Title: Establishment of the NHS Trust Development Authority (NTDA) **IA No:** 2037 **Lead department or agency:** Department of Health (DH) **Other departments or agencies:**	Impact Assessment (IA) **Date:** 21/03/2012 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries:**

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£-9m	n/a	n/a	No	NA

What is the problem under consideration? Why is government intervention necessary?

The Government set out a clear vision for a modernised NHS with an all Foundation Trust (FT) provider landscape. NHS trusts require support to achieve FT status, including an effective appointments process to ensure capable boards and robust governance. Trusts also require performance management and monitoring to maintain national standards. Currently these functions lie across different organisations. Subject to Royal Assent, under the proposals of the Health and Social Care Bill 2011 some of these organisations will be abolished and therefore these functions need to be located in another organisation to ensure the process of reaching an all FT provider landscape can be achieved.

What are the policy objectives and the intended effects?

Currently 50% of NHS trusts' FT status applications are rejected by Monitor, due to insufficiently robust governance. The remaining NHS trusts require support, with clear objectives to meet the criteria required to become FTs. With the proposed abolition of organisations that support this process there is a need to establish new responsibility for their undertaking to ensure continuity. The intention is to co-locate these functions and inter-related performance management and monitoring functions. The aim is for these to be undertaken in a co-ordinated, effective way, free from direct political control to achieve the Government's objective of all NHS trusts become FTs.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1 - Do Nothing (maintain the status quo) - NHS trust's functions - performance management; clinical quality, governance and risk monitoring; FT pipeline process support and appointments to NHS trust boards remain at the DH or another organisation. Previous estimates of future health system administration costs underpinning the Health Bill Impact Assessment 2011, assumed these functions would continue.

Option 2 - Establish the NHS Trust Development Authority as a special health authority to undertake these functions with respect to NHS trusts.

Option 2 is the preferred option. In transition to an all FT landscape it is logical, from an organisational perspective, to organise the remaining NHS trust management and support functions in a single organisation with specialist knowledge and clear objectives, in line with the Government's vision for an autonomous NHS, free from day-today political control.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 06/2016

Does implementation go beyond minimum EU requirements?			No			
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No	
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** n/a	**Non-traded:** n/a		

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: ..... Date: 22 March 2012

Summary: Analysis & Evidence

Policy Option 1

Description: Do Nothing (maintain the status quo) - NHS

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 4	Net Benefit (Present Value (PV)) (£m)		
			Low: £0m	**High:** £0m	**Best Estimate:** £0m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a		n/a	**n/a**
High	n/a		n/a	**n/a**
Best Estimate	£0m		£0m	**£0m**

Description and scale of key monetised costs by 'main affected groups'

There are no additional costs and benefits under the "do nothing" option. This permits an assessment of other options can be made against this benchmark. All other options are assessed in terms of their costs and benefits above and beyond the "do nothing" option. This is not the same as the current or baseline costs of the organisations undertaking performance management, monitoring, appointments and support functions with respect to NHS trusts, which are discussed further below.

Other key non-monetised costs by 'main affected groups'

n/a

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	n/a		n/a	**n/a**
High	n/a		n/a	**n/a**
Best Estimate	£0m		£0m	**£0m**

Description and scale of key monetised benefits by 'main affected groups'

There are no additional costs and benefits under the "do nothing" option. This permits an assessment of other options can be made against this benchmark. All other options are assessed in terms of their costs and benefits above and beyond the "do nothing" option. This is not the same as the current or baseline costs of the organisations undertaking performance management, monitoring, appointments and support functions with respect to NHS trusts, which are discussed further below.

Other key non-monetised benefits by 'main affected groups'

n/a

Key assumptions/sensitivities/risks — **Discount rate (%)** n/a

n/a

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Summary: Analysis & Evidence

Policy Option 2

Description: Establish the NHS Trust Development Authority as a Special Health Authority responsible for oversight of the remaining NHS trusts

FULL ECONOMIC ASSESSMENT

Price Base Year **2012**	PV Base Year **2012**	**Time Period Years** 3	**Net Benefit (Present Value (PV)) (£m)**		
			Low:	**High:**	**Best Estimate:** -£9

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low				
High				
Best Estimate	£3m		£3m	**£9m**

Description and scale of key monetised costs by 'main affected groups'

Costs of the NTDA will mainly be staff pay to undertake proposed functions with respect to NHS trusts. There will also be non-pay costs, for example to commission specialist knowledge to support the remaining trusts, many of which have significant challenges, in the transition to FT status. Additional costs presented here need to be considered in the context of overall administrative savings being made by the health system (unchanged by this Impact Assessment and discussed further below).

Other key non-monetised costs by 'main affected groups'

n/a

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

In transition to an all FT landscape the benefits of the NTDA are locating all the remaining functions with respect to NHS trusts in one organisation, with clear objectives and the specialist knowledge to support challenging trusts in their transition to FT status. In addition the NTDA will be at arms-length from day-to-day political control, to ensure the process can be completed in an effective, co-ordinated way. It has not been possible to monetise these benefits.

Other key non-monetised benefits by 'main affected groups'

Performance management, monitoring, appointment and support functions with respect to NHS trusts are inter-dependent and their effective undertaking is essential to the delivery of the Government's vision of an all NHS FT provider landscape. The proposed creation of the NTDA, at arms-length from day-to-day political control, will ensure the process can be completed in an effective, co-ordinated way. This is intended to support the realisation of a more efficient NHS provider sector.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

Current and future estimates of costs of NHS trust functions have been estimated by the Department of Health with the best available information, this has involved some assumptions and may be an underestimate. In addition assumptions have been made previously about the distribution of administrative savings across the health system, some of which have changed over time, while the overall level of administrative savings to be achieved remains the same.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			**In scope of OIOO?**	**Measure qualifies as**
Costs: n/a	**Benefits:** n/a	**Net:** n/a	No	NA

Evidence Base (for summary sheets)

There is discretion for departments and regulators as to how to set out the evidence base. However, it is desirable that the following points are covered:

Problem under consideration

1. The Government has set out a clear vision for a modernised NHS with all NHS trusts becoming Foundation Trusts (FTs), subject to Royal Assent of the Health and Social Care Bill 2011. NHS trusts require support to achieve FT status. This includes for example an effective appointments process to NHS trusts boards, to ensure that NHS trusts are effectively governed. The remaining trusts will also require performance management and monitoring to maintain national standards. Currently these functions lie across different organisations. Under the proposals of the Health and Social Care Bill 2011, subject to Royal Assent, some of these organisations will be abolished and this requires their functions to be re-located to ensure that the process of transition of all NHS trusts to FT status is completed effectively.
2. This transition is happening at a time of significant challenge for the health system in terms of the need to make up to £20bn of Quality Innovation Productivity Prevention (QIPP) efficiency savings by 2014/15, a significant proportion of which need to be delivered by the provider sector. An effective completion of the transition to FT status for the remaining NHS trusts is required to support these savings, and an effective system of oversight and support is required in the transition.
3. The Government's vision of care delivered in an all FT landscape means that NHS trusts must either become authorised as an FT, merge with an existing FT or move forward in another organisational form by 2014, unless otherwise agreed and possibly subject to new management arrangements. This process is known as the FT pipeline. The responsibilities for supporting trusts in this process currently lie partly within Strategic Health Authorities (SHAs) which, subject to the Royal Assent of Health and Social Care Bill 2011, will be abolished in April 2013[1]. SHAs are also currently responsible for clinical quality, governance and risk in NHS trusts.
4. The DH is currently responsible for performance management and clinical monitoring of NHS trusts. The organisational location of these functions need to be considered in light of the Government's vision for the NHS to have autonomy from political control.
5. Appointments functions to the Boards of NHS trusts currently lie with the Appointments Commission which, as intended, is also due to be abolished.
6. In light of the Government's vision for health care set out in the Health Bill, options for re-locating these functions to ensure their continuity and autonomy from direct political control need to be considered.

Rationale for intervention;

7. The organisational location of these functions needs to be resolved to ensure continuity of support in transition to an all FT landscape and to ensure that these functions can be undertaken at arm's length from political control, in light of the Government's vision for health care set out in the Health Bill.
8. The process of achieving FT status involves NHS trusts achieving a level of performance against a number of criteria set by Monitor – the FT regulator – these include, for example, financial performance, quality of care and how robust clinical governance arrangements are. This FT pipeline process is currently supported by the DH and SHAs. To date, 50 per cent of the NHS trusts whose applications for FT status are rejected by Monitor fail because they do not have sufficiently robust governance. It is proposed that SHAs will be abolished in 2013, so new support arrangements will be required to continue to support the FT pipeline process if all NHS trusts are to become NHS FTs by 2014.
9. The success of the FT pipeline process is partly dependent on other functions which relate to the way that NHS trusts operate and are governed. This includes performance management; appointments to the Boards of NHS trusts, and monitoring clinical quality, governance and risk.

[1] As set out in the DH's White Paper: Equity and Excellence – Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

With the proposed abolition of the Appointments Commission consideration needs to be given to which organisation will undertake appointments functions. SHAs are currently responsible for monitoring clinical quality, governance and risk, so if, under the Health and Social Care Bill (subject to Royal Assent), they are abolished, new arrangements will be required to undertake these functions.

10. Performance management is an inter-related function to the FT pipeline process. In line with the Government's vision for an autonomous NHS, free from political control there is a need for the performance management functions to be supported by an organisation which is free from direct political control, with clear objectives set by the Government.

Description of options considered (including do nothing);

11. The options that have been considered are:

Option 1 – Do Nothing – It is proposed that SHAs will be abolished in April 2013 with functions with respect to the FT pipeline and monitoring of clinical quality, governance and risk will be undertaken by another organisation, yet to be specified. The DH retains performance management functions for NHS trusts and for monitoring clinical quality, governance and risk. It is intended the Appointments Commission would be abolished with public appointments functions undertaken by another organisation. Previous calculations underlying the estimates of the total current and future administration costs (£4.5bn reduced to £3bn by 2014/15) of the health system have assumed that these functions will continue. This was underpinned by assumptions regarding the proportion of the total future administrative savings required of these functions.

Option 2 - Establish the NHS Trust Development Authority (NTDA) as a special health authority with the following statutory responsibilities:

- Performance management of NHS trusts;
- Management of the foundation trust pipeline;
- Monitor clinical quality, governance and risk in NHS trusts; and
- Public appointments to NHS trusts and NHS charities.

Option 1 – Do Nothing

12. In the case of the functions being considered below the Do Nothing option is a combination of explicit and underlying assumptions already made when previously analysing policy proposals for the Health Bill 2011 and the estimates of future administrative costs of the health system. Comparing the costs to this baseline ensures that costs or benefits are not potentially omitted or double counted.

13. For example the analysis for the Impact Assessment for the Health and Social Care Bill 2011 explicitly assumes that the appointments functions discussed below will be handled by the DH and / or potentially a special health authority. In the case of the SHA functions with respect to the FT pipeline these were included in the calculation for the administrative costs of the health system and the implicit assumption of total future administrative savings included a continuation of these functions.

Performance management of NHS trusts

14. The DH retains performance management responsibilities for NHS trusts. This would mean that the DH continues to have an NHS operational remit, incompatible with provider reforms to put NHS operational issues at arms-length from day-to-day political control.

Management of the FT pipeline

15. Under the Do Nothing assumption, as set out in the Health and Social Care Bill 2011 (subject to Royal Assent), all the NHS trusts will become FTs and therefore the functions of SHAs need to be undertaken at another organisation to continue to support this process.

Monitor clinical quality, governance and risk in NHS trusts

16. Currently monitoring clinical quality, governance and risks in NHS trusts is the responsibility of SHAs which, subject to Royal Assent of the Health and Social Care Bill 2011, are due to be

abolished in April 2013. These functions are expected to continue, and have been budgeted for, but it has not been specified which organisation will undertake those functions.

Public appointments to NHS trusts and NHS charities

17. The Appointments Commission currently makes appointments to NHS trusts and NHS charities. The Appointments Commission is due to be abolished in October 2012, as set out in the Arms Length Body Review[2]. The Do Nothing option based on the Health and Social Care Bill Impact Assessment[3] is that these functions will continue until no longer required, to be "handled by the Department and an NHS body, most likely to be a special health authority".

Option 2 - Establish the NHS Trust Development Authority as a special health authority with the following statutory responsibilities:

- Performance management of NHS trusts;
- Management of the foundation trust pipeline;
- Monitor clinical quality, governance and risk in NHS trusts; and
- Public appointments to NHS trusts and NHS charities.

18. Under this option the NTDA will be legally established in June 2012, initially with limited functions and eventually with substantive functions – the first of which will be conferred in October 2012. All it's substantive functions will be transferred by April 2013, in line with the timetable for the proposed abolition of SHAs and subject to Royal Assent of the Health and Social Care Bill 2011.

19. The NTDA will play a vital part in laying the foundations for the new health and social care system. If SHAs are abolished it will, from April 2013, provide essential governance, oversight and performance management of those NHS trusts, not yet FTs, to support them in delivering the vision of a fully autonomous provider landscape ensuring high quality services for patients throughout the country. The goal is to support the FT pipeline process and ongoing performance management of trusts to achieve an equitable, sustainable provider landscape that provides high quality services for patients and communities throughout the country. There is a strong expectation that the majority of NHS trusts will achieve FT status by April 2014 and that only by exceptional agreement made after close scrutiny of financial and clinical feasibility will they be allowed to continue in existence past this date.

Performance management of NHS trusts

20. Until the final NHS trust application for FT status has been authorised by Monitor – the independent regulator for FTs - the NTDA will remain responsible for oversight of the performance of each NHS trust.

21. The NTDA will be responsible for performance management of NHS trusts, by working with them on issues such as waiting times and hospital acquired infection rates that are assessed as part of the review of applications for NHS trusts to become FTs. It will help NHS trusts to reduce unacceptable and unjustified variations in clinical quality and safety. Together with the Care Quality Commission (CQC), the NHS Commissioning Board (NHSCB) and local clinical commissioning groups (CCGs), the NTDA will help to drive-up the quality of care provided in NHS trusts.

22. Under this option the NTDA will take over the role to ensure cost improvement programmes and long term financial plans are agreed by NHS trusts with clinical leads, involve patients in their design and include in-built assurance of patient safety and quality, building on the work now completed on a quality governance framework supporting FT applications. A single national process is being developed so that all current SHA clusters and the NTDA going forward take a consistent approach to quality assurance of cost improvement plans. This will be part of a broader common operating model for quality and safety that is being developed.

Management of the FT pipeline

23. Under this option the NTDA would be responsible for managing the FT pipeline, and providing support to NHS trusts to achieve FT status. They will be required to provide evidence to the

[2] http://www.dh.gov.uk/en/Aboutus/OrganisationsthatworkwithDH/Armslengthbodies/DH_120119

[3] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf

Secretary of State for Health (SofS) of an applicant's readiness for FT status, in line with Monitor's requirements as currently set out in Monitor's guidance. NHS trusts will still require the support of SofS until they become authorised as an FT by Monitor, but day-to-day operations will be at arms-length from political control.

Monitor clinical quality, governance and risk in NHS trusts

24. Under this option the NTDA will take over the functions and responsibilities from SHAs, following their proposed abolition, for monitoring clinical quality, governance and risk in NHS trusts.

Public appointments to NHS trusts and NHS charities

25. Under this option the NTDA would have responsibility for certain appointments to NHS trusts and trustees for NHS bodies, taking over these functions from the Appointments Commission, following it's proposed abolition in October 2012.

26. These four functions will come to an end when the FT pipeline process is complete and there are no longer any NHS trusts. FTs do not have appointments made by the Secretary of State.

Monetised and non-monetised costs and benefits of each option (including administrative burden);

Assessment of benefits

Option 1 – Do Nothing - benefits

27. The implications of the Do Nothing option are described in paragraphs 12 to 17 above. This Impact Assessment is concerned with the additional benefits of options being considered compared to the "Do Nothing" option. Therefore the costs and benefits of option 1 are set to zero, by default so this assessment can be made. This is not the same as the current costs and benefits of the organisations undertaking these functions, which are discussed further below.

Option 2 – Establish the NTDA as a special health authority

28. This option is described above under paragraph 18. In the DH's new role at arms-length from the operational running of the NHS, it would not be appropriate for the four functions set out above in paragraph 18 to be provided by a Department of State. Therefore, following wider consultation with stakeholders, the Command Paper *Liberating the NHS: legislative framework and next steps*[4] set out the arrangements for the transition period to 2014 including the creation of the NTDA, previously to be called the Provider Development Authority, to provide the required accountability to SofS.

Scope of the benefits discussed in this section

29. Each of the proposed functions of the NTDA and the ultimate goals of those functions has specific benefits attached to them. For example ongoing performance management of NHS trusts will help to ensure that national standards are maintained, until these are replaced by the incentives of an effectively regulated all FT provider landscape. The maintenance of the these standards bring about health benefits to patients, e.g. through maintaining low levels of Health Care Associated Infections. In addition the ongoing management of the FT pipeline process will enable the creation of an all FT landscape, which will support the realisation of the benefits set out in the Health and Social Care Bill 2011 Impact Assessment.[5] In addition this transition needs to be completed at a time of significant challenge for the health system in terms of making up to £20bn of QIPP efficiency savings, by 2014/15. An efficient provider sector is required to support the realisation of these savings which necessitates the transition to an all FT landscape and an effective oversight of challenging trusts in the interim.

30. The scope of this Impact Assessment is, however, which organisation or organisations will undertake the functions pertaining to NHS trusts, in light of the proposed reforms brought about by the Health and Social Care Bill 2011 (subject to Royal Assent) and in particular the abolition of SHAs. Hence the benefits described below relate to the undertaking of these functions by the

[4] See paragraph 6.40, page 129 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

[5] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf

NTDA. Policy on FTs and the aspiration for the speed at which an all FT landscape is achieved remains unchanged.

Benefits of the NTDA

31. The benefits of incorporating all of these functions into one organisation which is (at arms length) from the DH include:

- As described in the recent NAO report[6] as of 1 October 2011, there were 139 FTs at that point, the first of which was created in 2008. The task of progressing the remaining 108 NHS trusts[7] to FT status is challenging given the 'tripartite formal agreements' for 20 NHS trusts show they are not financially or clinically viable in their current form. Therefore to achieve this challenging goal and accelerate the FT pipeline process, locating all specialist knowledge and focus on the remaining NHS trusts in one organisation, the NTDA, will make it easier to achieve the objectives of an all FT provider environment without having to operate across organisational boundaries.
- The proposed functions of the NTDA should be performed at arms-length from the DH as there is a similar potential for conflicts of interest as set out in the Provider Regulation Impact Assessment paragraph B6, page 34[8]. In line with the Government's vision for an autonomous NHS the establishment of the NTDA will bring about an oversight and support system for NHS trusts which is free from day-to-day political control, with the appropriate accountability mechanisms and clear objectives set by the DH.
- That the proposed functions of the NTDA are inter-dependent and are therefore best performed by one organisation. For example the authorisation of NHS trusts as FTs requires them to reach minimum standards of financial and clinical performance. Both of these are dependent on the performance management processes in place and the strength of the board and governance. Therefore, in this example, the performance management, appointments and FT pipeline functions are inter-dependent. It is therefore logical from an organisational design perspective for these functions to be undertaken by a single organisation. In addition, as a specialist organisation the work of the NTDA could potentially be of a "higher quality" making it more likely that the policy objectives will be achieved.
- To date, 50 per cent of the NHS trusts whose applications for FT status are rejected by Monitor - the FT regulator – are rejected because they do not have sufficiently robust governance. In response to this the DH has developed the Board Governance Assurance Framework (BGAF)[9]. In order to achieve FT status NHS trusts will need strong leadership from their boards. Through the application of standardised support and development tools, such as the BGAF, the NTDA will ensure that boards will be effective in leading NHS trusts into an all FT landscape[10].
- *Liberating the NHS*[11] originally said that Monitor should take responsibility for overseeing any remaining NHS trusts from April 2013. However, the DH accepts the arguments made during the Listening Exercise[12] that these trusts are likely to need specialist turnaround support, and that providing this could be a distraction from Monitor's focus on introducing economic regulation.
- As stated in the Health and Social Care Bill 2011 Impact Assessment[13] the movement to an all FT landscape "will essentially mark the end of local NHS public appointments, and therefore public appointments will no longer be in sufficient volume to justify having a separate organisation to manage the process." The corollary of that is the merger of these functions, while they remain, in a specialist organisation responsible for other functions in relation to NHS trusts is logical.

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6 http://www.nao.org.uk/publications/1012/foundation_trusts.aspx

7 This is different from the 113 remaining NHS trusts as described in the NAO report, as 5 NHS trusts have reached FT status since publication.

8 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131547

10 ref: Building the NHS Trust Development Authority

11 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

12 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_127868

13 Paragraph E98
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf

i. Assessment of costs

Option 1 – Do Nothing - costs

32. This Impact Assessment is concerned with the additional costs and benefits of options being considered compared to the “Do Nothing” option. There are no additional costs and benefits under the "do nothing" option. This permits an assessment of other options against this benchmark. All other options are assessed in terms of their costs and benefits above and beyond the "do nothing" option. This is not the same as the current or baseline costs of the organisations undertaking performance management, monitoring, appointments and support functions with respect to NHS trusts, which are discussed further below.

Current costs

33. The current costs and trajectory of those costs included in the Health Bill Impact Assessment as part of the reduction in health system administration costs from £4.5bn to £3bn are presented in the table below. These are the costs against which the proposed costs of the NTDA are compared.

34. These costs were estimated at the time of the Health Bill Impact Assessment and were indicative estimates of administrative costs across the whole health system based on the Department’s best evidence and understanding of the costs of the different functions. The costs were based on estimates of staff costs and non-staff costs of undertaking these functions. This involved a degree of estimation as it involved separating out the costs of different functions from within organisations and attributing them in their existing form to future organisations. In splitting out these costs it is possible that the costs of some functions were underestimated or that the destination of these functions will have changed, this is believed to be the case in terms of SHA finance and performance functions which may not be fully captured below.

35. The trajectory of costs from 2011/12 to 2014/15 were calculated in line with the need to make administrative savings across the system as outlined in paragraph 32. At the time of this assessment assumptions were made regarding how these cost savings would be distributed across the different administrative functions of the health system, within the overall envelope of a one-third reduction in administrative costs. These costs are rounded and presented in table 1 below.

Table 1 – estimates of costs to organisations currently responsible for functions with respect to NHS trusts, and future trajectory based on estimated reduction in administrative costs across the Health system

Current organisation	Function	2011/12	2012/13	2013/14	2014/15
SHA	FT pipeline and provider management & performance management	15,200,000	15,000,000	8,000,000	8,000,000
DH	Trust performance management and provider development	2,000,000	2,000,000	1,000,000	1,000,000
AC	Appointments Commission	700,000	600,000	400,000	400,000
Extra NTDA functions in DH	New NTDA functions currently in DH	6,000,000	6,000,000	6,000,000	6,000,000

DH	DH provider development programme budget	6,300,000	6,000,000	6,000,000	6,000,000
	Total	33,000,000	30,000,000	22,000,000	21,000,000
Source: Department of Health estimates of the current costs of NHS trust facing functions **costs are discounted at 3.5%, 2012-13 is the first year (2011-12 costs provided for completeness)					

Option 2 – Costs - Establish the NTDA as a special health authority

36. The NTDA will have:

- operating costs associated with the ongoing running of the organisation and
- non-pay costs such as those associated with commissioning specialist knowledge to support challenging trusts in the FT pipeline, and to support due diligence requirements in approving trusts for FT status.

37. The costs presented below are indicative and are based on a number of assumptions. These are that:

- That there will be approximately 95 NHS trusts remaining when the NDTA takes on its substantive functions. This is based on a current estimate of 108 NHS trusts and an estimate from the DH on the number of trusts that will remain.
- There will be the costs of historic due diligence associated with these 95 NHS trusts, to be incurred by the NTDA, as part of the FT applications process. Based on previous DH and SHA experience of this historic due diligence process the estimated cost is £130,000 per NHS trust. That the Due Diligence will be phased over the years of the NTDA existence, with the majority of Due Diligence undertaken in 2012/13 and 2013/14.
- The costs are estimated on the assumption that the NTDA will have a workforce of up to 250 staff, the estimates of staff mix may vary but the estimates below present a maximum level of staff costs. Staff costs estimates have been made using DH and NHS pay scales. Estimates include an uplift for pensions and national insurance contribution. NTDA back office functions will be arranged through shared service arrangements, this will include HR, IT, estates, payroll, transactional finance and procurement.
- There is a risk as described below that the FT pipeline process may take longer than expected and therefore the total cost of the Due Diligence for NHS trusts would be spread over additional years. Action as described below is being taken to mitigate this risk.

Table 2

	2012/13	2013/14	2014/15
FT pipeline and provider management & performance management (SHA)	15,000,000	0	0
Trust performance management and provider development (DH)**	14,000,000	0	0
NTDA Staff Costs	0	19,000,000	19,000,000
NTDA Non-pay costs	0	6,000,000	6,000,000
NTDA Set-up and appointments functions (second half of 2012/13)	4,000,000	0	0
Total	33,000,000	25,000,000	25,000,000
Source: Department of Health estimates of the budget of the NTDA **DH functions are total of the 3 lines of costs labelled as DH functions in table 1 above			

Additional costs of option 2 – difference between tables above

38. This Impact Assessment is concerned with the additional costs of option 2 against the Do Nothing option, i.e. the difference between the two tables above. The additional costs of the preferred option in each year are therefore presented in the table below.

39. The costs estimated below represent a redistribution of the estimated trajectory of the administrative costs of the health system, rather than an additional cost that has not been budgeted for. The overall estimate of administrative costs in the health system and their trajectory to the period 2014/15 remain the same, as described in the Health and Social Care Bill Impact Assessment and outlined in paragraph 33 above. As stated in paragraphs 33 to 35 above – assumptions about the distribution of cost reductions were made at the time of the Health and Social Care Bill Impact Assessment. Over time these assumptions are being revised and the distribution of the savings is being changed, while the overall level of savings remains the same.

40. Table 3 below presents the difference between the estimated costs of functions with respect to NHS trusts at the time of the Health and Social Care Bill Impact assessment (table 1 above) and the currently estimated costs with respect to the proposed functions of the NTDA.

	2012/13	2013/14	2014/15
Additional costs	3,000,000	3,000,000	3,000,000
**Costs discounted at 3.5%, numbers are rounded			

Risks and assumptions;

RISK 1 – FT pipeline takes longer to complete than planned

41. As set-out in Building the NHS Trust Development Authority[14] there is a strong expectation that the majority of trusts will achieve FT Status by 2014. If this is not achieved then there could be a need for continued performance management and support for NHS trusts by the NTDA.

MITIGATION

42. As with all the new arms-length bodies the NTDA will be subject to a review of its continued need for existence, and this is likely to take place in 2016.

RISK 2 – Additional functional requirements of the NTDA

43. The NHS Trust Development Authority has additional work or functions not planned for in the resources and design of the organisation and is therefore unable to delivery it's core functions.

MITIGATION

44. Robust organisational design and resource mapping before the NHS Trust Development Authority is operational.

Direct costs and benefits to business calculations (following OIOO methodology);

There are no costs to business of the proposals.

Wider impacts

An equality impact assessment for these proposals has been completed.

Summary and preferred option with description of implementation plan.

45. The preferred option is the Establishment of the NHS Trust Development Authority (option 2) as described above. The implementation plan steps are set out in the table below. This has

[14] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131776

previously been published in “Building the NHS Trust Development Authority” (see references below), which contains additional information on implementation

February 2012:	Chief Executive designate of the NTDA appointed
March 2012:	Response to the Section 28 consultation letter published
Spring 2012:	People Transition Policy published
Spring 2012:	Designate chair and designate non-executive directors for the NTDA appointed
Spring 2012:	Recruitment process for NTDA senior staff begins
June 2012:	The NTDA established legally as a special health authority
July 2012:	First Board meeting
October 2012:	Appointments Commission functions transfer to the NTDA
April 2013:	NTDA fully operational

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