Between a rock and a hard place: Comparing arms' length bodies for public involvement in healthcare across the UK

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ABSTRACT

Arms' length bodies are often seen as a tool of technocratic governance, designed to insulate decision-making from the politicizing pressures of populist influence. This article examines a subset of arms' length bodies in the UK which challenge this convention: agencies which exist to 'champion' the voice of patients and the public in the four NHS systems (England, Northern Ireland, Scotland and Wales). We compare the functions of these agencies on paper and through qualitative interviews in each system which focused on public involvement in major service change (such as closing hospitals). We found that agencies in all four systems had struggled to demonstrate their legitimacy, squeezed between the demands of the elected Governments they answer to, the NHS organisations they are meant to support and challenge, and the publics whose voices they are meant to amplify. We argue that the evolving solutions found in each system demonstrate a foundational tension between locally-legitimate actors and nationally-capable political savvy.

1. Introduction

While patient and public involvement (PPI) in the UK NHS has generated a significant literature, this has relatively rarely focused on organisational reforms and how PPI is administered within the wider health system. Where system reforms have been the focus (for example [1,2]) analyses have rarely been explicitly connected with public administration debates about the creation, reform, and abolition of arms-length bodies and 'third party government' (for an important exception see [3]). This article addresses these gaps via data collected within comparative research into the way that publics are involved and consulted on contentious decisions about hospital services within the English, Northern Irish, Scottish and Welsh health systems. Specifically, it draws on qualitative interviews with policymakers and stakeholders in each system to describe and compare the work of, and reforms to intermediary bodies which exist in each system to support and (sometimes) eval-uate, practices of public involvement within the NHS. Our focus is on the creation, reform and functions (official and actual) of these organisations at the national level. This includes the significance of their relationship with their local branches or offices (where those exist), but our data speaks primarily to the national role.

Within the field of PPI, making major changes to healthcare provision (for example hospital or emergency department closures) is emerging as a key practical challenge for policy and practice on involving the public in healthcare, which has resurfaced unresolved conceptual tensions in this field of top-down 'invited' public participation (for a review, see [4]). Multiple recent studies emphasise the importance of effective public engagement in implementing change, and yet there are also consistent messages about the political and practical difficulties of this work [5,6–8]. Arms' length bodies for public involvement in health, with their responsibilities for representing the public, supporting healthcare organisations to involve the public better, and in some cases assuring the involvement that takes place, are a key actor in this knotty area of contemporary policy. In this paper we ask: what functions are fulfilled by this peculiar category of arms-length bodies? And why has this role endured repeated structural reorganisations and 'bonfires of the quangos' over a period of decades?

The waxing and waning of governmental enthusiasm for arms' length bodies have been one of the central concerns within

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the discipline of public administration in recent decades [9,10]. Defined by Durose et al. [11] simply as "a broad class of organisations that undertake a variety of public functions that otherwise could be located in a governmental department or ministry", Pollitt's [10]'working definition' adds: a status defined in public law, some degree of autonomy from the ministry while retaining a link (whereby central government can for example amend its functions and budget), having and exercising some public *authority* and not being a commercial entity. Literature variously refers to these as 'quangos', 'non-departmental public bodies' or, in Skelcher's [12] evocative phrase an 'appointed state'. Arms-length bodies initially grew in popularity as a New Public Management innovation, importing private sector rationalities and management styles into the state bureaucracy in ways that could remain bounded and therefore distinct. Much of the literature on arms-length bodies is centrally concerned with their emergence and their endurance (or otherwise) through changes of Government [13,14]. This article responds to calls made by several authors for greater, primarily qualitative attention to be paid the functioning, not merely the survival, of such organisations [9,15].

We focus specifically on the democratic consequences of arms' length bodies as a form of health policy. From the dominant perspective of agency theory, the proliferation of arms' length bodies in contemporary democracies is a threat to accountability and transparency. The trend is associated with 'expertisation' whereby policy areas are 'rendered technical' [16]; "mechanisms by which governing elites remove complex and contested issues from the public agenda" [17]. However more positive accounts of the work of arms' length bodies also exist. These have identified alternative narratives of arms' length bodies as defenders of particular forms of expertise in the public interest [18–20]. Boswell's [17] comparison of the Food Standards Agency and NICE explores the value of arms' length bodies as boundary workers, coordinating the action of state and non-state actors (such as professional associations and patient groups). Durose et al., drawing in particular from literature on the legitimacy or otherwise of *trans*national arms' length bodies, suggest that agencies can be "a means of reducing the privatism of elite partisan bargaining by protecting the participation rights of actors who otherwise would be marginalized" [11]. In this interpretation, arms' length bodies can be a force for *more* democratic approaches to policy-making, defending publics, especially minorities, from the vagaries of electoral turmoil and the elite bargaining that results.

However delivering on this potential as an arms' length body entails juggling several roles. A specific literature within management studies on regulatory arms' length bodies, while not centrally concerned with legitimacy or democratic contribution, offers some valuable lessons here. Comparing healthcare quality regulators working in the English, Welsh, Northern Irish and Scottish health systems, Furnival et al. [21] outline some of the challenges of simultaneously trying to support organisations to improve their performance, and assessing or assuring that performance. Such tensions between developing enough organisational trust and 'know-how' to effect change, while still being seen to be independent and impartial, are highly relevant to the topic of this paper. What makes the arms-length bodies discussed in this article particularly intriguing is their status both as centralised agencies of the state (conventionally assumed to be deleterious in their democratic consequences) and as 'champions' of the people (a framing which draws upon either explicitly democratic sentiments, or otherwise a more consumeristically framed concern with individual citizens).

Table 1
Interviews conducted.

Professional location of interviewees	Number of interviewees	Total
Scotland		**6**
Scottish Government officials	1	
Senior staff at intermediary body	3	
Experts with experience of policy advisory role	2	
England		**7**
Officials at Department of Health and NHS England	3	
Senior staff at intermediary body	1	
Experts with experience of policy advisory role	1	
Senior staff in consultancies employed to advise on or deliver consultations	2	
Northern Ireland		**7**
Department of Health officials	2	
Senior staff at NHS agencies	3	
Experts with experience of policy advisory role	1	
Senior staff at intermediary body	1	
Wales		**6**
Welsh Assembly Government officials	2	
Senior staff at NHS agency	2	
Experts with experience of policy advisory role	2	
TOTALS		**26**

2. Materials and methods

Within the UK there are four distinct health systems (in England, Northern Ireland, Scotland and Wales), which, while all 'NHS systems' have different organisational structures and, to a lesser degree, different commitments to providing healthcare free at the point of use [22]. There remains a dearth of literature which effectively compares the divergence of these emergent health systems, and particularly studies which take on the meso level of governance – the actors and practices which exist between the pronouncements of politicians and the perceptions of and outcomes for citizens [23]. This paper draws on a comparative four system study at this level.

We analysed written guidance and regulations around involving the public in major service change, including developing our understanding of differences in terminology between the four systems. On the basis of these searches we identified key individuals and organisations to approach for interview. Between May 2016 and February 2017 semi-structured interviews were conducted with 26 key informants working at the national level on or around policy for public involvement in major service changes (see Table 1). Our interviewees include: civil servants working on public involvement or service change within all four administrations; representatives of the intermediary bodies which 'champion' public involvement within each system; and relevant staff from other agencies with oversight of public involvement, major service change, or both. A notable gap within our national sample is the national Board of Community Health Councils in Wales, who we repeatedly tried and failed to contact. We supplemented interviews with documentary sources wherever possible, in order to add context to the perspectives shared in interviews. Carter and Martin's [24], p. 709) ethnographic research in the English context describes a "gap between rhetoric and reality" around policy in this area. Our study, by contrast, did not include any observational data collection: our comparative focus necessitated relying on documents and interviews in order to cover the necessary ground of four health systems.

Interviews were audio-recorded where possible (23 of 26 interviews, with detailed notes taken of the remaining 3) and questions covered: the interviewee's role in public involvement and major service change, key developments in policy for involving the public in service change, perceived strengths and weaknesses of the current system. We also conducted case studies of two specific examples of contentious service change per country, including interviewing members of the public campaigning against changes: these are not significantly drawn upon in this paper and are reported elsewhere [5].

Transcripts or written notes of interviews were analysed using NVivo software. Using an approach based on the Framework method [26], we identified a list of key themes based on discussion among all four authors. Authors 1 and 2 separately coded the same three transcripts to pilot the themes. Following further discussion, we amended our themes, and coded the rest of the data. Following analysis we undertook a process of respondent validation focused on checking for comprehensiveness and error reduction [27]. This included a roundtable discussion of preliminary findings with representatives of all four nations in September 2016, and a written briefing circulated for comment. This process allowed us to test our interpretations, and identify points of disagreement or uncertainty. We conducted a further three interviews to explore resulting issues (these interviews are included in the list of national interviewees in Table 1).

Ethical approval for the study was formally granted by [author 1's institutional ethics board]. As per this approval, and particularly in light of the sensitivity of some of our interviewees around changes which had attracted significant political and media attention, where quoting from interviews we have grouped interviewees into generic categories of professional location – official (including both civil servants and senior staff in NHS agencies), expert (including members of independent panels, and other policy advisors whose primary professional location is academic), consultant – in order to avoid individuals being identifiable. Within these groups we have specified the location (England, Northern Ireland, Scotland or Wales) and allocated numerical identifiers to individuals.

3. Results

In this section we will summarise the key formal functions of the four organisations, and then describe how interviewees described their roles in pratice. The structure, budget and statutory purposes of the four arms' length bodies at the time of our study in 2017 are as presented in Table 3. The statutory purposes cite different constellations of: the public, patients, and consumers; the Government: and local NHS organisations. Both Healthwatch (England) and the Patient and Client Council (PCC) (Northern Ireland) are designed to 'champion' and 'provide a powerful voice for' the public, while the Scottish Health Council and the Board of Community Health Councils (Wales) are more NHS-oriented, promoting public involvement in the NHS and monitoring the performance of local Health Councils respectively.

Klein and Lewis [28], p. 11) describe the first structures for PPI in the NHS as "invented almost by accident... their subsequent evolution and the uncertainties about their role reflect their improvised beginning". This spirit of improvisation is reflected in the frequency of reform and abolition of such bodies in the intervening years, as depicted in Table 2, which summarises a chronology of key reforms of the structures for public involvement around the NHS in each of the four systems. The Welsh replacement of Community Health Councils with a new 'Citizen's Voice' agency in 2019 took place beyond the timescale of our study, and yet demonstrates the general trend of reform but not removal of these functions. The amount of change is significant, although this varies in magnitude from the

sudden, and poorly consulted-on abolition of Community Health Councils in England in the NHS Act 2000 [2], to the thoroughly evidenced, incremental, but essentially unimplemented reforms to Welsh Community Health Councils in 2012 [29]. Structures have been subject to fairly regular reform (whether 'tinkering' or wholesale replacement) and yet in the last 30 years no part of the UK has been without an arms' length structure for PPI for any significant period of time. The relative 'stickiness' of some form of national agency for PPI within the four UK health systems is notable. This is particularly so when compared with relatively similar health systems like Canada and New Zealand, where public involvement has often been high on the policy agenda but which have no similar governmental agency for its promotion.

While there are important differences between the structure and role of the four organisations, our research suggested common tensions in the dual roles of supporting NHS organisations to involve the public, and providing Central Government and the wider public with assurance of the quality of that involvement. Intermediary organisations in all four countries were close to, but attempted to demonstrate independence from, political conflict over major service change. Interviewees in both Scotland and Northern Ireland stressed that the role of intermediary organisations in service change is limited to supporting and assuring the process of public involvement, rather than wider questions about the wider virtues of the decision.

"It seemed to me a role that's essentially being a referee... And it seemed to me at the time that they were probably equally unpopular with both the boards and with campaigning groups." (official 4, Scotland)

In Wales, interviewees described tensions where local CHCs had become involved in conducting consultation activities, rather than assessing their appropriateness or quality:

"carrying out their own engagement with the public on the proposals that had been put and then process[ing] that intelligence and represent[ing] it to the health board in the way they thought appropriate" (Expert 1, Wales).

Functions of conducting community engagement, and of assuring it, were here seen to be in tension, and in one case campaigners requested a judicial review of one CHC's decision *not* to refer a service change to the Minister [30]. Interviewees expressed concerns about the appropriate role for CHCs, as reflected in several independent reviews [31,32] and in their eventual replacement, shortly after our study concluded.

Similar tensions in the intermediary role in Scotland in the late 2000s had led to an independent review of the Scottish Health Council and the centralisation of major service change functions into the national office.

"It wasn't great with that assessment role sitting with an improvement role, you know, staff going to the boards one day saying 'we're here to support you' the next they're going and saying 'now we're going to assess what you've done'" (official 4, Scotland).

Removing the service change role from local offices was perceived as allowing local officers to improve their relationships with both Boards and the community, while the national Service Change Team became a more specialised resource for difficult changes. In Wales, this national role was via central Government. Officials described their own role in "light touch oversight" of change processes to avoid both CHC referrals to the Minister, and judicial review:

"we help to facilitate and broker a discussion and agreement... The previous Minister ...has been very specific in saying if

Table 2
Timeline of key reforms to public involvement agencies in the four systems.

	Wales	England	Northern Ireland	Scotland
1974	Creation of Community Health Councils (local) and Association of Community Health Councils in England and Wales (national)			Creation of Scottish Association of Health Councils (national) and Local Health Councils (local)
1991		Creation of Health and Social Services Councils (local)	Number of Local Health Councils reduced	
2000	CHCs grouped into nine federations			
2003		Abolition of CHCs Creation of Centre for Public and Patient Involvement in Health (national) and Public and Patient Involvement Forums (local)		
2004	Board of Community Health Councils (national) created			
2005				Creation of Scottish Health Council (national, with local offices who support local Public Partnership Forums
2008		Creation of Local Involvement Networks (local)		
2009			Creation of Patient and Client Council (national, with local offices) and Public Health Agency	
2010	New regulations reduce number of CHCs to eight.			
2011			Health and Social Care Board publishes a critical review, stating that patients are not aware of the PCC and their rights to complain about services. A communications campaign is launched in response.	
2012	Formal review of Community Health Councils recommends changes	Creation of Healthwatch England (national) and Healthwatch (local) put out to tender by local authorities.	Departmental guidance clarifies that PHA leads implementation of policy on PPI, while PCC promotes public involvement in decisions.	
2016		Healthwatch England (national) budget cut by x% and office moves into that of the Care Quality Commission.		
2017	Critical review of the Board of CHCs. Formal review of the organisation launched.			Critical review of the Scottish Health Council from Scottish Parliament Committee. Healthcare Improvement Scotland launch a formal review of the role of the organisation.

something comes to the stage where there's a formal referral to Ministers, it's a failure of the system. So we're custodians of that system and have a duty to make it work." (official 1, Wales).

England's greater fragmentation and scale makes such central oversight challenging. At the time of our study the English arms' length body was in a state of flux. The intermediary role in England has been subject to greater change than in any of the other three systems. Healthwatch England, established in 2012, had its role shifted (and budget slashed) in 2015 to one of coordinating and supporting local Healthwatch, shifting away from national work: "a lot of that... was a bit top down and what we're trying to do now is be very bottom up" (official 4, England). Local Healthwatch branches must win contracts from local authorities and as other research has noted [33] Healthwatch is easily overlooked. Interviewees acknowledged that a key challenge was simply "being able to participate in the development of [local] plans and just being recognised" (official 4, England). While similar challenges were described around the Scottish Health Council's early relationship with Boards, interviewees suggested that this had improved over time as the organisation had become established. Concerns about

local Healthwatch branches being funded by, and thus accountable to, commissioners [33] were not evident within our interview data.

In Northern Ireland, effectively influencing local organisations while demonstrating the independence of the Patient Client Council was similarly seen as a challenge:

"There's room for co-operation absolutely and co-ordination [between Trusts and] the PCC, but if you're not careful... it could compromise the PCC. Number one they're funded by government and number two then if they started to conduct our involvement exercises you could have a significant question of their independence." (official 6, Northern Ireland)

This concern was part of the rationale for separating the work of supporting Trusts to improve their involvement practice (which sat instead with the Public Health Agency) from speaking for patients and clients. This latter task was clearly the primary focus of the PCC, which was focused more on individuals and their experiences, rather than the wider community angle of their counterparts in other countries. Questions of capacity and resources, which loomed large across our Northern Irish fieldwork, were significant in this:

Table 3
Key characteristics of the contemporary organisations at 2017.

	Healthwatch	Scottish Health Council	Patient and Client Council	Community Health Councils
Country	England	Scotland	Northern Ireland	Wales
Existed	2012-present	2005-present	2009-present	1974 (multiple reforms since. Board of CHCs created 2004)-present
National or local focus	Locally-focused - small national organisation.	Nationally-focused, with local offices.	Nationally-focused, with local offices	Locally-focused - small national organisation.
Role in major service change	Varies by local context.	Advice to Board and formal report to Government.	Informal advice.	Formal approval required; can refer a decision to Government.
Annual budget in 2013/2014	£4,100,000	£2,424,000	£1,781,400	£3,854,000
Statutory purpose	Healthwatch England is a national, independent consumer champion for health and social care in England.	The Scottish Health Council promotes Patient Focus and Public Involvement in the NHS in Scotland. A key aspect of our role is to support NHS Boards and monitor how they carry out their statutory duty to involve patients and the public in the planning and delivery of NHS services.	The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:	The Board of Community Health Councils in Wales is responsible for monitoring the performance of the Community Health Councils (CHCs), the conduct of members and performance of officers as well as operating a Complaints Procedure.
	We provide leadership, support and advice to the wider Healthwatch network.	The SHC has several core functions:	• To represent the interest of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organizations to ensure that the needs and expectations of the public are addressed in planning, commissioning and delivery of health and social care services.	Seek the views of patients and the public on local services and use that information to inform our work with the NHS.
	We have powers to ensure the consumer's voice is heard by those who make the decisions.	• Community Engagement and Improvement Support- Providing proactive and tailored support for NHS Boards.	• To promote the involvement of patients, clients, carers, and the public in the design, planning, commissioning and delivery of health and social care.	Act as the public voice in letting managers of health services know what people want and the improvements they would like to see.
	We tell government bodies and local authorities in England about our findings, and report to Parliament every year.	• Participation Review- Reviewing and evaluating NHS Board's approaches to involvement through the Participation Standard.	• To provide assistance to individuals making or intending to make a complaint relating to health and social care.	Be consulted by the providers of local health services about any changes to health services within your area.
	We can also ask the health and social care regulator, the Care Quality Commission, to take action when we have special concerns.	• Service Change- Supporting the NHS Board to meet the requirement to involve people when planning or changing local services.	• To promote the provision of advice and information to the public by the HQC about the design, commissioning an delivery of health and social care services.	Inspecting NHS premises and make recommendation for improvement where necessary.
	(Source: Healthwatch Business Plan 2016–2017) http://www.healthwatch.co.uk/resource/our-business-plan-2016-17	• Participation Network- A centre for the exchange, support, development and ideas.	Source: http://www.patientclientcouncil.hscni.net/about-us/who-we-are-what-we-do	Scrutinising the NHS and work with service planners and providers to improve the patients experience of services
		• Volunteering in NHSScotland and Programme- Supporting NHS Boards to develop sustainable volunteering programmes.		Help, advise and support people who wish to make a complaint about NHS Services.
		Source: http://www.scottishhealthcouncil.org/about_us/what_we_do/what_we_do.aspx#.WddQLBNSzC8		Source: http://www.wales.nhs.uk/sitesplus/899/page/71598

"We're a small organisation in quite a big infrastructure [so] we try to provide a voice for those who have no voice, for those who haven't been heard" (official 3, NI).

In Northern Ireland, the PCC seemed to have focused on leveraging marginalised patient experience to influence national policy, rather than on shaping local organisational practice. The Public

Health Agency, meanwhile, had led on "the development of standards for PPI which was done in a very. . . collegiate way with all of the other HSC [health and social care] partners, service users and carers" (official 6, Northern Ireland).

There is a distinct difference in approach in whether agencies focus on eliciting and communicating public perspectives directly to Government (as Northern Ireland's Patient Client Council does) or instead advocate for and develop NHS capacity for practices of local engagement (epitomized by the Scottish Health Council). Here the work of local offices situated within communities is particularly significant in both England and Wales, with less focus on transmitting these views upwards for national campaigns. Befitting their network development focus, in England national Healthwatch staff described having collaboratively produced guidance on service change for local branches via a social media-like IT system and an online hub: "that's not all on our website. . . they're both password controlled, so a lot of the stuff we do isn't evident" (official 4, England).

At the point of our research, Healthwatch was thus focused on practice support for local branches, rather than on campaigning around public issues.

The PCC's explicit focus on 'unheard' stories - the plight of women suffering from endometriosis as an example – is a distinctive approach in keeping with Northern Ireland's longstanding concern with equalities issues. More conventionally, they also conduct regular data collection via questionnaires (reported as 'The People's Priorities' [34]), and collate complaints received. In terms of eliciting public perspectives, all the organisations seem to rely most heavily on a combination of survey-based research exercises, focus groups, and sharing of information from local offices. Notably, when the Scottish Government created 'Our Voice Scotland' as a quasi-deliberative exercise to engage the public in health and social care improvement, it located this outside (although working closely with) the Scottish Health Council. Likewise the ambitious but ill-fated 'NHS Citizen' experiment in England [35] was not spearheaded by Healthwatch, but by NHS England. These decisions can be read as a tacit admission that the role of arms-length bodies is seen as less about championing public views, and more in regulating how effectively local organisations manage their own public input.

4. Discussion

The creation of arms' length bodies is an enduringly popular option for politicians, but their abolition seems to have similarly enduring appeal for incoming administrations. The lesson of several documented periods of dramatic system reform is that headline announcements often mask a much more complex set of continuities and accommodations [36,37]. Why, given the regularity of review and reform, has the existence of arms' length bodies for PPI endured for decades? Other scholars have argued that a compelling storyline of the unique value of an organisation is crucial [19]. Arguably, in the case of these intermediary bodies their storyline is significantly detached from many of their actual functions. Few of the functions envisaged for the original Community Health Councils remain and at times the presence of *a* national agency for public involvement in health looks more like a policy placeholder; a symbolic gesture as much as a statement of intent.

Nonetheless our primary focus here is on understanding via our comparative study the advantages and challenges of different approaches to the intermediary role. Boswell [17] argues that rather than a specific skillset, the boundary status of the arms' length bodies he studied is central to their effectiveness; "their capacity to enable ongoing coordination while preserving the authority and autonomy of relevant expert spheres". Certainly those interme-

diary organisations which have endured have done so by careful evolution and expedient political management. However it is relations with an explicitly 'inexpert' sphere that gives this group of agencies their particular character. The task of championing a unified 'patient and public' interest is key: while the defining purpose of many ALBs is contested, it is hard to think of many where their role includes such diversity of intention, and so few acceptable methods of assessment of the appropriate stance on any given issue. Lehoux et al. [38] have written of the 'unbearable lightness of citizens' in processes of public deliberation on health policy, and the notion of a singular public will on many issues is, in political theory terms, a 'foundational fiction' of democracy [39]. As discussed above, techniques of hearing from the public in these agencies have largely remained traditional. The potential of digital technologies to hear from more people at lower cost had, at the time of our research, been only minimally taken up by any of these organisations, and this space had been filled by independent platforms which collect and transmit patient experiences of treatment direct to providers [40]. None of the intermediary organisations were at the cutting edge of novel approaches to eliciting and communicating public preferences on health services.

This is, we would argue, closely connected to these organisations' precarity within evolving health systems, and their realistic sense that survival depends more on Government whim than the patients and publics they speak for. While we interviewed people within these organisations passionately committed to engagement, it was apparent that the public is not their key constituency. Rather their organisational success rests on invoking and representing 'the public' in politically-acceptable ways, while navigating between local NHS organisations and central Governments. In moments of heightened political conflict about local decisions, arms' length bodies need to preserve their relationships with firstly, central Government, secondly, the local NHS organisations they seek to influence, and only finally, with the wider public. This tendency to look 'upwards' not 'downwards' is practically reflected in tensions around the relative allocation of resources and personnel between the national and local levels. In this, the local level has the advantage of involving recognisable functions which matter to citizens (eg specific services). Devolution of decisionmaking (and its attendant tasks) to the local level has been a strong current in governmental abolition of arms' length bodies [19]. The cuts in budget for Healthwatch England's national office, told to recreate itself merely as a 'network coordinator' and not as an actor in its own right, speak to a desire for localism. The difficulties that the Board of Community Health Councils in Wales has had in coordinating and reducing variability in quality of the Community Health Councils speak to a lack of national control. By contrast, the concentration of the Scottish Health Council's functions into the national office had the effect both of unifying practice, and of building expertise in the national office.

5. Conclusion

The very existence of governmental agencies with a remit to champion the public within health systems can be seen as a peculiar paradox; both a statement of commitment to democratic public administration, and an admission of the failures of health policy via representative democracy. Klen and Lewis [28], p. 151) argued four decades ago, that having created such organisations, political expediency dictated their retention to avoid the appearance of disrespecting "democracy, participation and consumerism – vague but vogue terms all". Studying the work of these agencies in practice only reveals further tensions.

Knowledge about how best to involve different publics is less-conventionally recognised as expertise than other parts of reg-

ulation (such as audit, or health technology assessment). Indeed the very respect for widely-distributed 'lay' knowledge which grounds much public involvement practice sits in uneasy tension with the idea of elevated expertise [41]. Nonetheless, perceptions that PPI could be organised more or less effectively was widespread among our interviewees, who identified this as valuable expertise. Multiple commentators have pointed to the problematic *loss* of expertise and institutional knowledge which has accompanied some of the more sweeping reforms of public involvement structures [1,2]. If substantial functions and responsibilities are to be located at the local level (in search of local engagement and legitimacy), then there is likely a need for substantial investment in training and support for these local offices, and on 'niche' or relatively infrequent matters (such as a contentious hospital closure) there is a strong argument for investing in stable national expertise.

However as well as supportively developing organisational capacity, these agencies also have reporting and oversight functions which might require a different set of skills and abilities. Furnival et al. [21] have persuasively outlined the challenges of trying to establish hybrid models of regulation, where regulatory arms' length bodies both work to support improvement and to detect failures in performance. This tension was a recurrent theme for arms' length bodies for PPI in Scotland and Wales, where they had a formal role in assuring the service change process. Avoiding it was seen as one advantage of the Northern Irish model, where the PCC's lack of procedural responsibility was seen as enabling it to advocate for causes more freely. Combining the work of regulating public involvement, and of championing those publics, is an unenviable balancing act which, at the time of our research, often seemed to elude the arms' length bodies discussed here.

CRediT authorship contribution statement

Ellen Stewart: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing - original draft. **Angelo Ercia:** Data curation, Formal analysis, Investigation, Writing - review & editing. **Scott L. Greer:** Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Writing - review & editing. **Peter D. Donnelly:** Conceptualization, Funding acquisition, Writing - review & editing.

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