



Public Health
England

Protecting and improving the nation's health

Transfer of the Commissioning of 0-5 Years Children's Public Health Services from NHS England to Local Authorities

Commissioning data covering
mandated services and other key
indicators

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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1. Introduction

In October 2015 the responsibility for commissioning of children's public health for the 0-5 years population will transfer from NHS England to local authorities. This marks the final part of the overall public health transfer that saw functions transfer successfully in 2013.

The aim of this document is to describe in detail the minimum standardised data collection and reporting requirements that support the effective commissioning of children's 0-5 years public health services. This is required in order to ensure that, in the first instance, regular local reporting on key performance indicators remains available throughout the transition and, in the second instance, collation of a national picture and local benchmarking may be made available.

Any requirements for access to identifiable record level data on individual children, for the purposes of direct delivery of care, are explicitly excluded from the scope of this document.

The primary audience for this document is:

- local authority leads who are planning to take over the commissioning of these services
- information managers who support these local authority commissioners

It will also assist:

- NHS England managers who currently commission these services and are working towards a handover
- information managers who support these NHS commissioners
- providers of these services

Preparing for the transfer is primarily a locally owned process. Local partners are working collaboratively to plan, deliver and assure the transfer so it is delivered in a safe and sustainable manner. It is critical that data continues to be collected at a local level, that quality assurance processes are in place and that validated key performance indicators can be reported to commissioners on a regular basis.

This document provides a detailed technical specification for individual items of data and key performance indicators and describes both interim and longer term plans for local and national reporting.

It is recommended that the key performance indicators featured provide a baseline specification for inclusion in local commissioning contracts, in order that local areas may share a common framework for understanding progress on important health and wellbeing outcomes.

A detailed state of readiness self-assessment tool specifically for data and information has been developed to help your organisation monitor its progress in preparing for the data and information elements of the transfer. The use of this tool at a local level is discretionary and no co-ordinated feedback is planned.

This document sets out background information and suggests some key actions.

2. Background

2.1 Transfer of commissioning responsibility and its benefits

The Healthy Child Programme (HCP) is the national public health programme, based on evidence of what works to achieve the best outcomes for all children. PHE is currently updating the evidence base for the Healthy Child Programme.

From 1 October 2015, local authorities take over responsibility for some aspects of the HCP from NHS England, notably the commissioning (ie planning and paying for) community based public health services for children aged 0-5 years. This includes the universal, targeted and community aspects of health visiting (subject to parliamentary approval), covering five mandated service touch points. The Department of Health has published the draft regulations, which make it clear there is no expectation of an uplift in performance at the point of transfer, and that local authorities will only be expected to take a reasonably practicable approach to delivering the checks and to continuous improvement over time. Providers should be able to share information about the current level of performance so that local authorities know their pre-transfer baseline. See http://www.local.gov.uk/web/guest/childrens-public-health-transfer/-/journal_content/56/10180/6950869/ARTICLE).

Local authorities are already responsible for commissioning public health services (and education and social care services) for children aged 5-19 years. Public health responsibility for 5-19 years was successfully transferred from NHS England to local authorities in 2013.

Local authorities know their communities and understand local need so can commission the most vital services to improve local children's health and wellbeing. Local authority commissioning of health visitor services and family nurse partnerships (FNP) offers

opportunities to link with wider systems, such as housing and early year's education providers, and to enable better integration of children's services. It will also be possible to secure continuity of children's public health services for a child, and their family, up to 19 years (and up to age 25 for young people with special educational needs and disability).

This in turn will provide a more joined-up, cost-effective service built around the individuals' needs, paving the way to deliver across a wider range of public health issues.

Local authorities understand the huge impact that primary prevention, early identification of need and early intervention have on ensuring positive outcomes for young children and families.

The following commissioning responsibilities, also essential elements of the HCP, will not transfer to local authorities but remain with NHS England:

- childhood immunisation
- antenatal, newborn and infant screening: including the 6-8 week GP review (which covers the infant physical examination)
- child health information systems (CHIS)

2.2 The health visiting service

Evidence shows that what happens in pregnancy and the early years in life impacts throughout the course of life. Therefore a healthy start for all our children is vital for individuals, families, communities and ultimately society.

Health visitors have a vital role to play and the scope of work involves a wide range of interventions and activities at a population and community level as well as at a family and individual level. These services are further described in the scope of transfer documentation (<https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities>).

The health visiting model is based on four levels:

- community services
- universal services
- universal plus services
- universal partnership services

The HCP delivers a prevention and early intervention programme that lies at the heart of the universal service for children and families. See

<https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life>.

The six high impact areas that have the biggest impact on a child's life are:

- transition to parenthood and the early weeks
- maternal mental health (including postnatal depression)
- breastfeeding (initiation and duration)
- healthy weight, healthy nutrition (including physical activity)
- managing minor illness and reducing accidents (reducing hospital attendance and admissions)
- health wellbeing and development of the child aged two – two-year-old review and support to be 'ready for school'.

Investment in the health visiting service is having a profound impact on supporting the lifelong health and wellbeing of young children and their families. Further details can be found in the National Health Visiting Service Specification 15/16.

2.4 The family nurse partnership

The FNP is an evidence based, preventive home visiting programme for vulnerable first-time young mothers and their children, starting in early pregnancy and lasting until the child reaches their second birthday.

It has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency.

FNP has specific data collection requirements and a dedicated information system, the FNP Information System (FNP IS) to support delivery and quality assurance and improvement. Family nurses also maintain clinical records in line with their local policies and systems which feed into the local CHIS. The FNP service specification is to be published shortly, NHS England Service Specification 27, FNP (see www.fnp.nhs.uk).

3. Information required for commissioning

There are a number of key performance indicators associated with 0-5 children's services, which it is critical to monitor and should be reflected in commissioning contracts.

Commissioners need a regular flow of aggregate information (data not limited to one person, but data that is tracked across time, organisations, populations or some other variable) to support performance monitoring of services for 0-5 year olds on an ongoing basis and also to inform the annual review of contracts. This also forms the building blocks for effective commissioning and supports the improvement of health and the reduction of health inequalities.

There are a number of key performance indicators associated with these services which it is critical to monitor and should be reflected in commissioning contracts. These include:

- service performance indicators associated with the proposed five mandated service touch points:
 - antenatal visits
 - new birth visits
 - 6-8 week reviews
 - one year reviews
 - 2-2½ year reviews
- Outcome indicators where the data comes directly from the activities of these services such as:
 - breastfeeding at 6-8 weeks
 - child health outcomes at 2-2½ years
- Wider outcome indicators which are influenced by the quality of these services but where the data does not directly come from these service activities. These include:
 - under-18 conceptions
 - smoking at delivery
 - low birth weight of term babies
 - infant mortality
 - A&E attendances (0-4 years)
 - emergency hospital admissions (0-4 years)
 - hospital admissions for unintentional and deliberate injuries (0-4 years)
 - school readiness
 - tooth decay at five years
 - excess weight at 4-5 years
 - vaccine coverage: MMR two doses (five years)

Progress against all of these outcome indicators is reflected in PHE's **Early Years Profiles**, at both national and local levels.

These key performance indicators and the associated metadata to support calculation are described in Appendix 1 and Appendix 2.

The next level of detail on individual data items, their standard structure, allowable responses and technical definitions are included in Appendix 3 and Appendix 4.

It is recommended that all services comply with this minimum standard for data and information, but naturally will be free to add additional data items and key performance indicators as they see fit and to be negotiated between commissioner and provider.

Standardisation of data items and key performance indicators will mean that services can compare themselves to one another across the country. It will also make national reporting easier, including the Public Health Outcomes Framework. In addition local reports can be used as benchmarking tools to support the improvement of services and health outcomes.

4. Plans for reporting

4.1 How local reporting will be delivered

How local reporting is delivered is down to local discretion; it is for commissioners to negotiate contracts which report performance against key performance indicators and any flow of data required for the quality assurance of those indicators. It is recommended that as local contracts are renegotiated then the opportunity is taken to reinforce the data, information and reporting requirements. Data sharing agreements between commissioners and providers may also be required to cover the quality assurance of all data and the validation of agreed key performance indicators. It is recommended that this data quality improvement requirement is also included in commissioning contracts.

The relevant sections in the NHS standard contract are:

Schedule 6B – information requirements

	Reporting period	Format of report	Timing and method for delivery of report	Application
Local requirements reported locally				
Insert as agreed locally				

Schedule 6C – data quality

Data quality indicator	Data quality threshold	Method of measurement	Milestone date	Consequence
Insert text locally				

For many indicators relating to outcomes for children, the data needed to calculate these indicators is **not** dependent on direct data collection by the providers of health visiting services. These indicators will continue to be reported nationally through existing channels, and are unaffected by the transition of 0-5 commissioning (see Appendix 1).

However, there are indicators that are reliant on effective local data collection and reporting by these service providers, and if this data reporting does not take place, then these indicators will not be available for the local area to monitor and report (see Appendix 2).

Reports on service activity and outcomes, for which the data flows directly from these services, (Appendix 2) must be generated on a periodic basis, most likely quarterly in the first instance. This should be done in a way that relates to both NHS and local authority interest; that is to say reporting firstly by local authority area based on the home residence of the child and secondly by the clinical commissioning group (CCG) based on registration with a local GP.

There is some flexibility in how local reporting is managed through the local CHIS and other local IT systems as long as data quality and assurance processes are in place and agreed.

4.2 Arrangements for local data collection

Generally service providers collect data directly as part of recording clinical activity. Processes for data entry currently vary but include automated electronic transfer from other systems, direct entry by clinical professionals and administrative data entry from paper records. In order to secure efficiency the data should be collected once into an electronic clinical record in a way that then becomes available for many uses. This includes provision of a child-centric record to support the delivery of care as well as the secondary uses of planning, contract monitoring and periodic renegotiation. Most local areas collect the child health record on a CHIS, which can support the new commissioning arrangements. CHIS are used for many reasons but the approach varies across England. Locally CHIS make data collection and reporting for commissioners easier but other local arrangements may be put in place if required.

CHIS will remain within the NHS technical infrastructure and NHS England will lead on the commissioning of these systems for the foreseeable future. This arrangement is described in Section 7A of the NHS mandate. The aim, as articulated in 2013, is that agreed improvement plans can be put in place 'to reach the required minimum standards (electronic support for childhood screening, immunisation and public health programmes and full reporting via the maternity and children's dataset)'.

4.3 How national reporting will be delivered in the longer term

NHS England will continue to lead the implementation of the Maternity and Children's Dataset (MCDS) via arrangements with **Health and Social Care Information Centre** (HSCIC). The MCDS will provide actionable business intelligence to service providers and commissioners in order to inform the improvement of service quality and efficiency, and to develop and target services in a way that improves health, reduces inequality and maximises return on investment.

The MCDS is made up of three standards. These are the:

- Maternity Services Data Set (MSDS)
- Children and Young People's Health Services (CYPHS) Data Set
- Child and Adolescent Mental Health Services (CAMHS) Data Set

The MCDS infrastructure will support the flow of standardised information on children's health from local IT systems to the HSCIC on a monthly basis. This will provide the longer-term strategic solution for both national and local reporting, including performance, benchmarking, activity, programme coverage and related health outcomes. The future planned architecture provides commissioner based access to a comprehensive range of pre-built reports and controlled access to the record level service data in a non-identifiable format.

The technical infrastructure for the children's component of MCDS (the CYPHS) will be ready to collect service data in a standard format from local CHIS from October 2015. It is a responsibility of local providers of children's public health services to ensure that their CHIS have been upgraded to meet this requirement, to comply with all these standardised data items and to flow this data.

This is a contractual and legal requirement, underpinned by the Health and Social Care Act 2012 and the NHS standard contract, for all care providers that deliver health services. In addition all CHIS service specifications and IT contracts require the provision of functionality which complies with any mandated health and social care datasets, of which this is one. All relevant data items initially required to support this programme of work are detailed in Appendix 3. The full detailed specifications can be found on the at [HSCIC website](#).

The national data platform for receiving data from the CYPHS dataset will be available during 2015/16. However it is expected to take some time for all providers of children's and young people's services to flow complete and accurate data.

4.4 How national reporting will be delivered in the interim

It is anticipated that in the interim a reporting system will be required until such time as the MCDS has reached full coverage and maturity, possibly even until 2017. Exactly how this interim national reporting system will work has not yet been agreed. This will be dependent upon collection, quality assurance and collation of standardised key performance indicators from local commissioners. The key performance indicators can be found in the health visiting service specification for 15/16 and in Appendix 2.

The focus in the first instance is on securing local reporting via robust data collection, quality assurance and validation of the key performance indicators detailed in Appendix 2. This includes the opportunity for reinforcement of these requirements via inclusion of the details in service contracts and other locally agreed performance management devices.

NHS England is currently running the processes for collection and collation of aggregate data, quality assurance of data and validation of relevant key performance indicators. Discussions are being held to determine national reporting arrangements during transition and beyond October 2015. Information regarding the interim decision will follow shortly.

As all reporting is in arrears there should not be any gaps in national data so long as local commissioners take steps to secure local reporting processes.

5. Key actions required

The following actions are recommended for commissioners in both sender and receiver organisations, to be supported by their local information and analytical teams.

Recommended actions
1) Undertake voluntary readiness self-assessment using data and information state of readiness tool . Please note there is no plan to audit this from a national perspective.
2) Become familiar with the standard set of key performance indicators (see Appendix 1 and Appendix 2)
3) Include standard set of key performance indicators into local contracts where possible (see Appendix 2)
4) Include plans for improvement of data quality into local contracts where possible (See Appendix 3)
5) Ensure local processes are in place to collect and quality assure data and to report on validated key performance indicators on a periodic basis, at least quarterly (see Appendix 4)
6) Be prepared to submit record level data and key performance indicators to support national reporting and local benchmarked reporting as required and agreed locally in line with national reporting timetables. (see Appendix 3 and Appendix 4)

6. Other relevant developments

6.1 Standards for CHIS

In 2012 the Department of Health published a set of clinical and technical standards for the information content and functionality of CHIS. These are cross-referenced in the Section 7A (public health functions) for the **NHS mandate**.

The standards include a CHIS **Information Requirements Specification**, which details information content and a CHIS **Output based specification**, which details technical requirements. These documents are intended to be utilised to inform any new procurements of CHIS as the minimum standards required.

These documents are currently being updated and the 2015 versions will be published in the near future by PHE. They will cover the current content and status of healthcare

and public health programmes for children, with some future proofing and introduce standards for the interoperability of IT systems across different settings.

6.2 Electronic Red Book

Parents of every child born in the UK are given a paper-based Personal Child Health Record (PCHR), informally known as the 'red book'. This record contains general information of a child's health, growth and development and is held by the parents of the child.

This record is intended to be updated whenever a child visits a doctor, midwife, dentist, or other healthcare professional; or by the parents of the child in the case of family medical histories, their own observations of their child and updating of address and other personal details.

The PCHR also contains information about other sources of information for parents should they require help and support. The PCHR has already fulfilled the P4 health (predictive, preventive, personalised and participatory) agenda.

The content and development of the national standard core PHCR is overseen by a multidisciplinary committee hosted by the Royal College of Paediatrics and Child health (RCPCH). There are also local variations of the PCHR.

In an increasingly digital world, where a number of everyday tasks, such as banking and shopping, are performed online, there is a widening gap between such sectors, and that of healthcare where the majority of patient records are still paper-based.

Currently, through a series of engagement exercises, work is under way to explore the introduction of an electronic web-based version, the ePCHR. Standards for an ePCHR have been developed by a clinical advisory group established by RCPCH.

The exploration of the development of the ePCHR has been endorsed by the RCPCH.

An online application may be accessed anywhere, at any time. Crucially, this would make an online PCHR always available at the point of need. An online PCHR could be accessible on a range of devices, not just a desktop computer: if a parent can access an online PCHR on their smartphone or tablet computer, they will always have the healthcare records of their child to hand.

6.3 Data linkage

Directors of children's services have expressed a requirement for access to identifiable (via postcode of residence) record level information from health services in order to plan school places and monitor the long-term impact of interventions from children's public health services.

National and local projects are running that have the potential to provide linked data between health and education but are outside the remit of the transfer of public health commissioning for 0-5 years and on a longer timescale than the transfer programme window.

Discussions have also been held regarding a centralised infrastructure for the provision of data on new mothers in the locality to children's centres.

7. Where to find more information

7.1 State of readiness self-assessment tool (data and information)

A state of readiness self-assessment tool for the data and information aspects of the transfer has been developed to enable you to monitor progress. The use of this tool is optional and there will be no central monitoring of its use or progress against the different dimensions.

Separately the Local Government Association will invite local authorities to complete a self-assessment tool which looks at the wider aspects of the transfer. Its purpose is to take stock of the readiness of local authorities in all areas including finance, contracting and data and information and to signpost local authorities to guidance and information to support them in their journey. The self-assessment is a 'light touch' process – the information will be used to identify outstanding barriers to a safe transition and identify support that councils and area teams need. The data and information state of readiness self-assessment tool is separate to the LGA process, and we have been working together to avoid unnecessary duplication.

The data and information state of readiness tool can be accessed at www.chimat.org.uk/resource/view.aspx?RID=231069.

Selecting a position statement from a drop-down menu and using the free text box enables you to record why you made the decision for future reference and to assess locally your state of readiness to commission these services efficiently.

Being prepared for the transfer is primarily a locally owned process, where responsibility sits for planning, delivery and locally assuring that the transfer happens in a safe way with continuity of business processes.

The benchmarking section provides a final summary position for your local area. Clicking on the export results button creates a new worksheet containing your summary position should you be requested to provide an update on progress.

An average score of 4.0 and 'red, amber, green' (RAG) rating of green means all processes are in place. An average score of 3 or less would suggest there is more work to be done to support good service transitions.

This tool provides a useful resource to structure local plans for the safe transfer of data and information to support 0-5 years commissioning to local authorities.

7.2 Child and Maternal Health Intelligence Network

The National Child and Maternal Health Intelligence Network, operated by PHE, works across the system to drive up standards in the use of data, information and intelligence, and enables informed decision making in order to improve services and outcomes for children, young people and their families.

Key resources can be found via www.chimat.org.uk and datagateway@phe.org.uk.

For further guidance, information or support please e-mail info@chimat.org.uk

Appendix 1: Outcome indicators where the data flows will be unaffected by the transfer

The following indicators can be used to measure the impact of the health visiting service in terms of outcomes for children in the area. They are for reference only and will be unaffected by the transition of early years commissioning. These indicator collections are published on line by PHE in the Public Health Outcomes Framework (<http://www.phoutcomes.info/>) and Early Years Profiles (<http://atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile>).

Reference	Definition	Numerator	Denominator	Method of measurement	Collection and reporting responsibility and arrangements
Under-18 conceptions	Under-18 conception rate per 1,000 females aged 15-17 years	Number of pregnancies that occur to women aged under 18 that result in either one or more live or still births or a legal abortion under the Abortion Act 1967	Number of women aged 15-17 living in the area	Crude rate per 1,000 population	<ul style="list-style-type: none"> collection is through routinely collected maternity and abortion figures quarterly reporting by the Office for National Statistics at local authority level and then annually in the Public Health Outcomes Framework and in the Early Years Profiles
Smoking at delivery	Proportion of pregnant women who smoke at the time of delivery	Number of women known to smoke at time of delivery	Number of maternities	Percentage	<ul style="list-style-type: none"> collection is by provider trusts’ maternity services. quarterly reporting by the HSCIC at local authority level and then annually in the Public Health Outcomes Framework and in the Early Years Profiles

Reference	Definition	Numerator	Denominator	Method of measurement	Collection and reporting responsibility and arrangements
Transition to parenthood (placeholder)	In development. No requirement for data collection until national definition is finalised				<ul style="list-style-type: none"> • Early Years Profiles
Maternal mental health (placeholder)	In development. No requirement for data collection until national definition is finalised				<ul style="list-style-type: none"> • Early Years Profiles • Public Health Outcomes Framework
Low birth weight of term babies	Live births with a recorded birth weight under 2,500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks	Number of live births at term (≥ 37 gestation weeks) with low birth weight ($< 2,500\text{g}$)	Number of live births at term (≥ 37 weeks) with recorded birth weight	Percentage	<ul style="list-style-type: none"> • collection is through routinely collected birth registration data • annual reporting by ONS, in the Public Health Outcomes Framework and in the Early Years Profiles

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Reference	Definition	Numerator	Denominator	Method of measurement	Collection and reporting responsibility and arrangements
Infant mortality	Rate of infant deaths under 1 year per 1,000 live births	Number of deaths of infants under 1 year, registered in the calendar years	Number of live births occurring in the calendar years	Rate per 1,000	<ul style="list-style-type: none"> reporting is via ONS, the HSCIC and PHE, and also in the Public Health Outcomes Framework and the Early Years Profiles
A&E attendances (0-4 years)	Rate of A&E attendances of children aged under 5 years	Attendances at any A&E department by a child aged under 5 years resident in the area	Children aged 0-4 years resident in the area, based on the ONS mid-year estimate	Crude rate per 1,000 population	<ul style="list-style-type: none"> collection is via trusts' routine reporting arrangements, and requires no action by local authorities annual reporting in the Early Years Profiles
Emergency hospital admissions (0-4 years)	Rate of emergency hospital admissions of children aged under 5 years	Emergency hospital admission as an inpatient (at any hospital) by a child aged less than 5 years resident in the area	Children aged 0-4 years resident in the area, based on the ONS mid-year estimate	Crude rate per 100,000 population	<ul style="list-style-type: none"> collection is via trusts' routine reporting arrangements, and requires no action by local authorities annual reporting in the Early Years Profiles
Hospital admissions unintentional and deliberate injuries (0-4 years)	Rate of emergency hospital admissions of children aged under 5 years for unintentional and deliberate injuries	Emergency hospital admission as an inpatient (at any hospital) by a child aged under 5 years resident in the area where one or more of the following ICD-10 codes is recorded in any diagnostic field on the admission record: S00-T79 and/or V01-Y36	Children aged 0-4 years resident in the area, based on the ONS mid-year estimate	Crude rate per 100,000 population	<ul style="list-style-type: none"> collection is via trusts' routine reporting arrangements, and requires no action by local authorities annual reporting in the Public Health Outcomes Framework and the Early Years Profiles

Reference	Definition	Numerator	Denominator	Method of measurement	Collection and reporting responsibility and arrangements
School readiness	Percentage of children achieving a good level of development at the end of reception	All children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS). Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy	All children eligible for the EYFS Profile in the area	Percentage	<ul style="list-style-type: none"> • Early years profiles • Public Health Outcomes Framework
Tooth decay at five years	Percentage of children with one or more obviously decayed, missing (due to decay), missing (due	Number of children with one or more obviously decayed, missing (due to decay) and filled teeth. The survey population is defined as all those children attending state	Total number of examined 5 year old children in area	Percentage	<ul style="list-style-type: none"> • collected and reported through the National Dental Epidemiology Programme for England. The details of future surveys are to be confirmed • also reported in the Early Years Profiles and a related indicator in

Reference	Definition	Numerator	Denominator	Method of measurement	Collection and reporting responsibility and arrangements
	to decay) and filled teeth	maintained primary schools within the local authority who have reached the age of five, but have not had their sixth birthday on the date of examination (excluding special schools)			Public Health Outcomes Framework (4.02 – tooth decay in children aged 5)
Excess weight at 4-5 years	Proportion of children aged 4-5 classified as overweight or obese	Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their body mass index is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England	Percentage	<ul style="list-style-type: none"> collection is via local authority public health teams reporting to the NCMP annual reporting by the NCMP and in the Public Health Outcomes Framework and the Early Years Profiles
Vaccine coverage: MMR two doses (5 years)	Percentage of children vaccinated against MMR by age 5 years	Number receiving two doses from 1 st birthday and before 5 th birthday	Total number of children reaching their 5 th birthday in the period considered	Percentage	<ul style="list-style-type: none"> collected through the COVER programme reported in the Public Health Outcomes Framework and Early Years Profiles

Appendix 2: Outcome indicators and service delivery metrics where the data originates directly from the activity of health visitors

Please see Appendix 4 for full indicator specifications and a suggested data collection process. Validation rules are suggested below for checking by the commissioner on receipt of the data file. Any files failing validation should be followed up with the provider, to ensure any problems in their aggregation are flagged or any deficiencies in recording data in the CHIS are addressed.

Indicators whose reference begins with C are taken from the 2015-16 National Health Visiting Core Service Specification (<http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/info/docs-res/#serv-spec>), and should be collected and monitored as part of contracting arrangements to ensure the service is delivering the minimum mandatory elements, and highlight any areas of concern.

The Service Specification introduced indicator C6ii – Percentage of children who received a 2-2½ year review using ASQ 3. It is anticipated that the data quality of this indicator should improve over time. Once data quality is sufficiently good, the data can be used to report on the outcome indicator C6iii: the proportion of children who are scoring above the cut off in the five domains of child development.

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Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C1-Mothers receiving antenatal visit	Mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above	Number of mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above	N/A	Due to the difficulties establishing a reliable denominator this is a count		Local reporting only
C2-% New birth visits <14 days	Percentage of births that receive a face to face NBV within 14 days by a health visitor	Total number of infants who turned 30 days in the quarter who received a face-to-face new birth visits (NBV) undertaken within 14 days from birth, by a health visitor with mother (and ideally father)	Total number of infants who turned 30 days in the quarter	Percentage, reported to one decimal place	The total denominator would be expected to be within 20% of the population (based on the relevant ONS mid-year estimate) of children aged 0 years, multiplied by 1/4	Local reporting only

Transfer of the Commissioning of 0-5 Years Children's Public Health Services from NHS England to Local Authorities: Commissioning data covering mandated services and other key indicators

Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C3-% New birth visits > 14 days	Percentage of face-to-face NBVs undertaken after 14 days, by a health visitor	Total number of infants who turned 30 days in the quarter who received a face-to-face new birth visits (NBV) undertaken after 14 days from birth, by a health visitor with mother (and ideally father)	Total number of infants who turned 30 days in the quarter	Percentage, reported to one decimal place	As above	Local reporting only
C8i-%6-8 week Review	Percentage of children who received a 6-8 week review	The number of children who received a 6-8 week review by the time they turned 8 weeks	Total number of children due a 6-8 week review by the end of the quarter	Percentage, reported to one decimal place		Local reporting only

Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C8ii-% breastfeeding at 6-8 weeks	Percentage of infants being breastfed (fully or partially) at 6 to 8 weeks	Number of infants totally breastfed + number of infants partially breastfed	Number of infants due a 6-8 week check	Percentage, reported to one decimal place	The number of infants due a 6–8 week check in each quarter should be greater than 90% and less than 110% of the minimum quarterly number of registered live births in the local authority over the last 5 years	Specific arrangements to be agreed, however, annual figures will be reported in Public Health Outcomes Framework and in the Early Years Profiles
C4-% 12 month reviews <12 months	Percentage of children who received a 12 month review by the time they turned 12 months	Total number of children who turned 12 months in the quarter, who received a review by the age of 12 months	Total number of children who turned 12 months, in the appropriate quarter	Percentage, reported to one decimal place	<ul style="list-style-type: none"> the total denominator would be expected to be within 20% of the population (based on the relevant ONS mid-year estimate) of children aged 1 years, multiplied by 1/4 the numerator would be expected to be lower than the denominator 	Local reporting only

Transfer of the Commissioning of 0-5 Years Children’s Public Health Services from NHS England to Local Authorities: Commissioning data covering mandated services and other key indicators

Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C5-% 12 month reviews <15 months	Percentage of children who received a 12 month review by the time they turned 15 months	Total number of children who turned 15 months in the quarter, who received a 12 month a review by the age of 15 months	Total number of children who turned 15 months, in the appropriate quarter	Percentage, reported to one decimal place	<ul style="list-style-type: none"> • the total denominator would be expected to be within 20% of the population (based on the relevant ONS mid-year estimate) of children aged 1 years, multiplied by 1/4 • indicator C5 is expected to have a greater percentage than indicator C4 as it will include all those who have had their 12 month review by the time they were 12 months as well as those who had it between 12 and 15 months • the numerator would be expected to be lower than the denominator 	Local reporting only

Transfer of the Commissioning of 0-5 Years Children's Public Health Services from NHS England to Local Authorities: Commissioning data covering mandated services and other key indicators

Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C6i-% 2-2½ year reviews	Percentage of children who received a 2-2½ year review	Total number of children who turned 2½ years in the quarter who received a 2-2½ year review, by the age of 2½ years of age	Total number of children who turned 2½ years, in the appropriate quarter	Percentage, reported to one decimal place	The total denominator would be expected to be within 20% of the population (based on the relevant ONS mid-year estimate) of children aged 2 years, multiplied by 1/4	Local reporting only
C6ii-% 2-2½ year reviews using ASQ 3*	Percentage of children who received a 2-2½ year review using ASQ 3	The number of children who received a 2-2½ year review by the end of the quarter for which the ASQ 3 is completed as part of their 2-2½ year review	Total number of children who received a 2-2½ year review by the end of the quarter	Percentage, reported to one decimal place	N/A	Local reporting only

Transfer of the Commissioning of 0-5 Years Children's Public Health Services from NHS England to Local Authorities: Commissioning data covering mandated services and other key indicators

Reference	Definition (see Appendix 4 for full technical specification)	Numerator	Denominator	Method	Suggested validation to be carried out on receipt of the data	National reporting arrangement
C6iii-% above cut off ASQ 3 (each domain)	Percentage of children who score above the cut off in in the five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development	The number of children for whom the ASQ 3 is completed as part of their 2-2½ year review, who scored above the cut off in all five domains	The number of children who received a 2-2½ year review by the end of the quarter for which the ASQ 3 is completed as part of their 2-2½ year review	Percentage, reported to one decimal place	This is an aspirational indicator, and will be collected and reported once coverage and data quality are assessed to be good enough	

Appendix 3: Data items and required definitions in line with the Children and Young People's Health Services dataset

In future, routine operational data collection, the following data items should be being collected by the provider and recorded accurately in the Child Health Information System in order to ensure compliance with the national data collection requirements of the Children and Young People's Health Services (CYPHS) dataset (<http://www.hscic.gov.uk/maternityandchildren/CYPHS>). Providers are encouraged to start collecting data as outlined below now as these are the standardised data items which support the generation of comparable key performance indicators. The national data platform for receiving the CYPHS dataset will be available during 2015/16. In the interim period, these data items will feed into local collection requirements for indicators described in Appendix 2.

Child

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition
ORGANISATION CODE (CODE OF PROVIDER)	The organisation code of the organisation acting as the healthcare provider	an3, an5 or an6		
ORGANISATION CODE (RESIDENCE RESPONSIBILITY) N.B. This is the local authority where the child is resident	The organisation code derived from the child's POSTCODE OF USUAL ADDRESS	an3		

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PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born	an10 ccyy- mm-dd		
POSTCODE OF USUAL ADDRESS	The POSTCODE of the ADDRESS nominated by the child with ADDRESS ASSOCIATION TYPE 'Main Permanent Residence' or 'Other Permanent Residence'	max an8		
PERSON GENDER CODE CURRENT	A person's gender currently	an1	0	Not Known (not recorded)
			1	Male
			2	Female
			9	Not Specified (indeterminate/ambiguous)
ETHNIC CATEGORY	The ethnicity of a PERSON, as specified by the PERSON.	an2		White
			A	British
			B	Irish
			C	Any other White background
				Mixed
			D	White and Black Caribbean
			E	White and Black African
			F	White and Asian
			G	Any other mixed background
				Asian or Asian British
			H	Indian
			J	Pakistani
			K	Bangladeshi
L	Any other Asian background			
	Black or Black British			

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			M	Caribbean
			N	African
			P	Any other Black background
				Other Ethnic Groups
			R	Chinese
			S	Any other ethnic group
			Z	Not stated
			99	Not known

GP practice registration

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	The ORGANISATION CODE of the GP Practice that the child is registered with	an6		

Care activity

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition
CARE CONTACT DATE	Date of care contact by CARE PROFESSIONAL	max an20	an10 ccyy-mm-dd	
CARE ACTIVITY TYPE CODE	The type of care activity performed during a care contact by a CARE PROFESSIONAL	an2		Health visitor antenatal contact
			08	Health visitor new birth visit
			09	Health visitor health review (6- 8 weeks)
			10	Health visitor health review (1 year)
			11	Health visitor health review (2 to 2½ years)
			12	Health visitor formal handover to school nursing service (4- 5 years)

Breastfeeding status

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition
CARE CONTACT DATE	Date of Care Contact by CARE PROFESSIONAL	max an20	an10 ccyy-mm-dd	
BREASTFEEDING STATUS	This is the type of feed a baby is receiving	an2	01	Exclusively breast milk feeding
			02	Partially breast milk feeding
			03	No breast milk feeding at all

Child development outcomes

Data Item Name	Data Item Description	Format	National Code	National Code Definition
DATE OF COMPLETION OF ASQ-3 QUESTIONNAIRE	Date of completions of ASQ-3 questionnaire	An10 ccyy-mm-dd		
ASQ-3 QUESTIONNAIRE USED	Version of ASQ-3 questionnaire used	An2		24 months 27months 30 months
ASQ-3 COMPLETED AS PART OF HCP REVIEW	Whether or not questionnaire was completed as part of health visitor health review (2 to 2½ years) or an integrated review			Health visitor health review (2 to 2½ years) Integrated review Neither
ASQ DOMAIN SCORE - COMMUNICATION	Numerical score from the communication skills dimension of the ASQ-3 assessment	An2		

Transfer of the Commissioning of 0-5 Years Children's Public Health Services from NHS England to Local Authorities: Commissioning data covering mandated services and other key indicators

ASQ DOMAIN SCORE – GROSS MOTOR	Numerical score from the gross motor skills dimension of the ASQ-3 assessment	An2		
ASQ DOMAIN SCORE – FINE MOTOR	Numerical score from the fine motor skills dimension of the ASQ-3 assessment	An2		
ASQ DOMAIN SCORE – PROBLEM SOLVING	Numerical score from the problem solving dimension of the ASQ-3 assessment	An2		
ASQ DOMAIN SCORE – PERSONAL-SOCIAL	Numerical score from the personal-social skills dimension of the ASQ-3 assessment	An2		

Miscellaneous from birth record

Data Item Name (Data Dict Element)	Data Item Description	Format	National Code	National Code Definition
PERSON BIRTH DATE (MOTHER)	Date of birth of mother from maternity episode	An10 ccyy- mm-dd		
GESTATIONAL AGE AT DELIVER (BABY)	Gestational age of baby on delivery in weeks of completed pregnancy	An2		

Appendix 4: Indicator technical specifications

General points on data collection

Data collection should cover all **children resident in the commissioner area**, that is, within the relevant local authority boundary.

The data should be collected in a way that allows reporting to both Local Authority and NHS interest; that is to say reporting firstly by local authority area based on home residence of the child and secondly by the clinical commissioning group (CCG) based on registration with a local GP.

All mothers and children are included in each indicator. This includes anyone being treated privately or not registered with a GP.

When families move, it is specified with which area or provider should be used. It is recognised that this will involve some providers counting visits that were carried out by providers in other areas as well as visits that were not carried out in other areas. It is specified where the number of births should be counted and the number of babies should be counted.

Data should be collected and submitted to a timescale agreed by commissioner and provider; monthly or quarterly collection is recommended and any annual audits as appropriate.

General points on data submission:

- all indicators detailed should be submitted in one file which must be prepared using individual records extracted from the CHIS or other relevant local IT system and supplied to the commissioner in an Excel or CSV file format
- the headings used and the order of the fields must be as specified in the table below
- none of the fields may be 'null'
- information for all relevant general practice codes must be supplied so that the denominator sums to the total activity carried out in the quarter by the provider, for the commissioner
- validation must be carried out as shown in the table below, before submission
- the file name should take the format <ORGANISATION CODE (CODE OF PROVIDER)>_<QUARTER OF RETURN>, for example R11_2015-12-31

- if an Excel file is being sent, it should be saved as an Excel 97-2003 workbook (it will be saved as an .xls file). It should not contain macros. It should contain only one worksheet where the data appears. No formatting or text aligning should be applied to the cells. Any column totals used for checking or other validation should be removed before sending
- the file should be sent by email, within an agreed timescale.

Table 1: Data submission file format

Data Item Name	Description	Format	Validation
QUARTER OF RETURN	The last day in the quarter to which the data relates	11 alphanumeric characters	dd-mm-yyyy
ORGANISATION CODE (CODE OF PROVIDER)	The organisation code of the organisation acting as the healthcare provider	3,5 or 6 alphanumeric characters	Against list of valid provider codes: http://systems.hscic.gov.uk/data/ods
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	The upper tier local authority code derived from the child's postcode of usual address	3 alphanumeric characters	Against list of valid local authority codes: http://systems.hscic.gov.uk/data/ods/datadownloads/nonnhs
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	The organisation code of the GP practice that the child is registered with.	6 alphanumeric characters	Against list of valid practice codes: http://systems.hscic.gov.uk/data/ods/datadownloads/gppractice
BREASTFEEDING_68_TOT+PAR	Number of infants recorded as being totally breastfed at 6-8 weeks + number of infants recorded as being partially breastfed	Numeric, whole number only	Whole number, between 0 and INFANTS_8_WEEKS
INFANTS_8_WEEKS	The number of infants due a 6–8 week checks during the quarter.	Numeric, whole number only	Whole number, 0 or greater

REVIEW_WITHIN_8_WEEKS	Number of infants due a 6-8 weeks review by the end of the quarter who had received a 6-8 week review by the time they turned 8 weeks	Numeric, whole number only	Whole number, between 0 and INFANTS_8_WEEKS
REVIEW_WITHIN_8_WEEKS_%	Percentage of infants due a 6-8 weeks review by the end of the quarter who had received a 6-8 week review by the time they turned 8 weeks	Numeric, between 0 and 100	REVIEW_8_WEEKS/ INFANTS_8_WEEKS*100
BREASTFEEDING_68_%	% of infants being breastfed at 6 to 8 weeks	Numeric, between 0 and 100	BREASTFEEDING_68_TOT+PAR / BREASTFEEDING_68_CHECK_DUE*100
ANTENATAL_SEEN_28+	Count of the number of pregnant women living in the area who had a first antenatal contact with a health visitor (or member of health visiting team) at 28+0 weeks of their pregnancy or above	Numeric, whole number only	Whole number, 0 or greater.
INFANTS_30_DAYS	Number of infants who turned 30 days within the quarter	Numeric, whole number only	Whole number, 0 or greater.
NBV_WITHIN_14_DAYS	Number of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother	Numeric, whole number only	Whole number, between 0 and INFANTS_30_DAYS
NBV_WITHIN_14_DAYS_%	Percentage of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother	Numeric, between 0 and 100	NBV_WITHIN_14_DAYS/ INFANTS_30_DAYS *100

NBV_ABOVE_14_DAYS	Number of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother	Numeric, whole number only	Whole number, between 0 and INFANTS_30_DAYS
NBV_ABOVE_14_DAYS_%	Percentage of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother	Numeric, between 0 and 100	$\frac{\text{NBV_ABOVE_14_DAYS}}{\text{INFANTS_30_DAYS}} * 100$
INFANTS_12_MONTHS	Number of infants who turned 12 months within the quarter	Numeric, whole number only	Whole number, 0 or greater.
INFANTS_15_MONTHS	Number of infants who turned 15 months within the quarter	Numeric, whole number only	Whole number, 0 or greater.
REVIEW_WITHIN_12_MONTHS	Number of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months	Numeric, whole number only	Whole number, between 0 and INFANTS_12_MONTHS
REVIEW_WITHIN_12_MONTHS_%	Percentage of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months	Numeric, between 0 and 100	$\frac{\text{REVIEW_WITHIN_12_MONTHS}}{\text{INFANTS_12_MONTHS}} * 100$
REVIEW_WITHIN_15_MONTHS	Number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months	Numeric, whole number only	Whole number, between 0 and INFANTS_15_MONTHS. Should be greater than REVIEW_WITHIN_12_MONTHS, but may not be

REVIEW_WITHIN_15_MONTHS_%	Percentage of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months	Numeric, between 0 and 100	REVIEW_WITHIN_15_MONTHS/INFANTS_15_MONTHS *100
2YR_REVIEW_DUE	Number of children due a 2-2½ year review by the end of the quarter	Numeric, whole number only	Whole number, 0 or greater.
2YR_REVIEW_RECEIVED	Number of children due a 2-2½ year review by the end of the quarter who received a 2-2½ year review by the time they turned 2½ years	Numeric, whole number only	Whole number, between 0 and 2YR_REVIEW_DUE
2YR_REVIEW_RECEIVED_%	Percentage of children due a 2-2½ year review by the end of the quarter who received a 2-2½ year review by the time they turned 2½ years	Numeric, between 0 and 100	2YR_REVIEW_RECEIVED/2YR_REVIEW_DUE*100
2YR_REVIEW_RECEIVED_ASQ3	Number of children who received a 2-2½ year review during the quarter for whom the ASQ 3 was completed as part of their review	Numeric, whole number only	Whole number, between 0 and 2YR_REVIEW_RECEIVED
2YR_REVIEW_RECEIVED_ASQ3_%	Percentage of children who received a 2-2½ year review during the quarter for whom the ASQ 3 was completed as part of their review	Numeric, between 0 and 100	2YR_REVIEW_RECEIVED_ASQ3/2YR_REVIEW_RECEIVED*100

Prevalence of breastfeeding at 6-8 weeks

The information required is:

- number of infants living in the commissioning area due a 6-8 week check during the quarter

Data submission file: data
item name

INFANTS_8_WEEKS

Figures should relate to infants born not more than 8 weeks before the quarter start, and born more than eight weeks before the quarter end. Child Health Information Systems could use 6 or 7 weeks if they prefer but the number of weeks must be the same each quarter, and must be 6, 7 or 8. It is accepted that some checks will take place before the quarter starts or some will take place after the quarter ends.

- number of infants recorded as being totally breastfed at 6-8 weeks + Number of infants recorded as being partially breastfed.

Data submission file: data
item name BREASTFEEDING_68_TOT+PAR

definitions:

- totally breastfed is defined as infants who are exclusively receiving breast milk (this may be expressed breast milk) at 6-8 weeks of age - that is, they are NOT receiving formula milk, any other liquids or food
- partially breastfed is defined as infants who are currently receiving breast milk (this may be expressed breast milk) at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food
- not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age

Prevalence is defined as the percentage of infants being breastfed (totally + partially) at the 6-8 week check, numerator/denominator * 100.

Data submission file: data
item name BREASTFEEDING_68_%

NOTE: Count the number of infants, not the number of mothers.

Include:

Each child due a 6-8 week review, even if seen early or late. In the case of multiple births this will be more than one.

Infants born who are not registered with a GP but are known to the Child Health Records Department, whether they have a 6-8 week check or not.

All children having their care privately, even if they are not seen by a GP or health visitor.

Exclude:

Babies who moved out of the area before their sixth week.

Babies who die before their 6-8 week review.

Infants who moved into the area following their 6-8 week check.

Breastfeeding status recorded at checks that take place as part of the handover from midwives at or before 4 weeks cannot be submitted as the breastfeeding status at 6-8 weeks. If the breastfeeding status for these infants is not recorded at 6-8 weeks then they should be counted as breastfeeding status not known.

Indicator C1 - Number of mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks of pregnancy or above.

Count of number of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or later, before they gave birth.

Data submission file: data ANTENATAL_SEEN_28+
item name

This should be a count of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or greater, before they gave birth. Visits which occurred within the quarter should be counted (for example for Q1 2014/15, visits which occurred between 1 April and 30 June inclusive). The number of visits, not the number of children should be counted.

Notes:

This is defined as a count rather than a percentage because of the difficulty of defining a denominator to which antenatal visits can be linked within current data collection systems.

Indicators C2 and C3 - Percentage of births that receive a face-to-face New Birth Visit (NBV) within 14 days by a health visitor (Indicator C2), or after 14 days (Indicator C3)

The information required is:

The total number of infants who turned 30 days within the quarter (denominator C2 and C3).

Data submission file: data
 item name **INFANTS_30_DAYS**

Total number of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother (and ideally father) (numerator C2).

Data submission file: data
 item name **NBV_WITHIN_14_DAYS**

Total number of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother (and ideally father) (numerator C3).

Data submission file: data
 item name **NBV_ABOVE_14_DAYS**

Definitions:

The total number of infants who turned 30 days within the quarter is defined as all those infants within the provider area of responsibility who turn 30 days within the quarter.

This is to make sure that we are picking up most NBVs even where they occur after the recommended 10-14 days. The table below shows the ranges of birth dates which should be included in each quarter.

Quarter	Earliest birth date included	Latest birth date included
Q1	2 March	1 June
Q2	2 June	1 September
Q3	2 September	2 December
Q4	3 December	1 March

NOTE: Count the number of children born, not the number of mothers.

The number of children who turned 30 days within the quarter who received a face-to-face NBV within 14 days is defined as the number of children defined above who also received an NBV within 14 days of their birth.

The number of children who turned 30 days within the quarter who received a face-to-face NBV after 14 days is defined as the number of children defined above who also received an NBV after 14 days after their birth.

We would expect that the vast majority of visits for those under 14 days will occur between 10-14 days as recommended, as midwives will be responsible for care prior to that. However there are occasions when an earlier visit is justified, so there is no lower limit for this indicator on how long after the birth the visit can occur.

Include:

Each child born. In the case of multiple births this will be more than one.

All children born privately, even if they are not seen by a health visitor.

Exclude:

Babies who die before their NBV.

Notes:

This definition is based on infants who should have received an NBV by the end of the quarter. There are infants who are neither born in the quarter referred to, nor receive an NBV in the quarter referred to. The definition has been set up so that those babies born towards the end of the specified period who receive an NBV later than 14 days are still counted as receiving a visit.

There are cases where it is not possible for an NBV to take place within the recommended period. It is not expected that these indicators would total 100%, nor that areas would achieve 100% under 14 days.

Indicators C4 and C5 - Percentage of children who received a 12 month review by the time they were 12 months and percentage of children who received a 12 month review by the time they were 15 months.

The information required is:

The total number of children who turned 12 months in the quarter (denominator C4).

Data submission file: data
item name INFANTS_12_MONTHS

The number of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months (numerator C4).

Data submission file: data
item name REVIEW_WITHIN_12_MONTHS

The total number of children who turned 15 months in the quarter (denominator C5).

Data submission file: data
item name INFANTS_15_MONTHS

The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months (numerator C5).

Data submission file: data
item name REVIEW_WITHIN_15_MONTHS

Definitions:

The number of children due a 12 month review by the end of the quarter is defined as all those who fulfil the following two criteria:

Are under the responsibility of the provider at the end of the quarter (for example for Q1 2014/15 this would be on 30 June 2014).

Were aged 12 months within the quarter (for example for Q1 2014/15 this would be those who were aged 12 months between April 2014 and June 2014, that is those who were born between 1 April 2013 and 30 June 2013 inclusive).

The number of children who turned 12 months within the quarter who had received a 12 month review by the time they turned 12 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 12 months. Note that children who received a review in a previous quarter should be included.

Include:

All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

Children who die before their 12 month review.

The total number of children who turned 15 months in the quarter is defined as all those who fulfil the following two criteria:

Are under the responsibility of the provider at the end of the quarter (for example for Q1 2015/16 this would be on 30 June 2015).

Were aged 15 months within the quarter (for example for Q1 2015/16 this would be those who were aged 15 months between April 2015 and June 2016. That is those who were born between 1 Jan 2014 and 31 March 2015 inclusive).

The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 15 months. This includes children who received a 12 month review in previous quarters, and those who had it before they turned 12 months.

Include:

All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

Children who die before their 12 month review.

Notes:

The numerator for indicator C5, percentage of children who have had their 12 month review by the time they have turned 15 months, should include all those who have turned 15 months who have received a 12 month review. This should include those who have had their review before the current quarter and also those who have had their review before they turned 12 months, as well as those who had their review between 12 and 15 months.

Indicator C6i - Percentage of children who received a 2-2½ year review

Definitions:

The total number of children due a 2-2½ year review by the end of the quarter (denominator).

Data submission file: data 2YR_REVIEW_DUE
item name

The number of children due a 2-2½ year review by the end of the quarter who received a 2-2½ year review by the time they turned 2½ years (numerator).

Data submission file: data
item name 2YR_REVIEW_RECEIVED

The number of children due a 2-2½ year review by the end of the quarter is defined as all those who fulfil the following two criteria:

Are under the provider's responsibility at the end of the quarter (eg for Q1 2014/15 this would be on 30 June 2014).

Were aged 2½ years within the quarter (for example for Q1 2014/15 this would be those who were aged 2½ years between April 2014 and June 2014, that is those who were born in Q3 2011/12, so between 1 Oct 2011 and 31 Dec 2011 inclusive).

The number of children due a 2-2½ year review by the end of the quarter who received a 2-2½ year review by the time they turned 2½ is defined as the number of those who fulfil the criteria above and who have received a 2-2½ year review by the time they turned 2½. Note that this should include those who had a 2-2½ year review in a previous quarter.

Include:

All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

Children who die before their 2-2½ year review.

Indicator C6ii - Percentage of children who received a 2-2½ year review using ASQ 3
The information required is:

The total number of children who received a 2-2½ year review by the end of the quarter (denominator).

Data submission file: data
item name* 2YR_REVIEW_RECEIVED

*Already collected for indicator C6i

The number of children due a 2-2½ year review by the end of the quarter for whom the ASQ 3 is completed as part of their 2-2½ year review (numerator).

Data submission file: data 2YR_REVIEW_RECEIVED_ASQ3
item name

Definitions:

The number of children due a 2-2½ year review by the end of the quarter is defined as all those who fulfil the following two criteria:

Are under the provider's responsibility at the end of the quarter (for example for Q1 2014/15 this would be on 30 June 2014).

Were aged 2½ years within the quarter (for example for Q1 2014/15 this would be those who were aged 2½ years between April 2014 and June 2014, that is those who were born in Q3 2011/12, so between 1 Oct 2011 and 31 Dec 2011 inclusive).

The number of children due a 2-2½ year review by the end of the quarter **who received** a 2-2½ year review by the time they turned 2½ (the **denominator**) is defined as the number of those who fulfil the criteria above and who have received a 2-2½ year review by the time they turned 2½. Note that this should include those who had a 2-2½ year review in a previous quarter.

Include:

All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

Children who die before their 2-2½ year review.

The number of children who received a 2-2½ year review by the end of the quarter for whom the ASQ 3 is completed as part of their 2-2½ year review (the **numerator**) is defined as the number of those who fulfil the criteria above and for whom the ASQ 3 is completed as part of their 2-2½ year review by the time they turned 2½. Note that this should include those who had a 2-2½ year review in a previous quarter.

Children who die before their 2-2½ year review.

Indicator C8 - Percentage of children who received a 6-8 weeks review

The information required is:

The total number of children due a 6-8 weeks review by the end of the quarter (denominator).

Data submission file: data INFANTS_8_WEEKS*
item name

*Already collected for breastfeeding at 6-8 weeks indicator

The number of children due a 6-8 weeks review by the end of the quarter who had received a 6-8 week review by the time they turned 8 weeks (numerator).

Data submission file: data REVIEW_WITHIN_8_WEEKS
item name

Definitions:

The number of children due a 6-8 weeks review by the end of the quarter is defined as all those who fulfil the following two criteria:

Are under the provider's responsibility at the end of the quarter (eg for Q1 2014/15 this would be on 30 June 2014).

Were aged from 6 to 8 weeks within the quarter. The table below shows the ranges of birth dates which should be included in each quarter.

Quarter	Earliest birth date included	Latest birth date included
Q1 (April to June)	4 February	19 May
Q2 (July to September)	6 May	19 August
Q3 (October to December)	6 August	19 November
Q4 (January to March)	6 November	18 February

NOTE: Count the number of children born, not the number of mothers.

The number of children due a 6-8 weeks review by the end of the quarter who received a 6-8 weeks review by the time they turned 8 weeks is defined as the number of those who fulfil the criteria above and who have received a 6-8 weeks review by the time they turned 8 weeks.

Include:

All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

Children who die before their 6-8 weeks review.

Appendix 5: Supporting assumptions

This work is based upon a set of assumptions about who needs what data and information, in what format and for what purpose. The assumptions were tested and refined via regional workshops held in autumn 2014 with commissioners, service providers and information managers from local authorities and the NHS. All localities were represented.

The conclusions were:

Local authority commissioners and integrated service providers require:

- aggregate, pre-analysed information to support planning and monitoring (to include quarterly and annual reports of benchmarked information on activity levels, service coverage and outcomes)
- anonymised record level information on individuals to support quality assurance of data and validation of key performance indicators
- that local agreements will be needed for ad-hoc reporting

In addition integrated service providers across health and social care require:

- Identifiable record level data on individual children and their families in order to support the direct delivery of care (this is important but outside the scope of this document)

Other assumptions include:

- health visitors and family nurses will need direct access to CHIS and CHRDs in order to deliver clinical practice. This will include access to identifiable record level information on individual children in order to ensure programme coverage and update the individual clinical records. Existing information governance arrangements within the NHS will continue to support this arrangement
- screening and immunisation leads may require direct access to CHIS or indirect access via CHRDs. This will include access to identifiable record level information on individual children in order to ensure programme coverage. Existing information governance arrangements within the NHS will continue to support this arrangement
- social workers and other professionals will require access to detailed information on individual children for child protection purposes. This should be managed between professionals at a local level in exactly the same way as it is managed at present. No change is anticipated as this arrangement is covered by existing data governance guidance

- commissioners will not require direct access to CHIS or CHR. They will require a cross boundary flow of aggregate pre-analysed information to support commissioning, contract monitoring and performance management at a local level. They will also require access to anonymous record level information for quality assurance and validation purposes
- there will also be a requirement for a national benchmarked flow of aggregate information highlighting performance against England average, geographic and statistical neighbours. The national flow of information will be less timely and only likely to be updated on an annual basis but can also include comparative performance on activity levels, service coverage and outcomes
- public health outcomes will continue to be reported via:
 - **Public Health Outcomes framework**
 - **Early Years profiles**
- local agreements will need to be in place to cover the provision of local ad-hoc reports which may be required for the investigation and/or ongoing management of incidents or issues
- there are no direct information technology requirements arising from this transition of commissioning responsibilities