating officer	(PHE 006, 2016)
007 Interpretation of the ring fenced grant conditions (confidential)	31-Aug-16	PHE and the Association of Directors of Public Health	(PHE 007, 2016)
008 Addressing wicked problems (power point)	01-Sep-16	PHE (Deputy director for health improvement)	(PHE 008, 2016)
009 Sharing Learning: University of Birmingham and PHE	19-Sep-16	PHE	(PHE 009, 2016)
010 Drugs and Alcohol Peer Challenge Session	21-Oct-16	PHE, Learning for Public Health, & Association of Directors of PH	(PHE 010, 2016)
011 Public health outcomes MC	May-17	PHE	(PHE 011, 2017)
012 Public Health outcomes MT	May-17	PHE	(PHE 012, 2017)
013 WORKING DRAFT FOR DISCUSSION: Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups	No date	DH	(DH 013, n.d.)

014 Drugs and Alcohol Peer Challenge Session self-assessment	No date	MT	(MT 014, n.d.)
015 MT PH Effective Commissioning Strategy 2014-2019	No date	MT	(MT 015, n.d.)
016 MT guidance on qualitative research methods	No date	MT PH intelligence team	(MT 016, n.d.)
017 Families drug and alcohol SROI tool	2016/17	PHE	(PHE 017, 2016)
018 MC Charity - KPIs on commissioned services	2016/17	MC Charity and PH team in MC	(MC 018, 2016)
Case authority documents (anonymised)	**Date**	**Reference**	
019 MT	Oct 2016	[Metro Town] (2016) *Financial Plan and Efficiency Strategy: Reflecting local priorities as we plan for the future*.	(MT 019, 2016)
020 MT	06 Mar 2013	[Metro Town] (2013) *Minutes. Shadow health and wellbeing board.*	(MT 020, 2013)
021 MT	June 2014	Weight? We can't wait: a call to action to tackle childhood obesity in [Metro Town]	(MT 021, 2014)
022 MT	September 2015	Lifestyle Choices: A Time to START and a Time to STOP	(MT 022, 2015)
023 MT	August 2016	Public Health Annual Report 2015/16: 150 years of Public Health in [Metro Town]	(MT 023, 2016)
024 MC	Dec 2013	[Midland City] Council (2013) *Planning [Midland City's] Future & Budget Consultation*	(MC 024, 2013)

		2014-15: A white paper.	
025 MC	30 Sept 2014	[Midland City] Council (2014) *Statement of accounts 2013/14.*	(MC 025, 2014)
026 MC	March 2016	[Midland City] Council (2016) *Business Plan and Budget 2016+.*	(MC 026, 2016)
027 MC	March 2017	[Midland City] Council (2017) *Business Plan and Budget 2017+.*	(MC 027, 2017)
028 MC	December 2017	[Midland City] Council (2018) *Budget Consultation 2018+.*	(MC 028, 2018)
029 MC	27 June 2013	Fit for the Future: [Midland City's] Childhood Obesity Strategy	(MC 029, 2013)
030 MC	June 2014	[Midland City] Joint Strategic Needs Assessment Annual Summary 2014	(MC 030, 2014)
031 MC	April 2013	[Midland City] Drug & Alcohol Needs Assessment 2013/14	(MC 031, 2013)
032 MC	April 2017	[Midland City] JSNA 2017/18 Strategic Overview	(MC 032, 2017)
033 MC Charity	July 2015	[Midland City] Report and financial statements for the year 2014/15	(MC Charity 033, 2015)
034 MC Charity	July 2018	[Midland City] Report and financial statements for the year 2017/18	(MC Charity 034, 2018)
035 MC	Nov 2016	[Midland City] STP slides prepared by CCG	(MC 035, 2016)

036 MC	Nov 2016	[Midland City] Health & Wellbeing Strategy	(MC 036, 2016)
037 MC	Jan 2017	[Midland City] Mental Health Commission Briefing Paper	(MC 037, 2017)
038 MT	Oct 2016	[Metro Town] Public Health Lifestyle Survey 2016	(MT 038, 2016)
039 MT	May 2017	[Metro Town] Joint Strategic Needs Assessment Focus On Outcomes	(MT 039, 2017)
040 MT	Sep 2013	[Metro Town] Health and Wellbeing Strategy 2013-2018	(MT 040, 2013)
041 MT	May 2017	[Metro Town] Health and Wellbeing Board Shortlisted Outcomes	(MT 041, 2017)
042 MT	Sep 2014	[Metro Town] Health Effective Commissioning Strategy 2014-2019	(MT 042, 2014)
043 MT	Oct 2016	The [Metro Town] Sustainability and Transformation Plan 2016-2021	(MT 043, 2016)