Patient Level Contract Monitoring (PLCM)

User Guidance for Providers and Commissioners

NHS England

Patient Level Contract Monitoring (PLCM): User Guidance for Providers and Commissioners

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Data Coordination Board

This Information Standard (DCB3003) has been approved for publication by the Department of Health and Social Care under section 250 of the Health and Social Care Act 2012.

Assurance that this Information Standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Data Coordination Board (DCB), a sub-group of the Digital Delivery Board.

This Information Standard comprises the following documents:

- Requirements Specification;
- Implementation Guidance.

An Information Standards Notice (DCB3003 Amd 62/2024) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the Standard.

The controlled versions of these documents can be found on the legacy NHS Digital website. Any copies held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Date of publication: 14 March 2025

Glossary of terms

Term	Acronym	Definition
Aggregate Contract Monitoring	ACM	Aggregate Contract Monitoring provides a summary of the volume of clinical activity performed by a healthcare provider and associated costs chargeable to the commissioner for that activity. This report serves the contractual requirement for the aggregate finance and activity report, submission of which is required under Schedule 6 of the NHS Standard Contract.
Clinical Commissioning Group	CCG	An organisation responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. They were comprised of groups of GP practices that were responsible for commissioning most health and care services for patients.
Commissioning Data Sets	CDS	Commissioning Data Sets (CDS) are maintained and developed by NHS England, in accordance with the needs of the NHS and the Department of Health and Social Care. They form the basis of data on activity carried out by organisations reported centrally for monitoring and payment purposes.
Commissioning Support Unit	CSU	An organisation that provides commissioners with external support, specialist skills and knowledge to support them in their role.
Data Landing Portal	DLP	A system that allows data to be securely transferred between organisations. The system enables Data Services for Commissioners Regional Offices to set up data specifications, against which incoming data from Providers is validated.
Data Services for Commissioners Regional Office	DSCRO	Regional offices staffed by NHS England that support the data management needs of commissioners with the provision of appropriate technical and procedural controls and legal basis to store and process personal confidential data.
Integrated Care Board	ICB	A statutory organisation that bring NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS. An ICB is responsible for planning how NHS services within the boundary of their host Integrated Care System will be delivered to best meet local needs; and contracting with Health Care Providers to deliver NHS services. Statutory functions of Clinical Commissioning Groups (CCG) were conferred on Integrated Care Boards in July 2022.

Glossary of terms (cont/...)

Term	Acronym	Definition
Information Governance	IG	The set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information at an enterprise level, supporting an organisation's immediate and future regulatory, legal, risk, environmental and operational requirements.
Information Standard Notice	ISN	A publication that announces new or changes to information standards published under section 250 of the Health and Social Care Act 2012.
Information Technology	IT	The use of any computers, storage, networking and other physical devices, infrastructure and processes to create, process, store, secure and exchange all forms of electronic data.
National Information Board	NIB	A partnership group with membership from organisations across the health and care system.
Patient Level Contract Monitoring	PLCM	Patient Level Contract Monitoring is a means to enable the interchange, in a uniform format, of monthly patient-level contract monitoring data between commissioners and providers of healthcare.
Secondary Uses Service	SUS+	SUS+ is a comprehensive repository for commissioning data sets in England. It is held by NHS England and it enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Contents

1. Background and context

The purpose of the Patient Level Contract Monitoring (PLCM) Information Standard (hereafter the Standard) is to enable the interchange, in a uniform format, of monthly patient level contract monitoring data between commissioners and providers of healthcare. This ensures that contract monitoring and reporting is consistent and comparable across all commissioning organisations and their footprints.

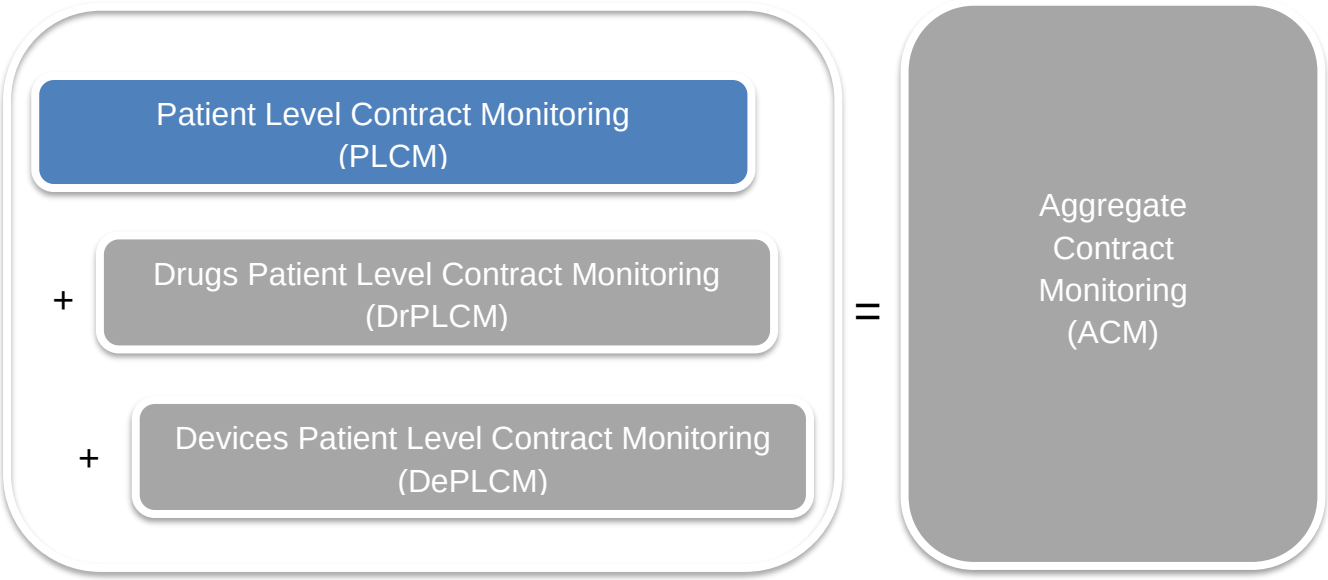
The PLCM is a patient level report containing patient identifiers. Its purpose is to substantiate and provide detail to the aggregate information contained within the Aggregate Contract Monitoring (ACM).

The ACM is the Activity and Finance Report which each provider is required to submit to its commissioners as a requirement of Schedule 6A of the NHS Standard Contract. It demonstrates the volume of activity and the aggregated cost of commissioned clinical care provided to patients as well as financial adjustments not attributed directly to clinical care.

It is expected that the PLCM will match the ACM for the relevant activity.

Diagram 1 below shows how the PLCM relates to the three other contract monitoring data flows, each of which is covered by a separate data standard.

Diagram 1.



1.1 Relationship to other policies, programmes, projects and services

This information standard is aligned to the National Information Board's (NIB) Domain H (Data Outcomes for Research and Oversight) and the high-level rationale for modular data. It is designed to collect data more efficiently and includes services either not recorded by Commissioning Data Sets (CDS) or services commissioned using different units of volume than those recorded by CDS. This information is essential to the efficient running, planning and development of the NHS and enables data to be analysed in new and different ways for the health and social care system.

1.2 Supporting information

This Standard should be read alongside the following supporting documents or information resources contained within the following websites:

#	Name	Summary
1.	Patient Level Contract Monitoring (PLCM): Implementation Guidance	Implementation guidance for users of the Standard.
2.	Patient Level Contract Monitoring (PLCM): Requirements Specification	Requirements specification for users of the Standard.
3.	NHS Data Model and Dictionary v3	Includes definitions for many of the data elements contained within the Standard
4.	Data Landing Portal	Resources and user guides relating to the Data Landing Portal (DLP) – the means by which providers can securely transfer data to Data Services for Commissioners Regional Offices (DSCROs).

2. Purpose and scope

2.1 Users of the Standard

Patient Level Contract Monitoring (PLCM) is to be used across the NHS and Independent Sector organisations in England, primarily within commissioning functions. The main users of this are:

- Staff in providers responsible for contracting, finance and business intelligence (informatics);
- National bodies which support the delivery of Health and Social Care such as NHS England and the Care Quality Commission;
- NHS England, its commissioning regions and local offices;
- All NHS England direct commissioning functions, integrated care boards (ICBs), Data Services for Commissioners Regional Offices (DSCROs) and organisations providing a commissioning support unit (CSU) service;
- Any other NHS organisations that replace any of the above and take on their functions in future.

2.2 Scope

The scope of the Standard is **all NHS-funded acute clinical care (excluding drugs and devices not covered by National Tariff which are covered by separate data standards) provided to patients, as well as financial adjustments not attributed directly to clinical care, for all commissioners**. The total charged to a commissioner in the PLCM must be equivalent to the monetary value (excluding drugs and devices not covered by National Tariff) shown in the ACM for a particular commissioner.

This covers:

- All NHS and independent sector acute providers operating under the full-length version of the NHS Standard Contract – see table below, but not primary care from whom the NHS commissions healthcare;
- All NHS commissioners;
- All contracted activities and financial adjustments not attributed directly to clinical care (excluding drugs and devices not covered by National Tariff).

The table below is a detailed list of the scope of the Standard for providers.

Provider Type and NHS Standard Contract version	Patient Level Contract Monitoring (PLCM)
NHS or Independent Sector provider commissioned to provide acute services under the full-length version of the NHS Standard Contract	Mandatory
NHS or Independent Sector provider commissioned to provide mental health services under the full-length version of the NHS Standard Contract	
NHS or Independent Sector provider commissioned to provide community services under the full-length version of the NHS Standard Contract	
NHS provider commissioned to provide ambulance services under the full-length version of the NHS Standard Contract	
NHS or Independent Sector provider commissioned to provide services of any type under the shorter-form version of the NHS Standard Contract	

In future, once SUS+ has sufficient coverage, is better aligned to record *all* health care activities and do so in a manner by which these services are commissioned, this should be the source by which the content of the ACM can be validated.

In order to utilise national commissioning data sets for this purpose it is important that both provider and commissioner assure the content and suitability (in terms of contract currency for example) of the national data set by performing local data reconciliations.

Until SUS+ is better suited for commissioning purposes, the Patient Level Contract Monitoring (PLCM) will be the means by which the contents of the Aggregate Contract Monitoring (ACM) can be verified.

2.3 Rationale

Previously, local providers and commissioners could agree amongst themselves the content and format of a contract monitoring dataset. For providers this resulted in a range of different formats for different commissioners and when multiplied by the number of providers across the country this soon became a large number of differing formats.

Where an individual provider was required to generate a different reporting format for each commissioning function it increased the data collation and reporting burden for that provider.

A requirement under the current Schedule 6 of the NHS Standard Contract is the production of an Activity and Finance Report and that *"…this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31)*". Aggregate Contract Monitoring (ACM) submissions can therefore be a means by which the initial monthly financial value claimed by the provider can be validated by the commissioner.

The PLCM is a patient level report, containing patient identifiers, whose purpose is to substantiate and provide detail to the information contained within the ACM. It also contains details about patient level clinical activities that are not found in standard CDS flows submitted to SUS+.

In order for a commissioning organisation to have a total view of its commissioning spend and commitments, there is a need to aggregate contract monitoring reports. In many instances this requires the re-mapping of differing provider returns into a common format, resulting in an additional administrative burden.

2.4 Benefits

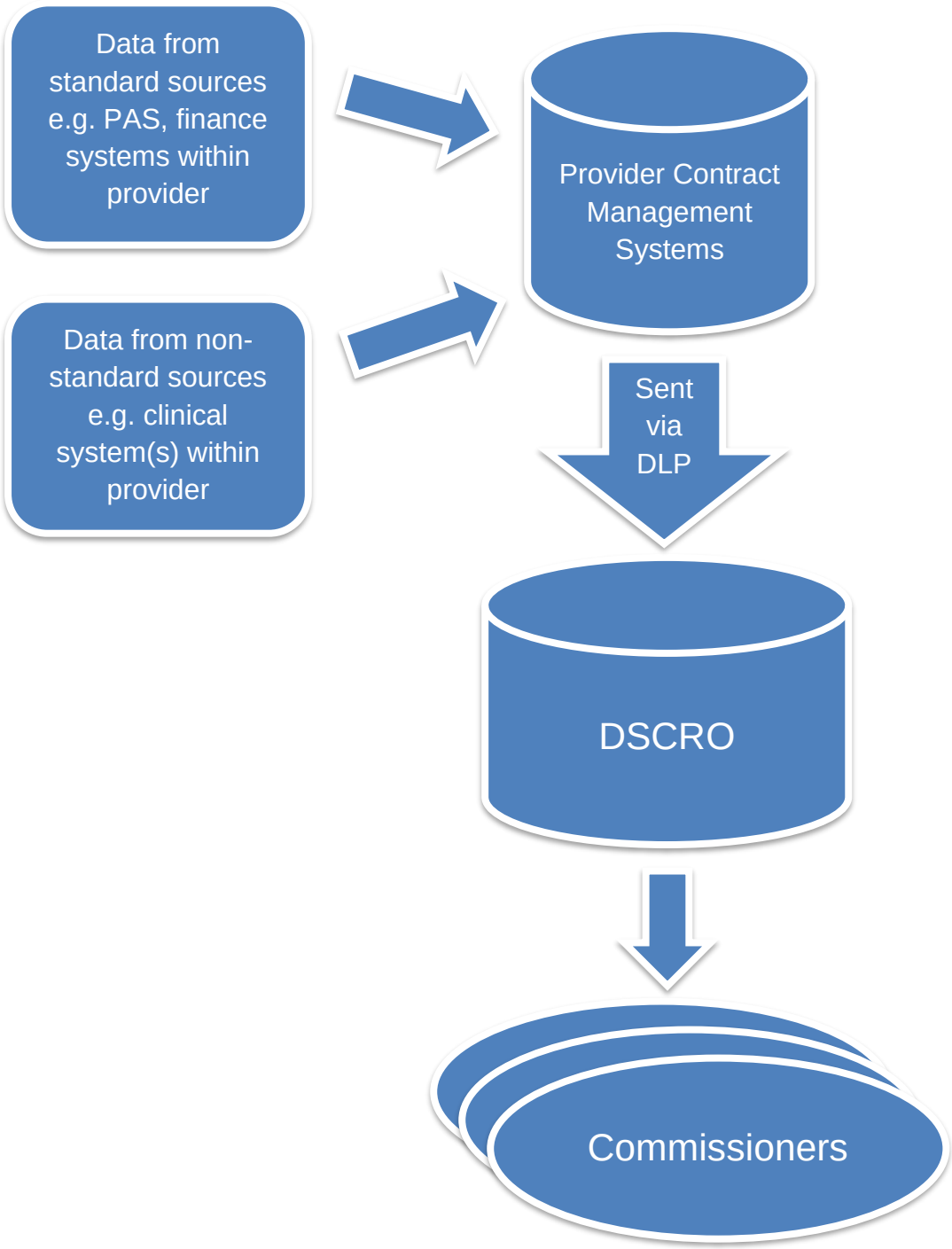
The Standard ensures that monthly contract monitoring data flowing from providers to commissioners via DSCROs contains a consistent set of data items of sufficient quality. This will:

- Minimise the burden on providers through convergence to a single report format for use by all commissioning functions regardless of organisation;
- Reduce the burden on commissioners and their CSUs through convergence to a single report format from all providers;
- Allow the development of a standard automated reconciliation process for secondary care activity and finance which will increase efficiency through removal of manual validation checks;
- Improve year-end forecasting and forecasting against plan for all services for commissioners, especially those not covered by SUS+;
- Improve the monitoring of access to healthcare services, especially those not evidenced in SUS+;
- Improve the national consistency of reporting NHS-commissioned services, resulting in national economies of scale.

2.5 High level process

Diagram 2 provides a high-level overview of the data flows associated with the production and submission of the Standard.

Diagram 2.



3. When should the Standard be submitted?

The submission of the Standard is an NHS Standard Contract requirement and must be in line with the timescale indicated in the National Requirements Reported Locally section within Schedule 6 of the NHS Standard Contract.

4. How should the Standard be submitted?

All submissions up to the agreed submission date must be on a bulk replacement/update basis i.e. each submission/resubmission will overwrite and replace in full any previous submissions for the same reporting period or periods.

The completed monthly PLCM should be transmitted using the Data Landing Portal (DLP). The DLP allows data to be transferred securely between organisations using a centrally managed system. It also facilitates the standardisation of local data transfers nationally.

Before first submission, users MUST alert their DSCRO so that the necessary loading files for the Standard can be created prior to use.

The DLP currently accepts files in a comma-separated value (CSV) format, or CSV files compressed using the gzip format. The first row must contain column headers, the names of which must match those in the specification being used when submitting the file. **Spaces used in the data element names of the Specification must be replaced by underscores.**

For more detailed guidance on submission of data using the DLP please refer to guidance on the Data Landing Portal (DLP) site.

5. How should the Standard be completed?

Providers must use a consistent method of completion to populate the Standard with data for each submission/resubmission.

The Standard must be completed in such a manner that it contains data relating to the current reporting month and all previous months, with all previous months shown individually. Each submission must contain data for each of the submission periods prior to the current submission period i.e. the submission relating to activity in Month 3 (M03) must also contain actual and plan data for activity and finance relating to Month 1 (M01), Month 2 (M02) and Month 3 (M03) **all shown separately**.

Where a financial credit is required to be documented within the Standard this must be shown by the presence of a negative (i.e. a minus) symbol in the TOTAL COST data element.

Patient-level details relating to high cost National Tariff-excluded drugs and devices should **not** be included in this Standard. Instead they should be included in the two respective patient level data Standards - the Drugs Patient Level Contract Monitoring (DrPLCM) and Devices Patient Level Contract Monitoring (DePLCM) whose total value for each month must match the aggregate totals contained within the Aggregate Contract Monitoring (ACM).

6. Generic completion guidance

All data elements must all be completed in UPPER CASE. The majority of data items, their format and definition can be found in the NHS Data Model and Dictionary v3.

Mandatory data elements must be populated using **a valid code** including codes used for missing or unknown values.

All organisation and GP practice codes (where used) must be populated using valid codes as issued by the Organisation Data Service (ODS). All healthcare resource group codes in the TARIFF CODE data element must be the current version for the reporting year in question.

Specialty codes included within the Specification must be ACTIVITY TREATMENT FUNCTION CODES (previously known as treatment function codes or TFCs) and not consultant main specialty codes.

POINT OF DELIVERY CODES (PODs) by themselves do not usually define a specific service. In order to achieve sufficient levels of granularity, PODs should be used *in conjunction* with other data elements within the data specification e.g. an activity treatment function code, service code or the healthcare resource group code found in the TARIFF CODE. In the case of non-activity based PODs it is not usually expected that the TARIFF CODE data element be populated.

The use of local codes is supported by the inclusion of some data elements e.g. LOCAL POINT OF DELIVERY CODE, LOCAL POINT OF DELIVERY DESCRIPTION, POINT OF DELIVERY FURTHER DETAIL CODE and POINT OF DELIVERY FURTHER DETAIL DESCRIPTION. It is expected that the need for local codes will allow the capture of greater levels of granularity and detail regarding the service(s) being commissioned. Descriptions should be provided for any local values used. All local codes **must** map to a POINT OF DELIVERY CODE with the **same** measure (unit of volume).

Monies relating to all CQUIN payments should be recorded with a POINT OF DELIVERY CODE of CQUIN.

7. Specific completion guidance

For a detailed technical specification of the Standard showing the individual data elements, lists of valid codes (where these are not contained within the NHS Data Model and Dictionary v3) and completion guidance please refer to the Patient Level Contract Monitoring (PLCM): Requirements Specification (Technical Detail – Specific Data Requirements) document.

Providers should populate the NON CDS UNIQUE IDENTIFIER data element in the Standard if the activity does not flow to SUS as a way of identifying and excluding this activity from the reconciliation process.

8. Specific completion guidance questions (FAQs)

Q1. What is the difference between Mandatory (M), Mandatory Where Relevant (R) and Optional (O) in the Standard?

A1.Data elements marked as Mandatory must be populated in all circumstances. Data elements marked as Mandatory Where Relevant (R) are mandatory in most circumstances but there will be specific instances where this is not possible or necessary. Further guidance regarding the population of Mandatory Where Relevant data elements can be found in Section 7. The population of optional data elements is optional or by agreement with a commissioner.

Q2. Should the TARIFF CODE data element include best practice tariff and specialised top-up flags?

A2.Yes. The Standard has been designed to accept an HRG code containing respective top-up suffixes where these are applicable.

Q3. What other supporting data sets are required to be submitted by providers as part of the contract monitoring process?

A3. The Aggregate Contract Monitoring (ACM) together with the Drugs Patient Level Contract Monitoring (DrPLCM) and Devices Patient Level Contract Monitoring (DePLCM) (where applicable) must be submitted in parallel to the Standard. The total value of the patient level data sets should match the Aggregate Contract Monitoring (ACM) for the relevant activity.

Q4. The POINT OF DELIVERY CODEs (PODs) in use locally are different from those released with the Standard specification and guidance. How should providers map local PODs to the nationally recognised list?

A4. It is understood that local commissioning processes will require a wide range of PODs to be recorded and reported on locally. As NHS England is looking to consolidate these local data sets, a level of consistency must be achieved. To ensure that aggregation to regional and national levels is possible a list of national PODs has been distributed with the Standard.

It is expected that the majority of activity and finance will fit within these categories. Where a local POD does not appear in the national list the nearest match should be found. Where a local POD offers a greater level of granularity than is required nationally a more generic POD should be selected.

Q5. Local reporting requirements require the capture of a number of additional data elements. Can providers add additional data elements to the Specification to support local reporting requirements?

A5. No. Additional data elements should never be added to the Standard. A number of free text data elements (CONTRACT MONITORING ADDITIONAL DETAIL and CONTRACT MONITORING ADDITIONAL DESCRIPTION) are incorporated in the Standard for this purpose. Patient Identifiable Data (PID) or sensitive data should **never** be recorded in these data elements.

Q6. Why are descriptions not included where only a coded data element value is included?

A6. The data set specification has been created with the minimum number of data items and contain no data elements which could otherwise be derived in order to minimise file size.

Q7. Can the Specification accommodate multiple adjustment lines?

A7. Yes. The PODs of 'ADJUSTMENT' and 'NAOTHER' should be used for the purposes of financial adjustments. The POINT OF DELIVERY FURTHER DETAIL CODE and POINT OF DELIVERY FURTHER DETAIL DESCRIPTION data elements should be used to provide further detail about what element of the contract the POD specifically relates. Records with non-activity based PODs should not be used to calculate levels of data quality compliance for patient-level specific data elements.

Q8. Why can we not send the current month and a year-to-date (YTD) position every month?

A8. The submission of a simple year-to-date data set that does not distinguish between individual months does not support a monthly validation process. Resubmissions would be lost in year meaning that individual activities and financial values would no longer be attributable to an individual month. The Standard must be completed in such a manner that it contains data relating to the current reporting month and all previous months, with all previous months shown individually.

Q9. How should block contracts, block payments and CQUIN be recorded within the Standard?

A9. The POINT OF DELIVERY data element **does not** code for the *type* of contract (e.g. block, cost and volume etc). This being the case, the use of the 'BLOCK' value in the POINT OF DELIVERY data element **must not** be used to denote a block contract.

Contract lines relating to any form of patient activity **should not** have a POINT OF DELIVERY of 'BLOCK' or 'NAOTHER' since these offer no understanding of the activity currency being measured.

Block *payment* lines should be recorded with a POINT OF DELIVERY CODE of ‘BLOCK’ or ‘CQUIN’ or ‘NAOTHER’, POINT OF DELIVERY FURTHER DETAIL CODE and POINT OF DELIVERY FURTHER DETAIL DESCRIPTION both populated indicating that to which the block value relates and a zero value in the ACTIVITY COUNT (POINT OF DELIVERY) and ACTIVITY_UNIT_PRICE data elements. For services where it is relevant, SERVICE CODE should also be populated.

Activity under block *contracts* should be recorded with the appropriate POINT OF DELIVERY CODE for that activity (e.g. a block contract for neonatal intensive care would have a POINT OF DELIVERY CODE of ‘UNBNCC’ for activity counted in cot days).

If a provider and commissioner have agreed a block payment for cancer multi-disciplinary attendances the supporting patient level detail must be included within the Patient Level Contract Monitoring (PLCM) data set with a POINT OF DELIVERY CODE of ‘MDT’.

Q10. How should packages of care be recorded in the Standard?

A10. Packages of care should be recorded with a POINT OF DELIVERY CODE of ‘POC’ but with differing ACTIVITY START DATE (CONTRACT MONITORING) and ACTIVITY END DATE (CONTRACT MONITORING) values. It is accepted that there may often be several records that relate to a single package of care but all of these particular elements activity should have the same value in the PACKAGE OF CARE OR YEAR OF CARE START DATE (CONTRACT MONITORING) data element.

Q11. How should unbundled activity be recorded in the Standard?

A11. Each unbundled activity should have its own unique record. It should not be combined with the underlying spell. For critical care, where a stay attracts multiple HRGs, a record is expected for each level of critical care with the number of days at that particular level being recorded in the ACTIVITY COUNT (POINT OF DELIVERY) data element.