NHS England Annual Accountability Statement for NHS Public Health Functions Agreements 2022-23 under Section 7A (s.7A)

21 January 2025

1. Background

The Secretary of State, through the annual Section 7A Public Health Functions Agreement (s7a 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 public health functions agreement 2022 to 2023 - GOV.UK (www.gov.uk) 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 2022/23.

Over 2022/23, NHS England commissioned the services listed at Annex A in accordance with the relevant individual service and pathway requirement specifications and guidance.

The annual Section 7A Public Health Functions Agreement (s7a Agreement) recognises the recent programme of public health reforms, which has included the creation of the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID) within the Department of Health and Social Care (DHSC); and the transfer of some functions to NHS England and building on lessons from the pandemic response.

2. Requirements of s.7A Public Health Function Agreement/ 2022/23

During 2022/23, NHS England continued to be held accountable for delivery of the annual Section 7A Public Health Functions Agreement (s7a Agreement) through the established monitoring and accountability mechanisms.

This agreement sets out headline objectives and budget arrangements with a focus on recovery, restoration, and transformation of services as well as improvements in equality and health inequality.

The requirements of NHS England during this period were to:

1. Deliver (via its commissioning and accountability cycle/ processes) high-quality NHS public health services in England, with efficient use of s7A resources, seeking to prevent avoidable ill-health; achieve earlier diagnosis with positive health outcomes, promote equality and reduce health disparities.

Achieving this objective meant:

1.1. securing services by setting national NHS contract service specifications to commission providers, (registered with the Care Quality Commission for services delivered within this agreement) and manage contracts so that providers deliver the required performance, variation in local levels of performance between different geographical areas is reduced and services are transformed where required. The NHS standard contract, where appropriate, included the KPIs set out in this Agreement. Providers were expected to fully restore services and deliver the agreed programme standards, evaluate their performance, undergo appropriate training and follow all relevant clinical and professional guidance.

1.2. showing evidence of quality and safety to ensure providers deliver and assure to the requisite quality standards, including the quality of patient experience, with patients able to access quality and equitable services delivered by providers with a suitably qualified and diverse workforce.

2. NHS England's **second objective** was to be responsible for the operational delivery of changes in services or introduction of new services as directed by DHSC, taking account of relevant clinical/ public health expert advice from UKHSA.

2.1 Statutory duties in relation to equality and health inequalities

NHS England continued to recognise the positive and transformative impact effective commissioning can have in addressing health inequalities. Building on actions in previous years, in 2022/23 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 whilst 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 2022/23

Collaborative and partnership working between NHS teams (including the NHS cancer and diagnostic programmes, primary care, community and treatment services and commissioning teams), the then NHS Digital, Health Education England (HEE) (organisations now transferred to NHS England), United Kingdom Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID) was critical to service recovery and delivery.

The key indicators monitored during the 2022/23 period are listed in Appendix A. The indicators use agreed standards as comparators. Screening and vaccination services have, where applicable, two targets for assessment – efficiency standard (lower threshold) and optimal performance standard (higher threshold) 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 services are expected to attain to assure patient safety and service effectiveness. The optimal performance standard is an aspirational target that services should aspire towards.

3.1 Screening

3.1.0 NHS Antenatal and Newborn Screening (ANNB)

The three NHS antenatal and three NHS newborn screening programmes (ANNB) maintained good screening coverage throughout 2022/23.

During 2022/23 NHS England commissioned services which resulted in screening 562,000 babies for 14-15 conditions and 631,000 pregnant women for fetal anomaly screening including Downs syndrome, Edwards' syndrome, Patau's syndrome, 11 physical conditions and hepatitis B, HIV, syphilis, sickle cell disease and thalassaemia.

Coverage for antenatal screening remained at above the optimal standards set for each programme during 22/23 – 95% for fetal anomaly screening coverage, and 99% for infectious diseases in pregnancy screening coverage and sickle cell and thalassemia screening coverage. Coverage across newborn blood spot, newborn hearing, and newborn and infant physical examination screening programmes fell slightly from the 2021/22 position but remained above efficiency standards.

Fetal Anomaly Screening Programme (FASP)

The Wolfson Institute for Population Health (the WIPH, hosted by Queen Marys University London), one of over 20 laboratories providing a laboratory service to the Fetal Anomaly Screening Programme (FASP) ceased NHS Down's syndrome, Edwards' syndrome and Patau's syndrome screening provision on 30 June 2022. Following the decision to cease this service, the 41 maternity providers contracted to the WIPH secured alternative

laboratory services/contracts with other NHS providers in the large part through the efforts of national and regional NHS teams and maternity providers to ensure the safe transfer of services with no adverse effects to the screening pathway or women.

Non-invasive Prenatal Testing (NIPT)

On 1 June 2021, non-invasive prenatal testing was added to the NHS screening programme pathway for Down's syndrome, Edwards' syndrome and Patau's syndrome in England.

NIPT, involving a maternal blood test, as an additional step in the screening pathway offering a further test to pregnant women whose initial NHS combined or quadruple screening test result shows that their chance of having a baby with one of these 3 conditions is greater than 1 in 150. Women who receive a higher chance result can now choose between no further testing, NIPT or prenatal diagnosis.

Following a UK National Screening Committee (UK NSC) recommendation, NIPT was introduced into the screening programme as an 'evaluative roll-out' also known as an in-service evaluation (ISE). This involves carefully monitoring how it performs in the NHS in England so that the screening pathway and processes can be amended and improved where required and will enable test performance to be evaluated in practice. The evaluative roll out has continued to run for the planned three years from June 2021 to end May 2024, and will report back to the UK NSC in Spring 2025 Following full evaluation, the UK NSC may require further changes to NIPT screening within the NHS FASP pathway for screening for Down's syndrome, Edwards's syndrome and Patau's syndrome.

Infectious Diseases in Screening Programme (IDPS)

In 2021, screen positive pathways for hepatitis B and syphilis were implemented. The Integrated Screening Outcomes Surveillance Service (ISOSS) carries out the surveillance of pregnancies to women with HIV, hepatitis B and syphilis, their babies and other children diagnosed with HIV, hepatitis B and congenital syphilis in England as part of the NHS Infectious Diseases in Pregnancy Screening Programme (IDPS).

Data analysed through ISOSS allows NHS England to assess the impact of the infectious diseases in pregnancy screening on:

- prevention of vertically acquired HIV, hepatitis B and syphilis
- protecting the health of women with HIV, hepatitis B and syphilis during and after pregnancy
- protecting the health of any children born to women with HIV, hepatitis B and syphilis
- protecting the health of infants and children diagnosed with HIV, hepatitis B, syphilis, and congenital rubella syndrome.

As part of this work, comprehensive observational surveillance of maternal hepatitis B virus (HBV) in England has taken place since 2021. Reporting of all women who screen positive

for HBV during pregnancy takes place through maternity units and includes demographics, pregnancy management and outcome measurements. Furthermore, paediatric HBV follow up is reported and includes data linkage with UK Health Security Agency's Immunisation, Hepatitis and Blood Safety team at 12-13 months after birth.

NHS Sickle cell and thalassaemia screening programme (SCT)

The coverage for antenatal SCT screening has steadily increased since 2014 and is now near 100%.

The sickle cell and thalassaemia (SCT) newborn outcomes solution is a web-based solution used by newborn laboratories, nursing centres and sickle cell treatment centres to make referrals for babies screened positive for SCT.

The solution allows users to view the status of patients along the care pathway, for example to enable a referring laboratory to see that a screen positive baby has entered into care; and automates the gathering and reporting of newborn outcome data on sickle cell and thalassaemia screen positive babies.

The fully implemented solution has improved data quality for the proportion of parents receiving newborn screen positive results before or at 28 days of age (Standard 8) and the proportion of newborn infants with a positive screening result who are seen at a paediatric clinic or discharged for insignificant results before or at 90 days of age (Standard 9) and is also being developed for other programme standards and electronic data capture.

Severe Combined Immuno-Deficiency (SCID)

The In-Service Evaluation on the introduction of Severe Combined Immuno-Deficiency (SCID) into the newborn blood spot screening programme went live in September 2021 offering screening to around 400,000 babies. SCID is a rare auto-immune condition that affects approximately 15 babies per year. To ensure sufficient data for evaluation, the ISE was extended for a further 6 months to the end of February 2024. The final report is in progress for presentation to the UKNSC for review.

3.1.1 NHS Abdominal Aortic Aneurysm (AAA) Programme

There were 314,865 men offered AAA screening between 1 April 2022 and 31 March 2023; 80.8% of those men offered an initial screen were conclusively tested within the screening year plus 2 months. This is a substantial improvement from the position in 2021/2022 when 70.2% of those 309,439 eligible men were conclusively tested within the national standard.

Nationally for 2022/23, 70.8% of men in the eligible cohort who lived in a lower super output area (LSOA) classed as decile 1 to 3 in the English indices of deprivation (IoD) 2019, were tested. This contrasts with 78.3% for the overall cohort as listed in Appendix A. The incidence of AAA is linked with deprivation and health inequalities. The incidence of AAA is

more significant in the most deprived tenth of England's population. Men in this group are twice as likely to have an AAA compared with the least deprived decile[1]. New functionality has been developed within the national software system which enables local services to obtain targeted data to support work to reduce health inequalities

3.1.2 NHS Breast Screening Programme

After 2021/22, activity within the breast screening programme in 2022/23 was the second highest in over a decade. There were more women invited for breast screening in 2022/23 (2.98 million) compared to pre-pandemic years (2.56 million in 2018/19 and 2.60 million in 2019/20).

More women were screened within 6 months of their invitation in 2022/23 (1.93 million) compared to 2018/19 (1.82 million) and 2019/20 (1.79 million), but uptake remains lower than it was before the pandemic (64.6% in 2022/23 compared to 71.1% in 2018/19)[2].

Pre-pandemic, the overall 70% efficiency standard threshold for coverage set by NHS England was being achieved, although there was variability in rates across England[3].

By Q4 2022/23, round length (appointment offered within 36 months of a previous screen), performance was still below pre-pandemic levels, but had improved over the year to 73.5%, compared to 45.7% Q4 2021/22. This standard has an acceptable threshold of 90% and an achievable threshold of 99%.

The NHS BSP had existing known challenges including workforce capacity, data capture constraints due to an aged invitation and screening digital platform, and equipment requiring replacement (mobile vans and mammography scanners).

A second national workforce survey was completed in 2022/23 aimed at supporting workforce planning at a local, regional, and national level and provide an evidence base for funded training provision.

In 2021/22 NHS England committed £50 million to support restoration following the pandemic. As part of the Women's Health Strategy for England (DHSC), published on 20 July 2022, it was announced that £10 million would be invested in kit and equipment for breast screening units in areas with the greatest challenges in screening uptake and recovery. This funded 28 new breast screening units including mobiles and nearly 60 life-saving upgrades to services, so more women can be checked for signs of cancer, speeding up diagnosis and treatment. In addition, nearly £9 million in capital funding via the NHS England Diagnostics Transformation Initiative was given to providers to utilise to support breast screening services. Breast screening services reported that the investments

[1] Inequalities in Abdominal Aortic Aneurysm Screening in England: Effects of Social Deprivation and Ethnicity - Journal of Vascular Surgery (jvascsurg.org)
[2] Breast Screening Programme, England, 2022-23 - NHS England Digital
[3] NHS population screening programmes: KPI reports - GOV.UK (www.gov.uk)

supported improved workforce efficiencies, increased screening activity, improved access and efficiency, reduced health inequalities within the service as well as improved service delivery and service user experience.

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

- work with clinical advisors to develop an approach to ensuring 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) was made, to ensure full utilisation of appointment slot capacity

- ongoing use of a national Demand and Capacity tool created in 2021/22 to support activity planning since this led to production of standardised data, real-time data dashboards and timely data flows published on the NHS Futures platform to support submission of monthly restoration situation reports. This enabled ongoing 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 services were reporting such as an aging workforce and increased vacancy rates; and work with imaging academies and training centres to increase trainee places

- ongoing use of a national digital Round Length Planning tool created in 2021/22 to support services to efficiently plan and manage screening clinics without the traditional manual processes

- due to the commitment of the breast screening services, including ensuring the availability of out of hours clinics, by the end of 2023, NHS breast screening services had removed the invitation backlog caused by the pandemic and shifted their focus onto developing uptake improvement strategies.

- developed a standards handbook to ensure accurate interpretation and consistent response by SQAS; launched an executive summary of data for breast units pulling together data from distinct sources to provide a single narrative describing their radiological practices and outcomes achieved

- completed the build of the NBSS AI interface and it is currently being used as part of the Libra Trial in Leeds breast screening service

The NHS England Cancer Development Fund, supported a bid in 2022/23 to commission a series of national evaluative projects in representative breast screening services, specifically to:

- understand the impact of different invitation methodologies with reference to factors such as age, previous screening history (attendance at first invitations/subsequent invites) and deprivation, in 7 breast screening services to inform future national policy
- understand the impact on screening uptake and the feasibility of processes to actively follow up women who have missed an appointment or not engaged with the service in 12 breast screening services
- ascertain the reasons why women do not attend breast screening via a survey to over 17,000 women, to address barriers to access.

The evaluation reports from all these projects are being reviewed and will inform commissioning and operational changes to improve uptake and coverage.

3.1.3 NHS Diabetic Eye Screening (DESP) Programme

During 2022/23 over 2.38 million people with diabetes attended routine digital eye screening. At the end of 2022/23, uptake performance at 79.1% stood above the required efficiency standard of 75%, up from 78.4% in 2021/22[4].

Post COVID-19, 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 NSC guidance. All services were fully restored in 2022.

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

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.

24-month screening intervals for eligible people was successfully implemented from October 2023. Due to the successful implementation of 24-month screening and the anticipated capacity release within the programme from October 2024, Optical Coherence Tomography (OCT) and R2 grading refinement will be implemented from October 2024.

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

3.1.4 NHS Cervical Screening Programme

In 2022/23, 4.62 million women and people with a cervix aged 25-64 were invited to participate in the NHS Cervical Screening Programme. As the routine recall intervals for the programme are set at 3 and 5 years (depending on the participant's age) it is expected that there will be natural fluctuations year on year for the number of individuals invited. Furthermore, the high volume of invitations that were issued in 2022/23 was in part due to the increased number of people being invited for early repeat tests due to the implementation of hrHPV primary screening.

As of 31 March 2023, 74.4% of eligible people aged 50-64 years had attended for cervical screening within the last 5.5 years. For the younger cohort (those aged 25-49 years) 65.8% had attended for cervical screening within the last 3.5 years. Coverage for both age cohorts has declined in recent years and is below the 80% standard[5].

Population growth in the lower age cohort is growing faster than the upper age cohort. This means that more aged 25 are becoming eligible (and invited for the first time) each year, but this group has always had the lowest uptake. As coverage is measured over a 3.5 and 5.5 year period, the coverage declines seen in 2021/22 may be due to events in the preceding years such as the impact of the COVID-19 pandemic in 2020/21 when screening attendance slowed down, therefore less samples were taken.

Turnaround time is defined as the interval between the date a sample is taken and the date when an individual is expected to receive their result letter. In 2022/23, 76.5% of results were received within 14-days, down from 79.6% in 2021/22[6]. However, this is significantly better when compared to pre-pandemic performance and reflects the impact of the introduction of HPV primary screening.

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 cervix, and included focused activity aimed at LGBTQ+ and ethnic minority groups which evidence shows are communities that are less likely to come forward for screening.

Data on the testing of overdue participants shows a statistically significant upturn in activity in the 50-64 age group.

A range of innovations were implemented to help strengthen capacity and improve access. For example, some Primary Care Networks now enable sample taking appointments to be made in any primary care setting rather than the just at the general practice where the person is registered. Appointments can also be made during evenings and on weekends. In

[5] Public Health Outcomes Framework - OHID (phe.org.uk)
[6] Cervical Screening Programme, England - 2022-2023 - NHS Digital

many areas to improve access, sample taking appointments are also offered in integrated sexual health services.

Work continued to deliver improvements and address inequalities in access to screening. For example, work continued to plan for the in-service evaluation of HPV self-sampling as a primary screening method. The findings from this evaluation will be used to inform a UK National Screening Committee recommendation and it is expected that self-sampling could lead to an increase in coverage as it will reduce some of the barriers that prevent people from attending for screening, including availability of appointments, physical disability, and trauma.

The NHS Cervical Screening Programme will cease or defer individuals from being invited for a number of reasons; informed choice (voluntary withdrawal), a best interests decision under the Mental Capacity Act, age (over 65), absence of cervix or undergoing radiotherapy. The historic ceasing audit, which covered participants ceased from the NHS Cervical Screening Programme between 1 April 2010 and 10 August 2021 and who did not receive a ceasing notification letter, was completed in 2022/23. The records of over 85,000 participants were reviewed and it was identified that the majority had been appropriately ceased from the programme. For those where it was identified that they had been inappropriately ceased or there was insufficient information in their record to validate their ceasing status with clinical certainty, action was taken to reinstate them into the screening programme. Reinstatement has been made in priority order and in two phases over a period of time. An assessment of potential harm has concluded that none of the participants reinstated in phase 1 have been harmed. The assessment of harm for participants reinstated in phase 2 of the audit will be undertaken in 2024/25.

Work continued to progress the development of the new Cervical Screening Management System (CSMS). When implemented CSMS will replace the current call and recall IT system for the NHS Cervical Screening Programme which sits on the NHAIS (National Health Application and Infrastructure Services) platform.

A review of the core national cervical screening data collection requirements has been undertaken and improved arrangements for the collection of the national invasive cervical cancer audit data are now in place. Routine data collection and reporting continues throughout the year, including the publication of the annual statistical bulletin, jointly with NHS Digital, and the annual standards report for cervical,

The cervical screening external quality assessment (EQA) including maintaining UK Accreditation Service (UKAS) accreditation continues to be effectively delivered.

3.1.5 NHS Bowel Cancer Screening Programme

In 2022/23, bowel cancer screening coverage for people aged 60-74 was 72.0% of all those eligible having received an adequate screen. This is an improvement from 70.3% in 2021/22 and 66.0% in 2020/21[7]. Bowel Screening uptake increased to 67.8% at Q4 2022/23.

The NHS Bowel Cancer Screening Programme roll out of lowering the age that people are offered a bowel cancer screening home testing kit continued, with the aim of inviting 50-year-olds to 74-year-olds by 31 March 2025. This is a major milestone in saving more lives and is a key commitment in the NHS England Long Term Plan. Extension to 56-year-olds has completed and extension to 54-year-olds is planned to be completed by end March 2024. Provisional plans for roll-out to 52- and 50-year-olds are being developed with the regional teams to complete full extension by end March 2025.

From July 2023, Lynch Syndrome 2 yearly colonoscopy surveillance has also been introduced into the Bowel Cancer Screening Programme.

On-going work supports the creation of additional screening capacity, especially developing endoscopy workforce, as well as new education and induction materials were produced to develop the underutilised screening practitioner role used to support the specialist screening practitioners and endoscopy nurses.

3.1.6 Screening Quality Assurance Service (SQAS)

The Screening Quality Assurance service provided the following functions in 2022/23:

- analysis, audits, and inspections to assess and assure the quality and safety of screening programmes.
- appropriate arrangements for timely internal sharing of quality assessments to support learning and mitigating actions, and transparency via published reports to ensure public confidence
- closely support 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 2022/23 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.

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

During 2022/23, the service:

- provided nearly three thousand technical and public health pieces of advice and guidance to screening providers and commissioners.
- published lessons learnt reports from screening incidents in 2022/3, shared with commissioners and providers to improve practice, safety and patient experience.
- delivered a total of 185 network, learning and education events across England for screening service providers as well as professional and clinical advisors (PCA) to share updates and guidance on changes to screening programmes and share learning
- devised and implemented QA reviews as an alternative intervention with providers. Guidance produced and resources developed to assist with delivering the reviews and to promote consistency.

Supported providers to implement recommendations from visits, reviews, and incidents

- continued to focus on addressing screening inequalities, working to ensure activities to reduce inequalities are consistently embedded in all screening functions. This included the use and development of resources for staff and the addition of inequalities in QA visit questionnaires. Continued work to develop the reporting, analysis and sharing of inequalities within incidents

3.1.7 Digital Transformation of Screening (DToS)

The Digital Transformation of Screening (DToS) programme was established to digitally transform the NHS national screening services. It will enable this transformation through the use of modern digital and data approaches, such as user-centred design, to develop and implement a National Screening Platform with digital and data capabilities and services to support all current and planned national screening programmes, replacing out-of-date technical and digital systems.

Its objectives are:

- To improve screening programme coverage, including round length compliance and uptake with a specific focus on disadvantaged communities with low rates of coverage
- To improve efficiency and experience of screening services and professionals (for clinicians, managers and administrators) working within services, to create the capacity to support improvement in coverage and uptake.

- To enable more flexible and rapid responses to UKNSC recommendations to change screening programmes (e.g. intervals) and initiation of new screening programmes, to ensure screening in England can adapt to change efficiently and effectively.
- To reduce Screening Incidents, improve clinical safety, experience and accessibility standards for the public who are screened (Participants).
- To improve support for Screening piloting, research, and evaluation, including improving experience for secondary users (commissioners, academics), to maximise Screening Outcomes

During 2022/23 work has focussed on the development and approval of the programme's business case, building on previous years' work, to produce the 5-case model Programme Business Case (PBC) required to approve the investment in the programme. This work included development of the case for change, costed plan, economic case and commercial strategy for the period up to the end of the current Spending Review period (March 2025)

The PBC was completed in January 2023 and approved by the NHS England Executive Transformation Group (ETG) in the same month. Then, following approval by the DHSC Investment Committee in February, it was submitted to HM Treasury for final approval, which had not been achieved at the end of March 2023 (note: HM Treasury approval was achieved in July 2023).

The initial focus of the Digital Transformation of Screening (DToS) programme will be the diabetic eye and breast screening programmes.

3.2 Vaccination and Immunisation

During 2022/23 work continued to improve vaccination uptake across all immunisation programmes. As with previous years there was a slow decline in performance across a majority of the immunisation programmes however there is continued focus on addressing health inequalities and increased access to improve uptake.

3.2.1 Childhood and Adult flu immunisation programme

The 2022/23 annual seasonal influenza (flu) vaccination programme was the second most successful in its history, with 21.2 million people taking up the offer of a vaccination, compared to a record 22.2 million in 2021/22 during the Covid pandemic[8].

In addition to implementing good practice identified from previous years such as co-promotion and administration, the programme was supported by new developments to

[8] Statistics » Vaccinations: Flu (england.nhs.uk)

information technology systems building on the learning from the COVID-19 vaccination programme which enabled a greater understanding of variation within and between communities. A national call/recall service was commissioned for at risk groups and 2–3-year-olds, using a combination of letters and text messages, to help improve information, increase demand and to supplement local call and recall services delivery by general practices for their registered populations.

21.2m people took up the offer of a vaccination in 2022/23, 22.2m in 2021/22 and 19.2m in 2020/21. Despite world-leading uptake figures, coverage fell for people aged 65 and over (79.9% in 2022/23 from 82.3% in 2021/22), at-risk groups (49.1% from 52.9%) and pre-school age (43.7% from 50.1%). Coverage for eligible school age children remained stable, just above the efficiency standard of 50%[9].

The NHS school flu programme achieved excellent uptake nationally, especially considering the expansion to secondary schools and complexity and disruptions of school closures. 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.

Uptake in pregnant women was lower in 2022/23 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 2023/24 delivery.

3.2.2 Childhood and School Age Vaccinations

Routine child vaccinations delivered via primary care continued as usual during 2022/23, 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 2022/23. The exception is PCV primary measured at 12 months, which changed from a 2 dose to a 1 dose course in 2021/22. All vaccination coverage levels were below the 95% optimal threshold.

[9] Public Health Outcomes Framework - OHID (phe.org.uk)

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 88.7%[10].

For vaccinations evaluated at 2 years of age, coverage of the first dose of MMR was 89.3%, a slight improvement from 2021/22. Coverage for the HibMenC, PCV and MenB boosters were also below 90% during 2022/23. DTaP/IPV/Hib/HepB was above 90% at 92.6%[11].

Coverage of 2 doses of MMR evaluated at 5 years of age decreased to 84.5%, down from 85.7% in 2021/22 The DTaP booster also showed a slight decline, with coverage at 83.3%, from 84.2% in children turning 5 years old during 2021/22[12].

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 & Measles Mumps and Rubella) alongside the routine programmes for the 2020/21 cohort.

Performance data for 2022/23 shows that HPV vaccination coverage was below the 80% efficiency standard. 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.

Throughout 22/23 NHS England worked with partners to develop implementation plans to operationalise the JCVI HPV sub-committee recommendation of a 2 dose HPV immunisation schedule for those aged 15 years and over primarily in schools, and Men who have Sex with Men (MSM) in sexual health services by September 2023.

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 cohorts in 2022/23 alongside vaccinating the 2022/23 cohorts, timing operational delivery alongside the seasonal flu vaccination and COVID-19 vaccination programme requirements.

Following recommissioning of the neonatal BCG vaccination programme in 2021/22 and the successful implementation of new delivery model to avoid any baby with suspected severe combined immunodeficiency (SCID) (an in-service evaluation being run in the newborn

[10] Public Health Outcomes Framework - OHID (phe.org.uk)
[11] Public Health Outcomes Framework - OHID (phe.org.uk)
[12] Public Health Outcomes Framework - OHID (phe.org.uk)

screening) being vaccinated with BCG, in 2022/23, BCG coverage by 3 months was 68.8%[13].

3.2.3 Improving Uptake

The NHS continued work to increase uptake across all vaccination programmes to achieve optimum coverage levels and reduce variation in uptake. Considerations are being made to enhance digital capabilities across all vaccination programmes including school aged vaccinations to record and capture data in a standardised and more timely manner, resulting in much less duplication of effort and manual reporting. This will also ensure completeness of data and accuracy in reporting.

In a focus on improving MMR uptake, catch up/ national reminder invites with two million text, email and letter reminders, were sent to parents and guardians of children aged one to six years who had not had a first and/or second MMR vaccination between Sept 2022 and Feb 2023. In total, over **165,000 MMR vaccinations** were administered. Around **one million families** were invited for a first dose with **83,343 (7%)** going on to get their first MMR vaccination. Over **730,000 families** were invited for a second dose and **82,059 (11%)** took up their second vaccination.

NHS England developed an MMR Improvement plan which included work to improve data and digital technology to expand access and community engagement alongside targeted communication campaigns to encourage people to come forward. All NHS regions continue to work on MMR elimination plans and borough level plans with local authority partners with clear actions and timelines for implementation of improvement initiatives. NHS England made use of timely data to complement additional insight to inform the approach to improving uptake, particularly for groups where uptake was lower.

Examples of targeted action included:

- Improving access to the vaccine outside of school through well-advertised community clinics at convenient times and locations
- Pop up vaccination clinics in areas of low uptake including in the school setting
- Targeted community engagement supported by local council teams to raise awareness and understanding of MMR, using NHS resources and scripts.

3.2.4 Adult Vaccinations

Shingles immunisation programme

[13] Childhood Vaccination Coverage Statistics, England, 2022-23 - NHS Digital

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

The efficiency standards and optimal performance standards for shingles vaccination coverage were not met, but there was a continued improvement in performance in 2022/23 with coverage for 70 year olds at 36.8%, compared to 31.2% in 2021-22. This is compared to the 31.9% achieved pre-pandemic in 2018-19.

NHSE continued to plan for extension of the shingles programme to offer Shingrix® at age 60 years old for immunocompetent individuals, and 50 years old for immunocompromised individuals. Eligibility is retained until individuals turn 80 years old.

The current routine shingles vaccination programme offers vaccination at 70 years old. Therefore, a catch-up of immunocompetent individuals aged between 70 and 60 years old, and of immunocompromised individuals aged between 70 and 50 years old will be required. Planning has begun for this transformation.

MPox

NHS Staff, sexual health services and other partners in health systems around 100,000 first and second doses of the MPox vaccination were delivered. Ensuring those who were eligible, were protected by March 2023[14].

3.3 NHS Child Health Information Services (CHIS)

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 now flows data to over 95% of child health information systems (2 to be onboarded soon). 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.

[14] Statistics » Vaccinations: Mpox (england.nhs.uk)

Early discovery work has taken place to direct further work on a strategy for the future provision of CHIS, the strategic direction will, in part, be informed by further discovery work with CHIS providers and users.

3.4 Health and Justice

Health and Justice services continued to deliver on both national s.7A targets (e.g., 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. These continued periods of 'lock down' significantly impacted Health and Justice service's ability to restore consistency and equity in their healthcare offer in comparison to community equivalent services. Health and Justice services recognise the importance of ensuring equivalence of care and remain committed to this, however, despite having set positive recovery plans initially after the pandemic, challenges in relation to collating adequate data providing assurance and recognised pressures of a changing organisational landscape have had ramifications on the execution of the proposed recovery plans. Therefore, towards the end of 2022-2023 Health and Justice started planning to deliver a revised plan in 2023-2024 that would not just continue to support restoration but also longevity in sustainable, equitable future delivery.

Health and Justice continue to actively work with OHID and HMPPS to improve performance on measures in relation to continuity of care of those leaving prisons. NHSE have worked with OHID on a community focused continuity of care audit, with the results of this now having been embedded into the work supporting the wider prison system. To ensure the health gains made when accessing S.7A services within the secure settings are safeguarded, custodial health care services are aware of the importance of collaborative working with non-custodial services, such as RECONNECT. For children and young people, twelve Framework for Integrated Care (Community) vanguards in England are providing psychologically informed capacity to other services to wrap round complex needs children to ensure they get the right support and to intervene earlier in their pathways to enable better outcomes. There have been a total of 2705 referrals to vanguards from 1 April 2022 to 31 March 2023.

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 amongst under-represented populations and continues to be complemented by a number of workstreams aimed at addressing health inequalities. SARC services are also being complemented via the national roll out of enhanced Mental Health pathfinder sites

aimed at responding to the needs of adult victims and survivors with complex Mental Health support requirements. This model once evaluated will be expanded into paediatric services. Providers are now required to report SARCIP data monthly and the resolution of remaining data quality issues is ongoing.

Key performance improvements are as follows:

- all PPDs resumed cancer and non-cancer screening services and continue to identify improved ways of working to drive up uptake
- IRC data has significantly improved for BBV figures in Q4 22-23
- substance misuse data from NDTMS continued to reflect improvements with performance during 22/23, with 77.4% of new treatment entrants starting treatment in the custodial estate within 3 weeks of arrival (from community or another custodial setting). In addition, 92.1% of the custodial treatment population receiving clinical treatment were also receiving concurrent psychosocial interventions to address substance misuse
- blood-borne virus (BBV) testing is achieving over 70% uptake, with TB screening achieving 97%
- the Flu vaccination was offered to the over 50s and under 50s who are clinically vulnerable to ensure protection over the winter and in line with the national NHS campaign
- flu vaccinations were consistent across regions with 55% of the eligible adult and IRC population being vaccinated in March 2023
- the COVID-19 vaccination programme for the autumn/winter campaign was completed offering the booster vaccination to the over 50s and under 50 clinically vulnerable and the primary course to all unvaccinated adults
- the uptake of the flu and COVID booster vaccine was 51% for each vaccine measured at the end of the campaign in February 2023
- continued access to COVID-19 testing was provided across prisons in response to outbreaks and to support access to COVID antivirals as per updated UKHSA guidance

3.5 Finance

In 2022/23 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 A: Summary of Key Indicators 2022-23

No	PHOF Ref	S7a indicator	Efficiency	Optimal	Latest period	Latest period value	Previous period value	Significant change
Early Years Immunisation Programmes								
1	-	Pre-natal pertussis vaccine coverage (pregnant women)	50%	60%	2022-23	60.7%	64.7%	↓
2	D03e	Rotavirus vaccination coverage for 2 doses (1 year old)	90%	95%	2022-23	88.7%	89.9%	↓
3	D03d	Men B vaccination coverage (1 year old)	90%	95%	2022-23	91.0%	91.5%	↓
4	D03c	DTap / IPV / Hib / HepB vaccination coverage (1 year old)	90%	95%	2022-23	91.8%	91.8%	→
5	D03f	PCV vaccination coverage (1 year old)	90%	95%	2022-23	93.7%	93.8%	→
6	D03h	DTap / IPV / Hib / HepB vaccination coverage (2 years old)	90%	95%	2022-23	92.6%	93.0%	↓
7	D03m	Hib / Men C booster vaccination coverage (2 years old)	90%	95%	2022-23	88.7%	89.0%	↓
8	D03k	PCV booster vaccination coverage (2 years old)	90%	95%	2022-23	88.5%	89.3%	↓
9	D03j	MMR vaccination coverage for one dose (2 years old)	90%	95%	2022-23	89.3%	89.2%	→
10	D03i	Men B booster vaccination coverage (2 years old)	90%	95%	2022-23	87.6%	88.0%	↓
11	-	Hib / Men C booster vaccination coverage (5 years old)	90%	95%	2022-23	90.4%	91.7%	↓
12	D04b	MMR vaccination coverage for one dose (5 years old)	90%	95%	2022-23	92.5%	93.4%	↓
13	D04c	MMR vaccination coverage for 2 doses (5 years old)	90%	95%	2022-23	84.5%	85.7%	↓
14	-	DTaP / IPV / Hib vaccination coverage (5 years old)	90%	95%	2022-23	93.2%	94.4%	↓
15	D04a	DTaP / IPV booster vaccination coverage (5 years old)	90%	95%	2022-23	83.3%	84.2%	↓
Other Immunisation Programmes								
16	D04e	HPV vaccination coverage one dose (females, 12 to 13 years old) [1]	80%	90%	2022-23	71.3%	69.6%	↑
17	D04e	HPV vaccination coverage one dose (males, 12 to 13 years old) [1]	80%	90%	2022-23	65.2%	62.4%	↑
18	D04f	HPV vaccination coverage 2 doses (females, 13 to 14 years old) [1]	80%	90%	2022-23	62.9%	67.3%	↓
19	D04f	HPV vaccination coverage 2 doses (males, 13 to 14 years old) [1]	80%	90%	2022-23	56.1%	62.4%	↓
20	D04g	Men ACWY vaccination coverage (13 to 14 years old) [1, 2]	80%	90%	2021-22*	69.2%	76.5%	↓
21	D06b	PPV vaccination coverage (aged 65 and over)	65%	75%	2022-23	71.5%	70.6%	↑
22	D06c	Shingles vaccination coverage (70 years old)	50%	60%	2022-23	36.8%	31.2%	↑
23	D03l	Flu vaccination coverage, children pre-school age, including those in risk groups [3]	-	-	2022-23	43.7%	50.1%	↓
24	D04d	Flu vaccination coverage, children school age, including those in risk groups [2, 3, 4]	-	-	2022-23	51.9%	51.7%	

25	D05	Flu vaccination coverage, at risk individuals 6 months to under 65 years, including pregnant women [3]	-	-	2022-23	49.1%	52.9%	↓
26	D06a	Flu vaccination coverage, aged 65 and over [3]	-	-	2022-23	79.9%	82.3%	↓
Cancer and Adult Non-Cancer Screening Programmes								
27	C24a	Breast cancer screening 3-year coverage (age 53-70)	70%	80%	2022-23	66.2%	65.2%	↑
28a	C24b	Cervical cancer screening 3.5-year coverage (age 25-49)	75%	80%	2022-23	65.8%	69.0%	↓
28b	C24c	Cervical cancer screening 5.5-year coverage (age 50-64)	75%	80%	2022-23	74.4%	74.6%	↓
29	C24d	Bowel cancer screening 2.5-year coverage (age 60-74)	55%	60%	2022-23	72.0%	70.3%	↑
30	C24e	Abdominal aortic aneurysm screening coverage	75%	85%	2022-23	78.3%	70.3%	↑
31	C24f	Diabetic eye screening uptake	75%	85%	2022-23	79.1%	78.4%	↑
Antenatal and Newborn Screening Programmes								
32	C24g	Foetal anomaly screening (foetal anomaly ultrasound) coverage	90%	95%	2022-23	98.8%	99.1%	↓
33	C24h	Infectious diseases in pregnancy screening - HIV coverage	95%	99%	2022-23	99.8%	99.8%	→
34	C24i	Infectious diseases in pregnancy screening - Syphilis coverage	95%	99%	2022-23	99.8%	99.8%	→
35	C24j	Infectious diseases in pregnancy screening - Hepatitis B coverage	95%	99%	2022-23	99.8%	99.8%	→
36	C24k	Sickle cell and thalassaemia screening coverage	95%	99%	2022-23	99.7%	99.7%	→
37	C24l	Newborn blood spot screening coverage	95%	99%	2022-23	96.8%	97.4%	↓
38	C24m	Newborn hearing screening coverage	98%	99.5%	2022-23	98.5%	98.7%	↓
39	C24n	Newborn and infant physical examination screening coverage	95%	97.5%	2022-23	96.2%	96.6%	↓

* 2022-23 not available

[1] Time period is the academic year.

[2] Data for indicator 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.

[3] The Public Health Functions Agreement did not set coverage standards for 2022-23 and instead set a 100% offer standard.

[4] Eligible school age population is Reception to Year 11 in 2021-22 and Reception to Year 9 in 2022-23. As such, 2022-23 values are not directly comparable to 2021-22.

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