NHS England

DCB3085 NHS Continuing Healthcare (CHC) Patient-Level Data Set

USER GUIDANCE

February 2024

Information and technology
for better health and care

Document Management

Revision History

Version	Date	Summary of Changes
0.1	02.09.2021	Initial draft for external & internal peer review
0.2	08.09.2021	Second draft following NHSE/I CHC data team review
0.3	02.11.2021	Amended after NHSE/I and NHSD discussion
0.4	10.11.2021	Amended by CHC data team following NHSD review
1.0	25.03.2022	Amended following discussion with NHS E&I (see Appendix A for specific changes made)
1.1	05.04.2022	Amended by CHC data team following NHSD review (unpublished version)
1.2	25.05.2022	Amended by DSDS team following peer review (see Appendix A for specific changes made)
1.3	12.01.2023	Amended by CHC data team following stakeholder discussions and user feedback. (see Appendix A for specific changes made)
1.4	19.06.2023	Amended by CHC data team (see Appendix A for specific changes made)
1.5	18.12.2023	Amended by CHC data team (see Appendix A for specific changes made)

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Rajeswari Nalabothu	Business and Operational Delivery Management Officer	02.09.2021	0.1
		23.01.2024	1.5
Helen Watts	Senior Analytical Lead CHC Data Team	08.09.2021	0.2
		04.11.2021	0.4
		15.03.2022	1.0
		25.05.2022	1.2
		21.12.2022	1.3
		08.06.2022	1.4
		18.12.2023	1.5
Raj Bhatt	Head of Analytics (NHS Continuing Healthcare)	14.09.2021	0.2
		05.11.2021	0.4
		15.03.2022	1.0
		25.05.2022	1.2
		03.01.2023	1.3

		14.06.2022 18.12.2023	1.4 1.5
Melanie Matthews	Senior Finance Lead, Finance & Information workstream, Continuing Healthcare Strategic Improvement Programme	17.09.2021	0.2
Mussarat Khan	Business and Operational Delivery Manager	09.09.2021 07.11.2021 10.11.2021 25.03.2022 05.04.2022 27.05.2022	0.2 0.3 0.4 1.0 1.1 1.2
Oliver Ducker	Senior Analytical Manager	15.03.2022 25.03.2022 25.04.2022	1.0 1.1 1.2

Approved by

This document has been approved by the following people:

Name	Title	Date	Version
Mussarat Khan	Business and Operational Delivery Manager	10.11.2021 25.03.2022 05.04.2022 27.05.2022	0.4 1.0 1.1 1.2
Stuart Richardson	NHS CHC PLD Programme Head Principal Business and Operational Delivery Manager	09.11.2021 25.03.2022 05.04.2022 27.05.2022	0.4 1.0 1.1 1.2
Tom Latham	DSDS Technical Manager	25.03.2022 05.04.2022 27.05.2022	1.0 1.1 1.2
Ed Onslow	DSDS Development Lead	28.06.2023 08.02.2024	1.4 1.5

Document Control

The controlled copy of this document is maintained in the NHS England corporate network. Any copies of this document 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.

Contents

1 About this Document 5

Purpose of the Document 5
Scope of the Document 5
Schedule for Updating this Document 5

2 Background Information 6
3 Configuration of local systems 7
4 Constructing Submission Files 8

Key points relating to mandatory fields and validation 8
Validation of records 9
Inclusion rules 10
Resubmitting data 11
Data submission examples 12

5 Data Item Guidance 16

Linkage and Identifier Data Items 16

6 Breakdown of Data Items by Table 17

CHC000 Header 17
CHC001 Master Patient Index 19
CHC101 Referral, Assessment and Outcome 22
CHC102 Care Package 33
CHC103 Review 38

Appendix A – Summary of Changes 41

CHC103 Review 42
CHC101 Referral, Assessment and Outcome 42
CHC103 Review 43
CHC101 Referral, Assessment and Outcome 43
CHC103 Review 44

Appendix B – Counting Transition Cases within the NHS CHC PLDS 46
Appendix C – Care Product Types Categories and Definitions 47
Appendix D – Historical Data / Legacy Based Systems 51
Appendix E – Abbreviations and Glossary 53

1 About this Document

Purpose of the Document
The purpose of this document is to outline:

- The background to the development of the NHS Continuing Healthcare (NHS CHC) Patient-Level Data Set v1.0 and the development approach.

- The manner by which the NHS Continuing Healthcare, NHS CHC Patient Level Data Set v1.0 should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data tables and data items, beyond that stated in the data set NHS CHC v1.0 Technical Output Specification (TOS), to further explain their use and validation.

Scope of the Document
This document is aimed at:

- Integrated Care Boards (ICB's) management professionals leading NHS CHC and NHS-funded Nursing Care (FNC) services in England
- Operational and Administrative personnel
- NHS CHC Informatics and IT Professionals
- Commissioning Support Units (CSU's) or other persons or bodies acting on behalf of a Responsible Commissioner ICBs with respect to CHC.
- IT system suppliers supplying NHS CHC systems
- NHS Staff and system suppliers supporting clinical systems designed to support NHS CHC services, such as CHC Electronic Management Systems (EMSs).

The following areas are out of scope of this document:
- Detailed justification for the development of the Information Standard.
- Data submission framework (i.e., how data is submitted by NHS CHC Providers to the Data landing platform.
- Restating information already accessible from the TOS.

This document should be read in conjunction with the following documents, which can be found here:
- NHS CHC PLDS Requirements Specification
- NHS CHC PLDS Technical Output Specification (TOS)
- NHS CHC PLDS Implementation Guidance
- NHS CHC PLDS Enhanced Technical Output Specification
- Data Landing Platform Guidance:
  Message Exchange for Social Care and Health (MESH) - NHS Digital
- NHS CHC Data Model and Dictionary

Schedule for Updating this Document
Please note this guidance document is considered a live document and NHS England reserves the right to review and update, when necessary, for example in response to stakeholder feedback. Changes to this document will not necessitate further acceptance from the Data Assurance Programme Board (DAPB), on the understanding that the changes do not affect the scope of the Information Standard.

2 Background Information

NHS CHC means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

NHS-funded Nursing Care (FNC) is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 FNC has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for FNC.

Note that the FNC Practice Guidance (https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice) sets out there may be occasions when 'urgent nursing care' can be put in place for up to six weeks without first carrying out an NHS CHC screening or assessment. Six-week 'urgent nursing care' (which is paid at the same rate as FNC but is not true FNC) is out of scope of the PLDS collection and should not be included in FNC data. If such cases were to need to extend beyond six weeks, they would need to go through the formal process for FNC and would then be included in the PLDS (if FNC eligible).

The NHS CHC Patient Level Data Set (PLDS) is a patient level, output based, secondary uses data set. It aims to deliver robust, comprehensive, nationally consistent, and comparable person- based information for people (over the age of 18 years) accessing NHS CHC services and FNC located in England.

As a secondary uses data set it intends to re-use operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets extracted or derived from information systems and sent to NHS England for analysis purposes.

The NHS CHC information captured in the data sets supports the NHS to deliver:

1. Better outcomes,
2. Better experience, and
3. Better use of resources, by providing detailed evidence that is currently unavailable.

This Information Standard has been approved by the Data Coordination Board (DCB) and has been assigned information standard number DCB3085. This mandates the patient-level NHS CHC Data Set as a national data standard.

The Information Standards Notice (ISN) does not directly place any requirement on system suppliers to accommodate the data set within their systems. It is the data set providers who must ensure that they have a system or systems which are compliant with delivering the requirements specified in the standard. IT system suppliers need to be aware of these requirements so that they can respond to the data set providers they support. The contractual agreement between data set providers and system suppliers will dictate whether system suppliers abide by the ISN and at what cost.

The data and information output is a comprehensive set of data, submitted each month to support delivery of NHS CHC.

It is an 'end-to-end' data set submitted by all Integrated Care Boards (ICBs) commissioning NHS CHC services.

For each individual included in the data set it will cover (where applicable):

1. Initial **screening** checklist
2. **Referral** for full assessment
3. Full **assessment** (including any requests for reviews of ICB eligibility decisions via the Local Resolution process or cases that have become newly eligible following an Independent Review)
4. Commissioning and costs of **care packages** including NHS CHC and FNC packages.
5. Ongoing delivery (annual and ad hoc **reviews**) of NHS CHC and FNC packages.

The intention of the comprehensive NHS CHC data set will be to support and deliver the above aspects of the NHS CHC assessment process. In respect of Health and Social Care Act 2012 section 254, NHS England operate a system for the collection and analysis of the NHS CHC PLDS. A copy of the Directions is published on the NHS England Directions webpage.

A comprehensive set of documentation has been developed for the NHS CHC PLDS information standard. These documents are available in two areas of the NHS Digital website as follows:

DCB3085 NHS CHC Patient Level Data set ISN web page: Contains DCB Information Standard documentation which define the standard and remain static.

NHS CHC webpage: Contains supporting technical documentation as well as organisational assessment and planning tools. These documents and tools are continually reviewed by DSDS and updated where necessary.

3 Configuration of local systems

The Technical Output Specification (TOS) defines the data items within the NHS CHC PLDS. The TOS splits the data set into a number of tables, each containing related data items.

The NHS CHC PLDS is an output data set. An output data set is a description of the data that needs to be extracted or derived from a patient administration system (PAS) or clinical system and does not directly support patient care. In many cases, the output data item will be identical to the input definition. However, the two may differ both in terms of the format of the data item and the range of values presented. The data collection system may represent the data in a different manner or in more granularity; however, provided the input data items can be mapped to the output data set, the input source will not require any modification. This can be illustrated in the following table:

Provider System (Input system)		National Data Set	
Data item name	Format/Values	Data item name	Format/Values
Date of Birth	dd/mm/yy	Person Birth Date	ccyy-mm-dd

The NHS CHC PLDS is not a specification for the standardisation of a patient care record. Service Providers have the flexibility to adopt any local data collection process or system as long as the local data collection frameworks can output and submit data, as per the data set specification, to the data landing platform.

The data set is not a patient care record (and is not designed to support direct patient care). ICBs should use their existing CHC clinical and operational systems to also support the implementation of this data set.

4 Constructing Submission Files

Key points relating to mandatory fields and validation

The TOS fully defines the data items within the output data set and splits the data set into a number of tables, each containing related data items.

Mandatory data items and/or tables

The requirements for each data item are outlined in the original levels of mandation as described to DAPB (as outlined in the mandatory/required/optional/pilot/derived column in the TOS):

> **Mandatory**: These data items MUST be reported. Failure to submit these items will result in the rejection of the record.
>
> **Required**: These data items MUST be reported **where they apply**. It is a legal and contractual requirement to submit these groups where the service has been provided to a patient. Failure to submit these groups will affect the derivation of national indicators or national analysis and the reported performance of the provider. Please note that the purpose of the data set is not to change clinical practice.
>
> **Optional**: These data items MAY be submitted on an optional basis at the submitter's discretion.
>
> **Pilot**: These data items have been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested.

The three phases of validation correspond to these mandation levels. So, for instance, if a data item is mandatory, it is likely to have data item level rejections for a null or invalid entry.

The table below illustrates examples of the respective validation rules applied in the NHS CHC PLDS:

Scenario	Example Error Code	Example message reported
Mandatory data item is blank	CHC1020101	CHC1020101 - Record rejected - C102010 CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) is blank.
Any data item has an incorrect data format	CHC1020401	CHC1020401 - Record rejected - C102040 CARE PACKAGE END DATE (NHS CONTINUING HEALTHCARE) has an incorrect data format. C102010 SERVICE REQUEST IDENTIFIER=<ServiceRequestId> C102040 CARE PACKAGE END DATE (NHS CONTINUING HEALTHCARE)=<EndDateCarePackage>

An invalid value is provided for a **required** data item	CHC1030502	CHC1030502 - Warning - C103050 CARE PACKAGE REVIEW ELIGIBILITY OUTCOME (NHS CONTINUING HEALTHCARE) contains an invalid CARE PACKAGE REVIEW ELIGIBILITY OUTCOME (NHS CONTINUING HEALTHCARE). C103010 CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE)=<CarePackageIDCHC> C103050 CARE PACKAGE REVIEW ELIGIBILITY OUTCOME (NHS CONTINUING HEALTHCARE)=<ReviewOutcomeCHCEligibility>
Required data item is blank (where applicable – see TOS)	CHC0010601	CHC0010601 - Warning - C001060 POSTCODE OF USUAL ADDRESS is blank. C001010 LOCAL PATIENT IDENTIFIER (EXTENDED)=<LocalPatientId>
An invalid value is provided for a **mandatory** data item	CHC1010303	CHC1010303 - Record rejected - C101030 NHS CONTINUING HEALTHCARE ACTIVITY TYPE contains an invalid NHS CONTINUING HEALTHCARE ACTIVITY TYPE. C101010 SERVICE REQUEST IDENTIFIER=<ServiceRequestId> C101030 NHS CONTINUING HEALTHCARE ACTIVITY TYPE=<ActivityTypeCHC>

Whilst a particular table itself may not be mandatory, if a record is entered in this table, then all of the table's mandatory fields must be completed.

The following tables are mandatory, and MUST be submitted for all patients otherwise all data connected to a patient's record will be rejected:

- CHC000 Header
- CHC001 Master Patient Index
- CHC101 Referral, Assessment and Outcome

In addition, the following table MUST contain a single record for each submission:

- CHC000 Header

Validation of records
Upon submission of the data to the central data warehouse, three phases of validation are undertaken:

1. **File level**

Leading to rejection or issuing of a warning message. A rejection would be of the entire submission against the selected reporting period, requiring identified issue(s) to be rectified and a resubmission made. Warning messages should be addressed and required actions undertaken.

Where these can be found File-Level Rejects tab

Example: CHCREJ002 - Failed Content Check. CHC001 MPI table is empty.

2. Group level

These compare records within or across multiple tables, leading to rejection of multiple records or a warning message being displayed. For example, they could be used to check referential integrity between tables or for duplicated records within a table. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tab.

Example: the CHC001 group will be rejected if there is no valid CHC101 group transmitted for this Local Patient Identifier (Extended).

3. Record level

These can be against a single data item or across multiple data items within a single record, leading to either the rejection of the record or a warning displayed. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tabs.

Example: If NHS Continuing Healthcare Standard Checklist Completed Date is populated and after Referral Request Or Notification Received Date, the record will receive a warning.

Each data item within the data set specification may have any of the above types of validation.

Please see the validations and warnings in the Enhanced Technical Output Specification eTOS (columns I to L), to understand the submission requirements for each table. The "Validation Rules" columns outline the data restrictions, and corresponding messages are shown in the "Error/Warning Messages" column. Please also see section 5 of this User Guidance which contains a description of each table.

Inclusion rules

The NHS CHC PLDS is a patient level, output based, secondary uses data set which includes person-based information for people (over the age of 18 years) accessing NHS CHC and FNC services in England.

The FNC Practice Guidance (https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice) sets out there may be occasions when 'urgent nursing care' can be put in place for up to six weeks without first carrying out an NHS CHC screening or assessment. Six-week 'urgent nursing care' (which is paid at the same rate as FNC but is not true FNC) is out of scope of the PLDS collection and should not be included in FNC data. If such cases were to need to extend beyond six weeks, they would need to go through the formal process for FNC and would then be included in the PLDS (if FNC eligible).

Users of the data set and this document should be aware that the current ISN only allows inclusion of data for "activity relating to adults (age 18 years and over) accessing NHS Continuing Healthcare and NHS-funded Nursing Care." If a person is below the age 18 at the end of the reporting period their data records will be rejected to prevent any data breach and not included in report outputs or publication. This means that transitional cases where an

individual is referred before their 18th birthday will not have any applicable activity included in any report outputs until they are 18. A definition of transition cases is included in Appendix B. Inclusion of transitional cases under the age of 18 at the time of the reporting period will be reviewed in the future.

The CHC PLDS is service request driven i.e. by referrals and / or other service request notifications (e.g. checklists or Local Resolution requests). Each monthly submission should include all active referrals or notifications (or those with active eligibility, an eligibility decision, care packages, or 3/12 month review activity attached to them) within that reporting period. Please see page 13 for examples.

All episodic tables (those with start and end dates) within the data set follow the same inclusion concept.

The rest of the tables have their own inclusion rules which specify when they should be included for a reporting period.

You can find out the rules by looking at the validations in the latest eTOS. The column "Additional Validation Rules" outlines the data restrictions. Please also see section 5 of this User Guidance which contains a description of each table, and Appendix D for information on historical data and data held on legacy systems.

As a general rule, activity data should be submitted in the reporting period in which the activity occurred. For example, data relating to activity that took place in April 2022 should be collected locally in the appropriate reporting period (i.e., during April 2022) and submitted in the corresponding May submission window (i.e., 1st May 2022 – 31st May 2022).

Resubmitting data

There will be opportunities to resubmit data for all PLDS data tables (apart from the Review table, as reviews refer to a fixed point in time). The resubmission of data is optional.

Unlimited resubmissions can be made during the relevant reporting window, but the 'last good file' (i.e. the last submission file containing valid data) will be accepted as the submission for that month for the purposes of ongoing analysis.

Resubmissions for previous months can also be made during subsequent reporting periods, as outlined below.

There is no requirement to resubmit data unless an issue is identified in a data provider's submission for the month that requires resubmission, or if the data being resubmitted has a consequential effect on other data (for example, where a change to April's submission impacts the May and June submissions, then all three months should be resubmitted).

Data submitters should submit the best possible data during the original reporting window and only resubmit data where there is a clear need to.

When making a resubmission, submitters should consider the following points:

- Data submitters will need to utilise the REPORTING PERIOD START DATE and REPORTING PERIOD END DATE in the CHC000 Header in their submission file to indicate the period for which they are making a resubmission.

- A separate submission file should be submitted for each resubmission of data, and these should be based on the original reporting months. For example, a resubmission

of April data can be made within a submission file covering April (as indicated by the dates in the CHC000 Header). However, if May data also needs to be resubmitted then a separate submission file covering May data should be submitted, rather than a single resubmission file covering April and May.

- Where a resubmission is received, the data will be processed in full, derivations will be applied, and data will be onward shared at the end of the reporting period when the resubmission was made.

- The resubmission will overwrite any previous submissions of data for that reporting month for the purposes of ongoing analysis.

- Resubmissions can only be made on a 'year to date' basis, i.e., only data for the current financial year (e.g., 1st April 2022 – 31st March 2023). For example, in August 2023 it will be possible to resubmit data for April 2023, May 2023 and June 2023 (as separate files), as well as making a (new) submission of July 2023 data. However, it will not be possible to resubmit data from before April 2023, i.e., for the previous financial year. This means that in April 2023, data submitters will be able to submit data from April 2022 to March 2023 (i.e., all reporting periods from the current financial year based on the open submission window, i.e. March 2023). However, from May 2023 only data from April 2023 (and nothing before that) can be submitted, as the open submission window is for April 2023 data.

Please refer to the separate MESH User Guidance for further information about using MESH to make NHS CHC PLDS submissions.

Please note that, where a resubmission of data is made to correct issues with data quality, missing data such as demographic information should be also corrected in the electronic CHC management system as well as in the data set submission files. However, in some cases, data may need to be amended (e.g. through the population of dummy dates) in order to enable it to pass validation for the NHS CHC PLDS. It is not expected that changes made simply for the purposes of enabling data to flow into the data set are also made in the electronic CHC management system.

Data submission examples

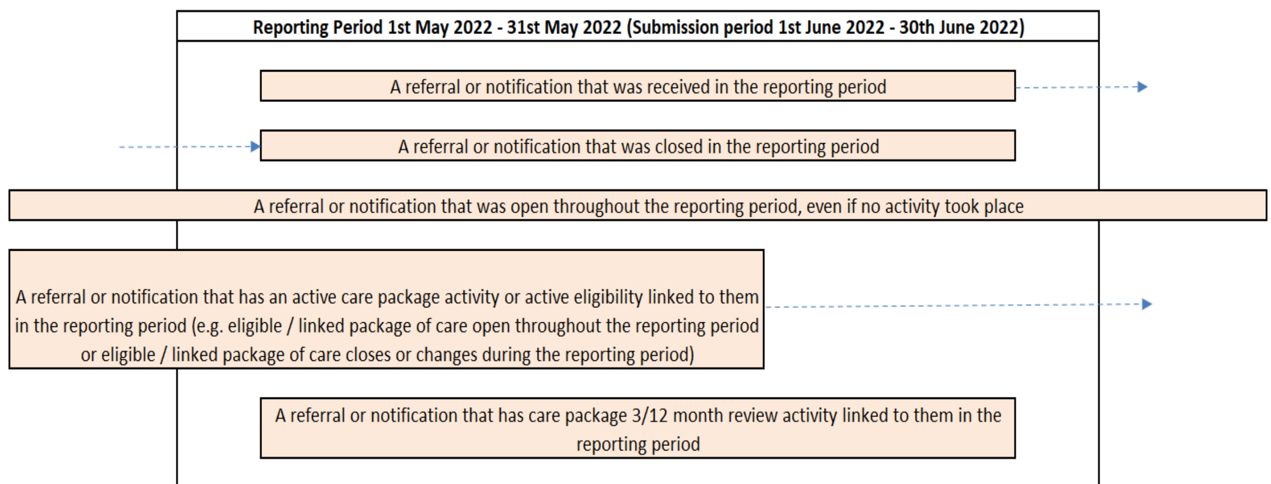
By way of illustration, the table below confirms the actions that should be taken for updates to a new or existing patient's activity in each reporting period:

Activity	Actions	Notes
Referral or Notification (New or Update to Existing)	Add (or amend) data to CHC001 MPI Table if not already there. Add (or amend) data to CHC101 Referral, Assessment and Outcome table.	Please note that linkage data items must be submitted in each table where they are included. The mandatory tables (CHC001 and CHC101) tables have to be sent with each submission for each patient.
Care Package (New or Update to Existing)	Add (or amend) data to CHC102 Care Package table.	Please note that linkage data items must be submitted in each table where they are included. The mandatory tables (CHC001 and CHC101) tables also have to

		be sent with each submission for each patient.
Review (New)	Add data to CHC103 Review table. If following an initial submission, it has been identified that missing reviews (i.e. records) were omitted from the reporting period, these records would need to be included via a retrospective resubmission.	Please note that linkage data items must be submitted in each table where they are included. In order to submit data within the CHC103 table, all of the other tables (CHC001, CHC101 and CHC102) must also be submitted for the relevant patient, referral, and care package.
Change in Patients MPI details (Update to Existing)	Amend data in CHC001 MPI Table.	Please note that linkage data items must be submitted in each table where they are included. The mandatory CHC101 table must also be submitted for that patient.

1) Data for **all patients** who had an open case at any point during the reporting period should be included within the data for each reporting period that the case is open, even if no activity took place. An open case includes an open referral or notification, or a referral or notification with an open care package or open eligibility linked to it. Examples include:

- referrals or notifications that were received in the reporting period
- referrals or notifications that closed in the reporting period
- referrals or notifications that were open throughout the reporting period, even if no activity took place
- referrals or notifications that have open eligibility or open care package activity linked to them in the reporting period. This includes eligible / linked packages of care open throughout the reporting period or eligible / linked packages of care that change during the reporting period e.g. eligibility / a linked packages of care closes on a date falling within the reporting period being submitted. Cases that have been eligible during the reporting period, but the package of care has not been set up yet should also be included.
- referrals or notifications that have active package 3/12 month review activity linked to them in the reporting period



Please note that any changes/updates to activity relating to prior reporting periods require resubmission of the relevant reporting period(s) for those changes to be reflected in reporting outputs. Resubmission of prior reporting periods is possible provided the months for resubmission fall within the current reporting financial year (please see 'Resubmitting Data' on page 11 for more information).

If any date event items[1] across any of the reporting tables (e.g. DECISION SUPPORT TOOL COMPLETED DATE, RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION OUTCOME COMMUNICATED TO PATIENT DATE, CARE PACKAGE REVIEW DATE etc.) fall during the reporting period it would be expected for the record (CHC101RefAssessOut service request information and any relevant linked tables) to be included in the monthly submission.

Cases which may not have date items falling within a reporting period but are still considered to be 'open' should also be included. Some examples of what constitutes 'open' cases are included below.

Service Request Type: 01 NHS Continuing Healthcare (Standard)

Data scenarios where Service Request is considered to be 'open'	Example description
Open checklist or notification	REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE with no REFERRAL OR NOTIFICATION OUTCOME
Open referral	REFERRAL OR NOTIFICATION OUTCOME = 01 Refer for full NHS Continuing Healthcare (Standard) assessment with no REFERRAL REQUEST DISCOUNTED DATE or RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION DATE
Open NHS Continuing Healthcare eligibility	RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION OUTCOME = 01 Eligible for NHS Continuing Healthcare

[1] The exception is CARE PACKAGE NEXT PLANNED REVIEW DATE (NHS CONTINUING HEALTHCARE) as this a future date however please also see advice on page 45 as this data item does not need to be completed and is planned to be removed in the future.

	(Standard) and FUNDING START DATE is populated with no FUNDING END DATE
Open NHS-funded Nursing Care eligibility	REFERRAL OR NOTIFICATION OUTCOME = 02 Do not refer for full NHS Continuing Healthcare (Standard) assessment but eligible for NHS-funded Nursing Care Or RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION OUTCOME = 02 Eligible for NHS-funded Nursing Care and FUNDING START DATE is populated with no FUNDING END DATE
Open care package activity	CARE PACKAGE START DATE with no CARE PACKAGE END DATE

Service Request Type: 02 NHS Continuing Healthcare (Fast Track)

Data scenarios where Service Request is considered to be 'open'	Example description
Open referral	REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE with no REFERRAL REQUEST DISCOUNTED DATE or REFERRAL REQUEST ACCEPTED DATE (NHS CONTINUING HEALTHCARE FAST TRACK)
Open Fast track eligibility	REFERRAL REQUEST ACCEPTED DATE (NHS CONTINUING HEALTHCARE FAST TRACK) and FUNDING START DATE with no FUNDING END DATE
Open care package activity	CARE PACKAGE START DATE with no CARE PACKAGE END DATE

Service Request Type: 03 NHS Continuing Healthcare Previously Unassessed Period of Care (PUPoC)

Data scenarios where Service Request is considered to be 'open'	Example description
Open PUPoC request	REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE with no NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION MADE DATE

Service Request Type: 04 NHS Continuing Healthcare Local Resolution

Data scenarios where Service Request is considered to be 'open'	Example description
Open Local Resolution	REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE with no RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION DATE
Open NHS Continuing Healthcare eligibility following a Local Resolution	RESPONSIBLE COMMISSIONER REVIEW ELIGIBILITY DECISION OUTCOME = 01 Eligible for NHS Continuing Healthcare (Standard) and LOCAL RESOLUTION START DATE with no LOCAL RESOLUTION END DATE

Open NHS Continuing Healthcare eligibility following Independent Review	NHS CONTINUING HEALTHCARE ELIGIBILITY START DATE FOLLOWING INDEPENDENT REVIEW with no FUNDING END DATE
Open NHS-funded Nursing Care eligibility following a Local Resolution	RESPONSIBLE COMMISSIONER REVIEW ELIGIBILITY DECISION OUTCOME = 03 Eligible for NHS-funded Nursing Care and LOCAL RESOLUTION START DATE with no LOCAL RESOLUTION END DATE
Open care package activity	CARE PACKAGE START DATE with no CARE PACKAGE END DATE

5 Data Item Guidance

This section provides additional guidance with regards to data items included within the TOS where this is deemed to be necessary. This includes fully explaining how groups may or may not repeat and extending descriptions and explanations of data items where space does not permit within the TOS.

Linkage and Identifier Data Items

Linkage data items appear in more than one table and allow the relationship between records within different tables to be identified.

The linkage data items are fully described within the TOS.

Please note that linkage data items must be submitted in each table where they are included, however not all of the tables are required to be sent with each submission.

The data items listed below act as linkage items within the data set:

LOCAL PATIENT IDENTIFIER (EXTENDED) - this is a number used to identify a PATIENT uniquely within the CHC local system. It may be different from the PATIENT's case note number and should be assigned automatically by the local computer system. This is a mandatory requirement to enable local linkage of the data.

SERVICE REQUEST IDENTIFIER – this is a unique identifier for a SERVICE REQUEST.

It would normally be automatically generated by the local computer system upon recording a new Referral or notification, although could be manually assigned.

CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) - The CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) is used to uniquely identify a CARE PACKAGE within the CHC local system.

It would normally be automatically generated by the local computer system upon recording a new Care Package, although could be manually assigned.

These items are a mandatory requirement to enable local linkage of the data.

The above identifiers will be accepted in the format max an20 (i.e., alphanumeric characters up to a maximum of 20) and do not need to be padded to 20 characters.

These three linkage items are listed below with details of the table where the respective item is a primary key:

LOCAL PATIENT IDENTIFIER (EXTENDED)
CHC001 Master Patient Index
CHC101 Referral, Assessment and Outcome

SERVICE REQUEST IDENTIFIER
CHC101 Referral, Assessment and Outcome
CHC102 Care Package

CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE)
CHC102 Care Package
CHC103 Review

NHS Number – Whilst a patient's NHS number ***should*** be supplied wherever it is known, it is accepted that there may be occasions where the NHS number is not known.

The capture of the NHS number is vital as this is the only identifier that allows a patient to be tracked across different organisations or across a single organisation.

In some cases, the NHS number can be used locally to link data across multiple systems where the Local Patient Identifier may differ. This could also support situations when a patient is referred to services using a number of different systems. In this case, the NHS number would act as an equivalent Local Patient Identifier data item locally but should not be submitted as is in the Local Patient Identifier field for information governance reasons.

Although the NHS number is not a mandated field, as not every person will have one, data quality reports will be produced to identify the completeness of this field and it is recommended that Providers use this as one of the primary data quality metrics for all patient level data sets.

In cases where a patient's NHS number is unavailable (which may be because the person does not possess one) data providers must submit a null NHS number and [07] *Number not present and trace not required* in NHS NUMBER STATUS INDICATOR CODE.

6 Breakdown of Data Items by Table

Please note that mandatory items are shown in the below table as **bold** text. In addition, linkage items are <u>underlined</u>.

CHC000 Header

CHC000 Header
Description
The Header should include metadata relating to the submission, including which organisation, and reporting periods the data relates to, the primary system in use and the date and time the submission was created. One occurrence of this table is required per submission.

Additional Notes on Data Items	
Data Item Name	**Additional Notes**
DATA SET VERSION NUMBER	The version of the NHS CHC TOS that the submission file is for. The current version of the data set is v1.0. ‘1.0’ should be entered as the version number, otherwise your file may be rejected.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care. Where another body (e.g. CSU) is authorised by an ICB to exercise any of its NHS CHC functions on its behalf, the organisation identifier used here should be for the organisation with statutory responsibility for NHS CHC (i.e. the ICB). The organisation identifier should also correspond to a correct ODS organisation code (see ODS Portal for codes).
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	This is the **Organisation Identifier** of the organisation acting as the physical sender of a data set submission. This Identifier provides an audit trail where a different organisation is undertaking the submission on behalf of the provider organisation. Where another body (e.g. CSU) is authorised by an ICB to submit on its behalf, the organisation identifier used here should be for the organisation submitting the data flow. The organisation identifier should also correspond to a correct ODS organisation code (see ODS Portal for codes).
PRIMARY DATA COLLECTION SYSTEM IN USE (NHS CONTINUING HEALTHCARE)	The name of the **Primary Data Collection System**. This is a free text field. Where multiple systems are in use, please indicate the primary system in use, i.e. the one from which the highest number of records is extracted, or which is used to record the main mandatory tables (CHC001 and CHC101).
REPORTING PERIOD START DATE	The **reporting period start date** to which this file refers. This should be recorded in the eGIF Date format CCYY-MM-DD
REPORTING PERIOD END DATE	The **reporting period end date** to which this file refers. This should be recorded in the eGIF Date format CCYY-MM-DD
DATE AND TIME DATA SET CREATED	The date and time the upload file was created. CHC management systems should have an automatic ‘date and time dataset created’ field. If a CHC management system does not automatically generate this field, it will need to be manually populated.

CHC001 Master Patient Index

CHC001 Master Patient Index	
Description	
This table contains information on patient identifiers, demographic information, and organisational data. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic locations. Providers should supply CHC001 data as it was at the end of the reporting period. Providers must populate all known data items in this table even if they are unchanged since the last submission. Do not just provide data for all "changed" data items. It is acknowledged there are small differences against a number of protected characterises between the NHS CHC Checklist, DST (Decision Support Tool) and Fast Track forms in comparison to the NHS CHC PLDS. Discussions are in progress with DHSC regarding the known differences, and if an update is required to national forms, ample advanced notice of any changes, including any possible updates to the PLDS (should changes be required), will be given. If there are any mismatches in the interim, these can be recorded using default codes such as 'Z - Not Stated' or '99 - Not known' until the small differences are resolved and any new categories and/or definitions have been jointly agreed and confirmed by all stakeholders. **Please note that the CHC001 table is mandatory and must be included in every submission file, along with the CHC101 table.**	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	This is an identifier used to identify a PATIENT uniquely within a Health Care Organisation. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system. This is not the NHS number. This is a linkage data item and the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table. Patients should have the same **Local Patient Identifier** across successive submission periods to make reconciliation of data possible. Where multiple systems are used it is acceptable to use a prefix to the **Local Patient Identifier** which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different patients in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct patient within a submission file, for example where a patient's records exist on two systems and therefore are potentially

	associated with different Local Patient Identifiers for the same patient. Duplicate **Local Patient Identifiers** within the same submission file will cause the entire file to be rejected.
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	This is to identify the **Organisation Identifier** of the organisation that assigned / issued the **Local Patient Identifier (Extended).** The organisation identifier (local patient identifier) should also correspond to a correct ODS organisation code (see ODS Portal for codes). It is necessary where organisations have gone through a merger or split into a new or existing organisation. If **Local Patient Identifiers** are not modified during the merger or split of an organisation, then the issuing **Organisation Identifier** of the **Local Patient Identifier** (even if now discontinued) should be sent in this field. However, if the **Local Patient Identifier** has been modified since the organisation change i.e., by prefix etc, then the new **Organisation Identifier** should be used.
NHS NUMBER	Although this is not a mandated field, as not all patients have NHS numbers, data quality reports will be produced to identify the completeness of this field. Duplicate NHS Numbers within this table will cause the entire file to be rejected. Duplicate NHS Numbers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.
NHS NUMBER STATUS INDICATOR CODE	This captures whether the NHS number of the patient has been verified. This data item is 'Required' however it is recommended that this is always completed, irrespective of whether an NHS number is present. In most cases, this data item will be submitted with value [01] - Number present and verified. The [01] will indicate that the data provider has validated the number against the central Personal Demographics Service (PDS), and therefore facilitates reliable data linkage. Data providers may flow data for patients with an NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage of groups will exclude these data groups (unless reliable linkage is available via LOCAL PATIENT IDENTIFIER data items). In cases where a patient's NHS number is unavailable (which may be because the patient does not possess one) data providers must submit a null NHS number and [07] Number not present and trace not required in NHS NUMBER STATUS INDICATOR CODE.
PERSON BIRTH DATE	This captures the date on which a patient was born or is officially deemed to have been born. This is required to enable the positive identification of the patient. This should be recorded in the eGIF Date format CCYY-MM-DD

POSTCODE OF USUAL ADDRESS	The **Postcode of Usual Address** as stated by the person. Where the person has no fixed abode, this should be recorded as ZZ99 3VZ. If the postcode is unknown ZZ99 3WZ should be used. For overseas residents, the postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode. A full list of pseudo postcodes is available from: https://digital.nhs.uk/organisation-data-service/data-downloads If the Postcode is provided and it is not in one of the accepted formats (see the Technical Glossary for details in TOS), the record will be rejected.
PERSON STATED GENDER CODE	Person Stated Gender Code is self-declared or inferred by observation for those unable to declare their Person Stated Gender. The current gender of the patient. The classification is phenotypical rather than genotypical i.e., it does not provide codes for medical or scientific purposes. The [X] *Not Known* national code should be used where the sex of the patient has not been recorded. The [9] *Not Specified* national code should be used where the gender of the patient is indeterminate i.e., unable to be classified as either male or female.
PERSON STATED SEXUAL ORIENTATION CODE	PERSON STATED SEXUAL ORIENTATION CODE is aligned with descriptors for "Sexual orientation findings" from the NHS Data Dictionary. The PERSON STATED SEXUAL ORIENTATION of a PERSON. The [U] is PERSON asked and does not know or is not sure The [Z] is Not Stated (PERSON asked but declined to provide a response) For more details for this data item please visit the below data dictionary link PERSON STATED SEXUAL ORIENTATION CODE (datadictionary.nhs.uk)

<table>
<tr><td>ETHNIC CATEGORY</td><td>Ethnicity, as specified by the person.

Codes [Z] – Not Stated, and [99] - Not Known should be applied as follows:

The [Z] Not Stated national code should only be used where the patient has been asked and has declined to provide their ethnic category because of refusal or the inability to choose.

The [99] Not Known national code should be used where the patient has not been asked or where the patient was not in a suitable condition to be asked.

Please note that the Ethnic Category data item is based on the 2001 Census code set. Locally, organisations can collect the 2021 codes but for CHC v1.0 these should be mapped to the current approved codes.</td></tr>
<tr><td>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE (NHS CONTINUING HEALTHCARE)</td><td>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE (NHS CONTINUING HEALTHCARE) is described as The RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION of a PERSON, as specified by a PERSON.

The Value list includes:

<table><tr><td>A</td><td>Baha'i</td></tr><tr><td>B</td><td>Buddhist</td></tr><tr><td>C</td><td>Christian</td></tr><tr><td>D</td><td>Hindu</td></tr><tr><td>F</td><td>Jewish</td></tr><tr><td>G</td><td>Muslim</td></tr><tr><td>H</td><td>Pagan</td></tr><tr><td>I</td><td>Sikh</td></tr><tr><td>J</td><td>Zoroastrian</td></tr><tr><td>K</td><td>Other</td></tr><tr><td>L</td><td>None</td></tr><tr><td>M</td><td>Declines to Disclose</td></tr><tr><td>N</td><td>Patient Religion Unknown</td></tr></table>
Please note NHS England is aware three codes from the data dictionary RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE list above are missing in the PLDS TOS (A Baha'I, H Pagan, and J Zoroastrian). These codes can still be used. Use of these codes will result in a national code error warning which can be disregarded. This is planned to be addressed in the future.</td></tr>
<tr><td>PERSON DEATH DATE</td><td>This must be submitted for any known death not only where a death certificate is issued.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
</table>

CHC101 Referral, Assessment and Outcome

CHC101 Referral, Assessment and Outcome

Description
This table contains information on the NHS CHC referral process (including screening / checklists), referrals, assessments, and outcomes (including those that result in FNC eligibility). The collection of these data items can be used to analyse screening and referral status, as well as eligibility decision outcomes. Providers should supply CHC101 data as it was at the end of the reporting period. Providers must populate all known data items in this table even if they are unchanged since the last submission. Do not just provide data for all "changed" data items. **Please note that the CHC101 table is mandatory and must be included in every submission file, along with the CHC001 table.** This table is to carry details of the screening and / or referral process that individuals are subject to. This table captures information on referrals (e.g. positive checklists, direct referrals, or Fast Track tools) or other types of notification (e.g. negative checklists, PUPoC Requests or Local Resolution Requests). One occurrence of this Group is permitted for each new service request. Table CHC101 should be provided for all cases for each reporting period they are open, even if there has been no activity during that reporting period (see page 14 for a definition of an open case).

Additional Notes on Data Items

Data Item Name	Additional Notes
SERVICE REQUEST IDENTIFIER	An identifier used to identify a referral or notification uniquely within a health care organisation. This is a linkage data item and the primary key that enables groups of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation. Duplicate Service Request Identifiers with the Service Referral group will cause the entire file to be rejected. Duplicate Service Request Identifiers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.
LOCAL PATIENT IDENTIFIER (EXTENDED)	This is a number used to identify a PATIENT uniquely within a health care organisation. It may be different from the PATIENT's case note number and may be assigned automatically by the computer system. This is not the NHS number.

<table>
<tr><td></td><td> This is a linkage data item and the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table. Patients should have the same Local Patient Identifier across successive submission periods to make reconciliation of data possible. </td></tr>
<tr><td>NHS CONTINUING HEALTHCARE ACTIVITY TYPE</td><td> Type of NHS Continuing Healthcare referral or notification. The value list includes:
<table>
<tr><td>01</td><td>NHS Continuing Healthcare (Standard)</td></tr>
<tr><td>02</td><td>NHS Continuing Healthcare (Fast Track)</td></tr>
<tr><td>03</td><td>NHS Continuing Healthcare Previously Unassessed Period of Care</td></tr>
<tr><td>04</td><td>NHS Continuing Healthcare Local Resolution</td></tr>
</table>
01 includes cases considered via the Standard NHS CHC process including those resulting from care package reviews. 01 may include Standard NHS CHC referrals (e.g. positive checklist or direct referral) or other types of Standard CHC notification (e.g. negative checklist).
02 includes cases that have been referred for NHS CHC via the fast-track process. The Fast Track tool is used where an appropriate clinician considers a person should be fast tracked for NHS CHC because they have a rapidly deteriorating condition which may be entering a terminal phase. The person may need NHS CHC funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting)
03 Previously Un-assessed Periods of Care (PUPoCs) are a specific request to consider eligibility for a past period of care, where there is evidence that the individual should have been assessed for eligibility for NHS CHC funding. PUPoCs may relate to either deceased or ongoing eligible cases. For example, an individual may be deceased, and their family may make a claim to consider eligibility for a past period of care in isolation, or an individual may be agreed eligible for Standard NHS CHC via the normal assessment route and also have a PUPoC request considered. In this case any data relating to the PUPoC should be recorded against its own unique Service Request ID using category 03. The Standard NHS CHC component should have a different Service Request ID using category 01 above.
04 Requests to review eligibility decisions via the Local Resolution (LR) process. LRs may relate to an initial standard NHS CHC assessment or a Previously Unassessed Period of Care (PUPoC) request. LRs may also result from 3 or 12 month reviews for Standard or Fast track NHS CHC cases. If a review results in a reassessment of eligibility (as set out in paragraphs 185 and 244 of the National Framework) this can result in an individual becoming no longer eligible and may therefore lead to an LR request. </td></tr>
</table>

<table>
<tr><td></td><td>Similar to 03 PUPoCs above, 04 LR requests should be recorded against their own unique Service Request ID separate to the Service Request ID for any initial assessment / care package they may relate to. When recording the date an LR request is received, use C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE). Do not use C101260 NHS CONTINUING HEALTHCARE REVIEW REQUEST RECEIVED DATE (see NHS CONTINUING HEALTHCARE REVIEW REQUEST RECEIVED DATE for further information).</td></tr>
<tr><td>REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE)</td><td>The date the REFERRAL REQUEST or NOTIFICATION was received by the ICB (or person or body acting on behalf of the ICB) with respect to the ICB’s CHC screening and referrals process.

If an eligible case is transferred from one responsible commissioner to another the receiving responsible commissioner can use the date they were notified of the transfer as the referral date. The eligibility decision date should be the date the receiving responsible commissioner verified responsibility for the case.

C101330 FUNDING START DATE (NHS CONTINUING HEALTHCARE) should then be completed according to the point at which the receiving responsible commissioner started to fund the care.

Note there are plans to introduce a referral type code for transferred cases for improved identification and recording of transferred cases in the future.</td></tr>
<tr><td>REFERRAL REQUEST OR NOTIFICATION TYPE (NHS CONTINUING HEALTHCARE STANDARD)</td><td>Type of referral request or notification type for STANDARD NHS CHC.

The value list includes:

<table><tr><td>01</td><td>NHS Continuing Healthcare Checklist</td></tr><tr><td>02</td><td>Direct Referral Request</td></tr></table>
An NHS Continuing Healthcare Checklist (01) is a screening tool which indicates whether a person requires referral for <u>assessment</u> for NHS Continuing Healthcare eligibility. Category 01 may include positive or negative checklists, including those resulting from care package reviews.

A direct referral request (02) is where a direct referral for assessment of CHC takes place without carrying out a checklist. Even though the usual route into CHC assessment is via a checklist screening there are scenarios in which individuals can go straight to DST assessment without completion of a checklist on the basis of clinical judgement. The ability to make direct referrals may be restricted to certain approved individuals sometimes referred to as ‘trusted assessor arrangements’.</td></tr>
</table>

<table>
<tr><td>SOURCE OF REFERRAL FOR NHS CONTINUING HEALTHCARE</td><td>The source of a REFERRAL REQUEST or notification. This could include the source of a referral for Standard CHC assessment, source of a negative checklist, or source of a Fast Track referral. Where a data provider has a more extensive list of referral sources, then they should be mapped to an appropriate value stated in the output data item list.

The value list includes:
<table>
<tr><td>01</td><td>General Medical Practitioner Practice</td></tr>
<tr><td>02</td><td>Acute Hospital Inpatient/Outpatient Department</td></tr>
<tr><td>03</td><td>Community Health Service (same or other Health Care Provider)</td></tr>
<tr><td>04</td><td>Local Authority Social Service</td></tr>
<tr><td>05</td><td>Hospice</td></tr>
<tr><td>06</td><td>Care Home</td></tr>
<tr><td>07</td><td>Mental Health Service</td></tr>
<tr><td>98</td><td>Other (not listed)</td></tr>
</table></td></tr>
<tr><td>REFERRING CARE PROFESSIONAL TYPE (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The type of CARE PROFESSIONAL who carried out the NHS Continuing Healthcare Checklist and referred the PATIENT for an NHS Continuing Healthcare (Standard) assessment or carried out a negative checklist.

The value list includes:
<table>
<tr><td>01</td><td>Occupational Therapist</td></tr>
<tr><td>02</td><td>Physiotherapist</td></tr>
<tr><td>03</td><td>General Medical Practitioner</td></tr>
<tr><td>04</td><td>District Nurse</td></tr>
<tr><td>05</td><td>Other Nurse</td></tr>
<tr><td>06</td><td>Social Care Worker</td></tr>
<tr><td>98</td><td>Other Care Professional (not listed)</td></tr>
</table></td></tr>
<tr><td>NHS CONTINUING HEALTHCARE STANDARD CHECKLIST COMPLETED DATE</td><td>Date on which the NHS Continuing Healthcare Standard Checklist was completed.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>NHS CONTINUING HEALTHCARE FAST TRACK PATHWAY TOOL COMPLETED DATE</td><td>The date the Fast-Track tool was completed by an appropriate clinician.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
</table>

<table>
<tr><td>PATIENT LOCATION (NHS CONTINUING HEALTHCARE CHECKLIST)</td><td>Location of the Patient i.e. the setting in which the Checklist was carried out.

The value list includes:

01 Own Home
02 General Medical Practitioner Practice
03 Acute Hospital Ward
04 Non-acute Hospital Ward
05 Care Home with Nursing
06 Care Home Without Nursing
07 Hospice
98 Other (not listed)</td></tr>
<tr><td>APPROPRIATE CLINICAL STAFF GROUP COMPLETING NHS CONTINUING HEALTHCARE FAST TRACK PATHWAY TOOL</td><td>This will indicate the staff group of the appropriate clinician that completed the Fast-Track tool.

The value list includes:

01 Registered Nurse
02 Registered Medical Practitioner</td></tr>
<tr><td>REFERRAL OR NOTIFICATION OUTCOME (NHS CONTINUING HEALTHCARE STANDARD)</td><td>Outcome of direct referral or checklist.

The value list includes:

01 Refer for full NHS Continuing Healthcare (Standard) assessment
02 Do not refer for full NHS Continuing Healthcare (Standard) assessment but eligible for NHS-funded Nursing Care
03 Do not refer for full NHS Continuing Healthcare (Standard) assessment and not eligible for NHS-funded Nursing Care</td></tr>
<tr><td>REFERRAL REQUEST DISCOUNTED REASON (NHS CONTINUING HEALTHCARE)</td><td>The reason the referral request for NHS Standard Continuing Healthcare or Fast Track was discounted by the Commissioner.

This data item only relates to referrals for assessment received by the Commissioner and does not relate to negative checklists. In the case of ‘positive’ checklist referrals received which turn out to be false positives (i.e. ‘positive’ checklist received but further quality assurance of the paperwork identifies that the checklist is in fact negative) these should be counted under ’04 Inappropriate referral request'.

The value list includes:

01 Patient deceased (fully funded at time of death)
02 Patient placed on fully funded interim care
03 Patient requiring further Acute treatment
04 Inappropriate referral request
05 Referral request withdrawn by patient/family
06 Other (not listed)</td></tr>
</table>

<table>
<tr><td></td><td>Please note that category ‘01 Patient deceased (fully funded at time of death)’ can be used for other valid circumstances in which a patient deceasing results in an NHS CHC referral being discounted e.g. where a local authority or the individual has funded services whilst awaiting assessment but the individual passes away within 28 days from the point of referral (the National Framework sets out NHS CHC payments would still need to be made for eligible cases that exceed 28 days referral time to cover costs of services from day 29 onwards).

Discounted cases may also include those discounted after assessment has taken place e.g. an individual is agreed eligible for NHS CHC but the patient or individual decide to withdraw from the process.</td></tr>
<tr><td>REFERRAL REQUEST DISCOUNTED DATE (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The date the referral request for NHS Standard CHC or Fast Track was discounted by the Commissioner.

This should be recorded in the eGIF Date format CCYY-MM-DD.

Users of the data set and this document should be aware that the data item name, TOS data item description and XML Schema Element Name for this item reference Standard CHC however this field can also be used for recording the discounted date for Fast Track referrals. Potential update to these items to reflect this will be reviewed in the future.</td></tr>
<tr><td>REFERRAL REQUEST ACCEPTED DATE (NHS CONTINUING HEALTHCARE FAST TRACK)</td><td>The date the Commissioner accepted the Fast-Track referral.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>PATIENT SETTING DECISION SUPPORT TOOL COMPLETED (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The setting of the patient at the time the Decision Support Tool was completed by the Multidisciplinary Team for NHS Standard Continuing HealthCare.

The value list includes:
<table><tr><td>01</td><td>Patient in an Acute Hospital</td></tr><tr><td>02</td><td>Patient not in an Acute Hospital</td></tr></table>
Acute care in a hospital is where a patient receives active short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. It is different from chronic care or longer-term care.

‘Acute hospital setting’ does not include those people in step down beds, community beds or people in a rehabilitation setting. Once someone moves into a step-down bed this is classed as interim arrangements as outlined in the National Framework and a checklist should only be completed once the individual has met their potential.

Where step down beds have been purchased from acute providers for the purposes of rehabilitation or reablement it is expected that this would not constitute an ‘acute hospital setting’.</td></tr>
</table>

<table>
<tr><td></td><td>Specialist rehabilitation centres (e.g., Spinal Cord Injury Centres) would also not constitute an acute hospital setting.</td></tr>
<tr><td>DECISION SUPPORT TOOL COMPLETED DATE (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The date on which the Multidisciplinary Team met with the patient to complete the Decision Support Tool for NHS Standard Continuing HealthCare.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>MULTIDISCIPLINARY TEAM RECOMMENDATION (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The recommendation of the Multidisciplinary Team once the Decision Support Tool has been completed for NHS Standard Continuing HealthCare.

The value list includes:

01 – Patient recommended for NHS Continuing Healthcare (Standard)
02 – Patient recommended for NHS-funded Nursing Care
03 – Patient recommended as not eligible</td></tr>
<tr><td>RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION DATE (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The date the Commissioner reached an eligibility decision for NHS Standard Continuing Healthcare.

This data item should also be used for NHS CONTINUING HEALTHCARE ACTIVITY TYPE ’04 NHS Continuing Healthcare Local Resolution’ to record the date of decision for a Local Resolution.

This data item can also be used for eligible cases that transfer from one responsible commissioner to another to capture the date the receiving responsible commissioner verified responsibility for the case.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION OUTCOME (NHS CONTINUING HEALTHCARE STANDARD)</td><td>The eligibility decision agreed by the Commissioner for NHS Standard Continuing Healthcare.

The value list includes:

01 – Eligible for NHS Continuing Healthcare (Standard)
02 – Eligible for NHS-funded Nursing Care
03 – Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care</td></tr>
<tr><td>RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION OUTCOME COMMUNICATED TO PATIENT DATE (NHS CONTINUING</td><td>The date the eligibility decision outcome was communicated in writing to the patient for NHS Standard Continuing Healthcare.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
</table>

HEALTHCARE STANDARD)	
START DATE REQUESTED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)	The start date requested for a Previously Unassessed Period of Care (PUPoC) which the Commissioner has been requested to review. This should be recorded in the eGIF Date format CCYY-MM-DD If an individual has a referral for Standard NHS CHC *and* a PUPoC request, the PUPoC should be recorded against its own unique Service Request ID separate to the Standard NHS CHC Service Request ID (see previous section 'NHS Continuing Healthcare Activity Type' category 03 for further information).
END DATE REQUESTED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)	The end date requested for the PUPoC period which the Commissioner has been requested to review. This should be recorded in the eGIF Date format CCYY-MM-DD
START DATE AGREED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)	The start date of eligibility agreed for a Previously Unassessed Period of Care (PUPoC). This should be recorded in the eGIF Date format CCYY-MM-DD. This should relate to the start date of eligibility within the period of care reviewed not the date the PUPoC was agreed eligible.
END DATE AGREED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)	The end date of eligibility agreed for a Previously Unassessed Period of Care (PUPoC). This should be recorded in the eGIF Date format CCYY-MM-DD. This should relate to the end date of eligibility within the period of care reviewed.
NHS CONTINUING HEALTHCARE REVIEW REQUEST RECEIVED DATE	**Please note this field does not need to be completed.** Please do not use this field and use C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) instead. Local Resolution (LR) requests should be recorded against their own unique Service Request ID separate to the Service Request ID for any initial assessment they may relate to. When recording the date an LR request is received, create a new C101010 SERVICE REQUEST IDENTIFIER and use C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) in combination with C101030 NHS CONTINUING HEALTHCARE ACTIVITY TYPE '04 NHS Continuing Healthcare Local Resolution'. Users of the data set and this document should be aware that 'NHS Continuing Healthcare Review Request Received Date' is a duplicate method to record the date an LR request is received. This will be reviewed for a future release of the data set.

<table>
<tr><td></td><td>This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>NHS CONTINUING HEALTHCARE LOCAL RESOLUTION INFORMAL MEETING DATE</td><td>The date on which the Informal Local Resolution Meeting took place.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>NHS CONTINUING HEALTHCARE LOCAL RESOLUTION FORMAL MEETING DATE</td><td>The date on which the Formal Local Resolution Meeting took place.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>RESPONSIBLE COMMISSIONER GROUP REVIEW ELIGIBILITY DECISION OUTCOME (NHS CONTINUING HEALTHCARE)</td><td>This is the eligibility decision agreed by the Responsible Commissioner following the Local Resolution request for review.

The value list includes:
<table>
<tr><td>01</td><td>Eligible for NHS Continuing Healthcare (Standard)</td></tr>
<tr><td>02</td><td>Eligible for NHS Continuing Healthcare (Fast Track)</td></tr>
<tr><td>03</td><td>Eligible for NHS-funded Nursing Care</td></tr>
<tr><td>04</td><td>Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care</td></tr>
<tr><td>05</td><td>Request discounted for NHS Continuing Healthcare</td></tr>
</table>

A date of decision should also be recorded using either C101190 RESPONSIBLE COMMISSIONER ELIGIBILITY DECISION DATE NHS CONTINUING HEALTHCARE STANDARD.</td></tr>
<tr><td>LOCAL RESOLUTION START DATE (NHS CONTINUING HEALTHCARE)</td><td>This is the start date of the period for which the individual has been found eligible following a Local Resolution request.

This should be recorded in the eGIF Date format CCYY-MM-DD</td></tr>
<tr><td>LOCAL RESOLUTION END DATE (NHS CONTINUING HEALTHCARE)</td><td>This is the end date of the period for which the individual has been found eligible following a Local Resolution request.

This should be recorded in the eGIF Date format CCYY-MM-DD.

Only required if eligibility has now come to an end, e.g., in the case of an individual who has now passed away.</td></tr>
<tr><td>LOCAL RESOLUTION ELIGIBILITY DECISION OUTCOME COMMUNICATED TO PATIENT DATE (NHS CONTINUING HEALTHCARE)</td><td>This is the date the ELIGIBILITY DECISION OUTCOME following the Local Resolution REQUEST FOR REVIEW was communicated in writing to the patient.

This should be recorded in the eGIF Date format CCYY-MM-DD.</td></tr>
</table>

FUNDING START DATE (NHS CONTINUING HEALTHCARE)	This is the start date from which the individual's care was funded from by the responsible commissioner (and therefore the date that eligibility started), including any backdated funding. This is the start date the funding / eligibility relates to not the date the funding actually gets paid (e.g. an invoice might come in 6 weeks after funding / eligibility started but relates to care with a funding start date 6 weeks prior). Funding Start Date is also not the date eligibility is agreed (which in the case of a Standard NHS CHC case would be recorded under RESPONSIBLE COMMISSIONER GROUP ELIGIBILITY DECISION DATE). If a Service Request relates to an assessment or reassessment following a care package review, and the outcome of that assessment is no change to eligibility, Funding Start Date can be left blank (as existing eligibility attached to the original Service Request ID still stands). Please see FAQs for further information. If an eligible case is transferred from one responsible commissioner to another, then Funding Start Date should be completed according to the point at which the receiving responsible commissioner started to fund the care. In this scenario C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) also needs to be obtained and completed according to the date of the **original** referral to the originating responsible commissioner (see REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) for further information). The **original eligibility** decision date should also be obtained from the originating responsible commissioner and included in the new record set up by the receiving responsible commissioner. This should be recorded in the eGIF Date format CCYY-MM-DD
FUNDING END DATE (NHS CONTINUING HEALTHCARE)	Last date on which the individual's care was funded to and therefore the date that eligibility ended. This is the end date the funding / eligibility relates to not the date the funding actually stops getting paid (e.g. a funding end date may come before a final invoice actually gets paid). In some cases, Funding End Date may fall after an individual has died (for example, if a care home charges a few days extra to allow for removal of personal possessions). This should be recorded in the eGIF Date format CCYY-MM-DD
NHS CONTINUING HEALTHCARE ELIGIBILITY START DATE FOLLOWING INDEPENDENT REVIEW	This is the date NHS CHC eligibility begins for a person found eligible for NHS CHC following an independent review process. Note this also covers Independent Review cases that have been found eligible following a Parliamentary Health Service Ombudsman review. Independent Review (IR) **requests** are not captured as part of this data set however this field is a means to capture cases that have become eligible following an Independent Review (and a not eligible Local Resolution). Please note this field only needs to be populated for IR cases agreed eligible where at least some of the period of eligibility falls within the current reporting year. Historical cases agreed eligible in the reporting year relating to periods of care falling wholly in

	previous reporting years do not need to be included. There are currently no data validations preventing submission of such cases but they will be omitted from reporting outputs and top line activity measures such as number of eligible CHC cases year to date. A case should normally go through Local Resolution before going to Independent Review, therefore the Independent Review field (if applicable as per above) should be attached to the service request ID for the associated Local Resolution. This should be recorded in the eGIF Date format CCYY-MM-DD. Users of the data set and this document should be aware that the XML Schema Element Name for this item ('DateEligibilityBeginsLocalResolution') references Local Resolution instead of Independent Review. This will be reviewed for a future release of the data set.
NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION MADE DATE	The date the OUTCOME OF THE REQUEST FOR a Previously Unassessed Period of Care (PUPoC) was made by the ICB. This should be recorded in the eGIF Date format CCYY-MM-DD
NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION OUTCOME	This is the ELIGIBILITY DECISION agreed by the ICB following the REQUEST FOR PUPoC (Previously Unassessed Period of Care) **The value list includes:** 01 – Eligible for NHS Continuing Healthcare for the full period claimed 02 – Eligible for NHS Continuing Healthcare for part of the period claimed 03 – Not Eligible for NHS Continuing Healthcare 04 – Request for NHS Continuing Healthcare Previously Unassessed Period of Care discounted
NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE ELIGIBILITY DECISION COMMUNICATED TO REQUESTER DATE	This is the date the ELIGIBILITY DECISION OUTCOME following the REQUEST FOR PUPoC was communicated in writing to the individual that made the request. This should be recorded in the eGIF Date format CCYY-MM-DD

CHC102 Care Package

CHC102 Care Package

Description	
This table contains information on care package, type of services commissioned, start and end dates of care package and related financial codes for the package. The collection of these data items can be used to analyse details of care packages agreed and commissioned for eligible NHS CHC or eligible FNC cases. Providers should supply CHC102 data as it was at the end of the reporting period. Providers must populate all known data items in this table even if they are unchanged since the last submission. Do not just provide data for all "changed" data items. One occurrence of this Group is permitted for each Care Package. Table CHC102 should be provided for all open cases for each reporting period they are open, even if there has been no activity during that reporting period (see page 14 for a definition of an open case).	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE)	The unique identifier for a CARE PACKAGE for the individual. It would normally be automatically generated by the local system upon recording a new care package, although could be manually assigned. If an individual's overall package of commissioned care is made up of different aspects, or care from different providers, it's possible for these to be recorded against different Care Package IDs. Examples of where multiple care package IDs may be recorded include (but are not limited to): • Two or more providers supply care as part of the overall commissioned package of care • Different aspects of the overall commissioned package of care are delivered by different PHB types e.g. part direct payment and part notional • Additional one-to-one support is supplied either by a different provider from the main care provision, or by the same provider as the main care provision (but there is a preference to split the one-to-one element out onto a separate care package ID rather than to record on the same care package ID as the main provision). This is a linkage data item and the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table. Users of the data set and this document should be aware that a number of the data item names, TOS data item descriptions, and XML Schema Element Names throughout the CHC102 Care Package Table reference 'NHS Continuing Healthcare' however this table can also be used for FNC packages. Potential update to the terminology to reflect this will be reviewed in the future.

<table>
<tr><td>SERVICE REQUEST IDENTIFIER</td><td>The unique identifier for a SERVICE REQUEST.

It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.

This is a linkage data item and the primary key that enables groups of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this group.

Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.

Duplicate Service Request Identifiers with the Service Referral group will cause the entire file to be rejected. Duplicate Service Request Identifiers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.</td></tr>
<tr><td>CARE PACKAGE START DATE (NHS CONTINUING HEALTHCARE)</td><td>The date that the CHC care package commenced.

This should be recorded in the eGIF Date format CCYY-MM-DD.

This is a mandated item.</td></tr>
<tr><td>CARE PACKAGE END DATE (NHS CONTINUING HEALTHCARE)</td><td>The date on which the care package ended.

This should be recorded in the eGIF Date format CCYY-MM-DD.</td></tr>
<tr><td>PERSONAL HEALTH BUDGET TYPE</td><td>Type of personal health budget which funds the care package.

The value list includes:
<table><tr><td>01</td><td>Direct payment</td></tr><tr><td>02</td><td>Notional payment</td></tr><tr><td>03</td><td>Third party payment</td></tr><tr><td>04</td><td>Not funded by Personal Health Budget</td></tr></table>
If a package of care is funded via multiple methods – e.g. part direct payment, part notional – this should be recorded against different Care Package IDs according to the respective commissioning arrangements (see CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) above for more information).</td></tr>
<tr><td>ORGANISATION IDENTIFIER (CODE OF PROVIDER)</td><td>A unique identifier for an ORGANISATION providing the care package (as per the ODS portal https://odsportal.digital.nhs.uk/). Note not all organisations will have a registered ID, where not ORGANISATION NAME (CARE PROVIDER) must be provided. Where available and required if ORGANISATION NAME (CARE PROVIDER) not submitted.</td></tr>
<tr><td>ORGANISATION NAME (HEALTH CARE PROVIDER)</td><td>Name of the Organisation care provider (as per the ODS portal https://odsportal.digital.nhs.uk/). Where available and required if ORGANISATION IDENTIFIER (CODE OF PROVIDER) is not submitted.</td></tr>
</table>

<table>
<tr><td>POSTCODE OF HEALTH CARE PROVIDER</td><td>Postcode of care provider.</td></tr>
<tr><td>COST CENTRE CODE (NHS CONTINUING HEALTHCARE)</td><td>The Integrated Single Finance System (ISFE) cost/revenue code for the ‘department’ with budgetary responsibility for this care package.

For more information on Cost Centre Code (NHS Continuing Healthcare), please see

the Future NHS Collaboration Platform* for detailed guidance.

https://future.nhs.uk/OIforC/view?objectId=29838160

* Registration is required for the Future NHS Collaboration platform, prior to accessing this guidance.

and
https://datadictionary.nhs.uk/attributes/cost_centre_code_for_nhs_continuing_healthcare.html?hl=cost%2Ccentre%2Ccode</td></tr>
<tr><td>SUBJECTIVE CODE (NHS CONTINUING HEALTHCARE)</td><td>The Integrated Single Finance System (ISFE) code that describes the type of revenue/cost/asset/liability being reported for this care package.

For more information on Subjective Code (NHS Continuing Healthcare), please see

the Future NHS Collaboration Platform* for detailed guidance.

https://future.nhs.uk/OIforC/view?objectId=29838160

* Registration is required for the Future NHS Collaboration platform, prior to accessing this guidance.

and
https://datadictionary.nhs.uk/attributes/cost_centre_code_for_nhs_continuing_healthcare.html?hl=cost%2Ccentre%2Ccode</td></tr>
<tr><td>CARE PRODUCT TYPE (NHS CONTINUING HEALTHCARE)</td><td>The type of service which is being funded by the care package.

The value list includes:
<table>
<tr><td>01</td><td>Care Home with Nursing</td></tr>
<tr><td>02</td><td>Care Home Without Nursing</td></tr>
<tr><td>03</td><td>Hospice</td></tr>
<tr><td>04</td><td>Other Type of Placement</td></tr>
<tr><td>05</td><td>NHS Continuing Healthcare Funded Home Care</td></tr>
<tr><td>06</td><td>NHS Continuing Healthcare Funded Care in Supported Housing</td></tr>
<tr><td>07</td><td>Day Care Facility</td></tr>
<tr><td>08</td><td>NHS Continuing Healthcare Funded Transport</td></tr>
<tr><td>09</td><td>NHS Continuing Healthcare Funded Therapy Service</td></tr>
<tr><td>10</td><td>NHS Continuing Healthcare Funded Equipment</td></tr>
<tr><td>11</td><td>NHS-funded Nursing Care Standard Rate</td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td>
<table>
<tr><td>12</td><td>NHS-funded Nursing Care High Rate</td></tr>
<tr><td>13</td><td>Other Non-Placement Care Package not included in National Codes 05 to 12</td></tr>
</table>
For further information and definitions on these categories please see Appendix C ‘Care Product Type Categories and Definitions’.
Types 01-04 are ‘Placement’ types. This is where a client resides in the establishment where the care is provided as part of the care package (as opposed to Home Care which is provided in a client’s own home/usual place of residence.
Types 05-13 are ‘Non-Placement’ types. This is where care is delivered either to a client’s own home/usual place of residence/a setting as if it were their own home or at a care setting where the client is not resident.
The most appropriate care product type should be selected for the service provided by the care package. Where the care package incorporates elements of more than one care product type, then the product type should be selected to correspond to the main element of the package e.g. where Therapy Services are an integral part of a NHS Continuing Healthcare Funded Home Care service, and delivered to the individual at their own home, and therefore not commissioned or identifiable as a separate aspect of commissioned care, and the main element of the care relates to NHS Continuing Healthcare Funded Home Care, this Care Product Type should be selected. If an aspect of commissioned care is commissioned or identifable separately (e.g. Therapy Services are commissioned from a different provider and delivered at a different location) then this can be recorded against a different Care Package ID (see CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) above for further information).
</td>
</tr>
<tr>
<td>CONTRACT UNIT COST (NHS CONTINUING HEALTHCARE)</td>
<td>
The contract cost per frequency unit of the care package.
Where the Contract Unit Cost is not available due to a block contract arrangement which is in place, please refrain from submitting a value within this dataset field; otherwise please populate the contract unit cost value accordingly.
Please note that this item should be submitted as a whole number, not a decimal. Any decimal values should be rounded to the nearest whole number for submission purposes.
</td>
</tr>
<tr>
<td>CONTRACT UNIT FREQUENCY CODE (NHS CONTINUING HEALTHCARE)</td>
<td>
The unit of frequency for which the CONTRACT UNIT COST applies.
The value list includes:
<table>
<tr><td>01</td><td>One-off cost</td></tr>
<tr><td>02</td><td>Hourly</td></tr>
<tr><td>03</td><td>Daily</td></tr>
<tr><td>04</td><td>Weekly</td></tr>
<tr><td>05</td><td>Other frequency</td></tr>
</table>
Wherever possible, care packages should be expressed as an hourly or weekly rate and daily rates should <u>only</u> be used where it is not possible to break the care delivery down to an hourly rate.
</td>
</tr>
</table>

<table>
<tr><td>NUMBER OF COMMISSIONED WEEKLY HOURS OF CARE (NHS CONTINUING HEALTHCARE)</td><td>The number of hours of care per week the care provider is contracted to supply.

Not required if CONTRACT UNIT is 'One-off cost' where recording by weekly hours is not applicable e.g. equipment.

Please note if CARE PRODUCT TYPE (NHS CONTINUING HEALTHCARE) is ‘11 NHS-funded Nursing Care Standard Rate’ or ’12 NHS-funded Nursing Care High Rate’ this field can be left blank.

Where the Care Product Type (NHS Continuing Healthcare) is a placement (e.g. 01-04) and the individual resides at the place of care as if it were their own home, the number of commissioned weekly hours of care would normally be expected to be submitted (i.e. 24 hours x 7 days a week).

However, it is also recognised there may be scenarios in which weekly hours of care exceed 168 hours within a given care package ID e.g.:

• Additional one-to-one care is provided over and above a 24-hour placement from the same provider.

• A complex case which may require multiple carers for the same individual from the same provider e.g. 2:1 or 3:1 care 24 hours a day, 7 days a week

In these types of scenarios, it is acceptable for weekly hours of care to exceed 168 hours.

It is also possible for an individual’s overall package of commissioned care to be made up of different aspects or care from different providers. Where required these can be recorded against different Care Package IDs (see CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE) above for further information).

In the case of multiple care package IDs it’s also the case that total care package hours may exceed 168 in certain scenarios e.g. a main care provision for a commissioned bed in accommodation may be 24 hours a day (168 hours a week), and additional 1:1 support captured against a separate Care Package ID is 35 hours.

Alternatively, if for example, the care package is a Nursing placement and 1:1 care is invoiced via this same nursing home as part of the overall package, and not identifiable separately, then users may want to add both elements of care under the same Care Package ID submitted as 168 hours with the cost for both elements.</td></tr>
</table>

CHC103 Review

CHC103 Review
Description
This table contains information on care package reviews (including Standard CHC, Fast Track CHC and FNC) and associated outcomes. The collection of these data items can

be used to analyse the review period, the review date, outcome of the review and track any eligibility status changes.

Providers should supply CHC103 data as it was at the end of the reporting period.

Providers must populate all known data items in this table even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.

To carry details of the reviews undertaken for the person.

One occurrence of this Group is permitted for the most recent Review that has taken place.

Table CHC103 is non-episodic, i.e., contains no start and end dates. Each review is captured as a distinct activity and should only be submitted in the reporting period when the activity took place.

Additional Notes on Data Items

Data Item Name	Additional Notes
CARE PACKAGE IDENTIFIER (NHS CONTINUING HEALTHCARE)	The unique identifier (ID) for a CARE PACKAGE for the individual. It would normally be automatically generated by the local system upon recording a new care package, although could be manually assigned. This is a linkage data item and the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table. Users of the data set and this document should be aware that all the data item names, TOS data item descriptions, and XML Schema Element Names throughout the CHC103 Review Table all reference 'NHS Continuing Healthcare' however this table can also be used for FNC reviews. Potential update to the terminology to reflect this will be reviewed in the future. Where an individual's total commissioned care is made up of multiple Care Package IDs, any one active Care Package ID can be entered for the Review (i.e. users do not need to replicate the same Review information multiple times against each Care Package ID).
CARE PACKAGE REVIEW TYPE (NHS CONTINUING HEALTHCARE)	An Indicator to show whether this is a 3-month, 12 month or other/ad hoc review. This is a mandated item. **The value list includes:** 01 – Three months review 02 – Twelve months review 03 – Other/Ad Hoc review
CARE PACKAGE REVIEW DATE (NHS CONTINUING HEALTHCARE)	The date the REVIEW of the CARE PACKAGE took place. This should be recorded in the eGIF Date format CCYY-MM-DD.

CARE PACKAGE REVIEW OUTCOME CODE (NHS CONTINUING HEALTHCARE)	**Please note this field does not need to be completed.** Users of the data set and this document should be aware that C103040 'CARE PACKAGE REVIEW OUTCOME CODE (NHS CONTINUING HEALTHCARE)' is not currently required for submission. This field will be reviewed and considered for removal in a future release of the data set.
CARE PACKAGE REVIEW ELIGIBILITY OUTCOME (NHS CONTINUING HEALTHCARE)	**Please note this field does not need to be completed.** Users of the data set and this document should be aware that C103050 'CARE PACKAGE REVIEW ELIGIBILITY OUTCOME (NHS CONTINUING HEALTHCARE)' is not currently required for submission. This field will be reviewed and considered for removal in a future release of the data set.
CARE PACKAGE ELIGIBILITY STATUS CHANGE DATE (NHS CONTINUING HEALTHCARE)	**Please note this field does not need to be completed.** Users of the data set and this document should be aware that C103060 'CARE PACKAGE ELIGIBILITY STATUS CHANGE DATE (NHS CONTINUING HEALTHCARE)' is not currently required for submission. This field will be reviewed and considered for removal in a future release of the data set. In the interim please be aware that leaving this field blank may generate a 'warning' message but these messages can be disregarded and won't prevent submission.
CARE PACKAGE NEXT PLANNED REVIEW DATE (NHS CONTINUING HEALTHCARE)	**Please note this field does not need to be completed.** Users of the data set and this document should be aware that C103070 'CARE PACKAGE NEXT PLANNED REVIEW DATE (NHS CONTINUING HEALTHCARE)' is not currently required for submission. Users may still wish to retain and use this field locally for operational planning purposes (e.g. to plan Reviews to take place at the appropriate time) but it will not be used for national reporting purposes. This field will be reviewed and considered for removal in a future release of the data set.

Appendix A – Summary of Changes

Below is the summary of changes made to NHS CHC PLDS User Guidance since the initial published version (v0.4)

<table>
<tr><td>V 1.0</td><td>25/03/2022</td><td>Amended following discussion with NHS E&I. Additional guidance added to Inclusion Rules under Section 4 explaining PLDS resubmission criteria, and to add additional guidance to Section 5 for specific data items, as follows:

Section 5 CHC001 Master Patient Index
Description updated guidance on reporting and managing deviations when documenting protected characteristics

Section 5 CHC101 Referral, Assessment and Outcome
C101040 Referral Request Or Notification Received Date: Updated guidance on how to obtain a referral date when a case is transferred from one commissioner to another. Which also affects C101330 FUNDING START DATE

C101190 Responsible Commissioner Eligibility Decision Date & C101360 Previously Unassessed Period Of Care Decision Made Date: Clarity added for when reporting C101030 Activity type - 04 relating to PUPoC cases.

C101260 NHS Continuing Healthcare Review Request Received Date: Deletion of duplicate sentence.

C101290 Responsible Commissioner Review Eligibility Decision Outcome: Extra guidance regarding where to record Eligibility Decision dates dependant on the outcome.

C101330 Funding Start Date: Clarification on when to record the Funding Start Date

C101340 Funding End Date: Additional information regarding deceased individuals

CHC103 Review
Notes were added to highlight fields that don’t currently need completing and are under review. These fields are:
C103040 Care Package Review Outcome Code
C103050 Care Package Review Eligibility Outcome
C103060 Care Package Eligibility Status Change Date

Inclusion of Appendix D Historical Data / Legacy Based Systems
Updates to general formatting of the document and tables.</td></tr>
<tr><td>V 1.2</td><td>27.05.2022</td><td>Amended following discussion with NHS E&I.
Wording changes for Funded Nursing Care, throughout guidance document. Adding clarification around FNC to various sections to stop ambiguity.

Changes to term the patient, referring instead to individual as per local suggestion.

Inclusion Rules Activity definitions relocated to page 15/16.</td></tr>
</table>

		Resubmitting Data Further information on resubmissions added. **Activity Type Scenario Tables page 17 onward** Clarity provided for Referral Request Discounted Reason and Funding End Date fields. Updated description for ICB Eligibility Outcome Removal of Care Package Review Eligibility Outcome Previously Unassessed Period Of Care Decision Outcome clarity for use of Code 03. Responsible Commissioner Review Eligibility Decision Outcome clarity for use of Code 03. **Section 5 CHC101 Referral, Assessment and Outcome** Description updated to include FNC references and additional section explaining what activity to capture in this section. C101130 Referral Request Discounted Reason additional section explaining code 01 Patient deceased. **CHC102 Care Package** Description updated to include FNC references and additional section explaining what activity to capture in this section. C102140 Number Of Commissioned Weekly Hours Of Care Guidance updated on how to capture commissioned weekly hours. **CHC103 Review** Updated description to specify when a review is to be capture in this section. C103010 Care Package Identifier Clarification on reporting multiple care packages. **Appendix D Historical data/legacy-based systems** Active referrals bullet point edited, and additional section added around re submissions.
V 1.3	12/01/2023	Wording changes for Funded Nursing Care, throughout guidance document. Adding clarification around FNC to various sections to stop ambiguity. **Data submission examples** Further information on CHC103 Review table added **Service Request Type: 01 NHS Continuing Healthcare (Standard)** Further information added to ICB ELIGIBILITY DECISION OUTCOME (NHS CONTINUING HEALTHCARE STANDARD) Reference to no active local resolution or independent review activity attached to case is deleted for FUNDING END DATE (NHS CONTINUING HEALTHCARE) **CHC101 Referral, Assessment and Outcome** 01 NHS Continuing Healthcare (Standard/Checklist) amended to include those resulting from care package reviews.

		PATIENT SETTING DECISION SUPPORT TOOL COMPLETED (NHS CONTINUING HEALTHCARE STANDARD) - Definition of Acute hospital setting is added to provide additional clarity FUNDING START DATE (NHS CONTINUING HEALTHCARE) amended when the outcome of that assessment has no change to eligibility. NHS CONTINUING HEALTHCARE ELIGIBILITY START DATE FOLLOWING INDEPENDENT REVIEW amended to include cases where eligibility falls within the current reporting year. Additional information relating to historical cases; and where cases have Local Resolution before going to Independent Review or Independent Review without a Local Resolution. **CHC102 Care Package** Additional information where an individual's overall package of commissioned care is made up of different aspects, or care from different providers. Type of personal health budget which funds the care package revised. The number of hours of care per week the care provider is contracted to supply revised to provide clarity. **CHC103 Review** The date the REVIEW of the CARE PACKAGE took place is now required. CARE PACKAGE NEXT PLANNED REVIEW DATE (NHS CONTINUING HEALTHCARE) does not need to be completed **Appendix B Counting Transition Cases within the NHS CHC PLDS** transition cases collected in the PLDS amended in line with data validation **Appendix D Historical data/legacy-based systems** record and submit dummy date/dates against historical data / data held in legacy-based systems edited to encourage best practice approach with least negative impact where date is not known **Appendix E – Abbreviations and Glossary** definition for 28 days referral time added
V1.4	30/06/2023	**CHC101 Referral, Assessment and Outcome** NHS CONTINUING HEALTHCARE ACTIVITY TYPE – Clarification added to 03 Previously Un-assessed Periods of Care (PUPoCs) that only qualified PUPoC requests are in scope of the PLDS.

		REFERRAL REQUEST OR NOTIFICATION TYPE (NHS CONTINUING HEALTHCARE STANDARD) – Definition for '02 Direct Referral Request' added and '01 NHS Continuing Healthcare Checklist' definition expanded. REFERRAL REQUEST DISCOUNTED REASON (NHS CONTINUING HEALTHCARE) – Further information added to clarify discounted cases may also include those discounted after assessment has taken place e.g. an individual is agreed eligible for NHS CHC but the patient or individual decide to withdraw from the process. NHS CONTINUING HEALTHCARE ELIGIBILITY START DATE FOLLOWING INDEPENDENT REVIEW – Previous information on cases which go straight to Independent Review removed due to being incorrect (A case should normally go through Local Resolution before going to Independent Review). **CHC103 Review** CARE PACKAGE NEXT PLANNED REVIEW DATE (NHS CONTINUING HEALTHCARE) – Further information added to clarify that although this field does not need to be completed for the purposes of the PLDS, users may still wish to retain and use this field locally for operational planning purposes (e.g. to plan Reviews to take place at the appropriate time).
V1.5	13/02/24	**General** Removal of references to 'NHS Digital' and references to 'NHS England and Improvement' changed to 'NHS England'. References to 'Clinical Commissioning Groups' also changed to 'Responsible Commissioner. **4 Constructing Submission Files** Description of 'required' data items updated. **Data submission examples** 'Review (New)' description updated and 'Review (Update to existing' removed to reflect resubmission of reviews is now possible (in the event records were missed from a prior submission). Service Request Type tabled examples updated based on examples where a Service Request is considered to be 'open' (and therefore should be included in submission) in place of previous examples based on where a Service Request is considered to be 'closed' (and therefore shouldn't be included). **Religious Or Other Belief System Affiliation Group Code (NHS Continuing Healthcare)** Note included to flag NHS England is aware three codes from the data dictionary RELIGIOUS OR OTHER BELIEF SYSTEM

		AFFILIATION GROUP CODE list above are missing in the PLDS TOS. **NHS Continuing Healthcare Activity Type** 03 Previously Un-assessed Periods of Care (PUPoCs) text updated. **Referral Request or Notification Received Date (NHS Continuing Healthcare)** Advice updated for if an eligible case is transferred from one responsible commissioner to another. The eligibility decision date can be the date the receiving responsible commissioner verified responsibility for the case (rather than the original eligibility date under the prior responsible commissioner). Note included to flag there are plans to introduce a referral type code for transferred cases for improved identification and recording of transferred cases in the future. **Responsible Commissioner Eligibility Decision Date (NHS Continuing Healthcare Standard)** Advice removed to use C101360 NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION MADE DATE if for a Local Resolution relating to a PUPoC rather than a Standard NHS CHC assessment. Advice added that this data item can also be used for eligible cases that transfer from one responsible commissioner to another to capture the date the receiving responsible commissioner verified responsibility for the case. **Responsible Commissioner Review Eligibility Decision Outcome (NHS Continuing Healthcare)** Advice removed to use C101360 NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE DECISION MADE DATE if for a Local Resolution relating to a PUPoC rather than a Standard NHS CHC assessment. **NHS Continuing Healthcare Previously Unassessed Period Of Care Decision Made Date** Advice removed to use this data item to capture the date of decision for a Local Resolution related to a PUPoC.

Appendix B – Counting Transition Cases within the NHS CHC PLDS

1. What are transition cases?

Transition cases refer to children and young people (under 18 years of age) that may potentially transition to adult NHS CHC services. ICBs and local authorities should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency. In such cases any future entitlement to adult NHS CHC should be clarified as early as possible in the transition planning process. This means that young people who may transition into adult NHS CHC should be referred for NHS CHC long before their 18th birthday and referral times are typically longer than non-transitional cases. For this reason, the latest National Framework for NHS CHC clarifies that the 28 days' timescale does not apply to transitional cases.

2. How are transition cases collected in the PLDS?

In data terms, some CHC systems include an identifier for cases that have come through the transitional route. For other systems, and for the purposes of the PLDS with respect to 28 days reporting measures (see next section below), transition cases are defined as those where the REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) was before the individual's 18th birthday.

Users of the data set and this document should be aware that the current ISN only allows inclusion of data for "activity relating to adults (age 18 years and over) accessing NHS Continuing Healthcare and NHS-funded Nursing Care." If a person is below the age 18 at the end of the reporting period their data records will be rejected to prevent any data breach and not included in report outputs or publication. This means that transitional cases where an individual is referred before their 18th birthday will not have any applicable activity included in any report outputs until they are 18. Inclusion of transitional cases under the age of 18 at the time of the reporting period will be reviewed in the future.

3. How will transition cases be counted in 28 days reporting measures?

If a person is under the age of 18 at the time of the reporting period, their records will not be included in reporting outputs and will therefore not appear in any 28 days reporting measures.

If a person was below age 18 at the point of referral but is 18 by the time of a subsequent reporting period, their personal records and any applicable activity will begin to be included in report outputs as appropriate. However as per the National Framework, for the purposes of any reporting post collection, transition cases will not be included in any 28 days performance monitoring metrics.

Appendix C – Care Product Types Categories and Definitions

National Code	Category	Definition
01	Care Home with nursing	A Care Home with Nursing is an Organisation Site. A Care Home with Nursing is a Care Home where, in addition to personal care and accommodation, is a place where qualified nursing care is provided, to ensure that the full needs of the PERSON are met. Examples of Care Homes with Nursing include: • Nursing home • Convalescent home with nursing • Respite care with nursing • Mental health crisis house with nursing. Note: The Care Quality Commission definition of nursing care is: "Nursing care means any SERVICE provided by a NURSE and involves: •The provision of care, or •The planning, supervision or delegation of the provision of care, other than any SERVICES which, by their nature and the circumstances in which they are provided, do not need to be provided by a NURSE." For further information on Care Homes, see the Care Quality Commission website at: Care homes.
02	Care home without nursing	A Care Home Without Nursing is an Organisation Site. A Care Home Without Nursing is a Care Home. Examples of Care Homes Without Nursing include: • Residential home • Rest home • Convalescent home • Respite care • Mental health crisis house • Therapeutic communities. For further information on Care Homes, see the Care Quality Commission website at: Care homes
03	Hospice	A Hospice is an Organisation. A Hospice:

		• provides a range of SERVICES for conditions where curative treatment is no longer an option, and people are approaching the end of their life • provides care, treatment and support for people and their families and carers, including respite care for people who live with friends or family at home • will generally employ or work with a broad range of health and social CARE PROFESSIONALS to meet the needs of people using the SERVICE. Care, treatment and support can be provided in accommodation or in the community. It can be long or short-term care, on an inpatient basis or provided through day care, day therapy or outreach services. Examples of Hospices include: • Adult Hospice • Children’s Hospice • Day Hospice • End of life care teams • Hospice at home For further information on Hospices, see the NHS website at: Finding a Hospice.
04	Other Type of Placement	Any placement that does not meet the definition of any of the other categories. This would be any funded residential placement not covered by types 1-3 (care home with/without nursing, hospice). This is where a client resides in the establishment where the care is provided as part of the care package (as opposed to Home Care which is provided in a client’s own home/usual place of residence).
05	NHS Continuing Healthcare Funded Home Care	Services funded by NHS Continuing Health Care that have been put in place to support an individual in their own home, either as part of an ongoing package of care or a short-term package, such as respite care. May also be known as 'Domiciliary Care'. This should not include NHS Continuing Health Care funded services that are delivered away from the individual's home e.g. NHS Continuing Health Care funded therapy services.
06	NHS Continuing Healthcare Funded Care in Supported Housing	NHS Continuing Health Care funded services provided to individual's living within Supported Housing, being any housing scheme where housing is provided alongside care, support or supervision to help people live as independently as possible in the community. It covers a range of different housing types, including hostels, refuges, supported living complexes, extra care schemes and sheltered housing. Supported housing can provide long term support for years for some vulnerable groups such as older people and disabled people or very short term immediate emergency help for when people are in times of crisis, such as use of hostels and refuges.
07	Day care facility	A Day Care Facility is a CLINIC OR FACILITY. Day Care Facilities may be called Day Hospitals, Centres, Facilities or Units.

		A Day Care Facility provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have Learning Difficulties. Day Care Facilities may be financed, planned and run solely by NHS Organisations or solely by non-NHS Organisations or jointly between NHS and non-NHS Organisations. Jointly run facilities should still be managed by only one Organisation. The facilities specifically do not have Hospital Beds and function separately from any WARD. A Day Care Facility is usually open during the five weekdays. In some places a SERVICE may be provided only once or twice a week and the SERVICE may take the form of evening or weekend sessions.
08	NHS Continuing Healthcare Funded Transport	Transport funded by NHS Continuing Health Care as specified in an individual's CHC care plan.
09	NHS Continuing Healthcare Funded Therapy Service	Services by any practitioner regulated by the Health and Care Professions Council that are funded by NHS Continuing Health Care as part of an individual's CHC care plan. This should exclude any such service that are already included as part of any other NHS funded Care Product Type e.g. NHS Continuing Health Care funded home care.
10	NHS Continuing Healthcare Funded Equipment	Equipment funded by NHS Continuing Health Care as specified in an individual's NHS Continuing Health Care, care plan.
11	NHS-funded Nursing Care Standard Rate	NHS-funded Nursing Care is an ACTIVITY GROUP. NHS-funded Nursing Care (NHS FNC) is funding provided by the NHS to a PERSON in a Care Home with Nursing who does not qualify for NHS Continuing Healthcare but has been assessed as requiring the services of a registered NURSE. For further information on NHS-funded Nursing Care, see the Department of Health and Social Care part of the gov.uk website at: National framework for NHS continuing healthcare and NHS-funded nursing care. NHS-funded Nursing Care Standard rate is a defined contribution towards the cost of registered nursing in a care home paid at the standard weekly rate set each year.
12	NHS-funded Nursing Care High Rate	NHS-funded Nursing Care is an ACTIVITY GROUP. NHS-funded Nursing Care (NHS FNC) is funding provided by the NHS to a PERSON in a Care Home with Nursing who does not qualify for

		NHS Continuing Healthcare but has been assessed as requiring the services of a registered NURSE. For further information on NHS-funded Nursing Care, see the Department of Health and Social Care part of the gov.uk website at: National framework for NHS continuing healthcare and NHS-funded nursing care. NHS-funded Nursing Care Higher rate is a defined weekly contribution towards the cost of registered nursing in a care home paid at the High band rate. This is in respect of individuals who were in receipt of the high band of NHS-funded Nursing Care under the three-band system that was in force until 30 September 2007. Individuals are entitled to continue on the high band rate until: a) on review, it is determined that they no longer have any need for registered nursing care; or b) they are no longer resident in a care home that provides registered nursing care; or c) they become eligible for NHS Continuing Healthcare; or d) they die. In addition, if on review, it is determined that their needs have changed, so that under the previous three-band system they would have moved onto the medium or low bands, the individual should be moved onto the single standard rate.
13	Other Non-Placement Care Package not included in National Codes 05 to 12	Any non-placement care package that does not meet the definition of any of the other available categories. This would be any type of care not covered by any of the other types. It is non-placement because it is expected that any ‘placement’ is covered by types 1-4, so it is expected to be care that is delivered either to a client’s own home/usual place of residence / a setting as if it were their own home or at a care setting where the client is not resident, and which is not covered by any other care product type.

Appendix D – Historical Data / Legacy Based Systems

1. What is historical data / legacy based systems?

Historical data refers to any data which exists in a legacy system (electronic or paper) prior to 1st April 2022 which has associated data stored relating to patients with an active care package as at the 1st April 2022 and onwards.

2. Is historical data required within the NHS CHC PLDS Data Submission file/s?

In summary yes. As per the user guidance (inclusion rules chapter above) we are expecting (from the 1st April 2022):

Each monthly submission should include all active referrals or notifications (or those with active care package or 3/12 month review activity attached to them) within that reporting period, which includes:

- referrals or notifications that were received in the reporting period
- referrals or notifications that closed in the reporting period
- referrals or notifications that were open throughout the reporting period, even if no activity took place
- referrals or notifications that have open eligibility or open care package activity linked to them in the reporting period. This includes eligible / linked packages of care open throughout the reporting period or eligible / linked packages of care that change during the reporting period e.g. eligibility / a linked packages of care closes on a date falling within the reporting period being submitted. Cases that have been eligible during the reporting period, but the package of care has not been set up yet should also be included.
- referrals or notifications that have active package 3/12 month review activity linked to them in the reporting period

Please note that any changes/updates to activity relating to prior reporting periods require resubmission of the relevant reporting period(s) for those changes to be reflected in reporting outputs. Resubmission of prior reporting periods is possible provided the months for resubmission fall within the current reporting financial year (please see 'Resubmitting Data' on page 12 for more information).

3. How can I submit/share historical data from legacy based systems?

For data items which may be required to be taken off legacy/historical systems or records, all data items which translate to 'Mandatory' dataset items on the PLDS will need to be included to prevent submission files being rejected and to support 'unique' identification of patients as well as the appropriate generation of unique service request ID's. e.g., Local Patient Identifier, Organisation Identifier etc. Patient Identifiable Dataset (PID) items such as Forename, Surname, Address etc… can be migrated to the new/current system (if required) but just to be clear these are useful for local matching across systems, so their relevance is for local use only.

'Required' items are those which SHOULD be reported where they apply. However, failure to submit these items will not result in the rejection of the record but may affect the derivation of

national indicators or national analysis. Our recommendation is to transfer as much ‘Mandatory’ and ‘Required’ information as possible from legacy / historical systems / records. We recognise that not all ‘required’ items will be available in historical records in all cases, however going forward these items should be collected and reported where they apply for all new cases recorded onto the current system.

‘Mandatory’ fields, if left blank, will be rejected at record level, and therefore priority should be taken to review and obtain missing information from historical/legacy- based systems for these cohort of dataset fields first, followed by ‘Required’ dataset items. Data submitters will be able to obtain a list of rejected records following a file submission onto the MESH data platform and can utilise the resubmission process to complete any gaps in missing data (if a resubmission is required), otherwise an attempt should be made to correct data during the original reporting period for which the record relates to.

4. Can I record and submit dummy date/dates against historical data / data held in legacy-based systems?

Under the Data Protection Act (DPA), data must be accurate and kept up to date and therefore any data submission pertaining to incorrect, falsified data would breach the DPA.

However, in some instances (such as a change in the PAS or EPR used locally, meaning that historical data is unavailable), a dummy date may need to be entered to allow an NHS CHC PLDS submission to be made (as per ‘3’ above) if a mandatory date is not known. For example, for the mandatory ‘REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE)’, if the original referral date is not recorded on the local system, and a reasonable estimate cannot be made, then the date when the system was first adopted could be used. Taking this approach allows historical cases which are still eligible within the year to date to be included in top line activity measures. Where a dummy REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE is used for this purpose, and the date is before the inception of the PLDS, this is likely to have little impact on the figures (e.g. metrics such as ‘number of referrals received’ in a current reporting month will not include referrals with these historical dummy dates).

Please note that while dummy dates may be required for NHS CHC PLDS submission purposes, there is no requirement to amend the patient’s record (or change clinical practice) to include these dummy dates or to add these dates to the PAS/EPR. The dates can be added to the NHS CHC submission only, e.g., through use of a local data warehouse and/or through manually updating the submission file prior to submission.

Furthermore, please note that a dummy date should not be unrealistic but should reflect the closest or most accurate reflection of the ‘REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE)’ where this information is not known, and every attempt should be made to obtain the correct information.

Appendix E – Abbreviations and Glossary

Term / Abbreviation	What it stands for
Case	All activity attached to a given Service Request. For example, a new referral for NHS CHC assessment would constitute a new Service Request (requiring a new Service Request Identifier to be set up within the PLDS against the activity type '01 NHS Continuing Healthcare (Standard)'). All of the activity recorded against this Service Request Identifier (e.g. referral outcome, package information, funding start and end dates etc.) then constitutes the 'case'. An individual may have more than one case (e.g. an NHS CHC referral and all associated activity with its own Service Request ID *and* a PUPoC Request with a different Service Request ID).
Referral or notification	A 'referral' is the act of referring someone or something for consultation, review, or further action. For example, a Standard NHS CHC referral is the earliest notification (to the ICB or person or body acting on behalf of the ICB) that full assessment of NHS CHC eligibility is required (e.g. a positive checklist or other notification that full assessment is required). A 'notification' is any other information passed onto an ICB that requires recording in the PLDS but does not constitute a referral (e.g. notification of a negative checklist). Each new referral or notification requires set up of its own Service Request Identifier and all information relevant to that referral or notification is then recorded against that Service Request ID. Referrals or notifications in the PLDS include positive checklists, negative checklists, Fast track referrals, PUPoC requests, or Local Resolution Requests.
28 days referral time	The National Framework sets out that "the overall assessment and eligibility decision making process should, in most cases, not exceed 28 calendar days". Counting of 28 days referral time starts from the earliest notification (to the ICB or organisation acting on behalf of the ICB) that *full assessment* of NHS CHC eligibility is required (e.g. a *positive* checklist or other notification that full assessment is required). This is the date that should be recorded against C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE). Referral time ends at the date the ICB makes a verified decision on eligibility (ELIGIBILITY DECISION DATE (NHS CONTINUING HEALTHCARE STANDARD) or the referral is discounted (C101140 REFERRAL REQUEST DISCOUNTED DATE). The National Framework does not specify any scenarios in which ICBs should 'stop the clock' when counting 28 day referral time. The earliest notification that full assessment is required (as per the above definition) should be recorded against C101040 REFERRAL REQUEST OR NOTIFICATION RECEIVED DATE (NHS CONTINUING HEALTHCARE) irrespective of (a) whether or not the consent form is included; (b) whether or not the consent question on page 6 of the Checklist is completed; (c) whether or not there is any other information missing or any

	questions unanswered on the Checklist; and (d) whether or not there is any further processing or triage required to determine whether the Checklist is positive or negative. Referrals submitted more than once due to incomplete or incorrect information should only be counted once and from the earliest notification for the purposes of counting 28 days. 28 days referral time relates to the initial assessment following a referral. Requests to review eligibility decisions via the local resolution process following initial assessment which are referred back to the MDT are not included.
Service Request	A new referral or notification (e.g. positive checklist, negative checklist, Fast track referral, PUPoC request, or Local Resolution Request). Each new referral or notification requires set up of its own Service Request Identifier and all information relevant to that referral or notification is then recorded against that Service Request ID.