09 November 2015

**NHS England Annual Accountability Statement for NHS Public Health Functions (S7A) Agreement for 2014-2015**

## Background

1. NHS England through the S7A public health functions agreement commissions certain public health services that drive improvements in population health. The Secretary of State through the S7A agreement delegates' responsibility to NHS England to commission the following programmes:
   - National immunisation programmes.
   - National screening programmes.
   - Children's public health services from pregnancy to age 5 (until 1st October 2015).
   - Child Health Information Systems.
   - Public health care for people in prison and other places of detention.
   - Sexual assault services.

2. As part of the requirements in the NHS Public Health Functions Agreement (S7A) NHS England is asked to report annually to the Secretary of State on its achievement against the expected deliverables set out in the agreement. This letter constitutes the NHS England Annual Accountability Statement for the S7A for 2014/2015.

## Requirements of S7A agreement 2014/2015

3. The S7A agreement aimed to continue to ensure stability of delivery and outcomes. DH and NHS England agreed that the scope of changes for 2014/15 should focus on evidence that proposals would improve public health outcomes.

4. The S7A agreement sets out key deliverables which NHS England are expected to achieve over the course of the agreement. These deliverables set baselines using historic performance of the programmes and are matched as far as possible to measures used in the Public Health Outcomes Framework and are the measures of how well NHS England performs its responsibilities under the agreement.

5. The agreement in 2014/15 stated that where baselines are included in the agreement, NHS England should seek to improve or at least maintain the national level of annual performance for each key deliverable.

6. The S7A agreement set out two overarching ambitions for NHS England:
   - To increase the pace of change for the implementation of the national service specifications.
   - To set performance 'floors' to reduce the range of variation in local levels of performance.

## NHS England Achievement of S7A Requirements in 2014/2015

7. The key achievements for 2014/15 include:
    - The number of FTE Health Visitors employed on 31st March was 12,157 (source: IHVC)
    - There were 16,250 NHS England funded FNP places at end of 2014/15 exceeding the goal of 16,000.
    - NHS England has worked closely in partnership with the DH, Local Government Association and Public Health England to develop plans locally and nationally to ensure a successful and safe transfer of commissioning of 0-5s children's public health services from NHS England to local government on 1 October 2015.
    - Approximately 1,200,000 children received the flu vaccination
    - The Men C programme for university entrants was introduced
    - NHS England continued to commission three cancer screening, two non-cancer screening and six maternity and new-born screening programmes.
    - Public Health England has worked closely in partnership with NHS England to develop National service specifications, which are now in place setting out the expectations of S7A programmes

8. NHS England has continued to commission a very high standard of public health protection in England. Data and evidence demonstrates that public health protection remains world class and we have achieved real success in the last year. We anticipate our success will continue as many aspects of the future public health programme have been secured.

9. By implementing the ambitions in the S7A agreement approximately 30 million children, adolescents and adults have access to screening and immunisation programmes each year, which impacts significantly on the wider prevention programme and supports the changes required to implement 'a radical upgrade in prevention and public health' as set out in the Five Year Forward View (FYFV).

**Programme Delivery**

10. There was the expectation that 2014-15 would continue to be a year of stability. In fact there continued to be a large number of change programmes, in particular managing the process for a safe transfer of 133 commissioning contracts for 0-5 year old children's public health from NHS England to Local Authorities. The transfer and securing the childhood flu programme for 2015 and beyond have required a significant commitment from commissioners in operational planning and assurance.

11. Real strides have been achieved in particular for children. The health visitor programme and FNP programme have increased access for children with an increase in the number of health visitors by around 50% and increased FNP places. This has increased professional capacity, capability and leadership to support families to ensure children get the best possible start in life. The health visitor recruitment programme has delivered what is thought to be the biggest percentage professional growth ever achieved in the NHS in this timescale.

12. Another outstanding achievement in 2014/15 has been securing the future of the childhood flu programme for 2015-16 and 2016/17. The aspiration for the programme in 2014/15 was that 4 year olds would be offered vaccination by GPs, and some secondary school age pilots would be conducted for one year alongside the primary school age pilots which started in 2013-14. The estimated uptake of influenza vaccine for all children of two, three and four years of age during the 2014-15 season in England was 38.5%, 41.3% and 32.9% respectively. An estimated 53.2% primary and secondary school children aged 4 to 13 years in 13 pilot areas received at least one dose of influenza vaccine, during the period 1 September 2014 to 31 January 2015. This winter (2015/16) will see a significant expansion of the programme, with the programme being extended to all 5 and 6 years olds (primary school Years 1 and 2). This will mean that a further 1.2 million children will be offered the vaccine.

13. A key part of our delivery in 14/15 has focussed on Sexual Assault Services as set out in the S7A. During 2014/15, we have developed performance indicators for SARCs which will be monitored by a management information stipulated template, Sexual Assault Services Indicators of Performance (SASIPs). This is a significant step as historically there have been no nationally acceptable minimum data set for Sexual Assault Referral Centres (SARCs). This approach will allow NHS England to commission SARCs providers to deploy a system appropriate to the provision, but still meet national reporting requirements for assurance.

14. Public Health S7A indicators have also been integrated into the Health and Justice Indicators of Performance (HJIPs) management tool. In 2015/16 ongoing reporting and intelligence will help establish trend data patterns from national level down to individual providers in prisons, enabling better informed commissioning decisions.

15. All local commissioners of public health services for people in places of detention in 2014/2015 used the national specifications to commission services. The first wave of 11 pathfinder sites for Blood Borne Viruses (BBV) opt out testing (within S7a resources) commenced in April 2014, PHE have undertaken an evaluation which indicates good outcomes for patients. 8 of out 11 pathfinder prisons stated that they identified positive results on individuals who would have hitherto remained undiagnosed under previous testing approach and describe a near doubling of BBV testing following the introduction of the opt-out testing approach.

16. An NHS Health Checks audit carried out across the prison estate indicated more work is required on the quality of health checks, but that uptake is of a similar level to the general population (24% in February 2015). In response, a national plan has been drawn up to support commissioners to increase quality and uptake. Although HJIPs indicators performance has only started meaningful reporting, early indicators are showing an improvement of 6% in access.

17. NHS England continued to commission in 2014-15 Child Health Information Systems (CHIS). The CHIS provides a critical role in the scheduling, recording and monitoring of public health programmes for children, including vaccination delivery and immunisation status of children in England.

18. A key project in 2014/15 has been the development of national S7A service specifications in partnership with PHE. This has enabled commissioners to drive improvements in provision of services by reducing variation.

**Finance**

1. Under the 2014/15 S7a agreement, NHS England is obliged to report against the £1,929m ring fenced sum. It is not obliged to report against the £394m primary care element.

2. Appendix 1.2 shows £1,998m of expenditure has been quantified against the £1,929m ring fenced sum (i.e. £69m more than the ring fenced sum).

3. This means that NHS England has met its obligation to only use the ring fenced funding for expenditure attributable to the performance of functions pursuant to the S7a agreement.

4. The reported ring fenced expenditure includes:
    a. The costs of contracts relating to S7a programmes with NHS and third party providers;
    b. Vaccines reimbursed by CCGs on behalf of NHS England's S7a programmes (i.e. adult flu and pneumococcal);
    c. Various S7a costs incurred by other organisations but not recharged to NHS England because NHS England did not receive the funding in the 2013 PCT baseline disaggregation (e.g. colposcopies);
    d. The S7a element of wider health and justice block contracts;
    e. Immunisation target payments and enhanced service payments to GPs; and
    f. Those elements of the Quality and Outcomes Framework (QOF) payments to GPs which directly relate to public health.

5. The reported ring fenced expenditure does <u>not</u> include:
    a. Non-cancer screening and immunisation costs in the maternity tariff (and incurred by CCGs);
    b. Vaccines supplied by Public Health England;
    c. Other centrally funded costs (e.g. Local Service Provider licences for CHIS);
    d. Commissioning costs which are in NHS England's running costs; or
    e. Any allowance for NHS England's general overheads (which would normally be included in a full economic costing).

6. The S7a costs in other organisations and in health and justice contracts are based on returns completed by NHS local teams in June 2015. These returns were supported by very comprehensive guidance. The estimates are more complete and accurate than previous returns, including 2014 returns which were the basis for the figures reported in the 2013/14 assurance statement.

7. Appendix 1.2 shows the total costs against the ring fenced sum before and after reclassifying the costs in other organisations against specific programmes.

8. NHS England is planning to conduct a comprehensive review of the unquantified costs in the maternity tariff.
    a. Costs are likely to be significant. Appendix 2 shows expenditure on non-cancer screening of £106m. This compares to an independent report which estimated

costs of £378m at 2010/11 prices[1]. The difference of £272m will be partly explained by the unquantified costs in tariff; in addition some new programmes and changes to existing programmes will have implications for the maternity tariff.

9. Expenditure against the £394m primary care element has been estimated as £324m. This only includes the costs for additional services that are embedded in the GP contract. These have been estimated as 7.2% of the total GP global sum. This is based on the global sum deduction a GP would suffer if they were to opt out of providing specific public health additional services.

[1] Technical Report upon the Costs of Non-Cancer Screening Programmes for the National Screening Committee, Health Economics Consulting, University of East Anglia, 3rd February 2012

**Future development of S7A**

19. S7A services will continue to develop in the context of the 'Five Year Forward View' but within a more constrained financial environment. The Five Year Forward View describes 'getting serious about prevention'; S7A services are a key dimension in this prevention agenda, for example, in access to cancer screening.

20. There are areas of the S7A which require further work, in particular our ambitions to gather robust evidence and improve consistency and quality through implementation of national S7A service specifications. In order to achieve success in these areas we will complete further work on S7A service specification compliance.

21. Despite many achievements, there have also been challenges and areas that need further improvement. These include:
    - Maintaining and improving vaccination uptake and coverage;
    - Improving quality and coverage and reducing inequality in uptake of national screening programmes;
    - Ensuring that S7A programmes are delivered in line with agreed service specifications

22. We will review the impact of changes in the commissioning landscape and will work with the DH and PHE and other partners to support new ways of working including supporting work with Greater Manchester on GM Devo.

23. There will continue to be a significant programme of change in 2015-16. A variation to the agreement for 2015-16 has been made to respond to JCVI advice regarding the public health outbreak and response to implement the Men ACWY vaccination. This has required a quick response and additional resource from across teams in PHE and NHS England to ensure the variation was made in a timely manner to ensure optimum operational effectiveness for delivery. The programme will continue to divert commissioning resources through implementation in 2015-16

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**Key deliverables for 2014-15**

| Key deliverables in S7A for 2014-15 | Key messages/actions to be developed |
|---|---|
| **Key ambitions and deliverables** | |
| Seek to improve or at least maintain the national level of annual performance for each key deliverable | Information on performance against key deliverables is set out in appendix 1. The internal NHS England governance structure (Public Health Oversight Group and Assurance Groups) has been strengthened to support delivery of S7A; with assurance dashboards shared and reported.<br><br>Local teams have access to data repositories for screening and immunisation, so can view local performance data for use for local level for managerial purposes in order to work with provider organisations to improve, and to facilitate sharing learning with their peers.<br><br>Screening and immunisation programmes in England are successful programmes with high-levels of achievement in comparison to other countries. There are areas where improvements can be made even within the context of high performing programmes (eg the national childhood immunisation programmes). PHE have recently noted and informed NHS England that COVER data for immunisations is showing a small but noticeable downward trend – which will need further investigation and action by NHS England to reverse this trend.<br><br>There are challenges in delivering these programmes in some parts of the country as well as data completion issues. NHS England through its assurance processes will seek assurances on data completion and will also conduct in-depth investigations into specific programmes where performance is showing either a downward trend or significant levels of variation. |

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| Over time, to reduce the range of variation in performance (performance floors) | NHS England has set performance floors for all the S7A programmes (shown in appendix 1), at a fixed bottom quintile combined with standard deviation, based on historical performance. The information has formed part of the reporting within data repositories for local teams to identify low levels of performance and set measurable objectives for changes in provider's performance to reduce the range of variation. |
| Quality of services addressing clinical effectiveness, patient safety and patient experience | NHS England has reviewed all the S7A service specifications for the screening and immunisation services to improve the contracting and guidance for delivery of services, such as: updating text for defunct and non-operational hyperlinks, improving clarity and therefore the translation of the specifications into contract, and deleting duplication for guidance such as the Green Book for immunisations.<br><br>NHS England has put the requirement to provide accessible means for patients to be able to express their views about, and their experiences of services, making best use of the latest available technology and social media as well as conventional methods into plan as set out in the 2014/15 commissioning intentions.<br><br>Local teams have been tasked with capturing patient experience feedback from a range of insight sources; providers should demonstrate robust systems for analysing and responding to that feedback. |
| Fully implement service specifications into national contracts and take steps to identify all cases of unacceptable or low performance by providers | NHS England has undertaken a review of service specifications. However, we do not have full assurance and we are aware of a number of areas where, while specifications are in contracts, service standards are not being met.<br><br>NHS England will embed a standardised approach to reporting on specification compliance through public health portfolio leads and the Public Health Oversight Group, to track progress and increase our confidence in meeting this ambition. |

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| | National service specifications for public health services have been welcomed by PHE and NHS England commissioners, to drive quality and consistency in public health programmes. NHS England and PHE have worked closely together in 2014-15 to improve the quality of the service specifications and increase the role as a contractual lever. |
| Statutory duties in relation to equality and health inequalities | The screening programme board and NHS England have undertaken specific patient and public engagement for adults with learning disabilities and increasing uptake in hard to reach groups has been added to the service specifications for S7A.<br><br>The NHS England Public Health commissioning intentions for 2015/16 include a national CQUIN to increase screening and immunisation uptake in mental health, people with learning disabilities and black and minority ethnic groups (BME) including maternity cohorts. As a result, specific health improvement actions in areas/ population groups where there is low uptake have been implemented e.g. Bowel health promotion service have redesigned their social marketing messages and communication plans to reach BME communities and the Diabetic eye screening programmes identified specific GP practices where there are low referral rates and direct engagement was been put in place to increase awareness and proactive identification of eligible patients from the GP practice risk registers<br><br>We are recording and learning from examples of excellent work such as a targeted campaign in Nottingham which has resulted in 90% coverage for the three dose HPV vaccination programme whilst having a very diverse ethnic and religious community. Other aspects that will be focussed on are:<br>• A work programme to ensure compliance to service specifications |

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| | • Agreeing a pro-active programme of work on analysis and action to reduce inequalities in immunisations through the Vaccine Coverage Liaison Sub Group<br>• Exploring the inclusion of the need to monitor underserved groups into the standard contract with the expectation that providers will report by those dimensions.<br>• Promotion of the adoption of examples of good work and targeted campaigns in areas with similar populations. |
| Seek to ensure that the views of service users and others are sought and taken into account in designing, planning and delivery services | The Childhood flu programme planning has included work with PHE colleagues who hold annual focus groups with parent regarding immunisation. UCL and LSHTM have had elements of their research which captured parental views of the programme. Views of service users can play a key role in designing, planning and delivery of services. |
| Offer childhood flu vaccination to all children between 2 – 4, continue delivery primary school children in the current pilot areas, and commence delivery to as many children of secondary school as is reasonably possible and agreed in the S7A variation | NHS England maintained the provision of flu vaccination for children aged 2 and 3 and added 4 year olds to the GP contract. Uptake was lower than aspirations and we are working to reinvigorate the programme in Primary Care.<br><br>Secondary school pilots were conducted in 12 geographical areas (700+ schools, ~ 350,000 children). Uptake was good (50.3%). These pilots will not continue in 2015/16. Six of the primary school pilot areas will continue to offer vaccination to children in Year 1-6. Efforts will be concentrated on phase 2 extension to primary school year 1 and 2 age children. |
| Implement as far as reasonably practicable the planned new MenC immunisation programme for university entrants. | NHS England implemented the new Men C ‘fresher’s campaign’ – NHS England working with partners are looking to make improvements in access and awareness as part of the Men ACWY catch-up campaign. |

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| To continue engagement with partners by planning for a safe and effective of transfer of commissioning arrangements for children's public health services from 0-5 and in particular explore opportunities for sign off for commissioning plans for 2014-15 with local authority Chief Executives. And to develop plans, nationally and for each local area, for transferring commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities, on the basis of effective partnership with local authorities so far as this is reasonably practicable. | Working in partnership, the 0-5 Healthy Child Transfer Programme was established in NHS England to ensure the safe transfer of commissioning responsibilities for 0-5 year old children's public health services from NHS England to Local Authorities on 1 October 2015. This equates to £427.4m transfer from NHS to Local Authorities in England. The programme centrally co-ordinated workstreams to assure safe transfer around finance and contracting, HR and data and information, supported by effective communications and delivered for safe transfer on 1 October 2015. |
| Work with PHE to help them to deliver their 60% commitment to roll out bowel scope screening by the end of March 2015, by support the involvement and engagement of screening centres. | NHS England supported PHE to reach and exceed the government commitment to open 60% of the bowel scope centres, as part of the process to improve access for all the eligible population. |
| Develop a plan for the commissioning of SARCs which will set out a review of the current commissioning arrangements and aim to standardise the core offer to the victim in 2014-15, and to commission services fully in accordance with the service specification no | The core offer for both adult services and paediatrics has been standardised. This has not been fully implemented in 2014-15 but procurement is currently being undertaken in the outstanding areas. The offer of HIV starter prophylaxis is part of the core offer across all SARCs. NHS England will undertake further work to ensure that services are compliant. |

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| later than 2015-16. The core offer should include roll-out of the provision of HIV starter prophylaxis in all SARCs in 2014-15 in accordance with the service specification. The improvement objectives for 2014-15 may otherwise take into account an assessment of the resources required and available to undertake such improvement actions. | |

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## Appendix 1: Summary of Key Deliverables

| Programme | 7a Deliverable | Actual | Performance floor | Bottom Quintile |
|---|---|---|---|---|
| **Vaccination (12 months)[I]** | | | | |
| DTaP/IPV/Hib (%) | 94.7% | 94.1% | 93.4% | 92.0% |
| Men C (%)[II] | 93.9% | - | 91.1% | - |
| PCV (%) | 94.2% | 93.9% | 92.8% | 91.8% |
| Hep B (%) | TBC | 84.0% | - | - |
| **Vaccination (24 months)[I]** | | | | |
| DTaP/IPV/Hib (%) | 96.1% | 95.6% | 95.2% | 93.9% |
| PCV Booster (%) | 91.5% | 92.1% | 90.1% | 89.0% |
| Hib/Men C (%) | 92.3% | 92.1% | 90.0% | 88.8% |
| MMR 1 (%) | 91.2% | 92.0% | 90.2% | 89.1% |
| Hep B (%) | TBC | 72.0% | - | - |
| **Vaccination (5 years)[I]** | | | | |
| DTaP/IPV/Hib (%) | TBC | 95.7% | - | 94.2.% |
| MMR 1 (%) | 92.9% | 94.5% | 92.5% | 93.1% |
| MMR 2 (%) | 86.0% | 88.6% | 84.6% | 85.3% |
| DTaP/IPV Booster (%) | TBC | 86.9% | - | 84.7% |
| Hib/Men C Booster (%) | 88.6% | 92.8% | 89.7% | 90.1% |
| **Adult and adolescent vaccination[III]** | | | | |
| HPV (3 doses) (%) | 86.8% | 86.7% | 79.6% | 82.9% |
| PPV (65+) (%) | 68.3% | 68.9% | TBC | 65.1% |
| Flu (65+) (%) | 73.4% | 72.7% | 71.0% | 70.3% |
| Flu (at risk) (%) | 51.3% | 50.3% | 48.8% | 47.5% |

| Programme | 7a Deliverable | Actual | Performance floor | Bottom Quintile |
|---|---|---|---|---|
| **Cancer Screening Programmes[IV]** | | | | |
| Breast Coverage (53-70) (%) | 76.9% | 75.9% | 69.5% | 69.7% |
| Cervical Coverage (25-64) (%) | 75.3% | 74.2% | 71.6% | 70.6% |
| Bowel Uptake (60-69) (%) | 55.8% | 57.5% | - | 51.6% |
| **Non-Cancer Screening Programmes[V]** | | | | |
| HIV (%) | 98.1% | 98.7% | 98.1% | 98.1% |
| Sickle Cell & Thalassaemia (%) | 98.0% | 98.5% | 98.3% | 98.0% |
| New born hearing (coverage) (%) | 97.5% | 97.7% | 97.3% | 96.8% |
| New born bloodspot (coverage) (%) | 92.3% | 95.4% | 92.4% | 92.6% |
| New born Physical Exam (%)[VI] | TBC | - | - | - |
| Diabetic Eye (%) | 80.2% | 82.7% | 74.4% | 79.3% |

| Programme | 7a Deliverable | Actual | Performance floor | Bottom Quintile |
|---|---|---|---|---|
| **Children's Public Health[VII]** | | | | |
| Health Visitors (FTE)[VIII] | 12,292 | 12,156 | - | - |
| Family Nurse Partnership[IX] | 16,000 | 16,250 | - | - |
| Low Birth Weight (%) | 2.85% | 2.8% | - | 2.2 |
| Breast Feeding initiation (%) | 74.0% | 73.9% | - | 63.7 |
| Breast Feeding prevalence 6-8 wk (%)[X] | 47.2% | - | - | - |
| Excess weight in 4-5 year olds (as defined in the PHOF indicator 2.06i) | 22.6% | 22.5% | - | 20.8 |
| Infant mortality (as defined in the PHOF indicator 4.01 – shared indicator with NHS Outcomes Framework 1.6i) | 4.1 deaths per 1,000 live births | 4.0 | - | - |
| Hospital admissions unintentional & deliberate injuries in under 18s (as defined in the PHOF indicator 2.07i) | TBC (per 10,000 resident population) | 140.8 | - | - |
| Tooth decay 5 year old (crude rate) | TBC | 0.94 | - | - |

**PH services for people in detention & prescribed settings**

**Under development/to be confirmed:**

- Substance dependence assessed on entry
- Successfully completed treatment
- Engaged in treatment in community
- Engaged in treatment on transfer

**Sexual Assault Referral Services**

**Minimum data set being developed including:**

- % of victims tested for sexual transmitted infections/BBVs
- % of victims referred to sexual assault services
- % of victims who received counselling within 14 days
- % of victims reported the incident to police

**Notes:**

*Data updated 28th August 2015 (using 2014/15 year end data where available). 7a Deliverables are taken from the NHS Public Health Functions Agreement 2014-15 (Public health functions to be exercised by NHS England). A large number of the indicators are taken from the Public Health Outcomes Framework (PHOF), data tool updated July 2015.

[I] Childhood vaccinations data is taken from the Cover of vaccination evaluated rapidly (COVER) programme. Quarterly vaccination coverage statistics for children aged up to five years, 2014/15 Quarter 4, January to March 2015.

[II] England coverage insufficient to provide MenC data. Currently only a small number of areas are able to supply one dose MenC vaccine coverage data for their area (in all of these areas coverage was similar to or exceeded that of other vaccines evaluated at one year). As a consequence a MenC vaccine coverage at one year cannot be produced for England.

[III] Adult and adolescent vaccination data is taken from the PHOF data tool. HPV and PPV relate to 2013/14. Flu vaccine uptake is those who received the flu vaccination between 1st Sept to 31st Jan in a primary care setting (GPs).

[IV] Cancer Screening Programmes, percentage of eligible women screened adequately for breast and cervical cancer, data for 2014 (PHOF data tool). Bowel screening data relates to data up to January 2015 (Open Exeter).

[V] Non-Cancer Screening Programmes data relates to quarter 3, 2014/15 KPI data submissions (01/10/2014 - 31/12/2014)

[VI] New born physical exam value not published for data quality reasons. Approximately two thirds of providers have not submitted data. The number of local maternity services which have a fully operational NIPE SMART system is increasing, but is not yet at a level of coverage across England that reliable and robust national and regional summaries can be calculated.

[VII] Children's Public Health: Unless otherwise indicated, many of these indicators are taken from the PHOF data tool. Low birth weight, 2012. Breastfeeding initiation, 2013/14. Children aged 4-5 classified as overweight or obese, 2013/14. Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births (2011-2013). Crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 resident population (2013/14). Mean severity of tooth decay in children aged five years - decayed/missing/filled teeth, 2011/12.

[VIII] The Health Visiting Implementation Plan completed on 31st March 2015. The four regions achieved a total of 12,157 FTE at this date against the original plan of 12,292 FTE. This is using the Indicative Health Visitor Collection (IHVC). The indicative data (IHVC) reported the following on 23rd April 2015 for the March end data: 12,157 FTE (total established in the workforce). This figure may have been used during April to report on the Government's commitment to increase the number of Health Visitors, as

the information available at the time. Comparatively, the official HV MDS validated and published on June 24th 2015 reported a slightly lower: 12,077 FTE (for the March end data).

[IX] There were 16,250 NHSE funded FNP places 2014/15 (year end), exceeding the goal of 16,000. A further 200 places came on board in July 2015, taking the current total of NHS England commissioned places to 16,450. There are approximately a further 400 FNP places operational funded from non-NHS England sources. There is an estimated 780 WTE NHS England commissioned family nurses at the end of 2014/15, and 788 in July 2015.

[X] Breastfeeding 6-8 week data is marked as unavailable for data quality reasons. This refers to the coverage required at the initial release of data (95%). The coverage target for 2013/14 and 2014/15 have been reduced to 85% for England level figures, but the data is marked as unavailable due to the update timetable on the PH outcomes website. The data has been released on the NHS England website. In England the breastfeeding prevalence rate at 6-8 weeks for 2014/15 was 43.8%, in 2013/14 prevalence at 6-8 weeks was 45.8%, in 2012/13 prevalence at 6-8 weeks was 47.2% and in 2011/12 47.2% of infants due a 6-8 week check were being breastfed at 6-8 weeks.

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**Appendix 2: Finance Summary**

| | Before reclassification £'m | Reclassification £'m | After reclassification £'m |
|---|---|---|---|
| Per the NHS England Ledger | | | |
| Children 0 to 5 | 810.2 | 5.2 | 815.4 |
| Cancer Screening | 326.2 | 62.7 | 388.8 |
| Immunisation Programmes | 282.5 | 69.3 | 351.7 |
| Non-cancer Screening Programmes | 106.0 | 1.4 | 107.4 |
| Child Health Information Systems | 32.8 | 4.2 | 37.1 |
| Sexual assault services | 14.2 | | 14.2 |
| Screening promotion | 2.3 | | 2.3 |
| Other | 0.0 | | 0.0 |
| Estimates based on local team returns | | | |
| Public health QOF | 168.8 | | 168.8 |
| Estimates based on local team returns | | | |
| Prison public health | 112.1 | | 112.1 |
| S7a costs in other organisations | 142.7 | (142.7) | 0.0 |
| **Total S7a costs against the ring fenced sum** | **1,997.9** | **0.0** | **1,997.9** |
| Less S7a ring fenced sum | (1,929.0) | | (1,929.0) |
| **Excess spend against the ring fenced sum** | **68.9** | **0.0** | **68.9** |