Department of Health

Accounting Officer system statement

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Introduction

The Permanent Secretary, as the Principal Accounting Officer of the Department of Health (DH), is accountable to Parliament for the proper stewardship of the resources allocated to the Department. The Government's reforms to the NHS and public health significantly affected the way accountability worked from April 2013. This statement updates the previous version published in September 2012.

The responsibilities of the Accounting Officer are set out in the Treasury guidance *Managing Public Money*. In summary, as applied to the health system, the responsibilities 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 provide assurance 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.

In line with the code of good practice on corporate governance in central government departments[1], 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 the DH 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.

The three parts of this statement describe, in turn, the DH Accounting Officer's responsibilities for the three services that DH oversees in England: the NHS, public health, and adult care and support.

This division has been the case since the mid-twentieth century. For the NHS, accountability is further sub-divided between commissioning and provision, a split that began in the 1990s and has been made more explicit following the 2012 Health and Social Care Act.

In practice, much accountability is held locally. Typically, a local authority will have accountabilities for public health and adult social care. Hospitals, mental health trusts and community health trusts will be held to account through their boards, and the local clinical commissioning group will have an accountable officer and a board.

At the national level, working with and through new national bodies (NHS England, the NHS Trust Development Authority, Health Education England, Public Health England) and others whose role has changed significantly (Monitor and CQC), the Department is able to hold the national system to account. The Department has prioritised building strong governance and boards in each of these organisations, and, where necessary, acts as a national co-ordinating mechanism.

[1] HM Treasury and Cabinet Office, Corporate governance code for central government departments, 2011

While the NHS, public health and adult care and support are funded and structured differently, and have different mechanisms for accountability, they are all now covered by a consistent set of outcome frameworks, describing the outcomes that need to be achieved. Collectively, these outcome frameworks 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.

The Department of Health as 'System Steward'

The Department of Health, on behalf of the Secretary of State, acts as 'system steward.' The Department is the only body with oversight of the whole heath and care system and is responsible for creating and updating the policy and legislative frameworks within which the health and care system operates.

As system steward, the Department has developed its approach to oversight of the health and care system building on research by the World Health Organisation on the role of health departments. Stewardship is "the careful and responsible management of the well-being of the population,"[2] and in the most general terms "the very essence of good government". The following actions are categorised under the Department's functions of stewardship:

- the generation of intelligence and formation of strategic policy so the effectiveness of the health and care system and current and future needs of patents and service users, are understood and can be responded to;
- the securing and allocating of money and resources so that the right services can be made available and priorities met;
- ensuring tools for implementation and building coalitions and partnerships so that the system works together effectively, remaining focused on patients and service users;
- ensuring alignment between objectives, structures and culture and ensuring accountability so that there is assurance that the needs of patients and service users are being met effectively and that both the architecture of the system, and the culture displayed by the people within it, work to this end.

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[2] The World Health Report 2000

PART ONE: THE NHS

1. NHS services in England are delivered locally against a range of national standards. They are funded with Parliament's authority by taxpayers' money and are available to all based on clinical need.

Accountability for the NHS

1.2. The DH Accounting Officer, as Principal Accounting Officer, has overall responsibility in Government for the proper and effective use of resources as voted by Parliament for the health and care system, including the NHS. The majority of resources are allocated annually to NHS England and its Chief Executive, as Accounting Officer, is responsible for the effective use of these resources.[3]

1.3. Under the reformed system, while the Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England and DH remains responsible for the health and care legislative framework, most day-to-day operational management in the NHS takes place at arm's length from the Department. With the exception of the remaining special health authorities, all organisations in the NHS have their own statutory functions conferred by legislation, rather than by delegation from the Secretary of State.

1.4. However, the Secretary of State (and thereby the Department) does have an explicit duty to keep under review the performance of NHS England and all of DH's other arm's length bodies (ALBs) and executive agencies (EAs). 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 with that direction, the Secretary of State may discharge that function directly or arrange for another organisation to do so.

1.5. The reformed system empowers front-line professionals whilst maintaining Ministerial accountability, and reduces the Department's involvement in operational decision-making. Nevertheless, as the rest of this part of the Statement explains, there is a robust system in place to allow the Accounting Officer to discharge her responsibilities, by providing assurance about:

a) the commissioning of NHS care; and

b) the provision and regulation of services.

Commissioning

1.6 The Department allocates the budget for commissioning of NHS services to NHS England: NHS England in turn decides upon the formula and the approach for allocating funds to clinical commissioning groups (CCGs). The Chief Executive of NHS England is the Accounting Officer for all NHS funds and these are usually deployed in three ways: firstly, contracting for primary care; second, to CCGs for purchase of healthcare and third, retained in NHS England for some specialised services.

1.7. The principal line of accountability for the NHS is through the commissioning line, following the flow of money from DH to NHS England to CCGs. This is underpinned by an annually agreed Mandate

[3] Annex F describes the accountability system prior to April 2013

in which the Government sets outcome-based objectives for the NHS that NHS England must, as set out in legislation, seek to achieve. The NHS Outcomes Framework is contained within the Mandate.

1.8. The Department of Health's Accounting Officer is able to gain assurance about the performance of commissioners through a range of mechanisms, including:

i) compliance with the framework agreement between DH and NHS England;

ii) evidence of performance against the Government's Mandate to NHS England;

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

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

The framework agreement and assurance process

1.9. As with DH's other ALBs and EAs, and in line with standard practice across government, a framework agreement is in place between DH and NHS England setting out the relationship between NHS England and the Department, lines of accountability, how NHS England provides assurance on its performance to the Department, and the core financial requirements with which NHS England must comply.

1.10. The Department holds its ALBs and EAs to account through regular performance reporting throughout the year. For example, DH monitors in-year financial performance data and year-end forecasts for all its ALBs and EAs, and also looks at how much each ALB or EA is delivering against its objectives. DH holds regular accountability meetings with each of its ALBs and conducts formal capability reviews at least once every three years. (Over 60 ALB/EA accountability meetings took place between April 2013 and January 2014.)

1.11. The assurance regime for NHS England is broadly the same as for other ALBs and EAs. The main difference is in how it is applied, given the scale and importance of NHS England in the system.

The Mandate for NHS England

1.12. The Secretary of State is required to publish the Mandate, setting out what the Government expects from NHS England on behalf of the public. Whereas the framework agreement deals with the ongoing way in which NHS England and the Department will work together, the Mandate sets outcome-based objectives for NHS England to seek to achieve within a specified time period.

1.13. The current Mandate between the Government and NHS England was published on 12 November 2013 and sets out objectives for NHS England, and the associated resources, over the period April 2014 – March 2015.

1.14. The Mandate (and reporting against it) is one of the main ways in which the Secretary of State discharges his accountability to Parliament, and in which NHS England demonstrates its accountability to the Secretary of State and the Department's Accounting Officer for the funding it receives. Because this mechanism requires greater transparency about what is being achieved in return for the resources that are allocated to NHS England, the Mandate is a key instrument for driving value for money.

1.15. The Mandate is part of a wider accountability cycle and the Health and Social Care Act also requires that:

- NHS England publish a business plan each year, stating how it intends to carry out its functions and deliver the objectives and requirements set out in the Mandate;
- the Secretary of State keep NHS England's performance under review, including how it is performing against the Mandate;
- NHS England publish a report at the end of each year saying how it performed against the Mandate;
- the Secretary of State publishes an assessment of NHS England's performance;
- the Mandate be refreshed annually. The Mandate may only be changed in-year if NHS England agrees, or in exceptional circumstances (or after a General Election), and the Secretary of State must report and explain any changes to Parliament.

A line of sight between Accounting and Accountable Officers

1.16. Unlike other ALBs or EAs, whose Accounting Officers are appointed by the Department's Accounting Officer, the Health and Social Care Act explicitly designates the Chief Executive of NHS England as its Accounting Officer. The formal relationship between NHS England's Accounting Officer and the DH Accounting Officer is clearly set out in the framework agreement.

1.17. The Accounting Officer of NHS England is accountable both for the direct actions of NHS England itself (for example the commissioning of specialised services) and for the proper functioning of the whole commissioning system. NHS England in turn appoints and holds to account the Accountable Officer of each CCG. Accountable Officers are 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.

1.18. This framework of Accounting Officers and Accountable Officers provides a line of sight from DH to the commissioning system, for example, enabling the Department to gain assurance that financial risks are being managed effectively across the sector.

1.19. As NHS England's Accounting Officer is accountable for the entire NHS commissioning budget, he prepares a set of annual accounts that consolidates the individual accounts of all CCGs with the accounts of NHS England. This is accompanied by a governance statement. Both the accounts and the governance statement are consolidated into the Department's annual report and accounts, which are signed off by the DH Accounting Officer. NHS England is audited by the National Audit Office, as are the Department and other ALBs.

Governance and accountability arrangements for CCGs

1.20. Just as there is a clear line of accountability and accompanying assurance from the Department to NHS England, so there is a similar line from NHS England to CCGs. NHS England has a number of ways to satisfy itself (and hence the Department) as to 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. NHS England's levers include those described below.

- A Clinical Commissioning Group Outcomes indicator set, which provides a direct line of accountability back to the expectations set out in the Mandate and reinforces each CCG's duty to exercise its functions consistently with the Mandate. This indicator set has been developed by NHS England to provide transparency and accountability about the quality of services that CCGs commission for their patients and about their role in reducing health inequalities.

- Ongoing assurance of CCGs through an annual performance assessment which, in addition to reviewing progress against the CCG outcomes indicator set, assesses how well the CCG has met its financial duties and other statutory duties. NHS England publishes a report annually summarising the results of all its performance assessments of CCGs.

- Other controls and reporting arrangements. For example, legislation enables NHS England to require all CCGs to provide it with financial reports and information. The Secretary of State is also able to require NHS England to provide such additional information to the Department as he considers necessary, and to oblige CCGs collectively to provide information to NHS England in relation to such a request. This enables 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 NHS England every year for their performance and use of resources. This includes the publication of an annual report as to 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 must include a governance statement encompassing both corporate governance and risk management.

- Powers to require a CCG to provide information or give an explanation, if NHS England believes it is failing, or might fail, to discharge its functions.

- 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 include instances where a CCG is failing or might fail to act consistently with the interests of the health service. NHS England'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.

1.21. The mechanisms described here illustrate that there is clear accountability from CCGs to NHS England, and from NHS England to DH, giving both NHS England's Chief Executive and the DH Permanent Secretary assurance about the use of resources across the commissioning system.

Provision and regulation of NHS services

1.22. 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.

Accountability for all providers

1.23. All providers are primarily accountable to their patients. Patients now have the opportunities to give feedback on their care or that of their friends and family. The NHS friends and family test was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment. This means

every patient in these wards and departments is able to give quick feedback on the quality of the care they receive, giving hospitals a better understanding of the needs of their patients and enabling improvements.

1.24 Providers must also fulfil the contractual expectations of their commissioners, who hold them to account for the services they deliver. This ensures that providers are delivering high-quality services that provide value for public money.

1.25. In addition, there is a system of independent regulation of 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 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. Enforcement actions include fines, suspension, special measures or even closure of services. The CQC conducts regular inspections, publishes reports on providers, and will in future rate their overall performance.

- Monitor has become a sector-wide regulator whose main duty is 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.

1.26. Monitor does this by exercising three specific functions, underpinned by a power to license providers. Firstly, Monitor has regulatory powers to tackle anti-competitive behaviour that may act against the interests of patients. Secondly, it works jointly with NHS England 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). Thirdly, Monitor oversees 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.

1.27. Accountability to DH therefore comes through commissioners (as described in the previous section) and through the combination of regulation by CQC and Monitor, which are arm's-length bodies of the Department that are held to account by DH for their performance. The DH Accounting Officer appoints the Accounting Officers of these bodies. The Department already had powers to intervene in the event of failure by CQC. The 2012 Act, provided equivalent powers allowing the Secretary of State to direct Monitor in the event of significant failure to perform its functions"

Accountability for public sector providers

1.28. In addition to these assurance mechanisms for providers, DH retains specific responsibilities for public sector providers – NHS trusts and foundation 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,"[4] their accounts, like those of DH's ALBs, are consolidated into DH's annual accounts.

1.29. The Department has no power of direction or intervention in foundation trusts (other than in an emergency, where the 2012 Act gave the Secretary of State 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.

1.30. This means that the DH Accounting Officer is not accountable for trusts' individual decisions or for the clinical care they provide. These matters are for trusts, their boards and their Accounting Officers or Accountable Officers and the regulators. DH's role is to ensure that there is a system of regulation and oversight that promotes quality, regularity, propriety and value for money, and provides assurance that the care provided by trusts in aggregate can be managed within the Department's budget. The following sections explain in turn the system for NHS trusts and for NHS foundation trusts.

NHS trusts

1.31. The Government's policy is that all NHS trusts should become NHS foundation trusts. Not all NHS trusts will be able to achieve foundation status in their current configuration. These trusts may merge with or be acquired by a foundation trust, or they may change to a different organisational form. There is a "pipeline" process that supports aspirant foundation trusts with strict financial governance and quality standards that must be met.

1.32. Formerly, Strategic Health Authorities (SHAs) were responsible for overseeing NHS trusts. From April 2013, when SHAs were abolished, this became the responsibility of the NHS Trust Development Authority (NTDA), which was established as a special health authority, accountable to the Department and exercising the Secretary of State's functions in relation to NHS trusts.

1.33. The NTDA is responsible for leading, supporting and developing the remaining NHS Trusts. It has one single purpose: to support NHS trusts to deliver high-quality, sustainable services in the communities they serve. As NHS trusts become well managed, financially robust organisations that are delivering high-quality, safe clinical services, they will be able to apply to Monitor to become foundation trusts.

1.34. The DH Accounting Officer appoints the Chief Executive as the Accounting Officer of the NTDA. The NTDA Accounting Officer is responsible for the appointment of Accountable Officers for each remaining NHS trust. Acting on behalf of the DH Accounting Officer, the Chief Executive of the NTDA must assure himself about the performance of individual NHS trusts through a combination of annual plans, performance agreements, ongoing monitoring and performance management, annual reports and accounts. NHS trusts continue to account in a format determined by the Department and are subject to public audit arrangements.

NHS foundation trusts

1.35. Under the legislation enacted 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:

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[4] Constitutional Reform and Governance Act 2010.

- Each foundation trust has an Accounting Officer, who has responsibilities for ensuring regularity, propriety and value for money, including signing the trust's accounts, governance statement and annual report. As with NHS England, 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 members and 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 Chair and board of directors of an NHS foundation trust are responsible for all aspects of the care and 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.

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

1.37. 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.

1.38. NHS foundation trusts have been required to apply to be licensed from 1 April 2013. As the sector regulator, Monitor has enduring powers that include powers to set and enforce requirements specifically on NHS foundation trusts to ensure they are well governed. Monitor also has 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.

1.39. Monitor's 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 "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. Monitor's task is to set and enforce requirements on NHS foundation trusts to mitigate and manage risk, proactively and consistently with foundation trusts' duty to exercise their functions effectively, efficiently and economically.

1.40. 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.

1.41. Further assurance comes from the policies that the Department has put 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 policies 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;

- a stronger regulator of safety and quality with a new Chief Inspector of Hospitals, of General Practice and of Social Care at the CQC;

- 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 step change 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 England; and

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

1.42. The Government considers that the combination of these policies, backed by a system of independent regulation, provides more powerful incentives for value for money in providers than could be achieved through direct management of hospitals by the Department. The Department considers that the measures described here are providing the DH Accounting Officer with the assurance needed and that Ministers need to discharge their ultimate accountability to Parliament for NHS services. The Department is monitoring the effectiveness of the system overall and will advise Ministers if and where any further measures are needed to ensure quality, financial sustainability and accountability.

PART TWO: PUBLIC HEALTH

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

2.1. The Government has increased 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 establishing an integrated public health service, Public Health England (PHE). PHE is an executive agency of DH and incorporates the functions of a range of previous public health organisations, including the Health Protection Agency, the National Treatment Agency and the Public Health Observatories.

2.2. The Department is responsible for setting national strategy and designing legislation. In the same way as for the NHS, the foundation of accountability arrangements is an Outcomes Framework published by DH, which sets out what needs to be achieved to improve and protect the nation's health and reduce health inequalities. In other words, DH articulates 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.

2.3. The public health Outcomes Framework sets out what needs to be done to improve outcomes across the public health system. Data published on an annual basis shows national and local progress and performance against these outcomes. This supports 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.

Local authorities' role in public health

2.4. From 1 April 2013, upper tier and unitary local authorities took on their new responsibilities for public health, funded by a ring-fenced grant from the Department under s31 of the Local Government Act 2003. Local authorities are expected to take such steps as they consider appropriate for improving the health of the population in their area. The Government has given 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, draws on advice from a Director of Public Health.

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

2.6. As with other local services, councils are primarily 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 are additional accountability arrangements for the money that DH allocates to local authorities for public health, and the Chief Executive of Public Health England has been designated as the Accounting Officer overall for the public health ring-fenced grant to local authorities.

2.7. The main ways in which DH gains assurance are described below.

- Transparency: PHE publishes data on national and local performance against the public health Outcomes Framework. This enables democratic accountability for performance against those outcomes, makes it possible for local areas to compare themselves with others across the country, allows local people to assess the performance of their local authority, and increases 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 provides a statement of grant usage setting out how the authority has spent its grant, and councils are clearly accountable for ensuring that grant conditions have been met.

- Delegated functions: the Health and Social Care Act gives the Secretary of State the power to delegate particular functions to local authorities, and councils are accountable to the Department for exercising them.

- Health premium incentives: the Department of Health incentivises progress against health improvement indicators through the use of a 'health premium' a financial incentive paid to local authorities who improve the health of the local population.

2.8. A Health and Wellbeing Board in each local authority provides a forum where 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.

2.9. Although the Department sets the public health outcomes framework and incentivises the achievement of certain national priorities through the health premium, there are no centrally-imposed targets, and no performance management of local authorities. It is for local authorities to determine their priorities, according to the needs of their population.

2.10. In the event of poor performance by a local authority, PHE provides advice and support as necessary. If a failure should occur related to delegated public health functions, the Secretary of State can make regulations to require local authorities to take certain steps, and he can 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 in place if a council fails to fulfil its functions.

Public Health England

2.11. PHE is a dedicated public health organisation, 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.

2.12. In particular, PHE is 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 is responsible for supporting public health delivery through information, evidence, surveillance and professional leadership. Establishing PHE as an executive agency provides 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 public health service.

2.13. Like DH's other arm's-length bodies, PHE has a framework agreement that sets out its relationship with the Department, and the Department holds it to account for its performance. The agency's chief executive is its Accounting Officer; the Accounting Officer is accountable to DH 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 are consolidated into DH's accounts.

The contribution of the NHS to public health

2.14. While the Government's reforms create greater clarity and accountability for public health, the NHS continues 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.

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

2.15. At the national level, the Secretary of State, on the advice of the Chief Medical Officer and the Department, includes public health objectives in the Mandate to NHS England. NHS England and its Accounting Officer are held to account for any objectives relating to public health contained in the Mandate.

2.16. There will be some public health programmes, such as immunisations and screening, that are best commissioned by NHS England, 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 NHS England that it should exercise aspects of his public health functions. Funding for the exercise of these functions would be included in NHS England's resource limit, but the terms of the agreement could include specific conditions or controls in order to provide further accountability.

PART THREE: ADULT CARE AND SUPPORT

3. The third part of this statement explains DH's accountability for adult care and support. The Government published its White Paper, *Caring for our future: reforming care and support* in July 2012, which set out its reform agenda for adult social care. Alongside the White paper, the draft Care and Support Bill was also published and intended to reform and modernise the legal framework for care and support. Following Parliamentary scrutiny the Bill received Royal assent on 14 May 2014.

3.1. The Department's core responsibilities for care and support for adults 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 care and support services (by holding the CQC to account, and retaining intervention powers as a matter of last resort).

The legislative and policy framework

3.2. The legal framework for care and support comprises numerous statutes, dating back to the National Assistance Act 1948. The legislation gave local authorities prime responsibility for care and support, through statutory duties to carry out assessments, arrange services and ensure that the needs of individuals are met. In May 2014, the Care and Support Act made a number of far reaching reforms to the system these include:-

- Enables the new Chief Inspector of Hospitals, appointed by the Care Quality Commission, to trigger a process to deal with unresolved problems with the quality of care more effectively; and
- makes it a criminal offence for health and care providers to supply or publish false or misleading information.
- Introduced stronger regulatory powers including allowing the Chief inspector of Social Care to hold providers to account.

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

3.4. Similar to the NHS and public health, an outcomes framework published by DH (and agreed with the local government sector) provides a consistent basis for local accountability, to enable comparison. The first adult social care Outcomes Framework was published in March 2011 and has since been updated on an annual basis.

Financial accountability

3.5. 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. From April 2013, DCLG introduced a new method of funding local Government – a Business Rates

Retention Scheme. Local authorities retain 50% of the business rates they collect. Local authorities are able to increase their income by growing their local economies and collecting more business rates. In addition, local authorities receive revenue support grants through DCLG and they raise funds via the Council Tax. Together, locally retained business rates and revenue support grants, council tax and other forms of income provide funding for a number of services, including care and support. The central government funds allocated to adult social care services take account of local need but are un-hypothecated and so not specifically ring-fenced for care and support.

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

3.7. The Department of Health's direct accountability for the allocation of resources to local government through specific grants is small by comparison. The main specific grants are the Local Reform and Community Voices Grant, and the Community Capacity Grant, of around £42 million and £129 million respectively (2013/14 and 2014/15). These are not ring-fenced, although specific guidance is given 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 care and support, as set out below.

Performance monitoring

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

3.9. 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 and comparison of the performance of individual local authorities, encourages sector-led improvement initiatives, and supports greater local accountability.

Inspection and intervention

3.10. 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.

3.11. 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 the CQC to ensure that any action it takes is proportionate to the risks, and is targeted only where it is needed.

3.12. The Care Act 2014 established the posts of Chief Inspector of Hospitals, Chief Inspector of Adult Social Care and Chief Inspector of General Practice as executive members of the CQC Board in statute to ensure their longevity. The Care Act also made a number of amendments to the Health and Social Care Act 2008, which are designed to increase the operational independence of CQC.

3.13. Over and above the 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.

3.14. 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.

CONCLUSION

4. This Statement provides the most up-to-date summary of how the DH Accounting Officer responsibilities work now. 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 the DH Accounting Officer can rely to provide assurance that resources will be spent with regularity, propriety and value for money. DH continues to monitor effectiveness of the system as a whole and advises Ministers if and where any further measures are needed to ensure accountability.

Una O'Brien
Permanent Secretary
Department of Health

6 October 2014

Annex A : How DH oversees its arm's length bodies and executive agencies.

A1. The Department has a number of arm's-length bodies (ALBs) and executive agencies (EAs), which share in managing or overseeing or overseeing the use of resources across the NHS, public health and social care. This annex describes the generic relationship between DH and its ALBs and EAs. Clearly, where an ALB or EA 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 ALBs and EAs. We use the term ALB to refer to the DH's non-departmental public bodies and special health authorities which, together with EAs, comprise the three main categories of our sponsored bodies:

- Executive agencies, which are legally part of the Department but have greater operational independence than a division within DH itself.
- Special health authorities, which are NHS bodies that can be created by order and are subject to the direction of the Secretary of State. The Health and Social Care Act states that 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).
- Executive non-departmental public bodies (NDPBs), 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 has a consistent approach through its sponsorship arrangements for holding ALBs and EAs to account and gaining assurance that they are carrying out their functions properly. This is underpinned by the new duty to keep ALBs' and EAs performance under review. A Senior Departmental Sponsor (SDS) is appointed for each of the ALBs and EAs and is supported by a dedicated sponsor team which provides the principal day-to-day liason. The SDS is responsible for ensuring that each organisation is sponsored effectively and in line with the Department's sponsor standards. DH's levers include:

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

- accountability from the Accounting Officer of each ALB and EA, 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 and EA Accounting Officers are discharging their responsibilities; and I shall appoint all ALB and EA Accounting Officers (except the Accounting Officer of NHS England, who is appointed directly by legislation and the Accounting Officer of MHRA who is appointed by HM treasury because of its Trading Fund status).

- framework agreements between the Department and each ALB or EA, setting out the relationship between the sponsored body and the Department, lines of accountability, the way in which the ALB or EA will provide assurance to the Department on its performance, core financial requirements that the ALB or EA must comply with, and the relationships between the ALB and other bodies in the system. The framework agreements set out how the

Department holds the ALB or EA 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 and EA must produce an annual business plan, which has to be agreed with the Department, demonstrating how its objectives will be achieved and forecasting financial performance. As a minimum, a quarterly accountability review is conducted with each ALB or EA by the senior sponsor in the Department, to provide assurance that the ALB or EA is delivering against its objectives, managing its finances, identifying and managing risks and working well with partner organisations. A formal accountability review takes place each year to review the past year's performance against objectives and look forward to the next year. Each ALB's and EA's annual report and accounts must be laid before Parliament.

- a formal triennial review of each ALB or EA at least every three years. The Department will carry out a review of each organisation's function and form, performance and capability, and efficiency and governance as part of its assurance that the wider health and care system is fit for purpose.

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 (they 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.

Annex B : DH's arm's-length bodies and executive agencies.

ALB	Function
NHS England (ENDPB)	National leadership for commissioning, and support to clinical commissioning groups.
NHS Trust Development Authority (SpHA)	Oversight of remaining NHS trusts
Monitor ("Office of the Independent Regulator for NHS foundation trusts") (ENDPB)	Role widened from specifically regulating foundation trusts to being a health sector regulator
Care Quality Commission (ENDPB)	Core CQC function unchanged (to regulate safety and quality), but HealthWatch England added as a national consumer champion
Public Health England (DH Executive Agency)	National public health service and support to local government
Health Education England (SpHA)	National leadership for education and training
NICE (National Institute for Health and Care Excellence) (ENDPB)	Formally established as an NDPB, with its role extended to social care
Health & Social Care Information Centre (ENDPB)	Formally established as an NDPB, but unchanged core function as a national repository of information
Medicines and Healthcare products Regulatory Agency (DH Executive Agency)	Regulation of medicines and medical products and devices
NHS Blood and Transplant (SpHA)	Ensure the provision of a safe supply of blood to hospitals in England and North Wales
NHS Litigation Authority (SpHA)	Administer indemnity schemes on behalf of the Secretary of State, to allow NHS bodies to pool some of their clinical and non-clinical liabilities
NHS Business Services Authority (SpHA)	Carry out a range of transactional functions, including administering the NHS Pensions Scheme and the remuneration of community pharmacists and dentists
Human Fertilisation and Embryology Authority (ENDPB)	License and monitor in vitro fertilisation, donor insemination and human embryo research
Human Tissue Authority (ENDPB)	Regulate use and storage of human tissue
Health Research Authority (SpHA)	Oversee approvals for health research

Explanatory Note:

- ENDPB – an executive non-departmental public body, created in statute with its on powers and unitary board.
- SpHA – a Special Health Authority; a non-statutory organisation established by the Secretary of State for Health.
- Executive Agency – an agency of the Department of Health, employing civil servants with an implied closer relationship to the Department than an ENDPB.

Annex C : Audit

Internal audit

C1. Internal audit arrangements 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 is committed to developing a group assurance model for DH and its ALBs; it aims 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 has periodic meetings with his equivalents in DH's ALBs.

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 and EAs, including NHS England.

C5. The Health and Social Care Act provides that CCG accounts, and the NHS Act 2006 provides that NHS Trust accounts will be audited by auditors appointed in accordance with the Audit Commission Act 1998. However these parts of the Audit Commission Act are being replaced by the Local Audit and Accountability (LAA) Act 2014, which includes the abolition of the Audit Commission in April 2015. The LAA Act sets out transitional arrangements so that the current audit appointments will continue to at least 2016-17. Then from 2017-18 the current centralised audit system will be replaced with local audit appointments by an accredited provider. In developing new arrangements, the Government have regard for the principles of public audit, including that there should be a "wide scope of public audit, covering the audit of financial arrangements, regularity, propriety and value for money". Under both arrangements 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.

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.

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 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.

Annex D: Governance of Informatics

Informatics is an area where the stewardship role of the Department is particularly important. The newly designated role of the Informatics Accountable Officer (IAO), on behalf of the Permanent Secretary, has responsibility for DH funded national IT programmes and services. Additionally, the IAO has a pivotal role to assure that both DH-funded informatics programmes and those funded by ALBs collectively deliver the outcomes required by the Health and Care system. Those outcomes are articulated through an information strategy, developed by the National Information Board (NIB) on behalf of the system as a whole. Specific responsibilities of the IAO include responsibility for:

- alignment of the informatics portfolio (ensuring that it reflects an alignment between the informatics strategy and ministerial priorities);
- control and oversight of the portfolio of national programmes, funded by DH and its ALBs, that collectively deliver the outcomes required by the Information Strategy;
- suitable assurance of DH and ALB sponsored IT Enabled Business Change programmes which, whilst not directly controlled by the IAO, must be aligned to the strategy;
- ensuring that information governance and information security is effective across the health and care system;
- ensuring the informatics spend of DH and its ALBs is used effectively and efficiently and delivers value for money, agreed benefits, and best outcomes for patients, users and the public.

The IAO is also responsible for ensuring delivery of the Government's information and technology priorities through an effective informatics governance structure. A revised operating model has recently been implemented to strengthen governance arrangements. The operating model makes a clear distinction between the core informatics business processes of: determining system-wide strategy and direction (the responsibility of the National Information Board - on behalf of the whole system); system delivery and expertise (Health & Social Care Information Centre); and securing system-wide assurance and portfolio management (achieved through an Informatics Assurance Group and an Informatics Portfolio Management Board).

The strategic component of the operating model is the responsibility of a National Informatics Director, who is appointed from within the health and care system by the Permanent Secretary. This National Informatics Director chairs the National Information Board and he has a duty to ensure alignment of strategy across the system. The Director also accounts for the Board's activity to the IAO - who in turn is accountable to the DH Permanent Secretary. The IAO/National Informatics Director is the main route through which government policy is articulated to the National Information Board; consequently, one of responsibilities of the IAO is to set objectives for the National Informatics Director.

Membership of the National Information Board comprises participants from the following organisations:

Department of Health
NHS England
Cabinet Office
Care Quality Commission
Health & Social Care Information Centre
Health Education England
Health Research Authority
Human Fertilisation and Embryology Authority
Human Tissue Authority
Medicines and Healthcare products Regulatory Agency
Monitor
National Institute for Health and Care Excellence
NHS Blood and Transplant
NHS Business Services Authority
NHS Litigation Authority
NHS Trust Development Authority
Public Health England
Association of Directors of Adult Social Services
Clinical Reference Advisory Group
Independent IG Oversight Panel
Local CIO Council
Local Authority Southend on Sea

Annex E : Case Studies

ACCOUNTABILITIES AND RESPONSIBILITIES EXAMPLES OF HOW THESE WORK

In this Annex we set out two short case studies to illustrate how aspects of accountability work in practice. The first describes the accountabilities for keeping elective waiting times within national standards. The second takes a different perspective, and shows overall responsibility for a specific service, in this case maternity services.

E1: Elective Waiting Times - the following organisations hold responsibility for the system and performance:

Organisation	Referral to treatment measurement responsibilities	Referral to treatment performance responsibilities
Department of Health	• Determine the national waiting time standards and tolerances. • Set national waiting times rules. • Determine NHS England mandate.	• Obtain assurance from NHS England, Clinical Commissioning Groups and the NHS more widely that national waiting time standards and rules are adhered to. • Obtain assurance from the system that the delivery of national waiting time standards represent value for money.
NHS England	• Develop national guidance on waiting time standards. • Provide ongoing support to trusts over recording waiting times, responding to individual queries. • Collect and publish monthly national waiting times data. • Carry out validation checks on aggregate waiting times data. • Work with providers to resolve data quality issues identified at an aggregate level. • Determine NHS Standard Contract requirements and sanctions.	• Provide assurance that CCGs are working with commissioners to ensure they deliver the best outcomes for patients with the financial resources available to them. • Determine NHS Standard Contract requirements and sanctions.
Monitor	• Provide assurance on the accuracy of provider-level data	• Assess the performance of individual NHS Foundation trusts to ensure they continue to be well run and able to deliver high-quality care on a sustainable basis.
NHS TDA	• Provide assurance on the accuracy of provider-level data	• Monitor the performance of NHS Trusts. • Provide assurance of clinical quality, governance and risk in NHS Trusts.
Individual providers/hospitals	• Submit waiting times data monthly to NHS England • Ensure that any information provided is accurate.	• Meet waiting time standards (as per Standard Contract terms)
CCGs	• Sign-off monthly provider data as accurate.	• Work with commissioners and providers to ensure they deliver the best outcomes for patients with the financial resources available to them.

E2 : Maternity Services - for maternity services the Accounting and Accountable Officers are responsible as follows:

Department of Health	NHS England	Health Education England
• Setting the policy framework for the delivery of high quality maternity services by the NHS. • Obtaining assurance from NHS England, CCGs and the NHS more widely that maternity services are appropriately commissioned funded and delivered. • Seeking assurance from the CQC that NHS maternity services deliver high-quality care. • Obtaining assurance from the system that maternity services represent value for money.	• Commissioning specialist maternity services, including foetal medicine and perinatal mental health. • Providing guidance to CCGs on the commissioning of high quality maternity services in line with the policy framework set by DH. • Obtaining assurance from CCG Accounting Officers that maternity services are appropriately commissioned, funded and delivered in line with local needs and choices. • Providing assurances to the DH Accounting Officer that high-quality maternity services are being commissioned to deliver improved outcomes and represent value for money.	The probity and efficient operation of HEE in delivering the government's mandate to HEE 2013 - March 2015, which includes, in respect of maternity services: • Commissioning a secure supply of the workforce associated with maternity services, ensuring the right numbers, skills, values and behaviours needed of this workforce, now and in the future are educated and trained to a high quality. • Providing guidance to LETBs and the Nursing & Midwifery HEE Advisory Group (HEEAG) on the high-quality education commissioning and supply of the maternity workforce in line with the policy framework set by DH. • Obtaining assurance from LETBs and the Nursing & Midwifery HEEAG that the education and training of a high-quality maternity workforce is sufficiently commissioned and funded in line with service demand and local priorities; • Providing assurances to the DH Accounting Officer that high-quality education and supply of the maternity workforce are being commissioned to deliver improved outcomes and represent value for money.

Annex F: System of Accountability September 2006 to April 2013.

The NHS

Between September 2006 and April 2013, Sir David Nicholson, the NHS chief executive and a senior civil servant within DH, was appointed by the Treasury as an Additional Accounting Officer for the NHS. He was 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). The DH Permanent Secretary was responsible for the rest of DH's budget. This included being accountable for the expenditure of DH's non-departmental public bodies (NDPBs) and for ensuring that the net expenditure of NHS foundation trusts, which are not subject to direction by DH, were contained within the Department's budget. A published memorandum of understanding set out our respective roles. This arrangement continued until the end of March 2013, in order to provide stable accountability during the transition period.

Public Health

Prior to April 2013, responsibility for public health was largely split between:

- Primary care trusts in the NHS, which were responsible for population health improvement at a local level. They were 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 lead on protecting the population against infectious diseases and other dangers to health The National Treatment Agency for Substance Misuse aimed to improve drug treatment across England; and the Department itself, which was responsible for policy development, for leading national public health campaigns (such as Change4Life), and for responding to national emergencies.

Adult Social Care

- Prior to the introduction of the Care and Support Act 2014, 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 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.