Department of Health & Social Care

NHS England

NHS public health functions agreement 2018-19

Public health functions to be exercised by NHS England

Title: NHS public health functions agreement 2018-2019, Public health functions to be exercised by NHS England
Author: EU, International and Prevention Programmes / Global & Public Health Group / Public Health Systems & Strategy / 10100
Document Purpose: Policy
Publication date: 26 March 2018
Target audience: NHS England Regional Directors
Contact details: Public Health Systems and Strategy

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www.gov.uk/DHSC

NHS England Publications Gateway Reference 07773

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Introduction

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

NHS England has a specific role to commission the public health services set out in this agreement and to hold to account providers to ensure that they deliver the contracts that have been agreed.

The Department of Health and Social Care (DHSC) is the overall steward of the system and holds NHS England to account for delivery under this agreement.

Direct commissioning of public health services by NHS England is based on national service specifications that have been produced by Public Health England (PHE) and agreed with NHS England, drawing on the best evidence in order to provide the public with evidence-based, safe and effective services.

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

- Improve public health outcomes and reduce health inequalities
- Contribute to a more sustainable public health, health and care system

This agreement sets out shared expectations for future years in order to assist effective planning. The Secretary of State expects

that the objectives stated in Chapter 1 will remain largely stable from year to year.

PHE provides DHSC with expert evidence and advice, and supports NHS England with information, expert advice, capacity and support at national and local level. PHE also works with NHS England to produce a joint assurance report each quarter.

PHE also holds an operational delivery role for some functions within the system. Examples include the design and implementation of pilots, the analysis and publication of data, procurement of vaccines and immunoglobins, and the provision of some IT systems. PHE has a quality assurance role in relation to screening programmes and provides support to local commissioning teams through the embedding of PHE staff.

PHE will be held to account for its responsibilities in relation to the agreement through its Quarterly Accountability Meeting with DHSC.

1. NHS public health functions 2018-19

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

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

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

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

- NHS England have agreed contracts with providers that are registered with the Care Quality Commission for services (see Annex A) within the contract, that these contracts deliver the s.7A agreement and that NHS England effectively manage these contracts to deliver the required performance
- National and local levels of performance will be measured in accordance with agreed standards and will have been improved (where below the agreed standard) or at least maintained (where at or above the agreed standard)
- Variation in local levels of performance between different geographical areas will have been reduced
- Patients have been able to access quality and equitable services delivered by providers with a suitably qualified and diverse workforce
- NHS England will have shown evidence in relation to high quality of services that:
    - Service specifications are in place with providers and that effective contract management has been exercised to ensure providers deliver to the requisite quality standard (using the Quality Assurance reports for screening)
    - The quality of patient experience will have been assessed as being both satisfactory and improving (to the extent that suitable data are available)
    - NHS England will have commissioned those public health services set out in this agreement within the financial allocations described in Chapter 4 (Finance). Those allocations have been set at levels that reflect expectations of efficiency gains in commissioning.

1.5. NHS England's **second objective** is to implement planned changes in s.7A services in a safe and sustainable manner, promptly and thoroughly. The key deliverables for implementing change from services provided in 2017-18 are listed in Annex B list B2.

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

2. Legal framework

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

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

2.3. The services listed in Annex A are to be provided or secured from 1 April 2018 to 31 March 2019.

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

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

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

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

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

- sections 83, 84 and 92 (primary medical services)
- sections 99, 100 and 107 (primary dental services)
- section 115 and 117 (primary ophthalmic services)
- sections 126 127, 132 and 144 (pharmaceutical services)

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

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

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

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

2.9. In exercising the Secretary of State's public health functions referred to in paragraph 2.1 above, NHS England must comply with the Public Sector Equality Duty (section 149 of the Equality Act 2010).

2.10. NHS England's duty to make an annual report on how it has exercised its functions (section 13U of the 2006 Act) applies to the functions exercised under this agreement. NHS England may include any part of the statement required under paragraph 3.12 as part of that annual report or as a separate document provided to DHSC as soon as practicable after the end of the financial year to which it relates.

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

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

2.13. In this agreement, references to "DHSC" are to the parts of the Department of Health and Social Care other than PHE.

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

3. Accountability and partnership

3.1. The agreed set of shared principles that supports development of the relationship between DHSC and NHS England are:

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

3.2. DHSC, Public Health England and NHS England will continue to work with local areas which are considering how place-based models of commissioning may support improved delivery of s.7A to their local population.

Oversight arrangements

3.3. DHSC will convene meetings of an oversight group which will be chaired by the DHSC Director General for Global and Public Health. The oversight group is called the "NHS Public Health s.7A Accountability Meeting". The accountability meeting:

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

3.4. Membership of the accountability meeting will include NHS England and PHE. Membership otherwise will be determined by the Chair with the consent of NHS England.

3.5. The accountability meeting will determine its own working arrangements, including the functions of any subgroups.

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

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

3.7. The accountability meeting is expected to have regard to the views of NHS England on the exercise of functions by NHS England under this agreement, having regard to its other functions including those mentioned in paragraphs 2.5 to 2.7. Arrangements in relation to consideration of a prospective variation to this agreement are given in paragraphs 3.15 to 3.20.

3.8. The parties recognise that the objectives set out in Chapter 1 of this agreement 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. For purposes of accountability, the Secretary of State and NHS England recognise that the funding provided under this agreement in accordance with paragraph 4.1 below is intended to provide the resources necessary to achieve the objectives of this agreement having regard to contributions expected to be made by the exercise of NHS England's other functions.

Assurance and reports

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

3.10. NHS England and PHE will work together to provide or secure the following information for assurance at regular intervals:

- Regular reports of relevant indicators of the Public Health Outcomes Framework (available at http://www.phoutcomes.info/) in relation to national levels of performance of s.7A services
- Reports of progress in relation to achievement of objectives of this agreement in relation to reducing variation in local levels of performance, and securing the full implementation of service specifications in contracts with providers (subject to 3.11 below)
- Progress reports to demonstrate the delivery of statutory duties on promoting equality and reducing health inequalities in relation to s7A programmes, including data on performance variation between different areas and populations.
- Reports of financial information of the financial year that show a breakdown of planned and actual expenditure on s.7A services

3.11. The accountability meeting may determine what if any further information is suitable for the purpose of assurance of progress in relation to achievement of the objectives of this agreement.

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

3.13. A further provision for the annual statement is that it may include performance information for a period before 31 March 2018, where this is necessary for effective reporting (for example, where indicators of the Public Health Outcomes Framework are reported at annual intervals).

3.14. NHS England will work with partners to support improvement in areas where significant performance issues are identified, ensuring action plans are developed and that progress is made in implementing these plans through the joint assurance process, including actions on addressing inequalities.

Changes

3.15. This agreement reflects consideration of priorities for an annual commissioning cycle, as mentioned in paragraph 3.6. This agreement may be varied by the Secretary of State and NHS England by written agreement. However such variations can never be routine, and the parties note that the achievement of the objectives of this agreement could potentially be jeopardised by unplanned changes. No variation or update for 2018-19 is expected.

3.16. Exceptional circumstances may require consideration of a prospective variation to this agreement and the accountability meeting may recommend a variation. A prospective variation will include any change that would have an impact on the commissioning obligations of NHS England under this agreement. The circumstances in which a prospective variation to this agreement may be considered include:

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

3.17. Consideration of a prospective variation should address the following factors, which are similar to considerations made before reaching this agreement:

- Evidence of impact, cost-effectiveness and cost saving
- Other evidence of rationale, including obligations under the NHS Constitution and NHS England Mandate
- Assessment of deliverability within existing operational resources, including commissioning capacity

- Any mitigating measures, such as lower expectations of performance in other services while delivery is implemented
- Any alternative options or timelines for delivery
- Affordability and confirmation of the availability of sufficient financial resources for delivery

3.18. The parties would expect to engage in thorough consideration of the affordability and financial matters mentioned in paragraph 3.17. DHSC expects that this will involve the views of the DHSC Director General of Finance and Group Operations and the NHS England Chief Financial Officer at a formative stage before recommendations on programme decisions are considered by Ministers.

3.19. It is noted that under section 13B of the 2006 Act, if the Secretary of State varies the amount of money specified under section 223D(2) (total revenue resource use), the Secretary of State must revise the Mandate accordingly.

3.20. The parties are committed to undertaking timely and efficient consideration of any prospective variation. The parties consider that public announcements about the likelihood of any additional commissioning being implemented by a prospective variation should be avoided until a recommendation has been made by the oversight group. DHSC will seek to ensure that PHE's public communications are consistent with this approach in relation to advisory committees' advice or recommendations on s.7A services or any prospective variation to this agreement.

3.21. NHS England will publish national service specifications developed by PHE for the s.7A programmes set out in Annex A. In the development of these specifications, PHE will continue to include the patient and public voice to assist it in the design of services and the patient pathway. Reviews of existing services will include, where appropriate, the views of the public – for example the bi-annual attitudinal tracking surveys conducted on immunisation programmes. The service specifications will be kept under review by PHE to ensure they are evidence based and support safe and effective service delivery.

3.22. All current service specifications are available at:

https://www.england.nhs.uk/publication/public-health-national-service-specifications/

Information

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

3.24. DHSC will ensure that PHE shares information about emerging evidence and the work of its advisory committees, in line with the arrangements described in paragraph 3.6.

3.25. NHS England and PHE will work to improve the sharing of data as appropriate in relation to s.7A services, specifically to support NHS England's commissioning functions. PHE and NHS England will also ensure that relevant unpublished information of appropriate quality is shared on a timely basis with DHSC for the purpose of assisting the Secretary of State to exercise his functions.

3.26. NHS England and PHE will also work to ensure effective and early communication takes place with regards to any programme service provider changes.

3.27. NHS England will without delay inform DHSC in writing of any significant concerns it has in relation to the performance of s.7A services.

Dispute resolution

3.28. As indicated in paragraph 2.11, any differences should be resolved quickly and constructively. The following provisions describe procedures to be followed to resolve any dispute in relation to:

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

3.29. At their discretion, an authorised senior representative of NHS England or DHSC may at any time declare a dispute under this agreement by a written notice to the chair of the accountability meeting. The notice should provide information about the dispute and how resolution of the matter has been attempted and failed. The day when the chair is notified is the "date of notification". The chair will have joint responsibility with the responsible NHS England Director to resolve the dispute.

3.30. 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 DHSC Director General of Finance and Group Operations, and the DHSC Permanent Secretary. They shall take steps to resolve the dispute within no more than 10 working days from the date of notification.

3.31. If the matter is not resolved in accordance with paragraph 3.29, 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 DHSC, 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. DHSC and NHS England agree to be bound by the decision of the Secretary of State and to implement any decision within a reasonable period.

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

4. Finance

4.1. The Secretary of State agrees to pay NHS England the sum of £1,205m from the public health budget for the purposes of performing the Secretary of State's functions pursuant to this agreement during the financial year 2018-19 (in addition to the funding referred to in paragraph 4.3). This is ring-fenced funding that may be used only for expenditure attributable to the performance of functions pursuant to this agreement.

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

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

4.4. The revenue resource limit for NHS England for the year 2018-19, as specified in the Mandate has been set so as to take into account the funding provided under this agreement under paragraph 4.1.

Annex A – “s.7A services”

Services to be provided 2018-19

All current service specifications are available at
https://www.england.nhs.uk/publication/public-health-national-service-specifications/

List of services to be provided pursuant to this agreement

Programme category or programme	**Services**
Immunisation programmes	Neonatal hepatitis B immunisation programme
	Pertussis pregnant women immunisation programme
	Neonatal BCG immunisation programme
	Immunisation against diphtheria, tetanus, poliomyelitis, pertussis,Hib and hepatitis B
	Rotavirus immunisation programme
	Meningitis B (MenB) immunisation programme
	Meningitis ACWY (MenACWY) immunisation programme
	Hib/MenC immunisation programme
	Pneumococcal immunisation programme
	DTaP/IPV and dTaP/IPV (pre-school booster) immunisation programme
	Measles, mumps and rubella (MMR) immunisation programme
	Human papillomavirus (HPV) immunisation programme
	Td/IPV (teenage booster) immunisation programme
	Seasonal influenza immunisation programme
	Seasonal influenza immunisation programme for children

	Shingles immunisation programme
Screening programmes	NHS Infectious Diseases in Pregnancy Screening Programme
	NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 & 13)
	NHS Fetal Anomaly Screening Programme - 18+0 to 20+6 weeks fetal anomaly scan
	NHS Sickle Cell and Thalassemia Screening Programme
	NHS Newborn Blood Spot Screening Programme
	NHS 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	NHS Breast Screening Programme
	NHS Cervical Screening
	NHS Bowel Cancer Screening Programme (including the Bowel Scope Screening Programme)
Child Health Information Services	Child Health Information Services
Public Health services for adults and children in secure & detained settings in England	Public Health Services for Children and Adults in Secure and Detained Settings in England
Sexual assault services	Sexual Assault Referral Centres

Annex B – Performance indicators and key deliverables

Performance indicators

1. The indicators shown in the following list are to be used as evidence in relation to the achievement of the first objective in Chapter 1.
2. Except where marked (**) the indicators mentioned in this list are indicators published in the 2016-19 Public Health Outcomes Framework. This refers to:
    - 'Improving outcomes and supporting transparency: Part 2: Summary technical specifications of public health indicators' https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019
    - The data tool www.phoutcomes.info/
3. NHS England will be held to account for its performance under the s.7A agreement in line with the following:
    - Where performance **meets or exceeds** the agreed standard, NHS England's performance will be rated as **Green.**
    - Where performance is **below the lower threshold**, NHS England performance will be rated as **Red.**
    - Where performance is **between the lower threshold and the agreed standard** NHS England's performance will be rated as **Amber**.
4. In addition to the above formal performance assessment, NHS England will provide management information provided through the quarterly assurance process that includes information on health inequalities.
5. Providers are expected to aim to meet agreed programme standards.
6. The origin of the performance standard assigned for each indicator is described beneath the indicator name.
7. The ambitions for indicators 22, 23, 24 and 25 are detailed in the Annual Flu letter published on www.gov.uk.
8. Indicator 39 applies to the general prison estate – not to smoke free prisons. In smoke free prisons, no smoking will be tolerated and the expectation is that all those requiring access to smoking cessation services will need to be able to receive this help.
9. Data collected under indicators 49, 50 and 51 on Sexual Assault Referral Centres forms part of an experimental dataset. Therefore, no performance standards have been set for these indicators.

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

No	Performance Indicator	Lower Threshold	Standard	Service Specification
Immunisation programmes				
1	**Pre-natal pertussis vaccine coverage for pregnant women**** Standard origin: PHE/DHSC coverage target	50%	60%	1A
2	**Rotavirus coverage (1 year old) – completed the two dose course**** Standard origin: PHE/DHSC coverage target	90%	95%	5
3	**Men B coverage (1 year old)**** Standard origin: PHE/DHSC coverage target	90%	95%	31
4	**3.03iii: Population vaccination coverage – DTaP- IPV-Hib / DTaP-IPV-Hib-HepB (1 year old)** Standard origin: WHO/DHSC coverage target	90%	95%	4
5	**3.03v: Population vaccination coverage - PCV (1 year old)** Standard origin: WHO/DHSC coverage target	90%	95%	8
6	**3.03iii: Population vaccination coverage – DTaP-IPV-Hib / DTaP-IPV-Hib-HepB (2 years old**) Standard origin: WHO/DHSC coverage target	90%	95%	4
7	**3.03vi: Population vaccination coverage - Hib/Men C booster (2 years old)** Standard origin: WHO/DHSC coverage target	90%	95%	7
8	**3.03vii: Population vaccination coverage - PCV booster (2 years old)** Standard origin: WHO/DHSC coverage target	90%	95%	8
9	**3.03viii: Population vaccination coverage - MMR for one dose (2 years old)** Standard origin: WHO/DHSC coverage target	90%	95%	10
10	**Men B booster coverage (aged 2 years old)**** Standard origin: PHE/DHSC coverage target	90%	95%	31
11	**3.03vi: Population vaccination coverage - Hib/Men C booster (5 years old)**	90%	95%	7

	Standard origin: WHO/DHSC coverage target			
12	**3.03ix: Population vaccination coverage - MMR for one dose (5 years old)** Standard origin: WHO/DHSC coverage target	90%	95%	10
13	**3.03x: Population vaccination coverage - MMR for two doses (5 years old)** Standard origin: WHO/DHSC coverage target	90%	95%	10
14	**DTaP-IPV-Hib / DTaP-IPV-Hib-HepB coverage (5 years old)**** Standard origin: WHO/DHSC coverage target	90%	95%	4
15	**DTaP/IPV booster vaccination coverage (5 years old)**** Standard origin: WHO/DHSC coverage target	90%	95%	4
16	**3.03xii: HPV vaccination coverage one dose (females 12-13 year olds)** Standard origin: PHE/DHSC coverage target	80%	90%	11
17	**3.03xvi: HPV vaccination coverage two doses (females 13-14 year olds)** Standard origin: PHE/DHSC coverage target	80%	90%	11
18	**Men ACWY vaccination coverage (13-14 year olds)**** Standard origin: PHE/DHSC coverage target	60%	70%	6
19	**3.03xiii: PPV vaccination coverage (aged 65 and over)** Standard origin: PHE/DHSC coverage target	65%	75%	8
20	**3.03xvii Shingles vaccination coverage (routine cohort 70-year olds)**** Standard origin: PHE/DHSC coverage target	50%	60%	14
21	**Shingles vaccination coverage (catch-up cohort 78-year olds)**** Standard origin: PHE/DHSC coverage target	50%	60%	14
22	**Flu vaccination coverage (children pre-school age including those in risk groups)**** Standard origin: 2018/19 vaccine uptake ambition	40%	48%	13A
23	**Flu vaccination coverage (children school age including those in risk groups)**** Standard origin: 2018/19 vaccine uptake ambition	50%	65%	13A
24	**3.03xv: Flu vaccination coverage (at risk individuals from age six months to under**	50%	55%	13

	65 years, including pregnant women) Standard origin: 2018/19 vaccine uptake ambition			
25	**3.03xiv: Flu vaccination coverage (aged 65 and over)** Standard origin: WHO target	70%	75%	13
National Screening programmes				
26	**2.20i: Breast screening – coverage** The proportion of women in a population eligible for breast screening who were screened adequately within the previous three years on 31 March Standard origin: Programme standard	70.0%	80.0%	24
27	**2.20ii: Cervical screening – coverage** The proportion of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March Standard origin: Programme standard	75.0%	80.0%	25
28	**2.20iii: Bowel cancer screening – coverage** The proportion of people in the resident population eligible for bowel screening who were screened adequately within the previous 2½ years on 31 March Standard origin: Programme standard	55.0%	60.0%	26
29	**2.20iv: Abdominal aortic aneurysm screening – coverage of initial screen** The proportion of men eligible for abdominal aortic aneurysm screening who are conclusively tested Standard origin: Programme standard	75.0%	85.0%	23
30	**2.20v: Diabetic eye screening – uptake** The proportion of those offered a routine diabetic eye screening appointment who attend and complete a routine digital screening encounter/event Standard origin: Programme standard	70.0%	80.0%	22
31	**2.20vi: Fetal anomaly screening (18^{+0} to 20^{+6} fetal anomaly ultrasound) – coverage** The proportion of pregnant women eligible for fetal anomaly screening for whom a conclusive screening result is available within the designated timescale	90.0%	95.0%	17

	Standard origin: Programme standard			
32	**2.20vii: Infectious diseases in pregnancy screening – HIV coverage** The proportion of pregnant women eligible for HIV screening for whom a confirmed screening result is available at the day of report Standard origin: Programme standard	95.0%	99.0%	15
33	**2.20viii: Infectious diseases in pregnancy screening – syphilis coverage** The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report Standard origin: Programme standard	95.0%	99.0%	15
34	**2.20ix: Infectious diseases in pregnancy screening – hepatitis B coverage** The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report Standard origin: Programme standard	95.0%	99.0%	15
35	**2.20x: Sickle cell and thalassaemia screening – coverage** The proportion of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report Standard origin: Programme standard	95.0%	99.0%	18
36	**2.20xi: Newborn blood spot screening – coverage (CCG responsibility at birth)** The proportion of babies registered within the clinical commissioning group (CCG) both at birth and on the last day of the reporting period who are eligible for newborn blood spot screening and have a conclusive result recorded on the child health information system by 17 days of age Standard origin: Programme standard	95.0%	99.9%	19
37	**2.20xii: Newborn hearing screening – coverage** The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes: well babies, NICU babies) or by 5 weeks corrected age (community programmes: well babies) Standard origin: Programme standard	97.0%	99.5%	20

38	**2.20xiii: Newborn and infant physical examination screening – coverage (newborn)** The proportion of babies eligible for the newborn physical examination who are tested for all 4 components (3 components in female infants) of the newborn examination within 72 hours of birth Standard origin: Programme standard	95.0%	99.5%	21
Health & Justice – Secure & Detained				
Stop smoking services				
39	**Stop Smoking services uptake (as a % of the eligible population)**** Standard origin: DHSC/PHE coverage targets	50%	80%	29
Physical Health Checks				
40	**Physical Health Checks Uptake (as a % of the eligible population)**** Standard origin: DHSC/PHE coverage targets	30%	50%	29
Blood borne viruses				
41	**HIV testing uptake (as a % of the eligible population)**** Standard origin: DHSC/PHE coverage targets	50%	75%	29
42	**Hepatitis C testing uptake (as a % of the eligible population)**** Standard origin: DHSC/PHE coverage targets	50%	75%	29
43	**Hepatitis B testing uptake (as a % of the eligible population)**** Standard origin: DHSC/PHE coverage targets	50%	75%	29
Substance misuse				
44 45	**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**	50% 50%	75% 75%	29

46	**interventions following release; or** • **Where they were transferred to another prison/C&YPSE, successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.** Standard origin: DHSC/PHE coverage targets	60%	85%	
47	**% of new treatment entrants starting treatment in the establishment within 3 weeks of arrival (from community or another custodial setting)**** Standard origin: DHSC/PHE coverage targets	70%	90%	29
48	**% of the treatment population receiving clinical treatment who are also receiving concurrent psychosocial interventions to address substance misuse**** Standard origin: DHSC/PHE coverage targets	80%	95%	29
Health & Justice – Sexual Assault Referral Centres				
49	**% of survivors for whom sexually transmitted infections, HIV, Hepatitis B and Hepatitis C was indicated and were:** **a) tested in the SARC or;** **b) referred elsewhere for testing****			30
50	**% of survivors in whom Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) was indicated, who received a PEPSE starter pack within 72 hours****			30
51	**% of survivors in whom emergency contraception was indicated, who were prescribed or were given Emergency Contraception****			30
Child Health Information Services				
52	**CHRDs report on newborn bloodspot on the moved in babies;** **Denominator – total number of children who were not in your residential postcode area at 5 days of age but were at any age up to and including 365 days.** **Numerator – PKU outcome recorded.**	N/A	N/A	28

Key deliverables

List B2: Key deliverables for implementing change from services provided in 2017-18

Key deliverables
NHS Newborn Blood Spot Screening Programme In 2018-19, NHS England will, with support from PHE, work to: • Ensure Saturday morning checking of results and appropriate action for Medium-chain acyl-CoA dehydrogenase deficiency (MCADD), isovaleric acidaemia (IVA) and maple syrup urine disease (MSUD).
NHS Cervical Screening Programme In 2018-19, NHS England will: • Continue to work with PHE to implement mitigation plans to ensure local service delivery during the development of planning to introduce HPV primary screening. • Work to take forward plans on the implementation of HPV Primary screening laboratory services across England based upon the outcome from an options appraisal. A full HPV Primary screening implementation plan will ensure a robust transition to HPV Primary Screening in 2019-20. • Ensure the new IT requirements for cervical screening are delivered safely and to time through its contractor relationship. • Continue to ensure local action plans are delivered in response to cervical cancer screening uptake and that progress is made in implementing these plans, including actions on addressing inequalities and promoting informed consent.
NHS Diabetic Eye Screening programme In 2018-19, NHS England will: • Work with PHE on a framework around improvements in the quality of grading to support moving to extended intervals. Demonstrable evidence of improvements in the quality of grading will be necessary prior to moving to extended intervals. • Work with PHE to develop the framework and process for the implementation of extended screening intervals including the specification of data and IT requirements.
NHS Breast Cancer Screening Programme In 2018-19, NHS England will: • Continue to ensure local action plans are developed on breast cancer screening uptake and that progress is made in implementing these plans, including actions on addressing inequalities and promoting informed consent.

NHS Bowel Cancer Screening Programme

In 2018-19, NHS England will:

- Continue to commission bowel scope screening centres to an agreed trajectory as part of the NHS Bowel Cancer Screening Programme.
- Work closely with key partners including PHE to implement the change in test used within the Bowel Cancer Screening Programme from gFOBt to Faecal Immunochemical Test (FIT).

Improving MMR vaccination uptake

In 2018-19, NHS England will:

- Continue to ensure opportunities to improve MMR uptake (which are part of existing contracts) are capitalised on, for example, by using the new patient GP registration, and by targeting school leavers and women at their 6 week post-natal check.
- Improve MMR vaccination coverage for first dose (at two and five years) in all areas and sustain national coverage for first and second dose.
- Continue to ensure that local action plans are developed on MMR uptake and that progress is made in implementing these plans.

Elimination of polio

In 2018-19, NHS England will:

- Improve coverage of childhood vaccines that include protection against polio to achieve 95% at 12 and 24 months as part of its contribution to the elimination of polio in the UK. This deliverable relates to the uptake of:
    - the 6 in 1 (hexavalent) vaccine which protects against diphtheria, tetanus, pertussis, polio, Hib and HepB (DTaP/IPV/Hib/HepB) and is offered at 8, 12 and 16 weeks;
    - the pre-school booster which protects against diphtheria, tetanus, pertussis and polio (DTap/IPV) and is offered at 3 years 4 months (or soon after).

Shingles immunisation programme

In 2018-19, NHS England will:

- Continue the rollout of the shingles vaccination programme to patients aged 70 years, and as a catch-up to those patients aged 78 years. These patients, and previously eligible cohorts, will remain eligible for a single dose of vaccine until they reach the age of 80 years.

HPV vaccination for men who have sex with men (MSM)

In 2018-19, NHS England will:

- Work with PHE to transfer responsibility for commissioning of the 42 pilot sites for HPV MSM to mainstream NHS commissioned services.
- Develop a trajectory to enable roll out to as many providers as operationally feasible during 2018/19 with the remainder coming on line as soon as possible in 2019/20.
- Identify a key performance indicator to be used to monitor the performance of HPV MSM from 2020/21.

Childhood flu immunisation programme

In 2018-19, NHS England will:

- Arrange provision of flu vaccine for all those aged two and three (but not four years or older) on 31 August 2018 (i.e. date of birth on or after 1 September 2014 and on or before 31 August 2016) through general practice.
- Arrange provision of flu vaccine for children in school years reception, 1, 2, 3, 4 and 5. Details of the date of birth ranges for school-age cohorts will be included within Service Specification 13A and the Annual Flu Letter for 2018-19.

Hexavalent vaccine

In 2018-19, NHS England will:

- Contine to ensure babies are offered a 6 in 1 (hexavalent) primary infant vaccine which protects against diphtheria, tetanus, pertussis, polio, Hib and HepB.
- Ensure GP practices offering the enhanced service aimed at protecting babies at increased risk of exposure to the HepB virus or complications of the disease follow the revised schedule which requires a mixed schedule of monovalent and hexavalent vaccine or a dose of monovalent vaccine at birth and at 4 weeks followed by a dose of hexavalent vaccine at 8, 12 and 16 weeks and a booster dose of monovalent vaccine at 12 months.

Child Health Information Services (CHIS)

In 2018/19, NHS England will:

- Maintain the safe, efficient and effective delivery of Child Health Information Services to support the delivery of the Healthy Child Programme.
- Work with PHE and NHS Digital to update and deliver a refreshed S7a Service Specification (28), which is aligned with developments for digital child health (Paperless 2020, infrastructure standards) and consistent with operating models for the Healthy Child Programme and supporting IT.
- Review funding flow options for the commissioning of the electronic version of the

Parent-held Child Health Record ‘RedBook’ (ePCHR), which is aligned with digital child health (paperless 2020, infrastructure and standards) and RCPCH standards for the PCHR.
Health and Justice – Secure and Detained Settings In 2018-19, NHS England will: • Deliver and improve the uptake rate of the new Health Checks in Prison Programme to the eligible population. • Deliver and improve the uptake rate of the blood borne virus (BBV) opt out programme across the whole estate. • Work closely with PHE to plan and deliver a HPV vaccination pilot to opportunistically vaccinate MSM aged 45 years and under.
Health and Justice – Sexual Assault Referral Centres (SARCs) In 2018-19, NHS England will: • Report quarterly to the Department of Health and Social Care from April 2018 on Sexual Assault Referral Centres Indicators of Performance (SARCIP) data. • Support SARCs to ensure robust data collection and submission to influence service priorities. • Develop and agree benchmark standards for SARCIPs, based on robust national and international evidence base and clinical input from the advisory forum, for the 2019-20 agreement. • Support commissioners of SARC services to act as system leaders to work in partnership with Local Authorities, CCGs and criminal justice commissioners, to develop a high quality, integrated SAAS care pathway.