Department of Health & Social Care

Appendix 1b

Accounting Officer System Statement

July 2018

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July 2018

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Accounting Officer System Statement

July 2018

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Section 1: Scope of the system

1.1 I am the Principal Accounting Officer for the Department of Health and Social Care (DHSC). This System Statement, which is current and forward looking, sets out all of the key accountability relationships and processes within my department, making clear who is accountable for what at all levels of the health and social care system.

1.2 DHSC supports Ministers in leading the nation's health and care, helping people to live healthier lives for longer. The department published a revised Single Departmental Plan[1] (SDP) in May 2018 which set out the work we are committed to achieving to improve the health and social care system over the course of this Parliament. The SDP objectives are:

- Keeping people healthy and supporting economic productivity and sustainable public services
- Transforming primary, community and social care to keep people living more independent, healthier lives for longer in their community
- Supporting the NHS to deliver high quality, safe and sustainable hospital care and securing the right workforce
- Research and innovation to maximise health and economic productivity
- Ensuring accountability of the health and care system to Parliament and the taxpayer; and creating an efficient and effective DHSC
- Creating value (reduced costs and growing income) by promoting better awareness and adoption of good commercial practice across the Health Family.

1.3 In January 2018 the Department of Health became the Department of Health and Social Care, with an additional Ministerial position for Social Care created, to help the Department deliver an even clearer focus on adult social care. This change signalled the move of long-term social care strategy back to the Department with the upcoming Green Paper, and was a reminder of the challenge of working across organisational boundaries to make the links work better across the health and care system, including working more closely with Local Authorities to deliver social care

1.4 The Health and Social Care Act 2012 and preceding acts provide the legal framework under which my department must operate, which has been decided by Parliament. Under the 2012 Act, the Secretary of State for Health and Social Care has a duty to promote a comprehensive health service in England, and is responsible to Parliament for delivery of this. The National Health Service Commissioning Board (known as NHS England) has responsibility for arranging the

[1] https://www.gov.uk/government/publications/department-of-health-single-departmental-plan/ department-of-health-single-departmental-plan

provision of health services in England and for securing their provision through clinical commissioning groups (CCGs).

1.5 The Secretary of State is required by the 2012 Act to publish a mandate for NHS England, which sets out the government's priorities for the health service, and a mandate for Health Education England, setting out the government's priorities for the planning, education and training of the NHS and public health workforce. These mandates specify the funding for these bodies and the Secretary of State is required to keep performance against each mandate's objectives under review. The most recent mandate to NHS England was published in March 2018[2] and for Health Education England in January 2018[3].

1.6 NHS trusts and NHS foundation trusts provide goods and services for the purposes of the health service. Monitor and NHS Trust Development Authority (TDA), operating as NHS Improvement, have a duty to protect and promote the interests of people who use health care services, and is responsible for regulating NHS providers.

1.7 Additionally, the Secretary of State has a duty under primary and secondary legislation set out in the 2012 Act to protect and improve public health in England, whilst local authorities in England have a duty to improve the health of the people in their area and must appoint a director of public health.

1.8 Working within this framework, the Secretary of State and other departmental Ministers have a duty to Parliament to account, and be held to account, for the policies, decisions and actions of this department and its agencies. They look to me as the department's Accounting Officer to delegate within the departmental group to deliver their decisions and to support them in making policy decisions and handling public funds.

1.9 As Accounting Officer, I am personally responsible for safeguarding the public funds for which I have been given charge under the DHSC Estimate (published as part of the HM Treasury Main Estimate[4]). Where I have appointed additional Accounting Officers, their responsibilities are also set out in this System Statement.

1.10 The statement covers my core department, its arm's length bodies (ALBs) and other arm's length relationships. This includes the three services that DHSC oversees in England: the National Health Service (NHS), public health, and adult care and support. It describes the current accountability for all expenditure of public money through my department's Estimate, all public money raised as income, and the management of shareholdings, financial investments and other publicly owned assets for which I am responsible.

1.11 My department works through a number of ALBs. NHS England (NHSE) leads the NHS in England and oversees the commissioning of health care services in England through CCGs. NHS Improvement (NHSI) (the umbrella organisation of Monitor and NHS Trust Development Authority) oversees providers of health care in England, including NHS trusts and foundation

[2] https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019

[3] https://www.gov.uk/government/publications/health-education-england-mandate-2017-to-2018

[4] https://www.gov.uk/government/collections/hmt-main-estimates

trusts, ensuring patients receive high quality care in local health systems that are financially sustainable. Together NHSE and NHSI are responsible for ensuring the NHS balances its budget. The Care Quality Commission monitor, inspect and regulate health and social care services. Health Education England works across England to deliver high quality education and training for a better health and health care workforce. Public Health England works to protect and improve the nation's health and wellbeing, and reduce health inequalities. My department has strong governance and boards in each of these organisations and its other ALBs, and, where necessary, acts as a national co-ordinating mechanism.

1.12 Healthcare services are commissioned from a range of providers, including local authorities and the voluntary and independent sectors, and my department also has relationships with a number of these bodies. For instance, it provides grant funding to local authorities to undertake work on public health in addition to grants to local authorities and voluntary sector bodies to support primary, community and social care.

1.13 This System Statement helps me ensure that appropriate action is being taken to support me in fulfilling my responsibilities as an Accounting Officer, in accordance with the Treasury's guidance set out in *Managing Public Money*. These responsibilities include:

- ensuring all the expenditure of DHSC, its ALBs and the NHS (including NHS trusts and NHS foundation trusts) is contained within the overall budget – the Departmental Expenditure Limit (DEL)
- providing assurance 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
- accounting accurately for DHSC's financial position and transactions, and
- ensuring Ministers are appropriately advised on all matters of financial propriety and regularity, and value for money, across the systems for which my department is responsible.

1.14 While the NHS, public health and adult care and support sectors are funded and structured differently, and have different mechanisms for discharging accountability, they are all 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 DHSC is achieving with its resources, working with and through the health and care delivery system.

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

1.16 This System Statement describes the accountability system that is in place at the date of this statement, and that will continue to apply until a revised statement is published.

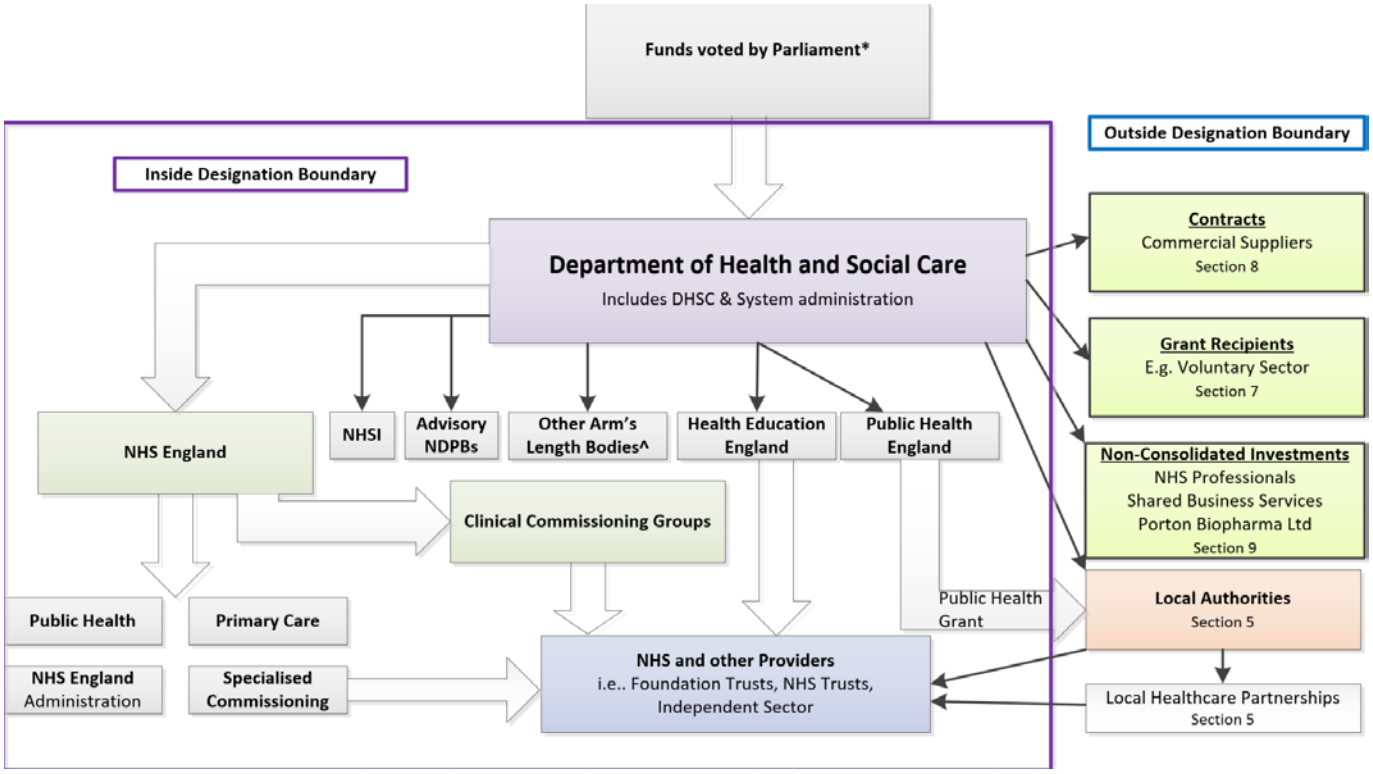
Sir Chris Wormald KCB
Permanent Secretary
Department of Health and Social Care

12 July 2018

Section 2: Diagram of the system

2 This section provides a diagram illustrating the accountability system covered by this statement.

Flow of funding in the health and care system



The Designation Boundary refers to those bodies designated within the Department of Health and Social Care control, and are subject to the Estimate set under the Government Resources and Accounts Act 2000 (Estimates and Accounts) Order 2018. Entities within the designation boundary are consolidated within the department's annual report and accounts.

**Funds voted by Parliament also includes National Insurance Contribution funding which is not voted by Parliament at the same time as the Estimate process, but instead agreed through existing legislation.*

^Other Arm's Length Bodies refers to special health authorities, executive non-departmental public bodies and other consolidated bodies (including regulators and limited companies) included within the Department's Estimate that are not otherwise represented in the diagram

Section 3: Responsibilities within the core department

3 This section of the statement covers the organisation of and accountability arrangements for the core DHSC, who lead the health and care system and have a unique role in that system as a Department of State, which includes:

- Providing direct support and advice to Ministers to help shape and deliver policy to meet the Government's objectives;
- Setting the strategic direction for the system, by leading the key strategic debates and linking into the wider government agenda;
- Driving accountability, by holding others to account and being held to account by Ministers and Parliament;
- Acting as the guardians of the frameworks for health and care, including but not limited to legislative, financial, administrative and policy frameworks, designed to ensure the systems work to enable services to be delivered; and
- Acting as the trouble shooters, who step in and help put things right if the system fails to work as it should.

Structure and accountability

3.1 The core DHSC is currently organised into six groups based on the areas of responsibility set out in section 1; these being:

- Global and Public Health
- Community Care
- Acute Care and Workforce
- Office of the Chief Scientific Adviser, overseeing the Science, Research & Evidence; Office for Life Sciences; and Office of the Chief Analyst directorates
- Finance and Group Operations
- Commercial

3.2 Each of these groups is led by a Director General (DG) or other senior official; responsible for the associated policy areas and senior sponsorship of the relevant delivery arms' length bodies and supported by a number of Directors to deliver these responsibilities.

3.3 At the start of the financial year, each DG will receive an accountability letter from the Principal Accounting Officer, and each Director will receive an accountability letter from the Chief Operating Officer (under delegation from the Principal Accounting Officer) and their DG, setting out their respective responsibilities for identifying, assessing, communicating, managing and escalating risk in their directorates. These letters also outline accountability for their allocated budget, delivery of business plan objectives, and sponsorship responsibilities for ALBs. A system of quarterly Performance, Risk and Corporate Reporting will ensure these risks are routinely reported and reviewed.

Boards and governance

3.4 In line with the code of good practice on corporate governance in central government departments[5], DHSC 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 Principal Accounting Officer, across all of DHSC's responsibilities. The Board scrutinises reports on performance, and challenges DHSC on how well it is achieving its objectives.

3.5 The Departmental Board is supported by a number of other committees. The Audit and Risk Committee (ARC) comprises non-executive Board members and Independent Members and provides independent challenge to DHSC's senior leadership. The ARC advises the Principal Accounting Officer and Departmental Board on risk management, corporate governance and assurance arrangements in the Department and its subordinate bodies, and reviews the comprehensiveness of assurances and integrity of financial statements. The committee also reviews the department's annual report and accounts and makes a recommendation to the Principal Accounting Officer on the report's sign-off.

3.6 The Executive Committee (EC) is chaired by the Permanent Secretary, and includes all Directors General, the Chief Medical Officer, Chief Commercial Officer and the Director of Strategy. The EC deals with core departmental business, including system-wide finance, talent management, staff engagement, and matching resources to priorities.

3.7 The Performance Committee (PC) is chaired by one of the department's Director Generals, and membership includes a non-executive director, the Permanent Secretary, Chief Medical Officer, Chief Scientific Advisor, the Directors General, the director of strategy, system oversight and performance, the director of finance and analysis and the deputy director for system oversight, planning and legislation.

3.8 The Strategy Committee (SC) is chaired by the department's Director Generals on a rotating basis, and is attended by the Permanent Secretary, Chief Medical Officer, Chief Scientific Advisor, Chief economist, all Directors General, the director of strategy, system oversight and performance and a non-executive director. The SC provides leadership of the department's role in setting strategic direction for health and social care.

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

3.9 Additional governance committees continue to support these key groups in overseeing material investment decisions, managing operational matters and ensuring appropriate governance arrangements are in place, and in providing advice on leadership and succession planning for DHSC and ALBs.

Financial Budget Accountability

3.10 Accountability in DHSC is now facilitated by a centralised corporate services operating model. In addition to the dedicated and expert support provided by commercial and legal functions under this model, financial management and low-value procurement activities are supported by a centre of expertise in the Finance Directorate, providing departmental Directors with access to financial and management information and specialist support.

3.11 Directors are financially accountable for their budgets and have the responsibility for delegating authority as appropriate. Authority to approve expenditure is set out within the Department's Financial Control Framework, relaunched in April 2018 and supported through access to the department's finance system, with named approvers based on sign-off provided by Directors. Approvers are accountable for making sure that spend:

- is within the ambit of the Vote from Parliament (i.e. is supporting DHSC objectives and not used inappropriately);
- represents value for money for the taxpayer;
- is in accordance with procurement guidelines (see section 8); and
- is affordable within the budget delegated to them.

Programme and project management

3.12 The Portfolio, Performance, Investment & Risk team (PPIR) acts as a centre of expertise for programme and project management (PPM) within the department. PPIR oversees the department's portfolio, acts as a contact point with the central government Infrastructure and Projects Authority, and provides training and support to the PPM community.

3.13 Major programmes and projects form part of the Government Major Projects Portfolio, and DHSC works closely with the Infrastructure and Projects Authority in the management of these. This includes participation in the Major Projects Leadership Academy and Project Leadership Programme, which equip Senior Responsible Owners with the competence and capabilities needed to lead major projects successfully.

3.14 Further, DHSC has an Investment Appraisals team, whom coordinate the review of business cases for significant investments. Significant investments are considered by the Director of Finance, DHSC Investment Committee, Technology and Data Investment Board (TDIB) or the Provider Investment Committee (alongside the NHSI board) as appropriate. This complements the oversight offered through quarterly Performance, Risk and Corporate Reporting and supports the management of the portfolio.

Health and Social Care technology and information systems

3.15 The Department's role in respect of technology and information changed considerably during 2016-17 with a new cross-system governance model now in place. A Chief Clinical Information Officer (CCIO) is appointed by DHSC, NHS England and NHS Improvement, and hosted by NHS England. The CCIO operates under a remit from the Department of Health and Social Care and is accountable to the Permanent Secretary for the portfolio of information and technology programmes and associated live services implementing the recommendations of "Personalised Health and Care 2020: A Framework for Action".

3.16 The CCIO chairs a cross system Digital Delivery Board (DDB), involving DHSC to ensure the information and technology portfolio collectively deliver the outcomes required by the health and care system.

3.17 NHS Digital is the principal delivery partner for the information and technology portfolio and is accountable, through DDB and DHSC sponsorship arrangements for the management and transparent financial reporting of the information and technology portfolio.

3.18 NHS Digital, as principal delivery partner, is subject to financial controls through DDB and its sub-group, the Technology and Data Investment Board (TDIB) which operates a gated approvals process on behalf of DDB. TDIB has delegated authority to make investment decisions, and is chaired by a DHSC Director. It operates on behalf of the health and social care system.

3.19 DHSC sets strategy context and policy, sponsors NHS Digital and NHS England, holds the CCIO to account for the fulfilment of his remit, and is accountable to Parliament.

Internal audit

3.20 Internal audit arrangements help organisations to identify problems proactively, and act on lessons immediately to ensure that risk management, governance and internal control processes are operating effectively in order to improve value for money.

3.21 Internal audit in DHSC is now provided by the Health Group Internal Audit Service (HGIAS); part of HM Treasury's Government Internal Audit Agency (GIAA). For audit work within DHSC, HGIAS reports directly to the DHSC ARC.

3.22 HGIAS helps the department to review the effectiveness of risk management, controls and governance, and conducts internal audit reviews of key systems and processes. It operates in accordance with Public Sector Internal Audit Standards and to an agreed internal audit plan. HGIAS updates the plan to reflect changes in risk profile and the revised plan is reviewed and approved by the ARC.

3.23 HGIAS will submit regular reports on the adequacy and effectiveness of DHSC's systems of internal control and the management of key business risks, together with recommendations for improvement. The status of internal audit recommendations and the collection of evidence to verify their implementation are reported to the ARC. The Head of Internal Audit for DHSC has

direct access to the Permanent Secretary and they meet periodically to review lessons arising from internal audit reports.

3.24 Internal audit arrangements and their latest overarching opinions are described in more detail in the Governance Statement in DHSC's most recent published Annual Report and Accounts.

Fraud

3.25 The DHSC Anti-Fraud Unit (DHSC AFU) has overall responsibility for the scope, strategy and direction of all Health Group counter fraud activity. On 1 November 2017, the NHS Counter Fraud Authority (NHSCFA), a new special health authority, was established replacing NHS Protect (the body previously responsible for investigating fraud and corruption in the NHS in England). The DHSC AFU holds NHSCFA to account for counter fraud work undertaken and standards in the NHS in England.

3.26 The NHSCFA aligns with DHSC counter fraud strategy, vision and strategic plans to act as the principal lead for anti-fraud activity affecting the NHS in England. The NHSCFA also leads, guides and influences the improvement of standards in counter fraud work across the NHS and Health Group, in line with Government and Cabinet Office Standards. In tandem with the launch of the NHSCFA, the new DHSC Counter Fraud Strategic Plan sets out work to tackle fraud across the healthcare system through to 2020, as we move towards raising standards and improving care for all.

Section 4: Relationships with ALBs

4 This section of the statement covers funding and accountability arrangements for DHSC's arm's length bodies (ALBs). Arrangements for local NHS bodies are covered in section 5.

4.1 DHSC has a number ALBs, which share in managing or overseeing the use of resources across the NHS, public health and social care. These ALBs fall within the following categories:

Executive Agencies	Executive agencies receive their funding direct from the department and are legally part of the department, but with greater operational independence than a division of DHSC itself.
Special Health Authorities	Special Health Authorities (SpHAs) 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 2012 states that any new SpHA must have a time limited life of three years or less (though this period may be extended further with the active approval of Parliament). SpHAs receive their funding direct from DHSC.
Executive Non-Departmental Public Bodies	Executive Non-Departmental Public Bodies (NDPBs) are established by primary legislation and have their own statutory functions. Their precise relationship with the department is defined in legislation. They receive grant-in-aid from the core department, and may charge for their services.
Advisory Non-Departmental Public Bodies and expert committees	Advisory NDPBs and expert committees are not separate legal entities. They form part of the core department, with their associated costs being included within DHSC's accounts.
Other bodies	DHSC's remaining ALBs take a variety of forms, including limited companies and public corporations, and are subject to governance arrangements appropriate to their status.
Non-Ministerial Departments	Non-ministerial government departments (NMGDs) are government departments that deal with matters for which direct political oversight has been judged unnecessary or inappropriate. Some fulfil a regulatory or inspection function, and their status is therefore intended to protect them from political interference. Those described here are ones over which DHSC has

sponsorship.

4.2 A full list of DHSC's ALBs appears in the department's latest Annual Report and Accounts, all of whom fall within its accounting boundary, with the exception of the Medicines and Healthcare Products Regulatory Agency and NHS Blood and Transplant. In addition to the new NHS Counter Fraud Authority (per paragraph 3.25 above), the DHSC also established a new limited company Supply Chain Coordination Ltd (1st April 2018) with the purpose of managing the supply of medical stocks and equipment to the NHS in England. This represents the key changes from the 2016-17 AOSS.

Oversight by DHSC

4.3 While the Secretary of State has Ministerial responsibility to Parliament for the provision of the health service in England and DHSC is 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. This approach empowers front-line professionals, whilst maintaining Ministerial accountability, and limits DHSC's involvement in operational decision-making. With the exception of 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.

4.4 The department has a consistent approach through its sponsorship arrangements for holding ALBs to account and gaining assurance that they are carrying out their functions properly. This is underpinned by the duty to keep their performance under review. Each of the ALBs has a Senior Departmental Sponsor (SDS), supported by a dedicated sponsor team, which provides the principal day-to-day liaison. The SDS is responsible for ensuring each organisation is sponsored effectively and in line with the department's sponsorship standards. DHSC's levers include:

- Power for the Secretary of State to appoint and remove 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 ALB's annual report and accounts. Accounting Officers are appointed by the Principal Accounting Officer, except for the Accounting Officer of NHS England, appointed directly by legislation; and the Accounting Officer of the Medicines and Healthcare Regulatory Agency; appointed by HM Treasury because of its Trading Fund status. The names of Accounting Officers can be found in DHSC's latest Estimate.

- Framework agreements between the department and each ALB, setting out the relationship between the sponsored body and the department, lines of accountability, the way in which the ALB will provide assurance to the department on its performance, the core financial requirements with which the ALB must comply, and the relationships between the ALB and other bodies in the system. The framework agreements set out how the department holds 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 produce an annual business plan, which has to be agreed with the department, demonstrating how its objectives will be achieved and forecasting its financial performance. As a minimum, a quarterly accountability review is conducted with each ALB by its SDS to provide assurance that the ALB 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 to look forward to the next year. The annual reports and accounts of executive agencies, SpHAs and executive NDPBs must be laid before Parliament.

- A programme of reviews that focus on cross-cutting thematic issues but can also look at individual ALBs. This programme ensures that each ALB is reviewed at least every five years. The department tailors reviews to ensure that they focus on the areas that will add value and not duplicate other work. The review team work closely with the ALBs involved to ensure the process is relevant and supports effective delivery.

4.5 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 established or amended by the Health and Social Care Act 2012 and the Care Act 2014 (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 to which the direction relates, or make arrangements for another organisation to do so. In all cases, the Secretary of State must publish the reasons for his intervention.

4.6 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 specific cases being dealt with by Monitor or Care Quality Commission (CQC). Ministerial powers are limited to situations of significant failure, as set out within the Health and Social Care Act 2012 and the Care Act 2014.

NHS England (ENDPB)

4.7 NHS England is an executive NDPB that leads the National Health Service (NHS) in England, setting the priorities and direction of the NHS.

4.8 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. DHSC allocates the budget for commissioning of NHS services to NHS England; who in turn decide upon the formula (advised by the independent Advisory Committee on Resource Allocation) and approach for allocating funds to clinical commissioning groups (CCGs).

4.9 NHS funds are usually deployed in three ways: first, retained in NHS England for direct commissioning of services such as primary care and specialised services; second, allocated to CCGs for purchase of healthcare; and third, retained in NHS England for national programmes and projects.

4.10 The principal accountability mechanism for the NHS is through the commissioning process. Provider organisations are held to account by commissioners (primarily CCGs), who in turn are held to account by NHS England and DHSC.

4.11 DHSC's Principal Accounting Officer gains assurance about the performance of commissioners through a range of mechanisms, including:

- compliance with the framework agreement between DHSC and NHS England;
- the relationship with NHS England's Accounting Officer, and his relationships with the Accountable Officers of CCGs;
- evidence of performance against the Government's mandate to NHS England, and
- the governance and accountability arrangements put in place for CCGs.

4.12 The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) explicitly designates the Chief Executive of NHS England as its Accounting Officer. The formal relationship between NHS England's Accounting Officer and the Principal Accounting Officer is clearly set out in the framework agreement.

4.13 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 approves the appointment of the Accountable Officer of each CCG, holding them to account for the stewardship of resources within each CCG, ensuring that the organisation complies with its duty to exercise its functions effectively, efficiently and economically. This framework of Accounting Officers and Accountable Officers enables DHSC to gain assurance that resources and financial risks are being managed effectively across the sector.

4.14 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.

4.15 The Secretary of State is required to publish an annually agreed 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 DHSC will work together, the mandate sets objectives for NHS England to seek to achieve within a specified time period. Continuing the multi-year approach first established in 2016-17, following public consultation, a mandate for 2018-19 was published in March 2018[6]. It again set out NHS England's objectives and it's budget to 2020, including a firm expectation that NHS England and NHS Improvement are jointly responsible for ensuring the NHS balances its budget.

4.16 The mandate forms part of a wider accountability cycle as defined within the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which requires:

[6] https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019

- NHS England to 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, including making progress against the NHS Outcomes Framework;

- the Secretary of State to keep NHS England's performance under review, including how it is performing against the mandate and the NHS Outcomes Framework;

- NHS England to publish a report at the end of each year saying how it performed against the mandate;

- the Secretary of State to publish an assessment of NHS England's performance; and

- the mandate to be refreshed annually. The mandate may be changed in-year, but only if NHS England agrees to the revision, there is a general election, or if the Secretary of State considers there are exceptional circumstances to make the revision necessary, at which point changes must be reported and explained to Parliament.

4.17 NHS commissioners have a legal duty to obtain advice on public health. 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 these objectives.

4.18 There are some public health programmes, such as immunisations and screening that are best commissioned by NHS England, because they are delivered by GP practices under existing NHS contracts or because they need to be integrated with wider NHS services. To enable this, the Secretary of State has powers to agree with NHS England that it should exercise aspects of his public health functions. Funding for the exercise of these functions is included in NHS England's resource limit, but the terms of the agreement can include specific conditions or controls in order to provide further accountability.

Governance and accountability arrangements for CCGs

4.19 Just as there is a clear line of accountability and accompanying assurance from DHSC to NHS England, there is a similar line from NHS England to CCGs. NHS England has a number of ways in which to satisfy itself (and hence DHSC) 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 CCG Improvement and Assessment Framework provides the means for NHS England to meet its statutory duty to conduct an annual assessment of every CCG, and thereby to hold them to account and to work with them to encourage change and improvement. It aligns with NHS England's mandate and with NHS Planning Guidance[7]. The Framework includes a set of indicators against which CCGs' performance is assessed. Additionally, independent panels provide ratings against six separate clinical priority areas.

[7] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

- 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 DHSC as he considers necessary, and to oblige CCGs collectively to provide information to NHS England in relation to such a request. This enables DHSC 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 to discharge its functions, 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.

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

NHS Improvement and accountability for providers

4.21 NHS Improvement is the result of Monitor and the NHS Trust Development Authority (TDA) coming together under common leadership, so that there is a single, consistent approach to supporting continuous improvements in the quality and efficiency of NHS trusts and foundation trusts. While Monitor and the TDA remain separate legal entities, they have a single, shared executive leadership, their Boards have shared membership, and NHS Improvement operates as a single organisation. The Principal Accounting Officer has appointed NHS Improvement's Chief Executive as Accounting Officer for both TDA and Monitor. NHS Improvement works closely with NHS England and with other system partners to support improvements in the sustainability of wider local health economies.

4.22 NHS Improvement does this by exercising three specific functions, underpinned by a power to license providers. First, it has regulatory powers to tackle anti-competitive behaviour that may act against the interests of patients. Second, 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). Third, it oversees a "continuity of services" regime to help commissioners secure continued access to essential NHS services and to protect patients' interests where a provider is at risk or is unsustainable in its current form.

4.23 Accountability to DHSC for providers therefore comes through commissioners (as described above) and through the combination of regulation and oversight by CQC, through inspection ratings, and NHS Improvement, via the single oversight framework. These powers are strengthened through a new Use of Resources component, with CQC and NHSI working jointly to provide better understanding of how effectively and efficiently trusts are using finances, workforce, estates and facilities, technology and procurement. CQC and NHSI are held to account by DHSC for their performance, with departmental powers to intervene in the running of either body in the event of any failure to perform their functions.

4.24 The Department has no power of direction or intervention in foundation trusts (other than in an emergency, where the 2012 Act gives the Secretary of State powers of direction over all providers of NHS services). Although DHSC does have powers to direct NHS trusts, the Government's policy is that the department should not generally intervene in day-to-day operational management.

4.25 This means that the Principal Accounting Officer is not directly accountable for trusts' individual decisions nor for the clinical care they provide. These matters are for trusts, their boards, their Accounting Officers or Accountable Officers and the regulators. DHSC's role is to ensure that there is a system of regulation and oversight that promotes quality, regularity, propriety and value for money including good financial management in trusts; and that in turn provides assurance that the services provided by trusts in aggregate can be managed within the departmental budget.

4.26 Much accountability for providers is exercised at a local level, and this is described in more detail in section 5.

NHS England and NHS Improvement

4.27 NHS England and NHS Improvement have distinct statutory responsibilities and accountabilities, and legislation means that a formal merger between the organisations is not possible. However, in recognition of public perceptions of the NHS as a single organisation, the potential benefits for patients and the public purse of collaboration and joint working, the two bodies have announced plans to establish a more joined-up approach to from September 2018.

4.28 Plans include proposals for joint governance and accountability, integrated regional teams and new regional geographies, managing change and aligning appropriate national functions across the two organisations, creating a set of new roles to support delivery including a single Chief Financial Officer (responsibilities include leadership of the integrated financial and operational planning and performance oversight process).

Funding arrangements for the NHS in England

4.29 Funding for the NHS in England is derived from National Insurance contributions and funds voted by Parliament during the estimates process, as shown in Section 2. Funding is initially provided to DHSC, before being transferred to NHS England as grant-in-aid. Each CCG receives grant-in-aid funding from NHS England in line with the locally set budget. NHS healthcare providers

predominantly earn income from commissioners by meeting contracted performance criteria under the NHS Standard Contract[8]. The contract was most recently revised in May 2018.

4.30 Providers also receive additional income from NHS England via the Sustainability and Transformation Fund, which is linked to providers achievement of specific financial-control and performance criteria. NHS England Funding and Resource 2017-19[9] provides further detail of the funding allocation for the NHS to 2019.

Other ALBs

4.31 Care Quality Commission (CQC), an executive non-departmental public body, is the independent regulator of health and adult social care in England. Under the Health and Social Care Act 2008, all providers of regulated adult social care activities are required to register with CQC. It has the power to recover costs associated with its registration functions under Section 85 of Act, and currently recovers around 95% of these costs. The role of CQC in ensuring accountability of health and social care providers is described in more detail in section 5.

4.32 Public Health England (PHE) is an executive agency of DHSC, and 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.

4.33 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. PHE receives its funding direct from DHSC, whilst also deriving some income from charges for its services. PHE performs the shareholder function for Porton Biopharma Ltd, a pharmaceutical development and production company 100% owned by the Secretary of State.

4.34 Health Education England is a non-departmental public body. Its function is to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place. Around 90% of the HEE operating expenditure goes towards supporting and training the healthcare professionals of the future.

4.35 The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. An executive non-departmental public body, it derives around 15% of its income from sales of scientific advice and other funding from health bodies and devolved administrations.

4.36 NHS Digital is an executive non-departmental public body. It provides national information, data and IT systems for health and care services. It derives around 25% of its income from services delivered, primarily to DHSC and NHS England.

[8] https://www.england.nhs.uk/nhs-standard-contract/2017-19-update-may/

[9] https://www.england.nhs.uk/publication/nhs-england-funding-and-resource-2017-19/

4.37 The Human Fertilisation and Embryology Authority (HFEA) is the UK's independent regulator of treatment using eggs and sperm, and of treatment and research involving human embryos. As an executive non-departmental public body, it sets standards for, and issue licences to, fertility clinics, and derives around 80% of its income from licence fees.

4.38 The Human Tissue Authority (HTA), an executive non-departmental public body, is the regulator for human tissue and organs. The Authority comprises a Chair and eleven Members who are appointed by the Secretary of State for Health and Social Care, with the exception of one Member appointed by the Welsh Minister and one by the Minister in Northern Ireland. Members are appointed for a three-year term of office initially. Members come from a variety of medical, scientific, legal, media, administrative and ethical backgrounds. This ensures that the Authority draws on a wide range of experience relevant to the governance of the HTA. By law, at least half must be lay Members. The HTA issues licences in accordance with the Human Tissue Act 2004 for the removal, storage, use and disposal of human organs and tissue from the living and deceased, and derives around 85% of its income for fees for these licences.

4.39 NHS Business Services Authority (BSA) is a special health authority responsible for the NHS Supply Chain business, supplying equipment and consumables to the NHS. The costs of this business are covered by charges to NHS customers. Additionally, BSA covers around half of its other operating costs through charges for its services. It reports on its charging schemes in its annual reports.

4.40 Supply Chain Coordination Limited (SCCL) is a limited company wholly owned by the Secretary of State, which has responsibility for managing the NHS Supply Chain contracts on behalf of BSA. As part of the governance arrangements for SCCL, DHSC is represented on the board.

4.41 NHS Resolution is a special health authority managing negligence and other claims against the NHS in England on behalf of its member organisations. It charges fees to its members for the costs of these claims and reports on its charging schemes in its annual reports.

4.42 NHS Property Services Limited (NHS PS) and Community Health Partnerships Limited (CHP) are limited companies wholly owned by the Secretary of State, which have responsibilities for management of the NHS estate. NHS PS owns around 10% of the NHS estate, mostly comprising clinical premises such as health centres, GP practices and community hospitals, and provides property and facilities management services. CHP acts as head tenant for the NHS Local Improvement Finance Trust (LIFT) estate, managing primary and community healthcare buildings across England. It owns shares in LIFT companies, which provide these buildings under public and private partnerships. As part of the governance arrangements for NHS PS and CHP, DHSC is represented on their respective boards.

4.43 Professional Standards Authority for Health and Social Care (PSA) is an unclassified public body, which oversees nine statutory bodies that regulate health and social care professionals in the UK. It is largely funded by fees charged to these bodies. Two of these bodies, the Nursing and Midwifery Council and the Health and Care Professions Council are also designated for consolidation within DHSC's accounting boundary, and their financial results are included within DHSC's group account.

4.44 Genomics England Limited (GEL) is a limited company wholly owned by the Secretary of State. Genomics England was set up to deliver the 100,000 Genomes Project. This flagship project will

sequence 100,000 whole genomes from NHS patients and their families. DHSC is represented on the board of GEL.

4.45 The Medicines and Healthcare products Regulatory Agency (MHRA) is an executive agency of DHSC which operates as a government trading fund, and is funded mostly by income from fees. It does not receive direct funding from DHSC, but earns approximately 20% of its income from DHSC. Additionally, MHRA is in receipt of approximately £1.3m Public Dividend Capital from DHSC. HM Treasury has appointed MRHA's Chief Executive as its Accounting Officer.

4.46 NHS Blood and Transplant is a special health authority, operating as a public corporation. It derives around 85% of its income from charges for its services. It reports on its charging schemes in its annual reports. The Principal Accounting Officer has appointed NHS Blood and Transplant's Chief Executive as its Accounting Officer.

4.47 Skipton Fund Limited is a company limited by guarantee with no share capital. Its principal activity was to implement and manage the UK-wide ex gratia payments scheme for people infected with the hepatitis C virus from treatment with NHS blood, blood products or tissue. The functions performed by Skipton Fund Ltd transferred to the NHS Business Services Authority on 1st November 2017, and the company will be dissolved during the 2018-19 financial year.

4.48 Advisory NDPBs and expert committees are not separate legal entities. They form part of the core department or its ALBs, with their associated costs being included within the accounts of the relevant body.

Non-Ministerial Government Departments

4.49 DHSC has sponsorship over one non-ministerial government Department, Food Standards Agency (FSA). Under section 2 of the Food Standards Act 1999, the Secretary of State for Health and Social Care has the power to appoint between four and eight members to the board of FSA, with the remaining four board members being appointed by the devolved administrations.

4.50 As a NMGD, FSA is accountable directly to parliament. As a national body, accounts are also laid before the National Assembly for Wales, the Scottish Parliament and the Northern Ireland Assembly. The FSA board of the FSA appoints its own Accounting Officer, who is responsible for ensuring the monitoring and managing of the FSA budget and spending, under The Government Resources and Accounts Act 2000 (Estimates and Accounts). No funding for FSA comes from DHSC.

Section 5: Local funding arrangements

5 This section of the statement covers local aspects of funding and accountability. This includes NHS trusts and foundation trusts, as well as local public health and adult care.

Financial accountability for local authority funding

5.1 The Accounting Officer of the Ministry of Homes, Communities and Local Government (MHCLG), formerly Department for Communities & Local Government, 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. DHSC's Principal Accounting Officer and other Departmental Accounting Officers rely on this system for assurance over the funding they provide for local authorities.

5.2 DHSC's allocation of resources to local government includes specific grants, which have conditions attached on the intended focus of the funds. DHSC 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.

Adult Social Care

5.3 Adult social care is delivered through English local authorities, which are accountable to their local populations for management and delivery of services. DHSC's national role sits within this local government context.

5.4 The legal framework for adult social care is set out in the Care Act 2014, which came into effect in April 2015. DHSC sets the strategic policy framework for care and support, working with local government as partners, to provide overall direction and set national objectives. However, delivery is the responsibility of local authorities, in line with their own locally determined priorities.

5.5 DHSC's core responsibilities for adult social care are to:

- set national policy and the legal framework, and provide leadership;
- agree the central government funding for adult social care through the Spending review settlement and setting the mechanisms for public reporting on the adult social care performance of local authorities within an overall system for local government funding overseen by MHCLG; and
- account to Parliament and the public for the performance of the system as a whole (including reporting against the Adult Social Care Outcomes Framework), and assure the approach to regulation, inspection and intervention in care and support services (by holding the Care Quality Commission to account, and retaining intervention powers as a matter of last resort).

5.6 Whilst DHSC is responsible agreeing the central funding for adult social care through the Spending Review settlement, MHCLG is accountable for the allocation of those funds to local authorities. Adult social care (and local government in general) is funded through a mixture of nationally and locally derived sources of income. In addition, local authorities receive revenue support grants through MHCLG and they raise funds via the Council Tax. Together, locally retained business rates, 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 and are authorised for care and support.

5.7 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 limited national performance management of local authorities in relation to care and support, focussing on how people flow between the NHS and adult social care services locally. In addition, DHSC is responsible for defining what information councils are required to provide, and this provides a basis for monitoring outcomes.

5.8 The Adult Social Care Outcomes Framework (ASCOF), published by DHSC and agreed with the local government sector, provides a consistent basis for local accountability and for measuring the outcomes and experience of people who use services. DHSC's outcomes frameworks, and performance against them, are described in more detail in the department's Annual Report and Accounts.

5.9 The Department of Health and Social Care and the Local Government Association work together on a range of social care improvement and health integration programmes as part of a wider sector-led improvement approach. The programme includes work on health and wellbeing boards, social care commissioning and market development, delayed transfers of care, safeguarding, care and health integration and the Better Care Fund. The DHSC funding for the programme is managed via a memorandum of understanding between the Department and the Local Government Association.

Inspection and intervention in social care

5.10 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.

5.11 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.

5.12 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 2014 Act created a new function for the CQC to oversee the financial sustainability of certain social care providers, in order to monitor the resilience of the

market and to support local authorities to protect people if a provider were to fail financially. This role supports CQC's remit for assuring the quality of care.

5.13 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 three 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.

- Section 48 of Health and Social Care Act (2008) includes; the power to undertake reviews or investigations of NHS or adult social care services. To use these powers there must be approval from, or be requested by, the Secretary of State for Health and Social Care and, with respect to local authority commissioning of adult social care services, MHCLG.

5.14 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.

5.15 In practice, formal intervention is likely to be triggered by an inspection by CQC, or a direct request from local government, 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.

Local authorities' role in public health

5.16 Local authorities are required to take such steps that they consider appropriate for improving the health of the population in their area. In addition, the Government has prescribed particular functions through regulations ("mandatory services"). Each local authority, acting jointly with Public Health England (PHE), must appoint a director of public health.

5.17 Local authorities are funded to carry out their specific public health responsibilities through a ring-fenced grant paid by PHE (£3,091m in 2017-18), on which DHSC places a limited number of conditions. Each year, the local authority Chief Executive (or Finance Director) and Director of Public Health (DPH) confirm that the public health grant has been spent in line with the grant conditions. The DPH is also required to produce an annual report on the health of the local population, which the local authority is required to publish. Together these provide an accountability mechanism both locally and to PHE for compliance with the grant conditions.

5.18 The Chief Executive of PHE is designated as the Accounting Officer for the public health ring-fenced grant to local authorities. Beyond this, as with other local services, local authorities are primarily accountable to their electorates, within a system of accountability that is overseen at the national level by MHCLG.

5.19 A Health and Wellbeing Board in each local authority is a forum comprising councillors, directors of public health, children's services and adult social services, CCGs, local HealthWatch and other relevant local organisations. It enables them to 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.

5.20 DHSC is responsible for setting national strategy and designing legislation to 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. Public health accountability arrangements are based on the Public Health Outcomes Framework (PHOF), which sets out what needs to be achieved to improve and protect the nation's health and reduce health inequalities. Accountability is determined through the local democratic processes, based on data published by PHE for each local authority. DHSC's outcomes frameworks, and performance against them, are described in more detail in the department's Annual Report and Accounts.

5.21 The main ways in which DHSC gains assurance on local authorities are described below:

- *Transparency*: PHE publishes data on national and local performance against the PHOF. Although there are no centrally imposed targets or performance management of local authorities, publication supports democratic accountability for performance against outcomes, enables comparison between local areas, and increases the incentives for local authorities to improve their performance.

- *Requirements relating to the proper use of the ring-fenced grant*: the Chief Executive or Chief Financial Officer (section 151 officer) and Director of Public Health of each receiving local authority provide a joint statement of grant usage setting out how the authority has spent its grant, and complied with grant conditions.

- *Prescribed functions*: the Health and Social Care Act 2012 gives the Secretary of State the power to require local authorities to take particular steps to improve or protect health.

- *Sector-led improvement*: DHSC funds the Local Government Association to provide peer support to local authorities and Health and Wellbeing Boards.

5.22 If a local authority experiences difficulties, PHE offers advice and support as necessary. The Secretary of State can make regulations to require local authorities to take certain steps, and in certain circumstances, he can require the local authority to review the performance of the Director of Public Health. More generally, as described in the system statement for local government by MHCLG's Accounting Officer, there is an established system of checks and intervention powers in place if a council fails to fulfil its functions.

Better Care Fund

5.23 The Better Care Fund (BCF) is one example of bringing together health and social care budgets to support more person-centred, coordinated care. Partnerships of clinical commissioning groups (CCGs) and local authorities enter into agreements under section 75 of the NHS Act 2006, creating pooled budgets to enable integrated commissioning of care from providers. These agreements are overseen by local authority led Health and Wellbeing Boards, who agree plans for how the

money will be spent. CCGs and local authorities report their share of pooled budget transactions in their respective annual accounts. CCG Accountable Officers are therefore accountable to NHS England, and ultimately to the Principal Accounting Officer, for the funds they place in pooled budgets.

5.24 CCGs receive ring-fenced BCF allocations from NHS England, with which they are required to enter into pooled budgets with local authorities. Additionally, NHS England sets national conditions with which local BCF agreements must comply. NHS England has statutory powers to retain or recover funds that are not applied in accordance with approved plans and through a section 75 pooled budget agreement.

5.25 In addition to amounts pooled by CCGs, the BCF includes grants paid directly to local authorities by DHSC and MHCLG. These include the Disabled Facilities Grant (DFG) and 'Improved Better Care Fund (iBCF)' grants for adult social care. MHCLG issues grant determination letters to local authorities setting out the conditions of usage of these funds.

5.26 DHSC provides funding for the DFG, but MHCLG is accountable for the allocation of funds to local authorities, as well as for the policy framework. A Memorandum of Understanding, signed by both DHSC and MHCLG, governs this arrangement.

Providers of health care

5.27 As described in section 4, health care providers are overseen at the national level by NHS Improvement and CQC, and are also accountable locally to NHS commissioners for the services they provide. NHS commissioners use their budgets to commission services from providers, which may be public sector bodies (NHS trusts or foundation trusts), independent contractors (such as GP and dental practices), or private or voluntary sector organisations.

5.28 The NHS friends and family test was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments, maternity services, GP practices and dental practices to their friends and family if they needed similar care or treatment. This enables patients to give quick feedback on the quality of care they receive, in turn giving service providers a better understanding of the needs of their patients and enabling improvements.

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

5.30 In addition, there is a system of independent regulation of providers, extended by the Health and Social Care Act 2012:

- Most providers of health and social care (whether they provide publicly or privately funded services) are regulated by the Care Quality Commission (CQC). The CQC has three chief inspectors (of hospitals, general practice and adult social care). It conducts regular inspections, publishes reports on providers and rates their overall performance. 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.

- NHS Improvement is the 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.

NHS Trusts

5.31 The Accounting Officer of TDA (who is the Chief Executive of NHS Improvement) is responsible for the appointment of Accountable Officers for each NHS trust. Acting on behalf of the Principal Accounting Officer, the Chief Executive 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 DHSC and are subject to public audit arrangements.

NHS Foundation Trusts

5.32 NHS Foundation Trusts have a unique role and legal status 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. Under the legislation enacted by Parliament in 2003, NHS foundation trusts are not directly accountable to DHSC. However, there is a series of mechanisms that provide assurance about the foundation trust sector:

- Each foundation trust has an Accounting Officer, who has responsibilities for ensuring regularity, propriety and value for money, including signing the trust's performance report, accountability report and financial statements. 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.

5.33 The 2012 Act gives DHSC powers to require NHS foundation trusts to provide it with information. This enables DHSC to ask NHS foundation trusts to report their planned and actual spending, as it also does for NHS trusts, to help the Department manage the overall budget.

5.34 NHS Improvement are responsible for exercising the following functions of Monitor in relation to NHS foundation trusts:

- to consider applications for authorisation of NHS trusts as foundation trusts and to exercise powers of oversight to ensure that foundation trusts continue to comply with the terms of their authorisation;

- to license foundation trusts and to set and enforce requirements to ensure that they are well governed, that they remain financially viable, and that they protect NHS assets, as necessary conditions of their continued ability to provide NHS services; and

- to set and enforce requirements on NHS foundation trusts to mitigate and manage risk proactively, consistent with their duty to exercise their functions effectively, efficiently and economically.

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

5.36 DHSC is working with the NHS to meet the current challenges facing health and care, in order to deliver safe and effective services as efficiently as possible. DHSC considers that the measures described here provide the Principal Accounting Officer with the assurance that he needs, and that Ministers need, to discharge their ultimate accountability to Parliament for NHS services. DHSC 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.

Devolution and local partnerships to improve healthcare

5.37 The Cities and Local Government Devolution Act 2016 creates provision for the devolution of health and social care delivery to local and combined authorities, to allow a place-based approach to delivery of these services.

5.38 The Act nevertheless ensures that the duties of the Secretary of State for Health to provide a comprehensive health service in England cannot be transferred to such authorities, and remain part of the NHS. This ensures a line of accountability back to DHSC and Parliament and means that the position of NHS services in relation to the NHS Constitution and the mandate to NHS England do not change and that the department will still hold NHS England to account for delivery of its mandate.

5.39 The NHS Constitution requires that any service under the banner of the NHS in England must, as a minimum, meet the statutory duties, rights and pledges it contains. This includes national access standards, including waiting times. Devolved authorities are not permitted to opt out of meeting these and other relevant current NHS duties and standards.

5.40 Local devolution deals may involve CCGs and or local authorities making use of existing legislative flexibilities to pool resources and establishing lead or joint commissioning arrangements, enabling them to make shared decisions about how best to use resources to improve quality of care and population health outcomes for their local population. The National Health Service Act 2006 provides additional flexibilities enabling NHS England to exercise some of its own commissioning

functions jointly with - or to delegate them to - CCGs and, subject to regulations, combined or local authorities. Whilst the 2016 Act prohibits the devolution of health service regulatory functions to a Combined or Local Authority, it is possible to transfer 'policing' aspects of commissioning carried out by NHS England, when transferring commissioning functions to a Combined or Local Authority.

Sustainability and Transformation Partnerships and Integrated Care Systems

5.41 In addition to devolution deals, to support the implementation of the Five Year Forward View[10] for the NHS, NHS organisations and local councils came together in 44 areas of England to form sustainability and transformation partnerships (STP), designed around the healthcare needs of the local area rather than the individual partner organisations. In some cases the partnerships have evolved to form Integrated Care Systems (ICS) which take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

5.42 One advanced example of an ICS and devolution in practice is The Greater Manchester Devolution Agreement. Here, a Memorandum of Understanding (MoU) has been signed by the combined authority, NHS England and the relevant CCGs, with the written support of the NHS trusts and foundation trusts in Greater Manchester. The MoUs make clear that Greater Manchester remains within the NHS and subject to the NHS Constitution and the mandate to NHS England, and that CCGs and local authorities retain their statutory functions and existing accountabilities. Provider organisations also remain accountable to the relevant national regulatory bodies (CQC and NHS Improvement). Nine other areas are working towards developing an ICS.

Strategic Partnership Boards

5.43 A Strategic Partnership Board (SPB), made up of representatives of CCGs, NHS providers, local authorities and NHS England, oversees delivery of a Strategic Plan, providing leadership, agreeing priorities and ensuring appropriate assurance frameworks are in place. A conglomeration of five STP, The London Health and Care SPB provides strategic and operational leadership and oversight for London. Arrangements for London governance have been developed in accordance with the applicable frameworks, including the National Health Service Act 2006 (the NHS Act), and supporting secondary legislation, local government legislation and the NHS England devolution criteria. Each organisation retains its statutory accountabilities.

New Models of Care

5.44 The new models of care programme closed at the end of March 2018. The NHS, in discussion with DHSC, developed new models for the integrated delivery of services such as community care. This involved the establishment of new bodies to deliver these services to specific populations.

[10] https://www.england.nhs.uk/five-year-forward-view/

5.45 For instance, Wiltshire Health and Care LLP is an NHS partnership established by three NHS foundation trusts to deliver adult community health services in the Wiltshire area. The partnership has a board and will publishes accounts annually.

5.46 The NHS foundation trusts that own the partnership remain accountable for their share of its operations and financial results. Additionally, as a publicly owned body delivering NHS services, the partnership has been designated as being within DHSC's accounting boundary, and therefore provides accounting information directly to DHSC for consolidation into the department's group account.

5.47 The examples above provide an indicative example of developing care models, with the broader nature of accountability and structural make-up of new models of care continuing to be modified as other models are developed throughout the year and beyond.

Section 6: Third party delivery partnerships

6 This section of the statement covers accountability for delivery partnerships with commercial or civil society sector organisations.

6.1 The DHSC works with a number of partner organisations to meet its objectives and deliver services to the public. Significant partnership arrangements involve formal working arrangements described elsewhere in this system statement. These include:

- Working with arm's length bodies such as NHS England, NHS Improvement and Care Quality Commission to lead and regulate the NHS, Public Health England to improve the health of the nation, and Health Education England to deliver a better healthcare workforce;
- Working with local authorities to deliver integrated health and social care and to improve public health at a local level;
- Grants provided to bodies in the private and voluntary sectors to fund projects in line with DHSC's objectives;
- Entering into contractual arrangements with commercial providers to support the delivery of services, such as through the provision of equipment and infrastructure;
- Investing in companies that play a role in the healthcare system.

6.2 Whilst DHSC may enter into other partnerships without such arrangements, these do not currently represent significant areas of the department's business.

Section 7: Grants to private and voluntary sector bodies

7 This section of the statement covers accountability for grant payments within the DHSC, which then provides a best practice model for other ALBs to follow.

Context

7.1 The DHSC currently award grants to private and voluntary sector organisations using a range of statutory grant awarding powers. Our system partners NHS England and PHE also have authority to award grants. Grants to private and voluntary sector bodies totalled £673m in the 2017-18 financial year.

Systems

7.2 DHSC's governance process for grant-making is overseen by a single centre of expertise, ensuring a consistent approach to assurance and approvals during the grants life cycle. Material grant awards are also subject to the Department's standard Investment and Improvement decision process, with Director General, Finance Director and Ministerial approval required where the awards are over £50m. The process is also subject to HM Treasury approval where the grant value is £1m or more.

7.3 This governance model embeds Cabinet Office Minimum Standards for grant-making and HM Treasury's *Managing Public Money*, with which DHSC is fully compliant. Further scrutiny is provided at the Cabinet Office's New Grants Advice Panel (NGAP) for grants deemed to be high value, high risk or novel and contentious. Grants are recorded on Government Grants Information System (GGIS), in line with the wider transparency agenda. Cabinet Office, through their latest trend report, have confirmed that 100% of expected data at both scheme and award level for 2017-18 is on GGIS.

7.4 Appropriate Ministerial, Secretary of State and HM Treasury approval is sought, as determined by the underpinning legal power. Grants are funded through grant agreements which specify the terms, conditions and key performance indicators the grant recipient must adhere to. Financial returns are required to ensure grant expenditure is in line with budget and is incurred as intended.

7.5 For multi-year awards, there is annual scrutiny to determine whether to continue in line with existing plans, make adjustments, or terminate the grant. Any surplus funding will be recovered.

7.6 Evaluation takes place at the end of the activities to determine how and where the project was successful, and how value for money has been achieved.

Section 8: Major contracts and outsourced services

8 This section of the statement covers arrangements for entering into and managing contracts, and outlines the department's approach to ensuring value for money.

8.1 DHSC procurement policy states that procurement must be based on value for money, achieved through competition, unless there are compelling reasons to the contrary. Supported by a structured process set out below, all DHSC staff are required to undertake procurement activities that are:

- Legal;
- Accountable and auditable;
- Economically effective;
- Responsible (ethically, environmentally and socially);
- Designed to identify and manage risk;
- Compliant with government policy objectives; and
- Open to continuous improvement and development.

8.2 All procurement professionals working at DHSC are tasked with achieving clear objectives aimed at driving value for money through procurement, and the departmental process for all staff involved in procurement activity ensures best practice is applied in a manner compliant with legislation.

8.3 There are procurement thresholds to determine the correct procurement route and ensure compliance with Official Journal of the EU (OJEU) requirements. The Department adopts a three-tiered approach (Gold, Silver and Bronze) for procurements falling over the OJEU threshold to determine a proportionate application of resource, governance and process based on the overall value and risk profile of each project.

8.4 DHSC and the ALB's apply a business case approval process and Cabinet Office controls, depending on the category and level of spend. Alongside this, DHSC develops a procurement strategy document for each project, outlining how value for money will be achieved, the preferred procurement route and how identified risks will be managed. The business case and procurement strategy are approved by the client and Procurement prior to advertising procurement opportunities. All requisitions require evidence of business case approval to progress to purchase order.

8.5 The ALB's are subject to Public Procurement legislation and ensure compliance with their internal financial controls. Prior to procurement's being advertised, Professional Service business cases,

above a set threshold, are submitted to DHSC Financial Approvals Panel via DHSC Procurement for review and approval.

8.6 DHSC offers a procurement support service to ALB's where they do not have the capacity or capability to carry out procurements; recent examples include procurements run on behalf of TDA, CQC and HEE. This work is undertaken using DHSC standards, practices and approvals process.

8.7 The DHSC provides a suite of standard terms and conditions, procurement tools & templates and a Master Indemnity Agreement (for the supply of loan equipment) for use by NHS trusts. Whilst these have been developed predominantly with trusts in mind, they can be tailored by ALB's.

8.8 The Department is embedding a standard approach to contract management to ensure that agreed service levels and standards are delivered and that value for money is achieved. The model being rolled out is based on a three-tiered (Gold, Silver and Bronze) model. The contract management operating model aligns with Crown Commercial Service Contract Management Principles[11], the National Audit Office Good Practice Contract Management Framework[12], and Cabinet Office Government Commercial Operating Standards[13].

8.9 The Contract Management Team has developed Toolkit documentation, aligned with best practice across government, to support robust contract management in each tier. This Toolkit includes tools such as a contract management plan, balanced scorecard, risk register and issues log, mobilisation and exit plans and is made available to all of the ALBs. In addition, for high risk contracts contingency plans will be introduced. This will ensure up front consideration and capture of potential contingency scenarios and actions required, to ensure continuity of service in the event of supplier failure.

8.10 Scorecards are produced for every Gold contract; these provide a balanced view of performance, risks and issues, finances and contractual issues, which inform an overall risk profile. A monthly contract management dashboard is then created to highlight key metrics in relation to contract management risks, issues and performance.

8.11 DHSC utilises a range of external information (e.g. financial reports/alerts) to obtain in-depth analysis of the health of suppliers. This information is used to highlight accounting, regulatory, or other developments that may require immediate action by the Contract Management Team.

8.12 Some of the ALBs manage contracts on behalf of the Department. Where high value / high risk contracts are being managed by another organisation, scorecards are provided to the Department. NHS trusts have local arrangements in place for procurement and contract management.

8.13 One such example of major procurement is the re-procurement of the NHS Supply Chain services as they approach their current contract end date. DHSC has constituted a major programme to co-ordinate and manage this activity, the Procurement Transformation Programme (PTP).

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[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395083/Contract_Management_Principles.pdf

[12] https://www.nao.org.uk/wp-content/uploads/2016/12/Good_practice_contract_management_framework.pdf

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/567659/Commercal_Standards_new.pdf

8.14 This programme has adopted an extensive business case approach to assure value for money and a clear strategy is in place for these contracts. This includes full DHSC Investment Authority, Cabinet Office spend controls and HM Treasury review and approval of the contracting approach, financial and economic models and targeted outcomes.

Section 9: Investments, joint ventures and other assets

9 This section of the statement covers DHSC's shares and investments in third party businesses.

Core Department Investments

9.1 DHSC owns 100% of the shares in a number of companies that are directly involved in meeting the department's policy objectives and in delivering its services, and which are consolidated within the DHSC group. These companies, NHS Property Services Limited, Community Health Partnerships Limited, Genomics England Limited and Supply Chain Coordination Ltd, are described in more detail in section 4. The department manages its interests in these companies through representation on the company boards. These companies are consolidated into the department's annual report and accounts.

9.2 Additionally, DHSC has shareholdings in a number of other bodies that fall outside its accounting boundary.

9.3 DHSC owns 100% of the shares in NHS Professionals (NHSP), which provides managed flexible worker services to the NHS. NHSP's bank of staff includes general and specialist nurses, doctors, midwives, administrative and other healthcare professionals. NHSP receives no funding from DHSC, but charges for its services. The department discharges its shareholder duties through representation by a member of the Senior Civil Service on the company board.

9.4 DHSC owns 50% less one share in NHS Shared Business Services Limited (SBS), which provides business support services, including finance, accounting, employment and procurement, to a range of NHS bodies. SBS is owned jointly with Sopra Steria. The department discharges its shareholder duties through representation by a member of the Senior Civil Service on the company board.

9.5 DHSC also owns 100% of the shares in the Medicines and Healthcare Products Regulatory Agency (MHRA), which is an executive agency of the department, and which operates as a trading fund. MHRA is described in more detail in section 4.

Investments by ALBs

9.6 In addition, Public Health England (PHE) performs the shareholder function in respect of the Secretary of State's 100% shareholding in Porton Biopharma Limited, a company involved in the production and development of pharmaceutical supplies. PHE are represented on the company board.

9.7 Community Health Partnerships Limited (CHP) owns minority investments in various LIFT companies, which are engaged in providing community-based healthcare facilities and related services. CHP is represented on the boards of these companies. Additionally, CHP owns 100% of

the shares in Partnerships for Health Limited, which is a dormant company that has never traded. These shares are valued at one pound.

Wholly owned subsidiaries in the provider sector

9.8 Where certain conditions are met NHS Trusts and NHS Foundation Trusts have the authority to establish limited companies where the functions performed by those companies deliver services to the establishing body(ies). The services delivered by these companies can be wide ranging and may include estates and/or facilities management/property functions, respite care, medical services, pharmaceutical services or equipment management. There are many legitimate reasons why trusts may choose to establish subsidiary companies (bringing contracted out services back into the NHS; generation of profit to reinvest in patient care; flexibility on terms and conditions such that better recruitment and retention of staff is achieved) with the key aims of the companies being to reduce expenditure for the owner trust(s) while delivering focus on improving those services provided, and providing an additional source of income for the owners where wider services provision occurs.

9.9 The intention is that during 2018-19, the proposed creation of subsidiary companies will now become a reportable transaction to NHS Improvement under the Transactions Guidance, irrespective of size. This would ensure that transactions are visible to NHS Improvement and that assurance could be sought that NHS trusts had properly identified and reviewed associated risks. This will allow timely intervention where necessary and satisfy the requirements on the system Accounting Officers. A formal requirement under Managing Public Money is for Accounting Officers (including the Principal Accounting Officer, individual trust Accounting Officers and NHS Improvement as the regulator) to ensure the establishment of these companies is not for the sole purpose tax avoidance.

9.10 The company structures are varied, with the governance arrangements generally being established by the parent trust. Whilst it is the responsibility of local NHS organisations to decide the most appropriate structures they need to deliver safe and efficient care, the Department (through NHSI) nevertheless has a role in ensuring subsidiary companies are being established in such a way as to minimise any risk to the financial stability of individual trusts. Central oversight arrangements in this area are being strengthened, and going forwards the creation of subsidiary companies will become a reportable transaction to NHS Improvement under the Transactions Guidance, irrespective of size. A further requirement has also been introduced for trusts to inform NHS Improvement of any subsequent changes to these companies. These reporting requirements will ensure that transactions are visible to NHS Improvement and that assurance could be sought that trusts had properly identified and reviewed associated risks. Trusts self-certify when creating subsidiary companies such that NHS trust boards can evidence they have considered and mitigated all relevant risks.

9.11 As DHSC Accounting Officer I retain a clear line of accountability for the proper and efficient use of public funds by subsidiary companies through the Accounting Officers of the parent trusts. The financial results of each wholly owned subsidiary are consolidated into the accounts of the parent entity, thereby ensuring their inclusion within the parent's overall financial limits. The Department's Group Accounting Manual (GAM) specifies that all DHSC group bodies (including NHS providers) must comply with the principles and standards enshrined in government's Managing Public Money (MPM), which establishes the fiduciary duties of those handling public

resources. MPM explicitly states an AO must have meaningful oversight of a subsidiary stating “it is not acceptable to establish ALBs or subsidiaries to ALBs in order to avoid or weaken parliamentary scrutiny