**Title:** **Health and Wellbeing Boards as theatres of accountability: A dramaturgical analysis**

**Authors:** Shelina Visram, senior lecturer in public health[a1] (ORCID profile: https://orcid.org/0000-0001-9576-2689, Twitter handle: @ShelinaVisram)

David J. Hunter, emeritus professor[a1]

Neil Perkins, research fellow[a2]

Lee Adams, independent consultant[*]

Rachael Finn, professor of organisation studies[b]

Jennifer Gosling, assistant professor in management[c]

Amanda Forrest, independent consultant[*]

**Affiliations:** [a] School of Medicine, Pharmacy and Health, Durham University, Thornaby, Stockton-on-Tees, TS17 6BH, UK

[b] Management School, University of Sheffield, Conduit Road, Sheffield, S10 1FL, UK

[1] Current affiliation for SV and DJH: Population Health Sciences Institute, Newcastle University, RVI, Newcastle-upon-Tyne, NE1 4LP, UK.
[2] Current affiliation for NP: Department of Nursing, Midwifery & Health, Faculty of Health & Life Sciences, Coach Lane Campus West, Northumbria University, Newcastle-upon-Tyne, NE7 7XA, UK.

[c] Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK

*LA and AF are independent consultants with no institutional affiliation

**Corresponding author:**

Address: Dr Shelina Visram, Population Health Sciences Institute, 5th Floor, Sir James Spence Institute, RVI, Newcastle-upon-Tyne, NE1 4LP, UK

Email: shelina.visram@newcastle.ac.uk

Telephone: +44 (0)191 208 2279

**Biographical notes**

***Shelina Visram*** is a senior lecturer in public health at Newcastle University (formerly an associate professor in public policy and health at Durham University, where the research detailed within the manuscript was undertaken). She has expertise on health inequalities, asset-based approaches and lay or peer involvement in public health, and is experienced in qualitative and mixed methods research. Shelina has over 15 years' experience of undertaking evaluations of complex, policy or system level interventions, often funded by local government partners as well as larger scale projects funded by the NIHR and Department of Health & Social Care.

***David J. Hunter*** is an emeritus professor at Newcastle University (formerly a professor of health policy and management at Durham University). His academic career spans over 40 years researching complex health systems with a focus on how health policy is formed and implemented. Former positions include: non-executive director, NICE (2008-16); appointed governor, South Tees Hospitals NHS Foundation Trust (2009-2017); and special advisor to the UK Parliamentary Health Committee. David is a visiting professor at the University of Chester, honorary member of the UK Faculty of Public Health, and Fellow of the Royal College of Physicians (Edinburgh).

***Neil Perkins*** is a research fellow at Northumbria University (formerly a postgraduate research associate at Durham University). Previous roles include research at the University of Manchester and University of Sheffield, focusing upon the transition of public health from the NHS into local government, the development of CCGs, and the impact of partnership working on safeguarding vulnerable adults from abuse. Neil's primary research interest is partnership working in health settings and his other interests include public health, poverty and social exclusion, 'race' and community development.

***Lee Adams*** was a director of public health, before moving into local government as a senior manager. She has transformed the performance and governance of several councils, and is experienced in equalities and community participation. Lee works with the University of Sheffield in health-related research and leadership with CCGs, and is an expert advisor to UK Healthy Cities network.

***Rachael Finn*** is a professor of organisation studies at Sheffield University Management School. She has expertise in health care reconfiguration and organisation, with a particular focus on institutional and organisational processes impacting upon collaboration across

boundaries. Rachael has published in internationally-renowned journals on leadership, knowledge management and innovation in public services. She has experience of process evaluations, qualitative methods and case study research funded by the ESRC, NIHR and Department of Health & Social Care.

***Jennifer Gosling*** is an assistant professor in management in the Department of Health Services Research and Policy at LSHTM. She spent 16 years as a manager in general practice. Her PhD research was on the managerialisation of general practice and the developing role of the practice manager. Jennifer's expertise and research interests are in the current reforms to primary care and the wider NHS; state/public provision of public services; management, governance, neo-liberalism and Labour Process Theory.

***Amanda Forrest*** is an experienced **s**enior manager and trustee in the public and voluntary sector, with particular skills in strategic planning, developing effective partnerships and engagement with consumer groups. She has built and operated highly developed networks in both sectors, as well as having a strong track record in public engagement in health and social care. Amanda is a lay member (non-executive) for NHS Sheffield CCG, with responsibility for engagement and quality assurance.

## Declarations


### *Acknowledgements*

The authors would like to thank those who gave up their time to take part in interviews and focus groups. Administrative support for the study was provided by Michelle Cooke and Lisa Monkhouse, and some initial interviews and observations were undertaken by Dr Chris O'Leary (all formerly at Durham University). Members of the project advisory group – which

included representatives from local government, Healthwatch and Public Health England, as well as a CCG lay member and an academic with expertise in public management – provided input into the sampling framework and data collection tools, as well as providing feedback on preliminary findings. The inspiration to apply a dramaturgical perspective came from conversations with Dr Peter van der Graaf, knowledge exchange broker at Teesside University and Fuse: the Centre for Translational Research in Public Health (www.fuse.ac.uk).

This work was supported by the National Institute for Health Research (NIHR) Policy Research Programme (grant number PR-X03-1113-11007; project title 'Evaluating the leadership role of health and wellbeing boards as drivers of health improvement and integrated care across England.'; lead D.J. Hunter). The views expressed are those of the authors and not necessarily those of the NIHR.

***Disclosure statement***

The authors declare that they have no conflicting interests.

***Data availability statement***

Consent for data sharing was not sought from the study participants.

**Health and Wellbeing Boards as theatres of accountability: a dramaturgical analysis**


## ABSTRACT

Health and Wellbeing Boards (HWBs) were established in England in 2013, bringing together partners from local government, health services and consumer champions, to ensure strategic planning based on local needs. Similar partnership-working arrangements have achieved limited success, particularly in terms of engaging members of the public in decision-making. Drawing on data collected in five heterogeneous case study sites, we examined the role of HWBs in enhancing local democracy and accountability. Interviews, focus groups and observations were used to explore relationships and interactions between HWB members and the public or their representatives. A dramaturgical perspective was then applied in analysing the data. HWBs were generally not perceived to have achieved their well-intentioned aims; instead, meetings represented carefully staged and scripted performances that tended to inhibit rather than enhance democratic accountability. Our dramaturgical analysis highlights key deficits in the governance of HWBs, which are explored in the paper.


**Abstract word count:** 146 words


**Keywords:** Health and Wellbeing Boards, partnership, governance, accountability, public engagement, dramaturgy


**Word count:** 7995 words (including declarations (216 words) and tables (272 words))

## Introduction

Partnership-working has been actively encouraged – and occasionally mandated – by successive UK governments as a means to improve public service delivery (Hunter et al. 2011). Health and Wellbeing Boards (HWBs) were established under the 2012 Health and Social Care Act as statutory partnerships to encourage integrated working between commissioners of health and social care services across England. Their remit included extending local democracy and public accountability, in terms of ensuring that citizens were able to contribute to decisions about services. A scoping review conducted in 2015 found little evidence to suggest that HWBs were fulfilling this requirement (Hunter et al. 2015). Given this gap in the literature, a need was identified for further research to explore emerging models of partnership-working and public engagement in greater depth.

This paper examines how different actors experience HWBs and perceive their role in relation to extending democracy and accountability. It employs Goffman's (1959) dramaturgical metaphor to describe the ways in which HWB members interact with one another and with other stakeholders, including members of the public (or their representatives). The paper begins with an overview of the introduction of HWBs, followed by a brief history of similar efforts to extend local democracy. This study adds to the literature by taking a dramaturgical approach to understanding inter-sectoral working, providing insights into the relationships between partners and the strategies used to either enhance or inhibit local democracy. The findings are relevant for HWBs and similar partnership-working arrangements which exist across many statutory and third sector organisations.

### *Health and Wellbeing Boards (HWBs)*

Every local authority in England was required to create a HWB as a statutory duty under the 2012 Health and Social Care Act (UK Parliament 2012). The act provided the legislative basis for the most far-reaching reforms in health and social care since the inception of the NHS. It also set in motion major changes in responsibility for public health, with local authorities being given new duties to improve the health of their populations. Directors of Public Health (DsPH), their staff and a ring-fenced budget were relocated into local authorities by early 2013. This shift was generally welcomed in recognition that services such as welfare, housing and education have the biggest impact on health, wellbeing and quality of life (Hunter, Marks, and Smith 2010). However, it took place at a time of unprecedented financial pressures on local authorities and of changing patterns of need that demand new ways of thinking and working (Ham, Dixon, and Brooke 2012).

HWBs brought together partners from healthcare, public health, adult social care and children's services, as well as elected members and representatives from local Healthwatch (the consumer champion for patients, service users and carers), in an effort to ensure strategic planning based on local needs. They were encouraged to engage providers in decision-making processes, ideally as formal – although not statutory – members. The main intended role of HWBs was to encourage integrated working between commissioners of health and social care services. Local authorities and CCGs already had statutory duties to develop Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). These were the mechanisms by which HWB members were able to jointly plan and support delivery of improvements to the health and wellbeing of their local populations, although they had no executive powers to ensure the implementation of the JHWS (Rogers 2012). .

HWBs became fully operational statutory bodies in April 2013, after almost two years in shadow form. Early evidence highlighted considerable heterogeneity in their configuration and operation (Humphries and Galea 2013). The fact that HWBs had statutory duties but no statutory powers suggested that their role was a 'soft' one, as brokers, enablers and catalysts for change (Miller et al. 2010). This led some to question whether they would become 'talking shops' as opposed to system leaders with real decision-making capacities (Humphries et al. 2012, Perkins and Hunter 2014). At the same time, there was optimism that HWBs offered a way of increasing accountability and inclusivity, and addressing the kinds of 'wicked issues' that individual organisations cannot resolve in isolation (Hunter, Marks, and Smith 2010, South, Hunter, and Gamsu 2014). Guidance produced by the Local Government Association (LGA) emphasised the importance of HWBs being agents of change and having clear strategies for communication and engagement with a range of stakeholders (2014). The LGA also commissioned a longitudinal review of HWBs, highlighting various drivers of and barriers to effectiveness. By 2017, a number of boards were reportedly focusing on the wider determinants of health and exercising place-based leadership, although Sustainability and Transformation Plans (STPs), devolution and financial pressures continued to pose challenges (Shared Intelligence 2017). A key recommendation from the LGA review involved seeing the HWB 'as being the centre of a network rather than just a meeting' (p. 12), performing an important hub function but also acting as the fulcrum around which things happen (Shared Intelligence 2015).

***Extending local democracy***

One key area of HWB activity relates to their role in extending democracy, in particular ensuring that local populations can contribute to decisions about health services. Evidence on how well previous efforts have fared relates mainly to bodies such as: Community Health Councils (CHCs), which were created in 1974 and abolished in 2003; patient forums, which

were the follow-on to CHCs until 2008; local authority-run Local Involvement Networks (LINks); and the role of lay members on Health Authorities (Learmonth, Martin, and Warwick 2009). More recently, the 2012 Act established a Healthwatch in each local authority area, with a remit to "strengthen the collective voice of local people" (Carter and Martin 2016, Department of Health 2012). Learmonth et al (2009) suggest that by the time of their abolition, CHCs had come to be seen as irrelevant and patient forums were ineffective. Lay members' views were generally given less weight than those of professionals and, as they were appointed rather than elected, they did not have the democratic mandate of local councillors. However, the Francis Report (quoted in Hudson 2015) judged that 'it is now quite clear that what replaced [CHCs]…failed to produce an improved voice for patients and the public, but achieved the opposite'. Others have identified structural constraints facing local Healthwatch, linked to the 'complex system of polycentric governance and […] crowded [patient and public involvement] environment' they operate within (Carter and Martin 2016). These experiences highlight how difficult it is for 'ordinary' people and their representatives to play a meaningful part in local governance (Martin 2011).

Several reports emphasise the need for third sector organisations and community groups to be involved in health decision-making, often without elaborating on how this might be achieved (Alderwick, Ham, and Buck 2015). One study, conducted when HWBs existed in shadow form, suggested that parish and town councils could be a way to feed in local views (Coleman et al. 2014). Others emphasise the need for local government in general and HWBs specifically to engage in community empowerment and utilise social networks to capture local voices (Colin-Thome and Fisher 2013, South 2015). It has been suggested that 'bringing on a few, select non-statutory members helps [HWBs] to better fulfil their strategic role' (Scrutton, 2013: 2). However, user organisations often become overloaded with requests to participate in meetings, and are then less able to devote time to supporting participation by

marginalised and minority groups (Freitas and Martin 2015, Martin 2011). Given that these groups are more likely to experience health inequalities, it is important that HWBs make efforts to include them in any participatory mechanisms. Perkins and Hunter (2014) highlight the need for HWBs to have regular reviews to identify which voices are not being heard. More research is needed in this area given that HWBs represent a new form of engagement in the public sector, in contrast with the loose alliances of the past.

## Materials and methods

### *Study design and sample*

This study was part of a wider evaluation of how well HWBs in England function as system leaders to facilitate collective decision-making and promote integrated service provision in order to improve health and wellbeing and reduce health inequalities. It involved exploring in-depth the experiences and perspectives of HWB members in five local authorities, alongside other work packages reported elsewhere (Hunter et al. 2018). A comparative case study design was employed (Yin 2008). The design incorporated both cross-sectional and longitudinal elements, to illuminate contextual factors that shape the likely impact of HWBs, as well as whether and how these factors changed over time.

Sampling criteria for the case study sites included the type of local authority, political affiliation, geographic location, population size, and rural/urban setting. Potential sites were approached via an invitation letter and briefing paper sent to the director of public health (DPH), who was invited to discuss the request with their HWB chair and/or chief executive. Invitations were sent to 27 local authorities and 21 declined to take part, for reasons that included time/workload pressures, and being in a period of transition. One failed to respond. Significant time and effort was expended on trying, without success, to recruit a London-based and/or Conservative-led authority. The process of site selection commenced in October

2015 and was completed by end of October 2016, at which point five local authorities had agreed to participate. Key features (at the time of fieldwork) are shown in table 1, highlighting the degree of heterogeneity achieved.

[Insert table 1 here]

HWB members in each site were contacted via email; these included the HWB chair (generally an elected member), vice chair (generally a CCG representative), DPH, adult social care and children's services lead(s), and local Healthwatch representative. Other key partners – primarily representatives of voluntary, community and faith (VCF) sector organisations and NHS providers – were identified through our initial discussions with HWB members. This form of 'snowball sampling' enabled us to locate other important actors in the health and social care system (Noy 2008). Representatives of VCF organisations in each site were also invited to take part in separate focus group discussions. In total, 23 individuals took part in VCF focus groups, 57 individuals took part in initial one-to-one interviews and a sub-sample of 22 participants took part in follow-up interviews (see tables 2 and 3).

[Insert tables 2 and 3 here]

***Data collection***

The primary mode of data collection involved semi-structured interviews with HWB members and other local partners (up to 12 per site) to explore: experiences of partnership-working, collaborative decision-making and integrated service provision; views on the impact of the HWB in terms of improving health and tackling inequalities; and any factors perceived to help or hinder in achieving these outcomes. Where possible, interviews were carried out in person, although several took place by phone by mutual agreement. Initial interviews were conducted between October 2015 and August 2016. Follow-up interviews were conducted

with a sub-sample of participants (up to five per site) to examine whether and how the role and function of each HWB had changed over time, in light of developments such as the introduction of STPs. These interviews took place largely by phone between November 2016 and February 2017.

Focus group discussions involving representatives of VCF sector organisations (up to six per site) were conducted to explore their views and experiences of the local HWB and its mechanisms for engaging citizens. We were particularly interested in assessing the extent to which each HWBs' approach to public engagement and involvement was perceived as authentic and effective. VCF infrastructure bodies assisted in identifying relevant organisations, distributing invitations and recommending appropriate venues. The focus groups took place between February and October 2016, were facilitated by two members of the team (including one with a VCF background), and lasted between one and two hours.

Our final method involved non-participant observation of a HWB meeting in each site to determine: how the board operated; what form discussions took; how important decisions were made; and where power appeared to lie within the system (particularly in relation to whether or not the views of local citizens were considered). At least one member of the team attended and observed the meetings, making detailed, unstructured notes throughout. One meeting was also observed online via a live webcasting facility. Copies of the agenda, minutes and other papers were obtained from HWB websites. The observations took place between November 2015 and July 2016, and lasted for up to three hours.

***Data analysis***

The interviews and focus group recordings were transcribed verbatim before being analysed in conjunction with the observation notes. NVivo v.10 qualitative analysis software was used to systematically organise and index materials around an initial coding framework. The coded

material was discussed during analysis workshops involving the research team. Analysis was first conducted at a 'within-case' level to integrate and triangulate data in order to holistically describe the composition and function of each HWB. Cross-case and longitudinal comparisons were then conducted across the sites to identify important similarities and differences.

We subsequently identified that a dramaturgical perspective would provide a useful tool for examining the organisation and operation of HWBs, particularly in terms of the relationships between members and local citizens. Dramaturgy concerns the study of 'the dramatic, performative nature of social and political life', in recognition that behaviours are 'consciously and unconsciously enacted in particular contexts and for particular audiences' (Boswell, Settle, and Dugdale 2015; 1364). It was first introduced in *The Presentation of Self in Everyday Life* (1959), where Goffman described the framing of performances in terms of the separation of frontstage – where performances are delivered – and backstage – where performances are rehearsed (O'Neill 2017).

Following instructive studies conducted by researchers working in similar fields (for examples, see: Boswell, Settle, and Dugdale 2015, Freeman et al. 2016), we drew on the work of Hajer (2005) in organising our data against the following analytic dimensions:

1. *Staging*: the ways in which actors consciously organise an interaction, including who is invited to participate and in what capacity
2. *Setting*: the physical space in which the interaction occurs and any props that are present
3. *Scripting*: particular roles assigned to the actors involved, in order to determine the characters in the performance and to provide cues for appropriate behaviour

4. *Performing*: the way in which the contextualised interaction produces social realities and (re)constructs knowledge or power relationships

The next section considers each of these dimensions in turn, using quotations from participants and extracts from our observation notes to illustrate the ways in which HWB meetings were staged, set, scripted and performed in order to achieve particular results. A number of key issues in terms of the governance of HWBs are raised and discussed using the TAPIC framework (Greer et al. 2019), which broadly categorises governance into five key domains: Transparency, Accountability, Participation, Integrity, and policy Capacity.

## Results

### *Staging*

There was variation in the size of the HWBs across the five sites; some had made a pragmatic decision to keep the boards small (involving only statutory members), whereas others had taken a more inclusive approach (involving providers and other local partners, e.g. housing, community safety or district councils). Both approaches had implications for the kinds of discussions that took place and actions that could be achieved as a result:

> *We've also gone for a very inclusive structure so there are lots of organisations represented around the table. […] Obviously it does push you in a particular direction. You end up with quite wide-ranging discussions that are about the organisations around the table maybe, rather than the sort of more action-orientated stuff or things that actually front-up decision-making to the public.* (Local authority assistant chief executive, site 3)

At the follow-up interviews, site 5 had broadened their HWB membership to include providers, despite initial concerns about potential conflicts of interest. There was also the issue of representativeness in areas with multiple NHS Trusts; providers in site 4 were eventually asked to elect their own representative. The rationale for who gets to be part of the board, and why, was sometimes unclear. For example, NHS England were originally statutory members but this did not necessarily mean they were committed to the HWB, whereas non-statutory VCF and provider representatives were keen to actively contribute to decision-making:

> *I've said for years – if we're not in the room, we don't exist. And again, that may be a bit of an exaggeration but it quite often is the reality. […] And it's, "You're across there guys and, yes, we'll use or get you involved when it needs a bit of community engagement", but actually the real discussions go on somewhere else.* (VCF focus group, site 2)

In terms of HWBs enhancing local democracy, this was often seen largely as the responsibility of the VCF and Healthwatch partners, in spite of concerns from these individuals about having limited time and resources to do this work effectively. They were described as playing an important role in taking messages back to their respective organisations and disseminating information via their networks, but also in providing challenge to the board particularly around public involvement:

> *We're there to ask key challenge questions to make sure that relevant patients and the public have been appropriately involved, consulted, listened to in any planning and any decision-making.* (Healthwatch representative, site 4)

One HWB chair referred to Healthwatch and the VCF being represented on the board – coupled with livestreaming of the meetings – as their three main engagement strategies,

enabling them to say *"we've ticked the box to say we're involving the public"*. Others referred to elected members being involved in health decision-making, in addition to HWB meetings taking place in public:

> *Surely the elected members are the voice of the public because they're the ones that have the democratic mandate? I don't have a democratic mandate and Healthwatch don't have a democratic mandate […] [The HWB] is also held in public. So how does the voice of the public get heard? All the consultations come here. You know, the JSNA's full of, our JSNA's brilliant. So the voice of the public comes through in myriad ways.* (CCG representative, site 5)

Members of the public were seen as difficult to engage, at least by those from the statutory sector. Examples were given of one-off public engagement events, for example, to inform production of the JSNA or the local authority plan. Direct involvement in HWB meetings was rare; while all meetings were open to members of the public, they rarely attended (see the quote below). In the meetings we observed, other observers tended to be academics or health professionals, and there was generally no effort made by the chairs to involve or seek input from these individuals.

> *In fact, as a real positive we actually had members of the public turn up to the Health and Wellbeing Board last week. And it's absolutely the first time and they asked a question as well. […] We sort of look at ways we can be better in terms of more engagement with the public because we do need to remember that they are the consumers of all this and, you know, we work in a bit of an ivory tower.* (HWB chair, follow-up interview, site 1)

***Setting***

There was variation between the sites in terms of venues used for HWB meetings. For example, all meetings in site 5 were held on council premises, while those in site 4 rotated between council and non-council venues following the recommendations of an independent review. Interviewees in site 4 reported that this change had helped to increase the visibility of the board, as well as promoting a sense of ownership amongst non-council members:

> *I think the idea of moving the venue was a good one. That's something that came out of the review because before it always used to be in [a local authority venue] and it just felt, because there was someone from the council chairing that actually it was, the board belonged to the council and everybody else was just there as kind of invited guests.* (VCF representative, site 4)

In site 1 there had also been a shift from formal to interactive HWB meetings, with a more open set-up to encourage participation:

> *I think originally it was set up as basically a normal sort of council-type meeting and was very formal. And now it's turned to much more sort of a forum. So rather than everyone sitting around a big board table as previously, we now sit around individual circular tables. It's much more inclusive.* (DPH, site 1)

Our observations reinforced the importance of the room layout in terms of helping to make members of the public and other observers feel more or less involved in the discussions (both in person and via livestreaming). This is illustrated by the following extract:

> *The tables were laid out in a horseshoe style, facing towards the back wall and screen. The chair sat at the top of the horseshoe, directly facing the screen, which meant she had her back to the public seats. It really emphasised that this was a*

> *meeting 'in public' rather than a public meeting.* (HWB meeting observation notes, site 2)

In this and other examples, there were no introductions at the start of the meeting, which meant that observers did not know who was present or speaking during the discussions. Some boards provided name cards, although these were not always visible to observers sitting on the outskirts of the room. In site 4, the name cards directed members where to sit and therefore who to sit with, leading to clustering by role; for example, NHS partners sitting together and the DPH off to one side on their own:

> *I found it very helpful that there's also somebody from Healthwatch on the board. So we kind of buddied up a bit. And interestingly we're usually put to sit together. The name cards put us together.* (VCF representative, site 4)

The only other 'props' tended to be the meeting papers, copies of which were not made available during the meetings (although they could in most cases be downloaded). The time and cost involved in printing the papers had implications for accessibility not only by members of the public, but also by VCF representatives who may be from small organisations with limited funding.

***Scripting***

Discussions taking place within HWB meetings tended to be determined by the agendas set by committees operating at sub-board level (site 1 also had a higher-level 'core group'). These sub-groups were generally seen as quite secretive, with no minutes produced and little in the way of reporting back to the main board. Their role was to devise agendas that allowed core business to be addressed, while avoiding more controversial topics that were deemed by some not to be appropriate for discussion in a public forum:

> *My feel is anything that actually requires work gets done at the [HWB sub-group], or outside the meeting. […] Well, if it doesn't get past the [sub-group], it doesn't make it onto the agenda.* (Healthwatch representative, site 4)

As a result, there was a sense of HWB meetings being *"well-orchestrated… so that public challenge doesn't happen"* (DPH, site 4). Lengthy agendas and infrequent meetings created little opportunity for discussion, exacerbated by the influence of national agendas and policy changes:

> *Government in a way wants these to be very local, and they've been set up to be very local, community-facing, democratically-led organisations. But they also get given a series of tasks to do by central government, which don't always fit with what you would say you really want that group to spend time on.* (Local authority assistant chief executive, site 3)

***Performing***

There was little evidence of tangible outcomes that were driven specifically by HWBs or of boards acting as system leaders in co-ordinating related areas of work. Instead, outcomes tended to be process-based or linked to long-term goals without achievable milestones:

> *We've got a very clear strategy and, if you like, it's focussed on Marmot and trying to prioritise those who are least able to help themselves. So people sign up to the kind of broad values and principles, and so we have got a strategy and a plan. But actually the outcomes are really not terribly clear. And some of our outcomes are much much longer term. So we haven't got - what would you call them - steps on the way.* (CCG representative, site 3)

In spite of this lack of demonstrable progress, most members seemed largely content to attend – and be seen to be attending – regular HWB meetings. The boards appeared to serve a symbolic function in terms of building and maintaining relationships (particularly between the NHS and local authority), fostering conversations (although not always within the space of board meetings), and demonstrating respect for the chair and, by extension, the partnership itself:

> *[The chair] has been around for a very long time and he's very well regarded and very respected, so it would be disrespectful. And so there's that element of it. There's the personality, you know, there's a person. But there's also the fact that the local authority and the [NHS] commissioners, we are working really, really well together. Even if it doesn't do anything, if you don't turn up it makes a statement that says we don't care about this relationship any more. And we really do care about this relationship.* (CCG representative, site 5)

The function of HWBs was largely described as rubber-stamping or ratification of various reports, as well as 'retro-fitting' actions to the JHWS rather than the strategy driving partners' activities. It was clear from our interviews and observations that issues tended to be reported with little discussion or debate, and that there was a lack of following-up on actions from previous meetings. This reluctance to challenge others was seen by some as linked to the fact that the meetings take place in public:

> *I don't think they [HWB members] feel comfortable to have difficult conversations because we're meeting in public. So I would say if there was a very fundamental disagreement between the local authority and the CCG, you wouldn't have it here. And there have been some quite thorny, you know… We don't have enough money and we're massively transforming the system – of course there are going to be rows.*

> *You know, very professional people personally get on, but there are challenges in doing that. You won't see any of that around the table.* (CCG representative, site 5)

In contrast, the smaller sub-group meetings were seen as a safe space to have these kinds of open and honest conversations, enabling partners to rehearse a more synchronised public performance:

> *[Speaking to CCG representative after the meeting] "The core group works well... there's a genuine acknowledgement of difference and we can air these and work through them before public consultation. We can start the informal consultation early and have some proper decisions, which didn't used to happen before we had the core group. And there are 30-odd members on the HWB!"* (Sub-group meeting observation notes, site 1)

Some interviewees were particularly concerned about meetings that were livestreamed (and occasionally recorded), in terms of the potential to stifle honest discussion. However, it was recognised that this approach could also increase accountability. There was a concern about important conversations taking place 'behind closed doors':

> *One of the challenges that we've always found with the Health and Wellbeing Board is because it's livestreamed or held in public, actually a lot of the honesty and the conversations don't happen. And therefore in particular with the STP, all of the work and the conversations and the challenge happen outside of the meeting, which we don't have access to. And then it's a very brief presentation and an update with the key headlines [at the HWB meeting], because it was all happening behind closed doors.* (DPH, site 4)

In general, local authority members were more familiar with livestreaming and therefore more comfortable within this approach. The NHS representatives tended to be less comfortable with it and were more likely to raise concerns; however, there were examples of individuals 'playing to the gallery' and using livestreaming as a tool to increase their visibility with the public:

> *I suppose I've used it as an opportunity to get key messages out. So when I've said certain things, I really haven't been talking to the board. You know, for instance if I'm raising issues like domestic violence as an example, I'm just trying to increase awareness in the population. […] If the Health and Wellbeing Board wasn't there I wouldn't have this stage on which to try and put in what I think should be a key priority for the city.* (CCG representative, site 4)

The HWB chair in site 4 contrasted this type of behaviour with 'speaking from the heart', which she illustrated using a personal example given during the meeting observed by the researcher (see quote below). This involved a description of a serious incident involving a local family, where she drew parallels with her own background. Elected members in some of the other sites also engaged in the discursive practice of sharing personal narratives, drawing on their own experiences or the experiences of others in a powerful way that differed from the usual issue-oriented discussion.

> *The meeting on Tuesday wasn't livestreamed, but it was a better meeting because people were not grandstanding. They actually were saying things from the heart. Because I wouldn't have given my example if I was on telly, it would be too personal. Okay? So I think there's a place for livestreaming but it does bring a different dimension to the level of the discussion. So I'm not a great believer in too much*

> *livestream stuff. If you really want to change a system, people have to be free to say what they think the problem is.* (HWB chair, site 4)

VCF and Healthwatch members took more opportunities to ask key challenge questions, but some reported feeling like a 'broken record'. Wider VCF partners generally felt that they were seen as irrelevant by HWBs. On the whole, HWBs were seen as little more than a performance, as opposed to a key decision-making body within the local health and social care system:

> *In a sense the Health and Wellbeing Board is a bit of drama, isn't it? It's bringing everybody together in the same room, it's people making comments on papers. But the decisions have already been made, the direction of travel has already been set and this is just, in a sense, a bit of a presentation.* (VCF focus group, site 1)

**The TAPIC framework and the importance of governance**

Through our dramaturgical analysis, a number of key issues in relation to the governance of HWBs are raised. In terms of transparency, there was uncertainty in some sites as to who gets to be part of the board and the rationale behind these decisions. There was also little transparency in the process by which the sub-groups determined the agendas of the HWB, as no minutes or actions were reported back to the main board. Meetings being held in public meant that contentious items tended to be kept off the table, highlighting a lack of accountability compounded by lengthy agendas and infrequent meetings. This was also exhibited in actions reportedly being 'retro-fitted' to JHWSs, with no clear roles or responsibilities allocated to organisations for enacting these strategies;

Participation was severely lacking, both in terms of the active participation of board members and the wider public. Greer et al (2019: 10) highlight that this domain is important because 'participation can be a route to legitimacy and ownership; while it will not always reconcile differences, the participation of key implementers is usually necessary to avoid...poor implementation'. Boards varied from being very inclusive to allowing very limited participation. However, the nature of participation amongst members was also limited, with many in the VCF sector feeling they were excluded from HWB activities even though there was an eagerness to participate. VCF and Healthwatch partners were effectively tasked with driving public and user involvement, even though they had limited resources or capacity to do so. The general public tended to be seen as difficult to engage and their attendance at HWB meetings was rare. The organisation and conduct of meetings, for example, lack of introductions, further limited opportunities for involvement.

Within the TAPIC framework, 'Integrity means that the processes of representation, decision-making and enforcement should be clearly specified. Individuals and organizations should have a clear allocation of roles and responsibilities and be involved in clear procedures that can be specified. These are the basics of well functioning, long-lasting, trustworthy organizations' (Greer et al. 2019: 10). The authors further contend that 'Policy capacity […] means the capacity to deliver health policies: to identify issues, formulate policies, operate large-scale stakeholder and public consultations (formal and informal), shepherd policies through the decision-making and implementation processes, and then monitor and evaluate them' (Greer et al. 2019: 15). Clear processes highlighted in these elements of the TAPIC framework are essential to achieve outcomes. However, there was little evidence of tangible outcomes driven by HWBs in the present study.

## Discussion

A key finding from this study was that although HWBs were generally perceived to be well-intentioned, they were also considered to be largely ineffective in facilitating action to improve health and wellbeing and reduce health inequalities. HWBs served a useful role in bringing people together across the health and social care system, but with limited challenge or success in holding partners to account. Agendas were generally designed to avoid difficult or controversial topics and reduce the likelihood of meetings turning into 'theatres of dissent' (Boholm 2008). However, bringing partners with differing or even conflicting views into conversation creates the possibility for transformational change. Suppressing these views – particularly if they are held by citizens motivated enough to attend official meetings – often results in frustration or apathy, and fuels a broader decline in public trust in institutions (Buttny and Cohen 2014). HWB meetings in our sites involved lengthy agendas that were often side-tracked by the high drama that tends to follow national policy announcements or initiatives like STPs. This highlights that HWBs were not in control of their own business and could be easily distracted from local priorities.

Early concerns about the status of HWBs as council committees appear to have been largely dispelled. All of the boards in our study had expanded their membership to include NHS providers, although some adopted a more inclusive approach than others. Holding meetings in non-council venues was perceived to have increased the visibility of HWBs, as well as promoting a sense of ownership amongst wider partners. However, meetings were generally not staged in ways to make them inclusive of observers and there were few examples of members of the public being involved. HWBs fit the definition of a public meeting in that access or participation is open to local citizens, yet they may still have restricted access to information available to professionals (Tracy and Dimock 2004). These restrictions can be physical – in terms of papers not being made available – or communicative – in terms of

being excluded from discussions through the use of jargon. Both were observed in this study. We found no examples of effective participatory mechanisms and instead public engagement was seen as the responsibility of specific individuals; namely, the VCF and Healthwatch representatives, with some contribution from elected members. Not only do the VCF and Healthwatch lack a democratic mandate, they also lack the time and resources to engage fully with the work of HWBs. The third sector as a whole is under-funded and under-utilised by many partners in health and social care (White 2018).

HWBs have been described as 'a single point of continuity in a constantly shifting health and care landscape… uniquely placed through their statutory basis, democratic accountability, roots into and knowledge of the local community and its needs, ability to link to the wider determinants of health, and set a long term vision for the place' (LGA 2019b). Many are considering ways to operate across larger footprints to support a system-wide approach to integrated health and social care provision, prevention, and tackling health inequalities (LGA 2019a). However, we identified no serious attempt at synergy between HWBs and STPs (now Integrated Care Systems, ICSs). The *NHS Long-Term Plan* makes passing mention of HWBs in stating that 'ICSs and Health and Wellbeing Boards will also work closely together' (NHS England 2019, p.30), but it is not clear what this will mean in practice or how their roles will complement one another. Instead there remains a risk of partnership overload, with HWBs in danger of being eclipsed if they do not take efforts to refresh or reinvent themselves (Perkins et al. 2020). Our findings highlight a potential unfulfilled role for HWBs, in line with widespread calls for greater public engagement in contemporary governance (Boswell, Settle, and Dugdale 2015).

Applying a dramaturgical perspective has enabled us to better understand the dynamics of board meetings as staged performances, designed to minimise conflict and exert control on participation. Differences in discourse observed at closed as opposed to public meetings

correspond well with Goffman's metaphor of frontstage and backstage (Goffman 1959/1990). However, conducting important conversations behind closed doors has implications for local democracy and public accountability. The behaviours observed when HWB members are thrust into the limelight are revealing of their need to present a particular reality to their specific audience. This highlights the importance of paying attention to relational issues in the context of HWBs and other public meetings.

We have sought to give a rich and rigorous account of the performances involved in HWBs, and to generate findings that may be transferable to other contexts by applying a dramaturgical lens to 'uncover the drama at the heart of policymaking' (Boswell, Settle, and Dugdale 2015: 1364). This approach has highlighted how HWBs were falling short in all domains of the TAPIC framework for good governance. It provides evidence of the system failure among boards when it came to being inclusive, accountable, transparent and effective in terms of achieving policy goals and outcomes.

## Conclusion

This study set out to examine the role of HWBs in England, adopting a dramaturgical approach to provide insights into the interactions between HWB members and local citizens or their representatives. On the whole, HWBs were not perceived to have achieved their aims, which included: enhancing local democracy and public accountability; supporting integrated health and social care provision; facilitating health and wellbeing improvement; and tackling health inequalities. The dramaturgical approach highlighted key concerns in relation to the governance of HWBs. They are statutory partnerships (albeit with no statutory powers) and therefore members were not able to opt out of attending meetings, which generally took place in public but involved little or no efforts to encourage participation by members of the public.

Instead, they served a largely symbolic function, demonstrating a commitment to partnership-working between local government and NHS representatives in particular. Agendas were set with the goal of avoiding conflict; difficult issues were addressed in closed sub-group meetings (i.e. backstage) so that public HWB meetings (i.e. frontstage) could run smoothly. The use of livestreaming or recording of meetings added to the sense of members being in the limelight. There was little evidence of HWBs acting as the 'fulcrum around which things happen', as opposed to carefully staged and scripted performances that primarily serve to inhibit rather than enhance democracy and accountability.

## TABLES

### Table 1: Case study site characteristics

| Characteristics | Details | No. of sites |
|---|---|---|
| **Region** | North | 2 |
| | Midlands | 2 |
| | South | 1 |
| **Type of authority** | County council | 1 |
| | Metropolitan council | 2 |
| | Unitary authority | 2 |
| **Political control** | Labour | 3 |
| | No overall control | 2 |
| **Geography** | Rural | 1 |
| | Urban | 4 |
| **Population size** | <300,000 | 2 |
| | >300,000 | 3 |
| **Number of CCGs** | Single | 2 |
| | Multiple | 3 |

**Table 2: Initial interviews**

| Role | Site | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| HWB chair/local authority chief executive | √√ | √√ | D | √ | √√ |
| Local authority strategic director | √ | √ | D | √ | |
| Director of adult and/or children's services | √√ | √ | √ D | √ | √ |
| Elected members | √ | √ | √√√ | D | √ |
| Director of public health | √ | √ | √ | √ | √ |
| CCG members | √√ | √√ | √ | √√ | √√ |
| NHS providers | √ | √ | √√ | √ | √ |
| Healthwatch chair/chief executive | √ | √ | √ | √ | √ |
| VCF representative | | √ | D | √ | |
| Others: District council representative<br>Housing/other provider<br>Local MP<br>HWB development lead | √ | <br>D<br>√ | <br>√<br><br>√ | | |

| | | | | | |
|---|---|---|---|---|---|
| Local authority assistant chief executive | | | √ | | |
| Public health consultant/deputy DPH | | | | √ | √√ |
| **Total number of interviews conducted** | **12** | **12** | **12** | **10** | **11** |

N.B. Blank cells in the table indicate roles that were not represented on the local HWB and not identified as part of the snowball sampling process, whereas D denotes those who declined the invitation to take part.

**Table 3: Follow-up interviews**

| **Role** | **Site** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| HWB chair/vice chair | √ | √ | √ | √ | √ |
| Director of public health | √ | √ | √ | √ | √ |
| CCG member | √ | √ | √ | √ | √ |
| Healthwatch chair/chief executive | √ | √ | √ | √ | √ |
| VCF representative | | √ | | √ | |
| **Total no. of interviews conducted** | **4** | **5** | **4** | **5** | **4** |

## REFERENCES


Alderwick, H, C Ham, and D Buck. 2015. Population health systems. Going beyond integrated care. London: The King's Fund.

Boholm, A. 2008. "The public meeting as a theatre of dissent: risk and hazard in land use and environmental planning." *Journal of Risk Research* 11 (1-2):119-140.

Boswell, John, Catherine Settle, and Anni Dugdale. 2015. "Who speaks, and in what voice? The challenge of engaging 'the public' in health policy decision-making." *Public Management Review* 17 (9):1358-1374.

Buttny, R, and JR Cohen. 2014. "Public meeting discourse." In *International Encyclopedia of Language and Social Interaction*, 1242-1252. Syracuse University bepress.

Carter, P, and G Martin. 2016. "Challenges Facing Healthwatch, a New Consumer Champion in England." *International Journal of Health Policy and Management* 5 (4):259-263.

Coleman, A, K Checkland, J Segar, I McDermott, S Harrison, and S Peckham. 2014. "Joining it up? Health and wellbeing boards in English local governance: evidence from clinical commissioning groups and shadow health and wellbeing boards." *Local Government Studies* 40 (4):560-580.

Colin-Thome, D, and B Fisher. 2013. "Health and Wellbeing Boards for a new public health." *London Journal of Primary Care* 5:56-61.

Department of Health. 2012. Local Healthwatch: A strong voice for people - the policy explained. edited by Department of Health. London.

Freeman, Tim, Ross Millar, Russell Mannion, and Huw Davies. 2016. "Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England." *Sociology of Health & Illness* 38 (2):233-251.

Freitas, C de, and G Martin. 2015. "Inclusive public participation in health: Policy, practice and theoretical contributions to promote the involvement of marginalised groups in healthcare." *Social Science & Medicine* 135:31-39.

Goffman, E. 1959/1990. *The Presentation of Self in Everyday Life*. London: Penguin Books.

Greer, SL, N Vasev, H Jarman, M Wismar, and J Figueras. 2019. It's the governance, stupid! TAPIC: a governance framework to strengthen decision making and implementation. Brussels: European Observatory on Health Systems and Policies.

Hajer, MA. 2005. "Rebuilding ground zero. The politics of performance." *Planning Theory & Practice* 6 (4):445-464.

Ham, C, A Dixon, and B Brooke. 2012. Transforming the Delivery of Health and Social Care: the case for fundamental change. London: The King's Fund.

Hudson, B. 2015. "Public and Patient Engagement in Commissioning in the English NHS: An idea whose time has come?" *Public Management Review* 17 (1):1-16.

Humphries, R, and A Galea. 2013. Health and Wellbeing Boards. One year on. London: The King's Fund.

Humphries, R, A Galea, L Sonola, and C Mundle. 2012. Health and Wellbeing Boards. System leaders or talking shops? London: The King's Fund.

Hunter, DJ, L Marks, and KE Smith. 2010. *The Public Health System in England*. Bristol: Policy Press.

Hunter, DJ, N Perkins, C Bambra, L Marks, T Hopkins, and T Blackman. 2011. Partnership Working and the Implications for Governance: issues affecting public health partnerships. London: NIHR Service Delivery and Organisation Programme.

Hunter, DJ, N Perkins, S Visram, L Adams, R Finn, A Forrest, and J Gosling. 2018. Evaluating the leadership role of Health and Wellbeing Boards as drivers of health

improvement and integrated care across England. Stockton-on-Tees: Durham University.
Hunter, DJ, S Visram, S Brown, R Finn, L Adams, A Forrest, and J Gosling. 2015. Interim report no. 1: Scoping the evidence base on Health and Wellbeing Boards and similar partnership arrangements. Stockton-on-Tees: Durham University.
Learmonth, M, GP Martin, and P Warwick. 2009. "Ordinary and effective: the Catch-22 in managing the public voice in health care?" *Health Expectations* 12 (1):106-115.
LGA. 2014. Making an impact through good governance. A practical guide for health and wellbeing boards. London: Local Government Association.
LGA. 2019a. Developing joint health and wellbeing board arrangements: issues to consider Accessed 5 April.
LGA. 2019b. "Health and wellbeing systems." Local Government Association, accessed 24 May. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/health-and-wellbeing-systems.
Martin, GP. 2011. "The third sector, user involvement and public-service reform: a case study in the co-governance of health service provision." *Public Administration* 89 (3):909-932.
Miller, R, J Glasby, B Cox, and A Trimble. 2010. "A liberated NHS – but will it lead health and social care together or force them apart." *Journal of Integrated Care* 18 (6):41-44.
NHS England. 2019. The NHS Long Term Plan. London: NHS England.
Noy, C. 2008. "Sampling knowledge: the hermeneutics of snowball sampling in qualitative research." *International Journal of Social Research Methodology* 11 (4):327-344. doi: 10.1080/13645570701401305.
O'Neill, M. 2017. "Police community support officers in England: a dramaturgical analysis." *Policing and Society* 27 (1):21-39.
Perkins, N, and D Hunter. 2014. "Health and Wellbeing Boards: a new dawn for public health partnerships? ." *Journal of Integrated Care* 22 (5/6):197-206.
Perkins, N, DJ Hunter, R Finn, S Visram, J Gosling, L Adams, and A Forrest. 2020. "Partnership or insanity: why do health partnerships do the same thing over and over again and expect a different result?" *Journal of Health Services Research & Policy* 25 (1):41-48.
Rogers, D. 2012. "Developing relationships – the role of local government." In *Getting Started: prospects for health and wellbeing boards*, edited by N Churchill, 28-36. London: The Smith Institute.
Shared Intelligence. 2015. Stick with it! A review of the second year of the health and wellbeing improvement programme. London: Shared Intelligence.
Shared Intelligence. 2017. The power of place. Health and Wellbeing Boards in 2017. London: Shared Intelligence.
South, J. 2015. A guide to community centred approaches for health and wellbeing. PHE publications gateway no. 2014711. London: Public Health England.
South, J, DJ Hunter, and M Gamsu. 2014. What Local Government Needs to Know about Public Health. London: SOLACE.
Tracy, Karen, and Aaron Dimock. 2004. "Meetings: discursive sites for building and fragmenting community." *Annals of the International Communication Association* 28 (1):127-165.
UK Parliament. 2012. "Health and Social Care Act 2012." The Stationery Office. http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted.
White, PJ. 2018. "Social prescribing is not always a win-win." *Third Sector*, 3 April.

Yin, RK. 2008. *Case Study Research: design and methods*. 4th ed. Newbury Park, CA: Sage Publications.