Department of Health

NHS England

NHS public health functions agreement 2015-16

Public health functions to be exercised by NHS England

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Introduction

The NHS has a critical part to play in securing good population health. This agreement between the Secretary of State for Health and NHS England enables NHS England to commission certain public health services that will drive improvements in population health.

Local government has responsibility for taking steps to improve the public's health, supported by the independent expertise of Public Health England (PHE) which is an executive agency of the Department of Health (DH). NHS England has a specific role to commission those public health services set out in this agreement and DH is the overall steward of the system. Direct commissioning of public health services by NHS England provides the public with evidence-based, safe and effective services, supported by information and expert advice from PHE.

This agreement sets out outcomes to be achieved by NHS England and arrangements for funding from the public health budget. The spirit of this agreement is a shared commitment to protect and improve the public's health. DH, NHS England and PHE share the vision of working in partnership to achieve the benefits of this agreement for the people of England. In line with the Government's strategies for the NHS and the public health system, we aim to:

- improve public health outcomes and reduce health inequalities
- contribute to a more sustainable public health, health and care system

This agreement sets out shared expectations for future years in order to assist effective planning. The Secretary of State expects that the objectives stated in Chapter 1 will remain largely stable from year to year.

1. NHS public health functions 2015-16

1.1. This agreement sets out the arrangements under which the Secretary of State delegates to NHS England responsibility for certain elements of the Secretary of State's public health functions, which add to the functions exercised by NHS England under the National Health Service Act 2006 ("the 2006 Act"). This agreement is made under section 7A of the 2006 Act.

1.2. This agreement focuses on achieving positive health outcomes for the population and reducing inequalities in health, through provision of the services listed in Annex A [("s.7A services")]. This reflects the two high level outcomes set out in the Public Health Outcomes Framework ("PHOF") referenced in Annex B.

1.3. NHS England is accountable to the Secretary of State for how well it performs its responsibilities under this agreement, and how well it drives improvement in s.7A services. In particular NHS England has agreed to achieve the following objectives.

1.4. NHS England's **first objective** under this agreement is to provide high quality s.7A services with efficient use of resources, seeking to achieve positive health outcomes and reducing inequalities in health. Achieving this objective would mean that:

- the national level of performance for each s.7A service has been improved or at least maintained, in relation to the relevant indicator or indicators set out in Annex B or otherwise a key performance indicator for the service (as described in paragraph 3.13)
- variation in local levels of performance between different geographical areas will have been reduced (while national and local levels of performance have been improved or maintained)
- NHS England will have shown evidence in relation to high quality of services that:
  - this agreement's specifications for s.7A services will have been fully implemented in contracts with providers
  - quality of patient experience will have been assessed as being both satisfactory and improving (to the extent that suitable data are available)
- NHS England will have commissioned those public health services set out in this agreement within the financial allocations described in Chapter 4 (Finance). Those allocations have been set at levels that reflect expectations of efficiency gains in commissioning.

1.5. NHS England has responsibility to deliver changes in s.7A services at pace and scale from those provided in 2014-15. NHS England's **second objective** is to implement planned changes in s.7A services in a safe and sustainable manner, promptly and thoroughly. Achieving this objective for 2015-16 would mean that:

- childhood flu immunisation will have been rolled out to offer vaccination to all children aged 2 to 6

- Immunisation against meningococcal B (MenB) for infants will have been rolled out, subject to DH and PHE procurement of the vaccine for this programme at a cost-effective price.
- NHS England has secured and maintained
  - the planned increase in the number of health visitors to an overall total of 12, 292 FTEs,
  - the planned increase in the number of Family Nurse Partnership (FNP) places to 16,000

  Including if necessary remedying any shortfall occurring at April 2015 before the transfer of commissioning responsibility for children's public health services (from pregnancy to age 5) to local authorities on 1st October 2015.
- NHS England has worked successfully with partners as follows:
  - alongside Health Education England, it has through commissioning levers supported qualified health visitors emerging from the training cohort begun in autumn 2014 into employment;
  - alongside the FNP National Unit, it has commissioned and supported FNP places to deliver the programme in accordance with the FNP license agreement
  - it has continued to commission the health visiting service transformation that was already in place at April 2015 and has maintained momentum around ongoing service transformation
  - with local authorities, it has played a major part in the smooth and effective transfer of the 0 – 5 years commissioning role to local authorities at 1 October;

  It is noted that assessment of the part of this objective relating to work with partners in relation to children's services will be informed by the views of the DH 0 to 5 Public Health Commissioning Transfer Programme Board.

Annex B further describes key deliverables in relation to achievement of this objective. Managing the transition to local authorities of children's public health services, including health visiting and family nurse partnership services, is a responsibility of DH and is not an objective under this agreement.

1.6. Where the first objective mentions local levels of performance, this refers to data of national levels of performance that are routinely published in disaggregated form appropriate to the collection, such as data for local authority areas.

1.7. In the longer term, in relation to those public health services which the parties expect to be commissioned by NHS England beyond 2016, there is a shared expectation that over a period of years NHS England will seek to raise national levels of performance in those services to align more closely with clinical advice as to public health outcomes. While this is not an objective for which NHS England is accountable, it may influence the manner in which reporting is carried out under the arrangements described in Chapter 3 (Accountability and Partnership).

2. Legal framework

2.1. Pursuant to this agreement, NHS England will exercise functions of the Secretary of State described in sections 2, 2A, 2B and 12 of the 2006 Act so as to provide or secure the provision of s.7A services (as described in paragraph 1.3). Where NHS England exercises these functions, they may be referred to in this document as "NHS public health functions".

2.2. NHS England was established as the National Health Service Commissioning Board by section 1H (1) of the 2006 Act. NHS England is a commissioning organisation, as made clear by its principal functions set out in section 1H(3) of the 2006 Act.

2.3. With the exception of children's public health services for persons from pregnancy to age 5, the services listed in Annex A are to be provided or secured from 1 April 2015 to 31 March 2016. Those children's services are to be provided or secured pursuant to this agreement from 1 April 2015 to 30 September 2015 and on 1st October those commissioning responsibilities will transition to local authorities. The child health surveillance additional service will not be affected.

2.4. The provision of the services listed in Annex A are steps which the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health, and may therefore be provided and arranged pursuant to the Secretary of State's duty under section 2A of the 2006 Act. Alternatively or in addition, with the exception of screening programmes and cancer screening programmes, the provision of the services listed in Annex A are steps the Secretary of State considers appropriate to improve the health of the people of England and may therefore be provided or arranged pursuant to the Secretary of State's power in section 2B of the 2006 Act.

2.5. This agreement is intended to include functions of the Secretary of State mentioned in paragraph 2.1 within the framework of other responsibilities of NHS England. By virtue of section 13Z4 of the 2006 Act (interpretation), references in the statutory provisions listed in that section to NHS England's functions include functions exercisable under section 7A arrangements. The effect is that the provisions listed in section 13Z4; including the provisions on NHS England's general duties as to improvement in quality of services and reducing inequalities, apply to the functions exercised by NHS England under this agreement as they do to its other functions.

2.6. This agreement is separate from and in addition to the objectives set for NHS England by virtue of the Mandate published by the Secretary of State under section 13A of the 2006 Act ("the Mandate").

2.7. Furthermore, this agreement applies only to the exercise of Secretary of State public health functions referred to in paragraph 2.1 above and does not apply to other functions of NHS England including in particular:

i. arranging the provision of services under NHS England's primary care functions, that is arrangements made under the following provisions of the 2006 Act:

- sections 83, 84 and 92 (primary medical services)

- sections 99, 100 and 107 (primary dental services)
- section 115 and 117 (primary ophthalmic services)
- sections 126 and 127 (pharmaceutical services)
- sections 134 and 127 (pharmaceutical services)

ii. Arranging the provisions of services under regulations made under section 3B of the 2006 Act (specialised and other services), and high secure psychiatric services (section 4 of the 2006 Act),

iii. NHS England's responsibilities for emergency preparedness or emergencies, including arrangements made under section 252A of the 2006 Act, and

iv. NHS England's responsibilities in relation to clinical commissioning groups, including functions under Chapter A2 of Part 2 of the 2006 Act.

2.8. NHS England may however exercise its other functions in order to deliver the objectives set out in Chapter 1, as described in paragraph 3.8 below.

2.9. NHS England's duty to make an annual report on how it has exercised its functions (section 13U of the 2006 Act) applies to the functions exercised under this agreement. NHS England may include any part of the statement required under paragraph 3.14 as part of that annual report or as a separate document provided to DH no later than the date on which that annual report is laid before Parliament.

2.10. This agreement is not a contract in law and should not be regarded as giving rise to contractual rights or liabilities. The Secretary of State and NHS England will jointly aim to resolve any dispute that might arise in relation to this agreement as quickly as possible through the processes outlined in this agreement.

2.11. As set out in section 7A(5) of the 2006 Act, any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by NHS England of any functions exercisable by it by virtue of this section are enforceable by or against that body (and no other person).

2.12. In this agreement, references to "DH" are to the parts of the Department of Health other than PHE.

2.13. The Secretary of State and NHS England may be referred to in this document as "the parties" where this is convenient.

3. Accountability and partnership

3.1. Critical elements of the relationship between DH and NHS England are defined in the Framework Agreement concluded between them in 2014. The agreed set of shared principles that supports development of the relationship is:

- Working together with each other, and with the Department's other arm's length bodies, for patients, people who use services and the public, demonstrating our commitment to the values of the NHS set out in its Constitution;
- Respect for the importance of autonomy throughout the system, and the freedom of individual organisations to exercise their functions in the way they consider most appropriate;
- Recognition that the Secretary of State is ultimately accountable to Parliament and the public for the system overall. NHS England supports the Department in the discharge of its accountability duties, and the Department supports NHS England in the same way;
- Working together openly and positively. This will include working constructively and collaboratively with other organisations within and beyond the health and social care system.

Oversight arrangements

3.2. DH will convene meetings of an oversight group which will be chaired by the DH Director General for Public Health. The oversight group is currently known as the NHS public health functions senior oversight group. The oversight group:

- provides arrangements for accountability in relation to this agreement
- may make reports and recommendations to the Secretary of State and NHS England, including any recommendations in relation to proposed updates of or variations to this agreement.

3.3. Membership of the oversight group will include the NHS England National Director - Commissioning Operations and the PHE Chief Executive. Membership otherwise will be determined by the chair of the oversight group with the consent of the NHS England National Director - Commissioning Operations.

3.4. The oversight group will determine its own working arrangements, including the functions of any subgroups. There is currently one general subgroup, known as the NHS public health steering group which has functions that include implementing arrangements for effective partnership working. (The Health Visiting programme board will continue to report to the oversight group while NHS England has commissioning responsibility for that programme.)

3.5. The oversight group, or as appropriate the steering group, will ensure that systems are in place to provide advanced information in relation to all priorities for s.7A services so that these are considered wholly or mainly as part of an annual commissioning cycle. This will include discussing plans at a formative stage so as to inform programme decisions by the Secretary of State on prospective changes, such as :

- a new or changed service that would be requested to be commissioned by NHS England under the functions mentioned in paragraph 2.1
- a request for roll-out of a service development by NHS England following a pilot phase, or
- consideration by DH or PHE of a pilot for a service, or an extension to a service, that in future would be requested to be commissioned by NHS England under these functions.

3.6. The parties expect that NHS England will be requested to commission the bowel scope screening programme from April 2016 with sufficient resources to undertake this commissioning, while PHE continues to be responsible for the roll out of this programme in 2015-16. NHS England will work with PHE in 2015-16 to help deliver the involvement of screening centres sufficient to meet the planned rollout and to support preparatory steps in other bowel cancer screening centres to implement by the end of 2016. The oversight group, or as appropriate the steering group, will discuss plans for the transfer of commissioning responsibility.

3.7. The oversight group is expected to have regard to the views of NHS England on the exercise of functions by NHS England under this agreement having regard to its other functions including those mentioned in paragraphs 2.5 to 2.7. Arrangements in relation to consideration of a prospective variation to this agreement are given in paragraphs 3.16 to 3.24.

3.8. The parties recognise that the objectives set out in Chapter 1 which are terms of this agreement may be delivered by a combination of the performance by NHS England of functions under this agreement and the exercise of its other functions, including primary care functions. An example is the commissioning of childhood immunisations through primary care contracts. For purposes of accountability, the Secretary of State and NHS England recognise that the funding provided under this agreement in accordance with paragraph 4.1 below is intended to provide the resources necessary to achieve the objectives of this agreement having regard to contributions expected to be made by the exercise of NHS England's other functions.

Assurance and reports

3.9. Assurance of performance of this agreement will be consistent with the principles mentioned in paragraph 3.1, without imposing excessive burdens. In particular, NHS England is working towards improving financial transparency for the total funding mentioned in Chapter 4 (that is, ring-fenced and non-ring fenced sums). NHS England is committed to openness and transparency of the total funding; achieving this is subject to having access to reliable data and sufficient capacity in NHS

England to continue to improve on the reporting of public health allocations and spend.

3.10. NHS England will provide or secure the following information for assurance at regular intervals:

- quarterly reports of relevant indicators of the Public Health Outcomes Framework in relation to national levels of performance of s.7A services
- reports of progress in relation to achievement of objectives of this agreement in relation to reducing variation in local levels of performance, and securing the full implementation of service specifications in contracts with providers (subject to 3.11 below)
- reports of financial information for each quarter of the financial year that show a breakdown of planned and actual expenditure on s.7A services within five weeks of the end of each quarter, in line with the matters stated in paragraph 3.9 (the oversight group will keep these arrangements under review and may request interim progress reporting on the non-ring-fenced sum)

3.11. The oversight group or as appropriate the steering group may determine what if any further information is suitable for the purpose of assurance of progress in relation to achievement of the objectives of this agreement. It is noted that a few time-limited derogation arrangements may still be appropriate at 31 March 2016 in relation to the full implementation of service specifications mentioned in paragraph 1.4. .

3.12. The following boards and other groups are recognised as contributing information and advice to the steering group, whether or not this is one of their main responsibilities. It is noted that, in fulfilling these functions, each of the following boards and other groups has membership including DH, PHE and NHS England and that each works in ways consistent with the shared principles set out in paragraph 3.1.

- Immunisation programme board
- Childhood flu immunisation programme board
- Screening programme board
- Secure and detained assurance group
- Sexual assault referral centres delivery assurance group
- Child health information systems programme board
- Health Visiting programme board/Family Nurse partnerships programme board

3.13. The steering group expects to invite certain proposals from the boards and other groups mentioned in paragraph 3.12. This invitation would seek to define proposals, by agreement in those boards or groups, for :

- any additional key performance indicators that should be used from existing measures, for example where reports of indicators of the Public Health

Outcomes Framework would not provide sufficient or timely evidence of a changing level of national performance

- rules for any RAG (Red, Amber, Green) rating of s.7A services, including where appropriate measures which reflect alignment with clinical advice as mentioned in paragraph 1.7

Any proposals made will be subject to determination as described in paragraph 3.11. The expectations described in this paragraph do not apply to the Health Visiting programme board or Family Nurse Partnership programme board.

3.14. NHS England will report annually to the Secretary of State in relation to this agreement on its achievement of the objectives set out in Chapter 1. NHS England will report to the Secretary of State after the end of each financial year on the use of the funding allocated under paragraph 4.1 and, if different, the total expenditure attributable to the performance of functions pursuant to this agreement. This annual statement will include a breakdown showing expenditure for each programme category or programme listed in Annex A.

3.15. Further provisions for the annual statement are that:

- the annual statement may include performance information for a period before 31 March 2015, where this is necessary for effective reporting (for example, where indicators of the Public Health Outcomes Framework are reported at annual intervals)
- the annual statement in relation to children's public health services from pregnancy to age 5 shall address performance up to 30 September 2015 only.

Changes

3.16. This agreement reflects consideration of priorities for an annual commissioning cycle, as mentioned in paragraph 3.5. This agreement may be varied by the Secretary of State and NHS England by written agreement. However such variations can never be routine, and the parties note that the achievement of the objectives of this agreement could potentially be jeopardised by unplanned changes. No variation or update for 2015-16 is expected other than.

- providing or updating a service specification for the MenB immunisation programme
- a variation to bring into effect key performance indicators or reporting arrangements as mentioned in paragraphs 3.11 to 3.13
- a controlled change of a service specification (as a technical update of minor consequence) as described in paragraph 3.23

3.17. Exceptional circumstances may however require consideration of a prospective variation to this agreement and the oversight group may recommend a variation. A prospective variation will include any prospective change that would have an impact on the commissioning obligations of NHS England under this agreement, unless or until the steering group deems it to be of minor consequence in line with the

arrangements described in paragraph 3.24. The circumstances in which a prospective variation to this agreement may be considered include:

- a significant new threat to the health of the people of England, or
- an unexpected and significant new opportunity to protect their health

3.18. Consideration of a prospective variation (other than that expected by paragraph 3.16) should address the following factors, which are similar to considerations made before reaching this agreement:

- evidence of impact, cost-effectiveness and cost saving
- other evidence of rationale, including obligations under the NHS Constitution and NHS England Mandate
- assessment of deliverability within existing operational resources, including commissioning capacity
- any mitigating measures, such as lower expectations of performance in other services while delivery is implemented
- any alternative options or timelines for delivery
- affordability and confirmation of the availability of sufficient financial resources for delivery

3.19. In particular, noting the context of a stable Mandate for 2015-16, the parties would expect to engage in thorough consideration of the affordability and financial matters mentioned in para 3.18. DH expects that this will involve the views of the DH Director General of Policy, Strategy and Finance and the NHS England Chief Financial Officer at a formative stage before recommendations on programme decisions are considered by Ministers.

3.20. It is noted that under section 13B of the 2006 Act, if the Secretary of State varies the amount of money specified under section 223D(2) (total revenue resource use), the Secretary of State must revise the Mandate accordingly. The resource limit for NHS England is specified in 4.4.

3.21. The parties are committed to undertaking timely and efficient consideration of any prospective variation. The parties consider that public announcements about the likelihood of any additional commissioning being implemented by a prospective variation should be avoided until either a recommendation has been made by the oversight group, or the steering group has deemed the prospective change to be of minor consequence in line with the arrangements described in paragraph 3.24. DH will seek to ensure that PHE's public communications are consistent with this approach in relation to advisory committees' advice or recommendations on s.7A services or any prospective variation to this agreement.

3.22. Consideration of technical updates of minor consequence may arise in relation to the service specifications in Annex C which set out requirements for and evidence underpinning each service to be commissioned. PHE has responsibility, as part of its functions as an executive agency funded by DH, for keeping service specifications under review as part of its role in offering scientifically rigorous and impartial advice, evidence and analysis to support NHS England's functions.

3.23. The service specifications may be updated by agreement between the parties:

- as described in paragraphs 3.16 and 3.17 by means of a variation to this agreement, considered by the oversight group , or
- as described in paragraph 3.24 by means of a controlled change, considered by the steering group

3.24. A controlled change of a service specification is a variation that is deemed by the steering group to be of minor consequence and is not appropriate for consideration by the oversight group. The steering group may determine arrangements (a minor changes protocol) to assess the case for a proposed controlled change and its consequences, with a view to recommending approval by the parties of an updated service specification.

3.25. Commissioners and providers will be encouraged to access the electronic published document of any service specification, rather than any printed copies, in order to ensure reference to the document that is in effect. Service specifications may accordingly be referred to as controlled or controllable documents.

3.26. The oversight group or as appropriate the steering group may provide joint guidance for commissioners and providers which may inform the carrying out of the provisions of this agreement. Such guidance will assist interpretation on the basis of a common understanding, for example where minor changes in circumstances have occurred.

Information

3.27. To fulfil the purposes of this agreement, DH, PHE and NHS England should each have the same timely and objective information available to them. It is necessary that public health experts and officials responsible to the Secretary of State, including the Government's Chief Medical Officer, receive information in relation to matters of expert, clinical or Parliamentary concern at the earliest possible time.

3.28. DH will ensure that PHE shares information about emerging evidence and the work of its advisory committees, in line with the arrangements described in paragraph 3.5.

3.29. NHS England and PHE will share performance information in relation to s.7A services. NHS England will also ensure that relevant unpublished information of appropriate quality is shared on a timely basis with PHE and DH for the purpose of assisting the Secretary of State to exercise his functions. PHE should similarly share relevant unpublished information, for example about issues of expert concern.

3.30. NHS England will without delay inform DH in writing of any significant concerns it has in relation to the delivery of s.7A services by providers

Dispute resolution

3.31. As indicated in paragraph 2.9, any differences should be resolved quickly and constructively. The following provisions describe procedures to be followed to resolve any dispute in relation to:

- the exercise of functions under this agreement
- any aspect of collaboration in relation to this agreement under section 7A of the 2006 Act.

3.32. At their discretion, an authorised senior representative of NHS England or DH may at any time declare a dispute under this agreement by a written notice to the chair of the oversight group. The notice should provide information about the dispute and how resolution of the matter has been attempted and failed. The day when the chair is notified is the “date of notification”. The chair will have joint responsibility with the National Director - Commissioning Operations of NHS England to resolve the dispute.

3.33. Any dispute remaining unresolved after a maximum of 5 working days from the date of notification shall be reported to the Chief Executive of NHS England, the DH Director General Policy, Strategy & Finance, and the DH Permanent Secretary. They shall take steps to resolve the dispute within no more than 10 working days from the date of notification.

3.34. If the matter is not resolved in accordance with paragraph 3.33, the matter must be referred to the Secretary of State for final determination. The Secretary of State must, after consultation with NHS England, appoint a person independent of DH, PHE and NHS England to consider the dispute and make recommendations, within a period specified by the Secretary of State on appointment. The Secretary of State must make a final decision within 10 days of receiving the recommendations. DH and NHS England agree to be bound by the decision of the Secretary of State and to implement any decision within a reasonable period.

3.35. This agreement is without prejudice to the exercise of the Secretary of State’s powers in respect of NHS England, including his powers in relation to any failure by NHS England to discharge, or to discharge properly, any of its functions (section 13Z2 of the 2006 Act).

4. Finance

4.1. The Secretary of State agrees to pay NHS England the sum of £1804m from the public health budget for the purposes of performing the Secretary of State's functions pursuant to this agreement during the financial year 2015-16 (in addition to the funding referred to in paragraph 4.3). This is ring-fenced funding that may be used only for expenditure attributable to the performance of functions pursuant to this agreement.

4.2. This does not preclude NHS England from choosing to allocate additional resources to prioritise public health spend within its overall resource limit(s).

4.3. As mentioned in paragraphs 3.8 and 3.9, there are contributions expected to be made by the exercise of NHS England's other functions. Accordingly there is a non-ring-fenced sum attributable to the public health budget for services provided through primary care which is included within the total allocation of resources to NHS England under sections 223B and 223D of the 2006 Act.

4.4. The revenue resource limit for NHS England for the year 2015-16, as specified in the Mandate has been set so as to take into account the funding provided under this agreement under paragraph 4.1.

4.5. NHS England will report to the oversight group any expected underspending of the funding allocated under paragraph 4.1 so that DH can take account of this in HM Treasury carry forward arrangements.

4.6. It is noted that the funding mentioned above (paragraph 4.3) includes implementation, if appropriate, of the proposed new MenB immunisation programme during 2015/16. NHS England will not be expected to implement this at a greater pace or scale than has been set out in the financial planning assumptions. These assumptions inform the 2015-16 S7A funding allocation as set out in paragraph 4.3.

4.7. A further agreement will be made to reduce the S7A ring fenced sum to reflect the transfer of commissioning responsibilities for children's 0-5 public health services from NHS England to Local Authorities on 1st October 2015.

4.8. The S7A funding that NHS England has received for 0-5 children's public health programme has taken into account the full year effect of the increasing numbers of health visitors and FNP places. NHS England will work with the DH to confirm the level of funding to be transferred back to DH in respect of this programme. The transfer should match the funding NHS England spends on 0-5 services within scope as a 'lift and shift'. Where there is any variation to these agreed principles, the DH and NHS England will work together to understand the financial impact on the agreement as a whole. At that point DH and NHS England have agreed that they will look again at the S7A agreement and re-prioritise programmes, if necessary, to ensure that the whole agreement remains deliverable within the ring-fenced sum.

Annex A – “s.7A services”

Services to be provided 2015-16

Each of the services in the following list is described in a service specification (Annex C).

List of services to be provided pursuant to this agreement

Programme category or programme	**Services**
Immunisation programmes	Neonatal hepatitis B immunisation programme
	Pertussis pregnant women immunisation programme
	Neonatal BCG immunisation programme
	Respiratory syncytial virus (RSV) immunisation programme
	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis and Hib
	Rotavirus immunisation programme
	Meningitis B (MenB) immunisation programme – in accordance with paragraph 1.5 (service specification to follow)
	Meningitis C (MenC) immunisation programme
	Hib/MenC immunisation programme
	Pneumococcal immunisation programme
	DTaP/IPV and dTaP/IPV (pre-school booster) immunisation programme
	Measles, mumps and rubella (MMR) immunisation programme
	Human papillomavirus (HPV) immunisation programme
	Td/IPV (teenage booster) immunisation programme
	Seasonal influenza immunisation programme

	Seasonal influenza immunisation programme for children
	Shingles immunisation programme
Screening programmes	NHS Infectious Diseases in Pregnancy Screening Programme
	NHS Down's Syndrome Screening (Trisomy 21) Programme
	NHS Fetal Anomaly Screening Programme
	NHS Sickle Cell and Thalassemia Screening Programme
	NHS Newborn Blood Spot Screening Programme
	Newborn Hearing Screening Programme
	NHS Newborn and Infant Physical Examination Screening Programme
	NHS Diabetic Eye Screening Programme
	NHS Abdominal Aortic Aneurysm Screening Programme
Cancer screening programmes	Breast Screening Programme
	Cervical Screening
	Bowel Cancer Screening Programme
Children's public health services (from pregnancy to age 5) until 30th September 2015	Healthy Child Programme and Health Visiting (universal offer)
	Family Nurse Partnership (nationally supported targeted offer)
Child Health Information Systems	Child Health Information Systems
Public health care for people in prison and other places of detention	Public health services for people in prison and other places of detention, including those held in the Young People's Secure Estate
Sexual assault services	Sexual assault referral services

Annex B – Performance indicators and key deliverables

Performance indicators

1 The indicators shown in the following list are to be used as evidence in relation to the achievement of the first objective in Chapter 1. Additional evidence may also be offered, including key performance indicators as described in paragraph 3.12.

2 Where a previous level of national performance is shown in the list, it records the minimum level that should be maintained for the purposes of the first objective. Any insignificant difference in the level of performance may be disregarded for that purpose, as may any insignificant differences between quarterly or monthly data and the annual level of performance for the same year.

3 Except where marked (**) the indicators mentioned in this list are indicators published in the Public Health Outcomes Framework. This refers to:

- the policy documents 'Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-16' as updated in November 2013 www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
- the data tool www.phoutcomes.info/

Other references and sources are identified for those items marked **

List B1: Performance indicators for services provided pursuant to this agreement

Performance indicators	**Previous level of national performance**	**Year, or time period**
Immunisation programmes **Pertussis vaccine uptake for pregnant women **** Health Protection Report Vol.8. No.17 http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/hpr/archives/2014/hpr1714.pdf		October 2013-March 2014

Pertussis vaccine coverage estimates (average of monthly estimates) *(The last published provisional data indicated that coverage was around 60%, October 2013 – March 2014. Due to move from manual to automated collection and a change in denominator definition, new data due to be published suggests coverage of 53-56%. This is understood to be an accurate reflection of coverage).*	To be confirmed	
Rotavirus vaccination coverage ** Health Protection Report Vole 8 No. 12 http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/hpr/archives/2014/hpr1214.pdf		
Rotavirus vaccination coverage - children evaluated at 25 weeks of age– First dose	To be confirmed	
Rotavirus – completed the two dose course *(Early evidence from GP systems suggests that 93% of children aged 25 weeks in February 2014 had received at least 1 dose, and 88% had received 2 doses, July 2013 to March 2014).*	To be confirmed	
Population vaccination coverage (as defined in Public Health Outcomes Framework indicator 3.3)		
3.3iii: DTaP/IPV/Hib vaccination coverage (1 and 2 year olds)	94.7% at age 1 96.3% at age 2	2012-13
3.3iv: MenC vaccination coverage (1 year olds)	93.9%	2012-13
3.3v: PCV vaccination coverage (1 year olds)	94.4%	2012-13

3.3vi: Hib/MenC booster vaccination coverage (2 and 5 year olds)	92.7% at age 2 91.5% at age 5	2012-13
3.3vii: PCV booster vaccination coverage (2 year olds)	92.5%	2012-13
3.3viii: MMR vaccination coverage for one dose (2 year olds)	92.3%	2012-13
3.3ix: MMR vaccination coverage for one dose (5 year olds)	93.9%	2012-13
3.3x: MMR vaccination coverage for two doses (5 year olds)	87.7%	2012-13
3.3xii: HPV vaccination coverage (females 12-13 year olds)	86.1%	2012-13 academic year
3.3xiii: PPV vaccination coverage (aged 65 and over)	69.1%	2012-13
Flu vaccination coverage ** www.gov.uk/government/uploads/system/uploads/attachment_data/file/319694/2902494_FluVaccineUptake_GPPatients2013-14_acc.pdf		
3.3xiv: Flu vaccination coverage (aged 65 and over)	73.2%	2013-14
3.3xv: Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)	52.3%	2013-14
Flu vaccination coverage (pregnant women)	39.8%	2013-14
Flu vaccination coverage (children aged two years old including those in risk groups)	42.6%	2013-14
Flu vaccination coverage (children aged three years old including those in risk groups)	39.5%	2013-14
Shingles vaccination coverage ** www.gov.uk/government/uploads/system/uploads/attachment_data/file/355892/hpr3514.pdf Cumulative shingles vaccine coverage in England by age cohorts		

1 September 2013 to end July 2014 Percentage of age cohort vaccinated (70-year olds) Percentage of age cohort vaccinated (79-year olds) *(Published provisional data on uptake rates for the period September 2013 - July 2014 shows that uptake is 60% for 70-year olds and 58% for 79-year olds. Full year data will be available subsequently. The 79-year old cohort is applicable until September 2015)*	 To be confirmed To be confirmed	September 2013 to end July 2014
Screening programmes **Access to non-cancer screening programmes (as defined in Public Health Outcomes Framework indicator 2.21)** http://www.screening.nhs.uk/kpi/data-collection 2.21i: HIV coverage: percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result 2.21iii: The percentage of pregnant women eligible for antenatal sickle cell and thalassemia screening for whom a conclusive screening result is available at the day of report 2.21iv: The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe	 98.9% 98.9% 93.5%	 2013-14 2013-14 2013-14
2.21v: The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes - well babies, all programmes - NICU babies) or 5 weeks corrected age (community programmes – well babies)	97.8%	2013-14

2.21vi The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth *(Early evidence from limited number of providers indicates 90.9% coverage)*	Not yet available	2013-14
2.21vii: The percentage of those offered screening for diabetic retinopathy who attend a digital screening event	80.2%	2012-13
NHS Abdominal Aortic Aneurysm Screening Programme *(Early evidence Key Performance Indicator pilot indicates 95.9%)* **The proportion of men eligible for abdominal aortic aneurysm screening to whom an initial offer of screening is made. ****	Not yet available	2013-14
Cancer screening programmes **Cancer screening coverage (as defined in Public Health Outcomes Framework indicator 2.20)**		
2.20i: The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period	76.3% coverage aged 53-70	Published in 2013
2.20ii: The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	73.9% coverage aged 25 to 64	Published in 2013
Bowel cancer screening programme **FOBt (faecal occult blood testing) Screening Coverage **** Source: NHS Cancer Screening Programmes	55.4%	Men and women eligible for routine FOBT screening on 30th November 2013 (This allows 6 months for episodes to complete)

Children's public health services (from pregnancy to age 5) NOTE – Provisions in relation to these services are for performance up to 30 September 2015 only **The Government's commitment to increase the number of health visitors by 4,200 against a May 2010 baseline of 8,092 and to transform health visiting services by April 2015. **** NHS workforce statistics - Health Visiting Minimum Data Set (June 2014, provisional statistics) www.hscic.gov.uk/searchcatalogue?productid=15436&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top	10,350 FTE qualified health visitors (ESR and non-ESR)]	June 2014
Low birth weight of term babies (as defined by the Public Health Outcomes Framework indicator 2.1) 2.1: Percentage of all live births at term with low birth weight	2.8%	2011
Breastfeeding (as defined in Public Health Outcomes Framework indicator 2.2) 2.2i: Breastfeeding initiation 2.2ii: Breastfeeding prevalence at 6-8 weeks after birth	73.9% 47.2%	2012-13 2012-13
Excess weight in 4-5 year olds (as defined in the Public Health Outcomes Framework indicator 2.6) 2.6i: Percentage of children aged 4-5 classified as overweight or obese	22.2%	school year 2012-13
Hospital admissions caused by unintentional and deliberate injuries in under 18s (as defined in the Public Health Outcomes Framework indicator 2.7) 2.7: Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in age 0-4 years, per 10,000 resident population.	134.7	2012-13
Infant mortality (as defined in the Public Health Outcomes Framework indicator 4.1 - shared		

indicator with NHS Outcomes Framework 1.6i) 4.1: Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births **Tooth decay in children aged five (as defined in the Public Health Outcomes Framework indicator 4.2)** 4.2: Rate of tooth decay in children aged 5 years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth (dmft) **Maintain and extend coverage of local delivery of the Healthy Child Programme, moving towards delivery of the full service specification. ****	4.1 deaths per 1,000 live births 0.94	2010-12 2011-12

Key deliverables

List B2: Key deliverables for implementing change from services provided in 2014-15

Key deliverables (shown in bold)
Childhood flu Immunisation programme **In 2015-16, NHS England will:** **a) arrange provision of childhood flu vaccination for all 2, 3 and 4 year olds;** **b) arrange provision for childhood flu vaccination for all children eligible for schooling in years 1 and 2 (i.e. 5 and 6 year olds, including those who turn 7 on or after 1 September 2015); , and** **c) Continue to arrange provision for all primary school aged children in those areas included in the 2014-15 pilots for primary school aged children**. The best uptake of vaccination among 5 to less than 17 year olds is likely to be achieved through a predominantly school-based programme, with a limited provision in other community settings in some localities. However, it is recognised that the capacity of existing school nursing and immunisation teams is not currently sufficient to enable the programme to be offered to all children in this way. Work is being undertaken jointly by DH and NHS England, and with PHE, Health Education England and professional bodies to: • support the workforce development of sustainable long-term solutions to ensure delivery of flu vaccination to all children aged 2 to less than 17, • ensure the availability of sufficient appropriately-trained staff, and • work with local government to develop the associated commissioning arrangements for school nursing to deliver the programme
MenB immunisation programme **In 2015-16, NHS England will Implement as far as reasonably practicable the proposed new MenB immunisation programme for infants, subject to the vaccine being procured by DH and PHE at a cost-effective price.**
Children's public health services (from pregnancy to age 5) **NHS England will aim to secure a steady state regarding the numbers and availability of health visitor posts and numbers of FNP places across the commissioning transition in 2015-16 by working closely with local authorities, Health Education England and the FNP National Unit. NHS England will continue to**

assure continuing momentum for transformation of the Health Visitor programme with a focus on commissioner-led system-wide transformation, including where appropriate in the view of NHS England programme-funded initiatives towards sustainable change.

In the context of the 0-5 programme, Area Teams are expected to maintain their performance in delivering (or making good any shortfall against 12,292 FTE health visitor numbers up to the point of transferring the 0 – 5 years commissioning role to local authorities. It is acknowledged that this requires close working with local authorities, such that sustainability of the workforce (numbers) going forward is engendered through joint dialogue about transition arrangements, especially those relating to contracts. This element of transition planning should aspire to a steady state regarding the numbers and availability of health visitor posts into the second half of the year, (and beyond the terms of this agreement), such that there is no reduction in the overall number of health visitors in employment.

Area Teams are similarly expected to maintain their performance in commissioning 16,000 FNP places by the end of March 2015 2015 and to deliver the FNP programme in line with the FNP license agreement. This requires close working with local authorities, to ensure those FNP places and teams established by October 2015 have stability through the transition of 0-5 commissioning responsibility.

Whilst overall leadership of the transition of the commissioning role for children's public health services, including health visiting services, is an objective of the DH 0 to 5 Public Health Commissioning Transfer Programme Board (of which NHS England is a key member), it is important that NHS England and its area teams engage in close effective joint working with local authorities in the period up to October 2015. This will help facilitate a smooth and safe transition of the 0 – 5 years services commissioning role.

Joint working with Health Education England (HEE) is important so that both organisations combine to support the autumn 2014 health visitor training cohort into employment, as their courses complete in 2015. This work should align with the deliverable of aiming to secure a steady state which can be sustained. It is noted that t The need for HEE's reciprocal input to this aim is reflected in its own mandated agreement. Collaborative work should involve timely communication with the trainees concerned about where posts may be available, and effective system wide working and dialogue to maximise employment of trainees.

The service transformation deliverables for the Health Visitor programme are:

- full delivery of new model of health visiting including universal elements of healthy child programme
- Ensure that commissioning of public health services for 0-5s is effective and embedded with commissioning of other early years services.
- Improvement in defined public health outcomes.

The above is not dependent on availability of additional, specific transformation funding and can be pursued through:

- inputs to support transformation (such as the contracting process);
- outputs (service delivery metrics and service transformation dashboard)

subject to data availability;

- Progress in improving public health outcomes to which health visiting makes a contribution.

Annex C – Service specifications

This agreement includes service specifications which set out requirements for, and evidence underpinning, each service to be commissioned in 2015-16. These are published as separate documents. In each case the service specification comes into effect from 1 April 2015, in accordance with paragraph 2.3.

This agreement includes the following service specifications in List C1.

Commissioners and providers should always download service specifications from GOV.UK to ensure that the latest 2015-16 document is used. All specifications can be found at:

https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2015-to-2016

List C1: 2015-16 service specifications

Number	
	Immunisation programmes:
0	Core Immunisation service specification
1	Neonatal Hepatitis B immunisation programme
1A	Pertussis pregnant women immunisation programme
2	Neonatal BCG immunisation programme
3	Respiratory syncytial virus (RSV) programme
4	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis, and Hib
5	Rotavirus immunisation programme
6	Meningitis C immunisation programme
7	Hib/MenC immunisation programme
8	Pneumococcal immunisation programme
9	DTaP/IPV and dTaP/IPV immunisation programme
10	Measles, mumps and rubella (MMR) immunisation programme
11	Human papillomavirus (HPV) programme
12	Td/IPV (teenage booster) immunisation programme
13	Seasonal influenza immunisation programme (2014-15 programme)

13A	Seasonal influenza immunisation programme for children (2014-15 programme)
14	Shingles immunisation programme
	Screening programmes
15	NHS Infectious Diseases in Pregnancy Screening Programme
16	NHS Down's Syndrome Screening (Trisomy 21) Programme
17	NHS Fetal Anomaly Screening Programme
18	NHS Sickle Cell and Thalassemia Screening Programme
19	NHS Newborn Blood Spot Screening Programme
20	NHS Newborn Hearing Screening Programme
21	NHS Newborn and Infant Physical Examination Screening Programme
22	NHS Diabetic Eye Screening Programme
23	NHS Abdominal Aortic Aneurysm Screening Programme
	Cancer screening programmes
24	Breast Screening Programme
25	Cervical Screening
26	Bowel Cancer Screening Programme
	Other programmes
27	Children's public health services (from pregnancy to age 5) – in effect until 30 September 2015
28	Child Health Information Systems (CHIS)
29	Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate

30	Sexual assault services