NHS England

Public Health Section 7A
Commissioning Intentions, 2015/16

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Publications Gateway Reference:	**02292**
Document Purpose	Guidance
Document Name	Public Health Section 7A Commissioning Intentions 2015/16
Author	NHS England
Publication Date	08 December 2014
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Directors of PH, Directors of Nursing, NHS England Regional Directors, NHS England Area Directors, Directors of Finance, Communications Leads,
Additional Circulation List	CSU Managing Directors, Medical Directors, Local Authority CEs
Description	This document sets out for commissioners and healthcare providers; notice of NHS England's commissioning intentions for Public Health Section 7A Programmes for 2015/16, in support of the ambitions for improving the quality of health services and health outcomes (linked to the wider determinants of health) and outlines the strategies and commissioning intentions required to achieve this.
Cross Reference	The Public Health Section 7A Commissioning Intentions should be read in conjunction with:- • NHS England; The Quality Assurance Framework • NHS England ;The Serious Incident Framework Immunisation & Screening National Delivery Framework & Local Operating Model http://www.england.nhs.uk/wp-content/uploads/2013/05/del-frame-local-op-model-130524.pdf Securing Excellence In Commissioning For Healthy Child Programme 0-5 Years 2013 - 2015, http://www.england.nhs.uk/wp-content/uploads/2013/08/comm-health-child-prog.pdf • The NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution • The NHS Mandate - http://mandate.dh.gov.uk/ Public health functions to be exercised by NHS England • Everyone Counts – NHS England Planning Guidance - http://www.england.nhs.uk/everyonecounts/ • NHS England Business Plan
Superseded Docs (if applicable)	Public Health Section 7A Commissioning Intentions 2014/15
Action Required	NA
Timing / Deadlines (if applicable)	**NA**
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Document Status

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Public Health Section 7a Commissioning Intentions

Version number: refresh 02

Updated: December 2014 - NHS England Gateway Number **02292**

Prepared by: Commissioning Intentions Design Team – Central, Regional and Sub Regional Teams

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;

Given due regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

The Equality Delivery System (EDS) for the NHS helps all NHS organisations, in discussion with local partners including patients, to review and improve their performance for people with characteristics protected under the Equality Act. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty.

If you have any questions in relation to equality or health inequalities please contact england.eandhi@nhs.net

This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities it is responsible for, including policy development, review and implementation.

NHS England is committed to securing alignment across all aspects of NHS commissioning and will work with Clinical Commissioning Groups (CCGs), Public Heath England (PHE), Department of Health (DH), and local authorities along with other partner NHS oversight bodies as appropriate to secure the best possible outcome for patients and service users within available resources.

1 Purpose

This document sets out for commissioners and healthcare providers; notice of NHS England's commissioning intentions for Public Health Section 7A Programmes for 2015/16, in support of the ambitions to improve health outcomes, tackle inequalities and secure best value for money. .

2 Background

The NHS Public Health Functions Agreement (Section 7A or s.7A) of the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines specific responsibilities for the National Health Service England (NHS England) for the commissioning of certain public health services as part of the wider system design to drive improvements in population health.

The agreement is based on a shared commitment to protect and improve the public's health – the Department of Health, NHS England and Public Health England 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

In order to achieve this NHS England under the NHS Public Health Functions Agreement 2015/ 2016 (s.7A) has two objectives:

1) provide high quality services with efficient use of resources within financial allocations which are set at levels that reflect expectations of efficiency gains in commissioning.
2) deliver changes in s.7A services at pace and scale, and to implement agreed changes in s.7A services in a safe and sustainable manner, promptly and thoroughly.

Achieving these objectives 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 of the Public Health Outcomes Framework or otherwise a key performance indicator for the service.

- variation in local levels of performance between different geographical areas will have been reduced, as evidence in relation to inequalities in health being reduced (while national and local levels of performance have been improved or maintained)

- the evidence in relation to high quality of services includes:
  - that agreed 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

3 Operating Model for Public Health Section 7A

Within the system for the delivery of public health services, partners including the Department of Health (DH) NHS England, Public Health England (PHE), Local Authorities (LAs), Providers, and Clinical Commissioning Groups (CCGs) will work together to deliver patient outcomes. The responsibilities of each partner are listed in Appendix 2.

4 The Scope of Public Health Services Covered by Section 7A

Section 7A describes services that will be commissioned by NHS England in 2015/16, subject to agreement by the NHS England board and Secretary of State, as follows:

- Screening Programmes including expansion of the new-born blood spot programme;
- Immunisation including expansion of the childhood flu vaccination programme, and the addition of Meningococcal B subject to successful vaccine procurement by DH;
- 0 to 5 healthy child – from 01 April - 30 September 2015 only (Health Visiting and Family Nurse Partnership services);
- Child Health Information Services (CHIS), including Child Health Records Department (CHRDs) and IT Systems;
- Public health services for people in prison and other places of detention, including those held in the Children & Young People's Secure Estate
- Sexual Assault Services (SAS).

Each programme is underpinned by a number of service specifications, which will be published later in the year to support commissioning and contracting.

Outside of scope of the 2015/16 s.7A, PHE is working closely with NHS England to pilot services that may become part of the s.7A in future years subject to negotiation. These are referenced in further detail on page 11.

The commissioning of the Children's Public Health service (with the exception of CHIS and the 6-8 week GP check which includes the New Born Infant Physical Examination (NIPE)) will transfer to local government on 01 October 2015 enabling local government to integrate 0 to 5 year olds with the commissioning of public health services for 5 to 19 year olds that they currently undertake.

5 Improving Access - linkages to wider determinants of Health

The delivery of s.7A services for armed forces personnel are part of our responsibilities for s.7A and part of the Armed Forces Covenants (Armed Forces Covenant and Armed Forces Community Covenant). We will look at pathway changes that work across Defence Medical Services (DMS) and NHS services that can to lead to improvements in access for s.7A services including immunisation and screening uptake, coverage and recording. (This includes continuation of the cervical screening programme established in 2014/15)

Service Specification 29 outlines NHS England's commissioning responsibilities in relation to provision of high quality health services for people in Prescribed Places of Detention (PPDs) that reduce inequalities, provide advice and expertise to facilitate healthy choices and supports them to live healthy lives with continuity of care on return to the community. Services providers will be required to comply with data requirements of the newly developed Health & Justice Indicators of Performance (HJIPs) and Sexual Assault Services (SAS).

NHS England with partners is jointly responsible for commissioning a cost-effective, integrated public health service response to sexual violence and rape to meet the needs of our population. This includes commissioning of health care and therapeutic pathways in 40 Sexual Assault Referral Centres (SARCs) in England and wider Sexual Assault Services more generally.

The provision of these services will be reliant on the development of effective co-commissioning relationships between NHS England, PHE, the Police, Police and Crime Commissioners (PCCs), clinical commissioning groups (CCGs) and local authorities. The ambition is to ensure robust care pathways for victims and appropriate referral at a time of crisis; including psycho-social intervention that may be required at the time of presentation, and ongoing therapeutic support. NHS England will work with these stakeholders regarding the alignment of commissioning and budgetary responsibility for sexual assault services; this will be supported by work to analyse the pathways of care for people needing these services. .

NHS England has developed a commissioning assurance process that will require demonstration of the development of collaborative commissioning approach/agreements for sexual assault commissioning. Effective pathways will take into account the physical and mental health needs of victims of sexual assault. NHS England has developed an appropriate performance and quality monitoring mechanism for SAS, including the paediatric element of services and the therapeutic care of victims. All providers will be required to demonstrate compliance by undertaking monthly returns.

Quality improvements within paediatric services were supported by a financial uplift in 2014/15 and are now part of allocations. A paediatric service framework for this responsibility will be published later in 2014/15 and will include national minimum guidance and key performance indicators (KPIs). This will be implemented by four early adopter sites during 2014/15.

Together with partners we will seek to develop professional practice for those non clinicians involved in SAS and develop a communication plan to promote services more widely, to encourage increased access.

5.1 Equality and Diversity

There are nine specific areas (or protected characteristics) which are covered by equality and diversity guidelines and legislation. These are as follows: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion and belief; Sex; Sexual orientation

It is a statutory requirement under the Equality Act 2010 and the NHS and Social Care Act 2008 that public sector agencies make 'reasonable adjustments' to their practice that will

make them as accessible and effective for individuals under the 9 protected characteristics. This includes making adjustments include removing physical barriers to accessing health services, but importantly also include making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for all parts of society.

In 2015/16 NHS England is focusing on improving access to public health screening programmes overall, and with a specific focus on improving access and uptake for people with learning disabilities.

In England approximately 1.2 million people have learning disabilities (300,000 children, 900,000 adults). People with learning disabilities have significantly higher rates of mortality and morbidity than their non-disabled peers. For 2015/16 we expect to commission and make quality improvements in this area and ensure adequate data collection to monitor the delivery of public health services for this population. Please refer to the following document and its recommendations in relation to National Cancer screening programmes http://www.improvinghealthandlives.org.uk/publications/1126/Making_Reasonable_Adjustments_to_Cancer_Screening

6 Capital Funding

S.7A allocations do not include funding for capital costs for example replacement equipment. The Provider is responsible for maintenance and re-procurement of equipment. Equipment must meet any national requirements and standards. Please refer to the NHS Standard Contract SC 15 on Services Environment and Equipment http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-b-cond-1415.pdf. Providers must seek capital funding for replacement equipment through their own capital programmes. For instance, in relation to equipment for the New Born Screening Hearing Screening Programme, NHS England is working with NHS Supplies to develop a new framework for providers to call off from, expected to be ready by end of 2015.

7 Patient and Public Engagement

In upholding the NHS Constitution, NHS England is committed to ensuring that patients are at the centre of every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England, through the geographical teams will ensure that this is demonstrated in the way care is provided and monitored through our formal contracting process with providers.

We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign.

It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

Providers of public health s.7A services should look 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.

As well as capturing patient experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

Specifically providers should report out comes of the Friends and Family Test for services specific to s.7A to identify levels of satisfaction every quarter and areas for potential improvement.

8 Training and Data Collection

Providers have the responsibility to ensure that service provision:

- is delivered and supported by suitably trained, competent healthcare professionals who participate in recognised ongoing training and development for example, as per PHE National Minimum Standards for Immunisation Training;

- Providers must make provision to ensure all staff training is current and covers competencies required, and evidence to give assurance to commissioners of this as appropriate;

- is supported by regular and accurate data collection using the appropriate returns.

9 Planned Programme Changes 2015/16

There are some planned changes to the existing 2014/15 service specification and details about these will be available following publication of s.7a in 2015/16

Additional resource will be secured in the s.7a for delivery of programmes below:

New Born Blood Spot Screening (NBBS) - expanded to screening for 4 more conditions. Homocystinuria (HCU), Glutaric Aciduria type 1 (GA1), Maple Syrup Urine Disease (MSUD), Isovaleric Acidaemia (IVA). Completion of full national rollout expected by March 2015	These screens identify additional metabolic disorders from apparently healthy people who may be at increased risk of disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.
Continuation of the temporary programme for	Continuation of current programme following Joint Committee for Vaccinations and Immunisations (JCVI) recommendation that temporary programme is extended for a further 5 years.

Maternal Pertussis	
Meningococcal B – if vaccine procured at cost effective price	JCVI recommendation: Programme to be implemented subject to successful DH contract negotiations on vaccine procurement with the supplier
Childhood flu vaccination programme	JCVI recommendation: Programme will continue implementation to 2, 3 and 4 year olds in primary care as agreed in 2014-15. In 2015/16 extension of the programme will be to children of school years 1 & 2

9.1 Childhood flu Vaccination Programme

Evidence shows that the impact of flu and flu related deaths can be reduced in older adults and people with clinical risk factors by directly averting transmission through children.

Based on this evidence, in July 2012 the JCVI recommended that the flu vaccination programme should be extended to healthy children aged 2 to less than 17 years.

On full rollout this will be the biggest vaccination programme in England with 9 million children and young people offered a Fluenz vaccination every autumn

Due to the scale of the programme, the extension is planned over a number of years from 2013-17. The programme will continue implementation to 2, 3 and 4 year olds in primary care as agreed in 2014-15. In 2015/16 extension of the programme will be to children of school years 1 & 2 age.

Transition from the pilot phases to national rollout is supported by a National Childhood Flu Task Force - a team of four people who will work with Area Teams to support planning, commissioning and contracting of the programme.

10 Changes in Year

10.1 Healthy Child 0-5

Commissioning the Healthy Child 0-5 Programme (Health Visitor and FNP Services)

Following an announcement in January 2014 the commissioning of the Children's Public Health Services will move to local authorities on 01 October 2015 enabling local government to integrate commissioning for 0-5 year olds with commissioning for 5-19 year olds.

Responsibilities to move to Local Authorities are:

- Health visiting services (universal (mandated for 18 months post 01 October 2015) and targeted services);
- Family Nurse Partnership (FNP) services (targeted service for teenage mothers)

Responsibilities to remain with NHS England are:

- Child Health Information Systems;
- 6-8 week GP check including New-born Infant Physical Examination screening programme (NIPE).

Until 30 September 2015, the model of health visiting as per the health visitor implementation plan, should be referred to, and delivery of the licenced model for FNP should be followed as outlined in Securing Excellence in Commissioning for Healthy Child Programme 0-5 Years 2013 - 2015.

A number of service improvement programmes have been agreed and are specified in our Public Health Outcomes. These include:

- Health Visiting including breastfeeding, smoking at time of delivery, MMR rates and school readiness;
- FNP including improved parenting practices and behaviour, fewer subsequent pregnancies and reduction in children's injuries neglect and abuse.

The aim is 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.

Specific contractual guidance is available from the central team in NHS England – see 16.2 below.

The focus of work to October 01 includes:

- Meeting Government commitment for Health Visitor and FNP trajectories;
- Working to ensure sustainability of services with local authorities until commissioning responsibilities move on 01 October – specifically:
    - 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.

In the context of the 0-5 programme, providers are expected to maintain their performance in delivering (or making good any shortfall) against 12,292 FTE health visitor numbers. This requires a steady state regarding the numbers and availability of health visitor posts into the second half of the year such that there is no reduction in the overall number of health visitors in employment.

Joint working with LETBs will be required to support the autumn 2014 health visitor training cohort into employment, as their courses complete in 2015

10.2 CHIS

The Senior Responsible Officer (SRO) for CHIS will remain with NHS England and we will work with stakeholders to develop a strategic approach to its future during 2015 to support the commissioning and delivery of services to children. At present NHS England is working with local authorities to establish systems to deliver good quality and timely information as set out in the provider performance framework, and to support mandation beyond 01 October using the s.7A Child Health Information Systems (CHIS) where appropriate.

11 Service Developments – PHE Pilots

NHS England will support the development and delivery of the following screening and immunisation pilots programmes funded by Public Health England that are not part of s.7A but could be transferred into future s.7A agreements subject to negotiation. This will ensure that planning and delivery fits with routine commissioning and development protocols within NHS England.

11.1 Bowel Scope Screening

The “Improving Outcomes – a Strategy for Cancer” (published in January 2011) committed to pilots for flexible sigmoidoscopy for bowel cancer screening commencing in 2011/12.

Building on the success of the pilots and the Wave 1 sites which commenced in 2013, it is expected that 60% of Bowel Scope Screening Centres will have commenced by the end of 2016.

All the NHS costs of the roll-out of bowel scope screening will be met by PHE in 2015-16. In 2016-17, subject to a negotiated agreement on the funding arrangements, NHS England will take on responsibility for further roll-out, .

NHS England must plan and work with clinical commissioning groups (CCGs) this year and in 2015/16 to ensure capacity in endoscopy services the for delivery of the two screening programmes FoBT and Bowel Scope Screening, and Symptomatic Services. Planning must factor in measures to ensure NHS England is ready to take commissioning responsibility from April 2016 and delivery does not negatively impact on other endoscopy services.

11.2 Breast Cancer

The breast cancer screening 6 year age extension trial will continue until end 2020. Transfer and continuation is subject to favourable outcomes from the trial and policy agreement with commissioners.

12 Collaborative Commissioning Across Pathways

Programmes under s.7A are directly commissioned by NHS England in order to develop a single approach to commissioning. Some flexibility and innovation is allowed in order to address specific challenges faced by some communities, and to ensure consistency of standards within available resources. This will help reduce inequalities and improve services across England.

Commissioners within the local health economies (CCGs, PHE, local authorities (LAs), Defence Medical Services, and NHS England) will work together across the whole pathway to develop evidence based pathways, e.g. bowel cancer and bowel scope screening to diagnosis, ensuring clarity of access for the relevant cohort across the commissioning landscape. These pathways can be used in contracting with providers, aligning incentives and accountability for outcomes. The approach of engaging commissioners will be the basis of future whole pathway commissioning.

Specifically, as part of its five year forward look, NHS England is evaluating alternative models for future commissioning, such as co-commissioning with its partners in order to deliver the quality outcomes for patients, and value for money. This will not only result in

improved equity of access for patients, but will also ensure a more effective and focused use of resources.

13 Commissioning Resources

Public Health services as part of s.7A, for 2015/16, will be funded directly by NHS England. NHS England will set budgets at a geographical level for all programmes undertaken by providers within the allocation for the s.7A agreement.

High quality Public Health s.7A services will be effectively managed within this finite resource by NHS England and providers working together.

Each region will be responsible for ensuring the financial and quality performance of the contracts it holds for the whole population including relevant armed forces personnel based within England. NHS England will work in line with contracting and the agreement within s.7A. Scrutiny and measurement will be via monthly finance reports.

13.1 Procurement

In line with the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, and guidance issued by Monitor entitled '[Substantive guidance on the Procurement, Patient Choice and Competition Regulations]', NHS England is committed to ensuring that when it procures health care services it satisfies the procurement objectives laid down in the regulations, namely to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving the efficiency in the provision of services, with participation expected in the assurance mechanisms required for s.7a.

14 Contracts

14.1 NHS Standard Contract

NHS England will be engaging with stakeholders to inform the development of a revised NHS Standard Contract for use in 2015/16 which will be published in December 2014.

The 2015/16 NHS Standard Contract will be used for all new contracts agreed for Public Health services from 1 April 2015 onwards. Where existing contracts do not expire at 31 March 2015, these will be updated for 2015/16 using Deeds of Variation which will be produced by NHS England early in 2015. Forms of contract other than the NHS Standard Contract will not be used.

Following feedback from commissioners on the s.7A service specifications NHS England and PHE are working together to embed the s.7A service specifications into the NHS Standard Contract template. This will be a rolling programme of activity.

- The aim of this work is:
    - Improved and more rigorous contract and performance management, through better use of contract levers, which will drive up quality and ensure equity of access from providers
    - To create efficiencies by developing templates to do it once at a national level

- Improve standardisation and consistency of commissioning by ensuring that all are working to standard specifications – reducing variation and therefore improving access
- maintain the quality and level of clinical advice in the current service specification, while ensuring that specifications are succinct and do not duplicate information

14.2 Single Provider Contract

The intention for 2015/16 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules. Contracting guidance will is available to support the 0-5 Transfer which may have implications for full year service delivery being implemented via two separate contracts or via contract model.

14.3 eContract

The eContract is currently undergoing changes which will be communicated separately CQUINS:

The Commissioning for Quality and Innovation (CQUIN) scheme for 2015/16 will be adopted for s.7a to include a national framework of 3 Public Health CQUINS, whereby organisations providing healthcare services under the NHS Standard Contract can earn incentive payments of up to 2.5% of their contract value by achieving agreed national and local goals for service quality improvement with the understanding were the quality improvements are not met the equivalent budget will be withheld. Regions will have to deliver at least one of the national CQUINs to fit with the planned ambitions within s.7A. The CQUINs are:

1. CHIS service interoperability;
2. Screening and immunisation uptake in mental health, people with learning disabilities and black and minority ethnic groups (BME) including maternity cohorts;
3. Integrated working between maternity and health visiting Services - Develop and implement an integrated shared assessment framework to ensure continuous high quality care between these services.

15 Service Specifications

During 2014 NHS England assessed compliance with all service specifications for s.7A programmes to inform the pace of change. Providers below minimum compliance level were asked to develop action plans to achieve compliance with specifications within a defined time period. These provider action plans are supported by a ‘derogation’. A derogation is a licence to operate outside a national service specification for a time-limited period.

NHS England will performance monitor the delivery of provider derogation action plans through routine contract monitoring mechanisms. NHS England will utilise contract sanctions where there is significant or persistent non-delivery against these plans. Where

commissioner-led service review work is required, this will be undertaken as part of the work plan, to include:

- Improved access and quality of service to the screening and immunisation programmes
- Improvement of services for healthy child programmes,
- Improved public health services for people in prison and other places of detention, including those held in the Young People's Secure Estate,
- Improvement of the Child Health Information Systems
- Improvement of public health services provided in Sexual Assault Referral Centres (SARCS).

A full report on service specification compliance will be delivered to the Public Health Oversight Group in March 2015.

16 Quality Assurance

Providers will participate fully in national quality assurance processes and respond in a timely manner to recommendations made. This will include submitting the following data to quality assurance (QA) teams within PHE who work alongside commissioners:

- data and reports from external quality assurance schemes
- minimum data sets as required – these may be required to be submitted to national external bodies
- self-assessment questionnaires / tools and associated evidence
- audits or data relating to nationally agreed internal quality assurance processes

Providers will participate fully in the QA visit process where required and cooperate in undertaking ad-hoc audits and reviews as requested.
Providers will respond to QA recommendations by the submission of action plans to address identified areas for improvement and any non-conformities / deviations from recommended performance thresholds.

Where a QA team believe there is a significant risk of harm to the population, they will recommend to commissioners to suspend a service.

16.1 Serious Incidents

The NHS England National Serious Incident Framework has been developed in partnership with providers, commissioners, regulators, and experts. The version published in 2013 is undergoing review to bring more consistency to the NHS response to serious incidents, a focus on learning, emphasise patient engagement and to simplify the process and timescales. It is anticipated the refreshed document will be published in late 2014.

In conjunction with this, PHE are refreshing the current Screening Serious Incidence guidance, which integrates with the document described above. This is due for publication later in the year.

Appendix 1

Services to be provided 2015-16

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 B (MenB) 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

Appendix 2

Partners' Roles and Responsibilities

The national and local operational models are subject to review with a refreshed version published later in the year. The outline below describes roles and responsibilities outlined in the 2013 document.

Department of Health (DH) is responsible for national strategic oversight, policy and finance for programmes which includes overall system stewardship, based in part on information provided by PHE, and for holding NHS England and PHE to account through their respective framework agreements, the Mandate and the s.7A agreement.

NHS England is responsible for the routine commissioning of the programmes under the terms of the s.7A agreement. Leadership for the commissioning of screening and immunisations requires local agreement about specific roles and responsibilities between the Screening and Immunisation Lead and the local Heads of Public Health. PHE currently hold most of the detailed data relating to s.7A and so management and access to the data for the s.7A programmes by local teams of NHS England in

development - for example rights of access, the establishment of data flows and access to information collected by PHE and other organisations, and guidance and updates for delivery.

Public Health England (PHE) is an executive agency of DH. The general function of PHE is to fulfil the Secretary of State for Health's statutory duty to protect health and address inequalities, and promote the health and wellbeing of the nation.

PHE is responsible for supporting both DH and NHS England, with system leadership, policy and service specification development, national planning, and implementation, (including the procurement of vaccines and immunoglobulins), piloting and initial roll-out when agreed, ensuring consistency in efficacy and safety of the immunisations and screening programmes across the country. PHE will also support the Directors of Public Health in local authorities in their role as leaders of public health locally.

PHE operates through its centres that work with NHS England's geographical teams and nationally, (including the Screening and Quality and Assurance Teams and the Knowledge and Intelligence Teams). Specific PHE staff are embedded as part of the public health commissioning team in each NHS England geographical team.

PHE is responsible for producing the service specifications for the s.7A services, ensuring that there is professional public health advice for NHS England's public health commissioning teams and publishing the Public Health Outcomes Framework. PHE support NHS England in its commissioning responsibilities through the provision of scientific, rigorous impartial advice, evidence and analysis. For more information refer to Framework Agreement between the Department of Health and Public Health England.

Local Government is the leader of the local public health system and is responsible for improving and protecting the health of local people and communities.

Providers of services need to deliver programme as outlined by the national service specifications.

Clinical Commissioning Groups (CCGs) have a duty of quality improvement and this extends to primary medical care services delivered by GP practices such as immunisation and screening services. As commissioners of treatment services that receive screen positive patients, CCGs will have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen positive patients and meet quality standards. CCGs will also hold the contracts for maternity services, and are providers of antenatal & new-born screening

Detailed information on the operating models for screening and immunisations can be found on: http://www.england.nhs.uk/wp-content/uploads/2013/05/del-frame-local-op-model-130524.pdf

Appendix 3 - Governance and assurance

The Governance arrangements s.7A are complex, with interfaces between and reflecting the interests of partners including: Public Health England, Department of Health, NHS England, and Local Authorities reporting from the Public Health Steering Group to the Senior Public Health Oversight Group, chaired by the DH.

Internal to NHS England, oversight of delivery of s.7A is led by the Public Health Oversight Group (Chair Regional Director - London) and six Assurance groups

- Screening
- Immunisation
- 0-5 Healthy Child
- Childhood Information Systems (CHIS)
- Sexual Assault Referral Centres
- Public Health for People in Places of Detention and Secure Settings.

The role of the Assurance Groups is to highlight where commissioning can be strengthened at a regional or national level. These Assurance Groups review performance data and soft intelligence to identify trends and variations at a regional and national level and manage risks in relation to their programme of work at Assurance Group level escalating to the Public Oversight Group by exception.

Appendix 4 Key Contact Information

Public Health Section 7a

Name	Job Title	Email
Assistant Head of Public Health	Dr Sandra Anglin	s.anglin@nhs.net
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