



NHS public health functions agreement 2019-20

Public health functions to be exercised by NHS England

December 2019

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Introduction

In November 2018 the Government set out its vision for preventing ill-health; for detecting ill-health earlier when it does occur, and for services working better together in a more personalised way for individuals and families when treatment is needed.¹

This focus on prevention is central to delivering the ambition of ensuring that people can enjoy at least five extra healthy, independent years of life by 2035, whilst narrowing the gap between richest and poorest.

A prevention Green Paper has now been published² identifying further policy proposals to deliver these objectives in addition to those set out in previous thematic strategies, such as those relating to childhood obesity and smoking.

The NHS itself has an important role to play in the prevention agenda. The NHS Long Term Plan sets out a more preventative, integrated and locally-empowering approach to population health, meaning GP surgeries, hospitals and care homes all working more closely with local authorities, schools, businesses, and charities. It also commits the NHS to increasing expenditure on primary medical and community services faster than other parts of the health system.

The Long Term Plan therefore underlines the critical part the NHS has 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, including our world-leading childhood and adult immunisation programmes, and screening programmes which span the many opportunities to detect and act on high risk of serious diseases across the life-course.

These programmes sit alongside and complement the work of local authority-commissioned health services, including the NHS Health Check programme which looks to detect and address a range of risk factors for cardiovascular conditions such as heart disease and stroke. Local directors of public health also play an important role in scrutinising local performance and identifying opportunities for improvement.

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.

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.

¹ <https://www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer>

² <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

This agreement sets out the outputs and outcomes to be achieved by NHS England and arrangements for funding from the public health budget. It is aimed primarily at NHS commissioners of services and sets out the statutory arrangements for exercise of some of the Secretary of State's public health functions; expectations around performance, and arrangements for holding NHS England to account.³

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.

This agreement is a shared commitment to protect and improve the public's health. DHSC, NHS England and PHE are working in partnership to achieve the benefits of this agreement across 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

Public health programmes are often in the headlines for the right reasons, but performance issues in the breast and cervical screening programmes have revealed a need to look closely at how these services are provided and run. This need is set against a backdrop of rapidly advancing technology and scientific developments including the exciting prospects of genomic medicine. Opportunities are emerging which should enable us to develop more targeted approaches to some of our national public health programmes, so we are supporting people with information and services that are closely aligned to their circumstances and needs.

Professor Sir Mike Richards has undertaken a wide-ranging review⁴ of how our national screening programmes operate and his recommendations. have implications for many aspects of current provision and organisation of screening programmes. We will begin to implement recommended improvements during this period and for future years revisit the performance indicators currently covered by this agreement. In the meantime, NHS England is expected to improve or maintain current performance against agreed standards.

³ A range of public information for individuals and families on the services providing under this agreement is available via www.nhs.uk

⁴ <https://www.england.nhs.uk/wp-content/uploads/2019/02/report-of-the-independent-review-of-adult-screening-programme-in-england.pdf>

1. NHS public health functions 2019-20

- 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 improved or maintained in accordance with current performance and agreed standards
 - 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 2018-19 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.
- 1.7 Public Health England provides DHSC with expert evidence and advice, and supports NHS England with timely information, expert advice, capacity and support at national and local level.
- 1.8 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 NHS England Regional Public Health Commissioning Teams through the embedding of PHE staff.
- 1.9 PHE will be held to account for its responsibilities in relation to the agreement through its Quarterly Accountability Meeting with DHSC.

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 2019 to 31 March 2020.
- 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 (Accountability Framework 2019/20) 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 s.7A 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 2019, 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.

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 in a timely manner within the contracting timetable, 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. NHS England will review the service specifications for financial and operational feasibility.
- 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 £1,271m from the public health budget for the purposes of performing the Secretary of State's functions pursuant to this agreement during the financial year 2019-20 (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 2019-20, 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 2019-20

List A1: 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 (Men B) immunisation programme Meningitis ACWY (Men ACWY) immunisation programme Hib/ Men C 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 Human papillomavirus (HPV) immunisation programme for men who have sex with men Td/IPV (teenage booster) immunisation programme Seasonal influenza immunisation programme Seasonal influenza immunisation programme for children Shingles immunisation programme

Programme category or programme	Services
Population 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 NHS Breast Screening Programme NHS Cervical Screening Programme NHS Bowel Cancer Screening Programme (including the Bowel Scope Screening Programme)
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- Child Health Information Services
- Public Health Services for Children and Adults in Secure and Detained Settings
- 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 drawn from the Public Health Outcomes Framework for 2019 to 2020.⁵
3. NHS England will be held to account for its performance under the s.7A agreement. It is expected to improve or maintain against current performance levels and in accordance with agreed standards.
4. NHS England will provide management information provided through the bi annual 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: <https://www.gov.uk/government/collections/annual-flu-programme>
8. Indicators 39 – 48 now apply (where relevant) to prisons and the Immigration Removal Centre estate.

⁵ Implementing changes to the Public Health Outcomes Framework 2016-19 following a consultation which ran from 21 January to 22 February 2019: <https://www.gov.uk/government/consultations/public-health-outcomes-framework-proposed-changes-2019-to-2020>

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

Immunisation programmes

No	Performance Indicator	Efficiency Standard (footnote 6)	Optimal Performance Standard (footnote 7)	Service Specification
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-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-HepB (2 years old) Standard origin: WHO/DHSC coverage target	90%	95%	4

⁶ This is the point at which programme delivery is considered to become efficient

⁷ This is the point at which programme delivery is considered to begin to operate optimally

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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) Standard origin: WHO/DHSC coverage target	90%	95%	7
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: 2019/20 vaccine uptake ambition	45%	50%	13A
23	Flu vaccination coverage (children school age including those in risk groups)** Standard origin: 2019/20 vaccine uptake ambition	60%	65%	13A
24	3.03xv: Flu vaccination coverage (at risk individuals from age six months to under 65 years, including pregnant women) Standard origin: 2019/20 vaccine uptake ambition	50%	55%	13

25	3.03xiv: Flu vaccination coverage (aged 65 and over) Standard origin: WHO target	70%	75%	13
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National Screening programmes

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
26	2.20i: Breast screening – coverage ⁸ 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 ⁹ 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

⁸ Indicator description subject to revision implementing recommendation 3.2 of the Independent Breast Screening Review: <https://www.gov.uk/government/publications/independent-breast-screening-review-report>

⁹ Indicator subject to revision following consultation on proposed Public Health Outcomes Framework changes.

29	<p>2.20iv: Abdominal aortic aneurysm screening – coverage of initial screen The proportion of men eligible for abdominal aortic aneurysm screening who are conclusively tested</p> <p>Standard origin: Programme standard</p>	75.0%	85.0%	23
30	<p>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</p> <p>Standard origin: Programme standard</p>	70.0%	80.0%	22
31	<p>2.20vi: Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage The proportion of pregnant women eligible for fetal anomaly ultrasound screening for whom a conclusive screening result is available within the designated timescale</p> <p>Standard origin: Programme standard</p>	90.0%	95.0%	17
32	<p>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</p> <p>Standard origin: Programme standard</p>	95.0%	99.0%	15
33	<p>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</p> <p>Standard origin: Programme standard</p>	95.0%	99.0%	15

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34	<p>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</p> <p>Standard origin: Programme standard</p>	95.0%	99.0%	15
35	<p>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</p> <p>Standard origin: Programme standard</p>	95.0%	99.0%	18
36	<p>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</p> <p>Standard origin: Programme standard</p>	95.0%	99.0%	19
37	<p>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)</p> <p>Standard origin: Programme standard</p>	98.0%	99.5%	20
38	<p>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</p>	95.0%	99.5%	21

	components in female infants) of the newborn examination within 72 hours of birth			
	Standard origin: Programme standard			

Health & Justice – Secure & Detained

Health & Justice – Secure & Detained: Stop smoking services

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
39	Stop Smoking services uptake (as a % of the eligible population)** ¹⁰	50%	80%	29
	Standard origin: DHSC/PHE coverage targets			

Health & Justice – Secure & Detained: Physical Health Checks

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
40	Physical Health Checks Uptake (as a % of the eligible population)** ¹¹	30%	50%	29
	Standard origin: DHSC/PHE coverage targets			

¹⁰ The general prison estate became smoke free in 2018. Future indicators are under consideration.

¹¹ For 2019/20 a programme to improve data collection will take place to improve the accuracy of reporting. Data will be collected but not RAG-rated in 2019/20.

Health & Justice – Secure & Detained: Blood borne viruses

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
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

Health & Justice – Secure & Detained: Substance misuse

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
44	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	50%	75%	29
45	Where they were transferred to another prison/C&YPSE, successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.	50%	75%	
46	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

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
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** Standard origin: DHSC/PHE coverage targets	80%	95%	30
50	% of survivors in whom Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) was indicated, who received a PEPSE starter pack within 72 hours** Standard origin: DHSC/PHE coverage targets	80%	95%	30
51	% of survivors in whom emergency contraception was indicated, who were prescribed or were given Emergency Contraception: In the SARC Referral outside of the SARC Standard origin: DHSC/PHE coverage targets	80%	90%	30

Child Health Information Services

No	Performance Indicator	Efficiency Standard	Optimal Performance Standard	Service Specification
52	<p>CHRDs report on newborn bloodspot on the moved in babies;</p> <p>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.</p> <p>Numerator – PKU outcome recorded.</p>	N/A	N/A	28

Key deliverables

List B2: Key deliverables for implementing change from services provided in 2018-19

Immunisation Programmes

Improving MMR vaccination uptake

In 2019-20, NHS England will:

- Maximise use of existing contractual levers to achieve 95% MMR vaccination coverage for first and second dose in all areas and ensure all local teams make meaningful progress in delivering elimination action plans in line with the UK-wide measles and rubella elimination strategy
- Continue to ensure all 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 entrants (age 4 to 5 years), the HPV vaccination and teenage booster appointments (Td-IPV and Men ACWY), school leavers and women at their 6 week post-natal check; and implement the MMR catch up for 10 and 11 year olds scheme via primary care (including a check and offer/update of any other childhood immunisations missing)
- Maximise opportunities to strengthen routine immunisation programmes and reduce inequalities in uptake, including through the review of vaccination contractual arrangements (for implementation in 2020 and 2021), and NICE guidance on reducing differences in the uptake of immunisations.

HPV vaccination programme

In 2019-20, NHS England will:

- Offer HPV vaccination to all 12 to 13-year-old-boys (school year 8) and those 13 to 14 year old boys (school year 9) in the following year where the dosage is offered across two academic years
- Ensure that any boy who misses a routine visit is automatically invited to the next planned sessions, or given a suitable, locally agreed alternative.

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

In 2019-20, NHS England will:

- Complete the national roll out by April 2019
- Identify a key performance indicator to be used to monitor the performance of HPV MSM from 2020/21.

Adult flu immunisation programme

In 2019-20, NHS England will take steps to ensure that providers comply with guidance from national authorities on the specific flu vaccines to use.

Childhood flu immunisation programme

In 2019-20, NHS England will continue phased extension of the childhood flu immunisation programme, arranging provision of vaccination for all children aged two to ten (but not eleven years or older) on 31 August 2019 as specified in the Annual Flu Letter for 2019-20.

Shingles immunisation programme

In 2019-20, NHS England will continue the catch-up programme offered to patients at 78 years of age (which is expected to be completed in 2020-21).

Screening Programmes

NHS Sickle Cell and Thalassaemia Screening Programme

In 2019/20 NHS England will support PHE in the implementation of a new system for referring Sickle Cell and Thalassaemia Screening screen positive infants from newborn screening laboratories into treatment services in order to improve patient safety.

NHS Newborn and Infant Physical Examination Programme

In 2019/20 NHS England will support PHE's lead to:

- Further embed the use of the national NIPE IT system to support accurate data collection and management of local screening pathways and failsafe processes

- Embed changes as a result of the move of NIPE SMART to the new IT platform SMaRT4NIPE (go live planned for Spring 2019).

NHS Diabetic Eye Screening Programme

In 2019-20, NHS England will:

- Commence moving to extended intervals in localities where safe and effective to do so, where services are able to demonstrate they can meet the appropriate quality criteria
- Continue, with support from PHE, to make measurable improvement in the quality of grading to support moving to extended intervals in all areas
- Continue to work with PHE on ensuring robust IT solutions support extended intervals in the interim, and as part of a system-wide approach to strategic IT development.

Cancer screening programmes

NHS Breast Cancer Screening Programme

In 2019-20, NHS England will:

- Implement all relevant Independent Breast Screening Review recommendations, including at the appropriate time promulgating and ensuring delivery against a new service specification, whilst improving performance against programme standards and KPIs, and addressing inequalities
- Work with PHE to facilitate replacement of the National Breast Screening System (NBSS) which has reached the end of its lifecycle, as part of a system-wide approach to strategic IT development
- Work with PHE to ensure that all screening services use the revised national templates when contacting women for call, recall and any other appointments relating to the screening process.

NHS Cervical Screening Programme

In 2019-20, NHS England will:

- Ensure the successful implementation of the delivery plan for HPV Primary Screening to achieve full geographical coverage across England by the end of December 2019, whilst working with PHE to ensure local service delivery during implementation meets the programme standards and guidance

- Ensure the timely revision and delivery of the relevant ICT systems for cervical screening through the contractor relationship with PCSE to ensure the requirements for HPV primary screening can be delivered safely
- Continue to ensure local plans are delivered in response to the decline in cervical cancer screening coverage and that progress is made in implementing these plans, including actions on addressing inequalities, promoting informed consent and improving access to screening.
- Ensure that action plans are delivered to improve access to cervical screening in sexual and reproductive health services.

NHS Bowel Cancer Screening Programme

In 2019-20, NHS England will:

- Continue to commission bowel scope screening centres to agreed position – to be confirmed
- Commission the Faecal Immunochemical Test (FIT) to replace gFOBt
- With advice from PHE, produce robust plans for the age extension of FIT-based bowel screening in line with commitments in the LTP and recommendations from the UK National Screening Committee.

Child Health Information Services

In 2019-20, NHS England will:

- Where CHIS systems and services currently provide a local call and recall function for routine immunisations continue to perform this function until a suitable, quality assured alternative is in place. Quality assurance to include maintained or improved immunisation coverage measured biannually
- Maintain the safe, efficient and effective delivery of Child Health Information Services to support the delivery of the Healthy Child Programme
- Implement the Professional Record Standard Body (PRSB) Child Health Standard which defines the formats for the capture and display of child health information and is a foundation for information sharing as described in the operating models for the Healthy Child Programme and supporting IT.

Public health services for adults and children in secure and detained settings

In 2019-20, NHS England will:

- Improve the uptake rate of the Health Checks in Prison Programme to the eligible population in adult prisons in England
- Improve the uptake rate of the blood borne virus (BBV) opt out programme in prisons and immigration removal centres (IRC) in England and working with Operational Delivery Networks increase access to treatment for Hepatitis C virus infection
- Work closely with PHE to deliver a HPV vaccination pilot programme in a selected cohort of prisons to opportunistically vaccinate MSM aged 45 years and under
- Continue to support the smoke-free prison estate in prisons and support of partial smoke-free policy in the Immigration Removal Centre (IRC) estate
- Implementation of latent TB infection (LTBI) testing and treatment in foreign national prisoners (pathfinder programme).

Sexual assault services

Sexual Assault Referral Centres (SARCs)

In 2019-20, NHS England will:

- Report biannually to the Department on Sexual Assault Referral Centres Indicators of Performance (SARCIP) data
- Support SARCs to ensure robust data collection and submission to influence service priorities
- Review benchmark standards for SARCIPs with the aim of setting robust lower threshold and standard indicators, based on robust national and international evidence base and clinical input from the advisory forum, for the 2020-21 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.

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