Child Health Information Services (CHIS) Provider Service Specification
## Document Purpose

This document is a provider service specification to outline the standards of delivery for the Child Health Information Service and Systems (CHIS) recognising that current practice and delivery requires improvement.

## Description

This document is a provider service specification to outline the standards of delivery for the Child Health Information Service and Systems (CHIS) recognising that current practice and delivery requires improvement.

## Cross Reference

NA

## Superseded Docs (if applicable)

None

## Action Required

Best Practice

## Timing / Deadlines (if applicable)

NA

## Contact Details for further information

Direct Commissioning Operations - Public Health
Skipton House,
80 London Road
London
SE1 6LH

## Document Status

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Equality statement

Equality and diversity are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- Reduce health inequalities in access and outcomes of healthcare services integrate services where this might reduce health inequalities
- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

SCHEDULE 2 – THE SERVICES

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Child Health Information Services; Child Health Records Department, Child Health Information Services and Personal Child Health Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Lead</td>
<td>To be completed by the local commissioner</td>
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<tr>
<td>Provider Lead</td>
<td>To be completed by the local commissioner</td>
</tr>
<tr>
<td>Period</td>
<td>xxx 2015 – April 2016</td>
</tr>
<tr>
<td>Date of Review</td>
<td>February 2016</td>
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</tbody>
</table>

1 Population Needs

1.1 National/local context and evidence base

The NHS Public Health Steering Group on 23rd November 2013, endorsed the decisions made by the Child Health Information Service (CHIS) Programme Board, to retain the responsibility for commissioning of CHIS services and systems within the NHS by section 7A of the National Health Act 2006 and agreements made under it) for steering the improvement of CHIS functionality until 2020. All CHIS IT systems (CHISS) provide a database of information on a population of children for the purposes of immunisation, screening and delivery of the Healthy child programme 0-5. However in some instances they have been developed to support the delivery of care to individual children and have become integrated within an electronic community child health record.

They are required to be interoperable with a large number of other NHS IT systems including Patient Demographic Service (PDS), NHS Numbers for babies (NN4B), GP Practice systems, maternity services and community health systems.

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1 Public Health Section 7A Agreement
The purpose of this document is to outline the standards of delivery for the Child Health Information Service and Systems, recognising that current practice and delivery requires improvement, support timely improvement plans via a continual service improvement plans and support contract management and monitoring – (see Section 5.3).

In order to ensure CHIS services are safe and stable from now and throughout the subsequent transition of commissioning clinical services to Local Authorities (LAs) planned for 2020, a CHIS improvement programme is required that will support the delivery of ‘securing excellence in Child Health Information Services’ as well as set the strategic direction through an effective technology strategy for child health.

In partnership with its stakeholders, NHS England via this document and the refresh of the Output Based Specification (OBS) seeks to innovate child health information services through the introduction of new digital ways of working.

A greater level of digital adoption is expected to generate gains for both the clinical quality and operational efficiency of child health services. There are several drivers for change to increase clinical effectiveness and efficiency in child health (see table below p8-9).

In terms of clinical outcomes, a digital child health service can support the effective delivery of the healthy child programme, with the intention of reducing risk of harm, ill-health and potential fatalities that are attributed to incomplete or inaccurate data and information.

From an efficiency perspective, there are potential workforce productivity gains through reduced administrative time taken, resulting in potential efficiency savings or future re-investment into clinical or CHIS services themselves.

The CHIS service consists of three components an IT system, the Child Health Information Service System (CHISS) a child health records department (CHRD), and a personal child health record (PCHR), otherwise known as the Red Book. They also form the basis in some instances of an Electronic Child Health record.

The service acts as a population register for commissioners to ensure that universal services such as immunisations, childhood screening, the Healthy Child Programme 0-5 years as well as support for children with special educational needs (SEN) are offered to children. Uptake is monitored and outcomes are recorded. An effective child health information service therefore requires a robust IT system to support it, and so the procurement of this IT system is therefore a critical part of service delivery for the Provider. As well as providing this database of information required for secondary purpose in some instances they have been developed to support the delivery of care to individual children and have become integrated within an electronic community child health record.

When Providers use IT system suppliers (who may be in other Providers) there needs to be a separate contract between the Provider and IT System Suppliers to ensure that the system supplier provides the necessary system support to the child health function and patient administration systems that provide a clinical record for individual children and support a variety of child health and related activities, including universal services for population health and support for statutory functions. Agreements with
system suppliers will be in the terms of the NHS Standard Contract and include the data processor terms required by Schedule 1, Part II, paragraph 12 of the Data Protection Act 1998.

1.2 Background and context

NHS England is responsible for the commissioning of the CHIS service as well as children’s public health services from pregnancy to 5 years old (until October 2015) screening, immunisation and as part of the annual national Public Health Section 7A Agreement.

A child health information service invariably comprises of three components:

1. An IT system the Child Health Information Service System [CHISS] - The systems while they vary considerably generally provide some sort of cohort analysis function as well as a call and recall function

2. A child health records department (CHRD), the people who run the system and

3. A personal child health record (PCHR), the ‘Red Book’

The service’s primary function is to provide a comprehensive local record of a child’s public health (screening, immunisation and other health protection or health improvement interventions including the Healthy Child programme 0-5) and of their community based healthcare. Children’s Public Health Services 0-5 years is transferring to LAs in October 2015, whilst commissioning of Child Health Information Service remains with NHS England. As well as providing this database of information required for secondary purpose in some instances they have been developed to support the delivery of care to individual children and have become integrated within an electronic community child health record

Child Health Information Services and Systems play a critical role in the scheduling, recording and monitoring of public health programmes, including vaccination delivery and immunisation status of children in England. They are the definitive source of immunisation uptake and coverage within England and, as such, are essential to limiting the spread of communicable diseases. They provide information about individual children’s health (which can be useful e.g. during an outbreak of a disease for which some children may be immunised), but also provide a population-perspective, enabling effective targeting of services (e.g. they capture non-GP-registered children enabling a whole population view to be taken about needs to inform a commissioning strategy).

The current immunisation, screening and other public health programs referred to within this document are detailed in other service specifications and may be subject to update as advancements in evidenced best practice procedures emerge. The development of CHIS service systems will need to allow for these updates.
1.3 Evidence Base

- Evidence for screening: UK National Screening Committee (UKNSC) Policy Recommendations and Guidance - [www.screening.nhs.uk](http://www.screening.nhs.uk)
- Standards for new-born blood spot screening, August 2013, NHS New-born Blood Spot Screening Programme
- [Failsafe processes (2011) NHS New-born Blood Spot Screening Programme](http://www.newbornbloodspot.screening.nhs.uk)
- NICE Guidance – PH 21 reducing differences in the uptake of immunisations - 2009
- The Healthy Child Programme (From 5 to 19 years). Department of Health and Department for Children, Schools and Families. October 2009.

2 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

The CHIS (Child Health Information Service System) shall support the Child Health Records Department (CHRD) to impact on the following outcomes:

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Potential years of life lost (PYLL) from causes considered amenable to healthcare</td>
</tr>
<tr>
<td>ii</td>
<td>Reducing deaths in babies and young children</td>
</tr>
<tr>
<td>1.b</td>
<td>Infant mortality* (PHOF 4.1)</td>
</tr>
<tr>
<td>ii</td>
<td>Neonatal mortality and stillbirth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2</th>
<th>Enhancing quality of life for people with long-term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 18s or above as provided by statute</td>
</tr>
</tbody>
</table>

| Domain 3 | Helping people to recover from episodes of ill-health |

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2 [https://indicators.ic.nhs.uk/webview/](https://indicators.ic.nhs.uk/webview/)
<table>
<thead>
<tr>
<th>Domain 4</th>
<th>Ensuring people have a positive experience of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)</td>
</tr>
<tr>
<td></td>
<td>4.8 Children and young people’s experience of outpatient Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 5</th>
<th>Treating and caring for people in safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.5 Admission of full-term babies to neonatal care</td>
</tr>
<tr>
<td></td>
<td>5.6 Incidence of harm to children due to ‘failure to monitor’</td>
</tr>
</tbody>
</table>

### 2.2 Public Health Outcomes Framework

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Improving the wider determinants of health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1 Children in poverty</td>
</tr>
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<td></td>
<td>1.2 School readiness</td>
</tr>
<tr>
<td></td>
<td>1.3 Pupil absence</td>
</tr>
<tr>
<td></td>
<td>1.4 First time entrants to the youth justice system</td>
</tr>
<tr>
<td></td>
<td>1.5 16-17 year olds or above as provided by statute not in education, employment or training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2</th>
<th>Health Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.1: Low birth weight of term babies</td>
</tr>
<tr>
<td></td>
<td>2.2: Breastfeeding</td>
</tr>
<tr>
<td></td>
<td>2.3: Smoking status at time of delivery</td>
</tr>
<tr>
<td></td>
<td>2.5: Child development at 2-2.5 years (Placeholder)</td>
</tr>
<tr>
<td></td>
<td>2.6: Excess weight in 4-5 and 10-11 year olds</td>
</tr>
<tr>
<td></td>
<td>2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years 2.8 Emotional well-being of looked after children</td>
</tr>
<tr>
<td></td>
<td>2.9 Smoking prevalence – 15 year olds (Placeholder)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3</th>
<th>Health Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.3: Population vaccination coverage</td>
</tr>
<tr>
<td></td>
<td>3.2 Chlamydia diagnoses (15-24 year olds)</td>
</tr>
<tr>
<td></td>
<td>3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 4</th>
<th>Healthcare public health and preventing premature mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.1: Infant mortality</td>
</tr>
<tr>
<td></td>
<td>4.2 Tooth decay in children aged 5</td>
</tr>
<tr>
<td></td>
<td>4.3 Mortality rate from causes considered preventable</td>
</tr>
<tr>
<td></td>
<td>4.8 Mortality rate from communicable diseases</td>
</tr>
</tbody>
</table>
4.11 Emergency readmissions within 30 days of discharge from hospital
4.12 Preventable sight loss

The provider shall achieve the minimum standard for CHIS service to enable delivery of immunisation, screening and the Healthy Child Programme services as set out in the National Service specification for ‘Children’s public health services from pregnancy to age 5’ DH (2013) Public health functions to be exercised by NHS England: Service specification No.27 children’s public health services (from pregnancy to age 5) by at the latest April 2015. Resulting in effective delivery of children’s public health services, improved data collection for population health measures, and better records on child health facilitating clinical and family decision-making. The CHIS shall publish a realistic roadmap for progression, within the funding envelope provided, to meet the gold standard set out in Information Requirements for Child Health Information Systems by April 2015 achieving excellence in CHIS.


2.3 Local defined outcomes

The Child Health Information Service will provide an essential function ensuring that key demographic and clinical information is maintained for all Children and Young People specifically:

- All children 0-18 as defined by the Children Act 1989
- Demographic and clinical information to support the Health Child Programme 0-19 [includes young people up to 20\textsuperscript{th} birthday]
- Young people up to the age of 25 [“former relevant children”] to whom the Local authority has duties
- Children and Young people up to the age of 25 with Special Educational Needs & Disabilities [SEND] including those with Educational Health and Care[EHC] Plans
- Some young people whose health care has not yet transitioned to adult health services
- Fail safe procedures are in place for incoming children to the local area either from another CHIS or from outside England.

The information collected and maintained by CHIS will form the definitive measure of success against a wide range of outcomes including:

- Immunisation coverage supported through effective provision of in-year data to support targeted intervention.
- Offer and uptake of the three national screening tests offered to new-born babies i.e. blood spot, hearing and new-born and infant physical examination
(NIPE)

- Improve health outcomes for the Health Child Programmes 0-5 and 5-19 and young people as defined above as provided by the population of PROVIDER TO INSERT and elsewhere as historically covered by this service. NHS England commissions services for registered population not resident. The geographic boundaries for this service will be reviewed during 2014/15.
- Management of disease outbreak
- Achievement of the minimum standard for CHIS to enable delivery of immunisation, screening and the Healthy Child Programme, across all local areas, at the latest, by April 2015 resulting in effective delivery of children’s public health services, improved data collection for population health measures, and better records on child health facilitating clinical and family decision-making

As a result of the key operational and strategic role that CHIS occupies, there is an expectation that records and interfaces be of the highest standard.

The Provider will carry out a privacy impact assessment of the information flows referred to in paragraph 3.6 below using an NHS England PIA template.

### 3 Scope

#### 3.1 Aims and objectives of service

The aim of Child Health Information Services (CHIS) is to ensure that each child in England has an active care record, supporting delivery of the clinical service, as a minimum, screening, immunisation and the healthy child programme services for which detailed service specifications are set out elsewhere in Part C of the Section 7A agreement. It should enable the health promotion and failsafe activities for clinical delivery to be carried out in a timely way. These records must be held within a secure information system, which meets appropriate requirements for information governance and IT security for managing personally-identifiable data within the NHS, and must be supported by an adequately resourced team to record and manage the relevant data. More specifically CHIS will:

- Support and is integral to the clinical provision of high quality screening programmes, that meet the policies, recommendations and standards of the UK National Screening Committee (UKNSC)
- Support and is integral to the clinical provision of high quality immunisation programmes, that meet the policies, recommendations and standards of Public Health England (PHE)
- Ensure that all babies eligible for new-born blood spot screening, age one year and under, are recorded on a child health information system along with their new-born blood spot screening status
- Ensure that all babies eligible for new-born hearing screening are recorded where it is delivered on a child health information system along with their screening status
• Ensure that all babies eligible for the 72 hour and 6-8 week new-born and infant physical examination (NIPE) are recorded on a child health information system along with their screening status
• Ensure that the mother’s Hepatitis B screening status is recorded and a vaccination schedule for the baby is generated
• Ensure that a maternal Hepatitis B positive status notification and a 1st Vaccination notice/alert is generated, to prompt a follow up of the vaccination schedule
• Ensure that all children eligible for routine childhood immunisations are recorded on a child health information system along with their immunisation status
• Enable recording of data from the National Child Measurement Programme
• Ensure that the recording element of screening and immunisation programmes consistently complies with the underlying principle that screening does more good than harm at a reasonable cost.

The CHIS (CHISS/CHRD/PCHR) will fulfil the processing of data returns and statutory reporting requirements to support the NHS and Public Health England (PHE) in the overall management of public health programmes and to track progress via the indicators detailed within the Public Health Outcomes Framework and the NHS Outcomes Framework. The efficient management and reporting of this information will therefore be critical to understanding local progress against the Public Health Outcomes Framework.

3.2 Objectives

The primary objectives that will be delivered through the implementation of this service specification are:

• To ensure that the Provider is using a Child Health Information Service System, which meets a minimum standard to support delivery of screening, immunisation and healthy child programme services including requirements from the maternity and children’s’ dataset and holds a record for each child and young person as defined above resident within the population.
• To ensure that these systems can take into account and support future changes to services (e.g. any potential changes to the Healthy Child Programme, or a change to an existing, or an introduction of a new, routine screening or immunisation programme). The changes and new service specifications themselves would be clearly described in revisions to and/or new service specifications.
• To identify any systems that do not meet the minimum standard of operation and reporting, and work with these areas to develop an improvement plan to an timeline agreed with their commissioner. This plan should wherever possible encourage and support future potential attainment, within the funding envelope, of the gold standard as set out in Information Requirements (2012) (See Section 4 below) and the Output Based Specification for Child Health Information Systems (2012) and their updates as necessary.

3 UKNSC (2014) ANTENATAL AND NEWBORN SCREENING PROGRAMMES
• To ensure compliance with national standards for infectious disease screening pertaining to follow up of antenatal screening for Hepatitis B
• To ensure compliance with national standards for New-born Blood Spot Screening (NBBS)
• To ensure that every new-born baby and those that move into the area up to the age of one year, have been offered NBBS screening and results are recorded
• To ensure that untested babies are identified promptly and appropriate action taken
• To ensure accurate and timely recording to maximise uptake of the NBBS in those babies for whom the offer of screening has been accepted
• To ensure that NBBS screen negative results are available for communication to parents within 6 weeks of birth
• To ensure compliance with national standards for New-born Hearing Screening and that hearing screening status is recorded using National Programme outcome codes and record, including date of attendance at audiology are maintained
• To ensure compliance with national standards for the new-born and infant physical examination (NIPE) by 72 hours and 6-8 weeks following birth, and that screening status is recorded using National Programme outcome codes and records are maintained
• To ensure that effective communications are in place between organisations and professional groups responsible for elements of the screening and immunisation pathways, for example, that Hepatitis B notification and schedule/reminders are sent to GPs.
• To ensure that appropriate failsafe mechanisms are in place for continuity and sustainability of the function, including agreeing cross-organisational responsibilities with screening laboratories, maternity services, and health visiting service (also see interdependencies)
• To ensure the scheduling of all routine childhood immunisation appointments, including human papilloma virus (HPV).
• To ensure the recording on the CHIS of immunisation status for all immunisation programmes
• To ensure that as well as HPV immunisation status being recorded on the CHIS that HPV status is uploaded to the cervical screening Exeter System
• To support the review of immunisation status at primary school entry and transition to secondary school through provision of immunisation status to the school nurse service
• To support national and local catch-up immunisation campaigns (specific support to be agreed for each catch-up campaign as required)

3.3 Service description/care pathway
The Provider is responsible for managing data and statistical information which supports the provision of services to children and young people as defined above.

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4 Conclusive result for PKU needs to be recorded on the CHIS equal to or less than 21 calendar days of movement in being recorded on the CHIS [new standard] from Standards for new-born blood spot screening, August 2013.
This includes notifications of new births and babies moving in to the area, requesting records, updating the child health information system with movements in and out, and managing school health records, public health intelligence support, screening, immunisations and record transfers. An element of this work is in supporting the local delivery of the national antenatal and new-born screening and immunisation programmes.

The following list of items summarises the core administrative functions most CHIS/CHRDs will provide across the relevant population.

- links with maternity services to receive initial birth details and NHS number
- providing a central data repository and fail-safe manager for the New Born Blood Spot Screening Programme
- acting as a failsafe for and enabling liaison with the New-born Hearing Screening Programme
- liaising with midwives and health visitors to ensure that new born blood spot screening is completed within the required timescales
- receiving NIPE programme results for 72 hours and 6-8 week examinations (including data from GP systems)
- receiving new born blood spot results from the central screening laboratory
- reporting to GPs of immunisations undertaken in schools or other venues, e.g. health visitor held clinics
- inputting immunisations undertaken within GP practice
- inputting immunisation history of children moved into the primary care organisation (PCO) area and sending information when a child has moved out of an area
- providing GP practices with lists of children’s outstanding immunisations
- providing screening and immunisation coordinators with relevant information for targeted vaccination in the event of an outbreak
- posting correspondence to parents/carers/practice mailers for immunisation appointments
- providing data on immunisation coverage to NHS England (COVER and UNIFY)
- recording information about screening of school age children using data provided by school nursing services
- recording national child measurement programme (NCMP) results
- posting out the result letter from NCMP
- recording human papillomavirus (HPV) and school-based vaccinations from school nurses
- Notifying other CHRDs of babies/children who have moved out of or in to the area.
- provision of routine and ad-hoc information requests from the commissioner

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6 http://newbornbloodspot.screening.nhs.uk/failsafe
3.4 Overarching principles

- There will be a core record – a shared child health record which must be available to appropriate healthcare professionals under regulation 3 of the Health Service (Control of Patient Information) Regulations 2002 or with the appropriate informed consent (the ‘consent framework’).

- A child health record will be built from neonatal information through to transition to adult services and may contain elements of the maternal record.
- Elements of the child health record will be retained on their adult record.
- Parents/carers/children will have access to their records under section 7 of the Data Protection Act 1998.
- A child’s record should pass from CHIS to CHIS as a child moves from one area of responsibility to another under the consent framework.
- There will be multi-agency sharing within the consent framework.
- The CHIS will demonstrate compliance with overarching principles CHiSOP001 to CHISOP011 as per Output Based Specification v2.0 p. 14-15.

3.5 Compliance with Output Based Specification for Child Health Information Service Systems (CHISS)

The Provider will undertake an audit of compliance against all applicable standards outlined within the Output Based Specification for Child Health Information Service Systems and/or updated versions as necessary and will report back to the commissioner with identification of any gaps in provision against the standard by the end of 2014/15. An on-line assessment tool is available: https://www.engage.england.nhs.uk/survey/8a60a5f9. This will then be used to inform service development plans and future commissioning requirements.

The CHISS must be able to demonstrate compliance with all applicable standards within the Output Based Specification on the following basis:

1. where MUST is outlined, this will indicate that the definition is an absolute requirement of the specification. Where noncompliance is identified, Providers will be granted a further three months from completion of the audit to evidence compliance (With time line for full compliance agreed with the commissioner.

2. where SHOULD is outlined, this will indicate that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course. Derogation will be at the discretion of the commissioner and a pace of change agreed with the Provider.

3. where MAY is outlined, this will indicate that the requirement is truly optional.

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9 On-line assessment tool; https://www.engage.england.nhs.uk/survey/8a60a5f9
The audit of compliance applies to all functional and non-functional aspects of CHISS as follows:

**Functional Requirements:**

- Core requirements
- Core interfaces
- Maternity
- Mental health
- Core Scheduling
- Core Reporting
- Core Printing
- Core data retention / archiving
- Core information governance
- Registration
- Safeguarding
- NIPE at 72 hours and 6-8 weeks
- New-born blood spot
- New-born hearing screening
- Handover from midwifery
- Health promotion
- Immunisation
- National child measurement programme (NCMP)\(^{10}\)
- Supporting looked after children
- Supporting children with disabilities or complex healthcare needs

**Non-Functional Requirements**

As defined in the [Output –Based Specification](#) for Child Health Information Systems (2012) and future iterations.

### 3.6 Specified Services and Pathways

The national specification identifies that all CHIS services will ultimately deliver pathways as described in [Information Requirements for Child Health Information Systems](#). Local provision currently varies and it is proposed that 2014/15 will see a review and re-specification of all services reflecting interdependencies with other services such as health visiting and school nursing. The provider is responsible for ensuring that a Personal Child Health Record (PCHR) is issued for each live birth.

#### 3.6.1 New births

The Provider will provide the following service for all new births:

- Registration of new births received from maternity units. CHRD record babies and mothers details and informs health visitor and other CHRDs for babies born in a local maternity unit but who are resident in their area. (transfer out

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\(^{10}\) Provider shall support the delivery of the NCMP as determined by commissioners, including to ensure that NCMP data are recorded in the child's record, results are shared with parents and the national return to the Health and social Care Information Centre is completed.
• Notification of new births to all health visiting teams within their geographical responsibility.

3.6.2 Antenatal Infectious Diseases Screening
The Provider will provide the following service for antenatal infectious diseases screening, in line with national standards and guidelines:

• Where a woman has a positive screen for Hepatitis B, or where the child is identified as high-risk of contracting hepatitis B, the responsible midwife will inform CHRD of the mother’s Hepatitis B status and that the first dose of vaccine has been administered to the baby postnatally.
• The provider will ensure that a process is in place for follow up appointments for the continuing vaccination schedule; issue prompts and identify missed appointments at each stage.
• The provider will identify the children who have incomplete Hep B immunisation status and provide a list to the screening and immunisation co-ordinator as part of the local Hep B failsafe arrangements
• The provider will cross check with PHE Health Protection notifications to check for discrepancies and report these to the local screening and immunisation co-ordinator
• To complete national, regional and local quarterly and annual data and KPI returns as required by NHS England, Public Health England, the UKNSC, HISC.

3.6.3 New-born Blood Spot Screening
The provider will provide the following service for new-born blood spot screening (NBBS), in line with national standards and guidelines:

• To identify the eligible population for screening, the CHRD will ensure timely recording on the child health system of notifications of birth and notifications of babies moving into and out of the commissioner’s designated area, issuing NHS numbers where required. The provider will be able to demonstrate that failsafe systems are in place to ensure that all notifications are received by the CHRD in a timely manner. The provider will maintain an eligible list and generate NHS numbers where necessary in time for NBBS for midwives without direct access to the information system.
• The CHRD, with the acute trust Screening Midwife, will ensure that a procedure is in place to ensure that the all eligible babies are identified, especially where babies have not been registered as ‘new births’, e.g. where born abroad.
• The CHRD will record on the child health system, on the day of receipt, notification of receipt of sample in the laboratory, or result or decline of screening using the status codes defined by the UK New-born Screening Programme Centre http://newbornbloodspot.screening.nhs.uk/getdata.php?id=12402
• For moved-in babies up to the age of one year, the CHRD will ensure that there is evidence of testing with the notification. Where there is no evidence of testing or decline of screening for all of the NSC approved blood spot tests,
arrangements will be made for screening to be offered up to the age of 1 years. The role of the CHRD in ensuring that screening is offered will be documented in a screening pathway policy and compliance regularly monitored. Communications systems between organisations, e.g. CHRD, maternity services screening midwives, health visiting services, and the Screening Laboratory will be documented in a local policy and be based on best practice. Providers will be able to demonstrate that up to date policies are in place and how compliance is assured.

- The CHRD will undertake a failsafe system whereby daily searches of the child health system are undertaken to identify babies where, by 14 days of age, there is no record of specimen received by laboratory, result or decline of screening and screening result incomplete.

- For babies born in the area, where there is no record of results by 14 days of age, there will be a documented policy for immediate response. The CHRD will notify the local screening midwife to:
  - Check screening status
  - Ensure rapid request for sample to be taken within 48-72 hours of request
  - Ensure an audit trail to enable tracking of the failsafe system

- For babies who are movers-in, where there is no record of results by 14 days of age, there will be a documented policy for immediate response. The CHRD will contact by letter, the named health visitor to:
  - Check screening status (including new born hearing test)
  - Ensure rapid request for sample to be taken within 48-72 hours of request
  - Ensure an audit trail to enable tracking of the failsafe system

- The provider will ensure that a screening test result is recorded on the child health system for each of the five conditions using NBBS screening status codes for all babies; this includes babies born in the area and those under one year who have moved into the area. This will be illustrated by the annual count, which the CHRD will undertake in accordance with the UK New-born Screening Programme guidelines.

- The provider will ensure that results are reported to the Health Visitor as soon as available. It is the responsibility of the Health Visitor to ensure that results are recorded in the parent held record by 8 weeks of age.

- For normal results of all five conditions, the CHRD will notify parents by letter, by 6 weeks of age

- To complete national, regional and local quarterly and annual data and KPI returns as required by the commissioner, the UKNSC and the Department of Health.

### 3.6.4 New-born and Infant Physical Examination

The provider will provide the following service for the new-born and infant physical examination, in line with national standards and guidelines:

- The provider, with the local screening midwife, will ensure that a procedure is in place to ensure that all eligible babies are identified, especially where babies have not been registered as ‘new births’, e.g. where they have moved in.

- The provider will ensure that a system is in place to record all screening test
results using the national outcome codes as defined by the NIPE programme centre.

- To complete national, regional and local quarterly and annual data and KPI returns as required by the commissioner, the UKNSC and the Department of Health.

### 3.6.5 Immunisation

The provider will provide the following service for immunisation programmes, in line with national standards and guidelines:

- Identify the eligible population for the national childhood immunisation programme by ensuring timely recording on the child health system of notifications of birth and notifications of babies moving into and out of the commissioner’s designated area, issuing NHS numbers where required.
- To ensure the scheduling of all routine childhood immunisation appointments and subsequent reminders for children who do not attend appointments.
- To ensure that for each child an up to date immunisation status is recorded on the CHIS.
- To ensure that HPV status is uploaded to the cervical screening system.
- To support the review of immunisation status at primary school entry and transition to secondary school through provision of immunisation status to the school nurse service.
- To support national and local catch-up immunisation campaigns as required (specific support to be agreed for each catch-up campaign as required).
- To complete national, regional and local quarterly and annual data and KPI returns as required by the commissioner, the UKNSC and the Department of Health.
- To ensure that there are appropriate failsafe mechanisms in place to ensure that all children are offered all immunisations for which they are eligible, this includes for school-aged children, who may be attending a private school, are home-schooled or who are under the care of the Local Authority.

### 3.6.6 New-born hearing screening

The provider will provide the following service for new-born hearing screening programmes, in line with national standards and guidelines:

- Identification of eligible population and scheduling of appointments.
- Recording and storing outcomes.
- Provision of local failsafe for, and enabling and liaison with, the new-born hearing screening programme.
- To complete national, regional and local quarterly and annual data and KPI returns as required by the commissioner, the UKNSC and the Department of Health.

### 3.6.7 Healthy Child Programme

The provider will provide the following services for the Healthy Child Programme in line with national standards and guidelines:

- send, receive and store health promotion activity records for each child.
• monitor the quality and coverage of the Healthy Child Programme delivery incorporating local and nationally defined quality measures where applicable.
• support the capturing of Common Assessment Framework (CAF\textsuperscript{11}) results
• provide information needed for secondary uses purposes including key outcome measures for children in line with the Public Health Outcomes Framework and the NHS Outcomes Framework and the children and young people’s outcome framework.
• support the capturing of results for the health promotion of children outlined within Universal Services Delivery Schedule for 0 - 19 year olds.
• schedule health promotion reviews for the following scenarios:
  o 6-8 weeks, all children, led by health visitor, face to face
  o 12 months\textsuperscript{12}, some children, led by health visitor
  o 2 - 2.5 years, all children, led by health visitor face to face,
  o School entry, led by school nurse.

**Delivery of the Healthy Child Programme activity requires further detailed discussion as in some areas this is currently commissioned via public health nursing (HV/SN) Providers who already have established systems in place to schedule appointments. Current arrangements will stand until any alterations are formally agreed by a variation order.

3.7 Failsafe arrangements

Quality assurance within screening and immunisation pathways is managed by the inclusion of failsafe processes. Failsafe processes are a back-up mechanism designed to ensure that where something goes wrong, processes are in place to identify what is going wrong and what actions are necessary to ensure a safe outcome.

The provider is expected to:

• Include appropriate failsafe mechanisms across appropriate screening and immunisation pathways as per specific details within individual service specifications
• Review and risk assess pathways in the light of guidance offered by Quality Assurance processes or the National Screening Offices
• Work with commissioners and Quality Assurance Teams to develop, implement, and maintain appropriate risk reduction measures
• Ensure that mechanisms are in place to audit implementation of risk reduction measures regularly and report incidents should these occur
• Ensure that appropriate links are made with internal Provider governance arrangements, such as risk registers
• Ensure routine staff training and on-going development takes place
• Ensure results are transferred to the parent and the health visitor for all NBBS

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\textsuperscript{11} CAF is a standardised approach to conducting a community based assessment of a child’s global needs and deciding how those needs should be met
\textsuperscript{12} In line with local practice, some areas may undertake this review at around 9 months [from Alison Burton].
Respond to all failsafe enquiries from any other Provider within the screening and immunisation pathways, the NHS England public health commissioning team (head of public health commission and screening and immunisation team) and the Quality Assurance (QA) team.

Report critical incidents via Provider internal governance arrangements and ensure that the PHE screening and immunisation co-ordinator is notified.

3.8 Role and Accountability

The provider must have clear lines of accountability and responsibility for all services carried out under this specification. The provider is responsible for the recruitment, appointment and training of personnel to meet the requirements of the service and the provision of local IT support to maintain continuity of service. The Provider will ensure that robust business continuity plans are in place and that all critical functions have been clearly mapped and have contingencies in place.

The provider service personnel will maintain a close working relationship with PHE NHS England public health commissioning team and other key stakeholders. The provider will attend relevant screening and immunisation governance groups to discuss performance and any issues arising with these services. This may require the production of specific reports.

3.9 Clinical and Corporate Governance

The Provider will:

- ensure that staff co-operate with, and are represented on, relevant local screening and immunisation governance arrangements. This includes the local of NHS England, PHE Centre and as required attendance at the relevant Local Authority Health Protection Sub-committees of the Health and Wellbeing Boards
- ensure clearly identified responsibility for CHRD at director level, or with a named individual with delegated responsibility from the Director
- ensure that there is appropriate internal managerial oversight of the CHIS elements of the screening, immunisation and Healthy Child Programme 0-19 or beyond if statute provides Programs
- regularly monitor and audit CHIS activities as part of the organisation’s clinical governance arrangements, thus assuring the organisation’s board of the quality and integrity of the service
- Undertake regular data cleaning and triangulate with GP practice data systems and Exeter [see comment above]
- provide evidence of clinical governance and effectiveness arrangements on request
- have a sound governance framework in place covering the following areas:
  - information governance and security, information quality, and records management (that is, be compliant with the HSCIC IG Toolkit to level 2)
  - equality and diversity, as defined by the Equality Act 2010
3.10 Population Covered
This specification relates to all children including young people as defined in Section 2.3 born in the [INSERT RELEVANT GEOGRAPHY], who are:

- Registered on specified NHAIS (GP) 13systems with specified GPs
- Resident in the specified area whether registered on NHAIS systems or not
- All children who are educated in the specified area

3.11 Acceptance or exclusion criteria and thresholds
No specific acceptance or exclusion criteria identified. Universally offered services for children.

3.12 Interoperability
The following interdependencies exist within this programme:

- Other providers of CHIS/ CHRD across [INSERT RELEVANT GEOGRAPHY]
- The Programme is supported under contract by a CHIS software supplier and corporate IT Provider
- Maternity services, paediatrics, clinical and information governance services
- GP practices
- School nursing, health visiting and immunisation teams depending on local provision
- NHS England commission CHIS services with reference to national guidance on quality standards, screening and immunisation and universal services intervals and failsafe arrangements as detailed within separate service specifications
- The Regional Quality Assurance Team has a role to play in the development and quality assurance of this programme.
- Expert Advisory Committees Joint Committee on Vaccination & Immunisation (JCVI) UK National Screening Committee (UKNSC) Screening Advisory Groups

Secure and timely transfer of clinical and demographic data where possible with associated services will be necessary to ensure:

- Complete coverage of the population
- Effective and timely flow of information to ensure complete datasets and to interface with other systems as necessary

13 http://systems.hscic.gov.uk/ssd/prodserv/vaprodopenexe
• Appropriate notifications to General Practices, Health Visiting, School Nursing, Secondary Care Child Health Services and Safeguarding teams
• Appropriate reporting and information provision for commissioning organisations

4 Applicable Service Standards

4.1 Applicable standards set out in guidance and/or issued by a competent body

System requirements and National standards and guidance

The electronic system employed by the CHIS should, as a minimum, meet the standards specified in the Information Requirements for Child Health Information Systems or any national document that is deemed to supersede it.

The Information Requirements for Child Health Information Systems is considered the gold standard for Child Health Information Systems. The document provides a detailed account of all functions and outputs that a CHIS system should provide. It is expected that the CHIS delivery in INSERT RELEVANT GEOGRAPHY will ultimately fully meet the information requirement listed.

The document can be viewed here:


The Maternity and Children’s Data Set (MCDS) http://www.hscic.gov.uk/maternityandchildren consists of three information standards as follows. These have all been previously approved by the Information Standards Board for Health and Social Care. Current details of the implementation schedule is listed below, any updates to this will be communicated by revised Information Standards Notices (ISN) following acceptance by the Standardisation Committee for Care Information (SCCI).

- Maternity Services Data Set (MSDS) – updated Information Standards Notice (ISN) was published in May 2014. Central submissions will begin in May 2015 (for April 2015 data), though providers should have started collecting the revised data set locally from November 2014.
- Children and Young People’s Health Services (CYPHS) data set. Central submissions will begin in October 2015 for September 2015 data.
- Child and Adolescent Mental Health Services (CAMHS) data set – updated ISN is expected to be published in mid-2015. Central submissions will begin in January 2016, with the possibility of submissions being backdated to include data from October 2015 onwards.

The system employed by the CHIS Provider should be responsive to all Information Standard Notices (ISN) ensuring that system is compliant with notices within the required timescale. A range of other documents and national guidance are pertinent to the provision of an effective Child Health Information Service.
The system should also be compatible with existing ISN relating to child health and should have the capability to submit electronically to all relevant national submissions – e.g. the children and young person health service secondary users dataset (for the Maternity and children’s dataset), COVER, Breast feeding etc.

- Antenatal health promotion visits – number and percentage covered
- New-born visit - number and percentage covered
- 6-8 week check – number and percentage covered, breastfeeding at 6-8 weeks
- 1 year assessment – number and percentage covered
- 2 to 2½ years assessment– number and percentage covered, child development outcomes aged 2 – 2½ years

4.2 Other applicable standards include:

- Output based specification/ Information Requirement Standard for Child Health Information Systems
- Securing excellence in Child Health Information Systems
- HSCIC IG Toolkit [https://www.igt.hscic.gov.uk/](https://www.igt.hscic.gov.uk/)

4.3 Applicable local standards

Local standards will be set and continuously monitored to ensure that Provider performance reflects all quality and performance requirements as per this service specification and other applicable standards. Local standards may be changed in response to updated publications and standards produced by national screening and immunisation advisory bodies and local requirements.

CHRD Providers will provide data and information to Commissioners, HSCIC, Quality Assurance Service, and other official requesting bodies in a timely manner as per reporting requirements set out in Provider contracts, individual service specifications and Standardisation Committee for Care Information (SCCI) accepted data returns. The following list is illustrative:

- High priority non-scheduled information requests e.g. in response to outbreaks of communicable diseases, unscheduled immunisation catch up programmes
- Low priority non-scheduled information requests to inform local planning and commissioning
- Quarterly GP practice level immunisation returns as required by COVER / HSCIC
- Quarterly / annual reporting of screening KPIs in accordance with National Screening Committee requirements

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14 Standards 1a, 1b, 2 and 12 and key performance indicators. From Standards for new-born blood spot screening August 2013.
- Monthly reporting healthy child programme 0-5 to meet requirements of health visitor dashboard returns

Any local information requests other than those to support reporting requirements set out in Provider contracts, individual service specifications and SCCI accepted data returns must be authorised by NHS England prior to initiation.

## 5 Applicable quality requirements and CQUIN goals

### 5.1 Applicable Quality Requirements

The commissioner will monitor the services they commission to ensure they conform to data quality, information standard notices (ISNs) and technical standards. The CHIS IT provision must be compliant with process and exchange information as determined by the NHS England. The CHIS Service must be adequately resourced and staffs appropriately trained to record and manage the relevant data within the child’s care record.

The provider will deliver to a set of quality and IT safety standards, including compliance with Information Governance Toolkit (IGT), interoperability toolkit (ITK) standards, clinical safety and assurance, network security, registration authority services and effective fail-safe systems that are continuously monitored to enable data management and exchange, as determined by the NHS England.

In accordance with the most up to date national guidance and best practice guidelines the provider should:
- ensure that all staff working in the CHRD are familiar with relevant clinical, programme and QA guidelines
- ensure that all staff maintain minimum standards, and adhere to the relevant national guidance and recommendations via internal audit and external QA monitoring
- take prompt action where standards are lower than expected to identify the causes and improve the service
- comply with agreed early warning systems and triggers with the NHS England public health commissioning team
- manage serious failures to provider services according to national and local protocols to the level specified in the most up to date guidelines
- participate in any relevant multi-disciplinary QA visits
- if relevant, use nationally developed and agreed letters and leaflets.

The provider is expected to have an internal quality assurance process that allows the Quality Assurance function in Public Health England and NHS England to manage the risks of commissioned programmes. Providers can use the Failures Modes and Effects Analysis (FMEA) method, which is recommended by the NHS National Patient Safety Agency’s risk assessment programme. Risks should be defined in the standard NHS format (where likelihood and severity are multiplied to give a RAG score).

The provider is expected to maintain a register of risks. They should work with NHS England public health commissioning team, and PHE QA staff to identify key areas of risk, and should ensure that these points are reviewed in contracting and peer review
processes. On a quarterly basis, high scoring risks will be identified and agreed between the Provider and commissioner, and plans put in place to mitigate these.

The provider will:

- meet national programme standards, or have plans in place to meet them
- participate fully in national quality assurance processes and respond in a timely manner to recommendations made
- ensure that data on participation from external quality assurance programmes are available to Quality Assurance Service, the national screening team, NHS England public health commissioning team.
- collect and submit minimum datasets as required, to assure NHS England public health commissioning team and the Quality Assurance Team in Public Health England of the safety and quality of the services provided
- participate in relevant 3-yearly QA visit processes and provide data for these visits in a timely fashion.

5.2 Serious Incidents

The Provider will:

- comply with the most up to date incident handling guidance
- have a serious incident policy and procedures in place including the IG Toolkit SIRI system, and ensure that all staff are aware of it and of their responsibilities within it
- inform the NHS England public health commissioning team within 24 hours, in the event of a serious adverse event and provide all reasonable assistance to colleagues in PHE and NHS England in investigating and dealing with it.
- comply with appropriate statutory regulations (e.g. the Data Protection Act, COSHH Regulations etc.) to ensure a safe working environment
- review their procedures and processes against the national screening and immunisation programme standards to reduce the likelihood of incidents occurring
- have a robust system in place that allows for concerns to be raised about the quality of services, and adequate arrangements to be made for the investigation of such concerns.

5.3 Continual Service Improvement

Where national recommendations and core and/or developmental standards are not fully implemented at present, the Provider will be expected to use service plans to indicate the changes and improvements that will be made over the course of the contract period.

The Provider will develop a CSIP (Continual Service Improvement Plan) on the basis of the findings of the KPIs and the results of internal and external quality assurance checks. The CSIP will respond to any performance issues highlighted by NHS England public health commissioning team and the, paying due regard to concerns raised via service user feedback. The CSIP will contain action plans with defined timescales and responsibilities, and will be agreed
5.4 Service Continuity

- Provider will construct, maintain, and test emergency preparedness and develop a business continuity plan. The plan must ensure that there is no diminution in the level of service provided.
- No services within this specification shall be sub-contracted by the Provider without the prior written agreement of NHS England public health commissioning team. Any agreed sub-contract must comply with the relevant national screening and immunisation guidance and standards and cover (at a minimum) accountabilities, responsibilities, quality, and performance standards.

5.5 Applicable CQUIN goals (See Schedule 4 Part [E])

No national CQUINs at present

6 Infrastructure and Application Management and Support

Child Health Information Service providers will be required to assure their commissioners that they have provided due diligence on the procurement and product implementation of their Child Health Information system before October 2015. In order to assist this service please refer to Appendix 3 System Infrastructure
# Appendix 1: Quality and performance standards

<table>
<thead>
<tr>
<th>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
<th>Monthly or annual application of consequence</th>
<th>Applicable Service Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current CHIS Providers are compliant with the latest published version of the Output-Based Specification for Child Health Information Systems &amp; (OBS)</td>
<td>90%</td>
<td>Initial self-assessment completed by provider 2014 against functional and non-functional requirements of OBS CHIS responsible commissioner annual Internal validation as appropriate dependent on risk</td>
<td>The provider will agree a service improvement plan by April 2015 monitored through provider contract meetings</td>
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<tr>
<td>Current CHIS Providers are compliant with the latest published version of the ) Information Requirements Specification (IRS)</td>
<td>90%</td>
<td>Initial self-assessment completed by provider 2014 against requirements of IRS CHIS responsible commissioner annual Internal validation as appropriate</td>
<td>The provider will agree a service improvement plan by April 2015 monitored through provider contract meetings</td>
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</tbody>
</table>
| MANDATORY: National KPIs - [www.screening.nhs.uk/kpi](http://www.screening.nhs.uk/kpi) | Threshold | Method of Measurement | Consequence of breach | Monthly or annual application of consequence | Applicable Service Specificatio

| | | | | | n |
|---|---|---|---|---|
| Current Provider systems can demonstrate interoperability with ; | 90% | Initial self-assessment completed by provider 2014 against requirements of OBS & IRS CHIS responsible commissioner annual Internal validation as appropriate dependent on risk | The provider will agree a service improvement plan by April 2015 monitored through provider contract meetings | | |
| 1. GP systems | | | | | |
| 2. Screening services | | | | | |
| 3. Secondary care Community & Acute Paediatric services | | | | | |
| 4. CHIS to CHIS | | | | | |
| NB1: Coverage (previous CCG responsibility at birth) The proportion of babies registered within the previous CCG both at birth and on the last day of the reporting period who are eligible for new-born blood spot screening and have a conclusive result recorded on the Child Health Information System | Acceptable level: ≥ 95.0% Achievable level: ≥ 99.9% | Review of monthly Service Quality Performance Report, subject to exception reporting. All reporting to be sent by email on day 10 after month end to: | Subject to General Condition 9 (Contract Management) | | |}

Subject to General Condition 9 (Contract Management)
### MANDATORY: National KPIs - [www.screening.nhs.uk/kpi](http://www.screening.nhs.uk/kpi)

<table>
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<tr>
<th><strong>Threshold</strong></th>
<th><strong>Method of Measurement</strong></th>
<th><strong>Consequence of breach</strong></th>
<th><strong>Monthly or annual application of consequence</strong></th>
<th><strong>Applicable Service Specification</strong></th>
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<tbody>
<tr>
<td>within an effective timeframe. For this KPI, Phenylketonuria (PKU) is used as a proxy for all tests and the test must be completed by 17 days of age.</td>
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<tr>
<td>NB3: Timeliness of result availability The proportion of new-born blood spot screening results which are screen negative for all five conditions, available for communication to parents, excluding movements in, within six weeks of birth.</td>
<td>Acceptable level: 95.0% Achievable level: 98.0%</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Monthly Child Health Information Service</td>
</tr>
<tr>
<td>NB4 Coverage (Movers in) The proportion of babies who become the responsibility of the CCG during the reporting period and for whom the CCG remains responsible on the last day of the reporting period and have a conclusive result recorded on the CHIS within an effective</td>
<td>Acceptable level: ≥ 95.0% Achievable level: ≥ 99.9%</td>
<td>Review of monthly Service Quality Performance Report, subject to exception reporting. All reporting to be sent by email on day 10 after month end to INSERT TEAM</td>
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<tr>
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<tr>
<td>timeframe. For this KPI, PKU is used as proxy for all tests and the result must be recorded on the CHIS equal to or less than 21 days of the movement in being recorded on the CHIS.</td>
<td>LEAD/ LEAD FAIL SAFE MANAGER</td>
<td>Each live birth to be entered onto the CHIS system, from a completed Birth Notification form by the end of the working day following receipt of the Birth Notification and stored retention of such forms.</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>Birth Notification</td>
<td>100% Birth Notification entered by the end of the working day following receipt of the Birth Notification</td>
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</tr>
<tr>
<td>Minimum dataset recorded for each live birth</td>
<td>100% of received birth notifications</td>
<td>Recorded on the CHIS system for each child: Name Date of Birth</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
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<tr>
<td>Recording New-born and Infant Physical examination(NIPE)</td>
<td>100%</td>
<td>Recording of NIPE performed on all children within the first 72 hours of birth</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>Recording of each child death</td>
<td>100% of child deaths recorded within 1 working day of receipt of notification of death</td>
<td>Recording on the CHIS system of each child death as they become notified</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>Health Visitor notification</td>
<td>100% recorded</td>
<td>Time between receipt of Birth Notification and informing Health Visitor shall be no longer than five working days</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>Recording Health Visitor new</td>
<td>100% recorded</td>
<td>Entry onto the CHIS system of the Health</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting –</td>
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</tr>
<tr>
<td>birth visit report</td>
<td></td>
<td>Visitor new birth visit within one month of receipt by the Provider</td>
<td>Management</td>
<td>frequency to be reviewed annually</td>
</tr>
<tr>
<td>New-born Hearing Screening Scheduling</td>
<td>100% recorded</td>
<td>All New-born Hearing screening that is required by national guidance (variable year by year and therefore reporting detail will be negotiated each year between the Provider and the Commissioner)</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>New-born Hearing Screening</td>
<td>100% recorded</td>
<td>Entry onto the CHIS system of the Health Visitor new birth visit within one month of receipt by the Provider</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td>Recording GP 6 to 8 week</td>
<td>100% recorded</td>
<td>Entry of GP developmental review</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting –</td>
</tr>
</tbody>
</table>
## MANDATORY: National KPIs

**www.screening.nhs.uk/kpi**

<table>
<thead>
<tr>
<th>Service</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
<th>Monthly or annual application of consequence</th>
<th>Applicable Service Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>developmental review</td>
<td></td>
<td>at 6 to 8 weeks to be entered onto the CHIS system within one month of receipt by the Provider</td>
<td>Management)</td>
<td>frequency to be reviewed annually</td>
<td>Information Service</td>
</tr>
<tr>
<td>New-born Blood Spot Scheduling</td>
<td>100% recorded</td>
<td>All Blood Spot screening that is required by national guidance (variable year by year and therefore reporting detail will be negotiated each year between the Provider and the Commissioner)</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>New-born Blood Spot screening</td>
<td>100% recorded</td>
<td>Results received by Day 14 from new-born blood spot screening entered onto the CHIS system within 1 working day of receipt</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
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<td>Applicable Service Specificatio</td>
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</tr>
<tr>
<td>Timeliness of result availability</td>
<td>100% recorded</td>
<td>Confirmation that normal blood spot screening results have been forwarded to the parents within six weeks</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>New-born Blood Spot screening</td>
<td>100% recorded</td>
<td>Abnormal or insufficient sample new-born blood spot results sent out to the Health Visitor within 3 working days of receipt by the Provider</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>New-born Blood Spot screening</td>
<td>100% recorded</td>
<td>Pursuit of new-born blood spot results for children who move into the area of jurisdiction and who are under 365 days of age</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Scheduling</td>
<td>100% recorded</td>
<td>All immunisations that are required by</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting –</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>100% recorded</td>
<td>Enter the results from vision screening onto the CHIS system within one month of receipt</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Information Service</td>
</tr>
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</tr>
<tr>
<td>Variable data records</td>
<td>100% recorded</td>
<td>Ensure data collection is occurring where appropriate for but not limited to the following: New-born BCG immunisation if administered Hepatitis B immunisation if</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Information Service</td>
</tr>
</tbody>
</table>

**MANDATORY: National KPIs - www.screening.nhs.uk/kpi**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
<th>Monthly or annual application of consequence</th>
<th>Applicable Service Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>National guidance (variable year by year and therefore reporting detail will be negotiated each year between the Provider and the Commissioner)</td>
<td>Management)</td>
<td>frequency to be reviewed annually</td>
<td>Information Service</td>
<td></td>
</tr>
<tr>
<td>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>Variable data records</td>
<td>100% recorded</td>
<td>NHS Number Completeness – number and percentage of children with an assigned NHS number which is used routinely in all clinical</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ad hoc immunisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Special educational needs and disabilities [SEND] status including those on Education Health &amp; Care [EHC] Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Congenital abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>School ad hoc medical examinations and reviews</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## National KPIs

| MANDATORY: National KPIs - www.screening.nhs.uk/kpi | Threshold | Method of Measurement | Consequence of breach | Monthly or annual application of consequence | Applicable Service Specificatio

<table>
<thead>
<tr>
<th>Immunisation status</th>
<th>100% recorded</th>
<th>The immunisation status received for each child aged 0 to 19 years per disease is recorded on the CHIS system within xx days of receipt</th>
<th>Subject to General Condition 9 (Contract Management)</th>
<th>6 month reporting – frequency to be reviewed annually</th>
<th>Child Health Information Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisations at 12 months</td>
<td>100% recorded</td>
<td>DTaP/IPV/Hib, Men C, PCV, Hep B, Rotavirus recorded as per Green book and JCVI guidance</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Immunisations at 24 months</td>
<td>100% recorded</td>
<td>DTaP/IPV/Hib, PCV booster, Hib/MenC, MMR, Hep B recorded as per Green book and JCVI guidance</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Immunisations at 5 years</td>
<td>100% recorded</td>
<td>DTaP/IPV/Hib, MMR, MMR2, DTaP/IPV,</td>
<td>Subject to General Condition 9 (Contract</td>
<td>6 month reporting –</td>
<td>Child Health</td>
</tr>
<tr>
<td>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
<td>Monthly or annual application of consequence</td>
<td>Applicable Service Specification</td>
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</tr>
<tr>
<td>Infant feeding status</td>
<td>100% recorded</td>
<td>The received feeding status of infants at 10 to 14 days are entered on the CHIS system</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Infant feeding status</td>
<td>100% recorded</td>
<td>The received feeding status of infants at 6 to 8 weeks are entered on the CHIS system</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>National Child Measurement Programme</td>
<td>100% recorded</td>
<td>Record status of Children as guided by the National Child Measurement Programme on the CHIS system</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Transfer of records</td>
<td>Occurrence count</td>
<td>Transfer of records to other NHS organisations within</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
<td>Monthly or annual application of consequence</td>
<td>Applicable Service Specification</td>
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</tr>
<tr>
<td></td>
<td>ten working days</td>
<td></td>
<td>be reviewed annually</td>
<td></td>
<td>Service</td>
</tr>
<tr>
<td>80% of children aspiring to 95%</td>
<td>Transfer of records completion when transferred from other NHS organisations within ten working days</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>6 month reporting – frequency to be reviewed annually</td>
<td></td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>OPTIONAL: Local Quality Requirements</td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
<td>Monthly or annual application of consequence</td>
<td>Applicable Service Specification</td>
</tr>
<tr>
<td>Completeness of coverage (CCG responsibility at birth)</td>
<td>Acceptable level: ≥ 95% of eligible babies are tested for all conditions. Achievable level: ≥ 99.9% of eligible babies are tested</td>
<td>Review of monthly Service Quality Performance Report, subject to exception reporting.</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Annual</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></td>
<td>Threshold</td>
<td>Method of Measurement</td>
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<td>Applicable Service Specification</td>
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</tr>
</tbody>
</table>
| for PKU, MCADD and SCD.  
≥ 98% of eligible babies are tested for CHT and CF. |  |  |  |  |  |
| Completeness of coverage (movers in) | Acceptable level:  
≥ 95% of eligible babies are tested for PKU.  
Achievable level:  
≥ 99.9% of eligible babies are tested for PKU. | Review of monthly Service Quality Performance Report, subject to exception reporting. | Subject to General Condition 9 (Contract Management) | Annual | Child Health Information Service |
<p>| Timely identification of babies with a null or incomplete result recorded on the child health information system. | Acceptable level: 100% CHRDs to perform regular checks for all babies ≥ 17 days and ≤ 364 days. | Review of monthly Service Quality Performance Report | Subject to General Condition 9 (Contract Management) | Annual | Child Health Information Service |</p>
<table>
<thead>
<tr>
<th>MANDATORY: National KPIs - <a href="http://www.screening.nhs.uk/kpi">www.screening.nhs.uk/kpi</a></th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
<th>Monthly or annual application of consequence</th>
<th>Applicable Service Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievable level: 100% CHRDs to perform regular checks for any of the five conditions, for all babies ≥ 14 days and ≤ 364 days.</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Annual</td>
<td>Child Health Information Service</td>
<td></td>
</tr>
<tr>
<td>Timeliness of results to parents, excluding movements in</td>
<td>Acceptable level: 100% within 6 weeks of birth.</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Annual</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Timeliness of results to parents (movers in)</td>
<td>Acceptable level: 100% within 6 weeks of notification</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Annual</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>OPTIONAL: Local Quality Requirement</td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
<td>Monthly or annual application of consequence</td>
<td>Applicable Service Specification</td>
</tr>
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</tr>
<tr>
<td>Primary Care patient registration and deduction lists processed within 5 working days of receipt for children aged 0-5, 10 working days of receipt for children aged 6 years +, and prior to receipt of the next report for school transfers.</td>
<td>100%</td>
<td>Review of monthly Service Quality Performance Report Internal audit by the provider and annual audit by the commissioner</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Monthly</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Proportion of eligible children aged 12 months to 5 years invited for MMR immunisation</td>
<td>100%</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Monthly</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>OPTIONAL: Local Quality Requirement</td>
<td>Threshold</td>
<td>Method of Measurement</td>
<td>Consequence of breach</td>
<td>Monthly or annual application of consequence</td>
<td>Applicable Service Specification</td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>CHIS to inform GP Practices of children that have had their scheduling suspended due to excessive DNA’s (applicable to Practices for which the CHIS schedules appointments) and to actively follow up to ensure that an outcome has been recorded on CHIS within 10 working days of the GP being sent notification. Child Health Information Service</td>
<td>100% of children registered on CHIS</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Monthly</td>
<td>Child Health Information Service</td>
</tr>
<tr>
<td>Quarterly production and upload of COVER and Child Immunisation statistics</td>
<td>100% of children registered on the CHIS</td>
<td>In line with the national immunisation and vaccination programme, including GP and local authority level data</td>
<td>Subject to General Condition 9 (Contract Management)</td>
<td>Quarterly</td>
<td>Child Health Information Service</td>
</tr>
</tbody>
</table>
### Optional: Local Quality Requirement

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Format of Report</th>
<th>Timing and Method for delivery of report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly and monthly COVER data at CCG and practice level</td>
<td>10 working days after month end</td>
<td>Monthly</td>
</tr>
<tr>
<td>Optional: Local Requirements</td>
<td>Reporting Period</td>
<td>Format of Report</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>------------------</td>
</tr>
<tr>
<td>and Child Immunisation statistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Lists at individual practice level (Exception reporting only i.e. nil returns not required)</td>
<td>10 working days after month end</td>
<td>As agreed with the Local Screening and Immunisation Team</td>
</tr>
<tr>
<td>Weekly reports for the neonatal Hepatitis B failsafe tracking system</td>
<td>Weekly</td>
<td>Criteria: Any infant on the fast track Hep B vaccination schedule – Any vaccination provided to such infants in the previous week (using locally provided template) include nil returns</td>
</tr>
<tr>
<td>Monthly Bloodspot Exception report</td>
<td>10 working days after month end</td>
<td>As agreed with the Local Screening and Immunisation Team</td>
</tr>
<tr>
<td>Exception report number of children with no recorded GP/school</td>
<td>10 working days after month end</td>
<td>As agreed with the Local Screening and Immunisation Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition</th>
<th>Frequency</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Child Health records on system, broken down as follows:</td>
<td>On a monthly basis the provider will supply the breakdown of the number of children that are registered on the CHIS System, this will be shown as a both a total by age group and as a total count for each GP Practice</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>1. Ages 0-4; 5-9; 10-14; 15-19 and TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total count for each GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Definition</td>
<td>Frequency</td>
<td>Method</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Number of births recorded in commissioned area</td>
<td>Born in, Lives In The Area – Baby born in a Hospital within the commissioned area</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Number of premature babies &amp; gestation in commissioned area</td>
<td></td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Number of children transferred into commissioned area (births) under 2 weeks old</td>
<td>Transfer (Birth) In To The Area – Born outside of the commissioned area but lives in the area (under 2 weeks old)</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Number of children transferred out (Birth) of in commissioned area under 2 weeks old</td>
<td>Transfer (Birth) Out Of The Area – Baby born in Hospital within the commissioned area but lives out of area (under 2 weeks old)</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Total number of transfers into commissioned area (over 2 weeks old) during the period</td>
<td>Child Moved In To The Area – Child moved into the commissioned area (Over 2 weeks old)</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Total number of transfers out of the commissioned area (over 2 weeks old) during the period</td>
<td>Child Moved Out Of The Area – Child moved out of the commissioned area (Over 2 weeks old)</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Total number of Children who live out of the commissioned area, but are treated In during the period</td>
<td>Child lives outside of the commissioned area but is treated by a CCG within the commissioned area</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
<tr>
<td>Item</td>
<td>Definition</td>
<td>Frequency</td>
<td>Method</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Total number of children who live in the commissioned area, treated out during the period</td>
<td>Child lives in the commissioned area but is treated by an GP outside of the commissioned area</td>
<td>Monthly</td>
<td>Review of monthly Service Quality Performance Report</td>
</tr>
</tbody>
</table>
# Appendix 2 – Routine Childhood Immunisations


## The complete routine immunisation schedule 2013/14

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Vaccine given</th>
<th>Immunisation site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Two months old</strong></td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and <em>Haemophilus influenzae</em> type b (Hib)</td>
<td>DTaP/OPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV (Proven 13)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotavirus (Rotarix)</td>
<td>By mouth</td>
</tr>
<tr>
<td><strong>Three months old</strong></td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/OPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal group C disease (MenC)</td>
<td>Men C (NexisVac-C or Menjugate)*</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotavirus (Rotarix)</td>
<td>By mouth</td>
</tr>
<tr>
<td><strong>Four months old</strong></td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/OPV/Hib (Pediacel)</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV (Proven 13)</td>
<td>Thigh</td>
</tr>
<tr>
<td><strong>Between 12 and 18 months old</strong></td>
<td>Hib/MenC</td>
<td>HibMenC (Menitrix)</td>
<td>Upper arm/ thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>PCV (Proven 13)</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>MMR (Prixir or MMR VaxPRO)*</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>Two and three years old</strong></td>
<td>Influenza* (from September)</td>
<td>Flu nasal spray (Fluenz; annual) (if flu vaccine unsuitable, use inactivated flu vaccine)</td>
<td>Nostrils Upper arm</td>
</tr>
<tr>
<td><strong>Three years four months old or soon after</strong></td>
<td>Diphtheria, tetanus, pertussis and polio</td>
<td>dTaP/IPV (RevapVax) or DTaP/IPV (Intanvac-PV)*</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>MMR (Prixir or MMR VaxPRO) (check first dose has been given)*</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>Girls aged 12 to 13 years old</strong></td>
<td>Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)</td>
<td>HPV (Gardasil)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>Around 14 years old</strong></td>
<td>Tetanus, diphtheria and polio</td>
<td>Td/IPV (Reavisat), and check MMR status</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>MenC*</td>
<td>MenC (Menillic, Menjugate or NesiVac-CF)*</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>65 years old</strong></td>
<td>Pneumococcal disease</td>
<td>PPV Pneumococcal polysaccharide vaccine (Pneumovax)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>65 years of age and older</strong></td>
<td>Influenza*</td>
<td>Flu injection (annual)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>70 years old</strong></td>
<td>Shingles (from September)</td>
<td>Shingrix (Zostavax)</td>
<td>Upper arm (subcutaneous)</td>
</tr>
</tbody>
</table>

**Immunisations for those at risk**

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Vaccine given</th>
<th>Immunisation site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At birth, 1 month old, 2 months old and 12 months old</strong></td>
<td>Hepatitis B</td>
<td>Hep B</td>
<td>Thigh</td>
</tr>
<tr>
<td><strong>At birth</strong></td>
<td>Tuberculosis</td>
<td>BCG</td>
<td>Upper arm (intradermal)</td>
</tr>
<tr>
<td><strong>Six months up to two years</strong></td>
<td>Influenza*</td>
<td>Inactivated flu vaccine (annual)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>Two years up to under 65 years</strong></td>
<td>Pneumococcal disease</td>
<td>PPV Pneumococcal polysaccharide vaccine (Pneumovax)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>Over two up to less than 18 years</strong></td>
<td>Influenza* (from September)</td>
<td>Flu nasal spray (Fluenz; annual)</td>
<td>Nostrils Upper arm</td>
</tr>
<tr>
<td><strong>18 up to under 65 years</strong></td>
<td>Influenza*</td>
<td>Inactivated flu vaccine (annual)</td>
<td>Upper arm</td>
</tr>
<tr>
<td><strong>From 28 weeks of pregnancy</strong></td>
<td>Pertussis</td>
<td>dTaP/IPV (llopopvax)</td>
<td>Upper arm</td>
</tr>
</tbody>
</table>

*Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All vaccines are given intramuscularly unless stated otherwise.

* Where a vaccine is manufactured by more than one supplier, it may on occasion be necessary to substitute an alternative brand.

* This is defined as children aged two or three years but not four years on 1 September 2013.

* The vaccine is given prior to the season – usually in September and October.

**This vaccination will be introduced during the 2013/14 academic year.**

**The vaccine supplied will depend on the brands available at the time of ordering.**

*See individual chapters of the Green Book for clinical risk groups.

*See CMO letter of October 2012.

---

**Immunisation**

The safest way to protect children and adults
### Vaccines used in the routine immunisation schedule 2013/14

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Product reference</th>
<th>Vaccine given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and <em>Haemophilus influenzae</em> type b (Hib)</td>
<td>Prevenar 13 (PCV)</td>
<td>Pediacel (DTP/MPV/Hib)</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>Pediacel (DTP/MPV/Hib)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningococcal group C disease (MenC)</td>
<td>NeisVac-C or Menjugate (MenC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotarix</td>
<td></td>
</tr>
<tr>
<td>Four months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>Pediacel (DTP/MPV/Hib)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>Prevenar 13 (PCV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hib/MenC</td>
<td>Monitorix (Hib/MenC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal disease</td>
<td>Prevenar 13 (PCV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella (German measles)</td>
<td>Priorix or MMR VaxPRO (MMR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two and three years old</td>
<td>Influenza</td>
<td>Flu Dez (Flu nasal spray) (annual) (if Flu Dez unsuitable, use inactivated flu vaccine)</td>
<td></td>
</tr>
<tr>
<td>Three years four months old or soon after</td>
<td>Diphtheria, tetanus, pertussis and polio</td>
<td>Repevax (TIV/IPV) or Infanrix-IPV (TIV/IPV)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>Priorix or MMR VaxPRO (MMR) (Check first dose has been given)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Girls aged 12 to 13 years old</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Around 14 years old</td>
<td>Tetanus, diphtheria and polio</td>
<td>Revacx (Td/IPV), and check MMR status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MenC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 years old</td>
<td>Pneumococcal disease</td>
<td>Prevenar 13 (PCV)</td>
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</tr>
<tr>
<td>65 years of age and older</td>
<td>Influenza</td>
<td>Flu injection (annual)</td>
<td></td>
</tr>
<tr>
<td>70 years old</td>
<td>Shingles</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Image of vaccines](image_url)

**Influenza vaccine is only free to children aged two and three years. Hep B and PPV are also chargeable. All other vaccines listed above are available free of charge at [www.immform dh.gov.uk](http://www.immform dh.gov.uk)**

**Immunisation Information**

*NB Where a vaccine is manufactured by more than one supplier, it may, on occasion be necessary to substitute an alternative brand.*
APPENDIX 3 IT system requirements

System Requirements

- compliant with Personal Demographics Service (PDS) within xx months/years electronically
- compliant with maternity services dataset (ISB 1513) by November 2014 [http://www.hscic.gov.uk/maternityandchildren/maternity](http://www.hscic.gov.uk/maternityandchildren/maternity)
- compliant with Children and Young People’s Health Services Dataset (ISB 1069) [http://www.hscic.gov.uk/maternityandchildren/CYPHS](http://www.hscic.gov.uk/maternityandchildren/CYPHS)
- compliant with Child and adolescent mental health services dataset (ISB 1072) [http://www.hscic.gov.uk/CAMHS](http://www.hscic.gov.uk/CAMHS)
- compliant with Clinical Risk Management: its Application in the Manufacture of Health IT Systems (ISB 0129) [http://systems.hscic.gov.uk/clinsafety/dscn](http://systems.hscic.gov.uk/clinsafety/dscn)
- electronically receive required data from maternity system within xx months/years electronically
- system can receive ITK new-born screening results message within xx months/years electronically [https://isd.hscic.gov.uk/trud3/user/guest/group/0/pack/13/subpack/94/releases](https://isd.hscic.gov.uk/trud3/user/guest/group/0/pack/13/subpack/94/releases)
- dashboard for monitoring the healthy child programme
- make contents of record available to parents electronically within xx months/years electronically

System Infrastructure

The Provider will maintain a secure electronic database that meets national requirements for data security, complies with Information Standard Notifications, provides continuity of service for all stakeholders and ultimately meets the requirements of the National Output Based Specification for Child Health Services and the document Information Requirements for a Child Health Service.

All equipment associated with the use of the core clinical system must comply with the Warranted Environment Specification for the systems, available from the Health and Social Care Information Centre and in force at the time of any system installation or upgrade.

The Provider will maintain a system infrastructure that:

- Is capable of meeting the functionality in section 4 of the Output-Based Specification for Child Health Information Systems or updated version once published
- Meets non-functional requirements stated in section 5 of the Output-Based Specification for Child Health Information Systems or updated
version when published

The Provider will be responsible for ensuring that a link to the NHS N3 network is installed and maintained that supports the requirements of the system, in line with current NHS England policies and procedures. When the Healthcare contract is changed to a different Provider, the NHS N3 network is subject to a ‘transfer of ownership’ requirement.

Fixed network equipment such as cabling installed by or used by the Provider will be transferable to the new provider as appropriate at the end of the Agreement.

**Maintenance and support**

The Provider will be responsible for ensuring that adequate and appropriate maintenance and support services and service level agreements are available and in place for all systems, infrastructure, hardware and software used in the delivery of the IM&T Services, including but not limited to helpdesk support highlighted earlier in this document.

The Provider will be responsible for obtaining, installing and maintaining software that is required to enable the core clinical system to function and that is required for the provision of contracted services; this includes software updates and on-going training requirements.

Other Provider subcontracted or otherwise authorised by the principle Provider, may use the PCs and network in order to provide services commissioned from the principle Provider with the consent of the Commissioner. This will be dependent on assurances being received from the principle Provider in respect of the subcontractors’ compliance with the contents of this document.

Maintenance and support should follow best practice guidelines including for example, ITIL.

**National Provision**

The Provider must cooperate with all parties (the Commissioner, local service Providers, national application service Providers, national infrastructure service Providers etc.) that are responsible for implementing the CHIS Programme.

The Commissioner will guide the Provider in obtaining access to NHS systems and services such as NHS mail, N3, Spine services, clinical systems, but the Provider will bear any charges for the use of these systems and services. The Provider will be responsible for meeting any compliance requirements in setting up this access.

The IM&T systems that are part of the national provision include (not all the following are currently available in the prison IM&T environment):

i. E-referral: use of the Directly Bookable Service (DBS) for all patient referrals into secondary care.
ii. N3: use of the national network for all external system connections to enable communication and facilitate the flow of patient information.

iii. Summary Care Record (SCR) service: use of the SCR to view recent medication and key safety information.

iv. NHS Care Records Service (CRS): use of CRS to ensure that all patient records are kept in the national compatible format and when available to communicate with the national spine services.

v. Electronic Transfer of Prescriptions (ETP): use of the electronic prescribing service for supply, administration and recording of medications prescribed and transmission to the Prescription Pricing Division (PPD).

vi. Patient Demographic Service (PDS): use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical correspondence (both electronic and paper based).

vii. NHSMail: use of the NHSMail email service for all email communications concerning patient-identifiable information.

viii. Calculating Quality Reporting System (CQRS): use of CQRS to demonstrate performance against Quality Outcome Framework (QOF) achievement targets to support quality improvements in services provided to patients.

**IM&T support and management**

The Provider will be responsible for IM&T support and management which will include:

i. backup of all data in a manner so that it can be retrieved easily and economically;

ii. supply and regular updates of virus protection software for each server and workstation such that all data exchanged from or via the IM&T Systems are subject to regular Virus checking procedures;

iii. prompt handling of system configuration changes required by the arrival, change and departure of staff including user account maintenance.

The Provider shall provide the IM&T Services to their users in accordance with, amongst other requirements:

i. Good Industry Practice.


iii. Any reasonable policies or directions of the Commissioner notified to the Provider from time to time.

iv. The common law duty of confidence.


The Provider shall provide the Commissioner with reasonable access to the premises from which the IM&T Services are provided in order to carry out an
**IM&T Audit.**

An IM&T Audit is any audit or inspection carried out so as to:

i. ascertain that the information which has been provided to the Commissioner or other bodies as required by this agreement in respect of IM&T Services is accurate; and/or

ii. determine whether the Provider has complied with its obligations in respect of IM&T Services.

The Provider shall comply with any audit recommendations arising from an IM&T Audit and establish an effective issue tracking process to ensure that recommendations are implemented in accordance with agreed timescales.

**Information governance and security**

The Provider must put in place appropriate governance and security for the IM&T Systems to safeguard patient information.

The Provider must ensure that the IM&T Systems and processes comply with statutory obligations for the management and operation of IM&T within the NHS, including, but not exclusively:

i. The NHS Care Record Guarantee;

ii. Common law duty of confidence;

iii. Data Protection Act 1998;


v. Freedom of Information Act 2000;

vi. Computer Misuse Act 1990; and


There is a statutory obligation to protect patient identifiable data against potential breach of confidence when sharing with other countries.

The Provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

i. NHS Confidentiality Code of Practice;

ii. Any registration under the ISO 27000 series of standards or other appropriate information security standards;

iii. Use of the Caldicott principles and guidelines;

iv. Appointment of a Caldicott Guardian;

v. Policies on security and confidentiality of patient information;

vi. Achievement of the data accreditation requirements of the IM&T Directly Enhanced Service;

vii. Clinical governance in line with the NHS Information Governance Toolkit; and

viii. Risk and incident management system.
As part of the formal agreement, the Provider will be required to submit policy documents defining how they will meet information governance requirements, including:

i. the role of all partners and sub-contractors involved in the delivery of the IM&T Services, including inter alia third-party disaster recovery service Providers;

ii. an incident management system;

iii. use of the NHS Information Governance Toolkit;

iv. formal reliability and recruitment checking of its staff or contractors who may access and use NHS Patient data, including a criminal records check of the individuals;

v. procedures for maintaining all systems up to date in line with any security-related patches and advice from their suppliers;

vi. procedures for any transfer or storage of NHS Patient data according to HSCIC-approved cryptographic standards (including transfers over N3);

vii. the maintenance of a full audit trail (in accordance with "NHS Records Management Code of Practice", Gateway Reference 6295), including systems support and maintenance activities"; and

viii. procedures for risk assessment of particular risks to information security, and the agreement of and completion of mitigation works within agreed timescales.

The Provider will need to agree to conform to any changes to the NHS Confidentiality Code of Practice or any other Information Governance standards defined by the Department of Health from time to time.

In summary, the general requirement will be for the Provider to demonstrate to the satisfaction of the Commissioner, that they have taken all reasonable steps to ensure that only authorised persons can gain access to information about patients with whom they have a legitimate clinical relationship.

**Premises**

The Provider will be required to show that the healthcare premises comply with BS ISO/IEC 17799-2005 (Code of Practice for Information Security Management) and ISO 27001:2005 (Information Security Management Systems - Requirements) for all systems used to provide IM&T Services unless otherwise agreed with the Commissioner.

**Training**

The Provider must ensure that the staff who carry out the IM&T Services are suitably skilled, experienced and qualified to carry out the IM&T Services for which they are, or will be, deployed.

IM&T Training shall include individual needs analysis for Provider staff/subcontractors, and training in the use of IM&T Systems. The Provider shall be responsible for maintaining a detailed record of all training received by each
of its staff and shall make this information available to the Commissioner as a part of any quality audit, as required.

**Intellectual property rights**

Any data relating to patients that is created by the supplier as part of providing the service remains the intellectual property of the Commissioner. The supplier must provide access to this data:

i. as part of regular performance reporting;
ii. by electronic link to the Commissioners’ data warehouse when this is implemented and in electronic form when requested in the meantime; and
iii. as part of a handover to another supplier at the end of the Agreement term (see also section exit plan).

Patient information, system documentation, templates, standard reports and all other configured items will remain the property of the Commissioner whether created by the Provider or not.

This excludes financial data that is used by the supplier as part of their continuing operations.

**Surveys**

The Provider shall cooperate with the Commissioner in respect of the intermittent collection of data or information for the purposes of sharing and spreading best practice through the NHS (“Surveys”). Such data collection may include but not be limited to:

i. Collecting information on subjective Patient health outcomes.
ii. Collecting information to allow benchmarks to be developed against which to judge the productivity of primary medical care Providers (and other NHS Providers).
iii. Distributing and collecting NHS standardised Patient questionnaires.
iv. Administering such data collection through existing systems or by distribution and collection of questionnaires.

The Commissioner shall own the Intellectual Property rights in any data, information or results collected through the use of Surveys.

The Provider shall provide any information relating to the Services or to Patients that the Commissioner reasonably requires in a form reasonably required by the Commissioner from time to time.

**Disaster recovery**

No failure of the Commissioner or any other subcontractor supplying IM&T services or infrastructure will relieve the Healthcare/IT Provider of their responsibility for delivering primary medical care services. Therefore, the Healthcare/IT Provider must have an IM&T Systems disaster recovery and business continuity plan to ensure service continuity and prompt restoration of all IM&T Systems in the event of major systems disruption or disaster.
Service Desk
Meet agreed service requirements confirmed by local responsible commissioner, including
- Working hours
- SLA
- Service Channels (web/phone) etc.
- Integration with ATOS service front end

IM&T exit management
The Healthcare/IT Provider will provide the Commissioner with an outline exit plan to
i. enable and effect a smooth transition of the IM&T Services to an alternative service Provider; and/or
ii. otherwise bring the relevant IM&T Services, or relevant part of the IM&T Services, to a satisfactory conclusion.

The plan will include
i. project methodology and resources to be used to manage the IM&T exit management plan, to be implemented by the Provider including identification of tasks and milestones;
ii. description of how all files, data records and any other materials or documents including procedures/process maps held by the Provider related to the IM&T Services, administration (or Patient care), will be made available to the Commissioner in a timely manner; and
iii. reasonable steps to mitigate any costs which the Commissioner may incur as a result of expiry or earlier termination the agreement to provide services.

The Provider will be required to provide a full plan based on the outline which the Provider and Commissioner will agree, within a timescale specified in the formal agreement.