NHS

Liberating the NHS:

Report of the arm's-length bodies review

DH Department of Health

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Contents

EXECUTIVE SUMMARY

1. Our arm's-length bodies (ALBs) have made a significant contribution to improvements in health and care. Given the wider system reforms outlined in the White Paper - *Equity and excellence: Liberating the NHS*[1] - and the current economic climate, we must now act decisively to ensure that our arm's-length body sector remains fit for purpose and affordable.

2. Over the next four years the Government is committed to reducing NHS administrative costs by more than 45% and to simplifying and reducing radically the number of NHS bodies, including the Department's arm's-length bodies.

3. This report sets out in more detail the work on reducing bureaucracy and improving efficiency outlined in chapter 5 of the White Paper. It explains how we propose to abolish arm's-length bodies that do not need to exist, streamline the functions of those that do, and transfer functions that can be better delivered by other organisations.

4. Overall, we intend to simplify the national landscape, removing duplication and better aligning the arm's-length bodies sector with the rest of the health and social care system by:

    - ensuring that functions related to quality and safety improvement are devolved closer to the frontline;
    - integrating and streamlining existing national health improvement and protection bodies and functions within a new Public Health Service;
    - creating a more coherent and resilient regulatory system with clarity of responsibilities and reduced bureaucracy around licensing and inspection;
    - centralising data returns in the Health and Social Care Information Centre;
    - maximising opportunities for outsourcing of functions and shared business support functions across the sector to reduce overall costs and seek to realise assets through the commercialisation of activities.

[1] www.dh.gov.uk

5. In future:

    - functions will only be carried out at national level where it makes sense to do so;
    - the number of arm's-length bodies will be kept to a necessary minimum and the scope of each arm's-length body will be clearly defined to avoid mission creep;
    - arm's-length bodies will be expected to collaborate and co-operate to avoid duplication of activities and minimise unnecessary burdens and costs to health and social care organisations;
    - arm's-length bodies will have less freedom to determine how they spend their money on pay, expenses, travel, consultancy, communications and IT, and they will be expected to publish information and benchmarking data online;
    - where appropriate, arm's-length bodies will be expected to exploit commercial opportunities and maximise commercial discipline across the sector.

6. We will engage on these proposals with the arm's-length bodies and other interested parties, and where necessary we will bring forward legislative proposals within this Parliament.

1. INTRODUCTION

1.1 The Government has guaranteed that spending on health will increase in real terms in every year of this Parliament and is committed to increasing the proportion of resource available for front-line services to meet the current financial challenges and the future costs of demographic and technological changes. To achieve this we will need to achieve unprecedented efficiency gains, with savings reinvested in frontline services. Over the next four years the Government is committed to reducing NHS administrative costs by more than 45% and to radically reducing and simplifying the number of NHS bodies, including the Department's arm's-length bodies.

1.2 Reduction on this scale cannot be achieved by year-on-year efficiency savings alone. It also requires simplifying and rationalising the administrative infrastructure of the health and social care system.

1.3 *Equity and excellence: Liberating the NHS* set out the Government's strategy for the NHS. Our intention is to create an NHS that is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.4 *Equity and excellence: Liberating the NHS* makes clear the Government's policy intentions, and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise.

1.5 This report on the review of our arm's-length bodies is part of a suite of papers published on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- *Commissioning for Patients*
- *Regulating Healthcare Providers*
- *Transparency in Outcomes*
- *Local Democratic Legitimacy in Health*

1.6. A network of organisations has been created at national level, but at "arm's length" from the Department of Health, to regulate the system, improve

standards of care, protect public welfare, support local services and provide specialist advice. The work these organisations undertake ranges from back office administrative functions to complex ethical or clinical-related work. Arm's-length bodies are Government-funded organisations which work closely with local services and other arm's-length bodies. The Department has three main types of arm's-length bodies: Executive Agencies; Executive Non-Departmental Public Bodies; and Special Health Authorities.

1.7 Our arm's-length bodies form a significant component of the national health and social care landscape. In 2009/10, the sector as a whole spent in the region of £1.6 billion on business operations, including baseline revenue funding from the Department of about £800 million, and our arm's-length bodies employ around 18,000 staff.

1.8 The Department has already gone a long way to rationalise and reduce costs across this sector. The last review of our arm's-length bodies, which took place in 2003/04, reduced the number of organisations from 38 to 18. Annex B sets out the changes in our arm's-length body sector from 2003/04 – 2012/13.

1.9 However, six years on, we now need to take stock and assess how fit for purpose the sector is in light of the current financial climate, the cross-government drive to reduce the number of quangos and the strategy for the NHS set out in *Equity and excellence: Liberating the NHS,* which was published on 12 July 2010. This set out a coherent policy framework to support increased autonomy and clear accountability at every level in the NHS.

1.10 We have undertaken a review of our arm's-length bodies which includes an Executive Agency of the Department of Health, the Executive Non-Departmental Public Bodies (set up in primary legislation with their own powers) and Special Health Authorities.

1.11 This report sets out the result of the review within the context of the wider changes envisaged for the NHS set out in *Equity and excellence: Liberating the NHS* and the cross-government agenda to increase accountability and transparency and to reduce the number and costs of public bodies. We will engage with stakeholders around the implementation of the changes outlined in this report.

1.12 Part 2 of this report outlines our plans to streamline the sector and ensure that only those functions that need to be undertaken at a national level and at arm's length remain in the sector. Part 3 sets out the new configuration of arm's-length bodies. Part 4 sets out how we will tighten accountability, reduce bureaucracy and increase efficiencies across the arm's-length bodies. Part 5 describes how we will make the changes happen.

2 OUR STRATEGY FOR THE ARM'S-LENGTH BODY SECTOR

2.1 The Government's reforms of the NHS will establish more autonomous NHS institutions, with greater freedoms, clear duties, transparency in their responsibilities to patients and their accountabilities, with power devolved to the front-line. Liberating the NHS will fundamentally change the role of the Department and those bodies accountable to it.

2.2 In future, the arm's-length bodies sector needs to mirror these reforms. It will carry out only those functions that should be done at a national level to support the Department's clear objectives. Those functions that are better delivered by other parts of the system should be devolved to the right level of the system and those organisations that carry out functions that no longer need to be carried out by the state should be abolished. The sector will be streamlined to deliver its functions more effectively, reduce management costs and remove duplication and unnecessary burdens on the front-line.

2.3 The Department will impose tight governance and accountability over the costs and the scope of its remaining arm's-length bodies. To prevent duplication and aid transparency, the Secretary of State will consider, for any organisation, setting out an explicit list of functions that it is expected to perform. In future, arm's-length bodies' independence will be about how they perform clear and agreed functions, not the freedom to assume new roles.

2.4 Arm's-length bodies will be required to deliver their functions effectively and efficiently, and minimise the burden on the front-line. Our arm's-length bodies will be expected to take full advantage of commercial opportunities to improve value for money in the delivery of their services.

2.5 There will need to be a step change in the drive for efficiency including driving down the cost of operational delivery as well as simply cutting waste. The challenge for the sector will be how it can best exploit the potential synergies between different bodies. The more that can be achieved in these areas, the more we can protect spending on front-line services.

2.6 The proposals set out in this document should be seen as an integral component of the Government's wider plans for rationalisation set out in *Equity and excellence: Liberating the NHS* to radically reduce the Department's NHS

functions, abolish the ten Strategic Health Authorities and replace Primary Care Trusts and practice-based commissioners with GP commissioning consortia. Taken together, these measures will create more autonomous institutions, with greater freedoms, clear duties and transparency. They will free up resources, devolve decision making and reduce bureaucracy.

Scope of the review

2.7 The Department's review covered its 18 arm's-length bodies. Annex A sets out the full list of those public bodies covered by the review.

2.8 *Equity and excellence: Liberating the NHS* sets out the changes across the wider health and social care system and the rationale for the changing roles for Monitor, the Care Quality Commission, the National Institute for Health and Clinical Excellence and the Health and Social Care Information Centre. In addition, the desire to create a shift of power to patients and clinicians has implications for the future role of information. Similarly, the creation of an NHS Commissioning Board and the system changes to the regional and local NHS management tier pose questions about whether functions currently in the arm's-length bodies sector might be better delivered elsewhere.

2.9 The main changes proposed in the White Paper which will have an impact on the current role and function of the arm's-length bodies sector are:

- the establishment of an NHS commissioning board, leading to opportunities to consolidate functions currently carried out in arm's-length bodies, such as the Care Quality Commission NHS commissioner assurance function and providing its role of national leadership on commissioning for quality improvement;
- the establishment of an economic regulator, leading to an expanded role for Monitor across health and social care;
- a strengthened and streamlined role for the Care Quality Commission as an effective quality inspectorate across both health and social care, with a role in strengthening the collective voice of patients and service users by the creation of Healthwatch England, a new independent champion within the Care Quality Commission;
- an expanded role for the National Institute for Health and Clinical Excellence and putting it on a firmer statutory footing, securing its independence and extending its remit into social care;
- the creation of a Public Health Service, to integrate and streamline existing health improvement and protection bodies and functions; and

- the centralisation of all data returns in the Health and Social Care Information Centre, leading to streamlining information and data collection functions across the arm's-length bodies sector; and putting the Health and Social Care Information Centre on a firmer statutory footing.

2.10 These wider changes provided us with an opportunity to undertake a detailed review of the functions of each arm's-length body to determine whether in the future health and social care system the functions are essential and whether they:

- are sufficiently technical that there is a scarcity of capability and expertise for the function to be provided by other means;
- need to be performed independently of Ministers to ensure political impartiality;
- provide accountability and assurance to patients, service users and taxpayers by independently establishing facts.

2.11 These criteria are consistent with those issued by the Cabinet Office for use in developing policy for the Public Bodies (Reform) Bill, announced in the Queen's Speech in May 2010. The aim of the cross-government work on public bodies is to increase accountability and transparency, as well as reduce the numbers' costs of public bodies. In addition, other factors might give preference to retaining functions at a national level, such as economies or scale of the need for consistency and standardisation.

2.12 From the work carried out it is clear that:

- some national functions are vital to safeguard the health and welfare of the public;
- some functions overlap and could be integrated to build on synergies and reduce overheads.
- some functions no longer need to be provided at a national level by the state.
- change is required to achieve greater alignment with the wider system changes and to deliver a more responsive service.
- real efficiencies have yet to be delivered across business support functions, including cost efficient estate utilisation.
- commercial opportunities have not been fully exploited.

Key principles for the arm's-length bodies sector

2.13 The following principles will be applied to the sector:

- devolution to the frontline: functions will only be exercised at a national level where it makes sense to do so.
- the number of arm's-length bodies will be kept to a necessary minimum. The scope of each arm's-length body will be clearly defined and each arm's-length body will be subject to triennial reviews to provide a regular assessment of the need for functions to continue and to ensure the organisations deliver value for money for the taxpayer.
- arm's-length bodies will be expected to collaborate and co-operate to ensure that duplication of activities, for example licensing and inspections, and data collection is minimised and unnecessary burdens and costs to the NHS are reduced.
- setting policy is the role of the Department of Health not arm's-length bodies, although arm's-length bodies will often have a role in policy development and implementation determined by the Department of Health.
- business support functions will maximise economies of scale while meeting the support needs of individual arm's-length bodies. Budgets will be benchmarked and managed down to ensure efficiency.
- in the interests of greater transparency and accountability, arm's-length bodies will be expected to publish performance information and benchmarking data online.
- where appropriate, arm's-length bodies will be expected to exploit commercial opportunities, for example outsourcing or divestment, to maximise commercial discipline across the sector.

Implications of the review

2.14 **A streamlined sector:** Fewer arm's-length bodies will mean fewer central organisations for frontline staff to have to deal with, and less resource tied up in administrative overheads associated with individual bodies, for example, boards and governance and business support functions such as finance, HR, and IT. Clarity of the scope of organisations will reduce mission creep.

2.15 **Less bureaucracy**: Key to the effective and efficient delivery of arm's-length bodies' functions will be their practical demonstration of the principles of good regulation (proportionate, accountable, consistent, transparent and targeted) throughout the range of their work. This will deliver an interaction with

providers that collectively impacts in a way which is far more positive than the sum of their individual activities.

2.16 **Reduced intervention:** Where appropriate, the level of intervention by arm's-length bodies will be rolled back, for example, integrated licensing and proportionate regulation using a risk-based approach to the frequency of inspections.

2.17 **Greater efficiency through contestability:** For large scale central functions, alternative organisational and delivery models may exist which will deliver services in a more cost effective way.

3 THE NEW CONFIGURATION OF ARM'S-LENGTH BODIES

3.1 Our White Paper *Equity and excellence: Liberating the NHS* sets out our intention to:

- establish an independent NHS Board;
- expand Monitor's role so that it becomes an economic regulator;
- strengthen and streamline the Care Quality Commission as a quality inspectorate;
- expand the role of the National Institute for Health and Clinical Excellence to develop quality standards for social care and put it on firmer statutory footing;
- put the Health and Social Care Information Centre on a firmer statutory footing; and
- create a new Public Health Service within the Department of Health.

3.2 The proposals set out in this document take account of these system changes and, where appropriate, essential functions will be transferred from our arm's-length bodies sector to other parts of the wider system.

3.3 The assessment of our arm's-length bodies means that, subject to Parliamentary approval:

- six of our arm's-length bodies have a clear future as arm's-length bodies, albeit operating in the most cost effective and efficient way: Monitor, the Care Quality Commission, the National Institute for Health and Clinical Excellence, the Medicines & Healthcare products Regulatory Agency, the Health and Social Care Information Centre and NHS Blood & Transplant;
- the functions of two of our arm's-length bodies will be transferred to other organisations to achieve greater synergies where appropriate: the Human Fertilisation and Embryology Authority and the Human Tissue Authority. Further work is required to examine in greater detail the practicalities involved and we propose that they remain as independent arm's-length bodies in the short term, with the aim that their functions will be transferred by the end of the current Parliament;

- two of our arm's-length bodies will be abolished as statutory organisations and their functions will be transferred to the Secretary of State as part of the new Public Health Service: the Health Protection Agency and the National Treatment Agency;

- there are four of our arm's-length bodies which we propose to abolish from the sector; the Alcohol Education Research Council, the Appointments Commission, the National Patient Safety Agency and NHS Institute for Innovation and Improvement.

- one of our arm's-length bodies will be moved out of the sector to operate on a full-cost recovery basis: the Council for Healthcare Regulatory Excellence;

- one of our arm's-length bodies will have its function transferred to an existing professional regulator: the General Social Care Council;

- two of our arm's-length bodies will be subject to a commercial review by industry experts to identify potential opportunities for greater efficiency through outsourcing, divestment and contestability and/or employee ownership: NHS Litigation Authority and NHS Business Services Authority.

3.4 Overall, these proposals will simplify the national landscape, reduce duplication and bureaucracy and better align the arm's-length bodies sector with the rest of the health and social care system by:

- ensuring that functions related to quality and safety improvement are devolved closer to the frontline;

- integrating and streamlining existing national health improvement and protection bodies and functions within a new Public Health Service;

- creating a more coherent and resilient regulatory system with clarity of responsibilities and reduced bureaucracy around licensing and inspection;

- centralising data returns in the Health and Social Care Information Centre;

- maximising opportunities for outsourcing of functions and shared business support functions across the sector to reduce overall costs and seeking to realise assets through the commercialisation of activities.

3.5 We propose the following for each of our arm's-length bodies:

Raising Standards

National Institute for Health and Clinical Excellence (NICE)

3.6 The National Institute for Health and Clinical Excellence is a Special Health Authority, which was established to improve the quality of care that patients receive and to reduce the variation in the quality of care. The National Institute for Health and Clinical Excellence provides national guidance on public health, health technologies, clinical practice and interventional procedures. Its authoritative advice will be essential in future to support the work of the NHS Commissioning Board in developing quality standards along each part of the patient pathway, and outcome indicators for each step. The National Institute for Health and Clinical Excellence will rapidly expand its existing work programme to create a broad library of standards for all the main pathways of care. The standards will extend beyond NHS care, informing the work of local authorities and the Public Health Service. We intend that the forthcoming Health Bill will contain provisions to put the National Institute for Health and Clinical Excellence on a firmer statutory footing securing its independence and core functions and extending its remit to social care.

3.7 We intend to expand the role of the National Institute for Health and Clinical Excellence to develop quality standards for adult social care. In addition, proposals for the creation of a Public Health Service are likely to impact on the National Institute for Health and Clinical Excellence's public health functions. It is envisaged that the National Institute for Health and Clinical Excellence will retain a public health function, and that it will provide advice to Secretary of State on specific topics he refers to them.

Rationalising the regulatory landscape

3.8 Best practice suggests that regulation should be relevant, effective and proportionate. This has implications for the way we organise the regulators in health and social care. Each should have a clear remit, with clear authority and minimal overlap between one regulator and another. But from the perspective of those who are regulated, it is also important to minimise the bureaucratic overhead due to multiple lines of accountability, licences, inspections, data collections, and so on.

3.9 Where we see an essential and continuing role for regulation, we have assessed whether the regulator's functions really do need to be delivered by an arm's-length body. If they do not, we have considered the alternatives. And, in all instances we have considered the cost effectiveness of the arrangements, for the benefit of the taxpayer and for those who are regulated.

3.10 So in future, we propose to have:

- one quality regulator;
- one economic regulator;
- one medicines and devices regulator; and
- one research regulator.

3.11 The quality and economic regulators will work closely together to deliver a joint licensing regime.

3.12 Over time we propose that these bodies will largely assume the responsibilities of the regulators currently responsible for human fertilisation and embryology, and for human tissue. We intend to transfer responsibility for the regulation of social workers out of the arm's-length bodies sector to an existing professional regulator and to remove from the arm's-length bodies sector the body responsible for oversight of the nine professional regulators.

Care Quality Commission (CQC) – a single quality inspectorate

3.13 The Care Quality Commission is an executive non-departmental body (NDPB) which registers health and social care providers against essential levels of safety and quality, and has significant powers of enforcement. The Care Quality Commission undertakes inspections and special reviews, and currently undertakes periodic reviews of health and social care, including commissioners. The Care Quality Commission is also responsible for protecting the rights of people detained under the Mental Health Act.

3.14 We consider that overall the Care Quality Commission's functions satisfy the criteria for arm's-length body status. There are significant benefits in retaining an integrated health and social care quality regulator. The Care Quality Commission has demonstrated cost effectiveness, delivering the registration of NHS organisations whilst making significant progress in realising economies of scope and scale from the bringing together of three predecessor bodies (the Mental Health Act Commission, the Health Care Commission, and the Commission for Social Care Inspection) into one organisation.

3.15 We therefore propose only limited changes to the Care Quality Commission's existing functions. The Care Quality Commission will continue to act as the quality inspectorate across health and social care for both publicly and privately funded care. To avoid double jeopardy and duplication, the NHS Commissioning Board will take over the current Care Quality Commission responsibility of assessing NHS commissioners, although the Care Quality Commission will continue to conduct periodic reviews of adult social care and retain its responsibilities under the Mental Health Act.

3.16 In relation to the NHS the Care Quality Commission will, together with Monitor, operate a joint licensing regime. The Care Quality Commission and Monitor already have a duty of co-operation in primary legislation to work closely together to ensure that the regulatory burden of multiple licences is reduced, whilst ensuring robust and proportionate regulation. In due course, subject to changes described elsewhere in this section, it is possible that the Care Quality Commission could take on responsibility for a broader range of licensing functions, including some of the functions of the Human Embryology and Fertilisation Authority and the Human Tissue Authority. Once again, we would expect to see a more integrated and coherent approach to licensing so that the outcome is effective and proportionate regulation, minimising the regulatory burden and maximising cost effectiveness.

3.17 The Care Quality Commission will continue to inspect providers against essential levels of safety and quality in a targeted and risk-based way, taking into account information it receives about a provider. We intend that this information will come through a range of sources including patient feedback and complaints, Healthwatch England, GP consortia and the NHS Commissioning Board. Where inspection reveals that a provider is not meeting essential levels of safety and quality, the Care Quality Commission will take enforcement action to bring about improvement.

3.18 Finally, we propose that Healthwatch England, a new independent consumer champion, which will be an advocate for patients' rights and concerns, will be located with a distinct identity within the Care Quality Commission and will enjoy the benefits of the Care Quality Commission's independence and scale of operations, including avoiding duplicating work on the assessment of public opinions on health and care issues.

Monitor – a single economic regulator

3.19 Monitor – currently responsible for authorising and regulating NHS Foundation Trusts – will, subject to legislation, be transformed into a new economic regulator. Economic regulation, and the future role of Monitor, is the subject of a separate document in this series and is therefore not discussed further here.

Medicines and Healthcare products Regulatory Agency (MHRA) – a single medicines and devices regulator

3.20 The Medicines and Healthcare products Regulatory Agency is an Executive Agency of the Department of Health, which regulates production of medicines and other healthcare products. It is responsible for ensuring that medicines and medical devices work and are acceptably safe. The Medicines and Healthcare products Regulatory Agency provides advice to the Secretary of State on medicines and devices, and leads the negotiation and implementation of the Medicines Act and European legislation. Its functions are essential, and it satisfies the Government's test for arm's-length bodies to remain in the sector. The Medicines and Healthcare products Regulatory Agency is largely self-funding through the fees it charges. Therefore, we do not propose to change the status of the Medicines and Healthcare products Regulatory Agency, nor do we intend to transfer its functions to another body. There is a question as to whether it would be most appropriate to transfer to the Medicines and Healthcare products Regulatory Agency some of the Human Tissue Authority's functions in respect of licensing establishments working with tissues and cells for human application. This would be subject to further work around how the transfer of the Human Tissue Authority's functions will be effected and would not be taken forward in the Health Bill.

A new research regulator

3.21 We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research which is expected to report in autumn 2010. Currently a number of different arm's-length bodies have responsibility for different aspects of research regulation, including giving permissions. There is a strong argument for rationalising this and creating greater strategic coherence around research by placing responsibility for these different aspects of medical research regulation within one arm's-length body that would perform a stand-alone technical function as a research regulator. This would streamline the process of gaining permission to undertake medical research, making it more attractive to universities and health institutions. Moreover, there is potential for a single research regulator to have wider cross-government reach.

3.22 In the light of the Academy of Medical Sciences review, we will consider legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification.

Human Tissue Authority (HTA)

3.23 The Human Tissue Authority was established in 2005 in response to inquiries into the taking and retention of body parts without consent at Alder Hey, Bristol

and elsewhere. It oversees the removal, storage and use of organs and tissue from deceased people, and the storage and use of organs and tissue taken from living people, for certain activities specified in the Human Tissue Act 2004. It also acts as the Competent Authority for the EU Directive on Tissues and Cells, overseeing the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells for human application.

3.24 Many of the functions performed by the Human Tissue Authority remain essential and satisfy the tests for arm's-length bodies, but we do not consider that there is a compelling case for the Human Tissue Authority to remain a separate entity. On the contrary, we believe that there is significant potential to achieve greater synergy and cost effectiveness through transferring the functions of the Human Tissue Authority to other organisations as follows.

3.25 First, we propose that the Human Tissue Authority's licensing activities, in respect of the removal, storage and use of tissue, should be transferred to the Care Quality Commission. These activities could potentially benefit from alignment with the Care Quality Commission's wider inspection and licensing teams to provide a single licensing framework for activities involving human tissue. This will be considered alongside exploring a possible role for the Medicines and Healthcare products Regulatory Agency in relation to tissues and cells for human application.

3.26 And second, we propose that the Human Tissue Authority's regulatory function relating to research could be transferred to a new research regulator, as described above. The research regulatory activities of the Human Tissue Authority are within the scope of the Academy of Medical Sciences review of medical and science research regulation, and subject to the outcome of that review we consider that there could be significant advantage in consolidating the Human Tissue Authority's research regulation with similar functions from the Human Fertilisation and Embryology Authority and the National Patient Safety Agency (i.e. the National Research Ethics Service).

3.27 The timing and detail of these changes will be dependent on the outcome of the Academy of Medical Sciences review and on a further detailed examination of the legislative implications, including the impact on devolved administrations. The legal framework within which the Human Tissue Authority operates is complex, and we recognise the extraordinary sensitivity of this subject area. Given the complexity of the legislative framework, and the amount of work needed to ensure that the functions which are transferred to other organisations (e.g. the Care Quality Commission and a research regulator) are fully integrated into their new organisation, we do not intend to legislate for this in the Health Bill in the autumn.

3.28 We will engage with the Human Tissue Authority and other key stakeholders to develop detailed proposals, including options for handling those functions currently carried out by the Human Tissue Authority that may not sit well with the Care Quality Commission or the proposed new research regulator (for example the regulation of the public display of human material and the approval of live donations of organs, bone marrow and peripheral blood stem cells for transplantation).

Human Fertilisation and Embryology Authority (HFEA)

3.29 The Human Fertilisation and Embryology Authority is responsible for licensing fertility treatments and research conducted using human embryos. As such, it deals with issues that are judicially and ethically complex and contentious. By being at arm's-length, the Human Fertilisation and Embryology Authority separates sensitive issues from government and its independence is trusted. The Human Fertilisation and Embryology Authority's functions satisfy the criteria for being undertaken by an arm's-length body.

3.30 Notwithstanding this, there are clear synergies between some of the functions performed by the Human Fertilisation and Embryology Authority, the Human Tissue Authority and the Care Quality Commission, and there is significant read across to the potential scope of a new research regulator. There are therefore opportunities to rationalise some of the Human Fertilisation and Embryology Authority's functions that would lead to a different organisational solution for the future. As with the Human Tissue Authority, the Human Fertilisation and Embryology Authority research licensing function is subject to the wider review by the Academy of Medical Science on research and governance regulation, due to report in the autumn. Moving this function to a new research regulator, to achieve the benefits described above, reduces the justification for the Human Embryology and Fertilisation Authority to continue as a separate regulator, and opens the way for its remaining functions relating to the regulation of fertility clinics to be transferred to the Care Quality Commission.

3.31 This would help ensure that maintenance of the register of treatment, the provision of information for donor-conceived people and researchers, the provision of a Code of Practice for centres, and information for patients and licensing are kept whole. There may be potential for the Human Fertilisation and Embryology Authority's information collection and retention functions to pass to the Health and Social Care Information Centre, in line with the general approach to other arm's-length bodies' information needs, but the particular confidentiality issues need further consideration.

3.32 As with the Human Tissue Authority, the legal framework within which the Human Fertilisation and Embryology Authority operates is complex, and we

recognise the extraordinary sensitivity of this subject area. Given the complexity of the legislative framework, and the amount of work needed to ensure that the functions which are transferred to other organisations (e.g. the Care Quality Commission and the research regulator) are fully integrated into their new organisation, we do not intend to legislate for this in the Health Bill in the autumn, but aim to introduce the necessary legislation within the Parliament. We intend to engage fully with the Human Fertilisation and Embryology Authority, the Human Tissue Authority and other key stakeholders to develop detailed proposals with a view to bringing forward legislation to achieve these changes in due course.

3.33 Therefore, we propose that the Human Fertilisation and Embryology Authority should remain as a separate arm's-length body in the short term with the aim that its functions will be transferred by the end of the current Parliament. In the meantime, we will examine in greater detail the practicalities (and legal implications) of how to divide the Human Fertilisation and Embryology Authority functions between a new research regulator and the Care Quality Commission.

Council for Healthcare Regulatory Excellence (CHRE)

3.34 The Council for Healthcare Regulatory Excellence is an Executive Non-Departmental Public Body responsible for scrutiny and quality assurance of the nine health care professions regulators in the UK. We have considered whether it is essential that there continues to be a regulator of the professional regulators. We concluded that the Council for Healthcare Regulatory Excellence does currently fulfill an ongoing need to quality assure professional regulation, but we will keep this under review.

3.35 Going forward, we see no compelling reason why the Council for Healthcare Regulatory Excellence should remain as an Executive Non-Departmental Public Body in the arm's-length bodies sector. Therefore, we propose to make it self-funding through a levy on those it regulates. We also propose to extend the Council for Healthcare Regulatory Excellence's remit to set standards for and to quality assure, voluntary registers held by existing statutory health and care professions regulators, and others such as professional bodies. We intend to include provisions in the Health Bill to make these and associated changes.

General Social Care Council (GSCC)

3.36 The General Social Care Council is an Exective Non-Departmental Public Body responsible for the regulation of social workers and social work students in England. It is anomalous as the only professional regulator answerable directly to the Secretary of State for Health.

3.37 We see no compelling reason why the General Social Care Council should remain as an Executive Non-Departmental Public Body in the arm's-length bodies sector, and we see potentially significant benefits from putting the regulation of social workers on a similar footing to the regulation of health professions. This involves the regulator being funded through registration fees charged to those registered, set at a level to cover the regulatory functions. In this way members of a regulated profession buy into their professional standards, which are set independently of government, and have an incentive to ensure these are upheld throughout the profession.

3.38 Therefore, we intend to abolish the General Social Care Council and move the regulation of social workers out of the arm's-length bodies sector to make it financially independent of government. We believe that in future, the most appropriate model for the ongoing regulation of the social care workforce is to transfer responsibility for these functions to the Health Professions Council, a well established and efficient regulatory body currently regulating over 200,000 registrants from fifteen professions. The Health Professions Council - which will be renamed to reflect its new remit - operates a full cost recovery scheme and currently charges an annual fee of £76 per year, which is considerably less than the likely registration fee if the General Social Care Council were to operate alone on a full-cost recovery basis.

3.39 The Health Professions Council has an existing comprehensive and cohesive system of professional regulation which would apply to social care workers. This differs from the General Social Care Council model in several ways:

- the Health Professions Council is solely responsible for setting standards of education and training for its registrants, whereas it is the Secretary of State's function to ascertain what training is required to become a social worker;

- unlike the General Social Care Council, the Health Professions Council do not register students, though as part of the approval process the Health Professions Council requires all Higher Education Institutes delivering pre-registration courses to operate a fitness for practice system for students;

- unlike the General Social Care Council, the Health Profession Council does not in practice approve post-registration courses apart from those related to prescribing drugs, although it has the power to do so.

3.40 We anticipate that the differences would be explored through a review of social care regulation. The abolition of the General Social Care Council, the transfer of functions in relation to the regulation of the social worker workforce and related changes will require primary legislation. The timing of these changes is

dependent on discussion with the Health Professions Council and the General Social Care Council to ensure an orderly transition.

3.41 Finally, the General Social Care Council is also responsible for the payment of Education Support Grants, and we propose that if this function is to continue it should transfer to another body.

A Public Health Service

3.42 We propose to support the cross-government public health strategy through the creation of a new Public Health Service directly accountable to the Secretary of State, to integrate and streamline existing health improvement and protection bodies and functions, with an increased emphasis on research, analysis and evaluation. As a part of that development we intend to abolish the Health Protection Agency and the National Treatment Agency for Substance Misuse as statutory organisations and transfer their functions to the Secretary of State as part of the Public Health Service.

3.43 The critical functions of the National Treatment Agency for Substance Misuse which support the local delivery of drug treatment services would be integrated into the Public Health Service. We believe that this move would tackle the dependency problems of individuals, and address the entire range of issues which users face. The full recovery of drug users back into society, housing and employment will provide significant benefits to all.

3.44 Our programme for public health will be set out later this year and more detail on what it means for these two organisations, and dedicated public health ring-fenced funding to support delivery of local services, will be set out in the context of the new Public Health Service. We will engage with the Health Protection Agency and the National Treatment Agency for Substance Misuse to ensure a smooth and orderly transition.

Alcohol Education and Research Council (AERC)

3.45 The Alcohol Education and Research Council was established as an Executive Non-Departmental Public Body via the Licensing (Alcohol Education and Research) Act 1981. The Alcohol Education and Research Council has charitable status and administers a fund of around £8m to support research into the prevention of alcohol-related harm. The Department does not provide funding for this arm's-length body. Overall, the organisation does not satisfy the criteria for Department of Health arm's-length bodies. We intend to remove this organisation from our arm's-length bodies sector while seeking to maximise opportunities for the organisation to contribute to the development of the evidence base for effective policy across Government to reduce harm from

alcohol misuse. We will engage with the Alcohol Education and Research Council on the options.

NHS Blood and Transplant (NHS BT)

3.46 NHS Blood and Transplant is a Special Health Authority, responsible for securing the safe supply of blood to the NHS in England and Wales, and similarly, solid organs, tissues, and stem cells across the UK. NHS Blood and Transplant works closely with the Devolved Administrations, charities and the NHS to promote altruistic donation for the benefit of patients. Through the Bio Products Laboratory, NHS Blood and Transplant also manufactures therapeutic plasma products which are supplied on a commercial basis to the NHS and world markets.

3.47 There are strong arguments for retaining the majority of these functions within a single national system. These arguments include: economy of scale and supply; public health requirements in relation to quality, safety and consistency across the blood, tissue and transplant service; and critically, public sensitivities regarding the voluntary donation of blood, tissues and organs. We consider that transferring NHS Blood and Transplant out of the arm's-length bodies sector and moving to a different delivery model would risk destabilising the current national donor system.

3.48 However, we do consider that Bio Products Laboratory will benefit from greater commercial freedom and closer integration with its plasma supply chain, and it will therefore be transferred into a Department of Health-owned limited company. There may be opportunities for more cost effective operations and commercial arrangement within the remaining divisions of NHS Blood and Transplant, such as contracting out some discrete functions, provided there is no conflict with the public health considerations. We therefore recommend that, with the exception of Bio Products Laboratory, the organisation remains within the arm's-length body sector and we will commission an in-depth review into opportunities to make it more commercially effective. Subject to the findings of the commercial review, we propose to work with the Devolved Administrations to explore the potential for the UK blood services to enhance opportunities for cost-effective working between them.

Information and Intelligence

Health and Social Care Information Centre (IC)

3.49. Information, combined with the right support, is the key to better care, better outcomes and reduced costs. However, within the arm's-length bodies sector and across the wider infrastructure supporting health and social care, there is a duplication of roles and responsibilities around collection, analysis and

dissemination of information. This is no longer acceptable as it places a significant burden and costs on the frontline. We intend to make aggregate data widely available to patients, the public, researchers and other organisations in a standard format.

3.50 To achieve this we propose that the Health and Social Care Information Centre will become the national repository for data across health care, public health and adult social care with lead responsibility for data collection and assuring the data quality of those returns. It will make data available for use by third parties. It will need to meet the needs of a multiplicity of customers: the DH, the NHS, local authorities, social care, regulators, researchers, the Office for National Statistics, the public and Parliament. This proposal would mean that other arm's-length bodies would relinquish their data collection roles to the Health and Social Care Information Centre. In future, the relationship between the NHS Commissioning Board and the Health and Social Care Information Centre will be critical to ensure that the NHS Commissioning Board can exercise its management functions. The forthcoming Health Bill will contain provisions to put the Health and Social Care Information Centre on a firmer statutory footing, with clearer powers across organisations in the health and care system, with a functional scope focussed on data collection and giving it powers across organisations in the health and social care system.

3.51 All of this is expected to minimise existing duplication and overlap in collections of data from multiple organisations as well as the overall cost of collection to the system.

3.52 The way in which the Health and Social Care Information Centre would perform this role will be covered further in an Information Strategy to be published later this year.

Public Appointments

Appointments Commission (AC)

3.53 The Appointments Commission provides recruitment services and related functions (managing suspensions) at reasonable costs, provides value for money and has built up considerable NHS expertise. The Commission has been a very valuable body for Department of Health and the NHS over the last decade. It has an important role to play to support reorganisation in both the NHS and arm's-length bodies sector over the forthcoming transition period, to ensure we retain effective boards and transitions are well-managed.

3.54 However, in the future, NHS Trusts are expected to become Foundation Trusts and SHAs are to be abolished. The Government's intention for the future of PCTs has been set out in the White Paper and the ending of PCT public

appointments means that in the future the Commission's NHS work would disappear. The emerging future model across government is one where there will also be a sizeable reduction in the number of national public appointments. Accountability for these appointments would rest with Ministers and the process will remain subject to scrutiny by the Commissioner for Public Appointments, to ensure the process remains open, transparent and appointments are made on merit. The Government has also signalled that key appointments may also be subject to Select Committee scrutiny.

3.55 The NHS and public appointments landscape is to change radically and there will be no need for an on-going central public body to carry out the functions the Commission currently provide beyond 2012. We therefore propose to abolish the Appointments Commission during 2012 and we will engage with the Commission on managing a transition period to abolition.

Quality and Safety Improvement

3.56 Patient safety is synonymous with improving overall clinical excellence and sits at the heart of the quality agenda. Currently, functions associated with quality and safety improvement are distributed across a number of arm's-length bodies as well as elsewhere in the health and social care system. This creates complexity and there is still some way to go to embed improvement fully across the NHS.

3.57 In future, the NHS Commissioning Board will provide national leadership on commissioning for quality improvement and we propose that some essential functions supporting this role from the National Patient Safety Agency and the NHS Institute for Innovation and Improvement should be brought together within the mainstream work of the NHS Commissioning Board to exploit the leverage that commissioning would provide in placing quality and safety at the heart of patient care.

National Patient Safety Agency (NPSA)

3.58 The National Patient Safety Agency was established as a Special Health Authority in 2001. Its core function is to improve the safety of NHS care by promoting a culture of reporting and learning from adverse events. It does this primarily through its Patient Safety Division, which runs the National Reporting and Learning Systems.

3.59 Following the last review of arm's-length bodies, a number of other discrete functions related to patient safety were brought together within the National Patient Safety Agency. The functions of the organisation, whilst necessary within a system supporting wider quality and safety improvement, do not of

themselves need to be performed at arm's-length of the Department and could be delivered elsewhere in the system.

3.60 We propose to abolish the National Patient Safety Agency. Some National Patient Safety Agency functions will become part of the remit of the NHS Board, while others will be supported to continue in other ways. The following functions will transfer to elsewhere in the wider health system:

3.61 The work of the Patient Safety Division relating to reporting and learning from serious patient safety incidents should move to the NHS Commissioning Board, as a Patient Safety sub-committee of the Board, covering the whole function from getting evidence to working up evidence-based safe services. This would provide an opportunity to preserve the synergy between learning and operational practice that already exists in the system. We will engage with the National Patient Safety Agency to discuss the transitional arrangements for the Patient Safety Division.

3.62 The National Clinical Assessment Service, which helps healthcare managers and practitioners to understand, manage and prevent concerns with the performance of doctors, dentists and pharmacists, should continue in the short term. It is valued by employers of doctors, dentists and pharmacists whose performance calls for rehabilitation to ensure continued safe practice. However, there is an expectation that revalidation of the medical profession and other incentives in the system will reduce the need for this service in the future. We propose that, over the next few years, the National Clinical Assessment Service will become a self-funded service and the Department intends to agree a date with the service for achieving self-sufficiency.

3.63 The National Research Ethics Service helps protect the interests of patients and research participants in clinical trials and facilitates and promotes ethical research. It includes recognising and authorising Research Ethics Committees, which approve individual research applications. We propose that the future of the National Research Ethics Service is considered as part of the wider Academy of Medical Science's review of research regulation with a view to moving this function into a single research regulatory body.

3.64 The National Patient Safety Agency currently commissions three confidential enquiries to provide learning on what went wrong in adverse healthcare incidents. In future, the enquiries could sit with the National Clinical Audit Patient Outcome Programme (NCAPOP – consists of 30 individual national clinical audits) managed on behalf of the Department by the Healthcare Quality Improvement Partnership (HQIP).

3.65 We will engage with the National Patient Safety Agency about the implementation of the proposals contained in this document.

NHS Institute for Innovation and Improvement (NHS III)

3.66 The NHS Institute for Innovation and Improvement was established as a Special Health Authority under the National Health Service Act 2006 and is an arm's-length body sponsored by the Department of Health to act as the NHS' "in house improvement organisation". Its purpose is to support the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership. It supports NHS organisations in analysing their current practices against best practice and implementing changes to achieve better results.

3.67 It is currently funded largely through grant in aid from the Department of Health; in addition it has been developing a commercial model selling additional services to the NHS and international organisations to generate revenue that can be reinvested in further NHS work.

3.68 The NHS Institute for Innovation and Improvement has provided leadership and tools to support quality improvements across the NHS. In future, the NHS Commissioning Board will assume a leadership role in commissioning for quality improvement and the responsibility for improving outcomes will occur at every level of the NHS.

3.69 In assessing the NHS Institute for Innovation and Improvement it does not satisfy the criteria for an arm's-length body and we intend therefore to abolish the NHS Institute for Innovation and Improvement as an arm's-length body, transferring to the NHS Commissioning Board those functions that will support the Board in leading on quality improvement and building capacity within the wider system.

3.70 We will engage with the NHS Institute for Innovation and Improvement on reviewing and evaluating its remaining functions with a view to determining whether opportunities exist for alternative commercial delivery models, for example, creating a social enterprise or independent membership organisation, and whether or not to stop providing certain functions altogether.

3.71 The NHS Institute for Innovation and Improvement also manages the NHS management training schemes along with their associated bursaries. The future of these schemes and their administration will be considered in the wider context of the recent White Paper.

Exploring commercial opportunities

NHS Litigation Authority (NHS LA)

3.72 The NHS Litigation Authority is a Special Health Authority, responsible for the management and settlement of very large current and future liabilities attached to NHS bodies. These liabilities accrue predominantly, but not wholly, as a result of clinical negligence claims.

3.73 There is a strong case for pooling risk between NHS organisations – there are obvious economies of scale and it does not make sense to disaggregate responsibility for managing the risk and processing the claims and payment. But, it is not clear that this function satisfies the criteria for arm's-length bodies status, and there may be potential for greater efficiencies. More importantly, we consider that there may be opportunities to introduce greater commercial management and practice to improve the efficiency of the services provided. We therefore intend to commission an industry review of the NHS Litigation Authority, to identify these potential opportunities for greater commercial involvement, recognising the impact on future organisational form, with a view to its likely removal from the arm's-length bodies sector as soon as is practicably possible.

NHS Business Services Authority (NHS BSA)

3.74 The NHS Business Services Authority processes transactions for the NHS where there are significant economies of scale in undertaking them once at a national level. The organisation provides, for example, pensions administration and dental and prescription payments. In addition, the NHS Business Service Authority has a number of discrete responsibilities (e.g. counter fraud, dental inspections and supply chain contract management) where there is less obvious alignment with the core purpose.

3.75 Although it is not clear that the NHS Business Services Authority functions satisfy the three criteria for arm's-length bodies status, there are economies of scale for some of their activities by performing them nationally. However, there may be potential for alternative delivery models and we consider that there may be significant opportunities to introduce commercial skills and management to improve the efficiency of the services provided. We therefore intend to commission a commercial review of the NHS Business Services Authority, to identify potential opportunities for greater private sector involvement, including the possibility of removing activities from the arm's-length body sector. In addition we will explore opportunities to remove from the NHS Business Services Authority their non-core activities, and where necessary finding an alternative approach to delivering the functions.

3.76 The NHS Business Services Authority was set up through secondary legislation, therefore any changes may not require primary legislation, though this would depend on the precise approach. We do not anticipate any NHS Business Service Authority specific provisions in the forthcoming Health Bill.

4 REDUCING BUREAUCRACY AND INCREASING EFFICIENCIES

4.1 Reconfiguration of organisations or rationalisation of functions will not, of themselves, offer up the scale of savings required, and in any event would largely be achieved towards the end of the savings period. But, together with the measures outlined below, such as tightening governance and aggregating business support functions, these changes will contribute to a comprehensive reduction in the Department's spend across the sector, a reduction in duplication and improved cost effectiveness.

4.2 Even where current arm's-length bodies remain relatively unchanged, there is an expectation that they will all contribute significant efficiency savings.

4.3 We will identify opportunities to raise capital and improve the commercial performance of trading activities within the arm's-length bodies sector and the Department of Health, increasing independent sector ownership and involvement in trading activities, and outsourcing. This builds on an existing commercialisation and divestment programme within the Department.

4.4 We will expect all arm's-length bodies to work towards integrating their business support functions to achieve greater efficiencies and economies of scale across arm's-length bodies and Department of Health business support functions, including finance and payroll. Allied to this, there is work to maximise efficient and effective use of arm's-length bodies and Department of Health estate leading to opportunities to reduce the number of properties across the arm's-length bodies and Department of Health portfolio and wherever possible, co-locate organisations.

4.5 We will also introduce tighter governance and accountability of the management of the arm's-length bodies sector, which could include:

- putting the Department of Health governance arrangements of arm's-length bodies on a professional footing to ensure: that all arm's-length bodies have clarity about the scope of their functions, accountabilities and objectives; stop mission creep; and drive up efficiency, effectiveness and value for money;
- increasing public accountability and transparency by requiring arm's-length bodies to publish more information, including financial and performance information; and

- ensuring that arm's-length bodies boards are streamlined and have the right skills and composition to operate effectively, drive value for money and challenge performance.

4.6 A key part of the future operation of arm's-length bodies will be to ensure that the burden of their activities on providers (and any other organisation) is both understood and justifiable. Cumulatively, across the arm's-length bodies sector, this burden should reduce year-on-year as measured by quantitative and qualitative feedback from providers.

4.7 To achieve this reduction will require individual arm's-length bodies to embed the principles of good regulation (proportionate, accountable, consistent, transparent and targeted) within the culture and practice of their organisations. Paramount within this will be to act on feedback from customers to develop and utilise more innovative methods to deliver their functions effectively.

4.8 To achieve a collective reduction in burden year-on-year, individual arm's-length bodies will work proactively in partnership with others, co-ordinating and scheduling activity, sharing methodologies, findings and views, to achieve a more complementary programme of activities from a provider perspective.

4.9 Centralisation of data collections in the Health and Social Care Information Centre is intended to help drive through a reduction in burden through the removal of duplication, overlap and similar requests in slightly different forms, and ensure that the flow of any future data collections is effectively dealt with.

5 MAKING IT HAPPEN

Engaging external organisations and transition to the new landscape

5.1 This report describes a set of changes across the arm's-length bodies sector within the context of the wider changes envisaged for the NHS in *Equity and excellence: Liberating the NHS.*

5.2 Much work now needs to be undertaken to implement the changes described in the document. We will engage with the arm's-length bodies and key stakeholders, including the Devolved Administrations and other government departments, to flesh out the detail of each recommendation and will draw on the expertise of the arm's-length bodies sector and others to develop detailed implementation plans.

5.3 We expect that implementation of the proposals will be completed by 2014 in line with the wider system changes. To support the changes envisaged across the whole system, the Department will issue a framework for managing the initial transition steps. This will include the principles and the values that the Department will hold itself to, to ensure that the transition is managed fairly and transparently, and in a way that respects staff and the contributions they make. Some organisations will disappear and some functions will shift to other organisations as a result of the changes described in this document. We will work with the individual arm's-length bodies to ensure that these changes are managed smoothly and ensure that business continuity is maintained throughout the transition period. Annex C sets out an indicative implementation timeline.

5.4 We intend as a priority to take forward proposals to reduce the cost of the business support functions of the arm's-length bodies by increasing the level of integration and sharing resources, and making greater use of private sector involvement. We will engage with arm's-length bodies on a programme to make some initial savings within 12-18 months, with a staged implementation to the optimum level of integration, sharing and use of the private sector over the next 2-3 years. The programme includes identifying opportunities for estate rationalisation and co-location of organisations.

5.5 We have already put in place spending controls around pay, expenses, travel, consultancy, communications and IT and we envisage that these controls will continue. Arm's-length bodies will have less freedom to determine how they spend their money in these areas.

5.6 We will introduce tighter governance and sponsorship arrangements from April 2011, and we intend to issue new framework agreements setting out clearly the Department's understanding of the scope of the arm's-length bodies' functions and clear objectives against which they will be held to account.

Legislative changes

5.7 Many of the changes outlined in this document will require primary and secondary legislation. The Queen's speech included a major Health Bill and a Public Bodies Bill for the first legislative programme. The Government will introduce these bills this autumn and the changes, where appropriate, will be enacted through one of these bills: our intention is that the majority of changes will be in place during 2012/13.

Arm's-Length Bodies reviewed 2010 Annex A

Arm's-length bodies	Type	Role	Proposal
Alcohol Education and Research Council	Executive Non-Departmental Public Body (ENDPB) and registered charity	Administers the Alcohol Education and Research Fund	**Abolish** as an ALB and remove from the sector, while seeking to maximise the opportunities for effective cross-government policy to reduce the harm from alcohol misuse.
Appointments Commission	ENDPB	Makes public appointments	**Abolish** as an ALB during 2012 in view of the very substantial reduction in the number of appointments required. Move remaining appointments to the Department of Health.
Care Quality Commission	ENDPB	Regulates health and adult social care provision	**Retain** as quality inspectorate across health and social care, operating a joint licensing regime with Monitor. Host organisation for Healthwatch England. Current responsibility of assessing NHS commissioning moves to the NHS Commissioning Board. May receive

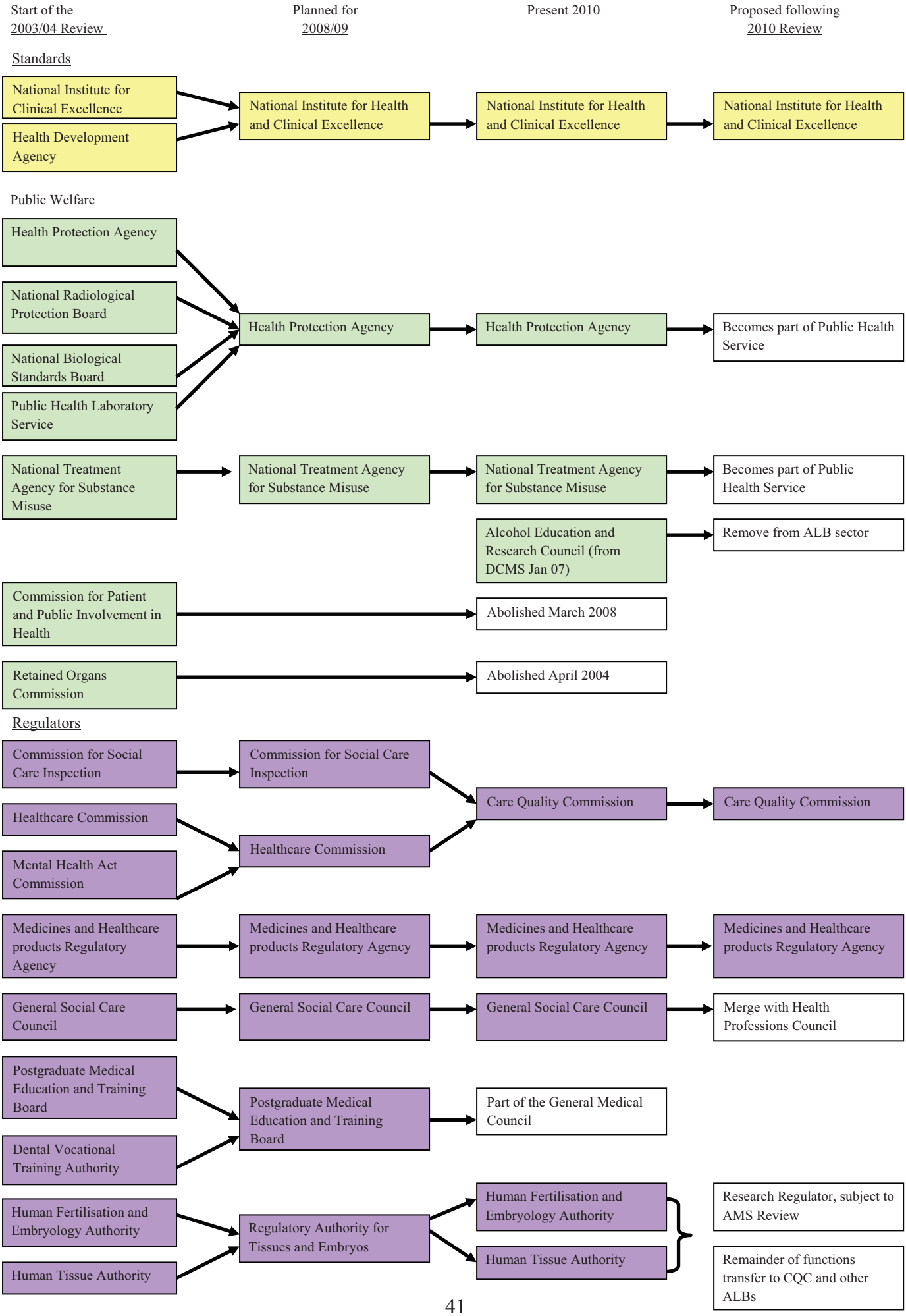
Arm's-length bodies	Type	Role	Proposal
			functions from other organisations, e.g. HTA and HFEA.
Council for Healthcare Regulatory Excellence	ENDPB	Oversees professional regulators	**Remove** from the sector. Make a self-funding body by charging a levy on regulators. Extend role to set standards for and quality assure voluntary registers.
General Social Care Council	ENDPB	Regulates social workers	**Transfer** the regulation of social workers to the Health Professions Council, which will be renamed to reflect its new remit.
Health and Social Care Information Centre	Special Health Authority(SpHA)	Collects and provides health and social care information	**Retain**, and put on a firmer statutory footing by establishing it in primary legislation. National repository for data collection across health care, public health and adult social care. Clearer focus on data collection, with a close working relationship with the NHS Commissioning Board.
Health Protection Agency	ENDPB	Protects the health and wellbeing of	**Abolish** as a statutory

Arm's-length bodies	Type	Role	Proposal
		the population	organisation and transfer functions to the Secretary of State as part of the new Public Health Service.
Human Fertilisation and Embryology Authority	ENDPB	Regulates human embryo storage, research and assisted reproduction treatment	**Retain** as a separate ALB for the time being, with the aim of transferring its functions by the end of the current Parliament. In the meantime, we will examine the practicalities (and legal implications) of how to divide the HFEA's functions between a new research regulator, the Care Quality Commission and the Health and Social Care Information Centre.
Human Tissue Authority	ENDPB	Regulates the removal, storage and use of human tissue and organs	**Retain** as a separate ALB for the time being, with the aim of transferring its functions by the end of the current Parliament. In the meantime, we will examine the practicalities (and legal implications)

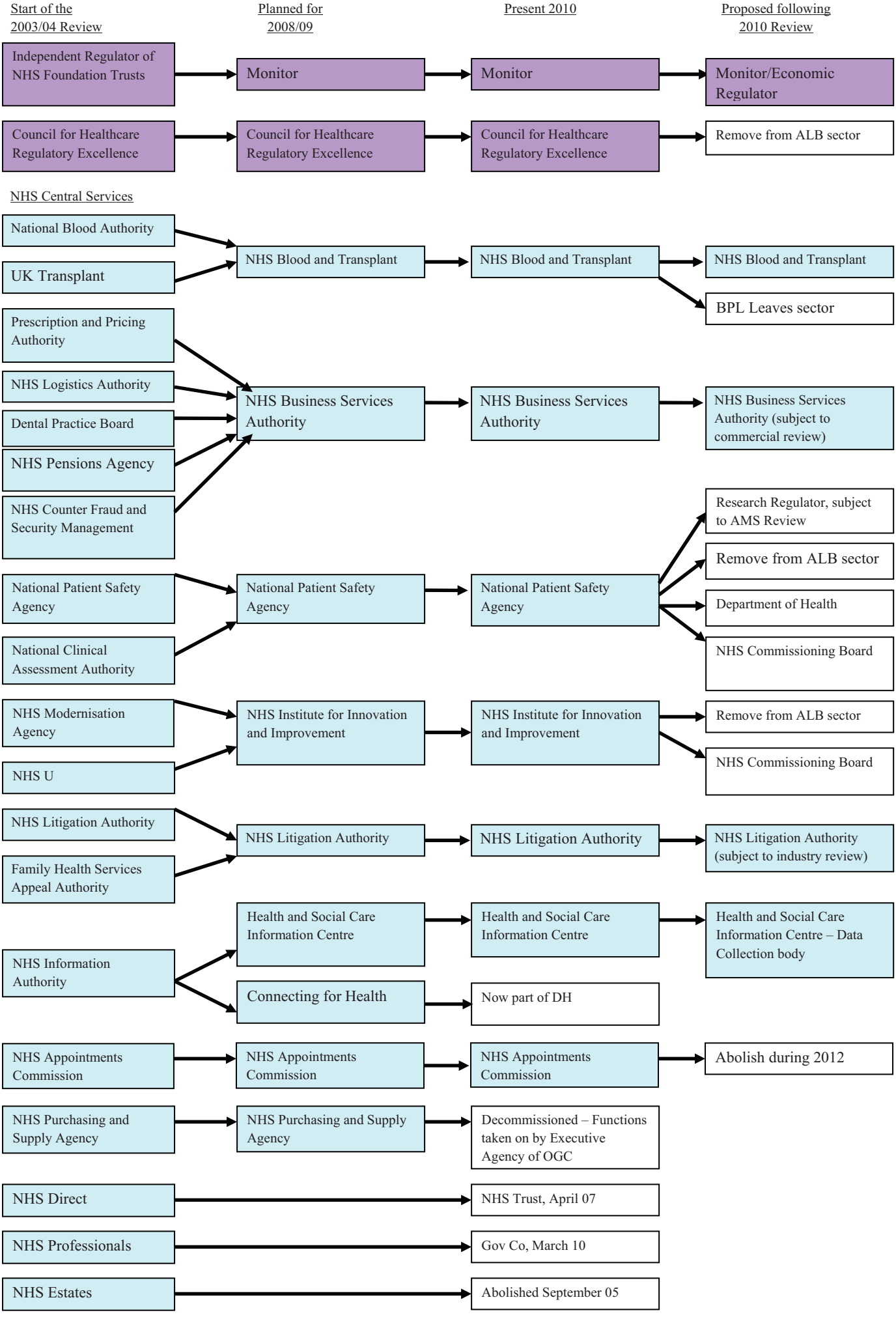
Arm's-length bodies	Type	Role	Proposal
			of how to divide the HTA's functions between a new research regulator, the Care Quality Commission and the Health and Social Care Information Centre.
Medicines and Healthcare products Regulatory Agency	Executive agency	Regulates medical devices and medicines	**Retain**, with the expectation that it will undertake its regulatory duties in the most cost effective way.
Monitor	ENDPB	Assesses, licences and monitors NHS Foundation Trusts	**Retain** and make an economic regulator, operating a joint licensing regime with CQC.
National Institute for Health and Clinical Excellence	SpHA	Provides national guidance on the promotion of good health and the prevention and treatment of ill-health	**Retain**, and put its advisory function on a firmer statutory footing by establishing it in primary legislation. Expand scope to include social care standards.
National Patient Safety Agency	SpHA	Promotes patient safety and manages the National Clinical Assessment Service, the National Research Ethics Service and confidential enquiries.	**Abolish** as an ALB. Safety functions retained and transferred to the National Commissioning Board. Explore transfer of National Research Ethics Service functions to single

Arm's-length bodies	Type	Role	Proposal
			research regulator. National Clinical Assessment Service to become self-funding over the next two to three years.
National Treatment Agency for Substance Misuse	SpHA	Works to increase the availability, capacity and effectiveness of drug treatment in England	**Abolish** as an ALB, and transfer functions to the Secretary of State as part of the new Public Health Service.
NHS Blood and Transplant	SpHA	Responsible for securing the safe supply of blood to the NHS in England and Wales, and similarly, solid organs, tissues, stem cells across the UK.	**Retain**, and commission an in-depth review of opportunities to make more commercially effective. Transfer Bio-Products Laboratory out of NHSBT into a Department of Health owned company.
NHS Business Services Authority	SpHA	Provides central services to the NHS	**Retain** in short term, and commission commercial review to identify potential for increased commercial opportunities, including potential to remove functions from the ALB sector.
NHS Institute for Innovation and	SpHA	Supports the NHS by spreading new	**Remove** from ALB sector. Move

Arm's-length bodies	Type	Role	Proposal
Improvement		ways of working, new technology and leadership	functions which will support the NHS Commissioning Board in leading for quality improvement to the Board. Review the potential for its remaining functions to be delivered through alternative commercial delivery models.
NHS Litigation Authority	SpHA	Handles negligence claims and works to improve risk management practices in the NHS	**Retain**, and commission an industry review to identify potential opportunities for greater commercial involvement.



Note: Proposals to be considered against Academy of Medical Sciences Review and other functions


Start of the 2003/04 Review
Planned for 2008/09
Present 2010
Proposed following 2010 Review
Independent Regulator of NHS Foundation Trusts
Monitor
Monitor
Monitor/Economic Regulator
Council for Healthcare Regulatory Excellence
Council for Healthcare Regulatory Excellence
Council for Healthcare Regulatory Excellence
Remove from ALB sector
NHS Central Services
National Blood Authority
UK Transplant
NHS Blood and Transplant
NHS Blood and Transplant
NHS Blood and Transplant
BPL Leaves sector
Prescription and Pricing Authority
NHS Logistics Authority
Dental Practice Board
NHS Pensions Agency
NHS Counter Fraud and Security Management
NHS Business Services Authority
NHS Business Services Authority
NHS Business Services Authority (subject to commercial review)
National Patient Safety Agency
National Clinical Assessment Authority
National Patient Safety Agency
National Patient Safety Agency
Research Regulator, subject to AMS Review
Remove from ALB sector
Department of Health
NHS Commissioning Board
NHS Modernisation Agency
NHS U
NHS Institute for Innovation and Improvement
NHS Institute for Innovation and Improvement
Remove from ALB sector
NHS Commissioning Board
NHS Litigation Authority
Family Health Services Appeal Authority
NHS Litigation Authority
NHS Litigation Authority
NHS Litigation Authority (subject to industry review)
NHS Information Authority
Health and Social Care Information Centre
Connecting for Health
Health and Social Care Information Centre
Now part of DH
Health and Social Care Information Centre – Data Collection body
NHS Appointments Commission
NHS Appointments Commission
NHS Appointments Commission
Abolish during 2012
NHS Purchasing and Supply Agency
NHS Purchasing and Supply Agency
Decommissioned – Functions taken on by Executive Agency of OGC
NHS Direct
NHS Trust, April 07
NHS Professionals
Gov Co, March 10
NHS Estates
Abolished September 05

Annex C

Implementation indicative timetable for action

Commitment	**Date**
Health Bill introduced in Parliament Public Bodies (Reform) Bill introduced in Parliament	Autumn 2010
NHS Litigation Authority – industry review completed NHS Business Services Authority – commercial review completed NHS Blood and Transplant – review of commercial opportunities complete	December 2010
Engagement on implementation with key stakeholders, including Devolved Administrations	Summer and autumn 2010
Shadow NHS Commissioning Board established as Special Health Authority	April 2011
NHS Commissioning Board fully established Public Health Service in place NICE put on a firmer statutory footing Monitor established as an economic regulator Healthwatch England established within the Care Quality Commission Health and Social Care Information Centre put on a firmer statutory footing Alcohol Education and Research Council removed from arm's-length body sector General Social Care Council functions transferred to Health Professions Council Health Protection Agency and National Treatment Agency for Substance Misuse transfer to Public Health Service	April 2012

National Patient Safety Agency transfer of some functions to NHS Commissioning Board and others transferred elsewhere NHS Institute for Innovation and Improvement complete transfer of functions and removal from arm's-length body sector completed	
Appointments Commission abolished	During 2012
Council for Healthcare Regulatory Excellence removed from sector and becomes self-funding Human Tissue Authority and Human Embryology and Fertilisation Authority abolished and functions transferred elsewhere	April 2013
Integration of business support functions across arm's-length bodies	By 2013/14

Glossary

Arm's-length bodies (ALBs) – ALBs are Government-funded organisations which work closely with local services, and other ALBs. In the Department they regulate the system, improve standards, protect public welfare and support local services. The Department has three main types of ALB: executive agencies, executive non-departmental public bodies, and special health authorities.

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Devolved administrations – the governments of Scotland, Wales and Northern Ireland.

Executive Agencies – executive agencies have responsibility for particular business areas. The agencies are still part of, and accountable to, the Department.

Executive non-Departmental public bodies (ENDPBs) – an ENDPB is a body set up by statute which has a role in the processes of national Government, but is not a Government Department or part of one.

Foundation trusts – NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control than others, enabling them to be more responsive to the needs of local populations.

Health Bill – proposals for a Health Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Health Bill will bring forward the legislative changes required for the implementation of the proposals in this White Paper.

Primary care trusts (PCTs) – the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services such as district nursing, for a local area.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Public Bodies (Reform) Bill – proposals for a Public Bodies Bill were included in the Queen's Speech for the first Parliamentary session of the coalition Government. The Bill forms part of the Government's strategy to increase accountability and transparency.

Special health authorities (SpHAs) – SpHAs are independent bodies, but are subject to ministerial direction like other NHS bodies. They provide a service to the public and/or the NHS, and generally provide a service for the whole population of England, rather than for a particular local community.

Strategic health authorities (SHAs) – the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

White Paper, *Equity and Excellence: Liberating the NHS* – published on 12 July 2010, the White Paper sets out the Government's long-term vision for the NHS.