

A Short Guide to

Selected health arm's-length bodies





About this guide and contacts

This Short Guide summarises the work of **selected health arm's-length bodies**, covering what they do, how much they spend, their performance and what to look out for.



If you would like to know more about the National Audit Office's (NAO's) work on the Department of Health and its associated organisations, please contact:

Jenny George

Value for Money Director,
Department of Health

✉ jenny.george@nao.gsi.gov.uk

☎ 020 7798 7819

Mike Newbury

Financial Audit Director,
Department of Health

✉ mike.newbury@nao.gsi.gov.uk

☎ 020 7798 5468

If you are interested in the NAO's work and support for Parliament more widely, please contact:

✉ parliament@nao.gsi.gov.uk

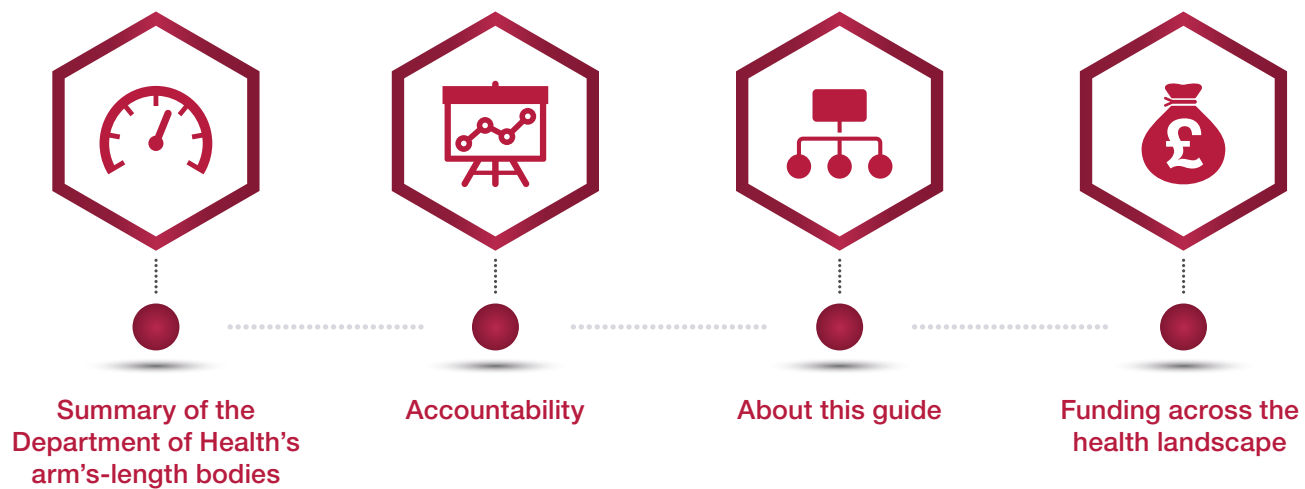
☎ 020 7798 7665

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Overview



Summary of the Department of Health's arm's-length bodies

The Department of Health (the Department) works through a number of arm's-length bodies. These arm's-length bodies share in managing, or overseeing, the use of resources across the NHS, public health and social care. The largest of the agencies and public bodies supporting the Department is NHS England. In September, we published [A Short Guide to the Department of Health and NHS England](#). This accompanying guide provides a short summary of seven of the other arm's-length bodies that we have had most significant engagement with, see [page 6](#). A full list of the Department's arm's-length bodies is provided as an [Appendix](#).

For each organisation we have:

- outlined its role, funding and staffing; and
- set out its objectives, key indicators of performance and, where applicable, things to look out for based on our previous work or other relevant reports or reviews.

Health arm's-length bodies fall into five categories:

- 1 Executive agencies**, which are legally part of the Department;
- 2 Special health authorities**, which can be created by legislation and are subject to direction by the Secretary of State. An example of this is the new NHS Counter Fraud Authority which was launched in 2017-18;
- 3 Executive non-departmental public bodies**, whose relationship with the Department is defined in legislation. They receive grant-in-aid funding from the Department and may charge for their services;
- 4 Advisory non-departmental public bodies and expert committees**, which form part of the core Department; and
- 5 Other bodies**. The Department's remaining arm's-length bodies take a variety of other forms, for example the National Information Board.

Arm's-length bodies expenditure

The majority of health funding goes to the Department's arm's-length bodies. In 2016-17 the Department had an overall revenue and capital budget of £122.2 billion. Less than 4% (£4.7 billion) of its funding was allocated to the core Department. The remainder (£117.5 billion) was allocated to its arm's-length bodies.

Accountability

The Department published its [Accounting Officer System Statement](#) in July 2017, setting out its accountability relationships and processes. The Department's principal accounting officer, who is the Permanent Secretary, is responsible for ensuring that:

- all of the expenditure of its arm's-length bodies is within the overall budget for the Department; and
- the arm's-length bodies are performing their functions and duties effectively, and have the necessary governance and controls to ensure regularity, propriety and value for money.

Each of the arm's-length bodies has its own accounting officer – appointed by the principal accounting officer, except for the accounting officer of NHS England who is appointed by legislation and the accounting officer of the Medicines and Healthcare products Regulatory Agency who is appointed by HM Treasury. These accounting officers hold the primary responsibility for compliance with the requirements set out in [Managing Public Money](#) and are accountable to Parliament for the use of public money and stewardship of public assets.

The Department is also able to gain assurance from its arm's-length bodies using:

- framework agreements setting out how the body will be held to account for the delivery of its objectives and outcomes for the use of public money;
- each body's annual business plan, which must be agreed with the Department, and performance against these plans; and
- a programme of reviews which ensure that each body is reviewed every five years.

The Secretary of State also has the power to appoint and remove chairs and non-executive board members.

Arm's-length bodies in government

In 2016 we published a [report](#) examining departments' oversight of arm's-length bodies across four other government departments: the Department for Business, Innovation & Skills; the Ministry of Justice; the Department for Environment, Food & Rural Affairs; and the Department for Culture, Media & Sport.

In this report we observed that getting the best from arm's-length bodies meant balancing assurance and control with allowing a body an appropriate degree of independence consistent with its function.

The Cabinet Office published its [Code of Good Practice for Partnerships between departments and arm's-length bodies](#) in February 2017, based on four principles: purpose, assurance, value and engagement.

About this guide

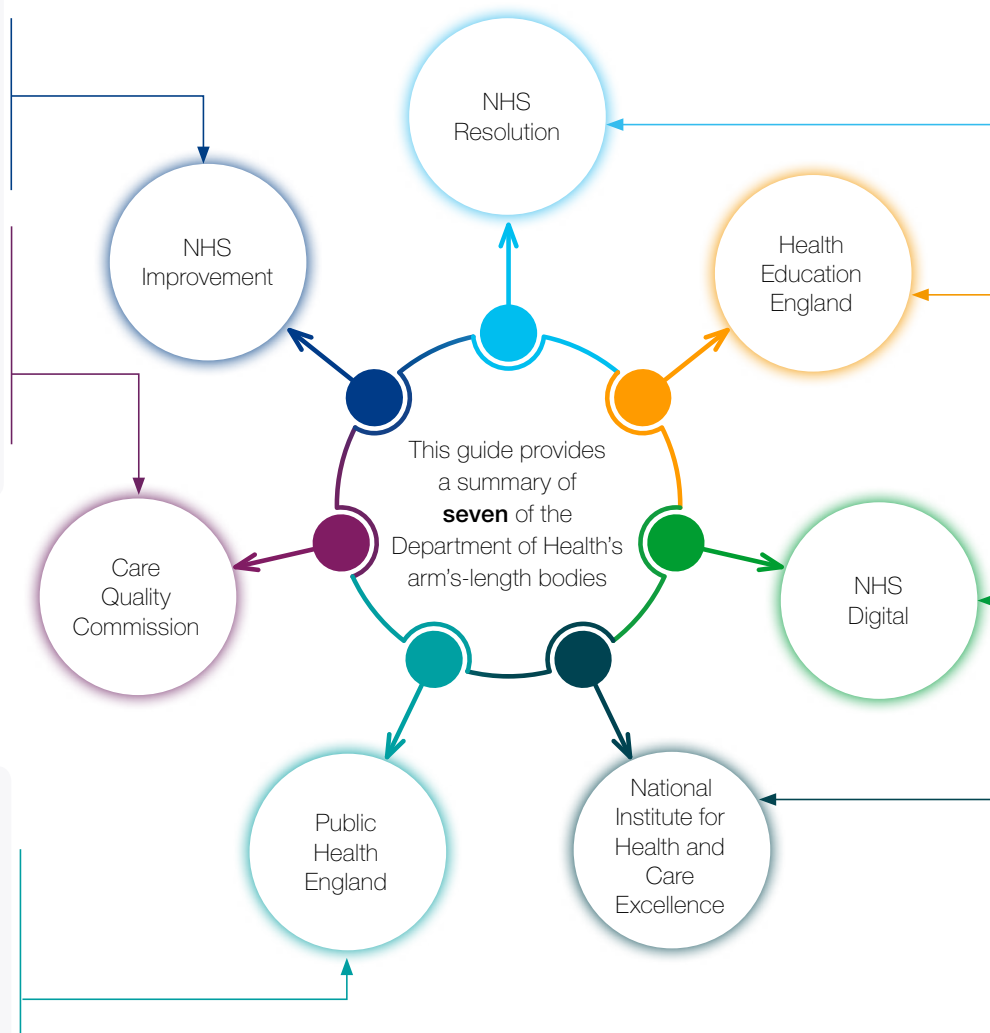
Regulators

Responsible for overseeing NHS foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It is intended to support financial sustainability, which is a key theme of our work and we have published a number of reports on this topic, including [here](#).

The independent regulator of health and adult social care in England. In 2015 we published a [report](#) examining the Care Quality Commission's capability and capacity to regulate the quality and safety of health and adult social care. In October 2017 we published another [report](#) focused on whether the Care Quality Commission is taking appropriate action to address the changing risks to patient care.

Responsible for undertaking some of the executive functions of the Department

In 2013 responsibility for commissioning local public health services passed from the NHS to local authorities. The following year we published a [report](#) looking at Public Health England's grant to local authorities. Public Health England provides advice and support on, for example, health improvement and health protection.



Central support functions and sector improvement

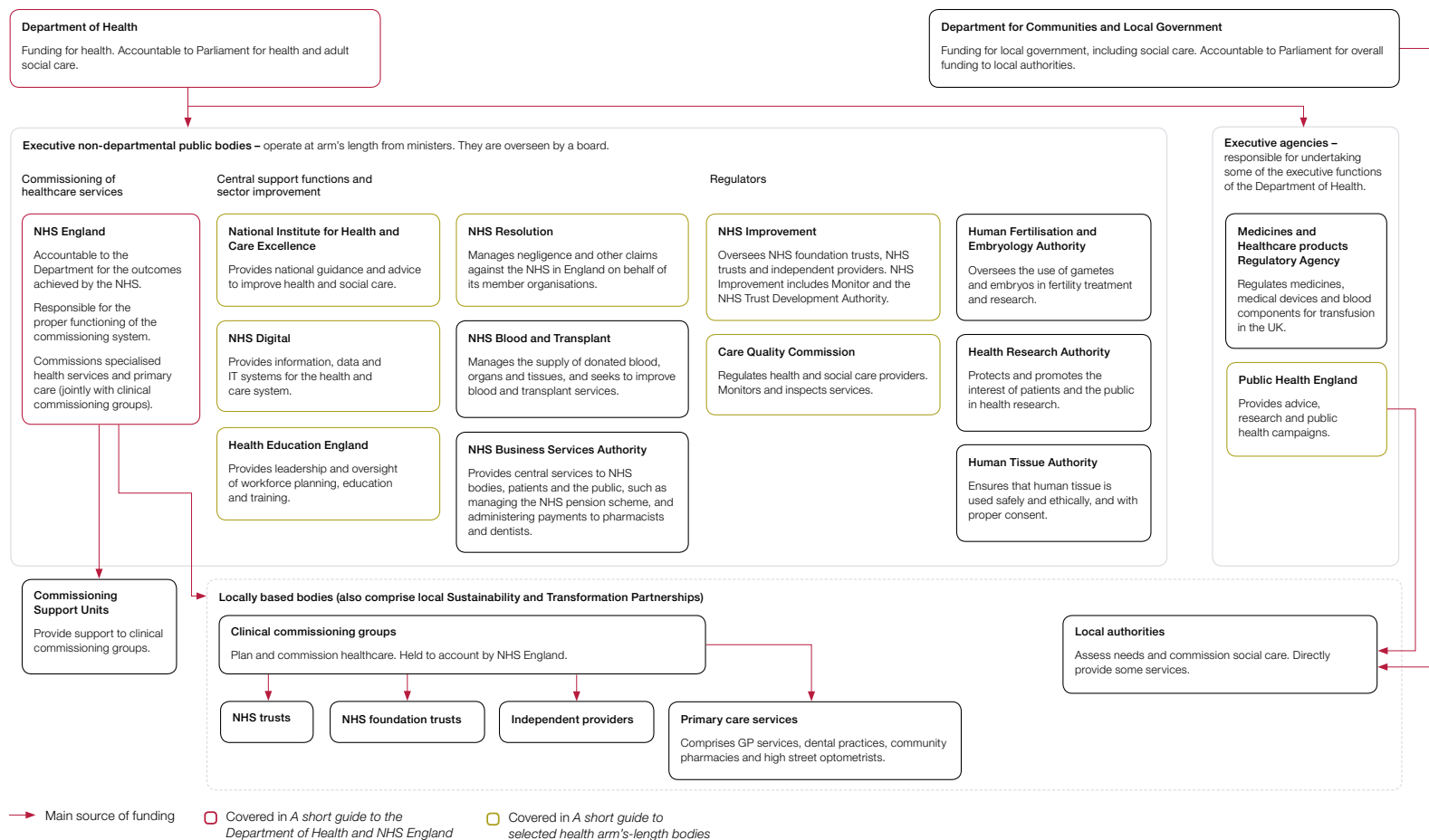
Manages negligence and other claims against the NHS in England on behalf of its member organisations. In 2017 we published a [report](#) which looked at spending on the Clinical Negligence Scheme for Trusts.

Responsible for providing leadership and oversight of workforce planning, education and training across England. In 2016 we published a [report](#) which examined whether the supply of clinical staff in the NHS was being effectively managed.

Responsible for providing national information, data and IT systems for health and care services, setting up and operating systems for the collection, analysis and publication of information relating to health services and adult social care. Many of our reports have looked at the use of data by health bodies, focusing on the use of data for assurance and understanding effectiveness. NHS Digital is involved in the collection of some of these data.

Provides national guidance and advice to improve health and social care which are evidence-based and focused on effective and good-value healthcare. Its guidelines are intended for those providing, commissioning and managing health and social care services.

Funding across the health landscape

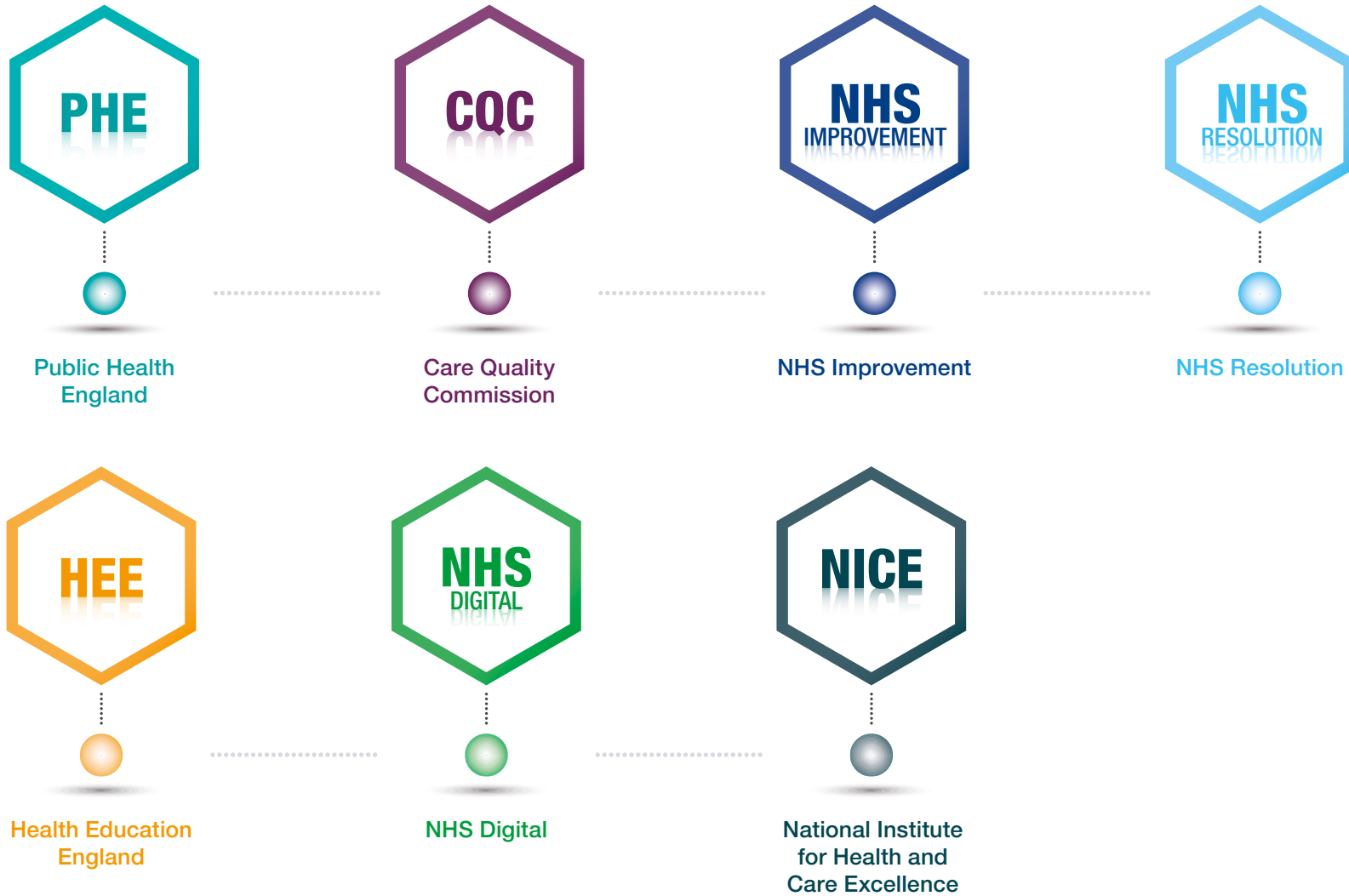


Note

¹ To simplify the diagram, we have not included: NHS Property Services Limited (a company wholly owned by the Secretary of State for Health); advisory non-departmental public bodies such as the NHS Pay Review Body and Review Body on Doctors' and Dentists' Remuneration; and a number of other bodies such as the National Information Board.



Arm's-length bodies



Public Health England

Overview

Public Health England provides national leadership, advice and support across four main areas:

- health improvement;
- health protection;
- population health, including public health input into health and care services; and
- public health system capability and capacity.

In April 2013, Public Health England was established as an executive agency of the Department. Public Health England absorbed some of the Department's previous functions and those of specialist agencies including the Health Protection Agency. As part of these changes responsibility for commissioning local public health services also passed from the NHS to local authorities.

The relationship between the Department and Public Health England is set out in a Framework Agreement and the Minister for Public Health sets out the government's requirements of Public Health England in an annual remit letter.

Public Health England spent £4.5 billion in 2016-17, three-quarters of which (£3.4 billion) was spent on grants to local authorities. This grant funding is ring-fenced and local authorities must use it to

improve the health of their local populations and reduce health inequalities. On 1 October 2015 responsibility for services for children aged 0 to 5 transferred from NHS England to local authorities, bringing with it additional funding as part of the grant. Between 2013-14 and 2016-17, expenditure on operating activities – covering pay and non-pay – decreased by £47.6 million (8.2%) while income relating to these activities fell by £6.1 million.

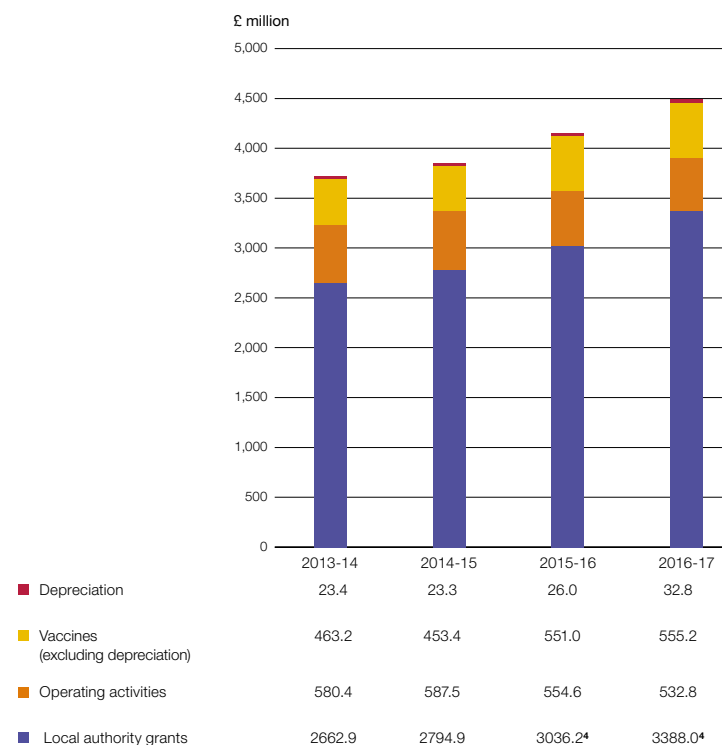
Public Health England receives funding from the Department but also receives income from services provided to customers, grant awarding bodies and the devolved administrations. For example, in 2016-17 Public Health England received £72.4 million from sales of vaccines to other government agencies, with most being to the devolved administrations. Total external income, which also includes research funding and national screening programmes, varies each year and amounted to £236.2 million in 2016-17.

Public Health England also owns a pharmaceutical development and production company called Porton Biopharma Ltd.

In 2016-17, Public Health England had, on average, 5,035 permanent full-time equivalent staff members, compared to 4,801 in 2013-14. Most are scientists, researchers and public health professionals.

Public Health England expenditure from 2013-14 to 2016-17

Local authority grants comprise the majority of Public Health England's expenditure



Notes

- Figures are not adjusted for inflation.
- Depreciation describes the cost of an asset over the period of its useful life.
- Any comparison of these figures over time should be treated with caution as both include expenditure relating to external income which has varied over the period; from £161.7 million in 2013-14 to £72.4 million in 2016-17 for vaccines and, over the same period, from £169.7 million to £163.8 million for operating activities.
- In 2015-16 and 2016-17, the expenditure on 'Local authority grants' includes funding for new responsibilities (equating to a planned £429.8 million for the second half of 2015-16 and £863.7 million in 2016-17), meaning expenditure for these years is not directly comparable to previous years.

Source: Public Health England annual report and accounts



How is Public Health England performing?

In 2014, Public Health England set out its seven priorities for protecting and improving the nation's health in [Evidence into Action](#):

- tackling obesity;
- reducing smoking;
- reducing harmful drinking;
- ensuring every child has the best start in life;
- reducing dementia risk;
- tackling antimicrobial resistance; and
- reducing tuberculosis.

In 2016, Public Health England published its four-year strategic plan, [Better outcomes by 2020](#). This plan set out 64 actions for 2016-17, to achieve its aims of protecting and improving the public's health and closing the gap on inequalities. These actions reflected other programmes, including the Department's [Shared Delivery Plan](#) and the [NHS Five Year Forward View](#).

Things to look out for

In December 2014, we published a [report](#) on Public Health England's grant to local authorities. The report found that Public Health England had made a good start in supporting local authorities with their new responsibilities for public health but that in parts of the system, local authority spending was not fully aligned to areas of concern.

This report was followed by an evidence session by the Committee of Public Accounts in January 2015. The Committee made a series of recommendations, including focusing on how the support provided by Public Health England to local authorities could be improved, targeting support to areas that could benefit the most and helping local authorities to understand the evidence base of what works.

In April 2017, the Department published its findings from its own [review](#) of Public Health England and concluded that it had made good progress with integrating staff, culture, working practices and physical assets of the organisations from which it was created. The review included 11 recommendations, some directed at the Department as well as Public Health England, seeking to further improve performance and deliver efficiencies.

How is Public Health England performing? *continued*

In Public Health England's [Annual Report](#), it rated its performance against each of its 64 actions during 2016-17 as **achieved**, **largely achieved** or **partially achieved**. Public Health England assessed that it:

- **achieved** 31;
- **largely achieved** 28; and
- **partially achieved** the remaining five actions.

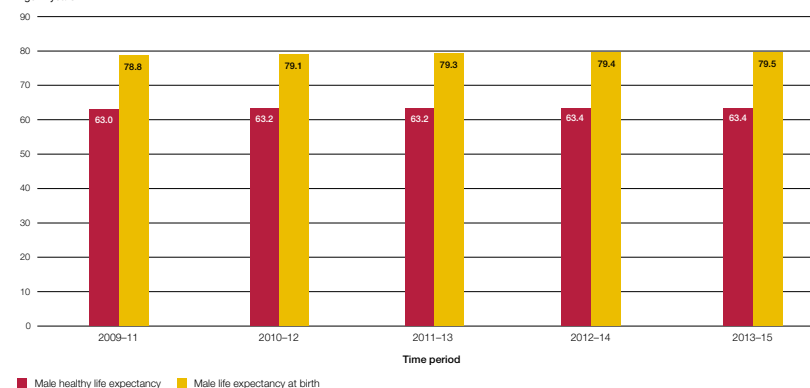
The [Public Health Outcomes Framework](#) sets out the desired outcomes and indicators to show how well public health is being improved and protected. These indicators include monitoring life expectancy by gender. Based on data from 2013-15, which are the most recent data available, both life expectancy at birth and healthy life expectancy have remained broadly stable since 2009-11. Total life expectancy remains lower for males (see bar charts).

Life expectancy by gender between 2009-11 and 2013-15

Life expectancy at birth and healthy life expectancy have both remained broadly stable

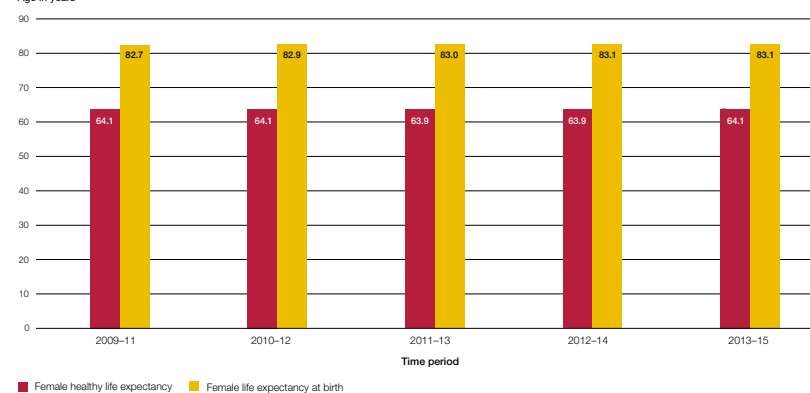
Male life expectancy over time

Age in years



Female life expectancy over time

Age in years



Note

1 Healthy life expectancy at birth is defined as the average number of years a person would expect to live in good health.

Source: Public Health Outcomes Framework

Care Quality Commission

Overview

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England and is a non-departmental public body. It began operating on 1 April 2009.

The Commission registers, monitors and inspects approximately 50,000 locations providing health and adult social care in England across three sectors: hospitals and ambulance services; primary medical services; and adult social care services. Any person (individual, partnership or organisation) that provides a regulated activity covered by the Commission must be registered with it.

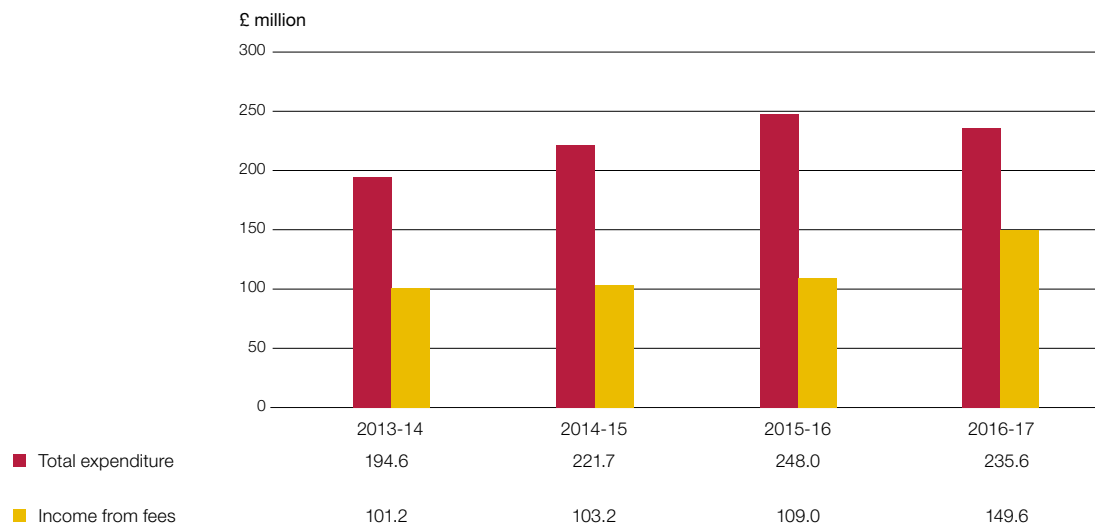
The Commission is operationally independent of the Department in the judgements it makes about the quality and safety of health and care services.

In 2016-17 the Commission spent £235.6 million, of which £149.6 million came from fees charged to providers. Over the four-year period, income from providers increased by 47.8% (see bar chart). This reflects the Commission's aim to recover the full cost of its core regulation activities (excluding enforcement) from provider fees by 2019-20. Between 2013-14 and 2015-16, the Commission's total spend increased by over a quarter (27.4%) but decreased by 5.0% in the year 2016-17.

As at 31 March 2017, the Commission employed 3,097 full-time equivalent staff members, just over a third of whom were inspectors.

The Commission's expenditure from 2013-14 to 2016-17

Expenditure increased between 2013-14 and 2015-16 but fell in 2016-17. Income from fees increased year on year



Notes

- 1 In our report on the *Care Quality Commission – regulating health and social care* published in October 2017 we reported the net operating expenditure for the Commission, which excludes non-cash transactions such as depreciation and pension scheme assets and liabilities.
- 2 Figures are not adjusted for inflation.
- 3 Total expenditure includes depreciation.

Source: Care Quality Commission annual report and accounts

How the Commission operates

The Care Quality Commission (the Commission) assesses the quality of care and tests whether providers are meeting the fundamental standards of care expected of them by using five key questions that ask if the service is:

- Safe
- Effective
- Caring
- Responsive
- Well-led

Registration

Registers healthcare and adult social care providers. As at June 2017 there were 49,355 registered provider locations. Registration is the first point at which the Commission tests a provider. When it receives a new application the Commission will assess systems and processes, inspect premises and interview applicants to judge whether the provider can meet a number of legal requirements, including fundamental standards of quality and safety.

Monitoring

Looks to identify evidence of potential risk to the quality and safety of care and that fundamental standards of quality and safety are being met.

Inspection

Inspects services to assess the quality of care and make sure they meet fundamental standards of quality and safety. Inspection teams visit services to: observe care; talk to staff and people who use services; and look at people's care records.

Action

The Commission can take a range of enforcement actions when care falls below fundamental standards: using requirement notices or warning notices to set out what improvements need to be made; making changes to a provider's registration to limit what they can do; suspending or cancelling registration; issuing cautions, penalty notices and prosecuting providers and individuals; and placing providers into special measures.

Report publication and rating

Publishes findings, including performance ratings on the services it inspects to help people choose care. Ratings are: Outstanding, Good, Requires improvement, Inadequate.

Note

1 The diagram excludes some regulatory activities.

Source: Comptroller and Auditor General, *Care Quality Commission – Regulating health and social care*, HC 409, Session 2017–19, National Audit Office, October 2017

How is the Care Quality Commission performing?

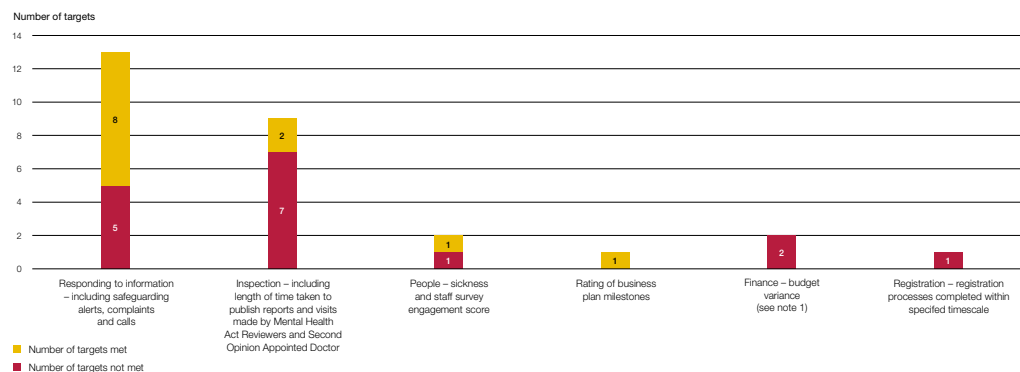
The Commission has two main purposes:

- to make sure health and social care services provide people with safe, effective, compassionate, high-quality care – addressed through the Commission's core regulation functions; and
- to encourage providers to improve the quality of care.

The Commission fulfilled its programme to inspect and rate all NHS hospitals, adult social care providers and GP practices (registered after October 2014) by January 2017, comprising over 28,000 locations. The Commission completed the programme in line with its 2016-17 business plan commitment, having missed earlier target dates due to difficulties in recruiting inspectors.

In 2016-17, the Commission met 12 out of its 28 key performance indicators (see bar chart). Indicators it did not meet include: timeliness of registering new providers; timeliness of publishing inspection reports following an inspection; and taking further action following the receipt of a safeguarding alert or concern.

The Commission's performance against its key performance indicators, by category, 2016-17



Note

¹ The Commission did not meet its key performance indicators to have 0% variation from revenue and capital budgets due to underspends in both areas.

Source: Care Quality Commission, Annual report and accounts 2016-17

Things to look out for

In October 2017, we published a [report](#) examining the Commission. It found that while value for money was improving, it needs to overcome some persistent issues with the timeliness of some of its regulation activities if it is to sustain further improvement.

Looking forward, the report concluded that the Commission's ambition to base more of its regulatory activities on intelligence and risk-based information introduces significant challenges. These must be carefully managed, and supported by digital systems and capabilities if it is to minimise the risk of missing poor care.

It made five recommendations covering: the delivery of its new strategy; the effectiveness of its digital systems; engagement with local stakeholders; the consistency of its regulatory judgements; and the appropriateness of the regulatory actions it takes.

NHS Improvement

Overview

[NHS Improvement](#) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. Its role is to support trusts and providers to give patients safe, high-quality and compassionate care which is financially sustainable.

NHS Improvement was established in April 2016. It is the operational name for the organisation that brings together: Monitor, NHS Trust Development Authority, Patient Safety including the National Reporting and Learning System, the Advancing Change Team, and Intensive Support Teams. Monitor and NHS Trust Development Authority continue to exist as legal entities and have separate budgets and accounts, although their boards have identical membership and meet jointly as one NHS Improvement Board.

Trusts are now regulated by a [Single Oversight Framework](#), which replaces those used separately by NHS Trust Development Authority and Monitor. NHS Improvement is also [proposing](#) to introduce a new set of healthcare provider licence conditions that, as far as possible and appropriate, replicate current NHS provider oversight for joint ventures and subsidiaries. These arrangements might

become more common and be used as the vehicle to hold contracts or deliver care on behalf of one or more trusts.

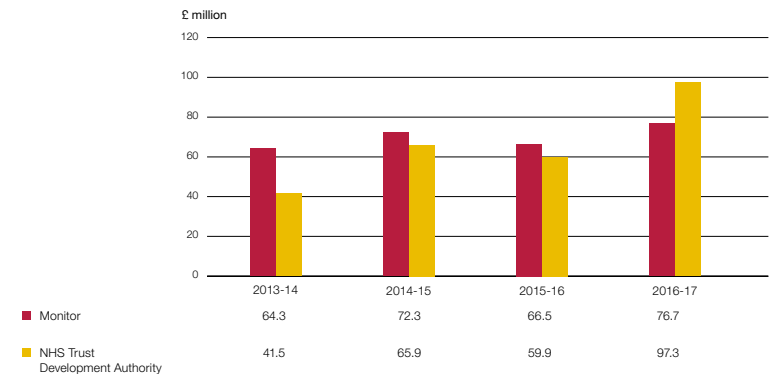
NHS Improvement spent a total of £174 million in 2016-17 (the combined expenditure of Monitor and NHS Trust Development Authority). Of this, it spent £92.5 million on staffing costs and the remainder on programme activities.

Between 2013-14 and 2016-17 Monitor's expenditure increased by 19%. Over the same period NHS Trust Development Authority's expenditure increased by 134% – this large increase is mainly due to the transfer of functions from NHS England (such as patient safety functions which were transferred on 1 April 2016), resulting in a higher number of staff and a higher programme spend (see bar chart).

In 2016-17, NHS Improvement employed an average of 916 permanent staff members. NHS Improvement staff are organised into a central team and four regional teams (London, North, Midlands and East and South) based in 11 sites across England.

Expenditure for NHS Improvement, 2013-14 to 2016-17

Expenditure by Monitor and NHS Trust Development Authority increased in all periods except for 2015-16



Note
1 Figures are not adjusted for inflation.

Source: Monitor and NHS Trust Development Authority annual report and accounts



How is NHS Improvement performing?

NHS Improvement plans to support healthcare providers to attain or maintain a Care Quality Commission 'good' or 'outstanding' rating. It plans to do this by focusing on five themes, as set out in its report [2020 Objectives](#), published in July 2016:



NHS Improvement's assessment of its performance in 2016-17, included the following:

- The percentage of trusts rated as outstanding increased from 1.3% in the previous period to 6.0% and the percentage rated good increased from 29.9% to 39.1%.
- At 31 March 2017, 11 trusts were in special measures for quality, compared to 16 at 1 April 2016 (although a further four entered special measures in April 2017).
- By the end of March 2017, two of the first five trusts that entered financial special measures (in July 2016) had successfully exited the programme, although a further seven trusts had entered special measures.
- Controls on agency spending reduced costs for the NHS by more than £700 million.

In future it will assess its performance against the five themes above.

How is NHS Improvement performing? *continued*

NHS Improvement identified the following risks to the organisation and its work in its annual report and accounts 2016-17, published in July 2017:

NHS Improvement integration

Risks associated with transforming the organisation (for example, the magnitude and extent of cultural and operational changes required) while developing and delivering NHS Improvement's work programme.

Joint/partnership working

Risk that it fails to align its operational actions and strategic approach with other arm's-length bodies, leading to confusion, duplication or omissions and threatening collaborative working initiatives.

NHS Improvement capacity and capability

Risk that it is unable to recruit, develop or retain key talent resulting in NHS Improvement lacking the knowledge, skills, capacity, culture and ability to deliver its business plan.

Availability and supply of sector workforce (including culture, leadership and improvement capability)

Risk that the NHS lacks capacity and/or capability (the right skills and the right number of staff in the most appropriate settings) resulting in deterioration of operational performance.

Balancing quality, finance and operational performance

Risk that it fails to balance quality, finance and access priorities appropriately, leading to an inability to maintain and improve performance against core quality and access standards while achieving financial balance.



Things to look out for

A recurring theme in our reports is the need for NHS Improvement to better coordinate work with other NHS organisations.

In our November 2016 report, [Financial sustainability of the NHS](#), we reported that some local bodies said that the pressure to meet the financial targets set by NHS Improvement had not incentivised them to work with other bodies in their local area to develop sustainability and transformation plans as required by NHS England and NHS Improvement.

In our July 2016 [Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough](#) we found that "neither the Department of Health, nor NHS England, nor Monitor was responsible for holding a holistic view of the contract, or assessing whether the anticipated benefits would merit continued support of this innovative approach."

In our December 2015 report, [Sustainability and financial performance of acute hospital trusts](#), we found that trusts' financial management had been undermined by a turbulent planning period and the multiple interventions by the Department, Monitor and the NHS Trust Development Authority that sought to control trusts' spending.

NHS Resolution

Overview

NHS Resolution has been the operating name of NHS Litigation Authority since April 2017. The NHS Litigation Authority was established in October 1995 as a Special Health Authority.

NHS Resolution's main roles are:

- providing indemnity schemes for the NHS in England and resolving claims for compensation fairly;
- resolving concerns about the performance of individual practitioners; and
- resolving primary care contracting disputes.

These latter two roles are carried out by its National Clinical Assessment Service and Family Health Service Appeals Unit, respectively.

NHS Resolution is an arm's-length body of the Department and, while an independent body, can be subject to ministerial direction. The Department sets policies for, and supports, NHS Resolution and holds it to account through a set of key performance indicators.

In 2016-17, NHS Resolution's total expenditure related to claims (legal fees and payments to

claimants) was £1.8 billion, of which about 90% was incurred by its Clinical Negligence Scheme for Trusts.

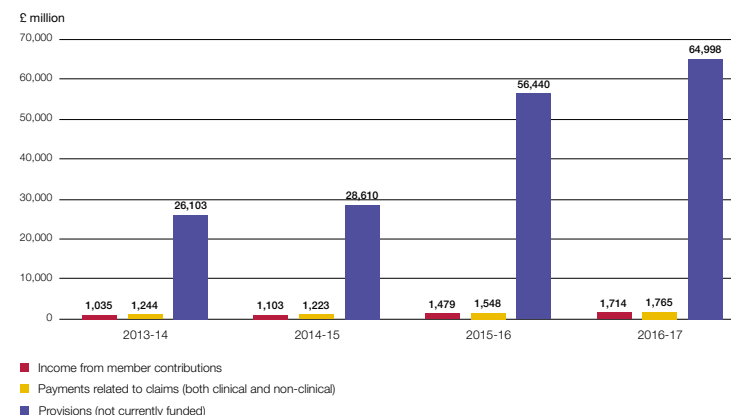
Its operational costs for processing of claims and its other day-to-day functions was £20.5 million.

NHS Resolution provides indemnity cover for claims (both clinical and non-clinical) against its members and is funded mainly through contributions from members (for example, NHS trusts, NHS foundation trusts and independent providers) on a pay-as-you-go basis. Contributions from members are set at a level to meet the payments due in each year.

There is also a liability recorded in the accounts for potential costs in future years for claims relating to incidents already incurred, whether a claim has been made or not. In 2016-17 the estimated present value of these future costs was £65 billion, the second biggest potential liability (provision) across the whole of government (see bar chart).

In 2016-17, NHS Resolution had 236 members of staff on average (full-time equivalent), against a budgeted 272. In 2013-14, NHS Resolution employed 199 people on average (full-time equivalent) against a budget for 240. Most of its claims staff are qualified solicitors, barristers or insurance professionals.

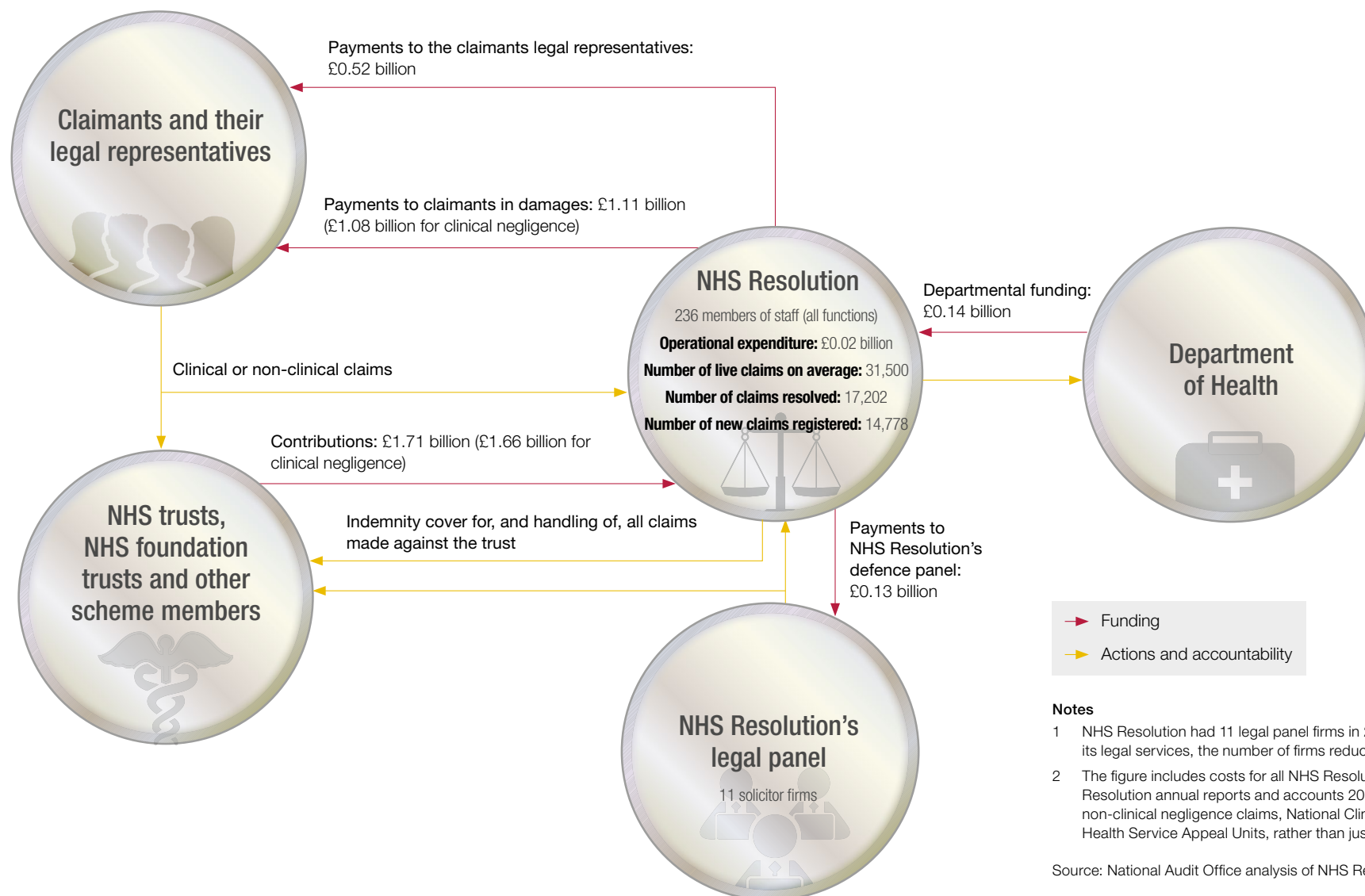
Income, expenditure and provisions for NHS Resolution, 2013-14 to 2016-17
Spending on claims has increased by 41.8% between 2013-14 and 2016-17, while provisions for claims have more than doubled



- Notes**
- 1 Figures are not adjusted for inflation.
 - 2 The operational cost by NHS Resolution is not included here as it accounts only for about 1% of its total spend in year. The income, payments and provisions are for both clinical negligence and non-clinical negligence claims, and therefore may differ from the figures in our [2017 report](#) which focused on the former.
 - 3 The provision covers: future payments for claims already agreed; estimated costs related to claims notified to NHS Resolution but not yet resolved; and estimated costs for incidents already incurred but no claims have been made.
 - 4 The size of the provision went up significantly in 2015-16 due to changes in the discount rates used by HM Treasury to calculate the present value of future government liabilities, and in 2016-17 due to the changes in the discount rate used by the court to calculate the size of compensations for claims.

Source: NHS Resolution and NHS Litigation Authority annual report and accounts

NHS Resolution's funding arrangements and operations, 2016-17





How is NHS Resolution performing?

NHS Resolution measures its performance against four priorities:

Resolution

Resolving concerns and disputes fairly and effectively. NHS Resolution reports its performance against a set of key performance indicators quarterly to the Department

Intelligence

Providing analysis and expert knowledge to the healthcare and civil justice systems, to drive improvement.

Intervention

Delivering in partnership, interventions and solutions that improve safety and save money.

Fit for purpose

Being fit for purpose by offering best value and delivering its people, relationships and infrastructure.



Things to look out for

In September 2017, we published a report on Managing the costs of clinical negligence in trusts. The report highlighted that, over the last ten years, spending on the Clinical Negligence Scheme for Trusts had quadrupled. It concluded that while NHS Resolution and the Department are proposing incremental measures to reduce existing costs, the expected savings from these schemes are small compared with the predicted rise in the overall costs and liabilities of clinical negligence.

The report suggested that the government needs to take a stronger and more integrated approach to fundamentally change the biggest drivers of increasing cost across the health and justice systems. Our specific recommendations included that the Department, together with the Ministry of Justice and others, should set out a coordinated strategy to manage the growth in costs by September 2018.

In 2016-17, NHS Resolution reported that it met 24 of its 32 key performance indicators. Seven of the eight indicators it did not meet were related to the timeliness of its operations, for example time to respond to a letter of claim or to resolve clinical negligence claims.

Health Education England

Overview

The Department set up [Health Education England](#) as a Special Health Authority in 2012 to provide national leadership and oversight on the development of the healthcare workforce, and allocate education and training resources. Its role is also to ensure that the NHS has the staff and skills it needs to meet the current and future needs of patients and help improve the quality of care that patients receive.

In April 2015, under the provisions of the Care Act 2014, Health Education England became an executive non-departmental public body. The Act set out Health Education England's remit, roles and responsibilities in detail, including its duty to ensure an effective system is in place for education and training in the NHS and public health system.

The Department allocates funding to Health Education England. Health Education England's expenditure has remained fairly constant, increasing by only 2% between 2013-14 and 2016-17 to £5.1 billion (see bar chart).

The majority (89%) of its expenditure is on supporting the development of health care professionals for the future, covering undergraduate and postgraduate medical and dental and on other clinical staff groups.

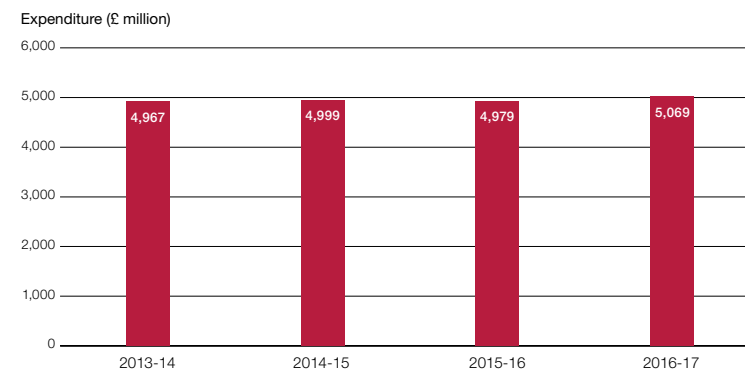
The funding includes payments to higher education institutions, providers for clinical placements and students to cover some tuition fees and living costs. Health Education England also contributes to junior doctors' basic salaries.

Running costs accounted for 1.5% of Health Education England's total expenditure.

In 2016-17, Health Education England employed 1,871 full-time equivalent permanent staff, an increase of 18% since 2013-14. Most of Health Education England's staff are based in four regional teams across England: South, North, Midlands and East, London and the South East.

Expenditure of Health Education England, 2013-14 to 2016-17

Expenditure has remained fairly constant since 2013-14



Note

1 Figures are not adjusted for inflation.

Source: Health Education England annual reports and accounts

How is Health Education England performing?

The Department sets objectives for Health Education England through an annual mandate and holds it to account for meeting these commitments. For 2016-17, the Department set Health Education England objectives to:

- develop the workforce to improve out-of-hospital care;
- create the safest, highest quality health and care services;
- deliver value for money;
- prevent ill health and support people to live healthier lives;
- support research, innovation and growth;
- build the workforce for the future; and
- improve services through the use of digital technology, information and transparency.

In 2016-17 Health Education England rated its performance against 86 deliverables, taken from its business plan and the mandate. During this period, Health Education England reported that it revised the delivery dates for some of the deliverables. Health Education England's assessment was that it had achieved – or was on track to achieve – all of its deliverables (when taking into account revised delivery dates).

As at June 2017 Health Education England reported nine risks on its corporate risk register. These risks were that it would:

Risks to the supply of clinical staff	Other risks
<ul style="list-style-type: none"> • Not be able to attract sufficient trainees into GP training. • Be unable to ensure sufficient supply of qualified clinical staff after September 2017 where some courses are funded through the student loans company rather than commissioned. • Recruit insufficient numbers of doctors into specialty training. 	<ul style="list-style-type: none"> • Be less clear about its role following the outcome of the 2017 General Election. • Be unable to meet its requirements – via the Leadership Academy – to support talent management in the NHS. • Have its priorities constrained due to financial pressures. • Not have access – via Local Workforce Advisory Boards – to the right skills and expertise to enable the development of an effective Sustainability and Transformation Partnership workforce strategy and delivery plan. • Not have the necessary data to adequately support workforce planning. • Not deliver IT infrastructure both nationally and locally.



How is Health Education England performing? *continued*

Things to look out for

In February 2016, our report on [Managing the supply of NHS clinical staff in England](#), found that the process for developing the national long-term workforce plan could be made more robust and Health Education England should be more proactive in addressing the variations in workforce pressures in different parts of the country.

Our report on [Improving patient access to general practice](#), published in January 2017, highlighted that:

- against a target of 3,250 GP training places in 2016-17, Health Education England only filled 3,019 (93%) places, although this was an increase from 2,769 in 2015-16; and
- the latest available data on part-time working in new GPs suggest that there may be 1,900 fewer full-time equivalent GPs by 2020 than Health Education England had estimated there would be.

Since August 2017, Health Education England has not covered the tuition fees for new students on nursing, midwifery and allied health professional undergraduate courses. These students are instead able to take out tuition loans and a higher level of maintenance loans through the standard student loan system.

NHS Digital

Overview

NHS Digital is the executive non-departmental government body responsible for setting up and operating systems which collect, analyse and publish information relating to health services and adult social care. It provides national information, data and IT systems for health and care services. Prior to April 2016 it was known as the Health and Social Care Information Centre, which was established in 2013. NHS Digital provides technology nationally for health and care services including maintaining the NHS Spine, the core systems that carry information across health and care services. NHS Digital also determines and publishes information standards for IT systems that organisations must comply with.

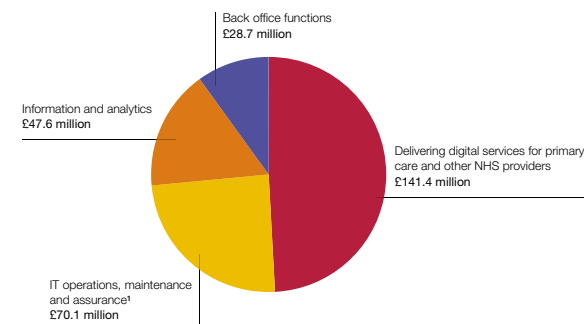
In 2016-17 NHS Digital's total expenditure was £287.9 million. Most of this (£243.6 million) is funded by the Department, with a further £44.3 million generated in income. In the three years from 2013-14, its expenditure has increased by 50% (see bar chart). Over this period it increased its support for cyber security and to GPs and also led efforts to improve the use of data and digital technologies in the health and care system. The rise in expenditure in 2016-17 reflects an increase in responsibilities for NHS Digital. In December 2016 a number of programmes and services previously owned by the Department were fully transferred to NHS Digital.

NHS Digital has also been tasked with delivering many of the commitments set out in the National Information Board's strategy, Personalised Health and Care 2020.

In 2016-17 it spent £141.4 million delivering digital services for primary care, other NHS providers and local authorities, and a further £70.1 million on IT operations, maintenance and assurance (see pie chart).

NHS Digital employed 2,665 full-time equivalent permanent members of staff (including secondees) in 2016-17. This equates to an increase of a third (34%) from 1,995 staff in 2013-14.

Breakdown of expenditure of NHS Digital by segment in 2016-17
Expenditure is focused on support to NHS organisations and assurance

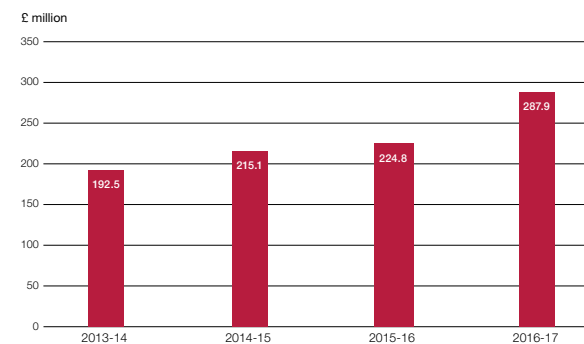


- Notes**
- 1 IT operations, maintenance and assurance includes spend on internal systems and supporting other organisations.
 - 2 Does not equal £287.9 million due to rounding.

Source: National Audit Office analysis of NHS Digital annual report and accounts

Expenditure of NHS Digital, 2013-14 to 2016-17

Expenditure has increased year on year



- Note**
- 1 Figures are not adjusted for inflation.

Source: NHS Digital annual report and accounts



How is NHS Digital performing?

In 2015 NHS Digital published [Information and technology for better care](#), its five-year strategy running to 2020. NHS Digital's priorities for 2016-17, as set out in its [business plan](#) and intended to reflect its five-year strategy, were to:

- ensure that every citizen's data are protected;
- establish shared architecture and standards so that everyone benefits;
- implement national services that meet national and local needs;
- support health and social care organisations to get the best from technology, data and information; and
- make better use of health and care information.

NHS Digital set out a number of its achievements over 2016-17 in its [annual report](#). For example, it estimates that insourcing of the NHS Spine, the core systems that carry information across health and social care, saves £21.2 million a year compared to 2014. It also reported that it had successfully delivered new systems for the National Breast Screening Service on time and to budget, as well as publishing 292 official and national statistical outputs and 30 clinical audit reports in the year. NHS Digital has four key performance indicators for which it reports red-amber-green ratings monthly, in [board reports](#). Performance for 2016-17 is summarised on the right.

Performance for 2016-17

Programme achievement

Rated as amber/green for most of the year, with delivery confidence reported as 64% in March 2017 across all programmes.

IT service performance

Rated as red or amber for much of the year, with three months reported as green, reflecting the variable availability of digital services.

Organisational health

Assessed as being amber for the whole year, reflecting the need to secure and develop a suitably capable workforce.

Financial management

Rated as green up to July 2016 and red from then until the end of the financial year, reflecting an underspend of £14.6 million for 2016-17.





How is NHS Digital performing? *continued*

Things to look out for

NHS Digital has been tasked with delivering the commitments set out in the National Information Board's strategy for Personalised Health and Care 2020.

NHS Digital conducted a review to identify what would be needed to deliver its commitments by 2020 and in July 2017 published its [findings](#). The headline findings from the review focused on areas for improvement, including that NHS Digital: had been adversely affected by unclear boundaries and expectations across health and social care; and was using out-of-date technology in key areas and was often too slow to adopt digital solutions.

In July 2015 we published an [investigation](#) into the General Practice Extraction Service, an IT system designed to extract data from GP practice computers.

The project began in 2007 by a predecessor of NHS Digital. We found that the project was delayed and many customers had not received data. We also found mistakes in the original procurements and contract management which contributed to losses of public funds.

In October 2017 we published an investigation into the [WannaCry](#) cyber-attack that affected the NHS in May 2017. During the attack NHS Digital provided central support and deployed 54 staff to support trusts, though communication with local bodies was initially difficult. We found that neither the Department nor NHS Digital knew how well prepared NHS organisations were for a cyber-attack, although plans to improve this have subsequently been put in place. Prior to the attack, NHS Digital had conducted an on-site cyber-security assessment for 88 out of 236 trusts, and none had passed. However, NHS Digital cannot mandate a local body to take remedial action even if it has concerns about the vulnerability of an organisation.

National Institute for Health and Care Excellence

Overview

The National Institute for Health and Care Excellence (NICE), was set up in 1999 to help reduce variation in the availability and quality of NHS treatments and care. In April 2013, following the Health and Social Care Act 2012, NICE became an executive non-departmental public body.

NICE's role is to improve outcomes for people using the NHS and other public health and social care services. NICE provides national guidance and advice, and produces quality standards for different diseases and conditions. These statements set out what high-quality and cost-effective care should look like. It also conducts evidence surveillance reviews and medical technology appraisals. The NHS Constitution sets out the right for people to receive drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor says they are clinically appropriate for them.

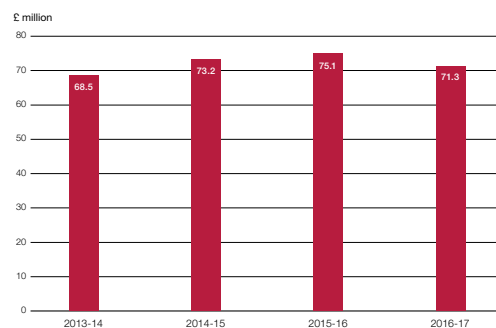
NICE is accountable to the Department. However, operationally, it is independent of government and its guidance and other recommendations are made by independent committees.

In 2016-17, NICE received the majority of its funding through grant-in-aid from the Department (78%). Between 2013-14 and 2016-17, NICE's expenditure increased by £2.7 million to £71.3 million. During this period grant-in-aid funding from the Department decreased but income, including from NHS England, Health Education England and devolved administrations increased by £8.9 million to £16.7 million in 2016-17. The largest area of expenditure is on producing NICE guidelines – £20.9 million in 2016-17 (see bottom bar chart).

NICE works with a range of experts including from the NHS, local authorities and life sciences industries and the private sector. From 2013-14 to 2016-17, NICE's permanently employed staff increased by 16%, from 513 to 595 full-time equivalent staff.

Expenditure for NICE, 2013-14 to 2016-17

Expenditure has remained relatively stable

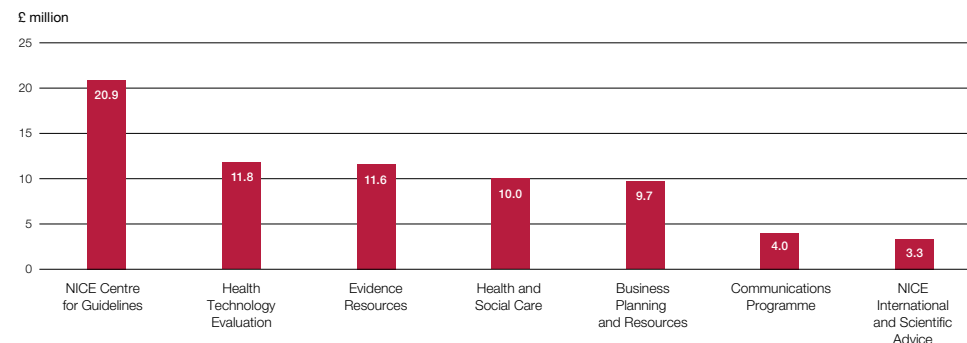


Note
1 Figures are not adjusted for inflation.

Source: NICE annual report and accounts

NICE's expenditure by centre and directorate 2016-17

Nearly a third of funding is used by NICE Centre for Guidelines



Source: NICE, Annual report and accounts 2016-17



How is the National Institute for Health and Care Excellence performing?

NICE's strategic objectives for 2016–2020 are to:

- produce guidance, standards and evidence services to enable high quality, sustainable care;
- work effectively with other organisations, inside and beyond the public sector, to shape and drive the use of its guidance, standards and evidence services;
- provide practical tools and other support to help users make the most of our work and to measure its uptake; and
- use its staff and its other resources efficiently and effectively.

NICE measures its performance based on 18 areas of its work – each representing a group of guidance or advice. Within each area of work, NICE set targets for the proportion of planned outputs to be delivered, ranging from 75% to 100%. During 2016-17, NICE met or exceeded its targets in 13 out of 18 areas.

NICE did not meet its targets on publishing the agreed number of outputs for the following areas:

- interventional procedures guidance;
- medical technologies (medtech) innovation briefings;
- highly specialised technology guidance;
- new and updated quality and productivity case studies; and
- Cochrane quality and productivity commentaries.¹

Things to look out for

In April 2017 NICE and NHS England introduced new measures intended to manage the cost of implementing new drugs and other treatments while ensuring rapid access to the most cost-effective technologies. The NHS is legally required to fund drugs and treatments recommended in NICE technology appraisal guidance, normally within three months of final guidance. In response to financial pressures on NHS budgets to pay for some of these new treatments new measures have been implemented for treatments which are predicted to cost more than £20 million in any of its first three years.

The new measures are intended to allow time for the NHS to negotiate with a drug company to reduce the cost of the treatment during its first three years. If negotiations do not bring the financial cost below £20 million then the NHS can make a case to NICE for phasing the introduction of the new treatment over a longer period than 90 days.

¹ Developed to help the NHS identify practices which could be significantly reduced or stopped completely. Topics selected are derived from a Cochrane systematic review.

Appendix

Link to the websites of Department of Health sponsored bodies

Executive non-departmental public bodies and special health authorities

Care Quality Commission

www.cqc.org.uk

Health Education England

www.hee.nhs.uk

Health Research Authority

www.hra.nhs.uk

Human Fertilisation and Embryology Authority

www.hfea.gov.uk

Human Tissue Authority

www.hta.gov.uk

National Institute for Health and Care Excellence

www.nice.org.uk

NHS Blood and Transplant

www.nhsbt.nhs.uk

NHS Business Services Authority

www.nhsbsa.nhs.uk

NHS Counter Fraud Authority

www.cfa.nhs.uk

NHS Digital¹

www.digital.nhs.uk

NHS England

www.england.nhs.uk

NHS Improvement²

www.improvement.nhs.uk

NHS Resolution

www.resolution.nhs.uk

Executive agencies

Medicines and Healthcare products Regulatory Agency

www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

Public Health England

www.gov.uk/government/organisations/public-health-england

Advisory non-departmental public bodies

Administration of Radioactive Substances Advisory Committee**Advisory Committee on Clinical Excellence Awards****British Pharmacopoeia Commission****Commission on Human Medicines****Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment****Independent Reconfiguration Panel****NHS Pay Review Body****Review Body on Doctors' and Dentists' Remuneration**

Other bodies

Accelerated Access Review**Morecambe Bay Investigation****National Data Guardian****National Information Board****Porton Biopharma Limited****Note**

- ¹ NHS Digital used to be called the Health and Social Care Information Centre. It changed its trading name in April 2016.
- ² Monitor, the NHS Trust Development Authority and a number of smaller bodies became a jointly led organisation, NHS Improvement, on 1 April 2016.