Recently the Government announced plans for a shake-up of its 18 arm’s-length bodies. Francesca Rivers looks at how some of the proposed changes might affect pharmacy and pharmacists.

In an attempt to claw back spending by over £180m in the next five years, the Government is taking a hard look at its 18 arm’s-length bodies (PJ, 7/14 August 2010, p137). More than seven are to be abolished, and a series of streamlining and commercialising exercises will leave none of them untouched. How might these changes affect pharmacy?

**Levy for regulators**

In a move that is certain to affect the General Pharmaceutical Council, the Council for Healthcare Regulatory Excellence is to be made a self-funding body by imposing a charge on the nine regulators that it oversees.

A spokeswoman said it is too early to say whether the levy will be the same for each body or will be set according to the number of registrants that each body has.

A fixed fee per body would have a disproportionate impact on the GPhC, which will have fewer than 70,000 registrants in total, compared with nearly 240,000 in the General Medical Council and well over 600,000 in the Nursing and Midwifery Council.

The GPhC has said it will work with the CHRE to ensure regulation of the pharmacy profession is fair, but would not be drawn on whether the levy will impact on its fees.

Another proposal will see the role of the CHRE extended to encompass setting standards for, and quality-assuring, voluntary registers. This could provide a vehicle for the regulation of practices such as homoeopathy and traditional Chinese medicine.

A DoH spokeswoman confirmed that the Government is currently reviewing the strategy for professional regulation “to ensure a system that provides effective assurance of professional standards for the public in a cost-effective manner.” More detailed proposals will be published later this year, she said.

**What is happening to the NPSA?**

The National Patient Safety Agency is being scrapped. However, the functions of the agency’s three arms — the Patient Safety Division, the National Clinical Assessment Service and the National Research and Ethics Service — will all be continued.

By April 2012 the NCAS is expected to become self-funding, while the responsibilities of the safety division will transfer to the national commissioning board (PJ, 17 July 2010, p73). Until further notice, essential safety activities such as incident reporting and alerts will continue to be handled in the same way — but with the transfer of responsibility comes a risk of service disruption and loss.

“It is vital that the key functions necessary to improve patient safety in the NHS are retained,” stressed chairman Sir Liam Donaldson. “The international evidence is clear that, in all healthcare systems, too many patients are being harmed from preventable errors. It remains a priority to turn this situation around.”

Responsibility for the NPSA’s research and ethics service will be transferred elsewhere, potentially to a new research regulator. It is hoped that bringing research governance under one umbrella will streamline the application process, thus encouraging more research.

The Academy of Medical Sciences is heading a review of the existing arrangements, and will report on the practicalities of establishing such a body in the autumn.

**Substance misuse services**

Along with the Health Protection Agency, the National Treatment Agency for Substance Misuse is being scrapped and its functions absorbed by the new public health service, details of which will be set out in a White Paper later this year.

**A firmer future for NICE**

Both NICE and the NHS Information Centre are to be retained and their roles extended. The scope of NICE will be expanded to include social care standards and the NHS Information Centre will be positioned as the national repository for data collection across healthcare, public health and adult social care.

Amendments to primary legislation are also planned in order to establish both organisations more firmly. The DoH said it cannot speculate as to the extent of these changes, which, The Journal notes, could range from merely making the organisations more difficult to abolish to casting their functions or jurisdiction in stone. Legislative changes could, for example, make it mandatory for local health authorities to make all NICE-approved drugs available, regardless of local budgets.

**Championing patient rights**

A new patient rights champion, “Healthwatch England”, will also be established in the Health Bill. Hosted by the Care Quality Commission, Healthwatch England will help to promote choice and handle complaints at a local level, and advise the NHS Information Centre on the type of information that would be of use to patients. It will also provide commissioning advice, and have the power to recommend the investigation of poor services.

**Commercialising the sector**

A number of proposals coming out of the ALBs review involve making the bodies more commercially driven. Although the status and functions of the MHRA are not going to be altered, there will be an expectation that it will operate in a more cost-effective way, and commercial reviews are being commissioned for a number of bodies including the NHS Business Services Authority and the NHS Litigation Authority.

Many of the consequences of the ALB reform remain to be seen, but a DoH spokeswoman assured The Journal that any matters relevant to the pharmacy profession will be raised with the appropriate pharmacy representative bodies as plans progress. More detailed plans of the overhaul will be set out in forthcoming documents including the Health Bill — which will reveal the precise nature of the proposals with respect to NICE and the NTA — and the public health service White Paper. Both are due later this year and will be implemented by 2012.