NHS England annual accountability statement for NHS public health functions agreements 2020/21 and 2021/22 under section 7A (s.7A)

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Contents

1. Background

The Secretary of State, through the annual section 7A (s.7A) public health functions agreement, delegates responsibility to NHS England to commission and drive improvements in population health through the following public health services:

- National NHS screening programmes
- National NHS routine immunisation programmes
- Child Health Information Services (CHIS)
- Public health care for people in prison and other places of detention
- Sexual assault referral services.

The s.7A agreement requires NHS England to report to the Secretary of State on its achievement against the expected objectives. This document is the NHS England accountability statement for 2020/21 and 2021/22.

For these two years, given the exceptional circumstances and unprecedented challenge of managing the response to the COVID-19 pandemic, letters were issued by the Department of Health and Social Care (DHSC) to NHS England[1] to put on record the arrangements for delegation of the Secretary of State's public health functions under s.7A of the National Health Service Act 2006 including functions transferring to NHS England from the body then known as Public Health England (PHE) as part of wider public health reforms, with effect from 1 October 2021 (see Appendix 1, Annex A).

It was agreed that over 2020/21 and 2021/22, NHS England would commission the services listed at Annex A of this assurance report and that these services should be provided in accordance with the relevant individual service and pathway requirement specifications; and updated where necessary with advice from PHE and subject to any agreed variations due to the COVID-19 pandemic.

[1] Then 'NHS England and NHS Improvement'.

2. Requirements of s.7A public health function agreement/ letters 2020/21 and 2021/22

During 2020/21 and 2021/22, NHS England continued to be held accountable for delivery of the s.7A agreement through the established monitoring and accountability mechanisms.

The mandate letters issued by government to NHS England in March 2020[2] and March 2021[3] set out headline objectives and budget arrangements and a requirement for NHS England to deliver the public health functions delegated under s.7A with a primary focus on a clinically prioritised COVID-19 response.

The requirements of NHS England during this period were to:

- continue to commission s.7A agreement services in accordance with individual service specifications with Public Health England (PHE) advice, subject to any agreed variations due to COVID-19
- maintain national immunisation programmes to avoid outbreaks of vaccine-preventable disease and avoid increasing further numbers of patients requiring health services
    - this included the delivery of the annual seasonal influenza vaccine programme as detailed in the annual flu letter
- ensure high coverage of time-critical screening opportunities (especially antenatal and newborn screening, those at very high risk) remained a population health goal
- recover performance on adult screening, school-age immunisation and other national public health programmes where activity was depressed by the pandemic
- reduce inequalities and improve outcomes through access to these services
- continue to deliver the COVID-19 vaccine programme in line with evolving population eligibility advice from JCVI, working closely with HM Government and PHE
- build on the innovation and changes across the system in the response to COVID-19 and continue the work underway to advance both COVID-19 recovery programme plans and longer-term transformation of services as set out in the NHS Long Term Plan.
- integrate plans to lower the age at which people are offered the bowel cancer screening home testing kit with COVID-19 recovery and restoration, while

[2] Public health commissioning in the NHS: 2020 to 2021 – GOV.UK (www.gov.uk)

[3] NHS public health functions (section 7A) agreement 2021 to 2022: letter from DHSC to NHS England – GOV.UK (www.gov.uk)

addressing the existing endoscopy capacity issues, within the wider improvement of screening.

2.1 Statutory duties in relation to equality and health inequalities

NHS England, through regional public health commissioning teams, continued to recognise the positive and transformative impact effective commissioning can have in addressing health inequalities.

Building on actions in previous years, in 2020/21 and 2021/22 all screening, vaccination and immunisation service specifications continued to include specific requirements for programmes to be delivered in a way which addressed locally identified health inequalities while restoring services impacted by the pandemic and tailoring and targeting interventions when necessary.

NHS England continued to monitor compliance with its responsibilities for public involvement and consultation and health equity audits during the period covered by this statement.

3 NHS England s.7A achievements and delivery of the requirements in 2020/21 and 2021/22

This section outlines the s.7A achievements and delivery requirements in 2020/21 and 2021/22, against the overarching objectives set down in Section 2 of this document.

The achievements and deliverables include the related delivery ambitions of the NHS Long Term Plan, published in January 2019, which include improving uptake and coverage of screening and immunisation programmes.

During 2020/21 and 2021/22, the priority was to ensure there was minimal impact on patients as a result of the evolving pandemic. NHS England worked closely with PHE and DHSC to ensure the highest risk patients were prioritised for invitation and diagnostic testing alongside ensuring robust plans were in place for timely recovery of services.

Despite the pandemic, the NHS also introduced a range of programme improvements such as starting to lower the age that people are offered the bowel cancer screening home testing kit as well as starting to accelerate digital transformation.

Key to ensuring s.7A service recovery, restoration and ongoing delivery, was collaboration and partnership working between commissioners, NHS teams (including the NHS cancer and diagnostic programmes; primary care, community and treatment services), the then NHSX, NHS Digital, Health Education England (HEE) (NHS England being the successor

organisation), PHE and its successor organisations: United Kingdom Health Security Agency (UKHSA) and OHID (Office for Health Improvement and Disparities).

The key indicators monitored during the 2020/21 and 2021/22 period are listed in appendices 3a and b. The indicators use agreed standards as comparators. Screening and vaccination services have, where applicable, two targets for assessment: efficiency (lower threshold) and optimal (standard) to allow for continuous improvement and to enable providers and commissioners to identify where improvements are needed.

The efficiency standard is the lowest level of performance that services are expected to attain to assure patient safety and service effectiveness. The optimal standard is an aspirational target that services should aspire towards. All screening, vaccination and immunisation services should exceed the efficiency standard; where they are not, NHS England develops plans to deliver sustained improvements.

In October 2021, NHS England welcomed colleagues from PHE when PHE was closed. Several screening functions were novated to NHS England from PHE, including contracting live IT services, publications/patient facing information and other contracts.

3.1 Screening

3.1.1 NHS antenatal and newborn screening

During 2020/21 and 2021/22 NHS England commissioned services which resulted in screening 1.15 million babies for 14-15 conditions and screening 1.275 million pregnant women for fetal anomaly (11 conditions), hepatitis B, HIV, syphilis, sickle cell disease and thalassaemia. During both 2020/21 and 2021/22, coverage for antenatal screening remained above 99.7%.

Coverage in the newborn blood spot and newborn and infant physical examination screening programmes remained above the acceptable threshold; however coverage for newborn hearing screening fell to 97.5% in 2020/21, before recovering to 98.7% in 2021/22.[4]

The six NHS antenatal and newborn screening programmes (ANNBs) were largely unaffected by the COVID-19 pandemic through the efforts of providers to continue these time-critical services.

The newborn hearing screening programme (NHSP) maintained good screening coverage. There were challenges within paediatric audiology to tackle a small backlog of assessments

[4] Public Health Outcomes Framework – OHID (phe.org.uk)

(which increased slightly at the height of the pandemic) for those babies referred from screening. A toolkit was developed, with support from PHE, to help NHS regions identify any babies whose screen or audiology assessment had been delayed so appropriate action could be taken.

The Wolfson Institute for Population Health (the Wolfson, hosted by Queen Marys University London) closed on 30 June 2022 with risk mitigation planning and delivery work taking place in 2021/22. The Wolfson was one of over 20 laboratories providing a laboratory service to the fetal anomaly screening pathway (FASP).

Following the decision to cease this service, the 41 maternity providers contracted to the Wolfson successfully secured alternative laboratory services/contracts with other providers. This success was only possible through the efforts of commissioners and maternity providers alongside the FASP programme and screening quality assurance service (SQAS), with an assured transfer of services with no adverse effects to the screening pathway or women.

The non-invasive prenatal testing (NIPT) evaluative rollout (in-service evaluation [ISE]) is an additional step in the FASP trisomy screening pathway aimed to improve the screening pathway and providing more accurate screening test results to women. The additional step is offered to women with a higher chance of a baby having Down's syndrome, Edwards' syndrome or Patau's syndrome. This equates to approximately 10,000 pregnancies per year.

The ISE commissioned by DHSC progressed well with contract reviews for all laboratories completed in February 2022, and live screening commencing in June and July of 2022. The ISE will be run by NHS England until end May 2024.

The ISE on the introduction of severe combined immuno-deficiency (SCID) into the newborn blood spot screening programme went live in September 2021, offering screening to approximately two-thirds of the birth cohort (circa 400,000 babies). SCID is a rare auto-immune condition that affects approximately 15 babies per year. The ISE will run to end Feb 2024 (including a recent six-month extension).

Work continued to implement a new system (newborn outcomes [NBO] solution) for referring sickle cell and thalassaemia screening screen-positive infants from newborn screening laboratories into treatment services, to improve patient safety and optimise access to dedicated clinical pathways.

The pilot for the new system went live in 2019 at the Central Middlesex, Leeds and Manchester laboratories and continued into 2020/21 to fully implement the solution. The

NBO ensures referrals are made, monitors attendance for first appointment, monitors commencement of entry to care and commencement of prophylactic penicillin.

3.1.2 NHS abdominal aortic aneurysm programme

During 2020/21 and 2021/22 380,000 men aged 65 were screened for an abdominal aortic aneurysm. In 2020/21, 55.0% of eligible men received a screen during the year (plus two months), down from 76.1% in 2019/20. During 2021/22, this had recovered to 70.3%.[5]

In March 2020, 32 NHS abdominal aortic aneurysm programme (NHS AAA) service providers temporarily paused invitations to support the pandemic response and protect patients and service providers from COVID-19. Nationally agreed principles and operational guidance were developed for providers to inform the restoration and recovery plans for local NHS AAA screening services with all services restarting invitations between June and August 2020 prioritising men most at risk of an AAA rupture/AAA-related death.

Restoration plans put in place to remove the backlog of initial screening invitations and for annual and quarterly surveillance screening resulted in a full return to pre-COVID-19 activity levels by 2022. Screen detection to vascular surgery waits were closely monitored. Over 90% of NHS AAA screening programme providers were recovered in 2021/22, in alignment with programme standards and a return to pre-COVID-19 activity.

3.1.3 NHS breast screening programme

During 2020/21 and 2021/22 the NHS breast screening programme (NHS BSP) screened 3.18 million women aged 50 to 70 for abnormalities in breast tissue. At the end of this period (31 March 2022), 65.2% of all women eligible for breast screening had been screened within the previous three years. This fell from 74.1% in the period just before the pandemic (31 March 2020).[6]

Before the COVID-19 pandemic, the NHS BSP faced existing known challenges including workforce capacity, IT and data capture constraints, due to an aged invitation and screening digital platform, and equipment requiring replacement (mobile vans and mammography scanners).

Of the 11 NHS screening programmes, breast screening was the most seriously impacted by the COVID-19 pandemic. All providers decided to pause screening alongside other services

[5] Public Health Outcomes Framework – OHID (phe.org.uk)

[6] Public Health Outcomes Framework – OHID (phe.org.uk)

at the height of the pandemic and lockdown for approximately three months (March-June 2020) for infection control and staff redeployment reasons.

The impact resulted in a significant backlog of screening invitations. Pandemic restrictions further impacted service capacity since there was the need for increased screening appointment times to accommodate infection control procedures (to protect both staff and patients within the confines of the screening unit environment), workforce sickness and self-isolation and, women delaying attending their routine appointment until they deemed it safe to attend.

NHS England committed £50 million to the restoration of breast screening in 2021/22.

Throughout the pandemic, NHS England nationally and regionally worked collaboratively with PHE and other key stakeholders across all sectors, on programmes including the SQAS, to restore breast screening services with a dedicated national team to support expediting restoration.

Recovery plans prioritised a reduction in the round length (the removal of the backlog of invitations and appointments for women who had waited longer than the recommended 36 months for their screening invitation).

Other key interventions and tools developed to support service restoration included the following:

- Work with clinical advisors to develop an approach to ensuring that women in the backlog who did not accept two invitations were invited again at their next due date; and a change in invitation methodology from fixed to open appointments to ensure full use of appointment slot capacity.
- Triallists ceased recruitment into the AgeX trial which created extra capacity.
- Creation of a national demand and capacity tool supported activity planning, since this led to production of standardised data, real-time data dashboards and timely data flows published on the FutureNHS platform to support submission of monthly restoration situation reports. This enabled monitoring of recovery and identification of areas requiring targeted support.
- Joint working with NHS England diagnostic teams on a focused review of workforce capacity and interventions such as international recruitment drives; a national workforce survey to evidence the issues that services were reporting, such as an

aging workforce and increased vacancy rates; and work with imaging academies and training centres to increase trainee places.

- Creation of a national, digital round-length planning tool to support services to plan and manage screening clinics efficiently without the traditional manual processes.
- Ongoing work on the Digital Transformation of Screening (DToS) Programme (launched in 2019).
    - The 2021/2022 DToS strategic delivery plan discovery work prioritised development of a set of digital capabilities that will support breast screening, such as creating an online booking system and more effective demographic data capture.
    - The aim will be to improve data capture that enables improved understanding of uptake and outcomes to better target appropriate interventions to improve uptake.

Due to the commitment of the breast screening services, including ensuring the availability of out-of-hours clinics by the end of 2021/22, NHS breast screening services made significant progress in recovery of their backlogs – with some services screening at levels comparable to pre-pandemic rates. Any services not on target for recovery had targeted support and intervention plans developed with national and regional commissioners and providers.

Since mid-October 2020, delayed women who should have been screened and had not yet begun the process of being invited reduced by 82% by mid-April 2022. Data in February 2022 showed activity numbers slightly above the activity delivered in February 2019 (pre-covid), with breast screening services screening at levels above pre pandemic rates by approximately 17% (adjusting for the AgeX trial).

3.1.4 NHS diabetic eye screening programme

During 2020/21 and 2021/22, over 3.2 million people with diabetes attended routine digital eye screening. At the end of 2021/22, uptake performance at 78.4% stood above the required efficiency standard of 75%, having dropped to 67.9% during 2020/21.[7]

NHS diabetic eye screening programme (DESP) providers paused routine screening during the first wave of the pandemic but continued to prioritise high-risk individuals, for example pregnant women, in line with NHS operational guidance developed and issued in collaboration with PHE.

[7] Public Health Outcomes Framework – OHID (phe.org.uk)

Local services still had some productivity issues due to venue availability and infection control measures. To increase service capacity, screening intervals for lower-risk individuals were extended as an interim measure by 12 months (to no more than 24 months between screens) and in line with UK National Screening Committee (NSC) guidance.

Restoration data, capacity monitoring, planning tools and support were provided to ensure services monitored progress and restored in a sustainable way. Where necessary, some services were provided with additional support by NHS England. Work took place in primary care to improve coding and recording to assist with the introduction of a new flagging system.

By March 2022, the NHS DESP had made significant progress in recovering from the disruption caused by the COVID-19 pandemic, with full restoration achieved by September 2022.

A new key performance indicator (KPI) supporting the aim to reduce health inequalities (KPI DE4) was developed for introduction in April 2022. The software used by the NHS DESP services is enabling analysis at a local level of inequalities, especially deprivation.

Work was undertaken to plan for the safe move to extended screening intervals within NHS DESP that will also support increasing capacity in symptomatic hospital eye services and enable individuals to remain in the digital surveillance pathway until a referral is appropriate. The change will take place once appropriate software changes have been made to the IT systems due in 2023.

3.1.5 NHS cervical screening programme

At 31 March 2022, 74.6% of all eligible people in the higher age cohort (50-64 years) had attended for screening within the preceding 5.5 years. For the younger cohort (25-49 years), this dropped to 67.6% who had been screened within the preceding 3.5 years. Coverage in both age cohorts has declined in recent years and is below the 75% efficiency standard.[8]

In 2021/22, over 5 million people aged 25-64 were invited to participate in the NHS cervical screening programme (CSP) and prevent cervical cancer; up 11.6% from the previous year, when 4.5 million people were invited. There was a similar increase in the number of individuals tested, with a high of 3.5 million individuals aged 25 to 64 tested in 2021/22, an increase of 15.5% from the previous year, when 3.03 million were tested. This is the highest

[8] Public Health Outcomes Framework – OHID (phe.org.uk)

number tested since the 2011/12 peak associated with the high-profile diagnosis and death of Jade Goody.[9]

The NHS CSP recovered quickly from disruption caused by the COVID-19 pandemic, with normal screening intervals restored by October 2020, and this standard has been maintained.

Invitations for the NHS CSP continued to be delivered throughout the COVID-19 pandemic. During the first wave of the pandemic, there was a reduction in the volume of invitations that were issued with those at high risk prioritised which was possible as the invitation process is run nationally. By the third quarter of 2020, invitations were sent at pre-pandemic intervals and in an average week, 89,000 cervical screening invitations were issued;[10] by 2021/22 this figure increased to 98,000 per week.

National and regional teams worked to put in place plans to support laboratory providers to clear their backlogs. The eight laboratories that test the cervical screening samples for human papillomavirus (HPV) continued to operate; since January 2021, they have received sample volumes well above pre-COVID-19 levels. As a result of increased testing, colposcopy services expanded their capacity to respond to increased demand for referrals.

National 14-day turnaround time for screening results continued to perform significantly better compared to pre-pandemic performance, reflecting the success of the introduction of HPV as primary test. In 2020/21, services reached 67.1% compared with performance of 44% in 2019/20, and against a 98% standard. This increased further to 79.6% in 2021/22.

During 2021, NHS England commissioned Jo's Cervical Cancer Trust to research how COVID-19 had impacted people's attitudes towards cervical screening. They produced communications material to help to restore confidence in attending health services for sample taking appointments. Deliverables included the development of social media responses and to identify and respond to women who are worried about attending for screening and to provide positive messages about recovery to encourage attendance.

To drive uptake, a national cervical screening campaign ran throughout February and March 2022. The campaign encouraged people to come forward as soon as possible and included headline messages on HPV screening. It was aimed at eligible women and people with a

[9] Cervical Screening (Annual) – NHS Digital

[10] Cervical Screening (Annual) – NHS Digital

cervix, and included focused activity aimed at LGBTQ+ and ethnic minority groups communities to improve inequalities.

A range of innovations were implemented to help strengthen capacity and improve access, for example: some primary care network areas enabled appointments to be made in any primary care setting, rather than the just at the general practice where a person is registered; NHS England regions commissioned sample taking in some areas via integrated sexual health clinics; laboratories analysing the samples began operating 24/7.

Work continued to deliver improvements and address inequalities including delivering an in-service evaluation of self-sampling for HPV which will enable people who do not want to come forward to test at home.

Due to a Scottish audit in 2020 where women were incorrectly excluded, phase 1 of a national ceasing audit was undertaken during 2020/21 with responses being actioned. The ceasing audit was designed to check if some people may have had invitations suspended inappropriately. Planning for Phase 2 began in 2021/22.

Responsibility for the delivery of the administrative service that supports the NHS CSP transferred from Capita Primary Care Support England (PCSE) to the North of England Commissioning Support Unit (CSU) on 1 August 2019. As part of the transition, around 100 Capita PCSE staff TUPE transferred to the North of England CSU; and the service continued to be delivered from Capita premises, using Capita IT until September 2020 on behalf of NHS England.

Work on a replacement national call/recall administration system to decommission its reliance on National Health Application and Infrastructure Services (NHAIS) that began in 2019 continued throughout 2020/21 and 2021/22.

3.1.6 NHS bowel cancer screening programme

At the end of 2021/22, bowel cancer screening coverage for people aged 60-74 was 70.3% of all those eligible having received an adequate screen (optimal performance standard target of 60%). 2021/22 saw an improvement from 66.1% at the end of 2020/21 and 64.3% at the end of 2019/20.[11]

The NHS bowel cancer screening programme responded well to the impact of the pandemic, and by January 2022 the backlog of screening invitations was completely removed. During

[11] Public Health Outcomes Framework – OHID (phe.org.uk)

the recovery, non-face-to-face specialist screening practitioner appointments continued as an additional option to face-to-face to manage capacity.

Despite the pandemic, the programme started to lower the age at which people are offered a bowel cancer screening home testing kit, starting with those aged 56 years, following the decommissioning of bowel scope screening to 55-year-olds. This was a major milestone in saving more lives and is a key commitment in the NHS Long Term Plan. Further age extension to 58-year-olds followed. The NHS Long Term Plan commitment is that everyone over 50 will be eligible for a home testing kit by 2025.

Ongoing work took place to support creation of additional capacity, especially developing endoscopy workforce.

Bowel screening uptake increased, in line with modelling assumptions, by around 6% during this same period.

3.1.7 Screening quality assurance service

With the relocation of PHE functions, in October 2021 the SQAS function transferred to NHS England (as did the central programme screening staff and the regional screening and immunisation teams). The function is noted in Appendix 2 of this assurance report as:

- undertaking analysis, audits and inspections to assess and assure the quality of screening programmes
- making appropriate arrangements for timely internal sharing of quality assessments to support learning and mitigations, and transparency via published reports to ensure public confidence
- closely supporting commissioning and operational delivery, with the ability to escalate through a separate NHS England reporting line or to the Care Quality Commission if necessary.

In 2020/21 and 2021/22 SQAS continued to work with the NHS screening programmes and screening services across England, providing independent scrutiny and expert advice on the quality and safety of the 11 national screening programmes outlined in this report including recovery and restoration activity. To deliver its function, SQAS staff used their knowledge and expertise and contracted with expert professional and clinical advisors (PCAs).

During the COVID-19 pandemic and during restoration, SQAS continued to:

- work with colleagues across organisations to develop technical guidance and give advice on safe delivery of screening services.

- co-ordinate the collation of technical guidance to ensure consistent messages were conveyed.
- support local commissioning teams and screening providers with advice.
- review data and information to ensure those eligible for screening, and most at risk, were prioritised during restoration.
- support NHS England and providers by issuing advice for managing screening incidents.
- support local services and commissioners during restoration to ensure services delivered were safe and of high quality.
- manage the transition of SQAS into the NHS England Medical Directorate, amending policies, procedures, and contract novation.

During 2021 to 2022, SQAS staff:

- gave technical and public health advice to screening providers and commissioners on 2,469 incidents and potential incidents
    - of these 1,458 were classed as screening incidents, 49 of which were serious incidents.
- delivered a total of 238 network and education events across England, targeting screening service providers and PCAs to give updates on changes to screening programmes and guidance documents, and to advise and support in the COVID-19 response.
- developed an interim screening quality assurance process (ISQAR) in 2020, as it was not possible to conduct a formal quality assurance (QA) visit during COVID and the ensuing recovery period.
    - in total, 502 screening providers across 11 different screening programmes had received an ISQAR assessment with outcome letters.
- continued to focus on addressing screening inequalities, working to ensure that activities reducing inequalities are consistently embedded in all of QA functions
    - This included the development of a new resource for staff and the addition of inequalities in QA visit questionnaires (which were also used in discussions during QA visits, at provider and commissioner meetings, and when reviewing incidents).

Other areas of SQAS achievement included:

- developing frameworks to support the quality monitoring of trial sites for breast screening including those trialling tomosyntheses and artificial intelligence
- continuing to work with UKAS on QA of screening laboratories

- contributing to UK National Screening Committee (NSC) workshops/work streams
- supporting the rollout of new screening programmes and changes to existing programmes such as NHS NIPT, NHS fetal anomaly screening programme, age extension for bowel screening, DESP extended screening interval.
- continued routine data collection and reporting throughout the year including the publication of the annual statistical bulletin, jointly with NHS Digital, and the annual standards report for cervical and breast screening.
- Updating and publishing the national cervical invasive cervical cancer audit protocol and data collection processes and the breast interval cancer manual
- sharing knowledge and data at local, regional, national and international conferences.
- continuing to effectively deliver the cervical screening external quality assessment (EQA), including maintaining UK accreditation service (UKAS) accreditation.
- continuing to develop quality assurance guidance for various programmes to maintain safety, reduce harm and improve quality.

3.2 Vaccination and immunisation

During 2020/21 and 2021/22 work continued to improve vaccination uptake across all immunisation programmes and to recover the routine children and adolescent programmes.

Data from 2020/21 shows an upward trajectory from the low of COVID-19 pandemic performance. The exception is HPV, most impacted by school closures. Providers continued with catch up campaigns and the 2021/22 performance data has shown improvements. Data is retrospective and less timely than operationally required.

3.2.1 Childhood and adult flu immunisation programme

The 2020/21 and 2021/22 the annual seasonal influenza (flu) vaccination programmes were the most successful in its history.

Despite the pandemic, the hard work by the NHS resulted in the best uptake levels yet, including in 2020/21 achieving over 80% uptake in the population aged 65 and over. This feat was achieved against a backdrop of expansion to include 50 to 64-year-olds and school age year 7.

In addition to implementing good practice identified from previous years, the 2020/21 programme was supported by new developments to information technology systems building on the learning from the COVID-19 vaccination programme, which enabled a greater understanding of regional and cohort variation.

For the first time, a national call/recall service was commissioned nationally for at-risk groups and 2 to 3-year-olds (using a combination of letters and text messages) to help increase demand and to supplement local call and recall services delivery by general practices for their registered populations.

22.2 million people took up the offer of a vaccination in 2021/22 and 19.2 million in 2020/21. Improvements were seen in the 50 to 64 years, 65 years+ and at-risk cohorts as well as children: 3.8 million children were vaccinated by the end of January 2022, compared to 3.3 million the previous year; and an additional four school years were included for the first time.

The NHS school flu programme achieved excellent uptake nationally, despite the expansion to secondary schools and complexity and disruptions of school closures. And, for the first time, school vaccination providers were commissioned to offer an alternative seasonal flu vaccine to children whose parents/guardians withheld consent to the live attenuated influenza vaccine (LAIV) nasally administered vaccine on grounds of porcine gelatine content.

London had the lowest uptake; a trend seen in other vaccination programmes and public health interventions (in part due to London's transient population).

Uptake in pregnant women was lower in 2021/22 than in previous years. Data issues resulting in under-reporting of vaccinations administered may be a factor, along with uncertainty on denominator accuracy and this continues to be investigated by UKHSA and NHS England.

A full review of lessons learned for both seasons was completed to inform preparedness for 2022/23 delivery.

3.2.2 Childhood and school age vaccinations

Routine child vaccinations delivered via primary care continued as usual during 2020/21 and 2021/22, with NHS England regional teams supporting general practices to make rapid progress in addressing any backlog in routine childhood immunisations.

Coverage for nearly all childhood vaccinations, measured at either 1, 2 or 5 years of age, fell between 2019/20 and 2021/22. The exception is PCV primary measured at 12 months, which changed from a two-dose to a one-dose course in 2021/22. All vaccination coverage levels were below the 95% optimal threshold.

Coverage for primary vaccinations evaluated at 12 months of age remained above the efficiency standard of 90% in MenB and the DTaP/IPV/Hib/HepB course, but coverage of rotavirus fell to 89.9%.

For vaccinations evaluated at 2 years of age, coverage of the first dose of MMR was 89.2%, falling below the 90% efficiency standard for the first time since 2010/11. Coverage for the HibMenC, PCV and MenB boosters was also below 90% during 2021/22.

Coverage of 2 doses of MMR evaluated at 5 years of age fell to 85.7%, down from 86.8% in 2019/20. The DTaP booster showed a similar position, with coverage at 84.2% in children turning 5 years old during 2021/22.

Immunisations in schools was impacted by the COVID-19 pandemic lockdown measures and school closures across England. School aged immunisation service (SAIS) providers continued to catch up adolescents from the 2019/2020 cohort who missed their immunisations (HPV1 and 2, meningococcal groups ACWY, tetanus, diphtheria and polio completing dose and measles, mumps and rubella) alongside the routine programmes for the 2020/21 cohort.

Performance data for 2021/22 shows that HPV vaccination coverage was below the 80% coverage efficient standards, having sat above prior to the pandemic. Work continued to tackle the decline in vaccination uptake by providing catch up clinics, including in general practice and at freshers' weeks, and ensuring more timely data flows to inform which areas require most support.

Coverage of the NHS SAIS providers improved from levels reported for the 2019/20 academic year. Lockdown and testing measures in school impacted provider recovery but they continued to catch up with all adolescent immunisations from the 2019/20 and 2020/21 cohorts alongside vaccinating the 2021/22 cohorts, timing operational delivery alongside the seasonal flu vaccination and COVID-19 vaccination programme requirements.

The NHS continued work to increase uptake across all vaccination programmes to achieve optimum coverage levels and reduce regional variation in uptake. NHS SAIS providers used a point of care data capture system to record data in a standardised and more timely manner, resulting in much less duplication of effort and manual reporting.

During 2021/22, the neonatal BCG vaccination programme was re-commissioned, and a new delivery model successfully implemented in September 2021, to avoid any baby with suspected severe combined immunodeficiency (SCID), an in-service evaluation being run in the newborn screening, being vaccinated with BCG.

3.2.3 Shingles immunisation programme

Many of the eligible shingles cohort were shielding during the pandemic and attempts to call in unvaccinated individuals were temporarily stood down, as it is not possible to co-administer the COVID-19 vaccination with the shingles vaccine.

The efficiency standards and optimal performance standards in 2021/22 were not met for shingles vaccination coverage, which showed an upturn in performance in 2021/22 from the pandemic associated decline in 2020/21.

NHS provision to extend the shingles programme was made to ensure those who missed their window of eligibility for the vaccination during lockdown were still able to access the vaccine.

3.2.4 NHS child health information services

Child health information services (CHIS) providers continued to deliver 'business as usual' with minimal disruption during the pandemic. The digital child health programme's national events management service (NEMS), led by NHS Digital, which can share newborn screening and childhood immunisation data between clinical settings went live, with a 60-80% rollout of the 0-5 population by October 2021. Several regions started re-procurement processes for their CHIS provision.

As more services (including the GP IT suppliers) adopt the system changes required to interoperate with the NEMS, more information can be shared across clinical settings, ensuring greater oversight, safeguarding and support for screening and opportunistic delivery of childhood immunisations.

Digital solutions continued to be explored to minimise the risk relating to the current reliance on manual recording systems for CHIS. Plans to digitalise the paper red book continued.

3.3 Health and Justice

Health and Justice services continued to deliver on both national s.7A targets (for example, for immunisations and cancer screening) and unique indicators relevant to the population residing within prisons and prescribed places of detention (PPDs). This includes indicators on substance misuse services and infectious disease screening. These unique services are commissioned directly in PPDs by NHS England to address health disparities experienced by this vulnerable population group.

Efforts were maximised in secure and detained settings to recover services that were paused or had reduced uptake due to the COVID-19 pandemic, particularly cancer and non-

cancer screening programmes and routine immunisations. Secure and detained settings should aim to meet equivalent community efficiency standards for these programmes.

COVID-19 outbreaks in prisons and PPDs continued in high numbers until April 2022 causing continued impact on healthcare service delivery. Prison restrictions were removed later than those in the community given the high-risk nature of the setting and population.

The decreased community screening activity, combined with the challenges of managing COVID-19 in PPD settings, meant access to national screening programmes was much reduced for people in PPDs. However, despite the challenges, health delivery has continued as much as possible and recovery plans are in place.

Sexual assault referral centre (SARC) services continued to operate throughout the pandemic with access to all key s.7a health interventions maintained. A national SARC awareness raising campaign has helped to raise the profile of services and promote accessibility among under -represented populations and efficacy will be monitored once full regional data is available.

SARC services are being complemented via the national roll out of enhanced Mental Health pathfinder sites aimed at responding to the needs of victims and survivors with complex Mental Health support requirements.

Key performance improvements are as follows and recovery plans are in place for all areas affected by the COVID-19 pandemic:

- All PPDs resumed cancer and non-cancer screening services.
- There was increased uptake in all bloodborne virus (BBV) testing, compared with quarter 4 2019-20
- All IRCs achieved 90% testing uptake for TB. The average uptake for all IRCs for TB testing was 73.8% during this period.
- Substance misuse data from NDTMS continued to reflect marginal improvements with performance at 65.8% for Q4 of 2021/22 (65.8% and 65.4% for Q3 and Q2 respectively) for successful treatment in custody.
- As of Quarter 1 2021-22, there were no regions achieving the efficiency threshold of 30% for the NHS health checks programme. This became a priority programme for 2022/23 with significant amount of preparatory work undertaken already (pre COVID-19 pandemic).
- The flu vaccination programme was targeted to ensure protection during this difficult period. All vulnerable groups were vaccinated.

- Increased uptake in all bloodborne virus (BBV) testing, remained steady through 2021/22 with a slight increase in Q4 for HIV, HepB and HepC uptake.
- Continued delivery of COVID-19 mass testing across prisons in response to outbreaks as per current UKHSA guidance.
- The COVID-19 vaccination programme continued to be delivered at pace.

3.4 Finance

In 2020/21 and 2021/22 some capacity normally dedicated to public health programmes was redeployed to support the response to the pandemic. As a result, funding for s.7A services was not ring-fenced, and the costs of delivering s.7A services could not be quantified accurately.

Appendix 1: Extract from the Public health functions (section 7A) agreement/letter 2021 to 2022 – Annex A services to be provided.

Annex A: Public health functions (section 7A) agreement/letter 2021 to 2022 – services to be provided.

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
- Covid-19 immunisation programme for adults (including boosters for eligible groups) and children.

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 and 13), and 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

Other services

- child health information services
- public health services for children and adults in secure and detained settings
- sexual assault services (sexual assault referral centres)

Appendix 2: Additional functions transferred from PHE to NHS ENGLAND from 1 October 2021

In addition, with effect from 1 October 2021, these arrangements under s.7A for the delegated exercise of the Secretary of State's public health functions by NHS England also include the following functions (previously exercised by PHE).

Screening: (i) functions providing national support for service commissioning and delivery of high quality, safe, effective, equitable and acceptable screening programmes

Functions relating to the development, oversight and quality improvement of extant and new population screening programmes, including:

- undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions
- arranging or securing the provision of IT and other services to support the provision of population screening programmes, to enable reporting and evaluation

Screening programmes will continue to be defined by the Secretary of State drawing upon recommendations of the UK National Screening Committee.

Screening: (ii) provision of an effective Screening Quality Assurance Service (SQAS)

Functions undertaking analysis, audits and inspections to assess and assure the quality of screening programmes:

- with appropriate arrangements for timely internal sharing of quality assessments to support learning and mitigations, and transparency via published reports to ensure public confidence.
- SQAS should closely support commissioning and operational delivery, with the ability to escalate through a separate NHS ENGLAND reporting line or to Care Quality Commission if necessary.

Healthcare Public Health Functions – applying public health sciences to the planning, commissioning, and provision of healthcare services.

The promotion of healthcare public health, including through:

- the provision of training in public health with due regard to any standards and requirements set by other national bodies
- supporting healthcare organisations to understand and use population health data, including understanding their existing health inequalities and the evidence base for improving population health and reducing inequalities

- supporting healthcare organisations to interpret population health data and evidence and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions, developments and strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care
- using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population's health to improve health outcomes and reduce health inequalities
- the development of population health policies and strategies and their implementation.

To aid safe transition of the functions and associated data and support were set out in memorandums of understanding and co-operation between DHSC, NHS England and the UK Health Security Agency.

Appendix 3a: Summary of key indicators 2020-21

No	PHOF ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Early years immunisation programmes								
1	-	Pre-natal pertussis vaccine coverage (pregnant women)	50%	60%	2020/21	67.8%	70.5%	↓
2	D03e	Rotavirus vaccination coverage (two dose, 12 mths)	90%	95%	2020/21	90.2%	90.1%	–
3	D03d	Men B vaccination coverage (12 mths)	90%	95%	2020/21	92.1%	92.5%	↓
4	D03c	DTap / IPV / Hib vaccination coverage (12 mths)	90%	95%	2020/21	92.0%	92.6%	↓
5	D03f*	PCV vaccination coverage (12 mths)	90%	95%	2019/20*	93.2%	92.8%	↑
6	D03h	DTap / IPV / Hib/ HepB vaccination coverage (2 years old)	90%	95%	2020/21	93.8%	93.8%	–
7	D03m	Hib/Men C booster vaccination coverage (2 years old)	90%	95%	2020/21	90.2%	90.5%	↓
8	D03k	PCV booster vaccination coverage (2 years old)	90%	95%	2020/21	90.1%	90.4%	↓
9	D03j	MMR vaccination coverage for one dose (2 years old)	90%	95%	2020/21	90.3%	90.6%	↓
10	D03i	Men B booster vaccination coverage (2 years old)	90%	95%	2020/21	89.0%	88.7%	↑
11	-	Hib / Men C booster vaccination coverage (5 years old)	90%	95%	2020/21	92.3%	92.5%	↓
12	D04b	MMR vaccination coverage for one dose (5 years old)	90%	95%	2020/21	94.3%	94.5%	↓
13	D04c	MMR vaccination coverage for two doses (5 years old)	90%	95%	2020/21	86.6%	86.8%	↓
14	-	DTaP/IPV/Hib vaccination coverage (5 years old)	90%	95%	2020/21	95.2%	95.6%	↓
15	D04a	DTaP/IPV booster vaccination coverage (5 years old)	90%	95%	2020/21	85.3%	85.6%	↓

No	PHOF ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Other immunisation programmes								
16	D04e	HPV vaccination coverage one dose (females 12 to 13-year-olds)	80%	90%	2020/21	76.7%	59.2%	↑
17	D04f	HPV vaccination coverage two doses (females 13 to 14-year-olds)	80%	90%	2020/21	60.6%	64.7%	↓
18	D04g*	Men ACWY vaccination coverage (13 to 14-year-olds)	60%	70%	2020/21	76.5%	88.0%	↓
19	D06b	PPV vaccination coverage (aged 65 and over)	65%	75%	2020/21	70.6%	69.2%	↑
20	D06c	Shingles vaccination coverage (70 years old)	50%	60%	2020/21	20.2%	26.5%	↓
21	-	Shingles vaccination coverage (catch-up cohort 78-year-olds)	50%	60%	2020/21	28.4%	25.8%	↑
22	D03l	Flu vaccination coverage, pre-school age (2 to 3-years-old) including those in risk groups	40%	48%	2020/21	56.7%	44.9%	↑
23	D04d*	Flu vaccination coverage, eligible school age children*	50%	65%	2020/21	61.7%	60.4%	↑
24	D05	Flu vaccination coverage, at-risk individuals 6 months to under 65 years	50%	55%	2020/21	53.0%	44.9%	↑
25	D06a	Flu vaccination coverage, aged 65 and over	70%	75%	2020/21	80.9%	72.4%	↑
Cancer and adult non-cancer screening programmes								
26	C24a	Breast cancer screening 3-year coverage (age 53-70)	70%	80%	2020/21	64.1%	74.1%	↓
27a	C24b	Cervical cancer screening 3.5-year coverage (age 25-49)	75%	80%	2020/21	69.4%	71.5%	↓
27b	C24c	Cervical cancer screening 5.5-year coverage (age 50-64)	75%	80%	2020/21	74.7%	76.1%	↓
28	C24d	Bowel cancer screening 2.5-year coverage (age 60-74)	55%	60%	2020/21	66.0%	64.2%	↑
29	C24e	Abdominal aortic aneurysm screening coverage	75%	85%	2020/21	55.0%	76.1%	↓
30	C24f	Diabetic eye screening uptake	70%	80%	2020/21	67.9%	81.5%	↓

No	PHOF ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Antenatal and newborn screening programmes								
31	C24g	Fetal anomaly screening (fetal anomaly ultrasound) coverage	90%	95%	2020/21	99.2%	99.1%	↑
32	C24h	Infectious diseases in pregnancy screening - HIV coverage	95%	99%	2020/21	99.8%	99.8%	↑
33	C24i	Infectious diseases in pregnancy screening - Syphilis coverage	95%	99%	2020/21	99.8%	99.8%	↑
34	C24j	Infectious diseases in pregnancy screening - Hepatitis B coverage	95%	99%	2020/21	99.8%	99.8%	–
35	C24k	Sickle cell and thalassaemia screening coverage	95%	99%	2020/21	99.7%	99.7%	↑
36	C24l	Newborn blood spot screening coverage	95%	99.9%	2020/21	97.2%	97.9%	↓
37	C24m	Newborn hearing screening coverage	97%	99.5%	2020/21	97.5%	98.2%	↓
38	C24n	Newborn and infant physical examination screening coverage	95%	99.5%	2020/21	97.3%	96.7%	↑

* From 1 January 2020, the infant vaccination schedule for pneumococcal vaccine (PCV) changed with babies getting their 1st dose of PCV with 12 weeks of age and a booster dose of this vaccine on or after their 1st birthday. This means it is not possible to provide an accurate estimate of coverage for completed courses of PCV vaccine at 12 months for 2021-22.

*For indicators 16 to 18, the time period is the academic year.

*For Indicator 23, the eligible school age population is Reception to Year 6 in 2019-20 and Reception to Year 7 in 2020-21.

*For indicators 5,18 and 23 the data is drawn from sources other than PHOF, despite the PHOF being referred to within the Public Health Functions Agreement, due to differences in indicator description.

Appendix 3b: Summary of key indicators 2021-22

No	PHOF Ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Early years immunisation programmes								
1	-	Pre-natal pertussis vaccine coverage (pregnant women)	50%	60%	2021-22	64.7%	67.8%	↓
2	D03e	Rotavirus vaccination coverage (two dose, 12 mths)	90%	95%	2021-22	89.9%	90.2%	↓
3	D03d	Men B vaccination coverage (12 mths)	90%	95%	2021-22	91.5%	92.1%	↓
4	D03c	DTap / IPV / Hib vaccination coverage (12 mths)	90%	95%	2021-22	91.8%	92.0%	↓
5	D03f*	PCV vaccination coverage (12 mths)	90%	95%	2021-22	93.8%		–
6	D03h	DTap / IPV / Hib/ HepB vaccination coverage (2 years old)	90%	95%	2021-22	93.0%	93.8%	↓
7	D03m	Hib/Men C booster vaccination coverage (2 years old)	90%	95%	2021-22	89.0%	90.2%	↓
8	D03k	PCV booster vaccination coverage (2 years old)	90%	95%	2021-22	89.3%	90.1%	↓
9	D03j	MMR vaccination coverage for one dose (2 years old)	90%	95%	2021-22	89.2%	90.3%	↓
10	D03i	Men B booster vaccination coverage (2 years old)	90%	95%	2021-22	88.0%	89.0%	↓
11	-	Hib / Men C booster vaccination coverage (5 years old)	90%	95%	2021-22	91.7%	92.3%	↓
12	D04b	MMR vaccination coverage for one dose (5 years old)	90%	95%	2021-22	93.4%	94.3%	↓
13	D04c	MMR vaccination coverage for two doses (5 years old)	90%	95%	2021-22	85.7%	86.6%	↓
14	-	DTaP/IPV/Hib vaccination coverage (5 years old)	90%	95%	2021-22	94.4%	95.2%	↓
15	D04a	DTaP/IPV booster vaccination coverage (5 years old)	90%	95%	2021-22	84.2%	85.3%	↓

No	PHOF Ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Other Immunisation Programmes								
16	D04e	HPV vaccination coverage one dose (females 12 to 13-year-olds)	80%	90%	2021-22	69.6%	76.7%	↓
17	D04f	HPV vaccination coverage two doses (females 13 to 14-year-olds)	80%	90%	2021-22	67.3%	60.6%	↑
18	D04g*	Men ACWY vaccination coverage (13 to 14-year-olds)	60%	70%	2021-22	69.2%	76.5%	↓
19	D06b	PPV vaccination coverage (aged 65 and over)	65%	75%	2020-21*	70.6%	69.2%	↑
20	D06c	Shingles vaccination coverage (70 years old)	50%	60%	2021-22	31.2%	20.2%	↑
21	-	Shingles vaccination coverage (catch-up cohort 78-year-olds)	50%	60%	2021-22	26.0%	28.4%	↓
22	D03l	Flu vaccination coverage, pre-school age (2-3 years old) including those in risk groups	40%	48%	2021-22	50.1%	56.7%	↓
23	D04d*	Flu vaccination coverage, eligible school age children*	50%	65%	2021-22	51.7%	61.7%	↓
24	D05	Flu vaccination coverage, at risk individuals 6 months to under 65 years	50%	55%	2021-22	52.9%	53.0%	↓
25	D06a	Flu vaccination coverage, aged 65 and over	70%	75%	2021-22	82.3%	80.9%	↑
Cancer and Adult Non-Cancer Screening Programmes								
26	C24a	Breast cancer screening 3-year coverage (age 53-70)	70%	80%	2021-22	65.2%	64.1%	↑
27a	C24b	Cervical cancer screening 3.5-year coverage (age 25-49)	75%	80%	2021-22	69.0%	69.4%	↓
27b	C24c	Cervical cancer screening 5.5-year coverage (age 50-64)	75%	80%	2021-22	74.6%	74.7%	↓
28	C24d	Bowel cancer screening 2.5-year coverage (age 60-74)	55%	60%	2021-22	70.3%	66.0%	↑
29	C24e	Abdominal aortic aneurysm screening coverage	75%	85%	2021-22	70.3%	55.0%	↑
30	C24f	Diabetic eye screening uptake	70%	80%	2021-22	78.4%	67.9%	↑

No	PHOF Ref	S7a indicator	Lower threshold	Standard	Latest period	Latest period value	Previous period value	Significant change
Antenatal and Newborn Screening Programmes								
31	C24g	Fetal anomaly screening (fetal anomaly ultrasound) coverage	90%	95%	2021-22	99.1%	99.2%	↓
32	C24h	Infectious diseases in pregnancy screening - HIV coverage	95%	99%	2021-22	99.8%	99.8%	–
33	C24i	Infectious diseases in pregnancy screening - Syphilis coverage	95%	99%	2021-22	99.8%	99.8%	–
34	C24j	Infectious diseases in pregnancy screening - Hepatitis B coverage	95%	99%	2021-22	99.8%	99.8%	–
35	C24k	Sickle cell and thalassaemia screening coverage	95%	99%	2021-22	99.7%	99.7%	–
36	C24l	Newborn blood spot screening coverage	95%	99.0%	2021-22	97.4%	97.2%	↑
37	C24m	Newborn hearing screening coverage	98%	99.5%	2021-22	98.7%	97.5%	↑
38	C24n	Newborn and infant physical examination screening coverage	95%	97.5%	2021-22	96.6%	97.3%	↓

* From 1 January 2020, the infant vaccination schedule for pneumococcal vaccine (PCV) changed with babies getting their 1st dose of PCV with 12 weeks of age and a booster dose of this vaccine on or after their 1st birthday. This means it is not possible to provide an accurate comparable estimate of coverage for the 2020-/21period.

*For indicators 16 to 18, the time-period is the academic year

*2021-22 data is not currently available for indicator 19.

*For Indicator 23, the eligible school age population is Reception to Year 7 in 2020-21 and Reception to Year 11 in 2021-22

*For indicators 5,18 and 23 the data is drawn from sources other than PHOF, despite the PHOF being referred to within the Public Health Functions Agreement, due to differences in indicator description.