Department of Health

NHS England

NHS public health functions agreement 2014-15

Public health functions to be exercised by NHS England

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NHS public health functions agreement 2014-15

Public health functions to be exercised by NHS England

Prepared by Public Health Policy and Strategy Unit, Department of Health

Contents

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 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 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, and
- contribute to a more sustainable public health, health and care system

A. General

Legal framework

A1. This agreement sets out the arrangements under which the Secretary of State for Health delegates to NHS England responsibility for certain elements of 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 as inserted by the Health and Social Care Act 2012 ("the 2012 Act).

A2. NHS England was established as the National Health Service Commissioning Board ("NHS CB"), by section 1H(1) of the 2006 Act as inserted by the 2012 Act.

A3. Pursuant to this agreement, NHS England will exercise functions of the Secretary of State under sections 2, 2A, 2B and 12 of the 2006 Act so as to provide or secure the provision of the services listed in Table 1, column 2, from 1 April 2014 to 31 March 2015. Where NHS England exercises these functions, they may be referred to in this document as "NHS public health functions".

A4. The provision of the services listed in Table 1 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 are therefore to be provided and arranged pursuant to the Secretary of State's duty under section 2A of the 2006 Act. In addition, with the exception of screening programmes and cancer screening programmes, the provision of the services listed in Table 1 are steps the Secretary of State considers appropriate to improve the health of the people of England and are therefore to be provided or arranged pursuant also to the Secretary of State's power under section 2B of the 2006 Act.

A5. This agreement follows that made for the financial year 2013-14 as part of continuing arrangements that are intended to provide stability for commissioners and providers. Similar agreements under section 7A of the 2006 Act are expected to be made for future financial years. In order to assist planning, this agreement for 2014-15 sets out some shared expectations for future years. The Government intends to take steps to transfer commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities from 2015.

A6. This agreement is intended to include functions of the Secretary of State mentioned in paragraph A3 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 its functions include functions exercisable under section 7A arrangements. The effect is that these provisions, 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.

A7. 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").

A8. Furthermore, this agreement applies only to the exercise of Secretary of State public health functions referred to in paragraph A3 above and does not apply to other functions of NHS England including in particular:

a) 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),

b) 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),

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

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

A9. This agreement is not intended to be a contract in law and should not be regarded as giving rise to contractual rights or liabilities. The Secretary of State for Health and NHS England will jointly aim to resolve any possible dispute that might arise in relation to this

agreement as quickly as possible with the processes outlined in this agreement.

A10. In this agreement, references to DH are to the parts of the Department other than PHE.

A11. Part C of this agreement sets out requirements for and evidence underpinning each service to be commissioned (referred to as "service specifications"). PHE has responsibility 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. NHS England and the Secretary of State may jointly agree to update the provisions of Part C (the service specifications) of this agreement as described below (paragraph A50).

A12. The Secretary of State for Health and NHS England may be referred to in this document as "the parties" where this is convenient.

Accountability

A13. The parties believe that accountability under this agreement should reflect the two high level outcomes set out in the Public Health Outcomes Framework 'Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency', first published in January 2012. This agreement therefore focuses on achieving positive health outcomes for the population and reducing inequalities in health through provision of the services listed in Table 1. 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 through the services listed. The key deliverables set out in this agreement should be the main measures of that performance. The key deliverables are matched as far as possible to measures used in the Public Health Outcomes Framework.

A14. In exercising the Secretary of State's functions under this agreement, NHS England will :

a) seek to improve or at least maintain the national level of annual performance for each key deliverable and supporting indicator wherever a previous level of performance is shown as a baseline in Table 2, or

b) seek to achieve the highest practicable national level of performance in relation to each key deliverable shown in Table 2 , Table 3 or Table 4.

NHS England is accountable to the Secretary of State for these key deliverables. NHS England will seek to sustain local levels of performance where these are above the national level of annual performance.

A15. As indicated in paragraphs A6 and A7, NHS England is accountable for the exercise of statutory functions and for the objectives set by virtue of the Mandate. Under this agreement, NHS England is accountable in particular for the matters described in paragraphs A16 to A23 and A26 to A29 below. The parties note that the main measures of performance for these accountabilities will be drawn from management information available to NHS England, without additional reporting burdens. NHS England will use reasonable endeavours to obtain the data necessary to measure local levels of performance for the purposes described in paragraphs A14 and A18. Information in relation to quality of services is expected to address clinical effectiveness, patient safety and patient experience.

A16. Part C of this agreement contains service specifications which set out the evidence underpinning each service to be commissioned. NHS England will have inherited a variety of practice in commissioning resulting in unacceptable variations in the local provision of services. The parties expect further work by NHS England will be needed to bring these consistently into line with the service specifications. In line with paragraph A13, achieving this will reduce health inequalities and support improvements in population health. Consequently, NHS England will work with partners to undertake a review of existing commissioning to be completed by 31 March 2014. Where arrangements in any part of England are not in accordance with the service specifications in Part C, NHS England will set out the steps and timescale ('pace of change') to bring services consistently into line with the service specifications. NHS England will provide the steering group (mentioned in paragraph A33) with its draft report on pace of change and have regard to any views expressed. A final report will be provided to the Senior Oversight Group (mentioned in paragraph A31 below) no later than 31 March 2014.

A17. Full national implementation of commissioning in accordance with the service specifications in Part C should be no later than 31 March 2015. It is recognised that there may be exceptional circumstances in some cases and a clear timetable and rationale for any exceptions will need to be provided as part of the draft report and final report.

A18. The parties expect over time that NHS England will reduce the range of variation in local levels of performance, while improving or at least maintaining the national levels of performance described in paragraph

A14. Before 31 March 2014, NHS England will take steps to identify all cases of unacceptable or low local levels of performance by providers. This will be included as part of the review of current commissioning arrangements mentioned in paragraph A16 and A17. Unacceptable or low local levels of performance will be determined having regard to any written advice that may be given by PHE, including acceptable levels of performance that may be stated in service specifications. It may be convenient to use the term 'performance floors' for the minimum levels of performance that are acceptable. NHS England will state in the draft report and final report a set of measurable objectives for sufficient and sustainable changes in providers' performance to reduce the national range of variation. The objectives for 2014-15 may take into account an assessment of the resources required and available to undertake such improvement actions.

A19. Both the Secretary of State and NHS England have statutory duties relating to equality and as to reducing health inequalities. Consistent with those duties, NHS England should apply fresh information, evidence and methodologies to support accountability under this and future section 7A agreements in relation to equality and reducing health inequalities. This will include the use of information on variations in services between different areas and populations. NHS England will be accountable for achieving and demonstrating a greater understanding of effective interventions to narrow health inequalities.

A20. Actions are being taken forward by NHS England in response to the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry) to transform the care people receive. Where not otherwise required by service specifications, NHS England will seek to ensure that the views of service users and others, including parents and carers, will be sought and taken into account in designing, planning, delivering and improving services that are provided pursuant to this agreement. In relation to this agreement, as indicated in paragraph A34(b), we expect the oversight group to review how the public and patients' voices are used both to develop insight to improve outcomes and reduce inequalities, and to help address under-performance.

A21. Where not otherwise required, in relation to any complaints relating to a service or services provided pursuant to this agreement, NHS England will ensure that information is shared appropriately with regulatory bodies and other organisations in the public health, health and care systems ("other bodies"), and that the fullest attention is given by NHS England to complaints whether received in the first place by NHS England or other bodies.

A22. Transparency is an organising principle. Where NHS England takes steps to remedy the level of performance or quality of any service provided pursuant to this agreement, it will provide information setting out remedial steps (an "improvement plan") and work with providers to ensure that objectives in the improvement plan are achieved in a timely manner..

A23. For the purposes mentioned in paragraph A31, NHS England is expected to develop financial reporting so that, in line with its other obligations including those mentioned in paragraphs A50, the oversight group can review quarterly information on the use of funding with a breakdown showing expenditure as described in paragraph A49. NHS England will provide information to the steering group about any incentivisation of providers through rewards or sanctions.

A24. The parties acknowledge the delivery challenges represented by the safe and effective implementation of planned changes represented by the key deliverables in Table 3 and Table 4. As indicated in paragraphs A34(b) and A53(b), these delivery challenges will be kept under review by the oversight group and the steering group.

A25. The parties recognise that key deliverables (described in Tables 2, 3 and 4) 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 A44 below is intended to provide the resources necessary to achieve the key deliverables of this agreement having regard to contributions expected to be made by the exercise of NHS England's other functions.

Specific programmes

A26. The Joint Committee on Vaccination and Immunisation (JCVI) has recommended that all children aged 2 years old to under 17 years old are vaccinated against seasonal flu on an annual basis. Once fully implemented, childhood flu immunisation will be the largest immunisation programme in England. Due to the significant scale and challenge of delivering this programme, a phased implementation began in 2013-14, with provision for all 2 and 3 year olds along with geographical pilots in a number of areas to test delivery in primary schools, to enable learning about delivery to inform more substantive implementation in 2014-15 and beyond. DH, NHS England and PHE

have a shared ambition for the next phase of implementation - to offer vaccine to all children between 2 and 4 years old and all secondary school aged children (11-16 year olds). Specific provisions for phased implementation in 2014-15 are set out in Table 4. NHS England is accountable for the key deliverables in Tables 2, 3 and 4.

A27. Following consideration of advice from the JCVI, it is possible that there may be a commitment by the Secretary of State to undertake population-based evaluation of use of meningococcal B (MenB) vaccine in infants and/or adolescents starting in 2014-15 or 2015-16 to investigate uncertainties in scientific evidence about the vaccine's effectiveness. Such an evaluation could involve, for example, national and/or regional temporary MenB immunisation programmes in England. If such an evaluation is undertaken, NHS England is expected to work with PHE to ensure that there would be sufficient capacity within the NHS to support development and/or delivery of such a population based evaluation. The senior oversight group will review the position once JCVI's advice has been received in November 2013.

A28. As mentioned in paragraph A5, the Government intends to take steps to transfer commissioning responsibilities for children's public health services from pregnancy to age 5 to local authorities from 2015. Arrangements are being developed through a task and finish group of the Children's Health and Wellbeing Partnership, of which both NHS England and DH are members. In relation to this agreement, NHS England is expected to continue its engagement with partners and planning for safe and effective transfer of commissioning arrangements, acknowledging the challenge that adaptation of plans may be necessary as steps proceed. NHS England is expected to explore, in particular, opportunities for sign-off of commissioning plans for 2014-15 with local authority Chief Executives. DH will retain responsibility for system assurance and due diligence for the transfer of responsibilities to local government.

A29. PHE will continue to be responsible in 2014-15 for the roll out of the bowel scope screening programmewhich will contribute towards the Mandate objective for England to become one of the most successful countries in Europe at preventing premature deaths.. . The Secretary of State's commitment is to have this programme rolled out to 60% of England by the end of March 2015, and to the rest of England by the end of 2016. NHS England will work with PHE to help deliver the involvement of screening centres sufficient to meet the 60% commitment and to support preparatory steps in other bowel cancer screening centres to implement by the end of 2016. The expectation has been that PHE would retain responsibility until after full roll out has been achieved, but NHS England might be requested to take responsibility for commissioning from 2015-16. The steering group

(mentioned in paragraph A33) expects to consider information about progress from the bowel scope screening delivery board.

Oversight and assurance

A30. The parties' commitment to partnership recognises the role of joint oversight and close collaboration in driving improvements in population health. PHE plays a key role as the national expert voice and centre of advice for public health, contributing to joint oversight and in day to day collaborative relationships with NHS England.

A31. NHS England and the DH will jointly 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:

a) will review planning, performance, risks and mitigating actions in relation to functions exercised under this agreement, which may be both nationally and in relation to any specific area, service or population group of concern to NHS England or the Secretary of State,

b) will secure arrangements for effective partnership working to deliver improvements in population health, and

c) may make reports and recommendations to the Secretary of State and NHS England, including recommendations in relation to proposed updates or variations of this agreement.

A32. Membership of the oversight group will include the PHE Chief Executive and otherwise will be determined by the chair of the oversight group with the consent of the NHS England Chief Operating Officer.

A33. The oversight group is expected to meet at least quarterly. The oversight group will determine its own working arrangements, including the functions of any subgroups. There is currently one subgroup. The NHS public health steering group, chaired by the NHS England Director of Partnerships, reports to and advises the oversight group. The steering group is expected to implement arrangements for effective partnership working and make every effort to resolve operational issues between bodies.

A34. The oversight group is expected to review:

a) matters described in paragraph A31(a)

b) information provided by NHS England and PHE in relation to paragraphs A16 to A23 and A26 to A29, including the pace of change mentioned in paragraph A16,

c) the quality of services delivered pursuant to this agreement, including any serious incidents or serious complaints, and steps taken to improve the quality of services, and

d) any prospective changes under this agreement, including those described in paragraphs A31(c) and A35.

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A35. The oversight group, or as appropriate the steering group, will discuss implementation plans at a formative stage so as to inform programme decisions by the Secretary of State on a prospective:

a) new or changed service that would be requested to be commissioned by NHS England under the functions mentioned in paragraph A3,

b) request for roll-out of a service development by NHS England following a pilot phase, or

c) 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.

A36. The oversight group is expected to consider 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 A6 to A8. For example, in connection with a prospective variation, the most appropriate times to implement planned changes under this agreement in relation to a commissioning cycle.

A37. The oversight group and the steering group will consider in each quarter the availability of new evidence and data in relation to key deliverables and baselines identified in Table 2, including the availability of any new or updated baselines. Any such proposed changes may be given effect by written agreement as described in paragraph A51 below, or may otherwise be the subject of guidance as described in paragraph A38.

A38. In order to exercise NHS public health functions more effectively, the oversight group or the steering group may make decisions as to guidance which may inform the carrying out of the provisions of this agreement.

Information

A39. To fulfil the purposes of this agreement. DH, PHE and NHS England should each have the same timely and objective information available to them. Achieving the best information flows, nationally and locally, requires full collaboration with each other, and with bodies such as the Health and Social Care Information Centre.

A40. DH, PHE and NHS England will share information to enable effective joint planning of service delivery and service improvement. This means that information will be shared at formative stages. For example, PHE should share its understanding of emerging evidence and the work of its advisory committees in relation to prospective changes in services or new services that may be commissioned under a future section 7A agreement.

A41. NHS England and PHE will share performance information in relation to services. NHS England will as far as is practicable share with the Health and Social Care Information Centre all information it collects, or requires providers to collect, in the exercise of its functions pursuant to this agreement. NHS England will also ensure that relevant unpublished information 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. NHS England will agree arrangements with PHE for the supply or exchange of relevant information and analyses.

A42. 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. NHS England will without delay inform DH in writing of any significant concerns it has in relation to the delivery of services by providers, including reports of serious failings or incidents, or major risks. This includes matters described in paragraph A21

A43. NHS England will work with DH and PHE to support: development of:

a) baseline data for Table 2 where this is currently not available,

b) detailed data to enable effective contract management of providers in relation to the purposes of this agreement mentioned in paragraph A13, and

c) excellent data quality and completeness in relation to items mentioned in Table 2 and management information as mentioned in paragraph A15.

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Finance

A44. The Secretary of State agrees to pay NHS England the sum of £1,929m from the public health budget for the purposes of performing functions pursuant to this agreement during the financial year 2014-15 (in addition to the funding referred to in paragraph A46). This is ringfenced funding that may be used only for expenditure attributable to the performance of functions pursuant to this agreement.

A45. This does not preclude NHS England from choosing to allocate additional resources to prioritise public health spend within its overall resource limit(s).

A46. Additional funding of £394m from the public health budget for services provided through primary care is included within the total allocation of resources to NHS England under sections 223B and 223D of the 2006 Act. This funding and that referred to in paragraph A44 amount to £2,323m allocated to NHS England from the public health budget for the financial year 2014-15 for the delivery of the services listed in Table 1.

A47. The revenue resource limit for NHS England for the year 2014-15, as specified in the Mandate has been set so as to take into account the funding provided under this agreement under paragraph A44.

A48. NHS England will report to the oversight group any expected underspending of the funding allocated under paragraph A44 so that DH can take account of this in HM Treasury carry forward arrangements. Any sum underspent which is made available as part of section 7A funding for the following financial year may also only be used for expenditure attributable to the performance of functions pursuant to this agreement or a similar future agreement.

Reporting

A49. NHS England will report annually to the Secretary of State in relation to this agreement, on its achievement of the key deliverables listed in Tables 2, 3 and 4. 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 A44 above and if different to the amount of funding allocated, then NHS England will report the total expenditure attributable to the performance of functions pursuant to this agreement. This annual report will include a breakdown showing expenditure for each programme category or programme listed in Table 1.

A50. 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 the specific report required under paragraph A49 as part of that annual report or as a separate document provided no later than the date on which that annual report is laid before Parliament.

Variation

A51. This agreement may be varied by the Secretary of State and NHS England by written agreement. The oversight group is expected to review plans and may make a recommendation about such a variation.

A52. A planned variation to this agreement is expected in relation to the extension of the seasonal influenza vaccination programme to children of secondary school age (12 to 16) as described in Table 4. The planned variation may also address associated or consequential changes for other programmes

A53. The nature of this agreement, and the intention to provide stability for commissioners and providers, implies that unplanned variations to this agreement will never be routine. The circumstances in which an unplanned variation to this agreement may be considered include:

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

b) a new assessment of operational implications in relation to a programme mentioned in Table 3 (key deliverables for implementing change),

c) a change of evidence or advice in relation to a service specification

A54. The parties note that if only limited or proportionate actions are required to respond to any of the circumstance described in paragraph A53, they will consider whether an unplanned variation can be agreed within NHS England's existing operational capacity and financial resources. If such agreement is not possible, an unplanned variation (that is, any variation other than a variation described in paragraph A52) may, among other things, provide for either or both of:

a) lower expectations of performance in other services while actions are implemented in relation to matters mentioned in paragraph A53(a) or (b) (for example, implementation of a new vaccination programme),

b) an amount of additional funding where the Secretary of State considers that there are exceptional circumstances that makes the additional funding necessary. 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..

Dispute resolution

A55. As indicated in paragraph A9, any dfferences should be resolved quickly and constructively. The following provisions are intended to resolve any dispute in relation to:

a) the exercise of functions under this agreement,

b) any aspect of collaboration in relation to this or future agreements under section 7A of the 2006 Act.

A56. At their discretion, an authorised senior representative of NHS England, DH or PHE may at any time declare a dispute under this agreement by a written notice to the chair of the oversight group that provides 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 Chief Operating Officer of NHS England to resolve the dispute and may delegate responsibilities to named individuals.

A57. 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.

A58. If the matter is not resolved in accordance with paragraph A57, 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.

A59. 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 the failure by NHS England to discharge, or to discharge properly, any of its functions (section 13Z2 of the 2006 Act).

B. Tables

B1. Table 1 is mentioned first in paragraphs A3 and A4.

Table 1: List of services by programme category

Programme category or programme	**Services**
Immunisation programmes	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 C (MenC) immunisation programme
	Hib/MenC immunisation programme
	Pneumococcal immunisation programme
	DTaP/IPV and dTaP/IPV 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 Thalassaemia 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)	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

B2. As described in paragraphs A13 and A14, the key deliverables shown in Tables 2, Table 3 and Table 4 should be the main measures of how well NHS England performs its responsibilities under this agreement, and how well it drives improvement through the services listed in Table 1. Baseline data in Table 2 normally shows a previous level of performance (that is, rather than a target or required level of performance). It should also be noted that paragraph A18 describes arrangements in relation to 'performance floors' for local levels of performance, and that service specifications in Part C may further describe requirements for quality and performance. .

B3. As described in paragraph A13, the key deliverables shown in Table 2 are matched as far as possible to measures used in the Public Health Outcomes Framework. This refers to the document 'Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-16' as updated in July 2013. Other references and sources are shown in the table. 'To be confirmed' is shown where the parties anticipate suitable baseline data becoming available.

Table 2 Key deliverables for services

Key deliverables (shown in bold) and supporting indicators	**Baselines**	**Year, or time period**
Immunisation programmes		
Pertussis vaccine uptake for pregnant women Health Protection Report Vol.7. No.40 http://www.hpa.org.uk/hpr/archives/2013/hpr4013.pdf	50%	Lower estimate of coverage achieved in first 9 months of the programme to June 2013
Population vaccination coverage (as defined in Public Health Outcomes Framework indicator 3.3)		
3.3i: Hepatitis B vaccination coverage (1 and 2 year olds)	To be confirmed	
3.3ii: BCG vaccination coverage (aged under 1 year)	To be confirmed	
3.3iii: DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)	94.7% at age 1 96.1% at age 2 To be confirmed at age 5	2011-12

3.3iv: MenC vaccination coverage (1 year olds)	93.9%	2011-12
3.3v: PCV vaccination coverage (1 year olds)	94.2%	2011-12
3.3vi: Hib/MenC booster vaccination coverage (2 and 5 year olds)	92.3% at age 2 88.6% at age 5	2011-12
3.3vii: PCV booster vaccination coverage (2 year olds)	91.5%	2011-12
3.3viii: MMR vaccination coverage for one dose (2 year olds)	91.2%	2011-12
3.3ix: MMR vaccination coverage for one dose (5 year olds)	92.9%	2011-12
3.3x: MMR vaccination coverage for two doses (5 year olds)	86.0%	2011-12
3.3xi: Td/IPV booster vaccination coverage (13-18 year olds)	To be confirmed	
3.3xii: HPV vaccination coverage (females 12-13 year olds)	86.8%	2011-12 academic year
3.3xiii: PPV vaccination coverage (aged 65 and over)	68.3%	2011-12
3.3xiv: Flu vaccination coverage (aged 65 and over)	73.4%	2012-13
3.3xv: Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)	51.3%	2012-13
Flu vaccination coverage (children aged two and three)	To be confirmed	
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	98.1%	2012-13
2.21ii :Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for	To be confirmed	

antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result		
2.21iii: The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report	98.0%	2012-13
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	92.3%	2012-13
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)	97.5%	2012-13
2.21vi The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth	To be confirmed	
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		
The proportion of men eligible for abdominal aortic aneurysm screening to whom an initial offer of screening is made.	To be confirmed	
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	76.9% coverage aged 53-70	Published in 2012

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	75.3% coverage aged 25 to 64	Published in 2012
Bowel cancer screening programme **FOBt (faecal occult blood testing) Screening Uptake (all rounds)** Source: NHS Cancer Screening Programmes	55.8%	Start of programme to end-August 2013
Children's public health services (from pregnancy to age 5)		
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. Health Visiting Minimum Data Set	9,133 FTE qualified health visitors (ESR and non-ESR)]	March 2013
The Government's commitment to more than double the April 2011 number of places on the FNP programme to at least 16,000 by April 2015.	11,475 FNP places as at 1 April 2013	
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	2.85%	2010
Breastfeeding (as defined in Public Health Outcomes Framework indicator 2.2) 2.2i: Breastfeeding initiation	74.0%	2011-12
2.2ii: Breastfeeding prevalence at 6-8 weeks after birth	47.2%	2011-12
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	22.6%	school year 2010-11
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 0-17 years, per 10,000 resident population. **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.**	To be confirmed 4.2 deaths per 1,000 live births To be confirmed	2011
Child health information systems **Maintain coverage of local delivery of Child Information Systems, with a plan to implement defined minimum standards as far as possible by April 2015 and encourage future attainment.**		
Public health care for people in prison and other places of detention		
People entering prison with substance dependence issues who are previously not known to community treatment (as defined in the Public Health Outcomes Framework indicator 2.16) 2.16: Proportion of people assessed for substance dependence issues when entering prison who then require structured treatment and have not already received it in the community	To be confirmed	

The proportion of individuals in secure environments that engage in structured drug and alcohol treatment interventions who at the point of departure from that establishment either: • successfully completed a treatment intervention in custody and did not represent to treatment (either in custody or the community) within 6 months of release; or • successfully engaged in community based drug and alcohol treatment interventions following release; or • where they were transferred to another prison/YPSE, successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.	To be confirmed To be confirmed To be confirmed	
Sexual assault services **Assure improvement in local delivery of sexual assault referral centres as described in Table 3. .**		

B4. Table 3 is first mentioned in paragraph A14.

Table 3: Key deliverables for implementing change

Key deliverables (shown in bold)
Immunisation programmes **Implement as far as reasonably practicable the planned new MenC immunisation programme for university entrants.** **Develop the extension of the seasonal influenza vaccination programme to children as described in Table 4, including vaccination coverage for children aged four that is as high as reasonably practicable.**
Children's public health services (from pregnancy to age 5) As described in paragraphs A5 and A28, arrangements in relation to transition of children's public health services from pregnancy to age 5 are being developed through a task and finish group of the Children's Health and Wellbeing Partnership, of which both NHS England and DH are members. **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.**
Sexual assault referral services **NHS England will provide by 31 March 2014 an improvement plan. The plan 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 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.**

B5. Table 4 is first mentioned in paragraph A26.

Table 4: Phased implementation of the extension of the seasonal influenza vaccination programme to children

Key deliverables (shown in bold)
In 2014-15, NHS England will: **a) make provision of childhood flu vaccination for all 2 and 3 year olds;** **b) make provision for 4 year olds;** **c) continue delivery to primary school aged children (5-11 year olds) in the current pilot areas; and** **d) commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible in the light of the circumstances below.** The best uptake of vaccination among 5-16 year olds is likely to be achieved through a school-based programme. However, it is recognised that the capacity of school nursing services (where appropriate locally working with specialist immunisation services) is not currently adequate 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 development of sustainable long-term solutions, • 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. NHS England will also work with PHE to undertake an assessment of the commissioning capacity to deliver a programme of this scale. NHS England will work towards delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible in 2014-15. However, it is recognised that full coverage may not be achievable within one year. The partners therefore intend to enter into negotiations following on the outcome of the assessments of workforce and commissioning capacity, with a view to agreeing by way of a variation to this agreement by April 2014, the extent to which the programme can be rolled-out and the expected uptake rates for vaccination in 2014-15.

C. Service specifications

C1. This part of the agreement includes the service specifications listed in Table 4 which are published as separate documents.

Table 4 : List of service specifications

Number		Publication date
	Immunisation programmes:	
1	Neonatal Hepatitis B immunisation programme	Nov 2013
1A	Pertussis pregnant women immunisation programme	Nov 2013
2	Neonatal BCG immunisation programme	Nov 2013
3	Respiratory syncytial virus (RSV) programme	Nov 2013
4	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis, and Hib	Nov 2013
5	Rotavirus immunisation programme	Nov 2013
6	Meningitis C immunisation programme	Nov 2013
7	Hib/MenC immunisation programme	Nov 2013
8	Pneumococcal immunisation programme	Nov 2013
9	DTaP/IPV and dTaP/IPV immunisation programme	Nov 2013
10	Measles, mumps and rubella (MMR) immunisation programme	Nov 2013
11	Human papillomavirus (HPV) programme	Nov 2013
12	Td/IPV (teenage booster) immunisation programme	Nov 2013
13	Seasonal influenza immunisation programme (2014-15 programme)	Nov 2013
13A	Seasonal influenza immunisation programme for children (2014-15 programme)	Nov 2013
14	Shingles immunisation programme	Nov 2013

	Screening programmes	
15	NHS Infectious Diseases in Pregnancy Screening Programme	Nov 2013
16	NHS Down's Syndrome Screening (Trisomy 21) Programme	Nov 2013
17	NHS Fetal Anomaly Screening Programme	Nov 2013
18	NHS Sickle Cell and Thalassaemia Screening Programme.	Nov 2013
19	NHS Newborn Blood Spot Screening Programme	Nov 2013
20	NHS Newborn Hearing Screening Programme	Nov 2013
21	NHS Newborn and Infant Physical Examination Screening Programme	Nov 2013
22	NHS Diabetic Eye Screening Programme	Nov 2013
23	NHS Abdominal Aortic Aneurysm Screening Programme	Nov 2013
	Cancer screening programmes	
24	Breast Screening Programme	Nov 2013
25	Cervical Screening	Nov 2013
26	Bowel Cancer Screening Programme	Nov 2013
	Other programmes	
27	Children's public health services (from pregnancy to age 5)	Nov 2013
28	Child Health Information Systems (CHIS)	Nov 2013
29	Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate	Nov 2013
30	Sexual assault services	Nov 2013