Department of Health

Accounting Officer system statement

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Introduction

1. As Permanent Secretary and Principal Accounting Officer of the Department of Health (DH), I am accountable to Parliament for the proper stewardship of the resources allocated to my Department.

2. My responsibilities as Accounting Officer are set out in the Treasury guidance *Managing Public Money*, but in summary are:

    - to ensure that all the expenditure of DH, its arm's-length bodies and the NHS (including NHS trusts and NHS foundation trusts) is contained within the overall budget – the Departmental Expenditure Limit (DEL);

    - to assure myself that the individual organisations within the system are performing their functions and duties effectively and have the necessary governance and controls to ensure regularity, propriety and value for money; and

    - to ensure that Ministers are appropriately advised on all matters of financial propriety and regularity, and value for money, across the systems for which the Department is responsible.

3. In line with the code of good practice on corporate governance in central government departments (HM Treasury and Cabinet Office, 2011), DH has constituted an enhanced Departmental Board chaired by the Secretary of State, including non-executives from outside government. The Board provides advice and support to Ministers, and to me as Principal Accounting Officer, across all of DH's responsibilities. The Board scrutinises reports on performance, and challenges DH on how well it is achieving its objectives.

4. The three parts of this statement describe, in turn, my responsibilities for the three services that DH oversees in England: the NHS, public health and adult social care.

5. Because the Government's reforms to the NHS and public health will significantly affect the way accountability works, this statement focuses particularly on the period after April 2013, when the majority of the reforms are expected to be in place.

6. While the NHS, public health and adult social care are funded and structured differently, and have different mechanisms for accountability, in future, and for the first time, they will all be covered by a consistent set of outcomes frameworks, describing the outcomes that need to be achieved. Collectively, these outcomes frameworks will provide a way of holding the Secretary of State and the Department to account for the results DH is achieving with its resources, working with and through the health and care delivery system.

PART ONE: THE NHS

7. The NHS is a nationally funded service; accountability runs from NHS organisations, through the Secretary of State, who is accountable overall for the health service, to Parliament.

a) Current accountability for the NHS

8. Since 2006, Sir David Nicholson, the NHS chief executive and a senior civil servant within DH, has been appointed by the Treasury as an Additional Accounting Officer for the NHS. He is accountable for the Department's own programme expenditure on the NHS and for overseeing the spending of all NHS bodies that are subject to direction by DH (that is, primary care trusts, strategic health authorities, special health authorities, and NHS trusts). I am responsible for the rest of DH's budget. This includes being accountable for the expenditure of DH's non-departmental public bodies (NDPBs)[1] and for ensuring that the net expenditure of NHS foundation trusts, which are not subject to direction by DH, is contained within the Department's budget. A published memorandum of understanding sets out our respective roles.

9. This arrangement will continue until the end of March 2013, in order to provide stable accountability during the transition period of implementing the Government's proposals for modernising the NHS.

b) Future accountability for the NHS

10. From April 2013, the post of NHS chief executive will no longer exist (Sir David will be chief executive of the NHS Commissioning Board instead), and I shall have sole Accounting Officer responsibility in DH for the proper and effective use of resources voted by Parliament for the health service.

11. Under the new system, while DH will remain responsible for the health and care legislative framework, and the Secretary of State will retain ministerial responsibility to parliament for the provision of the health service in England, most day-to-day operational management in the NHS will take place at arm's length from the Department. With the exception of the remaining special health authorities[2], all organisations in the NHS will have their own statutory functions conferred by legislation, rather than delegated to them by the Secretary of State.

12. However, the Secretary of State (and thereby the Department under my leadership) does have an explicit duty to keep under review the performance of the NHSCB and all of DH's other ALBs. In the event of a significant failure by any ALB to perform its functions properly or in a manner that the Secretary of State considers to be consistent with the interests of the health service, the Secretary of State has powers to intervene by issuing a direction. If the body fails to comply, the Secretary of State may discharge that function directly or arrange for another organisation to do so.

[1] These include, in particular, the two independent regulators in the NHS: the Care Quality Commission and Monitor (the Independent Regulator of NHS foundation trusts).
[2] Listed in Annex B, along with the Department's other current and future arm's-length bodies.

13. These changes, which are intended to empower front-line professionals, whilst maintaining Ministerial accountability, will reduce the Department's involvement in operational decision-making. However, as the rest of this part of the statement explains, there will be a robust system to allow me to discharge my responsibilities as Accounting Officer, by providing assurance about:

    a) the commissioning of NHS care; and

    b) the provision and regulation of services;

c) Commissioning

14. In future, the Department will allocate the budget for commissioning NHS services to the NHS Commissioning Board (NHSCB), rather than allocating it directly to primary care trusts, as at present. The NHSCB will commission some services from providers itself (such as national specialised services for rare diseases), as well as commissioning primary care services but will allocate the majority of its budget to local clinical commissioning groups (CCGs), which will be responsible for commissioning most NHS services.

15. As now, the principal line of accountability for the NHS will be through the commissioning line, following the flow of money from DH to the NHSCB to CCGs. This will be underpinned by an NHS outcomes framework that DH will publish, setting out the outcomes that need to be achieved in order to improve the quality of NHS care and reduce inequalities. DH will publish similar outcomes frameworks for public health and for adult social care.

16. As Accounting Officer, I will be able to gain assurance about the performance of commissioners through:

    i) compliance with the framework agreement between DH and the NHSCB;

    ii) performance against the Secretary of State's mandate to the NHSCB;

    iii) my relationship with the NHSCB's Accounting Officer, and his relationships with the Accountable Officers of CCGs; and

    iv) the governance and accountability arrangements put in place for CCGs.

i) The framework agreement and assurance process

17. As with DH's other ALBs, and in line with standard practice across government, there will be a framework agreement between DH and the NHSCB outlining: the working arrangements and lines of accountability between the NHSCB and the Department, the core financial requirements with which the NHSCB must comply, and the relationships between the NHSCB and other bodies in the system[3].

18. In the same way as for other ALBs, the Department will hold the NHSCB to account through regular performance reporting throughout the year. For example, DH will monitor in-year financial performance data and year-end forecasts for all its ALBs, including the

[3] Annex A describes in more detail how DH holds all of its ALBs to account, while Annex B provides a list of current and future ALBs.

NHSCB. DH will also carry out formal capability reviews of each of its ALBs, at a frequency yet to be determined, but at least every three years.

19. The assurance regime for the NHSCB will be broadly the same as for other ALBs. The main difference is in how it will be applied, given the scale and importance of the NHSCB in the system.

ii) The mandate for the NHSCB

20. In future, the Secretary of State will be required to publish a mandate, setting out what the Government expects from the NHSCB on behalf of the public. Whereas the framework agreement deals with the ongoing way in which the NHSCB and the Department will work together, the mandate will set specific objectives for the NHSCB to seek to achieve within a given time period. It will be a multi-year document, updated annually, and will be developed following full public consultation.

21. It will consist of objectives that the NHSCB must seek to achieve (including outcomes from the NHS outcomes framework), any requirements the Secretary of State considers necessary to ensure those objectives are met, and the resource allocation for the NHSCB.

22. The mandate (and reporting against it) will be one of the ways in which the Secretary of State discharges his accountability to Parliament, and in which the NHSCB discharges its accountability to the Secretary of State and the Department's Accounting Officer for the funding it receives. Because this mechanism will mean greater transparency about what is being achieved in return for the resources the NHSCB is allocated, the mandate will be a key lever for driving value for money.

23. The mandate is part of a wider accountability cycle. Specifically, the Health and Social Care Act requires that:

- The Government must publish a mandate to the Commissioning Board before the start of each financial year, setting objectives for the Board and its financial allocation:
- The Board must publish a business plan each year, saying how it intends to carry out its functions and deliver the objectives and requirements in the Mandate:
- The Secretary of State must keep the Board's performance under review including how it is performing against the Mandate:
- The Board must publish a report at the end of each year saying how it has performed:
- The Secretary of State must then publish an assessment of the Board's performance.
- The mandate is refreshed annually, but may only be changed in-year if the Board agrees, or in exceptional circumstances (or after a general election), and the Secretary of State must report and explain any changes to Parliament.

iii) A line of sight between Accounting and Accountable Officers

24. The chief executive of the NHSCB will be its Accounting Officer. Unlike other ALBs, whose Accounting Officers are appointed by the Department's Accounting Officer, the Health and Social Care Act explicitly designates the chief executive of the NHSCB as its Accounting Officer.

25. The formal relationship between the NHSCB's Accounting Officer and I as the Accounting Officer of the Department will be clearly set out in the framework agreement.

26. The Accounting Officer of the NHSCB will be accountable both for the direct actions of the NHSCB itself (for example, commissioning specialised services) and for the proper functioning of the whole commissioning system. The NHSCB will in turn appoint and hold to account the Accountable Officer of each CCG. Accountable Officers will be responsible for the stewardship of resources within each CCG, ensuring that the organisation complies with its duty to exercise its functions effectively, efficiently and economically.

27. This framework of Accounting Officers and Accountable Officers will provide a line of sight from DH to the commissioning system. For example, this will enable the Department to gain assurance that financial risks are being managed effectively across the sector.

28. As the NHSCB Accounting Officer will be accountable for the entire NHS commissioning budget, he will prepare a set of annual accounts which consolidates the accounts of the NHSCB itself with the individual accounts of all CCGs. This will be accompanied by a governance statement. Both the accounts and the governance statement will be consolidated into the Department's annual report and accounts, which will be signed off by me as DH Accounting Officer. As Annex C explains, the NHSCB will be audited by the National Audit Office, like the Department and other ALBs.

29. The mechanisms described in this section will provide assurance that the NHSCB Accounting Officer's responsibilities have been fulfilled.

iv) Governance and accountability arrangements for CCGs

30. Just as there is a clear line of accountability and accompanying assurance from the Department to the NHSCB, so there is a similar line from the NHSCB to CCGs. The NHSCB will have a number of ways to satisfy itself (and hence the Department) on how CCGs discharge their responsibilities, and to ensure that they are acting with regularity and propriety and providing value for money in the services they commission from providers. The NHSCB's levers will include:

- a Commissioning Outcomes Framework, which will provide a direct line of accountability back to the expectations set out in the mandate and reinforce CCGs' duty to exercise their functions consistently with the mandate. It will be developed by the NHSCB to provide transparency and accountability about the quality of services that CCGs commission for their patients and about their role in reducing health inequalities;

- an initial process for authorising CCGs to take on their full statutory responsibilities. Authorisation will include ensuring that the internal governance arrangements of the CCG are fit for purpose. All CCGs will be required by law to have a governing body, the main function of which will be to ensure that the CCG has in place appropriate arrangements to exercise its functions effectively, efficiently and economically, and that it complies with such generally accepted principles of good governance as are relevant to it. The governing body will include at least one registered nurse, a specialist doctor and two lay members – one of whom will have a lead role in overseeing key elements of governance, such as audit, remuneration and managing conflicts of interest;

- the ongoing assurance of CCGs, through an annual performance assessment which, in addition to reviewing progress against the Commissioning Outcomes Framework, will assess how well the CCG has met its financial duties and other statutory duties. The Board must publish a report annually summarising the results of all its performance assessments of CCGs;

- other controls and reporting arrangements. For example, the Act enables the Board to require all CCGs to provide it with financial reports and information. The secretary of State will also be able to require the Board to provide such additional information to the Department as he or she considers necessary, and to oblige CCGs collectively to provide information to the Board in relation to such a request. This will enable DH to gain the assurance it needs about financial management and value for money across the commissioning sector;

- a requirement for CCGs to account to the NHSCB every year for their performance and use of resources. This will include publishing an annual report on how they have discharged their functions, and producing annual audited accounts. In line with the requirements set out in HMT guidance on *Managing Public Money,* the accounts will include a governance statement encompassing both corporate governance and risk management;

- powers to require a CCG to provide information or give an explanation, if the NHSCB believes it is failing, or might fail, to discharge its functions; and

- powers of intervention, in the event that a CCG is unable to fulfil its duties effectively (for example, where it is failing to secure services to meet the needs of its population or is failing in its financial performance) or where there is a significant risk of failure. Grounds for intervention would include instances where a CCG is failing or might fail to act consistently with the interests of the health service. The NHSCB's powers to intervene will range from directing a CCG as to how it discharges its functions, to replacing an Accountable Officer, varying the CCG's constitution, exercising some functions of the CCG on its behalf, arranging for another CCG to exercise functions on its behalf, and in the absence of improvement, the power to dissolve a failing CCG.

31. The mechanisms described here illustrate that there will be clear accountability from CCGs to the NHSCB, and from the NHSCB to DH, giving both the NHS CB Chief Executive and the DH Permanent Secretary assurance about the use of resources across the commissioning system.

d) Provision and regulation of NHS services

32. NHS commissioners use their budgets to commission services from providers, which may be public sector bodies (NHS trusts or NHS foundation trusts), independent contractors (such as GP and dental practices), or private or voluntary sector organisations.

i) Accountability for all providers

33. All providers are primarily accountable to their patients, to their Boards or Partnerships and to commissioners, who hold them to account through contracts for the services they deliver.

This is the main way of ensuring that providers are delivering high quality services that provide value for public money.

34. In addition, there is a system of independent regulation for providers, which has been further extended by the Health and Social Care Act:

- All providers of health and social care (whether they provide publicly or privately funded services) are liable to be regulated by the Care Quality Commission (CQC). The CQC ensures that providers meet essential requirements for safety and quality, and has the power to take enforcement action where they do not, including fines and suspension or closure of services.

- Monitor, currently the regulator of NHS foundation trusts, will become a sector-wide regulator whose main duty will be to protect and promote the interests of people who use health care services by promoting value for money in the provision of healthcare services, while maintaining or improving quality.

  Monitor will do this by exercising three specific functions, underpinned by a power to license providers. First, Monitor will have regulatory powers to tackle anti-competitive behaviour that acts against the interests of patients. Second, it will work jointly with the NHSCB to construct pricing systems for paying providers and to set prices. This is a powerful way of driving greater value for money, by ensuring that payment follows patients' choices, and that providers face incentives to provide high quality care efficiently (for example, by setting prices that reflect the costs of excellent care rather than average price). Third, Monitor will oversee a "continuity of services" regime, to help commissioners secure continued access to essential NHS services and protect patients' interests where a provider is at risk or is unsustainable in its current form. This builds on the current arrangements for dealing with unsustainable NHS trusts and foundation trusts, and is intended to strengthen the incentives for efficiency and good financial management.

35. Accountability to DH therefore comes through commissioners (as described in the previous section) and through the combination of regulation by Monitor and CQC, which are arm's-length bodies of the Department and are held to account by DH for their performance. As DH Accounting Officer, I appoint their Accounting Officers. The Department already has power to intervene in the event of failure by CQC, and the Act ensures there are equivalent intervention powers in relation to Monitor.

ii) Accountability for public sector providers

36. In addition to these assurance mechanisms for all providers, DH retains specific responsibilities for public sector providers – foundation trusts and NHS Trusts. As public bodies, their expenditure counts against and must be contained within the Department's budget. Under the Government's Clear Line of Sight policy, their accounts, like those of DH's ALBs, will from 2011-12 be consolidated into DH's annual accounts.

37. The Department has no power of direction or intervention in foundation trusts (other than in an emergency, where the Health and Social Care Act gives the Secretary of State new powers of direction over all providers of NHS services). Although DH does have powers to

direct NHS trusts, the Government's policy is that the Department should not intervene in day-to-day operational management.

38. Therefore, I am accountable not for trusts' individual decisions (which are a matter for trusts, their boards and their Accounting Officers or Accountable Officers), but for ensuring there is a system of regulation and oversight which promotes regularity, propriety and value for money, and provides assurance that the spending of trusts in aggregate can be managed within the Department's budget. The following sections explain that system, now and in future, for NHS trusts and for foundation trusts.

iii) NHS trusts

39. The Government's policy is that all NHS trusts should become NHS foundation trusts, by 2014 or as soon as practicable thereafter, though not necessarily with the same configuration of services as in the predecessor NHS trusts. There is a "pipeline" process to support aspirant foundation trusts.

40. Currently, strategic health authorities are responsible for overseeing NHS trusts. From April 2013, when SHAs are abolished, this will become the responsibility of the NHS Trust Development Authority (NTDA) which will be established as a time-limited special health authority, accountable to the Department, and exercising the Secretary of State's functions in relation to NHS trusts. The NTDA will be established on 1 June 2012, will begin operating in shadow form on 1 October, and will be fully functioning on 1 April 2013.

41. As DH Accounting Officer, I will appoint the Accounting Officer of the NTDA, who will be responsible for the appointment of Accountable Officers for each remaining NHS trust.

42. Acting on my behalf, the chief executive of the NHS TDA will assure himself about the performance of individual NHS trusts through a combination of annual plans, performance agreements, ongoing monitoring and performance management, and annual reports and accounts. NHS trusts will continue to account in a format determined by the Department and will be subject to public audit arrangements.

iv) Foundation Trusts

43. Under the legislation agreed by Parliament in 2003, NHS foundation trusts are not directly accountable to DH. However, there is a series of mechanisms that provide assurance about the foundation trust sector:

- Each foundation trust has an Accounting Officer, with responsibilities for ensuring regularity, propriety and value for money, including signing the trust's accounts, governance statement and annual report. As with the NHSCB, foundation trusts' chief executives are designated as Accounting Officers by legislation.

- NHS foundation trusts are held to account by their governors, who represent the interests of their membership and the communities they serve. The 2012 Act defines the general duties of the council of governors as holding the non-executive directors to account for the performance of the board of directors, and representing the interests of the members of the public. It also extends the powers of governors (for example, to decide upon proposed mergers, acquisitions or "significant transactions" by the trust), in order to improve trusts' accountability to their patients and the public.

- The NHS foundation trust board of directors is responsible for all aspects of the performance of the organisation. A foundation trust's constitution must provide for all the powers of the trust to be exercisable by the board of directors on its behalf. The 2012 Act places a duty on the directors to promote the success of the organisation in order to maximise the benefits for the membership and the public. It also requires meetings of the board of directors to be open to members of the public.

- The 2012 Act gives DH power to require NHS foundation trusts to give it information: a power that did not exist previously. This will enable DH to ask NHS foundation trusts to report their planned and actual spending, to help the Department manage the overall budget.

- Monitor is responsible for authorising trusts as NHS foundation trusts. It has powers of oversight to ensure they continue to comply with the terms of their authorisation.

- From April 2013, Monitor will become a wider sectoral regulator, licensing all types of providers on a consistent basis. It is expected that NHS foundation trusts will be licensed from 1st April 2013. As the sector regulator, Monitor will have enduring powers that include powers to set and enforce requirements specifically on NHS foundation trusts to ensure they are well governed. Monitor will also have enduring powers to set and enforce requirements on NHS foundation trusts to ensure they remain financially viable and protect NHS assets, as necessary conditions of their continued ability to provide NHS services.

- Monitor's new powers as the sector regulator reflect the unique role and legal status of NHS foundation trusts as public benefit corporations, financed by the taxpayer, with a principal purpose defined in statute as "to provide goods and services for the purpose of the NHS." The Government has stated that NHS foundation trusts will continue to be the principal providers of NHS services. I therefore expect Monitor to set and enforce requirements on NHS foundation trusts to mitigate and manage risk, proactively and consistent with foundation trusts' duty to exercise their functions effectively, efficiently and economically.

- The Secretary of State has powers to attach terms to an NHS foundation trust's public debt to protect the value of the taxpayers' investment. These terms could include limits on an NHS foundation trust's borrowing, or its ability to acquire and dispose of property.

44. Further assurance comes from the policies that the Department is putting in place to promote quality and efficiency in NHS services. In line with Parliament's intention that the Government should not control foundation trusts directly, these do not relate to foundation trusts in particular, but apply across all types of provider. Policies and reforms that are designed to drive better value for money include:

- clinically-led commissioning, to align the financial decisions about commissioning with the clinical decisions that commit most NHS resources;

- greater choice for patients, providing a stronger incentive for providers to respond to the preferences of the patients they serve;

- improved information and transparency about the quality of services, to help patients exercise choice and to put pressure on providers to improve. For example, the Government has consulted on proposals for a “revolution” in the quality and availability of information;

- a national tariff payment system, where providers are paid a fixed price for their services, and money follows patients’ choices, creating an incentive for greater efficiency;

- a stronger voice for the public and service users through a new consumer champion, HealthWatch; and

- greater power for local authorities to influence NHS commissioning decisions and help join up local services round the needs of individuals.

45. The Government considers that the combination of these policies, backed by a system of independent regulation, will provide more powerful incentives for value for money in providers than could be achieved through direct management by the Department. I am satisfied that the measures described here, when fully implemented, will provide me with the assurance that I need as Accounting Officer and which Ministers need to discharge their ultimate accountability to Parliament for NHS services. That said, as the new system is brought into place, I will monitor its effectiveness and advise Ministers if and where any further measures are needed to ensure accountability.

PART TWO: PUBLIC HEALTH

46. The Department's second major area of responsibility is public health: action to protect and improve the health of the population.

a) Current accountability for public health

47. Currently, responsibility for public health is largely split between:

- Primary care trusts in the NHS, which are responsible for population health improvement at a local level. They are accountable, through strategic health authorities, to Sir David Nicholson as NHS chief executive and as Additional Accounting Officer;

- DH's arm's-length bodies. In particular, the Health Protection Agency leads on protecting the population against infectious diseases and other dangers to health (it is an NDPB, with its own Accounting Officer appointed by me). The National Treatment Agency for Substance Misuse aims to improve drug treatment across England (it is a special health authority, accountable to Sir David); and

- the Department itself, which is responsible for policy development, for leading national public health campaigns (such as Change4Life), and for responding to national emergencies.

b) Future accountability for public health

48. The Government intends to increase the priority given to the public's health by creating a ring-fenced public health budget; transferring responsibility for local health improvement from the NHS to local authorities; and setting up a new integrated public health service, to be known as Public Health England (PHE). This will be an executive agency of DH, and will incorporate the functions of a range of public health organisations, including the Health Protection Agency, the National Treatment Agency and the Public Health Observatories.

49. The Department will still be responsible for setting national strategy and designing legislation. In the same way as for the NHS, the foundation of accountability arrangements will be a public health outcomes framework published by DH, which will set out what needs to be achieved to improve and protect the nation's health and to reduce health inequalities. In other words, it will articulate what the public health system as a whole, working with a range of other partners in the statutory sectors and beyond, is aiming to achieve.

50. The public health outcomes framework will also set out what needs to be done to improve outcomes across the public health system. Data published each year will show national and local progress and performance against these outcomes. This will support greater transparency and accountability by ensuring that people and Parliament can assess local and national performance and hold local authorities and national government to account as appropriate.

51. The rest of this part of the statement explains the future accountability of local authorities and PHE, and of the NHS in its contribution to public health.

c) Local authorities' role in public health

52. From April 2013, upper tier and unitary local authorities will be under a new duty to take such steps as they consider appropriate for improving the health of the population in their area. The Government also intends to give local authorities new functions through regulations for taking steps to protect the local population's health, working closely with Public Health England, for providing NHS commissioners with population health advice, and for providing certain mandatory services. Each local authority, acting jointly with PHE, will be required to appoint a Director of Public Health to oversee its new public health functions.

53. Local councils will be funded to carry out their specific new public health responsibilities through a ring-fenced grant from 2013-14, on which DH will place a limited number of conditions. Under the Health and Social Care Act, councils will be required to have regard to the public health outcomes framework. The Director of Public Health will also be required to produce an annual report on the health of the local population, which the local authority will be required to publish, and which will provide an accountability mechanism both locally and to DH.

54. As with other local services, councils will primarily be accountable to their electorates, within a system of accountability that is overseen, at national level, by the Department for Communities and Local Government (DCLG). Beyond this, there will be additional accountability arrangements for the money that DH allocates to local authorities for public health, for which I will have Accounting Officer responsibility.

55. The main ways in which I will gain assurance are through:

- transparency. PHE will publish data on national and local performance against the public health outcomes framework. This will enable democratic accountability for performance against those outcomes; make it easy for local areas to compare themselves with others across the country; allow local people to assess the performance of their local authority; and increase the incentives for local authorities to improve their performance;

- requirements relating to the proper use of the ring-fenced grant. The chief financial officer (section 151 officer) of each receiving local authority will have to provide a statement of grant usage setting out how the authority has spent its grant, and councils will be clearly accountable for ensuring that grant conditions have been adhered to;

- delegated functions. The Health and Social Care Act gives the Secretary of State the power to delegate particular functions to local authorities, and councils will be accountable to the Department for exercising them; and

- health premium incentives. The Department of Health will incentivise progress against health improvement indicators through the use of a 'health premium.'

56. A Health and Wellbeing Board in each local authority will provide a forum in which councillors, directors of public health, children's services and adult social services, CCGs, local HealthWatch and other relevant local organisations can come together jointly, to

assess the needs of the local population, to use this as a basis for a joint health and wellbeing strategy, and to assess performance against that strategy.

57. Although the Department will set the public health outcomes framework and will incentivise the achievement of certain national priorities through the health premium, there will be no centrally-imposed targets, and no performance management of local authorities. It will be for local authorities to determine their priorities, according to the needs of their population.

58. In the event of poor performance by a local authority, PHE will provide advice and support as necessary. If a failure should occur related to delegated public health functions, the Secretary of State could make regulations to require local authorities to take certain steps, and he could require the local authority to review the performance of the Director of Public Health. More generally, as described below in Part Three, and in the system statement for local government by DCLG's Accounting Officer, there is an established system of checks and intervention powers if a council fails to fulfil its functions.

i) Public Health England

59. PHE will be established as an executive agency of DH. It will be a new, dedicated public health service, providing national leadership, advice and support across the three domains of public health: health improvement, health protection and the public health input into commissioning of health services.

60. In particular, PHE will be responsible for ensuring that there are effective arrangements in place at the national level for preparing, planning and responding to emergencies and health protection incidents. It will be responsible for supporting public health delivery through information, evidence, surveillance and professional leadership. Establishing PHE as an executive agency will provide a line of sight from the Secretary of State to the front line in health protection matters, whilst also providing sufficient operational independence for the new public health service.

61. Like DH's other arm's-length bodies, PHE will have a framework agreement that sets out its relationship with the Department, and the Department will hold it to account for its performance. I shall appoint the agency's chief executive as its Accounting Officer; the Accounting Officer will be accountable to me and to the Secretary of State for the proper use of public funds allocated to PHE, and for producing an annual report and accounts, which will be consolidated into DH's accounts.

ii) The contribution of the NHS to public health

62. While the Government's reforms will create greater clarity and accountability for public health, the NHS will continue to have a critical part to play in securing good population health outcomes, including through:

- providing accessible care to meet the needs of the local population;
- taking opportunities to have a positive impact on public health; and
- contributing to health protection and emergency response.

63. To support this, NHS commissioners will have a legal duty to obtain advice from public health experts.

64. At national level, the Secretary of State, on the advice of the Chief Medical Officer and the Department, will include public health objectives in the mandate to the NHSCB. The NHSCB and its Accounting Officer will be held to account for any objectives relating to public health contained in the mandate.

65. There will be some public health programmes, such as immunisations and screening, that will best be commissioned by the NHSCB, because they are delivered by GPs under existing NHS contracts or because they need to be integrated with wider NHS services. To enable this, the Health and Social Care Act provides power for the Secretary of State to agree with the NHSCB that it should exercise aspects of his public health functions. Funding for the exercise of these functions would be included in the NHSCB's resource limit, but the terms of the agreement could include specific conditions or controls in order to provide further accountability.

PART THREE: ADULT SOCIAL CARE

66. The third part of this statement explains DH's accountability for adult social care, as it currently exists and is likely to remain until 2014 at least. The Government conducted an engagement exercise on possible major changes to social care and its funding in 2011, and a white paper is planned for summer 2012.

67. The Department's core responsibilities for adult social care are to:

    a) set national policy and the legal framework, and provide leadership;

    b) secure funding, and set the mechanisms for public reporting on the social care performance of local authorities, within an overall system for local government funding overseen by DCLG; and

    c) account to Parliament and the public for the performance of the system as a whole, and assure the approach to regulation, inspection and intervention in social care services (by holding the Care Quality Commission to account, and retaining intervention powers as a matter of last resort).

a) The legislative and policy framework

68. The legal framework for adult social care comprises numerous statutes, dating back to the National Assistance Act 1948. The legislation gives local authorities prime responsibility for social care, through statutory duties to carry out assessments, arrange services and ensure that the needs of communities are met. The Government has announced that it will publish a draft Care and Support Bill during this Parliamentary session to modernise the social care statute. This will build on recommendations of the Law Commission for reform of the statute. There are no duties on the Secretary of State to ensure a comprehensive service for adult social care equivalent to those which underpin the NHS.

69. The Department of Health sets the strategic policy framework for adult social care, working with local government as partners, to provide overall direction and national objectives for adult social care. But delivery is the responsibility of local authorities, in line with their own locally-determined priorities.

70. Similar to the NHS and public health, an outcomes framework published by DH (and agreed with the local government sector) will provide a consistent basis for local accountability, to enable comparison. The first adult social care outcomes framework was published in March 2011.

b) Financial accountability

71. Almost all of the central government funds allocated to adult social care services are provided as part of the core grant to local government. While the Department of Health is responsible for securing funds for adult social care through the Spending Review settlement, DCLG is accountable for the allocation of those funds to local authorities,

through a formula grant mechanism that takes account of local tax-raising powers, and within which adult social care funding is not ring-fenced.

72. DCLG's Accounting Officer is accountable for the core system which provides the necessary assurances that local authorities will spend their resources with regularity, propriety and value for money. This system is relied on by me and other Departmental Accounting Officers who provide funding for local authorities

73. The Department's direct accountability for the allocation of resources to local government through specific grants is small by comparison. The main specific grant is the Learning Disability and Health Reform Grant, of around £1.3 billion in 2011-12. This is not ring-fenced, though specific guidance is attached on the intended focus of the funds. The Department accounts for the outcomes achieved through this grant as part of its overall approach to monitoring performance and safeguarding quality in adult social care, as set out below.

c) Performance monitoring

74. Local authorities are primarily accountable to their own populations for the performance of services and the outcomes achieved for local people. There is no national performance management of local authorities in relation to adult social care. However, DH is responsible for defining what information councils are required to provide, and this provides a basis for monitoring outcomes.

75. The adult social care outcomes framework, together with related local authority data collections, is the key mechanism for measuring the outcomes and experience of people who use services and of carers, and demonstrating what local authorities have achieved. The publication of this information allows for assessments of the performance of individual local authorities, encourages sector-led improvement initiatives, and supports greater local accountability.

d) Inspection and intervention

76. The Care Quality Commission (CQC) is the independent regulator for health and adult social care. Under the Health and Social Care Act 2008, all providers of regulated adult social care activities are required to register with CQC. In order to be registered, providers have to meet and continue to meet a set of 16 essential standards of safety and quality.

77. The CQC can take independent enforcement action against providers to bring about compliance with the registration requirements. CQC has a wide range of enforcement powers, which include the ability to issue a warning notice or a penalty notice, prosecute for specified offences, and suspend or cancel a provider's registration. The 2008 Act requires CQC to ensure that any action it takes is proportionate to the risks, and is targeted only where it is needed.

78. Over and above CQC's regulatory powers to ensure safety and quality in adult social care, the Secretary of State has powers to intervene in local authorities in situations where he judges that the authority has failed to comply with its statutory duties. There are two principal powers:

- Section 7D of the Local Authority Social Services Act 1970, which allows for directions to be given to the local authority where the Secretary of State judges it to have failed to comply with its social services duties; and

- Section 15 of the Local Government Act 1999, which provides a broader set of powers, including intervention, in the event that an authority is failing to comply with its statutory obligations. These powers allow direction to produce a performance plan, cause an inquiry to be held, or otherwise direct the actions of the authority. The Secretary of State may also direct that a nominated individual exercise the authority's functions on his behalf.

79. In practice, formal intervention is likely to be triggered by an inspection by CQC with a recommendation of further action. These powers have never been used in relation to adult social care, although they have been exercised in relation to other local government services, such as children's services.

80. As a further measure, the Health and Social Care Act provides power to extend and adapt any of Monitor's new functions as a sector regulator to adult social care. The Government is currently considering its position with regards to oversight in the social care market. It published a discussion paper on this issue in October 2011, as part of the Caring for our Future engagement exercise. The forthcoming Care and Support White paper will set out the Government's proposals to consult on the issue.

CONCLUSION

81. This statement provides the most up-to-date summary of how my Accounting Officer responsibilities work now and are likely to work from April 2013. The Health and Social Care Act will need to be underpinned by regulations and so it is likely that some of the details will evolve. I will therefore provide periodic updates of the statement.

82. However, as the statement shows, while the precise accountability mechanisms vary between the NHS, public health and adult social care, there is and will continue to be a robust system of oversight, incentives and intervention powers, on which I can rely as DH Accounting Officer to provide assurance that resources will be spent with regularity, propriety and value for money. Further, as stated earlier in paragraph 45, as the new system is brought into place, I will monitor its effectiveness and advise Ministers if and where any further measures are needed to ensure accountability.

Annex A: How DH oversees its arm's-length bodies

A1. The Department has a number of national arm's-length bodies (ALBs), which play an important part in managing or overseeing the use of resources across the NHS, public health and social care. We use the term ALB to refer to the DH's Executive Agencies, Non-Departmental Bodies and Special Health Authorities. This Annex describes the generic relationship between DH and its ALBs. Clearly, where an ALB has specific legislative powers, the relationship will be tailored to take account of these, but the general principles set out below apply to all.

A2. Annex B lists DH's current and future ALBs. As it shows, they fall into three main categories:

- Executive agencies – legally part of the Department, but with greater operational independence than a division within DH itself;
- Special health authorities – NHS bodies which can be created by order and are subject to the direction of the Secretary of State. The Health and Social Care Act states any new special health authority must have a time-limited life of three years or less (though this period may be extended further with the active approval of Parliament); and
- Executive non-departmental public bodies, which are established by primary legislation and have their own statutory functions. Their precise relationship with the Department is defined in legislation, and some NDPBs (particularly the regulators) have greater independence than others.

A3. Irrespective of their legal status, the Department will have a consistent approach for holding ALBs to account and gaining assurance that they are carrying out their functions properly. This will be underpinned by a new duty to keep ALBs' performance under review. DH's levers will include:

- power for the Secretary of State to appoint and remove ALBs' chairs and non-executive board members;

- accountability from the Accounting Officer of each ALB, who holds the primary responsibility for ensuring that the organisation discharges its responsibilities properly and uses its resources in accordance with the requirements of *Managing Public Money*. This includes preparing the governance statement, which forms part of the organisation's annual accounts. As Departmental Accounting Officer, I am responsible for assuring myself that ALB Accounting Officers are discharging their responsibilities, and I shall appoint all ALB Accounting Officers (except the Accounting Officer of the NHS Commissioning Board, who is appointed directly by legislation, as mentioned in paragraph 24);

- framework agreements between the Department and each ALB, setting out the lines of accountability, working arrangements between the ALB and the Department, core financial requirements the ALB must comply with, and the relationships between the ALB and other bodies in the system. The framework agreements will set out how the

Department will hold the ALB to account for the delivery of its objectives and outcomes, and for the use of public money;

- annual business plans and performance reporting against these plans. Each ALB must submit an annual business plan for approval by the Department, demonstrating how its objectives will be achieved and forecasting financial performance[4]. As a minimum, a quarterly accountability review will be conducted with each ALB by the senior sponsor in the Department, to provide assurance that the ALB is delivering against its objectives, managing its finances, identifying and managing risks and working well with partner organisations. An annual formal accountability review will take place to review the past year's performance against objectives and look forward to the next year. Each ALB's annual report and accounts must be laid before Parliament; and

- a formal performance and capability review of each ALB at least every three years. The Department will carry out a review of the ALB's performance, financial control and internal governance, and of its "organisational health", including its relationships with its key partners in the system.

A4. The Secretary of State retains formal powers to intervene in the event of significant failure, including where an ALB is not acting consistently with what the Secretary of State considers to be the interests of the health service. These failure powers apply to non-departmental public bodies (these are not needed for executive agencies or special health authorities, where Ministers are able to exert direct control). As a first step, the Secretary of State can issue a direction to the body. If the organisation fails to comply with the direction, then the Department may discharge the functions that the direction relates to, or make arrangements for another organisation to do so. In all cases, the Secretary of State must publish the reasons for his intervention.

A5. In order to safeguard the independence of the regulators, and avoid any perception of political interference, Ministers' intervention powers will not allow them to intervene in Monitor or CQC in relation to a particular case.

[4] As described from paragraph 20, there is a specific statutory process for the NHS Commissioning Board, to provide additional assurance for the budget that it will manage. Instead of simply signing off a business plan, the Department will set objectives and requirements in a formal mandate to the NHSCB. The NHSCB must publish a plan explaining how it will deliver the mandate, then report at the end of the year on how it has performed. The Department must then publish an assessment of this.

Annex B: DH's current and future arm's-length bodies

Now (June 2012)	Future (by April 2013[5])	Function
a) New ALBs		
NHS Commissioning Board Authority (SpHA)	NHS Commissioning Board (ENDPB[6])	• National leadership for commissioning, and support to clinical commissioning groups. Special health authority established from October 2011 to carry out preparatory work
	NHS Trust Development Authority (SpHA)	• Oversight of remaining NHS trusts
	Public Health England (DH Executive Agency)	• National public health service
Health Research Authority (SpHA)	– then ENDPB, subject to further Bill	• Oversee approvals for health research
	Health Education England (SpHA – then ENDPB, subject to further Bill)	• National leadership for education and training
b) ALBs being changed		
Monitor ("Office of the Independent Regulator for NHS foundation trusts") (ENDPB)	Monitor (ENDPB)	• Role will widen from specifically regulating foundation trusts to being a health sector regulator
Care Quality Commission (ENDPB)	As now, but incorporating HealthWatch England as a statutory committee (ENDPB)	• Core CQC function unchanged (to regulate safety and quality), but HealthWatch England added as a national consumer champion
NICE (National Institute for Health and Clinical Excellence) (SpHA)	NICE (National Institute for Health and Care Excellence) (ENDPB)	• Will be formally established as an NDPB, with its role extended to social care
Health and Social Care Information Centre (SpHA)	Health and Social Care Information Centre (ENDPB)	• Will be formally established as an NDPB, but unchanged core function as a national repository of information

[5] Subject to legislation and consultation where necessary
[6] Key: ENDPB: Executive non-departmental public body. SpHA: Special Health Authority

Now (June 2012)	Future (by April 2013[5])	Function
c) ALBs continuing unchanged		
Medicines and Healthcare Products Regulatory Agency (DH Executive Agency)		• Regulate the safety of medicines and medical devices
d) ALBs being reviewed		
NHS Blood and Transplant (SpHA)	An in-depth review has been conducted to see if opportunities exist to make it more commercially effective. Recommendations are currently being considered	• Ensure the provision of a safe supply of blood to hospitals in England and North Wales
NHS Business Services Authority (SpHA)	An in-depth review is currently in progress, which is looking explore potential commercial opportunities	• Carry out a range of transactional functions, including administering the NHS Pensions Scheme and the remuneration of community pharmacists and dentists
NHS Litigation Authority (SpHA)	Implementation of a review by industry experts, with reforms improving the service provided by the SpHA to the NHS.	• Administer indemnity schemes on behalf of the Secretary of State, to allow NHS bodies to pool some of their clinical and non-clinical liabilities
e) ALBs being abolished		
Alcohol Education Research Council (ENDPB)		• The assets of the AERC have been transferred to a new independent charity, Alcohol Research UK, which was launched in September 2011. The residual body will be abolished
NHS Appointments Commission (ENDPB)		• Remaining appointments functions transferred to DH and the NHS Trust Development Authority
National Patient Safety Agency (SpHA)		• Patient safety functions transferred to the NHS Commissioning Board. Research and Ethics Service functions to form core of Health Research Authority. National Clinical Assessment Service to become self-funding over

Now (June 2012)	Future (by April 2013[5])	Function
		the next two to three years
NHS Institute for Innovation and Improvement (SpHA)		• Quality improvement functions to transfer to NHSCB; exploring options to deliver other functions through alternative delivery models
Health Protection Agency (ENDPB)		• Functions being absorbed within Public Health England
National Treatment Agency for Substance Misuse (SpHA)		• Functions being absorbed within Public Health England
General Social Care Council (ENDPB)		• Functions being transferred to the Health and Care Professions Council (not a DH ALB)
Council for Healthcare Regulatory Excellence (ENDPB)		• Being renamed the Professional Standards Authority for Health and Social Care, and established as a self-funding regulatory body – no longer a DH ALB
Human Fertilisation and Embryology Authority (ENDPB)	Functions transferred out by 2015 (subject to public consultations and further legislation)	• License and monitor in vitro fertilisation, donor insemination and human embryo research
Human Tissue Authority (ENDPB)	Functions transferred out by 2015 (subject to public consultations and further legislation)	• Regulate use and storage of human tissue

Annex C: Audit

i) Internal audit

C1. Internal audit arrangements will ensure organisations are able to identify problems proactively, and act on lessons immediately, in order to improve value for money.

C2. The Department's Audit and Risk Committee and I are committed to developing a group assurance model for DH and its ALBs. Our aim is to create:

- a mechanism that delivers a clearer line of sight over the whole health system, to minimise surprises and instil confidence that system-wide risks are visible and being dealt with at the right level; and
- an assurance system that, through its consistency with the newly revised Corporate Governance Code for central government departments, sets high benchmarks for quality and ensures they are met across the group through appropriate systems, processes and resourcing structures.

C3. As further assurance, the non-executive chair of DH's Audit and Risk Committee will have periodic meetings with his equivalents in DH's ALBs.

ii) Audit of accounts

C4. The National Audit Office (NAO) is responsible for auditing the accounts of all government departments and agencies and reporting the results to Parliament. It audits the accounts of the Department of Health and its ALBs (this will include the NHS Commissioning Board in future).

C5. The Government has announced that the Audit Commission is to be abolished, on a timetable to be confirmed. While the Audit Commission remains, the Health and Social Care Act provides that CCG accounts will be audited by auditors appointed in accordance with the Audit Commission Act 1998, by an auditor or auditors appointed in accordance with arrangements made by the NHSCB. The Comptroller and Auditor General may examine the annual accounts and any records relating to them, and any report on them by the auditor/s. In future, the Government plans to replace the current centralised audit system with a local audit by an accredited provider. Robust audit will remain in place. In developing new arrangements, the Government will have regard for the principles of public audit, including that there should be a "wide scope of public audit, covering the audit of financial statements, regularity, propriety and value for money".

C6. In the case of foundation trusts, each trust's council of governors may choose to appoint an auditor who is not an officer of the Audit Commission. It is for the governors to appoint the auditor at a general meeting, and the auditor may be a member of any body of accountants approved by the Secretary of State. This will ensure a clear line of sight for Parliament following the enactment of the Constitutional Reform and Governance Act 2010.

iii) Value for money reports

C7. Under the National Audit Act 1983, the NAO can examine and report on the economy, efficiency and effectiveness of public spending. The NAO's value for money study programme examines health related issues and outputs, and provides assurances to Parliament on the extent to which the NHS and the Department of Health deliver economically, efficiently and effectively across the health care sector. These reports are generally subject to consideration, scrutiny and report by the Public Accounts Committee. For the purpose of carrying out value for money studies, section 8 of the NAO Act provides the Comptroller and Auditor General with a statutory right of access to information held by the Department, its ALBs and all NHS bodies.