Reconfiguring the Department of Health's Arm's Length Bodies

DH Department of Health

NHS

Reconfiguring the Department of Health's Arm's Length Bodies

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Introduction

1. Since *The NHS Plan* (2000), investment and reform have significantly improved outcomes for patients. At national level, the Department of Health has driven the reform, setting a clear and ambitious framework. Also at national level, but at "arm's length" from the Department, a network of organisations has been created to regulate the system, improve standards, protect public welfare and support local services. These "arm's length bodies" (ALBs) have contributed significantly to the pace of change described in *The NHS Improvement Plan* published last month.

2. Strong national leadership was needed to give momentum to overhauling and modernising the system, but only as a prelude to what has since been unprecedented devolution of power and responsibility to frontline staff and patients. The *Shifting the Balance of Power* programme and the creation of locally accountable NHS Foundation Trusts have strengthened power at local level, with Strategic Health Authorities holding Primary Care Trusts to account for the services they commission. Over the next few years, the balance of power in the NHS will continue to shift towards the frontline, as mapped out in *The NHS Improvement Plan*. Now, at national level, the Department of Health is undergoing a radical transformation, reducing in size by over a third to focus on strategic direction and holding the whole system to account.

3. Devolution is possible within a national service because a clear framework of national standards has been established, overseen and supported by key ALBs such as the Healthcare Commission. But the wider network of ALBs built up over the years is now too cumbersome in the context of devolution. To remain relevant, the ALB sector must reflect the shifting balance of power towards frontline staff and patients. It needs to be coherent and fit for purpose in this context. This thinking underlies the first thorough-going review of ALBs for many years.

4. Part 1 of the report outlines a new approach to the Department of Health's ALBs. A new configuration that reduces the number of ALBs from 38 to 20 is set out in Part 2.

5. Part 3 summarises the approach that will be taken to achieve the reconfiguration. Implementation plans will be required to reduce the cost of the ALB sector by at least £0.5 billion and the number of posts by around 25%, by 2007/8. No ALB will be exempt from the need to become more efficient.

1

A new approach to arm's length bodies

Background

1 "Arm's length bodies" (ALBs) are stand-alone national organisations sponsored by the Department of Health undertaking executive functions. The work they undertake ranges from back office administrative functions to complex ethical or clinical-related work. Examples of their long list of functions are: paying dentists; countering fraud; blood collection and processing; ensuring the ethical conduct of embryology research and infertility treatment; maintaining surveillance to detect emergence of new diseases like SARS; improving the safety of care; and reducing the number of mistakes that can prove fatal to patients.

2 ALBs range widely in size but normally have boards, employ staff and publish accounts. ALBs are accountable to DH and sometimes directly to Parliament. Most of the ALBs receive substantial funding from DH.

3 There are three main types of ALB:
- Executive Agencies of the Department of Health;
- Executive Non-Departmental Public Bodies (set up in primary statute with their own powers);
- Special Health Authorities (set up in secondary legislation to perform functions delegated to them by the Secretary of State).

4 This review does not cover expert committees (also known as Advisory Non-Departmental Public Bodies) such as the Committee on Safety of Medicines, or tribunals such as the Mental Health Act Tribunal.

5 The first ALB to be established formally was the Dental Practice Board in 1948. A number of current ALBs were established in the 1970s, although a 1979 review led to some rationalisation of the then configuration. Several more current ALBs were created in the early 1990s. After 1997, the desire to focus independent action on key areas and respond to gaps in the regulatory structure required an

expansion in the number of ALBs. In 2003/4 there were 38 ALBs. In that year, the sector as a whole spent a total of £4.8 billion, including operating costs of £1.8 billion, and employed staff in around 25,000 posts.

Drivers behind the Review

6 In an increasingly devolved and diverse local delivery system, there will continue to be a need for ALBs to provide high profile co-ordination and cohesion. But the view of many frontline staff is that ALB activities are often associated with considerable levels of bureaucracy, and that co-ordination and cohesion is not always offered with a whole system approach in mind. The sheer number of ALBs is a diversion for frontline staff and there is a strong view that ALBs do not try hard enough to minimise the time that needs to be spent by frontline staff in responding to their requirements.

7 ALBs need to be streamlined in number and functions but must also adopt a different approach, continuing to deliver their functions effectively but minimising the burden on frontline staff. The ALBs need to drive this new approach with real commitment.

8 Lifting burdens goes hand in hand with increased efficiency. The ALB Review is a significant component of the Government's drive to make the public sector more efficient following the publication earlier this year of the Gershon Efficiency Review. Linked with this, the review carries forward the principle of the Lyons Review, that public sector jobs should be relocated away from London and the South East.

9 Joint working between health and social care services at the local level is continuing to improve. The health and social care ALBs are working increasingly closely together and links between them should be forged and maintained.

10 The 5 key drivers behind the Review are:
- Devolution to the frontline
- Appropriate impact for minimal burden
- The Gershon Efficiency Review
- The Lyons Review of public sector re-location
- Taking an overview of ALBs across the health and social care system

11 From the work carried out during the scoping stage of the Review it was clear that:
- Some national functions performed by ALBs are vital to safeguard the health and welfare of the population
- ALB-style agencies are an important feature of other major health systems around the world
- ALB functions overlap and could be integrated to build synergy and reduce overheads
- Some activities are over-burdensome
- Back office functions (HR, finance, IT, estates) could be done more efficiently
- Some functions could benefit from greater stakeholder control, especially from the NHS
- There is scope for significant efficiency and productivity gains particularly in the ALBs providing central operational functions for the NHS

Key principles for ALB sector

12 The following 10 principles have been developed, based on the drivers and background to the review, to apply to the ALB sector:

i) Devolution to the frontline: functions will only be exercised at the national level where it makes the most sense, for example to ensure that patients and public are not put at risk.

ii) Contracting out to the independent sector will be considered where a case for national functions rests on economies of scale. Where the independent sector has the developed capacity to provide a cost-effective service to the necessary scale, good reasons will be needed to keep the service in the public sector.

iii) The number of ALBs will be kept to a necessary minimum. Each ALB will have a remit consolidated from functions in related areas or similar business processes. The remits of ALBs will be clear and distinct.

iv) Where an ALB is needed now but not in the long term it will be set up for a fixed term. All ALBs will be reviewed regularly to make sure that they are still fit for purpose.

v) Setting policy is the role of DH not ALBs. ALBs will often have a role in policy development and implementation.

vi) ALBs will be expected to undertake their functions effectively with the minimum bureaucratic burden on the service. ALBs will work together, taking account of the whole system perspective not just their own. They will focus on outcomes not processes, setting parameters rather than micromanaging.

vii) Back office functions will maximise economies of scale while meeting the support needs of each ALB. Budgets will be benchmarked to ensure efficiency.

viii) Where ALBs provide services they will need to be more responsive to their customers. This may be helped by changes in governance. For the NHS, the "Top Team" forum (of DH and NHS leaders) will maintain an overview of the added value and responsiveness of each ALB. High-performing ALBs will enjoy a greater degree of freedom from DH control.

ix) ALBs will not be funded centrally for the services they provide to frontline organisations or the overheads they incur, wherever cost-effective charging systems can be developed. Regulatory ALBs will seek full cost recovery wherever appropriate.

x) ALBs will be expected to locate outside London and the South East wherever possible.

Implications of the new approach

13 **Less bureaucracy**. Strong guidelines and management are sometimes essential to ensure safety, quality and accountability for the use of public funds. Not all bureaucracy is bad, but it needs to be reduced. ALBs are now subject to a simple gateway process run by DH to restrict their output of guidance and paperwork. In addition, a concordat has recently been signed by relevant ALBs to cut the number of inspections and enquiries and the amount of paperwork generated.

14 ALBs will be required to monitor the effectiveness of these and other arrangements to reduce bureaucracy and to measure their success, for example through customer surveys. ALB Chief Executives will be held accountable for this.

15 **Streamlined ALB sector**. Fewer ALBs will mean fewer central organisations for frontline staff to deal with and less resource tied up in the essential overheads associated with separate bodies, e.g. boards, governance.

16 **Reduced intervention by ALBs.** Where appropriate, the threshold for ALB involvement and intervention in frontline activities will be rolled back.

17 **Appropriate sponsoring and commissioning relationships for ALBs.** The Department will always need to sponsor each ALB to ensure that the strategic policy is being delivered and that public money is being used appropriately. In future, the relationships will vary depending on the function of the ALB as well as its statutory form:

- **Regulation** – ALBs in this category hold the health and social care system to account. They often have their own primary powers and substantial independence from direction by the Secretary of State. Nevertheless, the Department remains sponsor.
- **Standards** – ALBs in this category establish national standards and best practice. In future, to reflect devolution, the sponsorship role will be shared with the NHS Top Team.
- **Public welfare** – ALBs in this category are focused primarily on safety and the protection of public and patients. DH's sponsorship role is derived from central government's responsibility to secure public welfare, and prevent unnecessary deaths and harm, in the face of challenges that can range between local, national and international settings.
- **Central services to the NHS** – these ALBs provide economies of scale and focused expertise. Such services can be commissioned by the recipients of the services and run with commercial discipline. Commissioning will be overseen by the NHS Top Team, either itself or using a lead Strategic Health Authority.

18 Networks will be developed around these four categories to enable ALBs, the Department and others to engage together in strategic discussions, plan ahead and resolve problems. At the same time, a risk-based approach to managing its relationships with ALBs is being developed by the Department with input from the ALBs. The new approach will enable ALBs to enjoy a greater degree of management independence from the Department provided they continue to discharge their responsibilities to a high standard. This will reduce the level of day to day bureaucracy that can exist between the Department of Health and the ALBs.

19 **Devolution of ALB functions.** For large scale, central service functions, alternative organisational models exist and are being developed based on not for profit, stakeholder governance. These models combine commercial discipline with public sector safeguards and can be operated within a national framework of standards and inspection. The NHS Foundation Trust model is one example. The company limited by guarantee (e.g. the Social Care Institute for Excellence) is another. There is a Bill currently before Parliament to establish a new model - the community interest company (CIC). CICs will offer the flexibility and certainty of the company form but with special features to ensure they benefit the community. CICs will report to an independent regulator based in Companies House on how they are delivering for the community and how they are involving their stakeholders in their activities. CICs are intended to encourage social entrepreneurship but it is possible that the NHS or the Department could contract with a CIC for the delivery of certain services.

20 **UK wide arrangements.** Many of the ALBs cover other UK countries besides England (whether legally or by service level agreement) and those that do not are usually mirrored by parallel arrangements in the other countries. The ALB Review will be implemented in line with the Devolution Settlements. The Department will work closely with the National Assembly for Wales, the Scottish Executive and the NI Department of Health, Social Services and Public Safety to ensure that the new arrangements reflect the needs of frontline staff, patients and public throughout the UK.

2

Reconfiguration of arm's length bodies

I REGULATION

1 The Review has considered the ALBs within 4 categories. Some ALBs have functions spanning more than one category but usually their primary purpose is clear:
   - **Regulation** – ALBs in this field hold the health and social care system to account. They often have their own primary powers and extra independence from direction by the Secretary of State.
   - **Standards** – ALBs in this field establish national standards and best practice.
   - **Public welfare** – ALBs in this field are focused primarily on safety and the protection of public and patients.
   - **Central services to the NHS** – these ALBs provide economies of scale and focused expertise.

Regulation

2 The regulation category embraces regulators of providers and services, professionals and medicines. The following ALBs operate primarily in this field:
   - Healthcare Commission
   - Independent Regulator of NHS Foundation Trusts
   - Commission for Social Care Inspection
   - Mental Health Act Commission
   - Commission for Patient and Public Involvement in Health
   - Human Fertilisation and Embryology Authority
   - Human Tissue Authority (subject to legislation)
   - Council for the Regulation of Health Care Professionals
   - General Social Care Council
   - Postgraduate Medical Education and Training Board
   - Dental Vocational Training Authority
   - Medicines and Healthcare products Regulatory Authority

3 Patients need to be able to rely on the quality and consistency of the services they receive. This is not something that can be managed from Whitehall. Services should be delivered locally within national standards. Regulators have a key role to play in making sure that local services

really do meet those standards so that patients and users can rely on them. Regulation is a key component of the ALB sector. Being an ALB gives regulators operational independence within the overall national framework.

4 The future configuration of ALB regulators will be as follows.

Regulation of providers and services

Healthcare Commission

5 The Healthcare Commission will continue to inspect the quality of NHS and independent health care and make public reports to help improve services and assist the public in making informed choices. It will move towards full cost recovery for its inspections of independent health care providers and, subject to changes in the relevant legislation, apply a slimmed down system of proportionate inspection. It will also take on new functions as follows.

6 The Healthcare Commission will take on responsibility for the regulation of the care of people detained under the Mental Health Act. The Mental Health Act Commission will then be abolished as part of wider changes to be made through the forthcoming Mental Health Bill. In the meantime, the Healthcare Commission and the Mental Health Act Commission will work closely together, while retaining their separate statutory responsibilities.

Independent Regulator of NHS Foundation Trusts

7 The Independent Regulator of NHS Foundation Trusts will continue to be an independent organisation responsible for licensing and regulating NHS Foundation Trusts. When a suitable legislative opportunity arises, the Regulator will be formally established as a Non-Ministerial Government Department. This is a technical change and will not have a significant impact on the current organisational arrangements.

Commission for Social Care Inspection

8 The Commission for Social Care Inspection will continue to perform a parallel role in social care to that of the Healthcare Commission in health. Decisions on a move to full cost recovery will be taken as part of a review of the current charging system. Although the direction of travel is towards combined health and social care inspection, any merger with the Healthcare Commission at this time would be a distraction from the heavy agenda of both sides and would impact on the ability of both to regulate providers and thereby protect patients and service users.

Regulatory Authority for Fertility and Tissue

9 A new regulatory body, the Regulatory Authority for Fertility and Tissue (RAFT), will be created to be responsible for the regulation and inspection of all functions relating to the whole range of human tissue – blood, organs, tissues, cells, gametes and embryos. RAFT will therefore replace the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA) in their entirety. In the interim, the HTA will be set up under the Human Tissue Bill currently before Parliament. The HTA will carry out the intense work needed to develop standards and codes of practice and implement

operational/inspection procedures before the functions are absorbed into the new, wider body.

10 This change reflects the many similarities between the HFEA and the HTA, both of which are designed to:

- be competent authorities under the EU Tissues and Cells directive
- regulate ethically sensitive areas
- focus on technical matters of safety and quality
- set standards
- enforce compliance
- cover research as well as therapy
- cover settings outside healthcare, e.g. sperm banks (HFEA) and university anatomy schools (HTA)
- operate UK wide

11 RAFT will become the single competent authority for the EU Tissues and Cells directive. It will also become the competent authority for the Blood directive, and for the EU Organs directive when created. RAFT will enforce safety and quality requirements for all human applications (as set out under the EU directives and elsewhere). It will also regulate other uses of tissue for research and education as required under the Human Tissue Bill.

12 We will consider whether RAFT should also take on the regulatory-style functions of the National Blood Authority and UK Transplant in order to ensure the separation of regulation from service provision.

13 RAFT will be UK wide and will require primary legislation. In the meantime, we will review the HFE Act 1990, as already planned, to determine any other changes needed to update that Act.

Regulation of professionals

Council for the Regulation of Health Care Professionals

14 The Council for the Regulation of Health Care Professionals (CRHP) will continue to oversee the various statutory professional self-regulatory bodies (themselves beyond the scope of the ALB Review) and to facilitate closer working between them. It may need to develop a stronger role over time as part of the process of development referred to in the *NHS Improvement Plan* (paragraph 2.29). This is expected to lead to a greater commonality of approach across the professional regulatory bodies, possibly extending to include the regulation of social care staff. We do not propose to extend CRHP's functions at this stage, but the position will be reviewed in the light of the report of the Shipman Inquiry, which is expected later in 2004. In the meantime, CRHP is exploring the potential for the professional regulatory bodies to make savings by sharing back-office functions.

General Social Care Council

15 The General Social Care Council (GSCC) will continue to register individual social care workers and regulate their conduct and training. The introduction of this regulation, in response to fears about client safety, has been welcomed by the social care field. Over time, regulation will extend from professional social workers to other social care worker groups but this extension must be undertaken with the minimum burden on frontline staff.

16 Although their basic functions are different, it is important that CRHP and GSCC continue to work closely together to reflect the fact that in practice the boundary between health and social care workers is blurred. Shared back office arrangements should be considered.

17 It should in principle be possible for the social care student bursaries payment function currently with the GSCC to be transferred to the student grants unit recently taken over by the NHS Pensions Agency, offering scope for efficiency savings.

18 The GSCC was deliberately set up as a statutory state regulator to ensure there was proper responsiveness to service users. Over time, it may be possible to consider a move towards self-regulation and a role for the CRHP in overseeing both the health and social care professions. However, this may need to be considered in the context of the Shipman Inquiry's report and other regulatory developments.

Postgraduate Medical Education and Training Board

19 The Postgraduate Medical Education and Training Board (PMETB) will continue to supervise postgraduate medical education and training for the UK. Its remit will now be extended to cover the postgraduate dental training responsibilities of the small Dental Vocational Training Authority (DVTA). Consideration will be given to how the DVTA's functions – which cover England and Wales – will map onto the PMETB's existing functions – which are UK wide. The DVTA will be abolished.

Regulation of medicines

Medicines and Healthcare products Regulatory Agency

20 The Medicines and Healthcare products Regulatory Agency (MHRA) will continue to ensure that all medicines, medical devices and equipment on the UK market meet appropriate standards of safety, quality and performance. The MHRA is the outcome of the recent merger of the Medicines Control Agency and the Medical Devices Agency. The cost of MHRA's medicines operation is largely recovered from UK drug companies under legislation. The extension of this principle to cover its medical devices work will be considered.

21 The Agency runs a Device Evaluation Service, which reviews equipment and advises NHS providers and purchasers on the best choice of device for particular purposes. A study has been commissioned into the need for a DES, and the options for its future home and funding. This study will report shortly and will be taken forward by the Healthcare Industry Task Force.

22 Summary of future configuration:

ALB	Regulatory area
Independent Regulator of NHS Foundation Trusts	NHS Foundation Trusts
Healthcare Commission	Health services, commissioners, oversight of patient involvement
Commission for Social Care Inspection	Social care
Regulatory Authority for Fertility and Tissue	Fertility treatments and use of human tissue
Council for the Regulation of Health Care Professionals	Oversees the General Medical Council, General Dental Council, Nursing and Midwifery Council, General Chiropractic Council, General Optical Council, General Osteopathic Council, Health Professions Council, Royal Pharmaceutical Society of Great Britain, and the Pharmaceutical Society of Northern Ireland
General Social Care Council	Social care workers
Postgraduate Medical Education and Training Board	Supervises postgraduate medical education and training and vocational training for dentists
Medicines and Healthcare products Regulatory Agency	Manufacture of pharmaceuticals, UK compliance on manufacture, distribution, sale, labelling, advertising and promotion of medicines and medical devices. Adverse reports and incidents.

II STANDARDS

1 This category of ALB covers bodies with responsibility for developing and setting standards for service delivery. The following ALBs operate primarily in this field at present:
- National Institute for Clinical Excellence
- Health Development Agency

2 Devolution is ensuring that local services have the flexibility to deliver choice and high quality care to patients. But the NHS must keep its coherence, and standards are crucial to avoiding problems of 'post code prescribing'. The new ALB configuration will have one ALB concentrating on standards. However, the Department of Health will encourage the development of a wider network of standards organisations including, for example, the Food Standards Agency and the Social Care Institute for Excellence.

National Institute for Clinical Excellence

3 The National Institute for Clinical Excellence (NICE) will continue to provide patients, public, health professionals and other health improvement organisations with authoritative, robust and reliable guidance on current best practice in relation to health technologies and the clinical management of specific conditions.

4 In addition, NICE will now take on the functions of the Health Development Agency to create a single excellence-in-practice organisation covering both prevention and treatment of ill health. A centre for excellence in public health will become part of the NICE infrastructure, evaluating public health interventions and enabling their cost effectiveness to be weighed against the cost effectiveness of treatment in later years. The forthcoming White Paper on improving health will deal with related issues, including non-NHS issues, in more detail. The HDA will be abolished.

5 NICE is the current funder of the three National Confidential Enquiries (covering: suicide and homicide; maternal and child health; and perioperative death) into ways to improve the safety and treatment of patients. Responsibility for the Enquiries will move to the National Patient Safety Agency (NPSA) whose functions are most closely related. NPSA will maintain close liaison with NICE and with the Healthcare Commission to ensure that the Enquiries continue to serve the interests of all major stakeholders.

6 Summary of future configuration:

ALB	Function
National Institute for Clinical Excellence	Guidance on best practice in prevention and treatment of ill health

III PUBLIC WELFARE

1 Current ALBs working primarily in public welfare are:
- National Patient Safety Agency
- National Clinical Assessment Authority
- Commission for Patient and Public Involvement in Health
- Health Protection Agency
- Public Health Laboratory Service
- National Radiological Protection Board
- National Biological Standards Board
- National Treatment Agency for Substance Misuse

2 The welfare of patients and public must be a central concern and a national capacity is needed. The future configuration of ALBs in public welfare will be as follows.

Patient safety and well being

National Patient Safety Agency

3 The National Patient Safety Agency (NPSA) will continue to co-ordinate system-wide efforts to improve the safety of care and reduce the number of mistakes that result in injury to patients. It provides a statutory focus in an area where previously the NHS lacked co-ordination, shared-information and awareness. Internationally, the NPSA is a trailblazer. Its reporting system places the minimum burden on frontline staff and will contribute to improved patient safety. The NPSA will also take on the following functions.

4 The NPSA will host the support service to NHS employers who are concerned about the performance of individual doctors and dentists but where regulatory intervention seems disproportionate. The National Clinical Assessment Authority (NCAA), which currently does this work, will be brought together with the NPSA and will be established as a separate division within it. This will ensure the continuation of the centrally important work the NCAA has done to support an integrated NHS quality and patient safety agenda. The NCAA has helped poorly performing doctors to be identified much earlier that before, thereby protecting patients. The NCAA has also allowed fairer treatment of doctors, averting ‘knee jerk’ suspensions and placing emphasis on rehabilitation when this can be safely done. This work is likely to increase in the future as all doctors are subject to five-year re-licensing by the General Medical Council (‘revalidation’).

5 There will therefore be a clearly defined National Clinical Assessment Service within the NPSA. It will have its own Director and senior management team and a direct link with the main board. Absolute confidentiality will be maintained between the functions so that anonymous reporting within the main NPSA is unhindered.

6 The NPSA will also take the lead on hospital food, cleanliness and safe hospital design. These functions, currently performed by NHS Estates, will enable the NPSA to deepen its focus on safety and improving the patient experience. The NPSA will be able to make available expert advice to the NHS so that lessons from adverse incidents can be designed into NHS facilities as well as changes made to operational procedures.

7 Responsibility for the three National Confidential Enquiries will move from NICE to the NPSA whose functions are more closely related. NPSA

will maintain close liaison with NICE and with the Healthcare Commission to ensure that the Enquiries continue to serve the interests of all major stakeholders.

8 Research ethics is closely connected to patient safety and confidence. The NPSA will take the national lead in supporting the development of ethics committees that review clinical trials with medicines, and also NHS research ethics committees. The aim is to provide consistent UK wide systems to support independent ethical review of all research that could affect the dignity, rights, safety and well being of individuals. The NPSA will take on responsibility for the Central Office of Research Ethics Committees (COREC) from the Department of Health.

9 A priority is to ensure the independence of the ethics committees and high quality appointments. The NHS Appointments Commission will take on functions necessary to guarantee the independent appointment of chairmen and members of ethics committees. The Commission will eventually cover appointments both to ethics committees recognised for the review of clinical trials with medicines, and to NHS research ethics committees.

Patient and public involvement

10 The Commission for Patient and Public Involvement in Health will be abolished. Patients' Forums will remain the cornerstone of the arrangements we have put in place to create opportunities for patients and the public to influence health services.

11 Stronger, more efficient arrangements to provide administrative support and advice to Forums will be put in place. These will enable Forums to concentrate on their core functions, maximising the resources available for spending on real involvement rather than administration. The NHS Appointments Commission will appoint Forum members in the future.

12 A clear quality framework for Forum activities in monitoring and reviewing health services will be established and communicated to Forums. The best body to do this will be identified in discussion with others including the Healthcare Commission, which itself has a duty to improve services in the interests of patients and public. It will be important that the details are discussed fully with stakeholders before the necessary primary legislation is taken forward.

Health protection

Health Protection Agency

13 The Health Protection Agency Act 2004 brings together – in the Agency – the key elements in public health protection – emergency preparedness, biological, chemical and radiological expertise – within a regional, national (UK wide) and international network of scientific excellence. This arrangement is necessary to ensure that the UK retains and extends its capacity to protect the public from new and rapidly emerging threats to public health such as SARS.

14 The HPA therefore represents a positive rationalisation of functions previously carried out by other ALBs. The Public Health Laboratory

Service Board and National Radiological Protection Board are due for abolition in the near future.

15 This rationalisation will be taken a step further with the abolition of the National Biological Standards Board and the transfer of its functions to other ALBs, primarily the HPA. Responsibility for running the National Institute for Biological Standards and Control (NIBSC) which standardises and controls the biological substances used in medicines including vaccines – is likely to move to the HPA to bring together biological health protection expertise under the control of a single board. This should not mean the loss of NIBSC's brand, associated with over 90% of the world's primary standards for biological medicines.

16 NIBSC is also the testing and release agency for biological vaccines produced currently at the HPA's facility at Porton Down. It may be preferable for this regulatory-style function not to be passed to the HPA itself. The issue requires detailed discussion with national and international regulators, the pharmaceutical industry, the World Health Organisation, professional bodies and others.

Substance misuse

17 The National Treatment Agency for Substance Misuse was set up to focus effort on drug treatment and deliver the Government's main drugs target by 2008. It will continue to deliver this until a programme of mainstreaming within the NHS is in place. In practice, achieving the target – and successful drug treatment beyond 2008 – needs more than the NTA can itself deliver. Success will be the provision of drug treatment services as a core part of NHS business, with the necessary arrangements in place to sustain delivery at national, regional and local level.

18 The NTA's central organisation will work with the Home Office and the Department of Health to drive this transition forward. In future, strategic health authorities working in partnership with primary care trusts and providers will lead the delivery of drug treatment services. Independent inspection of drug treatment services by the Healthcare Commission will reinforce local delivery.

19 The NTA's regional staff and roles, including the provision of advice and assistance to Strategic Health Authorities, will pass to existing mainstream structures as soon as possible. The Home Office and the Department of Health will agree an appropriate balance of responsibilities at regional level.

20 These proposals will reinforce the Department of Health's commitment to deliver drug treatment, including treatment for offenders, as a part of the mainstream delivery of the NHS. They will also ensure the effective co-ordination and support of the Government Offices for the English Regions and Strategic Health Authorities in the delivery of their responsibilities under the Government's drug strategy. A joint DH/HO review of progress in 2006 will assess progress and agree any further action which may be needed to ensure drug treatment has been fully and effectively mainstreamed into the NHS including the future of the NTA's national functions.

21 Summary of long term configuration:

ALB	Function
National Patient Safety Agency	Promotes system wide improvements to avoid patient accidents and improve the patient environment
Health Protection Agency	Protection of people's health, reducing the impact of infectious diseases, chemical hazards, poisons and radiation hazards, emergency planning
National Treatment Agency for Substance Misuse	Focuses effort on drug treatment to deliver the Government's main drugs target by 2008

IV CENTRAL SERVICES TO THE NHS

1 This category of ALB covers central services to the NHS where economies of scale and focused expertise are required. The following existed, or were planned, when the review was announced:
- National Blood Authority
- UK Transplant
- NHS Litigation Authority
- Family Health Services Appeal Authority (Special Health Authority)
- NHS Appointments Commission
- NHS Modernisation Agency
- NHSU
- NHS Information Authority
- Prescription Pricing Authority
- Dental Practice Board
- NHS Pensions Agency
- NHS Counter Fraud and Security Management Service
- NHS Purchasing and Supply Agency
- NHS Logistics Authority
- Dental Special Health Authority
- NHS Direct
- NHS Professionals
- NHS Estates

2 Central services are needed where local skills are scarce and where there are economies of scale to be achieved. But there is scope for rationalisation, and devolution has increased the capacity of the NHS to run services itself.

3 The future configuration of ALBs in this category will be as follows.

Donation

Blood and Transplant Authority

4 A new national Blood and Transplant Authority (BaTA) to support the donation and safe use of human tissues comprehensively will replace the National Blood Authority (NBA) and UK Transplant (UKT). The two current organisations will pool their experience of collecting, allocating and distributing blood and organ donations. The new body will be given the role of promoting donation more comprehensively than any current organisation is able to do.

5 The work of both the NBA and UKT will be reviewed to examine the scope for more efficient operation, given the overall scale and operational importance to the NHS. The new organisation might, in the future, benefit from being outside the ALB sector as some kind of public benefit organisation. Full account will be taken of the UK wide and Republic of Ireland remit of UKT and the responsibilities in Wales of the NBA.

6 We will consider further whether the new Regulatory Authority for Fertility and Tissue should take on the regulatory-style functions of the NBA and UKT to ensure the separation of regulation from service provision.

Litigation, redress, FHS appeals

NHS Litigation Authority

7 The NHS Litigation Authority (NHSLA) will continue to administer schemes for the NHS to fund the costs of clinical negligence litigation through risk pooling arrangements. The NHSLA has improved the handling of clinical negligence

claims in the NHS, capped legal costs and is increasingly promoting Alternative Dispute Resolution (ADR).

8 *Making Amends,* the CMO's proposals for reforming the approach to clinical negligence in the NHS, gave a strong steer that the NHSLA should oversee the NHS Redress Scheme and manage the financial compensation element at national level. The NHSLA will be reconstituted to do this. Further details on how the NHS Redress Scheme will operate will be published later this year, and implementation will require primary legislation.

9 The NHS Litigation Authority will also take on the functions of the Family Health Services Appeal Authority (Special Health Authority) which is too small to continue as a separate ALB and will be abolished. In the longer term consideration will be given, in consultation with the professions and other interests, to the scope for introducing alternative ways of resolving disputes that reflect more appropriately the devolution of management responsibility to frontline organisations.

Appointments

NHS Appointments Commission

10 The NHS Appointment Commission needs to remain independent of any single NHS organisation. Primary legislation will be pursued to give it specific powers to make appointments to other bodies – including non-NHS ones – should it be commissioned to do so. Responsibility for the appointment of Patients' Forum members will be transferred to the Commission. The Commission will also appoint chairs and members of local research ethics committees.

Service improvement

NHSU

11 The NHSU improves services in the NHS by supporting training and development. It is currently subject to a more detailed study, within the overall ALB Review process, which will be completed shortly.

12 The NHS Modernisation Agency (MA) has played a crucial role in the achievement by the NHS of many targets. Now that the NHS has a better appreciation of the benefit of such techniques and focused programmes it is time to devolve such programmes to NHS ownership. The MA is already undergoing a change process to achieve this. It will be necessary to keep a relatively small (currently estimated to be around 150 posts) national modernisation resource close to the Department for the time being. This core will support the Department and the NHS by undertaking diagnostic analysis and designing new improvement programmes. These programmes will now incorporate technical innovation. Further work is in hand on its future organisational form but it will not become a standalone ALB.

Information & IT

Health and Social Care Information Centre

13 A new Health and Social Care Information Centre will reduce burdens on the frontline by co-ordinating information requirements across a wide range of bodies. The new Centre will set data standards, carry out co-ordinated collections on behalf of the whole system, and have the capacity to undertake analysis. It will become the focus for those needing information, thereby reducing the number of information requests on the frontline. It will facilitate accessible and reliable information flows between patients, commissioners and suppliers; and it will improve the credibility of reported NHS information.

14 The new Centre will retain some of the information-related functions of the current NHS Information Authority (NHSIA) and will take on the statistics and information management functions of the Department of Health.

National Programme for IT

15 The National Programme for IT (NPfIT) will develop, procure and implement modern, integrated IT infrastructure and systems for all NHS organisations in England by 2010. By providing for the safe and efficient transfer of information across the health and social care system, the National Programme is aimed at improving care for patients and transforming the experience of clinicians and other NHS staff. It is essential to delivering the NHS Plan. To build on the progress and momentum achieved to date, and reflect its sheer scale, NPfIT will become a time limited Executive Agency for 3 to 5 years and will incorporate the IT infrastructure functions of the NHSIA. The NHSIA will be abolished.

NHS business services

NHS Business Services Authority

16 The NHS Pensions Agency, Prescription Pricing Authority (PPA) and Dental Practice Board (DPB) each specialises in transactions about individuals, particularly payments. Each processes information against a set of rules: the NHS pensions rules, the drug tariff or the arrangements for NHS dental services. Although the subject matter differs, some of the basic business processes are very similar. The three separate authorities will merge to create a new payment and transactions processing entity. The new body will be able to develop general business skills, drawing on the best practice of each of the constituent bodies. The new body may be well placed to provide back office support to other ALBs and the NHS if it can achieve benchmarked efficiency levels. This aspect will be considered further in the implementation phase. A transformed NHS Purchasing and Supply Agency (PASA) (see below) will commission services from the new body on behalf of the NHS.

17 The approach and functions of the new body will be influenced by a review of the business processes of a number of ALBs being undertaken now by the Department's Commercial Directorate. This is expected to clarify the scope of the new organisation and the opportunities across a number of ALBs where back office and other functions might be amenable to transformation.

18 The NHS Pensions Agency already processes NHS student bursaries in addition to its pensions work. In addition to this, it should in principle be possible for the social care student bursaries payment function currently with the General Social Care Council to be transferred to the student grants unit recently taken over by the NHS Pensions Agency, offering scope for efficiency savings.

19 The PPA carries out other functions such as administration of the scheme under which people on a low income can get help with health costs, and has been asked to administer the future European Health Insurance Card scheme. These functions will for the most part remain with the new body. The information analysis functions of the PPA and DPB will be considered in the context of the new Health and Social Care Information Centre.

20 The NHS Counter Fraud and Security Management Service has had a pivotal role in ensuring good systems and processes for managing risk in the NHS and through its national and regional capacity has secured some major financial gains. The functions of CFSMS continue to be important but no longer need to exist in a standalone ALB. The CFSMS's compliance work will be devolved to the local level. It will be necessary to retain a strong focus of national policy and operational expertise, for example to tackle any new areas of fraud. A national unit for this purpose will be part of the new NHS Business Services Authority. The same approach will apply to the security management role of the CFSMS.

Procurement

21 The NHS Purchasing and Supply Agency (PASA) will be reshaped as part of a major programme to support the NHS in handling purchasing and supply more effectively and to free up further substantial resources for reinvestment in patient care. The Department's Commercial Directorate has developed plans to streamline the supply chain in the NHS. As these plans are implemented, a transformed PASA will play a crucial role in applying procurement best practice to maximise savings. PASA should be able to take on procurement and contracting functions from other ALBs, helping to reduce the cost of the ALB sector further.

22 The Commercial Directorate will be market testing the work of the NHS Logistics Authority. If it shows that the function should be contracted out, then the NHS Logistics Authority will be outsourced and the contract held by PASA. If not, other potential mergers will be considered.

Other current ALBs

23 As the functions of the Dental Vocational Training Authority and the Dental Practice Board are now to be taken on by other ALBs, the planned Dental Special Health Authority will no longer be created. For the time being, the Department of Health will retain responsibility for the remaining functions planned for the Authority.

24 NHS Direct will continue to be commissioned as a national service in order to achieve national consistency and economies of scale. Its growing role in supporting GP out-of-hours services, e-booking and policies around choice point to a degree of local commissioning as well.

25 NHS Direct needs time to mature as a service and it will retain its ALB status for 2 to 3 years. But in the meantime, we will work with NHS Direct to consider how it may prepare itself for transfer to independent status as a body established on foundation principles to operate in the public interest. This may require primary legislation.

26 NHS Professionals, responsible for managing and providing temporary staff to the NHS, will also prepare to take on independent status after 2 to 3 years. It is already anticipated that NHS Professionals will be self-financing by 2007/8.

27 NHS Estates combines central policy functions with functions it undertakes on behalf of the NHS. Central policy is the role of the Department, with delivery devolved to the frontline wherever possible. A small core estates team will be brought into the Department. The number of business cases for capital investment which need to be handled at national level is reducing significantly under devolved arrangements. Current expertise in NHS estates used for advising the NHS on the application of guidance can now be transferred to the NHS where it will strengthen the capacity to handle devolution. Work on hospital food, cleanliness and safe hospital design will transfer to the NPSA. NHS Estates will be abolished and its trading arm, Inventures, disposed of.

28 Summary of future configuration:

ALB	Function
Blood and Transplant Authority	Collects, prepares, distributes and encourages donation of tissues
NHS Litigation Authority	Effective litigation handling and pooling of risk, new redress functions and FHS appeals
NHS Appointments Commission	Makes non-executive appointments to NHS and other organisations
NHSU	Improves services in the NHS by supporting training and development
Health and Social Care Information Centre	Centre of analytical skills and a data warehouse for 'collected only once' information
National Programme for IT	Implements the IT infrastructure to support better patient care and information
NHS Business Services Authority	Performs back office, payments and central counter fraud functions for the NHS
NHS Purchasing and Supply Agency	Purchasing and supply contracting

3

Implementation

Costs and posts

1 In 2003/4, ALBs spent a total of £4.8 billion, including operating costs of £1.8 billion, and employed staff in around 25,000 posts. The principles outlined in Sir Peter Gershon's Efficiency Review will be applied to the ALB sector to generate more than £200 million in cash-releasing savings for the frontline, for example by sharing back office services and by carrying out activities more efficiently. No ALB will be exempt from the need to improve efficiency. In addition, £150-200 million will be released to frontline control by devolving functions from ALBs. The scope for achieving full cost recovery for regulation will be investigated and taken forward.

2 The Department's Commercial Directorate is scrutinising the business processes and procurement activities of many of the central services ALBs to establish the full scope of the efficiencies to be made, especially in relation to the money (about £3 billion) that is spent by ALBs on behalf of frontline organisations on NHS supplies, temporary staff and litigation services. The Commercial Directorate's work on the NHS supply chain is already well advanced, suggesting savings of approximately £150-200 million in the period to the end of 2007/8.

3 We are confident that expenditure on ALBs can be reduced by at least £0.5 billion by 2007/8. Savings of this magnitude will be associated with a reduction in the number of posts in the ALB sector of about 25 per cent.

4 The Lyons Review into the location of public sector organisations, also published in the spring, calls for a more vigorous test of the need to locate ALBs in the capital. Its recommendations will be carried through into the implementation of the ALB review and around 1000 posts in ALBs will be relocated from London and elsewhere in the South East, taking into account the reconfiguration set out in this report.

Making it happen

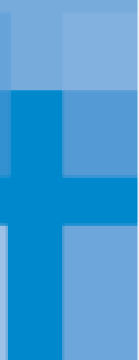
5 This report has set out the decisions that Ministers have taken regarding reconfiguration of the ALB sector. The Department will now move to detailed discussion with all interested parties about how to implement each change. Some of the changes will require primary or secondary legislation so Parliament will be able to play its role. Some statutory consultation will be required on specific changes.

6 Over the next 3-4 months the Department will work closely with the Devolved Administrations, ALBs, staff interests and other stakeholders to draw up implementation plans. These will include decision points on new ALB functions and processes, staffing levels, budgets, location and timescales for the transfer.

7 Our goal is for as much of the change as possible to be led by the ALBs, supported by their sponsors in the Department and their new NHS sponsors where applicable. A central departmental team working to a Minister and the Departmental Board will manage the overall planning and rollout of the new ALB configuration, focusing in particular on implementation processes requiring a cross-ALB approach, such as legislation, back office and estates strategy, HR strategy, finance and communications.

8 In planning and implementing the new ALB configuration between 2005 and 2008 we will:

- monitor and mitigate any risks to business continuity, regulatory standards and patient safety during the transition process
- ensure that support is available to ALB staff, providing maximum opportunities to retain experience and career opportunities within the wider NHS



A

List of ALBs considered in the review

ALBs in 2003/4

1 **CHI** – Commission for Health Improvement – *abolished on 31 March 2004*
2 **CPPIH** – Commission for Patient and Public Involvement in Health
3 **CRHP** – Council for the Regulation of Health Care Professionals
4 **DPB** – Dental Practice Board
5 **DVTA** – Dental Vocational Training Authority
6 **FHSAA(SHA)** – Family Health Services Appeal Authority (Special Health Authority)
7 **GSCC** – General Social Care Council
8 **HDA** – Health Development Agency
9 **HFEA** – Human Fertilisation and Embryology Authority
10 **HPA** – Health Protection Agency
11 **IR** – Independent Regulator of NHS Foundation Trusts
12 **MHAC** – Mental Health Act Commission
13 **MHRA** – Medicines and Healthcare products Regulatory Agency
14 **NBA** – National Blood Authority
15 **NBSB** – National Biological Standards Board
16 **NCAA** – National Clinical Assessment Authority
17 **NCSC** – National Care Standards Commission – *abolished on 31 March 2004*
18 **NHS AC** – NHS Appointments Commission
19 **NHS CFSMS** – NHS Counter Fraud and Security Management Service
20 **NHS Direct**
21 **NHS Estates**
22 **NHS IA** – NHS Information Authority
23 **NHS LA** – NHS Litigation Authority
24 **NHS Logistics Authority**
25 **NHS Modernisation Agency**
26 **NHS PA** – NHS Pensions Agency
27 **NHS PASA** – NHS Purchasing and Supply Agency
28 **NHS Professionals**
29 **NHSU**
30 **NICE** – National Institute for Clinical Excellence
31 **NPSA** – National Patient Safety Agency
32 **NRPB** – National Radiological Protection Board
33 **NTA** – National Treatment Agency for Substance Misuse
34 **PHLS** – Public Health Laboratory Service
35 **PMETB** – Postgraduate Medical Education and Training Board
36 **PPA** – Prescription Pricing Authority
37 **ROC** – Retained Organs Commission – *abolished on 31 March 2004*
38 **UKT** – UK Transplant

Others covered by the review

These became operational on 1 April 2004:
39 **CSCI** – Commission for Social Care Inspection
40 **HC** – Healthcare Commission

These have not yet become operational:
41 **Dental Special Health Authority**
42 **HTA** – Human Tissue Authority

B

Background Data

Source: Annual Accounts except where stipulated

Notes:

1. Additionally there is approximately £3bn spent by ALBs directly on frontline services.
   For example:
   NHS Logistics Authority £600m
   NHS LA £2,000m
   NHS Professionals £400m
2. NCSC, CHI and ROC were abolished on 1 April 2004
3. Gross operating costs exclude:
   Depreciation and Amortisation
   Capital Charges
   Profit/Loss on Disposal of Fixed Assets
   Impairments

Arm's Length Body	Gross Operating Costs (see notes)	Staff	
	£000		
CHI	36,660	376	
CPPIH	23,666	150	
CRHP	1,436	3	
DPB	23,896	325	
DVTA	298	4	
FHSAA (SHA)	954	13	Revenue figure excludes prescription penalties and provisions
GSCC	9,892	146	Revenue figure excludes training grants and bursary costs
HDA	13,121	132	
HFEA	7,324	106	Staff figures from DH data
HPA	172,473	2,518	
IR	2,794	28	Revenue figure from ALB (Feb 2004) and staff figure from DH data. Three month figures
MHAC	3,884	45	
MHRA	55,852	747	
NBA	364,541	5,916	
NBSB	17,045	305	Staff figure from DH data
NCAA	6,075	71	
NCSC	133,866	2,726	
NHS AC	4,344	46	
NHS CFSMS	13,352	250	
NHS Direct	120,000	2,000	Revenue figure from ALB (Feb 2004) and staff figure from DH data
NHS Estates	29,519	218	Staff figure does not include the 204 Inventure staff
NHS IA	204,837	918	
NHS LA	11,207	182	
NHS Logistics Authority	64,590	1,377	Revenue figure excludes cost of sales
NHS Modernisation Agency	232,400	765	Revenue figure from ALB (Feb 2004) and staff figure from DH data
NHS PA	19,136	277	
NHS PASA	20,841	318	
NHS Professionals	33,000	671	Revenue figure from ALB (Feb 2004) and staff figure from DH data
NHSU	27,888	234	Figures from DH data
NICE	17,561	81	
NPSA	17,040	149	
NRPB	15,158	315	
NTA	9,134	79	
PHLS	4,211	69	Figures from DH data
PMETB	3,000	27	Revenue figure from ALB (Feb 2004) and staff figure from DH data
PPA	64,826	2,919	
ROC	1,210	18	
UKT	10,512	121	
CSCI	110	11	Three month figures
HC	3,622	84	Three month figures
TOTAL	**1,801,275**	**24,740**	

C

Summary of reconfiguration

	Long Term ALBs	ALBs whose functions will be taken on by other ALBs or removed from the ALB sector
Regulation	1 Healthcare Commission 2 Independent Regulator of NHS Foundation Trusts 3 Commission for Social Care Inspection 4 Regulatory Authority for Fertility and Tissue 5 Council for Regulation of Health Care Professionals 6 General Social Care Council 7 Postgraduate Medical Education and Training Board 8 Medicines and Healthcare products Regulatory Agency	Mental Health Act Commission Human Fertilisation and Embryology Authority Human Tissue Authority Dental Vocational Training Authority
Standards	9 National Institute for Clinical Excellence	Health Development Agency
Public Welfare	10 National Patient Safety Agency 11 Health Protection Agency 12 National Treatment Agency for Substance Misuse	National Clinical Assessment Authority Commission for Patient and Public Involvement in Health Public Health Laboratory Service National Radiological Protection Board National Biological Standards Board
Central Services	13 Blood and Transplant Authority 14 NHS Litigation Authority 15 NHS Appointments Commission 16 NHSU (detailed review under way) 17 Health and Social Care Information Centre 18 National Programme for IT 19 NHS Business Services Authority 20 NHS Purchasing and Supply Agency	National Blood Authority UK Transplant Family Health Services Appeal Authority (Special Health Authority) NHS Modernisation Agency NHS Information Authority NHS Pensions Agency Prescription Pricing Authority Dental Practice Board NHS Counter Fraud and Security Management Service NHS Logistics Authority NHS Direct NHS Professionals NHS Estates

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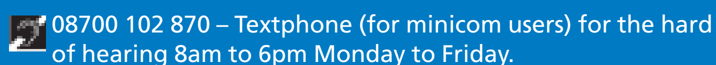

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