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Technocracy, the Market, and the Governance of England's National Health Service

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Abstract

England's publicly-funded National Health Service has become heavily influenced by expert authority and the market economy. This has had implications for accountability and for the receptiveness of health decisions to stakeholder needs. One response is the introduction of a range of regulatory provisions designed to facilitate stakeholder engagement. These provisions are scrutinized using three conceptual devices (i.e., core accountability, social reporting, and social learning). It is demonstrated that they have significant implications, since they enable technical experts to: form closed communities; communicate amongst themselves mainly about economic and financial matters; and make decisions that aid the market without meaningful recourse to citizens. While technical experts are necessary for helping to manage complex areas, current arrangements reinforce an existing gap between economic and democratic values through hardened technocratic approaches to health care governance.

Keywords: health care regulation; stakeholder engagement; expertise; accountability, technocracy.

1. Introduction

Bringing order and stability to complex areas of public life presents increasing challenges to policymakers (Vibert 2007; Burris *et al.* 2005). One response has seen ever more regulatory and decision-making authority being transferred, by policy communities, to independent experts (Vibert 2007). While this might bring potential benefits (e.g., decisions *might* be quicker), expert decision-making processes are not always comprehensible, and cannot always be properly questioned by stakeholders (e.g., citizens), which is a concern when considering crucial decisions can affect the welfare of many (Baldwin *et al.* 2012; Vibert 2007; Feldman and Khademian 2002; Ogus1994). With this in mind, a pressing question emerges: Does regulatory governance address the needs of stakeholders?

This question is significant in the context of England's National Health Service (NHS). The NHS is a large and complex organization providing publicly-funded health care. It is the fifth largest employer in the world (World Economic Forum 2015), dealing with around one million patients every 36 hours (Department of Health 2005). It is arguable, given such scale, that more than ever the NHS needs experts to manage issues involving, say, new technological risks (Beck 1992), and intricate regulatory solutions (Vibert 2007). But it is also arguable that designing solutions should involve experts and non-experts. After all, health care personally affects stakeholders, like patients, who are unlikely to be involved with managing day-to-day regulatory processes. Furthermore, health care often involves mixtures of technical knowledge (e.g., how much resource) and political considerations (e.g., allocation of resource) (Prosser 2010; Vincent-Jones 2011; Mullen *et al.* 2011). Yet, devising solutions and formulating an appropriate dialogue across different groups will not be easy. Different actors are likely to construct different identities and communicate in different ways (Black 2002). Governments

have navigated these problems by creating mechanisms to involve patients and citizens in decisions (Horton and Lynch-Wood 2018).

This article focuses on NHS regulation and governance, and particularly how expert authority and the market (that is, the space where supply and demand principles operate and where buyers (e.g., purchasers of health care services) and sellers (e.g., hospitals) interact (Marshall 2013; Samuelson 1983)) have been enhanced through regulatory changes. This has had implications for accountability and for how receptive health care regulation is to stakeholders' needs (Horton and Lynch-Wood 2018). Acknowledging these implications, successive administrations have introduced measures to ensure services are accountable and address stakeholder needs. This has been supported by political ambitions and expressions, such as putting 'patients at the heart of the NHS' (Department of Health 2010, p. 3). In considering whether the needs of stakeholders are properly addressed, the authors scrutinise current stakeholder engagement provisions using three conceptual devices (i.e., core accountability, social reporting, and social learning). These devices enable an assessment of the degree and quality of interaction and responsiveness between one set of stakeholders (e.g., experts like economic regulators) and another (e.g., lay persons like patients). This is important, as there might be differences between the economic concerns of, say, economic regulators (e.g., use of scarce resources) and the democratic concerns and values of patients (e.g., dialogue over patient needs, experiences and decision-making transparency).

The analysis of regulatory provisions shows that the current framework enables technical experts to: form closed communities; engage and communicate with each other mainly about economic and financial issues; and make critical decisions without meaningful recourse to citizens. The authors

claim existing arrangements give primacy to economic values and financial objectives over social interests (e.g., equality). The arrangements are technocratic, making provision for complex tasks and activities that are mostly procedural, market-focused (e.g., publishing competition guidance) and supportive of market-functioning (e.g., accounting). The article starts by outlining the growth of expert authority. Then, it looks at the implications for openness and accountability, and how administrations have responded by introducing provisions that modify accountability and promote stakeholder engagement. The article then analyzes the existing governance framework using the three conceptual devices. It ends with the discussion and conclusions.

2. Rise of Expert Authority

England's NHS can be divided into five important areas of activity. Each activity, as is now shown, has come to be dominated by independent experts (Table 1). Tables 2 to 6 outline the constitution of the relevant bodies involved.

The first activity is commissioning. This involves Clinical Commissioning Groups (CCGs) contracting, on behalf of patients and within a particular geographical area, with hospitals that provide health services. CCGs, which exercise considerable financial autonomy, are comprised of medical doctors, known as General Practitioners (GPs), plus a lay member (an individual who is not a CCG member or health care professional) and experts in accountancy, nursing and specialist care (The National Health Service (Clinical Commissioning Groups) Regulations 2012, Reg. 11–13). As Table 2 shows, CCG members are managed and appointed by a non-departmental public body, called NHS England, although members can be nominated by existing CCG members. NHS England comprises experts in law, statistics, economics and medicine (NHS England 2018a). Its members are appointed by the

Secretary of State for the Department of Health as well as the non-executive members of the NHS England Board. The establishment of NHS England and CCGs echo previous reforms that encouraged distance between government and commissioning authorities for the purposes of creating a quasi-market in health care (see Department of Health 2003; National Health Service and Community Care Act 1990 (NHSCCA)).

Health care provision is the second activity. It covers services not provided by GPs (e.g., services provided by hospital). NHS Foundation Trusts are typical providers for a local area, although these bodies operate within a health care market where entry is limited to providers that can meet published licensing criteria. Established by the Health and Social Care (Community Health and Standards) Act (HSC(CHS)A), NHS Foundation Trusts are provided with a greater degree of economic independence than their predecessors (i.e., NHS Trusts established under the NHSCCA). NHS Foundation Trusts comprise directors that typically have considerable technical expertise in areas such as medicine and finance, although some have professional backgrounds in areas like social work and public relations.[i] Members join through a mix of invitation and application, whereas some figures are appointed (e.g., the Chair and non-executive directors must be appointed by a Council of Governors) and elected (e.g., the Council of Governors) (Table 3).

Since 1990 the NHS market began steadily to develop. Over time, this prompted the emergence of a third area of activity in 2003, which we call economic regulation. An important development was the establishment of Monitor, established as an independent economic regulator of health care providers (HSC(CHS)A 2003, s 2(1)). As Table 4 shows, Monitor is led by a Chair, who is appointed by the Secretary of State for Health. Monitor's other Board members are appointed by existing non-executive

members who have expertise in areas of banking, accountancy and finance (Monitor 2018). Monitor's regulatory powers have recently been strengthened. It is now empowered to issue, set, modify and revoke licences and enforce general competition laws.

The fourth activity is consumer championing. This is led by Healthwatch England, a committee located inside the Care Quality Commission (CQC) (see below). Healthwatch England has members with both technical expertise (e.g., accountancy) and other expertise (e.g., journalism) (Healthwatch England 2018). As Table 5 shows, members are appointed by the Secretary of State and the Chair. The main functions of Healthwatch England are to build a picture of health care across England, to oversee Local Healthwatch Organisations (LHOs) (Health and Social Care Act 2012 (HSCA), s 181(2)),[ii] and to provide advice to relevant bodies on the views, needs and experiences of health care users (HSCA 2012, s 181(4)).[iii] LHOs are tasked with making the views and experiences of local people known to Healthwatch England and commissioners, as well as with promoting and supporting the involvement of local people in commissioning and provision and enabling people to monitor and review access to local services, choices relating to them, and standards (Local Government and Public Involvement in Health Act 2007 (LGPIHA), s 221(2); HSCA, s 182(4)). Composed of local lay (i.e. patient) representatives, there are presently 152 LHOs across England. At least one member must sit with local authority and CCG members on local partnership forums known as Health and Wellbeing Boards (HWB) (HSCA 2012, s 194(e)).

The last activity concerns the regulation of quality (Table 6). This involves two main bodies. The first is the National Institute of Health and Care Excellence (NICE), which was established in 1999 (National Institute for Clinical Excellence (Establishment and Constitution) Order 1999). NICE produces quality

standards and practitioner guidance on how treatment should be provided (HSCA 2012, ss 232 and 233). NICE is staffed with members that have clinical, financial and policy expertise (NICE 2018). They are appointed by the Secretary of State and other members. The second body is the CQC, which is led by a Chair, appointed by the Secretary of State, who appoints members with clinical and financial expertise (CQC 2018). The CQC is mainly responsible for inspecting, investigating and prosecuting providers that pose quality and safety concerns. Note that the CQC has more independence than its predecessors, the Commission for Health Improvement and the Commission for Social Care Inspection. The CQC was recently given new powers of 'market oversight' over social care.[iv]

We should note that the bodies mentioned, like others using public finance, must, for the purposes of financial assessment, disclose their accounts to an additional body of technical expert authority: the Comptroller and Auditor General (CAG). The CAG oversees public financial reporting in England (Budget Responsibility and National Audit Act 2011, s 11) and is responsible for examining the efficiency and effectiveness of public bodies (National Audit Act 1983, s 6(1)). The current CAG is a former global managing partner of PriceWaterhouseCoopers (National Audit Office 2018).

This has illustrated the rise in independent expertise and a more technocratic approach to NHS regulation. For the most part, expert authorities are required to undertake technical tasks (e.g., accounting, auditing, health care contracting, regulating competition) that support the market and ensure financial prudence. Relevant, too, are the procedures that govern the constitution of the bodies considered. With few exceptions (i.e., the constitution of NHS Foundation Trusts; Secretary of State's power to appoint), these procedures create scope for closed communities of experts to form

through closed processes of governance. The appointment of expert members is often made by existing expert members. Granted, the professional backgrounds of those sitting on these expert authorities are diverse, ranging from social work to public relations (Tables 2 to 6). But many of these individual professional backgrounds, whilst important, are peripheral to the economic and financial focus of many prescribed regulatory tasks.

The article builds on these observations by linking them to the idea that NHS regulatory governance creates a gap between economic values and democratic interests and values. Vincent Jones (2011) attributes this gap to the privileging of individual choice over democratic voice in healthcare reform. We approach this slightly differently. For us, the framework not only creates a gap, but puts in place extensive – albeit subtle and not easy to untangle – structures that reinforce it. We find these structures to embody a hardened technocratic approach to governance that is market-shaping and market-supporting. We now approach this in four stages. The first (section 3) draws on concerns that the public's desire for accountability and openness has become difficult to meet owing to a growth in independent expert authority (see Baldwin *et al*. 2012). The second (section 4) outlines the stakeholder engagement measures that have been introduced to meet this desire, but which have been criticised as undermining accountability, reducing openness and restricting potential for making regulatory decisions with all stakeholders in mind (Horton and Lynch-Wood 2018). The third stage (section 5) outlines three key conceptual tools (i.e., core accountability, social reporting and social learning) used to analyze current stakeholder engagement arrangements. The fourth stage (section 6) uses these tools to help understand existing arrangements. Overall, it is claimed that existing stakeholder engagement arrangements aid the health care market through technocratic decision-making, and reinforce the gap between economic and democratic values.

3. Accountability Concerns

Accountability is the condition of being answerable for past actions. It can, however, take different forms. Monitor, for example, can hold health care providers legally accountable for any practices that may be regarded and found as anti-competitive. Simultaneously, Monitor can be held politically accountable, a process largely reinforced through reports on its performance to the Secretary of State and Parliament. To some extent, legal and political accountability reflects a more traditional view of accountability, where public institutions are required to explain their conduct to courts, citizens and their representatives (Bovens 2007; Scott 2000). Yet this old view of accountability is said to be restricted in its ability to provide a reliable view of how regulatory and public authorities actually function (Lodge and Stirton 2012; Vibert 2007; Scott 2000). Indeed, the marketisation of public (health) services has been said to fragment accountability (e.g., due to contracting out) (Lodge and Stirton 2012; Scott 2000) and regulation now involves informal negotiation, bargaining and communication between regulators and regulatees (see Sanderson *et al*. 2017; Black 2008). This suggests traditional mechanisms of accountability are less prominent, and arguably less easy to identify. The rise of expert authority has, among other things, certainly meant that the public's desire for accountability and openness is more difficult to meet (Baldwin *et al*. 2012). What is important to note is that policymakers, in recognising accountability concerns, have attempted to modify levels of accountability and openness by introducing measures to enhance stakeholder engagement. We more consider these in more detail.

4. Governance and stakeholder engagement

Stakeholder engagement, here seen as mechanisms (e.g., reports, meetings) that encourage relevant actors to communicate, share information, and make decisions, has for years been a feature of NHS

governance. In recent years, it has become more prominent. Community Health Councils (CHCs) were established in 1973. As independent bodies with local patient representatives, CHCs were tasked with ensuring health care practice was informed by patients' views (Porter 1980) and with obtaining information from hospitals (Hogg 2007). The workloads of CHCs were later increased, as market-based reforms took hold in 1990, and they became less effective as an independent voice (Hogg 2007). Public rights to information about standards of local care were introduced shortly after (Department of Health 1991) and commitments were made to promote 'listening', 'discussing', 'reporting' and responsiveness between stakeholders (NHS Management Executive 1992; Cabinet Office 1999; Department of Health 2002a). Nevertheless, policies in this area were described as ambiguous (Pollock 1992). The marketization of public services and creation of new modes of regulation also appeared to produce what some described as a democratic deficit (see Giddens 1998). Attempting to address this perceived deficit in the NHS, measures were introduced to: enable local people to elect NHS Foundation Trust members (Department of Health 2002b); populate commissioning authorities with a range of health professionals and lay persons (Department of Health 2003); and develop clinical standards in collaboration with patients (Department of Health 2002a).

In 2003, CHCs were replaced with Patient and Public Involvement (PPI) Forums. Unlike CHCs, PPI Forums were administrated by NHS Trusts, and so tended to be less independent than CHCs. PPI Forums were also overseen by an expert body, the Commission for Patient and Public Involvement in Health (CPPIH) (National Health Service Reform and Health Care Professions Act 2002), but it was abolished in 2008. PPI Forums were replaced by LINks (see LGPIHA 2007). Interestingly, LINks held no statutory rights to obtain information about health care services and inspect hospitals (Hogg 2007). LHOs later replaced LINks (HSCA 2012) and were established against a background of growing

expectation that independent expert bodies should appear before Parliamentary select committees (Baldwin *et al.* 2012).

So, there appeared to be a need to further boost accountability in NHS regulation and governance, and to empower citizens through greater levels of engagement (Department of Health 2010). But opinions have been divided on precisely what these policies and ambitions mean (Horton and Lynch-Wood 2018). A suggestion is that stakeholder engagement emphasizes patient choice of provider rather than patient voice in decision-making (Vincent-Jones 2009, 2011) and forces citizens to trade in their dependency on the medical profession for a dependency on the market (e.g., by encouraging self-responsibility for health) (Veitch 2010). While measures have been introduced to modify stakeholder engagement in the manner described above, these provide only a partial picture of NHS regulatory governance. It is important to consider the extensive framework for stakeholder engagement that exists (i.e., reporting and non-reporting mechanisms). Crucially, we examine what this framework actually does – what it might mean for practical actions. To do this, we use three conceptual devices, which we briefly outline.

5. Conceptual Devices

There are other ways of analyzing the existing stakeholder engagement framework. It could be explored from a legitimacy perspective, and whether experts have proper justification for their roles and decisions. We have chosen the following three devices, since we want to consider whether and how a disparate and complex set of provisions can operate coherently and secure important stakeholder needs.

Core Accountability

Bovens (2007) says core accountability relates to the relationship between one actor (accountor) and another actor (accountee), and the obligation of the former to explain and justify conduct to the latter. While core accountability is relevant to concerns that exist over whether an actor's conduct is visible to a relevant population (see Baldwin *et al*. 2012), it goes to the heart of how conduct is explained or justified. Core accountability, for instance, is central to whether actions and decisions are explained either financially or procedurally (see Ogus 1994) or whether conduct is made the subject of information that is accessible to stakeholders, open to critique, and released in a timely manner (Bovens 2010). What is notable is that core accountability can provide a benchmark against which regulatory provisions generally can be analyzed, as it emphasises some specific activities (e.g., explaining conduct, positing probing questions).

Social Reporting

A widely used regulatory mechanism, reporting is a process for measuring, recording and disclosing information (Hess 1999, 2008). NHS bodies and stakeholders must report on many aspects of their work. The concept of social reporting is designed to stimulate a culture of exchange and feedback between stakeholders, yet specifically to encourage identification of stakeholder values. The idea, among other things, is to promote greater organizational reflexivity by exposing reporting bodies to the gaze and assessment of their primary and secondary stakeholders (see Pruzan 1997). Social reporting is thought to lead to greater levels of accountability and stakeholder democracy, and practices that are more consistent with social needs (Hess 2008). Social reporting and core accountability are potentially mutually reinforcing, for both might involve accounting or providing explanations and justifications for socially-beneficial actions.

Social Learning

Social learning refers to the development of stakeholder capacities and competencies to deliberate and reflect on matters of public importance. Vincent Jones (2011) identifies three types of social learning, contending that each provides necessary albeit insufficient conditions for reflexive governance. The first is derived from neo-institutional economics. This posits that improvements in public services may be achieved by overcoming the problems of monopoly power and incentivizing actors to make responsive decisions. The second is built on democratic exchange via the facilitation of dialogue, counter-argument and dissent (e.g., ongoing consultations on approvals for changes in services). And the third form is founded on pragmatism. This facilitates joint enquiry, forward planning, transparent problem-solving (e.g., benchmarking, internal reflection), acting on information, and adaptation of decision-making procedures and practices.

These conceptual devices are not mutually exclusive. Without, say, relevant explanations of past conduct (core accountability), or dialogue and feedback mechanisms (social reporting), the potential for social learning is impeded. Crucially, core accountability, social reporting and social learning provide the institutional conditions that are important for bridging the gap between economic values (e.g., efficiency) and democratic interests and values (e.g., meaningful exchange between the public and experts about patient needs). Using these tools, we now explore the existing framework.

6. Stakeholder Engagement

There are two parts to this analysis. The first examines the stakeholder engagement activity of reporting, while the second examines non-reporting activities (e.g., consultations, meetings and advice).

Reporting

Tables 7 to 11 summarise the different reporting duties undertaken by key bodies. The Tables and analysis are organized using three questions derived from the conceptual devices. The first question is: does the regulatory framework specify the report's substance? This is relevant as a governance provision specifying substance is one that might facilitate explanations of conduct (core accountability) and the identification of important stakeholder values (e.g., equality) relevant to that conduct (social reporting). The second question is: to which parties must the report be presented? This is important since a provision specifying the recipients is one that can enable explanations of conduct to be distributed to relevant stakeholders (core accountability), aid dialogue between interested actors (social reporting) and enable stakeholders to learn about this conduct and build their learning capacities for the purposes of making judgements and decisions (social learning). The third question is: are the report's recipients required to respond? Again, this is important as the reporter might actually receive feedback from the reportee (social reporting), which can enable the reporter to learn of the reportee's concerns (social learning) and meet requests for any further information (core accountability). For purposes of analysis, these areas have been broken down in to substance, target addressee, and reaction.

Substance

The CQC is unique. It is the only expert body across the areas reviewed that is expressly required to report on 'regulated activities' as well as disclose the steps taken to involve patients in discussions about health care provision (Table 11). 'Regulated activities' are vaguely defined as involving, or being connected with, health or social care provision (HSCA 2008, s 8). This does not mean that those not expressly required by the legislation to disclose their regulated activities are closed off from scrutiny.

All expert bodies – including the CQC – have annual reporting duties. But these duties are limited to disclosing 'how' functions and duties are discharged. As the emphasis on 'how' suggests, it is the methods these bodies use to make decisions and conduct their activities that must be disclosed. The core duty of the annual report makes no reference to the substance of decisions and activities. These bodies only have to report on 'how' they do what they do, which may have significant implications for the types of information that is released (see Horton and Lynch-Wood 2018).

As a separate yet related matter, all expert bodies reviewed, while not having an annual duty to report on the substance of past conduct and activities, do have specific duties to report on certain activities that we can define as regulatory. As is illustrated in Tables 7, 8 and 9, there are specific duties placed on bodies like NHS England, Monitor and NHS Foundation Trusts. NHS England must publish a response to its consultation regarding CCG dissolution. This is important since CCG dissolution might impact on the degree to which local populations access health care services (NHS England 2016). Also, Monitor must publish its assessment of likely significant impacts on health services caused by its activities (such as, major changes to standard license conditions). As for NHS Foundation Trusts, they are required to report annually on matters of performance, director's pay, and finances (Table 8). These reporting duties promote transparency on these matters but the substance of what must be reported on here could be described as narrowly focused and vague (e.g., meaning of 'performance'). By contrast, most annual reporting duties across the majority of areas of activity require the disclosure of a broader range of matters (i.e., how functions and duties have been discharged). But as highlighted already, this annual reporting mechanism does not mandate the disclosure of past conduct and activities. This suggests that, when it comes to identifying important democratic interests and values, there are potential weaknesses in the existing provisions, particularly when they are explored

through the lens of our three conceptual tools. For instance, existing provisions obligate the disclosure of information about procedural affairs, primarily. It is therefore arguable that core accountability is constrained due to limitations placed on expert bodies to explain their conduct, to justify it, address probing questions from stakeholders (i.e., local citizens) and enter into dialogue with them on issues that go beyond those matters required to be disclosed. This, then, shows restricted potential for social reporting, for the reporting mechanisms do not tend to stimulate a culture of exchange and feedback between stakeholders, and, moreover, they are not concerned with encouraging the identification of important social interests, such as decision-making transparency. With both core accountability and social reporting limited in this way, the potential for social learning seems also constrained. For social needs and concerns (e.g., equality and access to care) to be identified by all relevant stakeholders, exchanges, deliberations and feedback mechanisms between experts and other stakeholders (particularly those to whom the reporting content relates (e.g., service-users) must relate to matters beyond those that are technical and procedural. Indeed, such issues often cannot be separated from considerations which non-experts (e.g., service-users) are able to draw on using their distinct experience (Vincent-Jones 2011).

Developing this point, the reporting framework in all areas of functioning is configured, primarily (though not solely), to support the coordination of technical activities that aid the market. Tables 7 to 11 give numerous examples, but they include accounting, competition law enforcement, tariffs, inspections, payments, price modifications and license conditions. Of course, some provisions require disclosures that refer to actions taken to reduce inequality (see Table 7) and promote public involvement (see Tables 7 and 11). They are exceptions. When drawn together as a coherent whole, the reporting provisions focus mainly on technical and market-oriented matters.

Addressee

The governance framework, in many cases, expressly states that information has to be transferred from one named expert body to another. The Tables suggest there is little deliberation and collaboration provided for between experts and the lay community, indicating there is little by way of explanation of conduct between important stakeholder groups and therefore restricted opportunities for some stakeholders to learn about, and understand, the needs of other stakeholders. So, Table 7 indicates most reporting activities in the area of commissioning take place between expert bodies (i.e., NHS England and CCGs). Again, by way of example, Table 7 shows that NHS England is required to direct its commissioning guidance reports to Healthwatch England. Likewise, Monitor is generally required to direct its reports to other expert bodies, such as NHS England, the CQC, and the CMA (see Table 9), while Monitor itself is an expert addressee of disclosures made by NHS Foundation Trusts (see Table 8). It can also be seen that Monitor must send its notice to modify licence conditions to Healthwatch England (see Table 8), that the CQC must report on inspections to persons carrying out regulated activities (e.g., hospitals), and that NICE is required to disclose information to the CAG (Table 11). As a final illustration, Table 11 shows that the CQC is required to report information to, for example, inspectors and other persons carrying out regulated activities.

We are trying to show that most reporting activity is conducted between expert bodies. There are exceptions, of course. As Tables 7 to 11 demonstrate, many reports have no specified audience. And while some reports are required to be directed to certain non-expert audiences (i.e., Secretary of State, Parliament and local authorities), the crucial point to note is that LHOs are specified as a target audience for a predominantly expert body (i.e., Healthwatch England) on two occasions (Table 10). Now, as statutorily-created groups of local patient and public representatives, LHOs are a potential

source of intelligence and information about local needs over health care services for many expert authorities. The fact that the governance framework does not specify LHOs (and for that matter service users and the public generally) as a target audience for most other reports, and indeed as actors who question expert authorities, judge their past conduct, deliberate problems and participate in crucial decisions with them suggests patients and citizens, as key stakeholders, are not afforded meaningful opportunities to engage.

It is appropriate to consider briefly the different publication requirements (Tables 7 to 11). A requirement to publish a report only has meaning if there is an expectation that it is to be accessed and read by someone (i.e., potential recipient). It is interesting that the word 'publication' is not defined in statute. A publication can therefore be as broad or narrow as the reporting body desires. However, it could be argued that the requirement for certain bodies (e.g., Monitor) to present their annual reports to Parliament is one of the more robust forms of publication. Indeed these reports are usually published as Parliamentary papers, customarily. But questions remain over the accessibility and relevance of publications to lay persons affected by NHS delivery since existing reporting arrangements do not expressly target the latter.

Reaction

Critical to the conceptual tools is the ability of those stakeholders targeted for engagement to respond in some way. Response mechanisms are essential so that questions can be asked and information elicited (core accountability) and so that collaboration can occur for the purposes of identifying needs and planning future activities (social reporting and social learning). Interestingly, current stakeholder engagement provisions impose only a limited number of requirements on target addressees to react

or respond. They primarily involve engagement between commissioning authorities (Table 7), competition authorities (Table 9), and other expert bodies (e.g., CQC) and the CAG (see Table 11). Particularly interesting when we consider issues around reaction are the reporting requirements that relate to LHOs. LHOs do of course have to report annually to NHS England, CCGs and the CQC. But there is no requirement for these latter bodies to engage LHOs in response - that is, there is no requirement for reaction, reciprocation, exchange and dialogue to occur between experts and non-experts, thus potentially undermining notions of core accountability, social reporting and social learning.

6.2. Non-reporting

This part of the analysis focuses on the requirements for stakeholders to engage in activities that do not involve reporting (Tables 12 to 15). Non-reporting activities can generally be divided into meetings, consultations, advice, assistance, guidance and recommendations. Again, we have questions to underpin the analysis that are derived from the conceptual tools highlighted. The first question is: what is the substance of non-reporting activities? Like the substance of reporting, this is important as it might facilitate a judgement on how effective it is at providing opportunities for explaining conduct (core accountability) and enabling dialogue about stakeholder needs (social learning). The second question is: which audience does the mechanism target? The answer to this question will help to reach a conclusion about the extent to which the mechanism provides a basis for dialogue, exchange and questioning (core accountability) to occur between certain stakeholders (i.e., experts and citizens). The third question is: are target audiences provided with meaningful engagement opportunities? The answer to this may help determine whether and how non-reporting mechanisms stimulate ongoing dialogue between stakeholders (i.e., experts and non-experts), and the degree to

which those most affected by decisions (i.e., non-expert citizens) are provided with opportunities to scrutinise, question, elicit information from and pass judgement on experts for the purposes of core accountability and social learning. Again, we have broken these questions down into *substance*, *target addressee*, and *engagement opportunity*.

Substance

Several bodies reviewed are, subject to confidentiality and public interest considerations, required to hold publicly-accessible meetings on matters typically relating to their functions (Tables 12 to 15). Again, when considering duties on expert bodies to consult, the substance underpinning these consultation duties largely depends on the functions of the body carrying out the consultation. For instance, CCGs and NHS England must consult on commissioning matters (Table 12), while Monitor must consult on competition matters (Table 13). The NICE and CQC must, with some exceptions, consult on health care quality matters (Table 15). We must be mindful, however, that there are limitations placed on the substance of consultations in a number of key areas affecting service-users.

As Table 15 shows, NICE is under a duty to consult the public when preparing quality standards and when establishing procedures for preparing such standards. We need to stress that it is the methods (i.e., preparation and procedures) these bodies use to devise quality standards that form the basis of the duty. That is, the duty to consult makes no reference to important considerations that go beyond the preparation of quality standards and beyond the establishment of procedures for setting them (e.g., conformity of health services with current clinical knowledge). Service-users and the public have an interest in learning about these considerations. However, by limiting NICE's duty to consult in this way, no clear opportunities to engage the public on matters of substance are being provided. In terms our analysis, this suggests there is limited scope to raise questions of, elicit information about, and

pass judgement on, important issues that go beyond the preparation of quality standards and the establishment of procedures for setting them (core accountability). Indeed, both core accountability and social learning are potentially undermined here, as extant provisions allow for the exclusion of values and interests held by the public on these matters, preventing them from informing the adaptation of procedures and decision making through questioning and dialogue.

Interestingly, in the area of consumer championing, expert authorities are not required to engage LHOs in any capacity. An exception, however, is Healthwatch England's duty to advise and assist LHOs on the latter's contractual arrangements with local authorities and on how (i.e., procedures) LHOs should carry on their prescribed activities (Table 14). Crucially, this shows the role and status of LHOs to be mostly circumscribed. Not only do they lack a formal relationship with CCGs (Tritter 2013), LHOs are afforded limited opportunities to meaningfully enter into exchanges with expert authorities on matters beyond contractual arrangements and how they carry on their prescribed activities, and inform regulatory decision-making with the values and concerns of their representees.

Addressee

The sole target for publicly-accessible meetings of expert bodies in all of the areas reviewed, are the members of these bodies. Interestingly, the public has to target these bodies by attending the meeting if they so wish (Horton and Lynch-Wood 2018). Looking at consultations, Monitor's duties to consult are targeted at other expert bodies (e.g., NHS England) and are concerned with matters relating to economic regulation (see Table 13). In other words, there is no formal opportunity for non-experts to learn, or voice their concerns, about how economic regulation may affect them (e.g., issues around the financial health of a local hospital). Similarly, Table 15 shows that, in addition to the Secretary of

State, the CQC must primarily consult NHS England and inspectors (that is, experts) on a range of matters, such as confidential information handling and inspection frameworks. And while consultations on the part of the CQC on how it will regard the views of service users can be commended, it is slightly troubling that extant governance frameworks are vague in terms of who might be the relevant target audience. This is because, as Table 15 shows, the reference is to appropriate persons. We can contrast the NICE, which is under a duty to consult appropriate persons and the public on preparing quality standards and establishing procedures for creating these standards. While this shows some level of broad engagement, we have seen above how NICE's duty to consult on these matters, which is largely to do with preparatory measures and procedural issues, limits the scope for these stakeholders to ask questions, elicit information, pass judgement and enter into ongoing exchange. What these points suggest is that the governance framework – when analyzed from a core accountability and social learning perspective – is piecemeal and haphazard. For instance, although the CQC's duty to consult on a broad range of matters may enhance the potential for accountability and learning, the narrow target audience (i.e., experts) may act as a constraining factor. Similarly, the broad target audience associated with NICE's duty to consult (i.e., the public) is closely aligned with the aforementioned two conceptual tools, while its limited remit (e.g., confining consultation to the establishment of procedures, and not actions, conduct and decision making) is not.

Engagement Opportunity

In relation to the publicly-accessible meetings of expert bodies (see Tables 12 to 15), it can be seen that members of the public may be refused access for 'special reasons' (National Health Service Act 2006 (NHSA), Schedule 7, para. 13(2)) and do not have a specific entitlement to ask questions and elicit information from members. As has been suggested earlier, such entitlements are essential for

social needs to be identified and for the exchange of ideas to occur between stakeholders. Such exchange is a cornerstone of accountability and social learning. Table 12 shows that NHS England and CCGs must make arrangements to involve the public on commissioning matters whether by consultation 'or' providing information 'or' using other ways. The reference to 'or' appears both critical and deliberate, since it allows expert bodies to limit the scope for proper deliberation and engagementbetween experts and the public. This potentially undermines judicial consultation standards (i.e., opportunities for comment).[v] Arrangements, then, do not prevent sole reliance on non-consultative methods, such as surveys (see NHS England 2018b), despite such methods being questionable in their ability to secure the ongoing dialogue, exchange and questioning needed to facilitate core accountability and social learning, especially in the deliberative and pragmatic sense.

Finally, the area of consumer championing does not have incorporated into it any meaningful feedback features. As Table 14 illustrates, Healthwatch England must receive from LHOs advice and assistance on several matters that trigger a duty for Healthwatch England to react by engaging expert bodies mainly (i.e., Monitor, NHS England and the CQC), some political bodies (i.e., Secretary of State and local authorities), but not LHOs, service-users or the public. Interestingly, these bodies have a duty to respond to Healthwatch England only, in writing. There is, then, some reciprocity. LHOs are not, however, supported to the same extent. Healthwatch England must advise and assist LHOs, but only in relation to how the latter carry on their activities and discharge their contractual obligations to local authorities. Opportunities for LHOs to respond and engage are not specified. This suggests that engagement opportunities for LHOs to raise concerns with Healthwatch England that go beyond how LHO activities are carried out (i.e., procedural issues), and respond to Healthwatch England's advice

and assistance through questioning (core accountability) and collaboration (social learning), are limited.

7. Discussion

Current provisions appear to lack alignment to ideas of core accountability, social reporting and social learning. Our broader concern is what this says about the nature and purpose of NHS governance. As constructed, the provisions provide opportunities for experts to engage predominantly with each other, share technical knowledge, and share common interests on the health care market, how it functions, and the technical competences of those supporting it. Drawing from Vibert (2007), the framework provides scope for the creation of closed epistemic communities that interact on issues primarily concerning economic, procedural and financial affairs. This is seen in Monitor's duties to report to the CMA and NHS England about market investigations and financial levies, respectively. It is seen in Monitor's requirement to: issue guidance to CCGs about the National Tariff rules; issue notices to providers and CCGs of proposals to modify licences; and to engage the CMA about how competition should be regulated. On commissioning, CCGs and NHS England are required to engage each other mainly on decisions over commissioning matters and CCG dissolution. NHS England must engage with other experts (e.g., itself, in Board meetings, and the CAG) over technical matters relating to commissioning and finances, respectively. The NICE is required to disclose its accounts to the CAG, provide advice on health care quality to NHS England for commissioning purposes and publish quality standards for health care providers to follow. Likewise, the CQC must engage the CAG, inspectors and itself in Board meetings. A mixture of bodies is required to do a mixture of things, but the common thread is that there tend to be requirements on expert bodies to communicate about the market and the ability of expert bodies to undertake tasks supporting it.

Where governance arrangements provide for non-experts (i.e., LHOs) to advise and assist bodies composed predominantly with technical experts (i.e., Healthwatch England and commissioners), we see that a series of subsequent engagement channels are provided for, in response, that involve expert bodies only. Indeed, more broadly, where experts (e.g., regulators) are required to consult with the public, service-users or with bodies on which lay members sit, we have shown that the scope to interact on crucial matters of social importance, is limited.

Not only has the rise of technical expertise and the market been facilitated by a transfer of authority away from the policy-making arena, our analysis shows that this is being affected in subtle ways by extensive and disparate regulatory provisions. These provisions create a framework around which closed epistemic worlds of technical knowledge and information-sharing can form and which limits input from non-experts. It is a technocratic framework: one that places independent expert authority in formal relationships of engagement that primarily serve to overcome the potential problems of monopoly power through compliance with complex legal rules (see Davies 2013), externalities, limited consumer choice, financial competency and financial prudence.

While technical expertise is now a critical feature of regulation, the public's desire for accountability and openness may be difficult to meet if expertise becomes too dominant (Baldwin *et al.* 2012). We show that NHS governance reinforces a narrow, albeit familiar economic approach to decision-making and social learning (Vincent-Jones 2011). We also show that this is being achieved through arrangements that emphasise technocracy and market functioning. Such arrangements, like neo-institutional economic approaches to social learning, are – to some measure – necessary to help

close the gap between economic and democratic values. But, they are not necessarily sufficient, in and of themselves, for closing it. Other approaches (e.g., pragmatic social learning) may be needed. But existing regulatory and governance frameworks, and the political thinking informing them, would need reviewing and overhauling significantly for this to happen.

8. Conclusion

We began by asking whether regulatory governance addresses the needs of all stakeholders. Arguably, it does not. We see a picture of governance that is closed, expert-led, market-focused, and not responsive to those most affected by decisions. Our view then is that governance does not properly institute social learning. If social learning strategies were to be instituted, this would require resources to be carefully managed due to competing claims on the way those resources are allocated (Vincent-Jones 2011). It would also require regulatory reform. In the end, we have drawn attention to what is an extensive set of provisions – underpinned by policy ambitions to meet the needs of all stakeholders – that represent something significant when analyzed together. We see a deliberate, curious, concealed and important picture of regulatory governance. It consolidates technocracy and the market, and raises new questions regarding the purpose of regulatory governance in crucial areas of public life.

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The Care Quality Commission (Healthwatch England Committee) Regulations 2012

The National Health Service (Clinical Commissioning Groups) Regulations 2012

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

ENDNOTES

[i] The NHS Foundation Trust Directory 2018 lists all NHS Foundation Trust websites. These websites host relevant information on the professional backgrounds of all Trust directors.

[ii] Inserting Schedule 1, para. 6(1A) and (1B) of the HSCA 2008.

[iii] Inserting s 45A(5) of the HSCA 2008.

[iv] Care Act 2014, ss 53–57; The Care and Support (Market Oversight Criteria) Regulations 2015 (SI 2015/314), Reg 3.

[v] *R (Moseley) v Haringey London Borough Council* [2014] UKSC 56.

Table 1 Overview of NHS regulation

Type of activity	Relevant bodies	Overview of tasks
Commissioning	NHS England	CCG oversight
	CCG	Contracting for health care services
Health care provision	NHS Foundation Trusts; private providers	Contracting to provide health care services
Economic regulation	Monitor	Regulating competition
	CMA	Investigating anti-competitive conduct
Health care quality regulation	CQC	Inspection and prosecution
	NICE	Devising quality standards
Consumer championing	Healthwatch England	Providing advice and information

CAG, Comptroller and Auditor General; CCG, Clinical Commissioning Groups; CMA, Competition and Markets Authority; CQC, Care Quality Commission; HSCA, Health and Social Care Act; Local Healthwatch Organisations; NHS, National Health Service; NICE, National Institute of Health and Care Excellence.

Table 2 Constitution of expert authority (commissioning)

Body	Method of constitution	Entities involved in and/or responsible for constitution
CCG	Nomination and appointment	CCG; social services; NHS England
NHS England	Appointment and consent	SoS; non-executive members

Constitution procedure governed by The National Health Service (Clinical Commissioning Groups) Regulations 2012, Reg. 11–13 and The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, Reg. 24. NHS England appointment procedure governed by NHSA 2006, Schedule A1, paras 2–3, as added by Schedule 1 of the HSCA 2012. CCG, Clinical Commissioning Group; NHS, National Health Service; NHSA, National Health Service Act; HSCA, Health and Social Care Act; SoS, Secretary of State.

Table 3 Constitution of expert authority (health care provision)

Body	Method of constitution	Entities involved in and/or responsible for constitution
NHS Foundation Trusts	Invitation; application; eligibility; election; appointment; approval	Individuals; constituents; a qualifying local authority; a relevant university; CoG members; non-executive directors; committee of the chairman, chief-executive and non-executive directors

Constitution procedure governed by NHSA 2006, Schedule 7, paras. 6–10 and 17. CoG, Council of Governors; NHS, National Health Service; NHSA, National Health Service Act.

Table 4 Constitution of expert authority (economic regulation)

Body	Method of constitution	Entities involved in and/or responsible for constitution
Monitor	Appointment and consent	SoS; non-executive members

Constitution procedure governed by HSCA 2012, Schedule 8, paras. 1–2. HSCA, Health and Social Care Act; NHS, National Health Service; SoS, Secretary of State.

Table 5 Constitution of expert authority (consumer championing)

Body	Method of constitution	Entities involved in and/or responsible for constitution
Healthwatch England	Appointment	SoS; Chair; the Committee

Constitution procedure governed by The Care Quality Commission (Healthwatch England Committee) Regulations 2012, Reg. 2–4. Local Healthwatch Organisation, LHO; National Health Service, NHS; SoS, Secretary of State.

Table 6 Constitution of expert authority (health care quality regulation)

Body	Method of constitution	Entities involved in and/or responsible for constitution
CQC	Appointment	SoS; non-executive members
NICE	Appointment and approval	SoS; non-executive members

Constitution procedure governed by HSCA 2008, Schedule 1, paras. 3 and 3A as amended by ss 88 and 89 of the Care Act 2014; The Care Quality Commission (Membership) Regulations 2015, Reg. 3; and HSCA 2012, Schedule 16, para. 1–2. CQC, Care Quality Commission; HSCA, Health and Social Care Act; NHS, National Health Service; NICE, National Institute for Health and Care Excellence; SoS, Secretary of State.

Table 7 Reporting activities (commissioning)

Body	Format	Substance	Addressee	Publication	Reaction
CCG	Plan	How functions/duties will: be exercised; improve services; reduce inequalities; involve public	NHS England; HWB	Yes	HWB may give NHS England its opinion on the matter, but CCG must be sent a copy
	Document	Revisions to the plan	NHS England; HWB	Yes	Not specified
	Annual Report and Accounts	How functions/duties have been exercised; contribution to delivery of joint health and wellbeing strategy	NHS England	Yes	CAG may examine accounts
	Papers	Matters relating to meetings	Not specified	Yes, unless not in the public interest	Not specified
NHS England	Annual Report	How functions/duties have been effectively discharged; extent to which: objectives in mandate met; business plan proposals given effect	Parliament; SoS	Yes	SoS must send letter to NHS England on NHS England's performance
	Annual Accounts	Finances	SoS; CAG	No	CAG to examine accounts and lay before Parliament
	Report	CCG performance assessment	Not specified	Yes	Not specified
	Report	Response to consulta ion on CCG dissolution	CCG; local authority; 'appropriate persons'	No	Not specified
	Business Plan	How functions/duties: will be exercised; will improve service quality and safety; reduce inequalities; involve public	Not specified	Yes	Not specified
	Guidance	Planning; public involvement in planning; involving service-users in care-related decisions, treatment, diagnosis, prevention; payments to providers; CCG dissolution; safety; discharge of CCG functions; obtaining expert advice by CCGs; patient information processing	CCGs; Healthwatch England; registered persons	Yes	Not specified
	Statement and notice	Whether objectives of TSA's report achievable; reasons for not providing a statement on whether TSA objectives achievable	Parliament	Yes	Not specified

Reporting activities governed by: HSCA 2012, ss 23 (inserting ss 13S(1), 13T and 13U of the NHSA 2006), 26 (inserting ss 14W(2), 14Z2(4), 14Z8(1), 14Z11, 14Z12, 14Z13(4)–(6), 14Z14 14Z15(1), (5) and (6), 14Z16(6), 14Z22(3) of the NHSA 2006), Schedule 1, para. 16 (inserting Schedule A1 of the NHSA 2006) and Schedule 2, para. 17(6)–(7); NHSA 2006, s 65F(5) and (6); The National Health Service (Clinical Commissioning Groups) Regulations 2012, Reg. 16(1). CAG, Comptroller and Auditor General; CCG, Clinical Commissioning Groups; HSCA, Health and Social Care Act; HWB, Health and Wellbeing Board; NHS, National Health Service; NHSA, National Health Service Act; SoS, Secretary of State; TSA, Trust special administration.

Table 8 Reporting activities (health care provision)

Body	Format	Substance	Addressee	Publication	Reaction
NHS Foundation Trusts	Annual Report,	Performance, Director's pay, remuneration, expenses	Monitor	No	Not specified
	Accounts and any auditor's report	Finances	Monitor; auditor; Parliament	No	Auditor to carry out audit; Monitor to send consolidated accounts to the CAG. CAG must examine accounts
	Document	Information relating to forward-planning, having regard to the views of the CoG	Monitor	No	Not specified

Reporting activities governed by HSCA 2012, ss 154(4) and (8) (inserting Schedule 7, paras. 24(1A) and (4A) of the NHSA 2006), 156(1) (inserting Schedule 7, para. 26(2)(ab) and (ac) of the NHSA 2006), Schedule 8. para. 17 and NHSA 2006, Schedule 7, paras. 25(4) and (4A) (as amended by s 154(7) of the HSCA 2012) and 27. CoG, Council of Governors; HSCA, Health and Social Care Act; NHSA, National Health Service; NHSA, National Health Service Act;

Table 9 Reporting activities (economic regulation)

Body	Format	Substance	Addressee	Publication	Reaction
Monitor	Annual Report	How functions have been discharged, aims promoted, conflicts in functions resolved, enforcement action	SoS; Parliament	No	Not specified
	Annual Accounts	Finances	SoS; CAG	Yes	CAG must examine accounts and lay copies before Parliament
	Document	National Tariff	Not specified	Yes	Not specified
	Notice	Imposition of financial levies	SoS; NHS England; potentially liable provider; CQC; appropriate persons	Yes	Not specified
	Notice	Consultation on proposals for National Tariff	CCGs; providers; appropriate persons	Yes	Not specified
	Notice	Decisions on local price modifications	SoS; providers; CCGs; appropriate persons	Yes	Not specified
	Notice	Actions to modify conditions; inclusion of special conditions	Licencees; SoS; NHS England; CCGs; CQC; Healthwatch England	Yes	Not specified
	Reference; Notice; Information	Investigations; changes made to references for investigation	CMA; relevant persons	Yes	Report and investigation by CMA
	Register; Licences	Licensees; standard licence conditions	Register available for inspection	Yes	Not specified
	Guidance	Trust administration criteria	CCGs	Yes	CCGs to refer to TSA guidance
	Guidance	Discretionary requirements; enforcement undertakings	Not specified	Yes	Not specified
	Guidance	National Tariff rules; price and service variations	CCGs	No	Have regard to guidance
	Statement	How conflicting duties resolved; actions to review functions/burdens	Not specified	Yes	Not specified
	Assessment; statement	Significant impacts	Not specified	Yes	Not specified
	Notification	Significant service risks; local price modifications	NHS England; CCGs	Yes	Not specified
	Notification	Enforcement action taken	NHS England; CCGs; those who exercise relevant regulatory functions	No	Not specified

Reporting activities governed by HSCA 2012, ss 67(4), (8), 68(4), 69(4), 93(1) and (3), 94(1), 95(2) and (3), 99(3) and (4), 100(2) and (3), 108(1)–(2), 109(1), 110(1), 116(1), (2) and (7), 118(1) and (2), 125(6)–(7), 141(3)–(4), 175(1) (inserting s 65DA(4)(c) of the NHSA 2006); Schedule 8, paras. 17(1), (4) and (7), 19(2)–(3) and 21 and Schedule 10, para. 1, 3, 4 and 6. CAG, Comptroller and Auditor General; CCG, Clinical Commissioning Groups; CMA, Competition and Markets Authority; CQC, Care Quality Commission; HSCA, Health and Social Care Act; Local Healthwatch Organisations; NHS, National Health Service; SoS, Secretary of State; TSA, Trust special administration.

Table 10 Reporting activities (consumer championing)

Body	Format	Substance	Addressee	Publication	Reaction
LHOs	Annual Report	Activities of the organisation; such matters as the SoS may direct; spending	NHS England; CCG; CQC; Healthwatch England; local authority; local authority scrutiny committee	Must be made publicly available	Not specified
Healthwatch England	Annual Report	How functions have been exercised	Parliament; SoS; LHOs	Yes	Not specified
	Report	The views of people who use health services and the needs and experiences of the public; the views of LHOs on the standard of provision and whether or how the standard could be improved	SoS; LHOs		
	Other reports	Matters relating to health care, as appropriate	Not specified	Yes	Not specified

Reporting activities governed by HSCA 2012, s 181(4) (inserting ss 45A(5) and (6) and 45C(1)–(3) of the HSCA 2008); s 227(2)–(4) of the LGPIHA 2007 (amended by s 187 of the HSCA 2012). CCG, Clinical Commissioning Groups; CQC, Care Quality Commission; HSCA, Health and Social Care Act; LGPIHA, Local Government and Public Involvement in Health Act; LHO, Local Healthwatch Organisations; NHS, National Health Service; SoS, Secretary of State.

Table 11 Reporting activities (health care quality regulation)

Body	Format	Substance	Addressee	Publication	Reaction
CQC	Annual Reports and Accounts	How functions have been discharged; service provision; Healthwatch England's annual report; finances; regulated activities; steps taken to implement proposals on service-user involvement	Parliament; SoS; CAG	No	CAG to examine accounts and lay them before Parliament
	Statement	Promotion of service user awareness of functions; ensuring proper regard for service user views; exercise of CQC functions by service users	Not specified	Yes	Not specified
	Report	Assessment of provider performance	Not specified	Yes	Not specified
	Report and Information	Matters relating to CQC functions	SoS, if a request is made	No	Not specified
	Statement; indicators	Performance assessments	Not specified	Yes	Not specified
	Report	Inspections carried out for registration purposes	A person carrying out regulated activity	Yes	Not specified
	Document	Inspections; inspection framework and programme	SoS, inspectors, appropriate persons; persons specified by Order	No	Not specified
	Report; Document	Special reviews and investigations into NHS services	Not specified	Yes	Not specified
	Details	Functions of Healthwatch England	Not specified	Yes	Not specified
	Information	NHS services; regulated activities	Information must be publicly available	No	Not specified
	Information	Enforcement action pursuant to regulations	Not specified	No	Not specified
	Notification	Payment of penalties; offences committed	NHS England; relevant CCG; appropriate persons	No	Not specified
NICE	Annual Report; Accounts	How functions are exercised throughout the year; finances	Parliament; SoS CAG	No	CAG must examine accounts and lay them before Parliament
	Reports and Information	Matters relating to NICE functions	SoS, on request	No	Not specified
	Document	Explanation of NICE's functions and how they are exercised	Not specified	Yes	Not specified
	Statement	Draft quality standards	Not specified	Yes	Not specified

Reporting activities governed by: HSCA 2008, ss 5(1), 39, 46(1), 48(4); s 58(1), 61(2), 81(1), 83(1)–(5), 89(1); and Schedule 1, para. 10, Schedule 4, para. 5(1)–(2); and HSCA 2012, ss 181(4) (inserting s 45A(9) of the HSCA 2008), 234, 242(1)–(2), Schedule 16, paras. 12(1)–(3) and 14(1)–(3). Care Act 2014, s 91(2) (amending s 46 of the HSCA 2008). CQC, Care Quality Commission; CAG, Comptroller and Auditor General; Care Quality Commission; NHS, HSCA, Health and Social Care Act; National Health Service; NICE, National Institute of Health and Care Excellence; SoS, Secretary of State.

Table 12 Non-reporting activities (commissioning)

Body	Format	Substance	Addressee	Engagement opportunity
CCG	Meeting	Commissioning; presenting annual report (meetings closed to the public if substance is confidential or prejudicial to the public interest)	CCG members, but meetings are publicly accessible	Not specified
	Consultation	Planning; how plans take account of health and wellbeing strategy; enabling summaries of views about plans; explaining how views taken into account; reviewing CCG contribution to delivery of joint health and wellbeing strategy	HWB; recipients of primary care in a CCG's area	HWB to provide CCG and NHS England with opinion on the matter
	Consultation	Assessing relevant needs	Appropriate persons	Not specified
	Involvement	Preparation of strategy to meet relevant needs	LHOs; people who live and work in the area;	Not specified
	Involvement	Preparation of commissioning plans	HWBs	Not specified
	Promotion of involvement of service-users	Preventing illness; diagnosis of illness	Service-users, carers and their representatives	Not specified
	Consultation "or in other ways"	Involvement in: planning; development and consideration of proposals/decisions regarding changes	Those to whom services are provided or may be provided	Not specified
NHS England	Advice	Obtaining professional expert advice	Professional expertise	Not specified
	Consultation	Varying CCG's constitution; guidance relating to discharge of CCG functions; CCG contribution to joint health and wellbeing strategy; CCG dissolution	CCGs affected; Healthwatch England; HWB; relevant local authorities	Not specified
	Consultation "or in other ways"	Involvement in: planning; development and consideration of proposals/decisions regarding changes	Those to whom services are provided or may be provided	Not specified
	Meeting	Commissioning (meetings closed to the public if substance is confidential or prejudicial to the public interest)	Board members, but meetings are publicly accessible	Not specified
	Advice	Service safety	Appropriate persons	Not specified

Non-reporting activities governed by HSCA 2012, ss 23 (inserting ss 13Q(2), 13R(4) and 13Z(2) of the NHSA 2006), 25 (inserting ss 14F(4), 26 (inserting ss 14U(1), 14Z2(2), 14Z13(1)–(6), 14W(1), 14Z(8),14Z15(6), 14Z16(4) and 14Z22(1) of the NHSA 2006), 26 (inserting ss 14Z8(3) and s 14Z13(2)–(6) of the NHSA 2006), 192 (inserting s 116(8A) of the LGPIHA 2007), 193 (inserting s 116A(5) of the LGPIHA 2007), and Schedule 5, para. 7(b) (inserting Schedule, para. 1(fa) of the PB(ATM)A 1960). CCG, Clinical Commissioning Groups; HSCA, Health and Social Care Act; HWB, Health and Wellbeing Board; NHS, National Health Service; NHSA, National Health Service Act; PB(ATM)A, Public Bodies (Admission to Meetings) Act.

Table 13 Non-reporting activities (health care provision and economic regulation)

Body	Format	Substance	Addressee	Engagement opportunity
NHS Foundation Trust	Meeting of members	Present annual report, accounts, auditor reports; voting; accountability	Foundation Trust members, but meetings are publicly accessible (members of the public may be refused access for 'special reasons')	Not specified
	Meeting of Directors	Matters relating to Foundation Trust management	Board of Directors, but meetings publicly accessible. The Trust's constitution may exclude the public for special reasons	Not specified
	CoG meeting, held annually or more	Annual report; accounts; auditor reports	CoG members	Not specified
Monitor	Meeting	Economic regulation (meetings closed to the public if substance is confidential or prejudicial to the public interest)	Monitor Board members, but meetings are publicly accessible	Not specified
	Consultation	National Tariff	CCG; relevant provider, appropriate persons	Monitor may not publish the national tariff if CCGs and relevant providers object and percentage of objection below prescribed percentage
	Consultation	Imposition of financial levies	NHS England; potentially liable providers; SoS; appropriate persons	Monitor may not give notice of levies if potentially liable providers object and percentage of objection below prescribed percentage
	Consultation	Producing or revising publishable guidance for the imposition of discretionary requirement and enforcement undertakings	Appropriate persons	Not specified

Non-reporting activities in the area of health care provision governed by HSCA 2012, ss 152(5) (inserting s 18E(1) and (2) NHSA 2006) and 157 (inserting paras. 27A and 28 of the NHSA 2006). Non-reporting activities in the area of economic regulation are governed by HSCA 2012, ss 108(3), 118(13), 120(1)–(3); 141(7), 142(1)–(3) and Schedule 13, para. 2 (inserting Schedule, para. 1(bk) of the PB(ATM)A 1960; NHSA 2006, Schedule 7, para. 13(2)). CCG, Clinical Commissioning Groups; CQC, Care Quality Commission; HSCA, Health and Social Care Act; NHS, National Health Service; PB(ATM)A, Public Bodies (Admission to Meetings) Act; SoS, Secretary of State.

Table 14 Non-reporting activities (consumer championing)

Body	Format	Substance	Addressee	Engagement opportunity
Healthwatch England	Assistance, advice and provision of information	Views of: service user/public needs and experiences; improving standards	SoS; Monitor; local authorities; NHS England; CQC	Respond to Healthwatch England in writing
	Advice and assistance	Contractual arrangements; the carrying-on of LHO activities to: promote and support involvement of local people in commissioning, provision and scrutiny; enable people to monitor and review access to local services, choices relating to them and standards; make the views and experiences of local people known; produce reports about how services can be improved; provide advice and information about access to services and choices; recommend special reviews and investigation	LHOs	Not specified
	Meetings	Consumer championing (meetings closed to the public if substance is confidential or prejudicial to the public interest)	CQC and Healthwatch England Committee members, but meetings are publicly accessible	Not specified
LHOs	Advice, assistance, and information; recommendations	To promote and support involvement of local people in commissioning, provision and scrutiny; enable people to monitor and review access to local services, choices relating to them and standards; make the views and experiences of local people known; produce reports about how services can be improved; provide advice and information about access to services and choices; recommend special reviews and investigation	Healthwatch England; commissioners; local care services	Healthwatch England to advise SoS, Monitor, NHS England, CQC
	Meetings	Health care and treatment quality (meetings closed to the public if substance is confidential or prejudicial to the public interest	LHO members, but meetings are publicly accessible	Not specified
	Recommendations	Improvements in local health care services; service investigations	Healthwatch England	Not specified

Non-reporting activities governed by: LGPIHA 2007, ss 221(2) and 222; HSCA 2012, ss 181(2) inserting Schedule 1, para. 6(1A) and (1B) of the HSCA 2008, 181(4) inserting s 45A(2) of the HSCA 2008; and HSCA 2012, ss 182(4) inserting s 45A of the HSCA 2008 and s 221(2)(e)–(i) of the LGPIHA 2007 and 45C(14) of the HSCA 2008, 181(14) and 189(1) inserting Schedule, para. 1(bl) of the PB(ATM)A 1960. CCG, Clinical Commissioning Groups; CQC, Care Quality Commission; HSCA, Health and Social Care Act; LHOs, Local Healthwatch Organisations; LGPIHA, Local Government and Public Involvement in Health Act; NHS, National Health Service; NHSA, National Health Service Act; PB(ATM)A, Public Bodies (Admission to Meetings) Act.

Table 15 Non-reporting activities (health care quality regulation)

Body	Format	Substance	Addressee	Engagement opportunity
CQC	Consultation	How the Commission will, among service users: promote awareness of its functions; engage in discussion about provision; have regard to the views of service users; and arrange for any of its functions to be carried out by service users; regulations of regulated activities	Persons the Commission considers appropriate	Not specified
	Consultation	Guidance issued concerning the control of infectious diseases	Persons the Commission considers appropriate	Not specified
	Consultation	Drafting guidance on compliance with those requirements imposed by the Secretary of State to secure the avoidance of harm in relation to regulated activities	Persons the Commission considers appropriate	Not specified
	Consultation	Indicators on performance assessment, prior to publication	SoS; persons the Commission considers appropriate	Not specified
	Consultation	Drafting the code of practice on handling confidential personal information; draft document on special reviews and investigations	SoS; NHS England; a person specified by Order; Persons the Commission considers appropriate	Not specified
	Consultation	Issuing guidance in relation to enforcement action; inspection framework and programmes	Appropriate persons; prescribed persons; SoS, inspectors, person specified by Order	Not specified
	Meetings	Health care quality (meetings closed to the public if substance is confidential or prejudicial to the public interest)	CQC members, but meetings are publicly accessible	Not specified
NICE	Consultation	Preparation of, and establishing procedures for, quality standards	Members of the public; appropriate persons	Not specified
	Advice or guidance	Quality matters	SoS; NHS England	Not specified
	Advice and information concerning guidance directed by NHS England	Preparation of commissioning guidance; NICE must also disseminate commissioning guidance in manner specified in a request	NHS England; such persons as may be specified in a request	Not specified
	Consultation[+]	Procedure for giving advice, guidance, information and recommendations	NHS England	Not specified

[+]Duties which may be conferred by Secretary of State (SoS) or NHS England in future regulations.

Non-reporting activities governed by: HSCA 2008, ss 5(3), 20, 23, 24(1), 46(7), 80(3), 81(2), 88(4) and Schedule 4, para. 5(2) and Schedule 5, para. 55(b) inserting Schedule, para 1(bj) of the PB(ATM)A 1960; and HSCA 2012, ss 234(3), 236(1), 237(7) and 241(3). CAG, Comptroller and Auditor General; CQC, Care Quality Commission; HSCA, Health and Social Care Act; Local Healthwatch Organisations; NHS, National Health Service; NICE, National Institute of Health and Care Excellence; PB(ATM)A, Public Bodies (Admission to Meetings) Act; SoS, Secretary of State.