6/4/81

1. Mr Yeatle ?/to see + return   H/B13/26.   31A

(52)

Mr Nodder

FUTURE MANAGEMENT OF CENTRAL BLOOD LABORATORIES

1. As you know we have been working for some time on a submission to Ministers, but regarding future management, for practical reasons, as a lower priority than redevelopment of BPL* and future plasma supply.

Background

2. The new BGRL* accommodation in Oxford (part of an existing building on the Radcliffe Infirmary site) will be ready in January 1982. We have so far taken no steps to alter the interim arrangements whereby, like BPL, it is managed by a joint committee of DHSS and NW Thames RHA. NWT continue to manage both laboratories day to day, and are providing works services for the BGRL move and the interim BPL development. We are negotiating with them about the long term development of BPL.

3. The BPL branch at Oxford (the PFL*) should move to Elstree eventually but that will not be until BPL is redeveloped.

4. The Scottish plant at Liberton, Edinburgh, is managed by the Common Services Agency.

Future management of BTS as a whole

5. There has long been pressure from the BTS itself, supported by some RHAs, for an integrated service run and funded nationally, which would take over the RTCs*. Views differ within the Department about the merits of this. Dr Harris and I are however agreed that it is not a move to be considered at the moment. (This is, we think, also CMO's view.) The situation may change because of:

(i) technological developments

(ii) a further swing in the balance of the service away from material collected and consumed within the regions to material collected regionally but processed centrally or to material supra-regionally collected (eg at a few large plasmapheresis centres)

(iii) a change in the role of RHAs, making it impossible for them to continue as management bodies.

In any of these events a case for centralisation could appear. We are agreed that management of RTCs by individual DHAs would not be desirable, even if feasible.

The Scottish dimension

6. One eventual possibility, in which I personally see considerable attraction, is to bring Liberton and BPL under the same management - particularly as we are already expecting Liberton to meet some of the needs of the rest of the UK for Factor VIII. This is not an immediate runner - the Scots are afraid that a merger would operate to Scottish disadvantage until England is more nearly self-sufficient - but our administrative colleagues in Scotland agree that it is a possibility which should be allowed for in our management arrangements.

*Key: BPL = Blood Products Laboratory
BGRL = Blood Group Reference Laboratory
PFL = Plasma Fractionation Laboratory
RTC = Regional Transfusion Centre

Future management of Central Blood Laboratories

7. The present arrangements were set up for the short term and pose many problems. All concerned are agreed that they cannot continue.

8. For simplicity this minute assumes that BPL/PFL and BGRL will continue under the same management. This we regard as the most sensible arrangement, though not essential. It only marginally affects the main argument.

9. We have considered many possibilities, but really there are only three runners - management by a Health Authority; management by an enlarged and reconstituted PHLS; and a special Health Authority. All present advantages and problems, which were considered at a recent office meeting chaired by Dr Harris. Our conclusion was that a Special Health Authority was the clear first choice.

10. The first point to make is that the Laboratories, or at any rate the BPL, could not be run properly by the ordinary RHA and RTO structure without modification. BPL is a large, complex and highly specialised factory operation which needs much special expertise, in our view at "Board" as well as management level. This expertise includes pharmaceutical manufacturing and processing generally, fractionation technology, sterile production on a manufacturing scale, factory management, and industrial budgeting and cost control. To get all this we must get in people with the right commercial and industrial skills and experience. We have discussed with Mr David Smart of Glaxo, lately President of the ABPI, the availability of such people, and he is optimistic, given the right management arrangements.

11. Another task for the "Board" is to pursue the links with industry, including joint development projects, which Ministers are keen to foster.

12. We envisage that the members, or at any rate the "Chairman" would exercise considerable oversight over the management, which does not and cannot possess all the necessary skills and is, to boot, a little idiosyncratic.

13. In principle the "Board" could be a sub-committee of PHLS or a Health Authority, or a corporate body in its own right. It could be confined to the CBLs or have wider responsibilities. However Mr Smart confirms that good people from industry are much more likely to be interested if they have clear authority and accountability in their own right. He also believes that people will be more interested in a relatively limited and clear-cut enterprise like the CBLs than a mixed one.

(i) PHLS

14. The argument for PHLS is that it is the only existing statutory body which could possibly do the job; that some of the management skills needed by BPL might also benefit CAMR, Porton; and that a larger enterprise than the present PHLS would more readily justify the provision of some expertise, eg works, which is presently rather thin. However the scientific base is different; the upheaval for PHLS would be considerable and could not be justified unless shown to be necessary anyway to make sense of Porton; Mr Smart thinks a CBL/Porton mix of responsibilities would not be very attractive to industrialists; and PHLS could not take on wider responsibilities (paras 6 and 7 above) without a major change in the balance of their activity and risk to the microbiological side. We have concluded - in my case with some reluctance - that this is not an option which we can favour.

(ii) A Health Authority, ie N W Thames RHA

15. The advantages are that no addition would be needed to the overall NHS management structure and that the RHA has readily available personnel, financial and works services which a SHA would not be large enough to provide. I am not sure how important the first argument is, given the proposal to establish SHAs for several of the specialist postgraduate hospitals.

16. The disadvantages are however substantial. The RHA would need to establish and be accountable for a sub-committee whose activities it would only dimly understand and which ought to have a deal of independence. Much policy (eg financial arrangements, scale of development) would have to be decided by us, and unless the service is to be put on an economic charge basis, with all that that entails, we should have to decide not only capital but revenue allocations. We should in any case have to determine the allocation for non-service activities, eg r. and d. Ie the RHA's accountability would be very difficult to exercise and it would find itself ground between millstones; but it would have to carry the can. There would also be difficulty about the accountability, in practice if not in theory, of the staff concerned. The sub-committee itself would pretty certainly find this situation disagreeable - and indeed quite at odds with what would be thought appropriate in industry. It might well be difficult to get and retain good people for the sub-committee.

17. Separate arrangements would probably have to be made for BGRL. If not there would be the awkwardness of NWT managing a body embodied in an Oxford hospital. However this is not a major argument.

18. The RTO is very keen not to be given the job, and although the indications are that the Authority would take it if pressed, their reluctance would be a poor omen.

19. In addition to the immediate disadvantages, the solution is not conducive to the possible changes in paras 6 and 7. Quite apart from the load on the RHA, neither other RHAs nor Scotland would be willing for one English RHA to manage their services. If we wanted to bring either change about - and of course if the RHA role changed - we would have to make a further switch.

(iii) A SHA accountable to the Department

20. The disadvantages and advantages are substantially the converse of the RHA arguments, ie

(a) another management body, and accountable to the Department (but not necessarily increasing our work - indeed a competent SHA might well give us less difficulty and fewer decisions than a body of lesser standing);

(b) the body would be small (its revenue expenditure would be about £4 million per year, and the commercial value of its products £10 million plus, compared with a range of £9-21 million revenue expenditure for the six BGs proposed to become SHAs); it would have under 200 staff; it could not provide many necessary services; the RHA would be willing to provide these on an agency basis; this would be satisfactory only so long as no conflict of interest or priorities arose;

(c) for the same reason there could be difficulty in finding good quality administrative back-up; though my own view is that the job might be quite attractive;

(d) we would probably find it easiest to find good members for a SHA;

(e) accountability problems would be avoided; and the communication line between management and the real point of decision would be shorter;

(f) BGRL could more easily be accommodated;

(g) this solution best allows for possible future changes.

Other factors

21. I do not believe we could leave setting up a RHA sub-committee to the RHA, nor the determination of its modus operandi. The matter is too sensitive. Moreover we, not the RHA, have the industrial contacts. We should therefore have to work jointly with the RHA, which would offset the avoidance of some of the mechanical work. I regard this factor as neutral, or at any rate insufficient to offset the merits of the case.

22. Whatever body is responsible for management, it will have to have regard to the wider NHS interest. In the case of a SHA I would see this being dealt with by having some members from the NHS, and possibly by a requirement to consult, eg about future demand.

Summary

23. The more we have studied this, the stronger the case for a SHA, rather than RHA management, has become - both on immediate merits and on future flexibility. We believe the practical problems can be overcome. We should like to make a SHA our clear recommendation to Ministers.

24. Are you content for us to proceed on this basis, or would you like a meeting first?

GRO-C

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cc: Mr Collier
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