

DCB3085 NHS All Age Continuing Care (AACCC) Data Set

USER GUIDANCE

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Document Management

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Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
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Approved by

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Name	Title	Date	Version
Tom Latham	Head of Data Design	27.09.2024	1.0
Ed Onslow	Lead Data Architect, Data Design	20.01.2026	1.1

Document Control

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1 About this Document

1.1 Purpose of the Document

The purpose of this document is to outline:

- The background to the development of the NHS All Age Continuing Care (NHS AACC) Data Set v2.0 and the development approach.
- The manner by which the NHS AACC Data Set v2.0 should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data groups (tables) and data items, beyond that stated in the data set NHS AACC v2.0 Enhanced Technical Output Specification (ETOS), to further explain their use and validation.

1.2 Scope of the Document

This document is aimed at:

- Integrated Care Board (ICB) management professionals leading NHS AACC services in England.
- Operational and administrative personnel.
- NHS AACC informatics and IT professionals.
- Commissioning Support Units (CSUs) or other persons or bodies acting on behalf of an ICB with respect to AACC.
- IT system suppliers supplying NHS AACC systems for ICBs.
- NHS staff and system suppliers supporting clinical systems designed to support NHS AACC services, such as AACC 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 AACC Providers to the data landing platform).
- Restating information already accessible from the ETOS.

This document should be read in conjunction with the following documents made available as part of the [AACC Information Standard](#)¹:

- NHS AACC Data Set Requirements Specification
- NHS AACC Data Set Technical Output Specification (TOS)
- NHS AACC Data Set Implementation Guidance
- NHS AACC Data Set Enhanced Technical Output Specification (ETOS)

Further implementation tools and guidance are linked from the [AACC Guidance Hub](#), including:

- Message Exchange for Social Care and Health (MESH) data landing platform guidance
- AACC Item Completion Guide (visual guide to what items to populate and in what context)
- AACC Glossary

¹ <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb3085-all-age-continuing-care-data-set>

1.3 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 it 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

The NHS All Age Continuing Care (AACC) programme encompasses different types of NHS Continuing Care for adults and young people and includes the following:

- Adult activity types under the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#)¹:
 - NHS Continuing Healthcare (CHC)
 - NHS-funded Nursing Care (FNC)
 - Jointly funded (JF) packages of health and social care
- Children and Young People's (CYP) Continuing Care (as set out in the [National Framework for Children and Young People's Continuing Care](#)²).

The AACC data set expands upon the NHS Continuing Healthcare Patient Level Data Set (NHS CHC PLDS) to include CYP and JF activity, as well as new information on eligibility disputes.

For detail on AACC activity and what is in and out-of-scope of the AACC data set, see section [4.1. Data Set Scope](#).

As a secondary uses data set, the NHS AACC data set 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.

3 Configuration of local systems

The Enhanced Technical Output Specification (ETOS) defines the data items within the AACC data set. The ETOS splits the data set into a number of groups (also referred to as tables), each containing related data items.

The AACC data set 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 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:

¹ <https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care>

² <https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework>

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 AACC data set 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 submission platform.

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

4 Constructing Submission Files

4.1 Data Set Scope

The AACC data set is submitted at sub-ICB location level, as set out in the Requirements Specification as part of the [Legal Directions](#) for the collection.

This section details which CHC, FNC, CYP, and jointly funded package activity should be submitted in the AACC data set.

Generally, all activity described in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care or the National Framework for Children and Young People's Continuing Care should be included. Where there is overlap between the two National Frameworks or with local policy, this section will clarify the rules for submission.

For detailed information on what should be submitted for each activity, and in what form, please refer to the ETOS alongside [section 6](#) of this document. The ETOS, along with other documents and tools that may help with implementation can be found on the [AACC Implementation Tools and Guidance page](#)¹.

4.1.1 New requests for NHS Continuing Healthcare

All new and ongoing activity relating to NHS Continuing Healthcare (CHC), from receipt of a service request (see below for service request types), outcome of checklist (e.g. ICB decision on whether to refer for full assessment or other outcomes possible at the screening stage e.g. FNC eligible), and for those cases fully assessed, MDT recommendation, ICB eligibility decision, care package details, and reviews (3 month and 6 month).

Expected new request types that should be captured are:

- Checklist received (positive, negative, or undefined).
- Direct referral.
- Fast track referral.
- Request for a previously unassessed period of care.
- Joint Package of Health and Social Care Request
- Referral for re-assessment following a care package review

¹ <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/continuing-health-care-data-set/nhs-all-age-continuing-care-aacc-patient-level-data-set>

- Local resolution request
- Inter-agency dispute
- Transferred case from another ICB

4.1.2 NHS-funded Nursing Care

NHS-funded Nursing Care (FNC) is another type of funding that can result from the CHC assessment process. FNC is provided by the NHS to a person in a nursing home who does not qualify for CHC but has been assessed as requiring the services of a registered nurse. In all cases individuals should be considered for eligibility for CHC before a decision is reached about the need for FNC. A decision on FNC eligibility needs to be taken by a registered nurse following a nursing needs assessment as set out in the [FNC Practice Guidance](#)¹.

In the case of a negative checklist indicating an individual does not require a referral for assessment for CHC, an individual may still be eligible for FNC.

A referral (e.g. positive checklist) for full assessment of CHC may still also result in eligibility for FNC, if the CHC assessment decision outcome indicates the individual is not eligible for NHS CHC but requires FNC.

4.1.3 Reviews of eligibility including disputes

Where a previous eligibility decision is to be reviewed by the ICB, these should be included in data set submissions as a new service request. Previous decisions that might be reviewed include:

- from an individual / their representative, triggering the Local Resolution procedure.
- from a local authority or other agency, triggering the Inter-Agency Dispute procedure.
- Reassessment of eligibility following a care package review.

4.1.4 New requests for Children and Young People's Continuing Care

Children and Young People's (CYP) Continuing Care is a package of care that is required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

Types of eligibility for CYP include the following:

- **Children and Young People's Continuing Care:** funded by the NHS.
- **Children and Young People's Continuing Care - Joint with Social Care:** joint funded by the NHS and a Local Authority (where the Local Authority funds social care).
- **Children and Young People's Continuing Care - Joint with Education:** funded by the NHS and a Local Authority (where the Local Authority funds education).
- **Children and Young People's Continuing Care - Tripartite with Social Care and Education:** joint funded by the NHS and a Local Authority (where the Local Authority funds both social care and education).

All new and ongoing activity relating to CYP Continuing Care, from receipt of service request (see below for in-scope service request types), ICB decision whether to refer for assessment, and for those cases fully assessed, MDT recommendation, ICB eligibility decision, care package details, and review (3 month and 12 month) details.

Expected new CYP request types that should be captured are:

- Pre-assessment checklist received (positive, negative, or undefined outcome).

¹ <https://www.gov.uk/government/publications/nhs-funded-nursing-care-practice/nhs-funded-nursing-care-practice-guidance>

- Direct referral.
- Fast track (see section [4.1.7 CYP Fast Track](#)).
- Referral for reassessment following a care package review
- Local Resolution
- Inter-agency Dispute
- Transferred case from another ICB.

For CYP transitioning to CHC, see section [4.1.6 CYP Transitioning to CHC](#).

4.1.5 Joint Funded Package of Health and Social Care

A Joint Funded Package of Health and Social Care is a joint package of health and social care as described in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care whereby a person is assessed 'not eligible for CHC' but has some specific needs identified that are beyond the limits of the local authority (LA) to meet on its own. In such cases an LA may make a request to an ICB for joint funding for an individual's care or support package to be funded by both the NHS and the LA (exclusive of FNC only payments).

For the purposes of the AACC data set, adult Joint Funding only refers to cases that have had a full assessment for CHC using a Decision Support Tool (DST) and were found not eligible for CHC but still had some assessed needs beyond the limits of the LA which the ICB and LA agree to jointly fund (exclusive of NHS-funded care only payments).

Any joint funding arrangements that are not related to a full CHC assessment with a 'not eligible for CHC' decision are out of scope. Please see FAQs for further information and examples.

The request for a joint funded package of care from the local authority should be submitted as a new service request record, distinct from the initial record relating to the 'not eligible' CHC assessment (see section [4.1.8 When to Generate a New Service Request Record](#)).

There is no need to submit details to the AACC data set that relate to the local authority element of the care. Only the health element of the service request, care package and reviews are needed.

For the purposes of the AACC data set, any health aspect of a Joint Funding request that is met via existing or universal services is considered out of scope of eligible Joint Funding activity. It is only where the NHS needs to commission services or make a financial contribution to a Joint Package that it should be captured as eligible activity. If a Joint Funding request as per the definition can be wholly met by existing services, then the Joint Funding request should still be counted but the outcome would be recorded as 'not eligible for Joint Funding'.

For Joint Funded packages completion of contract unit cost, frequency, and weekly hours is optional. Where this information is completed, it should relate to the NHS contribution to Joint Funded packages only.

It is possible for an individual to be eligible for FNC *and* a Joint Funded Package of Health and Social Care as per the Joint Funding definition. Where this is the case, the FNC outcome should be recorded against the service request for the initial CHC assessment, whereas the Joint Funded aspect should be recorded under a new service request (under ACTIVITY TYPE '02 Joint funded package of health and social care' and SERVICE REQUEST RECEIVED TYPE '10 Joint Package of Health and Social Care Request').

4.1.6 CYP transitioning to CHC

Where an individual eligible for CYP is due to be considered for CHC, a new CHC checklist will be submitted to the ICB. This normally happens prior to the individual's 18th birthday. Where this occurs, the ongoing CYP service request record should be submitted to the AACCC data set, as well as a CHC checklist service request record. Note that this does not constitute double-counting in reporting metrics generated by NHS England. This represents a genuine instance of both CHC and CYP activity for the same individual and both activity types would therefore be reported on.

4.1.7 CYP Fast track

A standardised national fast track process and fast track tool does not currently exist under the Children's Framework in an equivalent way as it does for adults under the CHC National Framework. Fast track assessment is however recognised in the CYP framework:

"Children and young people who require fast-track assessment because of the nature of their needs (such as a palliative care need) should be identified early and the child or young person's needs met as quickly as possible. The continuing care process should not restrict access to end-of-life care for children and young people who require immediate support over a shorter period, and should not result in any delay to appropriate treatment or care being put in place" (paragraph 54).

In the absence of a standardised national process and tool, ICBs may utilise different local approaches in relation to CYP fast track. For some ICBs the CYP fast track process may be similar to adult CHC whereby a full assessment is not needed to determine eligibility. If this is the case, CYP fast track eligibility should be recorded under SERVICE REQUEST OUTCOME. Other ICBs may adopt a process whereby a full assessment is still required following a fast track referral in which case the SERVICE REQUEST TYPE should be recorded CYP / fast track, but the eligibility outcome should be recorded under ASSESSMENT DECISION OUTCOME.

4.1.8 When to generate a Service Request record

A service request record refers to a record submitted in the AACCC101Referrals, Assessments, and Outcomes group. In more general terms, a service request record refers to any ongoing CHC, FNC, CYP, or joint funded eligibility, and any new requests to the ICB e.g. for an assessment or eligibility decision.

A new service request record should be generated when:

- A new CHC checklist is received, including for a CYP transitioning to CHC, or a new referral resulting from a care package review e.g. an FNC Review identifies an individual may now be eligible for CHC and a referral for CHC assessment is made using a positive checklist.
- A new fast track referral is received.
- A new request for a previously unassessed period of care is received
- A new CYP pre-assessment checklist is received
- A new request for a joint funded package of health and social care is received
- A direct referral is received
- A transferred case is received
- A re-assessment for existing eligibility is to be made based on a care package review e.g. a CHC case may no longer be CHC eligible and a re-assessment is required. This would be recorded under a new service request record with the type '11 Referral for re-assessment following a care package review'.
- A local resolution request related to an eligibility decision has been raised
- A formal inter-agency dispute of an eligibility decision has been raised.

Service Requests for ongoing cases of any type (for example, where there is no funding end date or discounted date) should continue to be submitted every reporting period. Please see 4.1.9 Open Activity below.

As new Service Requests are generated for any new AACC requests or notifications into the ICB (as outlined above), this means there can be more than one service request per individual (and therefore patient ID). For example, a local resolution request received following a full assessment would constitute two service requests, one for the initial CHC referral / assessment and one for the subsequent local resolution request. It's also possible for individuals to be subject to more than one referral relating to different periods of care e.g. an individual may be referred for CHC assessment with a 'not eligible' outcome, but several months later their needs materially change and they are referred for CHC assessment again (again this would be represented by two service requests, one for each referral, for the same individual / patient ID).

4.1.9 Open Activity

A case record is considered to have open activity requiring a report submission in either of the following scenarios:

- Any date items (e.g. Service Request Received Date, Service Request Outcome Date, Decision Support Tool Completed Date etc.) contain dates that fall within the reporting period, provided the record does not meet the definition of a 'closed' case in a prior reporting period (see Closing a Case Record below).
- A case may not have date items falling within a reporting period but is still considered to be 'open' e.g. FUNDING START DATE with no FUNDING END DATE. Please see 4.5 Data submission examples for other examples of 'open' cases.

4.1.10 Closing a Case Record

A case record is considered closed when either:

-
- For cases that do not require assessment and are not eligible for FNC (e.g. positive checklist with SERVICE REQUEST OUTCOME = 03 Do not refer for full assessment and not eligible for FNC), there is a Service Request Outcome Date.
- For discounted referrals (or assessments which are completed but the funding never starts), there is a Referral Discounted Date.
- For cases fully assessed as ineligible for CHC, FNC, or CYP:
 - If an **Eligibility Decision Communicated to Patient Date** is recorded, this constitutes the closure date.
 - If this date is missing, the **Assessment Decision Date** constitutes the closed date instead.

Note: The Eligibility Decision Communicated to Patient Date should ideally always be provided following a full assessment. If it is not, the case would otherwise remain open indefinitely in the data set. Using the Assessment Decision Date as a fallback therefore ensures closure and prevents data anomalies.

- For cases eligible for CHC, FNC, CYP, or a jointly funded package:
 - If a **Funding Start Date** is recorded, the case is closed when a **Funding End Date** is entered.
 - If there are **no Funding Start/End Dates** (for example, where an assessment or re-assessment occurs as part of a care package review, and eligibility remains unchanged, therefore an existing eligible service request and linked

care package still stands), the **Assessment Decision Date** constitutes the closure date.

Note: This approach ensures that cases linked to ongoing funding remain open until the funding ends, while cases without funding start dates close after the assessment decision.

Records that fit any of the above criteria should be submitted in the reporting period that aligns with the respective date item(s). Provided no further record updates occur which meet the 'open activity' criteria above, or result in the record closing in a different reporting month than previously reported, then closed records do not need to be submitted in subsequent reporting periods.

4.1.11 Out-of-scope activity

This section details activity that might be managed in the same systems, or by the same teams as AACC, but does not need to be submitted.

New and ongoing joint funded packages of care that have not undergone a full CHC assessment with a 'not eligible' decision do not need to be submitted to the AACC data set (see section 4.1.5 for further detail).

The FNC Practice Guidance sets out that there may be occasions when 'urgent nursing care' (UNC) can be put in place for up to six weeks without first carrying out an CHC screening or assessment. These are out-of-scope of the AACC data set. FNC beyond the 6 weeks UNC will need to go through the formal FNC process, and will become in-scope of the data set.

Cases funded under the Mental Health Act (e.g. section 117 aftercare) are sometimes managed in the same system by the same teams as AACC. These are outside the scope of the AACC data set. If an individual is funded under a Mental Health Section *and* eligible for AACC then please include the activity related to AACC only and do not include any activity covered by the Mental Health Act.

Individuals receiving interim care or temporary funding pending consideration of eligibility (sometimes referred to as 'funding without prejudice') should be excluded from eligible activity or care package information. This includes those receiving interim care under discharge to assess arrangements or those receiving temporary funding pending the outcome of an eligibility consideration process or eligibility decision. Interim arrangements put in place following an AACC referral (e.g. an NHS CHC referral has resulted in interim funding rather than proceeding to assessment for NHS CHC), should still have the relevant aspects of the AACC referral included but should not be counted as eligible AACC activity (e.g. in the example above the referral would be discounted with DISCOUNTED REASON = 02 'Individual placed on fully funded interim care' and a DISCOUNTED DATE completed).

4.2 The Enhanced Technical Output Specification

The **Enhanced Technical Output Specification (ETOS)** fully defines the data items (sometimes referred to as fields) to be submitted, as well as details of how groups (tables) should be submitted, and how files should be submitted.

Each data item defined in the ETOS has an identifier, name (standard and XML), standard validation, and additional validation, detailing the format and conditions in which values should be submitted.

Data items are grouped together according to their relationship with other items, referred to as groups. Groups can be thought of as equivalent to tables in a data structure, with defined relationships to other groups/tables. Groups are split into tabs in the ETOS.

As well as item-level standard and additional validations, validation is also applied on submission at the submission file level and the group level, details of which can be found in the ETOS.

Data items in the ETOS that have a grey background are derived items. These items are calculated post-submission using the values provided in the submission.

Please note that the Technical Output Specification (TOS) that is provided as part of the AACCC data set Information Standard contains only the input data items (items to be submitted by ICBs), and does not contain information on NHS England processing, namely derivations and validations. It is recommended that the ETOS is used when implementing the data set.

4.3 Validation

Validation is the application of logical rules to elements of the data set submission to check whether the file, groups, and items submitted are suitable for ingestion into NHS England systems.

Validation results are conveyed to submitters in an output file generated after submission. This file details validations that failed, and whether they resulted in a:

- **Warning** (the element that failed can be ingested, however they may affect data quality) or
- **Rejection** (the element that failed will result in rejection of that group / record for that patient, and the record will not be ingested).

Data items and groups are subject to a mandation status, detailing the requirement for that element. The types of mandation are:

- **Mandatory (M)**: These data items or groups **MUST** be submitted. Failure to submit these items or groups will result in the rejection of the record.
- **Required (R)**: These data items or groups **MUST** be reported **where they apply**. It is a legal and contractual requirement to submit this data where the service has been provided to a patient. Failure to submit this data 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 (O)**: These data items or groups **MAY** be submitted on an optional basis at the submitter's discretion.
- **Pilot (P)**: These data items or groups have been included within the specification for piloting purposes only to support future implementation. This data has not been approved and/or mandated and **SHOULD NOT** be submitted unless specifically requested.

4.3.1 Validation Levels

Upon submission of the data set, three levels of validation are undertaken:

1. File level

A number of checks are carried out across the submission to determine whether it is suitable for ingestion into NHS England systems. If any of these checks fail, nothing in the submission file/s will be transferred into NHS England systems, requiring identified issue(s) to be rectified and a resubmission made.

Where these can be found: File-level rejections are detailed in the File-Level Rejects tab in the ETOS. Where a file-level rejection relates to a data item (e.g. Postcode or NHS Number), these are also detailed against the item in its respective group tab.

Example: AACCREJ002 - Failed Content Check. AACCC001 MPI group is empty.

2. Group level

Group level validation forms the data structure and referential integrity between groups. The group structure is defined as a set of rules that include how many of each group to submit, which groups are mandatory, and what other linked groups should be submitted.

One or more records might be rejected due to a group validation failure, for example where a record has been submitted with patient group (MPI) but no Referral, Assessment, and Outcome group, the entire group will be rejected.

Where these can be found: Each group tab in the ETOS defines group-level validation at the top of the page. A visual representation of the group structure can be seen on the AACC Data Model.

Example: the AACCC001 group will be rejected if there is no valid AACCC101 group transmitted for this Local Patient Identifier (Extended).

3. Record level

Record-level validation checks the validation rules recorded against each data item, as detailed in the ETOS. These validations are a mixture of standard and additional validation (see Item Validation section) and can be either rejections or warnings. Record level rejections will result in that record (group) being rejected and the data not being ingested into NHS England systems. Record level warnings still allow the data to be ingested, however they may affect data quality.

Where these can be found: In the 'Validation Rules' and 'Record Level Error/Warning Messages' against each data item in the ETOS.

Example: If Assessment Decision Date is before Service Request Outcome Date, a warning will be generated.

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

4.3.2 Data Item Validation

Standard validations are assigned to every data item in the ETOS, and are represented as columns in the ETOS group sheets.

The first standard validation column is called Mandatory (M), Required (R), Optional (O), Derived (D), Pilot (P). These single-letter codes describe the mandation of the item (see 4.3 Validation).

Other standard validations in the ETOS are shown in columns 'Recvd Item Blank', 'Format Error', and 'National Code Error'. These define what happens when a submitted value is blank, incorrectly formatted, or incorrectly coded (a code was submitted that was not in the list defined for that data item). Values in these columns will either show Reject (the record will be rejected), Warning (a warning will be generated), or N/A (the data item is not checked for this standard validation).

The ETOS also defines additional validations in the Additional Validation Rules column. These validations are unique to the data item and consist of additional checks against

submitted values that are outside of standard validation. Additional validation logic is written in a pseudocode format.

Each standard and additional validation has a defined error message shown in the Record Level Error/Warning Messages column. These are the messages that are generated and inserted in the submission's error report.

The table below illustrates some examples of the respective validation rules applied in the NHS AACC data set:

Scenario	Example Error Code	Example message reported
Mandatory data item is blank	AACC1020101	AACC1020101 - Record rejected - C102010 CARE PACKAGE IDENTIFIER (NHS ALL AGE CONTINUING CARE) is blank.
Any data item has an incorrect data format	AACC1020401	AACC1020401 - Record rejected - C102040 CARE PACKAGE END DATE (NHS ALL AGE CONTINUING CARE) has an incorrect data format. C102010 SERVICE REQUEST IDENTIFIER=<ServiceRequestId> C102040 CARE PACKAGE END DATE (NHS ALL AGE CONTINUING CARE)=<EndDateCarePackage>
An invalid value is provided for a required data item	AACC1030402	AACC1030402 - Warning - C103040 CARE PACKAGE REVIEW OUTCOME CODE (NHS ALL AGE CONTINUING CARE) contains an invalid C103040 CARE PACKAGE REVIEW OUTCOME CODE (NHS ALL AGE CONTINUING CARE). C103040 CARE PACKAGE REVIEW OUTCOME CODE (NHS ALL AGE CONTINUING CARE)=<AACCCarePackageReviewOutcome>
Required data item is blank (where applicable – see ETOS)	AACC0010601	AACC0010601 - Warning - C001060 POSTCODE OF USUAL ADDRESS is blank. C001010 LOCAL PATIENT IDENTIFIER (EXTENDED)=<LocalPatientId>
An invalid value is provided for a mandatory data item	AACC1010303	AACC1010303 - Warning - C101030 NHS ALL AGE CONTINUING CARE ACTIVITY TYPE contains an invalid NHS ALL AGE CONTINUING CARE ACTIVITY TYPE. C101010 SERVICE REQUEST IDENTIFIER=<ServiceRequestId> C101030 NHS ALL AGE CONTINUING CARE ACTIVITY TYPE=<ActivityTypeAACC>

4.3.3 Group Level Validation

Whilst a particular group may not be mandatory, if a record is submitted then all of its group's mandatory fields must be completed.

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

- AACC001 Master Patient Index
- AACC101 Referral, Assessment and Outcome

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

- AACC000 Header

4.4 Resubmitting data

There will be opportunities to resubmit data in all groups. 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 AACC000 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 periods. For example, a resubmission of April data can be made within a submission file covering April (as indicated by the dates in the AACC000 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 period 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 2025 – 31st March 2026). For example, in August 2026 it will be possible to resubmit data for April 2026, May 2026 and June 2026 (as separate files), as well as making a (new) submission of July 2026 data. However, it will not be possible to resubmit data from before April 2026, i.e., for the previous financial year. This means that in April 2026, data submitters will be able to submit data from April 2025 to March 2026 (i.e., all reporting periods from the current financial year based on the open submission window, i.e. March 2026). However, from May 2026 only data from April 2026 (and nothing before that) can be submitted, as the open submission window is for April 2026 data.

Please refer to the separate MESH User Guidance for further information about using MESH to make NHS AACC data set 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 AACC 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 on the submission file only) in order to enable it to pass validation for the AACC data set. 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 AACC management system.

4.5 Data submission examples

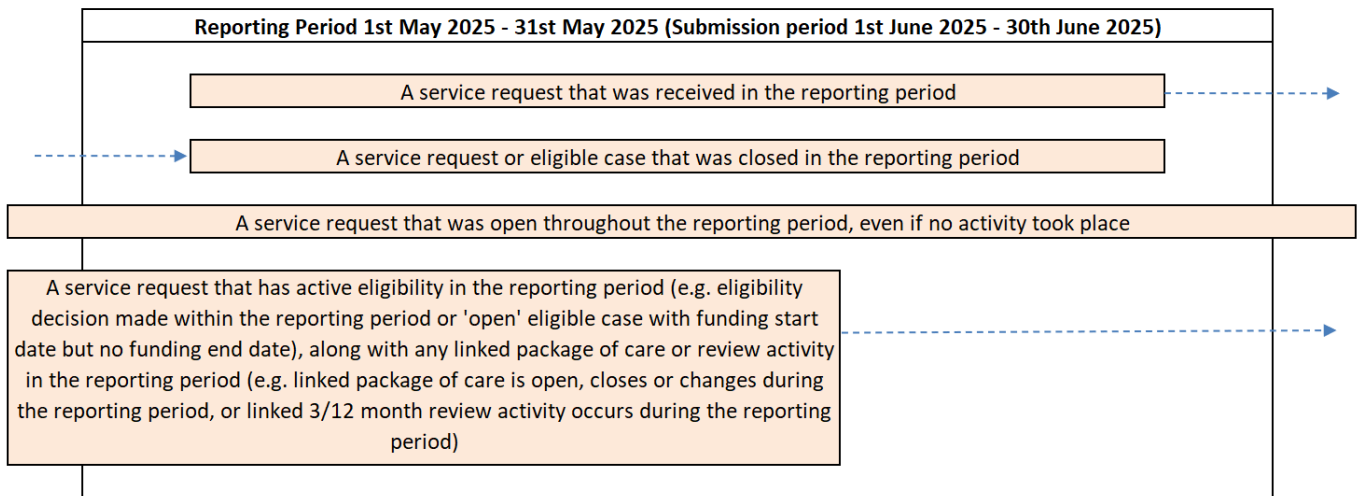
By way of illustration, the table below confirms the actions that should be taken for updates to a new or existing patient's activity in each reporting period:

Activity	Actions	Notes
AACC101 - Service Request (New or Update to Existing)	Add (or amend) data to the AACC001 MPI group if not already there. Add (or amend) data to AACC101 Referral, Assessment and Outcome group.	Please note that linkage data items must be submitted in each group where they are included. The mandatory groups (AACC001 and AACC101) groups have to be sent with each submission for each patient.
AACC102 - Care Package (New or Update to Existing)	Add (or amend) data to the AACC102 Care Package group.	Please note that linkage data items must be submitted in each group where they are included. The mandatory groups (AACC001 and AACC101) also have to be sent with each submission for each patient.
AACC103 - Review (New or Update to Existing)	Add data to the AACC103 Review group. If following an initial submission, it has been identified that missing reviews (i.e. records) were omitted from the reporting period, or included incorrect information, these records would need to be included via a retrospective resubmission.	Please note that linkage data items must be submitted in each group where they are included. In order to submit data within the AACC103 group, linked groups (AACC001 and AACC101) must also be submitted for the relevant patient and service request.
AACC001 – Patient (Update to Existing)	Amend data in AACC001 MPI group.	Please note that linkage data items must be submitted in each group where they are included. The mandatory AACC101 group 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. Examples include:

- service requests that were received in the reporting period
- service requests that closed in the reporting period
- service requests that were open throughout the reporting period, even if no activity took place
- service requests that have open eligibility in the reporting period. This includes eligible cases open throughout the reporting period or eligible cases that change during the reporting period e.g. eligibility / a linked package of care closes on a date falling within the reporting period being submitted, or 3/12 month review activity is linked to the case in the reporting period. Cases that have been agreed eligible during the

reporting period, but the package of care has not been set up yet should also be included.



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 section 4.4 Resubmitting Data for more information).

Cases which are 'open' during the reporting period should be included. Some examples of 'open' cases are included below.

Open checklist, pre-assessment, or notification	An open checklist, pre-assessment, or notification is indicated by the presence of a SERVICE REQUEST RECEIVED DATE with no SERVICE REQUEST OUTCOME or REFERRAL DISCOUNTED DATE.
Open referral	An open referral is indicated where SERVICE REQUEST OUTCOME indicates an onward referral for CHC/CYP, with no ASSESSMENT DECISION DATE or REFERRAL DISCOUNTED DATE .
Open eligibility	Open eligibility is indicated where SERVICE REQUEST OUTCOME or ASSESSMENT DECISION OUTCOME indicates an eligible decision, with no REFERRAL DISCOUNTED DATE, or FUNDING START DATE is populated, with no FUNDING END DATE. If no REFERRAL DISCOUNTED DATE or FUNDING START DATE is provided then a case is considered 'closed' according to the ASSESSMENT DECISION DATE.
Open care package activity	Ongoing care package activity is indicated where CARE PACKAGE START DATE is populated, with no CARE PACKAGE END DATE. Note that if FUNDING END DATE is completed with no CARE PACKAGE END DATE the case is considered closed with CARE PACKAGE END DATE defaulting to FUNDING END DATE for the purposes of reporting outputs.

5 Data Item Guidance

This section provides additional guidance with regards to data items included within the ETOS 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 ETOS.

5.1 Linkage and Identifier Data Items

An identifier item uniquely identifies a record within a group, and can also appear in other groups to allow the linkage of data, forming the complete case record. Where an identifier appears in another group for linkage, this is referred to as a linkage item. The use of identifier and linkage items is directly equivalent to the joining of tables in a database using primary and foreign keys.

The linkage data items are fully described within the ETOS.

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

Identifier and linkage items within the data set are described below, along with guidance on where they might be found in local systems:

LOCAL PATIENT IDENTIFIER (EXTENDED) – the local AACC system will assign a unique identifier to a patient. Local identifiers are unique to each organisation, but usually take the form of a short string of numbers and/or letters. Note that NHS Number is a national identifier NOT a local identifier. Local patient identifier may be different from a patient's case note number.

The local patient identifier should be included in the AACC001 group to uniquely identify the patient, and in the AACC101 to link the patient service request/s to the patient record.

SERVICE REQUEST IDENTIFIER – the AACC data set refers to items received into the AACC system for action as “service requests”, which may be checklists, referrals, fast track referrals, local resolution requests etc. Generally, each request into the local system will automatically generate a unique identifier, although these are sometimes manually assigned.

The service request identifier should be included in the AACC101 group to uniquely identify the service request, as well as AACC102 to link the care package/s to the service request, and in AACC103 to link any review/s to the service request.

CARE PACKAGE IDENTIFIER

A care package identifier will be assigned in the local AACC system to uniquely identify a care package. It would normally be automatically generated upon recording a new Care Package, although could be manually assigned.

Care package identifier should be included in the AACC102 group to uniquely identify a care package. It does not appear in any other groups.

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.

Note that the AACC103 group does not require its own unique identifier, as records can be uniquely identified by the linked service request identifier, care package review type, and care package review date.

LOCAL PATIENT IDENTIFIER (EXTENDED)

AACC001 Master Patient Index (unique identifier)

AACC101 Referral, Assessment and Outcome (linkage item)

SERVICE REQUEST IDENTIFIER

AACC101 Referral, Assessment and Outcome (unique identifier)

AACC102 Care Package (linkage item)

AACC103 Review (linkage item)

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 departments and systems in 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 the AACC data set local patient identifier item 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 code in the NHS NUMBER STATUS INDICATOR indicating why (for example, [07] *Number not present and trace not required*).

6 Breakdown of Data Items by Group

Please note that mandatory items are shown in the below group as **bold** text. In addition, linkage items are underlined.

6.1 AACCC000 Header

AACCC000 Header	
Description	
<p>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.</p> <p>One occurrence of this group is required per submission.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
DATA SET VERSION NUMBER	<p>The version of the NHS AACCC ETOS that the submission file is for. The current version of the data set is v2.0.</p> <p>'2.0' should be entered as the version number, otherwise your file may be rejected.</p>
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	<p>This is the ORGANISATION IDENTIFIER of the NHS ORGANISATION commissioning healthcare.</p> <p>Where another body (e.g. CSU) is authorised by an ICB to exercise any of its NHS AACCC functions on its behalf, the organisation identifier used here should be for the organisation with statutory responsibility for NHS AACCC. As the AACCC data set is submitted at sub-ICB location level, this should be the sub-ICB location the data relates to. The organisation identifier should also correspond to a correct ODS organisation code (see ODS Portal¹ for codes).</p>
ORGANISATION IDENTIFIER (CODE OF ICB PLACE)	<p>This is the ORGANISATION IDENTIFIER of the constituent geography commissioning healthcare.</p> <p>This is a placeholder for the possible future introduction of new ODS codes for 'place' in the future that will correspond to the geographical make-ups of ICBs.</p> <p>Do not submit values under this item until otherwise notified by NHS England.</p>

<p>ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)</p>	<p>This is the Organisation Identifier of the organisation acting as the physical sender of a data set submission.</p> <p>This Identifier provides an audit trail where a different organisation is undertaking the submission on behalf of the organisation (code of commissioner).</p> <p>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. The organisation identifier should also correspond to a correct ODS organisation code (see ODS Portal for codes).</p>
<p>PRIMARY DATA COLLECTION SYSTEM IN USE (NHS ALL AGE CONTINUING CARE)</p>	<p>The name of the Primary Data Collection System, i.e. the local system in which AACC is managed.</p> <p>This is a free text field.</p> <p>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 groups (AACC001 and AACC101).</p>
<p>REPORTING PERIOD START DATE</p>	<p>The reporting period start date to which this file refers.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>REPORTING PERIOD END DATE</p>	<p>The reporting period end date to which this file refers.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>DATE AND TIME DATA SET CREATED</p>	<p>The date and time the upload file was created.</p> <p>AACC management systems should have an automatic 'date and time data set created' field. If an AACC management system does not automatically generate this field, it will need to be manually populated.</p>

6.2 AACCC001 Master Patient Index

AACCC001 Master Patient Index

Description

This group 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 AACCC001 data as it was at the end of the reporting period.

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

It is acknowledged there may be minor differences between the lists of protected characteristics defined in the data set compared to CHC and CYP Checklist/assessment tools, DSTs (Decision Support Tool) and Fast Track forms. 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 data set (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 AACCC001 group is mandatory and must be included in every submission file, along with the AACCC101 group.

Additional Notes on Data Items

Data Item Name	Additional Notes
<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>	<p>This is an identifier used to identify a PATIENT uniquely within a Healthcare Organisation.</p> <p>It may be different from the PATIENT's case note number and may be assigned automatically by the local computer system. This is not the NHS number.</p> <p>This is a linkage data item and the primary key that enables item groups 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.</p> <p>Each patient should have the same Local Patient Identifier across successive submission periods to make reconciliation of data possible.</p> <p>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</p>

	<p>records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same patient.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)</p>	<p>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).</p> <p>It is necessary where organisations have gone through a merger or split into a new or existing organisation.</p> <p>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 specified 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.</p>
<p>NHS NUMBER</p>	<p>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 group will cause the entire file to be rejected.</p>
<p>NHS NUMBER STATUS INDICATOR CODE</p>	<p>This captures whether the NHS number of the patient has been verified.</p> <p>This data item is 'Required' however it is recommended that this is always completed, irrespective of whether an NHS number is present.</p> <p>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.</p> <p>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).</p> <p>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 code in the NHS NUMBER STATUS INDICATOR indicating why (for example, [07] Number not present and trace not required).</p>
<p>PERSON BIRTH DATE</p>	<p>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.</p>

	This should be recorded in the eGIF Date format CCYY-MM-DD
POSTCODE OF USUAL ADDRESS	<p>The Postcode of Usual Address as stated by the person.</p> <p>Where the person has no fixed abode, this should be recorded as ZZ99 3VZ.</p> <p>If the postcode is unknown ZZ99 3WZ should be used.</p> <p>For overseas residents, the postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode.</p> <p>A full list of pseudo postcodes is available from the ODS downloads page¹.</p> <p>If the Postcode is provided and it is not in one of the accepted formats (see the Technical Glossary for details in ETOS), the record will be rejected.</p>
PERSON STATED GENDER CODE	<p>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.</p> <p>Person Stated Gender Code is self-declared or inferred by observation for those unable to declare their Person Stated Gender.</p> <p>The [X] <i>Not Known</i> national code should be used where a gender of the patient has not been recorded.</p> <p>The [9] <i>Not Specified</i> national code should be used where the gender of the patient is indeterminate i.e., unable to be classified as either male or female.</p>
PERSON STATED SEXUAL ORIENTATION CODE	<p>The PERSON STATED SEXUAL ORIENTATION of a PERSON.</p> <p>PERSON STATED SEXUAL ORIENTATION CODE is aligned with descriptors for "Sexual orientation findings" from the NHS Data Dictionary².</p> <p>National code [U] is PERSON asked and does not know or is not sure</p> <p>National code [Z] is Not Stated (PERSON asked but declined to provide a response)</p> <p>For more details for this data item please visit the below data dictionary link</p> <p>PERSON STATED SEXUAL ORIENTATION CODE³</p>

¹ <https://digital.nhs.uk/services/organisation-data-service/export-data-files/csv-downloads>

² https://datadictionary.nhs.uk/data_sets/supporting_data_sets/nhs_continuing_healthcare_patient_level_data_set.html

³ https://www.datadictionary.nhs.uk/data_elements/person_stated_sexual_orientation_code.html

<p>ETHNIC CATEGORY</p>	<p>Ethnicity, as specified by the person.</p> <p>The [Z] <i>Not Stated</i> 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.</p> <p>The [99] <i>Not Known</i> 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.</p> <p>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 AACCC v2.0 these should be mapped to the current approved codes.</p> <table border="1" data-bbox="528 609 975 1895"> <tr> <td></td> <td>White</td> </tr> <tr> <td>A</td> <td>British</td> </tr> <tr> <td>B</td> <td>Irish</td> </tr> <tr> <td>C</td> <td>Any other White background</td> </tr> <tr> <td></td> <td>Mixed</td> </tr> <tr> <td>D</td> <td>White and Black Caribbean</td> </tr> <tr> <td>E</td> <td>White and Black African</td> </tr> <tr> <td>F</td> <td>White and Asian</td> </tr> <tr> <td>G</td> <td>Any other mixed background</td> </tr> <tr> <td></td> <td>Asian or Asian British</td> </tr> <tr> <td>H</td> <td>Indian</td> </tr> <tr> <td>J</td> <td>Pakistani</td> </tr> <tr> <td>K</td> <td>Bangladeshi</td> </tr> <tr> <td>L</td> <td>Any other Asian background</td> </tr> <tr> <td></td> <td>Black or Black British</td> </tr> <tr> <td>M</td> <td>Caribbean</td> </tr> <tr> <td>N</td> <td>African</td> </tr> <tr> <td>P</td> <td>Any other Black background</td> </tr> <tr> <td></td> <td>Other Ethnic Groups</td> </tr> <tr> <td>R</td> <td>Chinese</td> </tr> <tr> <td>S</td> <td>Any other ethnic group</td> </tr> <tr> <td>Z</td> <td>Not stated</td> </tr> <tr> <td>99</td> <td>Not known</td> </tr> </table>		White	A	British	B	Irish	C	Any other White background		Mixed	D	White and Black Caribbean	E	White and Black African	F	White and Asian	G	Any other mixed background		Asian or Asian British	H	Indian	J	Pakistani	K	Bangladeshi	L	Any other Asian background		Black or Black British	M	Caribbean	N	African	P	Any other Black background		Other Ethnic Groups	R	Chinese	S	Any other ethnic group	Z	Not stated	99	Not known
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<p>ETHNIC CATEGORY 2021</p>	<p>Placeholder data item to accommodate the new ethnic categories introduced by the 2021 census when these go live.</p>																																														

	Do not submit values in this data item until otherwise instructed to do so by NHS England.																												
<p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</p>	<p>The RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION of a PERSON, as specified by a PERSON.</p> <p>The value list includes:</p> <table border="1" data-bbox="529 450 959 1232"> <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>E</td><td>Jain</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>	A	Baha'i	B	Buddhist	C	Christian	D	Hindu	E	Jain	F	Jewish	G	Muslim	H	Pagan	I	Sikh	J	Zoroastrian	K	Other	L	None	M	Declines to Disclose	N	Patient Religion Unknown
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J	Zoroastrian																												
K	Other																												
L	None																												
M	Declines to Disclose																												
N	Patient Religion Unknown																												
<p>PERSON DEATH DATE</p>	<p>This must be submitted for any known death not only where a death certificate is issued.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>																												
<p>DISABILITY INDICATOR</p>	<p>An indication of whether a PERSON has been diagnosed as disabled or considers themselves to be disabled.</p>																												

6.3 AACCC101 Referral, Assessment and Outcome

AACCC101 Referral, Assessment and Outcome	
Description	
<p>This group contains information on the NHS AACCC referral process, including screening/checklists, referrals, assessment details, and eligibility decisions.</p> <p>This group, along with the data items submitted within this group, are sometimes referred to as service requests.</p> <p>Providers should supply AACCC101 data as it was at the end of the reporting period.</p> <p>Providers must populate all known data items in this group, even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.</p> <p>Please note that the AACCC101 group is mandatory and must be included in every submission file for each patient, along with the AACCC001 group.</p> <p>This group is to carry details of the screening and / or referral process that individuals are subject to.</p> <p>This group captures information on CHC/CYP referrals (positive checklists/pre-assessments, direct referrals, Fast Track tools, and joint packages of care) or other types of notification (negative checklists, PUPoC requests, local resolution requests, reassessments following review, or disputes).</p> <p>One occurrence of this group is required for each new service request.</p> <p>The AACCC101 group 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).</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<u>SERVICE REQUEST IDENTIFIER</u>	<p>An identifier used to identify a referral or notification uniquely within a health care organisation.</p> <p>This is the unique identifier of the AACCC101 group and is used as a linkage item in the AACCC102 (Care Package) and AACCC103 (Review) groups. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p> <p>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.</p> <p>Duplicate Service Request Identifiers with the Referral Assessment Outcome group will cause the entire file to be rejected.</p>
LOCAL PATIENT IDENTIFIER (EXTENDED)	<p>This is a number used to identify a PATIENT uniquely within a healthcare organisation.</p>

	<p>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.</p> <p>This is the unique identifier for the AACCC001 (Master Patient Index) group and is included here to enable linkage to that group. As such this is a mandated item, and the record will be rejected if a value is not provided.</p> <p>Patients should have the same Local Patient Identifier across successive submission periods to make reconciliation of data possible.</p>						
<p>NHS ALL AGE CONTINUING CARE ACTIVITY TYPE</p>	<p>The type of ACTIVITY for NHS ALL AGE CONTINUING CARE. The value list includes:</p> <table border="1" data-bbox="555 663 1225 831"> <tr> <td data-bbox="560 663 619 712">01</td> <td data-bbox="624 663 1225 712">NHS Continuing Healthcare</td> </tr> <tr> <td data-bbox="560 719 619 768">02</td> <td data-bbox="624 719 1225 768">Joint funded package of health and social care</td> </tr> <tr> <td data-bbox="560 775 619 824">03</td> <td data-bbox="624 775 1225 824">Children and Young People's Continuing Care</td> </tr> </table> <p>01 is to be used for referrals and notifications for adult CHC, as described in the National Framework for CHC and FNC. This includes any CHC checklist, adult fast track referrals, previously unassessed periods of care, direct referrals, CHC local resolution requests or formal inter-agency eligibility disputes.</p> <p>02 is to be used where a jointly funded package of care has been requested by a local authority following a 'not eligible' CHC ASSESSMENT DECISION OUTCOME by the ICB (see section 4.1.3 for further detail).</p> <p>03 is to be used for referrals and notifications for children and young people's continuing care, as described in the National Framework for CYP Continuing Care. This includes any pre-assessment checklist, CYP fast track referrals, direct referrals, CYP local resolution requests, or inter-agency eligibility disputes.</p>	01	NHS Continuing Healthcare	02	Joint funded package of health and social care	03	Children and Young People's Continuing Care
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<p>SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date the service request was received by the ICB.</p> <p>The date the service request was received by the ICB (or person or body acting on behalf of the ICB) with respect to the ICB's CHC/CYP screening and referrals process.</p> <p>If an eligible case is transferred from one ICB to another the receiving ICB can use the date they were notified of the transfer as the service request received date. The eligibility decision date should be the date the receiving responsible commissioner verified responsibility for the case.</p> <p>C101330 FUNDING START DATE (NHS ALL AGE CONTINUING CARE) should then be completed according to the date at which the receiving responsible commissioner started to fund the care from.</p>						

<p>SERVICE REQUEST RECEIVED TYPE (NHS ALL AGE CONTINUING CARE)</p>	<p>SERVICE REQUEST RECEIVED TYPE (NHS ALL AGE CONTINUING CARE) includes details as to how the service request arrived at the ICB. Values include:</p>	
	01	Checklist - positive (NHS Continuing Healthcare)
	02	Checklist – negative (NHS Continuing Healthcare)
	03	Checklist - undefined (NHS Continuing Healthcare)
	04	Pre-assessment / checklist - positive (Children and Young People's Continuing Care)
	05	Pre-assessment / checklist - negative (Children and Young People's Continuing Care)
	06	Pre-assessment / checklist - undefined (Children and Young People's Continuing Care)
	07	Direct referral (NHS All Age Continuing Care)
	08	Fast Track (NHS All Age Continuing Care)
	09	Previously Unassessed Period of Care (NHS Continuing Healthcare)
	10	Joint Package of Health and Social Care Request (NHS Continuing Healthcare)
	11	Referral for re-assessment following a care package review (NHS All Age Continuing Care)
	12	Local resolution (NHS All Age Continuing Care)
	13	Inter-agency dispute (NHS All Age Continuing Care)
	14	Transferred case (NHS All Age Continuing Care)
<p>SERVICE REQUEST RECEIVED TYPE refers to the type of service request received whereas SERVICE REQUEST OUTCOME refers to the outcome of that service request following any processing or quality checking by the ICB. For example, if a 'negative' CHC checklist is received, but following checking by the ICB it is determined the checklist is in fact positive, this should still be recorded as a 'negative checklist' received in SERVICE REQUEST RECEIVED TYPE, with the SERVICE REQUEST OUTCOME '01 refer for full assessment'.</p> <p>01-03 are to be used where a checklist for adult CHC was received, with the 3 options corresponding to the type of checklist received – positive, negative, or undefined.</p> <p>04-06 are to be used where a pre-assessment checklist for CYP was received, with the 3 options corresponding to the type of checklist received. CYP pre-assessment checklists may be positive (04) or negative (05) if a process for scoring checklists prior to submission to the ICB has been defined locally. For pre-assessment checklists that do not specify</p>		

	<p>positive or negative scoring at point of submission to the ICB, use code 06 Undefined.</p> <p>07 is to be used where a care professional has made a direct referral to the ICB for a full CHC or CYP assessment without the use of a checklist (e.g. this is sometimes known as a 'trusted assessors' process locally). Direct referral can also be used where direct FNC provision is set up without the completion of a CHC checklist in certain scenarios. This applies, in exceptional circumstances, where it's been deemed completion of a checklist is not necessary during the process to consider potential CHC eligibility (as per paragraph 121 of the National Framework - please also see FAQs for further information).</p> <p>08 is to be used for fast track referrals for CHC or CYP. Please see 4.1.7 for further information on how to record CYP fast track cases depending on local processes.</p> <p>09 is to be used for requests for previously unassessed periods of care (applicable to CHC only)</p> <p>10 is to be used where a new service request has been generated for a package of care jointly funded by the ICB and local authority. See section 4.1.3 and 4.1.5 for further detail on the definition of Joint Funding for the purposes of the AACC data set.</p> <p>11 is to be used where a new referral has been generated for a reassessment of existing eligibility resulting from a care package review.</p> <p>12 is to be used where a new service request has been generated for a review of an eligibility decision (requested by a patient or representative) under the local resolution process.</p> <p>13 is to be used where a new service request has been generated following a formal inter-agency eligibility (e.g. local authority) dispute being raised. Only formal disputes relating to an eligibility decision are in scope. The amount of contribution of an ICB or local authority to a joint package, or operation of the refunds guidance is out of scope.</p> <p>14 is to be used where an eligible patient's case has been transferred in from another ICB.</p>
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<p>REFERRING ORGANISATION TYPE (NHS ALL AGE CONTINUING CARE)</p>	<p>The type of ORGANISATION of the referring care professional that carried out the NHS All Age Continuing Care service request (e.g. checklist or fast track referral). The value list includes:</p> <table border="1" data-bbox="555 271 1090 857"> <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</td></tr> <tr><td>04</td><td>Local Authority Social Services</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>08</td><td>Integrated Care Board</td></tr> <tr><td>98</td><td>Other (not listed)</td></tr> <tr><td>99</td><td>Unknown</td></tr> </table>	01	General Medical Practitioner Practice	02	Acute Hospital Inpatient/Outpatient Department	03	Community Health Service	04	Local Authority Social Services	05	Hospice	06	Care Home	07	Mental Health Service	08	Integrated Care Board	98	Other (not listed)	99	Unknown
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<p>REFERRING CARE PROFESSIONAL TYPE (NHS ALL AGE CONTINUING CARE)</p>	<p>The type of CARE PROFESSIONAL who carried out the NHS All Age Continuing Care service request (e.g. checklist or fast track referral). The value list includes:</p> <table border="1" data-bbox="555 1003 1082 1444"> <tr><td>01</td><td>Occupational Therapist</td></tr> <tr><td>02</td><td>Physiotherapist</td></tr> <tr><td>03</td><td>Registered Medical Practitioner</td></tr> <tr><td>04</td><td>Registered 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> <tr><td>99</td><td>Unknown</td></tr> </table>	01	Occupational Therapist	02	Physiotherapist	03	Registered Medical Practitioner	04	Registered Nurse	05	Other Nurse	06	Social Care Worker	98	Other Care Professional (not listed)	99	Unknown				
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<p>NHS ALL AGE CONTINUING CARE CHECKLIST OR FAST TRACK REFERRAL COMPLETED DATE</p>	<p>Date on which the service request was completed by the referrer. This item should always be used to provide the completed date of a checklist or fast track referral tool, but can also optionally be used as the date of completion for any other service request type.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD.</p>																				

<p>PATIENT LOCATION (NHS ALL AGE CONTINUING CARE CHECKLIST OR FAST TRACK REFERRAL)</p>	<p>Location of the patient when the checklist or fast track referral tool (or other service request, see above item) was carried out.</p> <p>The value list includes:</p> <table border="1" data-bbox="552 293 1358 904"> <tr> <td>01</td> <td>Own Home</td> </tr> <tr> <td>02</td> <td>General Medical Practitioner Practice</td> </tr> <tr> <td>03</td> <td>Acute Hospital Setting</td> </tr> <tr> <td>04</td> <td>Non-acute Hospital Setting</td> </tr> <tr> <td>05</td> <td>Care Home With Nursing</td> </tr> <tr> <td>06</td> <td>Care Home Without Nursing</td> </tr> <tr> <td>07</td> <td>Hospice</td> </tr> <tr> <td>08</td> <td>Educational Setting – Non-residential</td> </tr> <tr> <td>09</td> <td>Educational Setting – Residential</td> </tr> <tr> <td>98</td> <td>Other (not listed)</td> </tr> <tr> <td>99</td> <td>Unknown</td> </tr> </table>	01	Own Home	02	General Medical Practitioner Practice	03	Acute Hospital Setting	04	Non-acute Hospital Setting	05	Care Home With Nursing	06	Care Home Without Nursing	07	Hospice	08	Educational Setting – Non-residential	09	Educational Setting – Residential	98	Other (not listed)	99	Unknown
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<p>SERVICE REQUEST OUTCOME DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date the service request outcome for NHS All Age Continuing Care was verified by the ICB, or the date a Fast Track referral was accepted.</p>																						
<p>SERVICE REQUEST OUTCOME (NHS ALL AGE CONTINUING CARE)</p>	<p>Outcome of a service request following checking and verification by the ICB. The value list includes:</p>																						

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<p>REFERRAL DISCOUNTED REASON (NHS ALL AGE CONTINUING CARE)</p>	<p>The reason the referral for NHS All Age Continuing Care was discounted by the NHS responsible commissioner.</p> <p>The value list includes:</p> <table border="1"> <tr> <td>01</td> <td>Individual deceased</td> </tr> <tr> <td>02</td> <td>Individual placed on fully funded interim care</td> </tr> <tr> <td>03</td> <td>Individual requiring further Acute treatment</td> </tr> <tr> <td>04</td> <td>Inappropriate referral request</td> </tr> <tr> <td>05</td> <td>Referral request withdrawn by individual/family</td> </tr> <tr> <td>98</td> <td>Other (not listed)</td> </tr> <tr> <td>99</td> <td>Unknown</td> </tr> </table>	01	Individual deceased	02	Individual placed on fully funded interim care	03	Individual requiring further Acute treatment	04	Inappropriate referral request	05	Referral request withdrawn by individual/family	98	Other (not listed)	99	Unknown						
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	<p>Please note that category '01 Individual deceased' can be used for valid circumstances in which a patient deceasing results in an AACC 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).</p> <p>Discounted cases may also include those discounted after assessment has taken place e.g. an individual is agreed eligible for CHC/CYP but the patient or individual decide to withdraw from the process, or an individual passes away before the package / funding starts (and no reimbursement is due – similar to 28 days example above). In this scenario it would be expected for assessment decision outcome to still be completed along with Discounted Reason / Date. Funding Start Date does not need to be completed if the funding never started.</p> <p>Please see FAQs for examples of other checklist and discounted counting scenarios.</p>																						
<p>REFERRAL DISCOUNTED DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date the referral for NHS All Age Continuing Care was discounted by the ICB. This should be recorded in the eGIF Date format CCYY-MM-DD.</p>																						
<p>PATIENT LOCATION DECISION SUPPORT TOOL (NHS ALL AGE CONTINUING CARE)</p>	<p>The setting of the patient at the time the Decision Support Tool was completed by the Multidisciplinary Team as part of the CHC/CYP assessment process. The value list includes:</p> <table border="1" data-bbox="555 1182 1107 2033"> <tr> <td>01</td> <td>Own home</td> </tr> <tr> <td>02</td> <td>General Medical Practitioner Practice</td> </tr> <tr> <td>03</td> <td>Acute Hospital Setting</td> </tr> <tr> <td>04</td> <td>Non-acute Hospital Setting</td> </tr> <tr> <td>05</td> <td>Care Home With Nursing</td> </tr> <tr> <td>06</td> <td>Care Home Without Nursing</td> </tr> <tr> <td>07</td> <td>Hospice</td> </tr> <tr> <td>08</td> <td>Educational Setting – Non-residential</td> </tr> <tr> <td>09</td> <td>Educational Setting – Residential</td> </tr> <tr> <td>98</td> <td>Other (not listed)</td> </tr> <tr> <td>99</td> <td>Unknown</td> </tr> </table>	01	Own home	02	General Medical Practitioner Practice	03	Acute Hospital Setting	04	Non-acute Hospital Setting	05	Care Home With Nursing	06	Care Home Without Nursing	07	Hospice	08	Educational Setting – Non-residential	09	Educational Setting – Residential	98	Other (not listed)	99	Unknown
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	<p>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.</p> <p>‘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.</p> <p>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’. Specialist rehabilitation centres (e.g. Spinal Cord Injury Centres) would also not constitute an acute hospital setting.</p>																		
<p>DECISION SUPPORT TOOL COMPLETED DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date on which the Multidisciplinary Team met with the patient to complete the Decision Support Tool for the CHC/CYP assessment.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>																		
<p>MULTIDISCIPLINARY TEAM RECOMMENDATION (NHS ALL AGE CONTINUING CARE)</p>	<p>The eligibility recommendation of the Multidisciplinary Team following completion of the Decision Support Tool. The value list includes:</p> <table border="1" data-bbox="555 1061 1417 1691"> <tr> <td data-bbox="555 1061 628 1120">01</td> <td data-bbox="633 1061 1417 1120">NHS Continuing Healthcare</td> </tr> <tr> <td data-bbox="555 1126 628 1184">02</td> <td data-bbox="633 1126 1417 1184">NHS-funded Nursing Care</td> </tr> <tr> <td data-bbox="555 1191 628 1263">03</td> <td data-bbox="633 1191 1417 1263">Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care</td> </tr> <tr> <td data-bbox="555 1270 628 1328">04</td> <td data-bbox="633 1270 1417 1328">Children and Young People's Continuing Care</td> </tr> <tr> <td data-bbox="555 1335 628 1406">05</td> <td data-bbox="633 1335 1417 1406">Children and Young People's Continuing Care - Joint with Social Care</td> </tr> <tr> <td data-bbox="555 1413 628 1485">06</td> <td data-bbox="633 1413 1417 1485">Children and Young People's Continuing Care - Joint with Education</td> </tr> <tr> <td data-bbox="555 1491 628 1572">07</td> <td data-bbox="633 1491 1417 1572">Children and Young People's Continuing Care - Tripartite with Social Care and Education</td> </tr> <tr> <td data-bbox="555 1579 628 1637">08</td> <td data-bbox="633 1579 1417 1637">Not eligible for Children and Young People's Continuing Care</td> </tr> <tr> <td data-bbox="555 1644 628 1691">09</td> <td data-bbox="633 1644 1417 1691">MDT could not agree recommendation</td> </tr> </table>	01	NHS Continuing Healthcare	02	NHS-funded Nursing Care	03	Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care	04	Children and Young People's Continuing Care	05	Children and Young People's Continuing Care - Joint with Social Care	06	Children and Young People's Continuing Care - Joint with Education	07	Children and Young People's Continuing Care - Tripartite with Social Care and Education	08	Not eligible for Children and Young People's Continuing Care	09	MDT could not agree recommendation
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<p>ASSESSMENT DECISION DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>Depending on the type of service request type, this item is to include:</p> <ul style="list-style-type: none"> -For CHC/CYP referrals, the date the ICB reached an eligibility decision following a full assessment or re-assessment. -For a local resolution or inter-agency dispute, the date the outcome was decided. -For a transferred case, the date the ICB verified responsibility for the case. 																		

	<p>This data item is not applicable to Independent Reviews. See DATE AGREED ELIGIBLE FOLLOWING INDEPENDENT REVIEW (CURRENT YEAR CASES ONLY) below.</p>																
<p>ASSESSMENT DECISION OUTCOME (NHS ALL AGE CONTINUING CARE)</p>	<p>Depending on the type of service request, this item is to include:</p> <ul style="list-style-type: none"> -For a CHC/CYP assessment, the ICB's eligibility decision. -For a local resolution or inter-agency dispute, the ICB's eligibility decision. -For a transferred case, the eligibility type. <p>The value list includes:</p> <table border="1" data-bbox="555 607 1417 1178"> <tr> <td>01</td> <td>NHS Continuing Healthcare</td> </tr> <tr> <td>02</td> <td>NHS-funded Nursing Care (NHS Continuing Healthcare)</td> </tr> <tr> <td>03</td> <td>Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care</td> </tr> <tr> <td>04</td> <td>Children and Young People's Continuing Care</td> </tr> <tr> <td>05</td> <td>Children and Young People's Continuing Care - Joint with Social Care</td> </tr> <tr> <td>06</td> <td>Children and Young People's Continuing Care - Joint with Education</td> </tr> <tr> <td>07</td> <td>Children and Young People's Continuing Care - Tripartite with Social Care and Education</td> </tr> <tr> <td>08</td> <td>Not eligible for Children and Young People's Continuing Care</td> </tr> </table> <p>Please note that CYP fast track outcomes should only be recorded against ASSESSMENT DECISION OUTCOME if an ICB is adopting a local fast track process whereby a full assessment is required. Where an ICB's local fast track process adopts a local version of a CYP 'fast track tool' (or similar) whereby a full assessment is not required to determine eligibility, a fast track eligibility outcome can be captured under SERVICE REQUEST OUTCOME instead. See 4.1.7 for further information on how to record CYP fast track cases depending on local processes.</p>	01	NHS Continuing Healthcare	02	NHS-funded Nursing Care (NHS Continuing Healthcare)	03	Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care	04	Children and Young People's Continuing Care	05	Children and Young People's Continuing Care - Joint with Social Care	06	Children and Young People's Continuing Care - Joint with Education	07	Children and Young People's Continuing Care - Tripartite with Social Care and Education	08	Not eligible for Children and Young People's Continuing Care
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02	NHS-funded Nursing Care (NHS Continuing Healthcare)																
03	Not eligible for NHS Continuing Healthcare or NHS-funded Nursing Care																
04	Children and Young People's Continuing Care																
05	Children and Young People's Continuing Care - Joint with Social Care																
06	Children and Young People's Continuing Care - Joint with Education																
07	Children and Young People's Continuing Care - Tripartite with Social Care and Education																
08	Not eligible for Children and Young People's Continuing Care																
<p>ELIGIBILITY DECISION OUTCOME COMMUNICATED TO PATIENT DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date the ICB communicated the eligibility decision outcome, in writing, to the patient or representative.</p>																
<p>START DATE REQUESTED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)</p>	<p>The start date requested for a Previously Unassessed Period of Care (PUPoC) which the ICB has been requested to review.</p> <p>If an individual has a referral for NHS CHC <i>and</i> a PUPoC request, the PUPoC should be recorded against its own unique Service Request record, separate to the NHS CHC Service Request.</p>																

<p>END DATE REQUESTED (NHS CONTINUING HEALTHCARE PREVIOUSLY UNASSESSED PERIOD OF CARE)</p>	<p>The end date requested for the PUPoC period which the ICB has been requested to review.</p>
<p>LOCAL RESOLUTION INFORMAL MEETING DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date on which the Informal Local Resolution Meeting took place.</p>
<p>LOCAL RESOLUTION FORMAL MEETING DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>The date on which the Formal Local Resolution Meeting took place. This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>DISPUTE STAGE RESOLVED (NHS ALL AGE CONTINUING CARE)</p>	<p>The stage at which an inter-agency dispute is resolved.</p> <p>An Inter-Agency Dispute relates to the process whereby a relevant ICS partner disputes an eligibility decision following an assessment for AACC. For example, in the case of adult CHC this is where a local authority raises a dispute with an ICB following a CHC assessment which has resulted in a 'not eligible for CHC' decision by the ICB.</p> <p>Disputes may relate to:</p> <ul style="list-style-type: none"> • An initial assessment for All Age Continuing Care • A reassessment for All Age Continuing Care following a review • A Previously Unassessed Period of Care assessment for NHS Continuing Healthcare <p>There may also be up to three stages of a dispute:</p> <ul style="list-style-type: none"> • Informal • Formal • Independent Arbitration <p>For the purposes of the AACCCDS, only formal or independent arbitration disputes raised after an assessment is complete are in scope. Informal disputes which take place before an assessment is complete are not included.</p> <p>It is also only disputes relating to an eligibility decision which are in scope e.g. in the case of adult CHC, eligibility disputes arise when an LA does not agree with a 'not eligible' decision for CHC following a full assessment. The process is the same or similar for Joint Funded cases and eligibility disputes may sometimes also arise for CYP cases. The amount of contribution of an ICB or local authority to a joint package, or operation of the refunds guidance is considered out of scope.</p>
<p>FUNDING START DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>This is the start date from which the individual's care was funded by the ICB (and therefore the date that eligibility started), including any backdated funding.</p>

	<p>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).</p> <p>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 record still stands). Please see FAQs for further information.</p> <p>If an eligible case is transferred from one ICB to another, then Funding Start Date should be completed according to the point at which the receiving ICB started to fund the care (see SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE) for further information about how to record transferred cases).</p> <p>This data item is not applicable to Independent Reviews. See INDEPENDENT REVIEW FUNDING START DATE (CURRENT YEAR CASES ONLY) below.</p>
<p>FUNDING END DATE (NHS ALL AGE CONTINUING CARE)</p>	<p>Last date on which the individual's care was funded to and therefore the date that eligibility ended.</p> <p>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).</p> <p>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).</p> <p>This data item is not applicable to Independent Reviews. See INDEPENDENT REVIEW FUNDING END DATE (CURRENT YEAR CASES ONLY) below.</p>
<p>NHS ALL AGE CONTINUING CARE DATE AGREED ELIGIBLE FOLLOWING INDEPENDENT REVIEW (CURRENT YEAR CASES ONLY)</p>	<p>The date the NHS responsible commissioner agrees the eligible decision of an independent review for CHC.</p> <p>Note this also covers Independent Review cases that have been found eligible following a Parliamentary Health Service Ombudsman review.</p> <p>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).</p> <p>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.</p> <p>A case should normally go through Local Resolution before going to Independent Review, therefore the Independent Review field (if</p>

	<p>applicable as per above) should be attached to the service request record for the associated Local Resolution.</p> <p>Please note this data item is not applicable to CYP.</p>
<p>NHS ALL AGE CONTINUING CARE INDEPENDENT REVIEW FUNDING START DATE (CURRENT YEAR CASES ONLY)</p>	<p>This is the date from which the individual's care was funded, including any backdated funding, for an eligible independent review for CHC. This is the start date the funding / eligibility relates to, not the date the funding actually gets paid. 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.</p> <p>Please note this data item is not applicable to CYP.</p>
<p>NHS ALL AGE CONTINUING CARE INDEPENDENT REVIEW FUNDING END DATE (CURRENT YEAR CASES ONLY)</p>	<p>This is the last date on which the individual's care was funded for an eligible independent review for CHC. 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). 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.</p> <p>Please note this data item is not applicable to CYP.</p>

6.4 AACCC102 Care Package

AACCC102 Care Package	
Description	
<p>This group 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 AACCC cases.</p> <p>Providers should supply AACCC102 data as it was at the end of the reporting period.</p> <p>Providers must populate all known data items in this group even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.</p> <p>One occurrence of this group is permitted for each Care Package.</p> <p>Group AACCC102 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 section 4.5 for a definition of an open case).</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p><u>CARE PACKAGE IDENTIFIER (NHS ALL AGE CONTINUING CARE)</u></p>	<p>The unique identifier for a CARE PACKAGE for the individual. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p> <p>It would normally be automatically generated by the local system upon recording a new care package, although could be manually assigned.</p> <p>An individual's commissioned CHC or CYP may be conveyed across multiple care package records in local systems. Examples of where multiple care package records may be recorded against a single instance of CHC or CYP include (but are not limited to):</p> <ul style="list-style-type: none"> • 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 (and the one-to-one element is split out onto a separate care package record rather than recorded on the same care package record as the main provision). See NUMBER OF COMMISSIONED WEEKLY HOURS OF CARE below for further information on recording one-to-one care.
<p>SERVICE REQUEST IDENTIFIER</p>	<p>This is the unique identifier for the AACCC101 (Referral, Assessment, and Outcome) group, and is included here to enable linkage to that group. As such this is a mandated item, and the record will be rejected if a value is not provided. It would normally</p>

	be automatically generated by the local system upon recording a new Referral, although could be manually assigned.								
CARE PACKAGE START DATE (NHS ALL AGE CONTINUING CARE)	The date that the care package commenced.								
CARE PACKAGE END DATE (NHS ALL AGE CONTINUING CARE)	The date on which the care package ended.								
PERSONAL HEALTH BUDGET TYPE	<p>Type of personal health budget which funds the care package.</p> <p>The value list includes:</p> <table border="1"> <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>99</td> <td>Not funded by Personal Health Budget</td> </tr> </table> <p>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 records according to the respective commissioning arrangements (see CARE PACKAGE IDENTIFIER (NHS ALL AGE CONTINUING CARE) above for more information).</p>	01	Direct payment	02	Notional payment	03	Third party payment	99	Not funded by Personal Health Budget
01	Direct payment								
02	Notional payment								
03	Third party payment								
99	Not funded by Personal Health Budget								
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	A unique identifier for an ORGANISATION providing the care package (as per the ODS portal https://www.odsdatabaseandexport.nhs.uk/).								
COST CENTRE CODE (NHS ALL AGE CONTINUING CARE)	<p>The Integrated Single Finance System (ISFE) cost/revenue code for the 'department' with budgetary responsibility for this care package.</p> <p>For more information on Cost Centre Code (NHS Continuing Healthcare), please see the Future NHS Collaboration Platform* for detailed guidance.</p> <p>https://future.nhs.uk/OIforC/view?objectId=29838160</p> <p>* Registration is required for the Future NHS Collaboration platform, prior to accessing this guidance.</p> <p>and https://datadictionary.nhs.uk/attributes/cost_centre_code_for_nhs_continuing_healthcare.html</p>								

<p>SUBJECTIVE CODE (NHS ALL AGE CONTINUING CARE)</p>	<p>The Integrated Single Finance System (ISFE) code that describes the type of revenue/cost/asset/liability being reported for this care package.</p> <p>For more information on Subjective Code (NHS Continuing Healthcare), please see the Future NHS Collaboration Platform* for detailed guidance.</p> <p>https://future.nhs.uk/OIforC/view?objectId=29838160</p> <p>* Registration is required for the Future NHS Collaboration platform, prior to accessing this guidance.</p> <p>and https://datadictionary.nhs.uk/attributes/cost_centre_code_for_nhs_continuing_healthcare.html?hl=cost%2Ccentre%2Ccode</p>																										
<p>CARE PRODUCT TYPE (NHS ALL AGE CONTINUING CARE)</p>	<p>The type of service funded in the care package.</p> <p>The value list includes:</p> <table border="1" data-bbox="544 797 1366 1559"> <tr><td>01</td><td>Care Home Services with Nursing</td></tr> <tr><td>02</td><td>Care Home Services 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>Home Care</td></tr> <tr><td>06</td><td>Care in Supported Housing</td></tr> <tr><td>07</td><td>Day Care Facility</td></tr> <tr><td>08</td><td>Transport</td></tr> <tr><td>09</td><td>Therapy Service</td></tr> <tr><td>10</td><td>Equipment</td></tr> <tr><td>11</td><td>NHS-funded Nursing Care Standard Rate</td></tr> <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> <p>For further information and definitions on these categories please see Appendix A 'Care Product Type Categories and Definitions'.</p> <p>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).</p> <p>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.</p> <p>The most appropriate care product type should be selected for the service provided by the care package. Where the care package</p>	01	Care Home Services with Nursing	02	Care Home Services Without Nursing	03	Hospice	04	Other Type of Placement	05	Home Care	06	Care in Supported Housing	07	Day Care Facility	08	Transport	09	Therapy Service	10	Equipment	11	NHS-funded Nursing Care Standard Rate	12	NHS-funded Nursing Care High Rate	13	Other Non-Placement Care Package not included in National Codes 05 to 12
01	Care Home Services with Nursing																										
02	Care Home Services Without Nursing																										
03	Hospice																										
04	Other Type of Placement																										
05	Home Care																										
06	Care in Supported Housing																										
07	Day Care Facility																										
08	Transport																										
09	Therapy Service																										
10	Equipment																										
11	NHS-funded Nursing Care Standard Rate																										
12	NHS-funded Nursing Care High Rate																										
13	Other Non-Placement Care Package not included in National Codes 05 to 12																										

	<p>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. For example, where Therapy Services are an integral part of an 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 identifiable 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 Identifier (see CARE PACKAGE IDENTIFIER (NHS ALL AGE CONTINUING CARE) above for further information).</p>										
<p>CONTRACT UNIT COST (NHS ALL AGE CONTINUING CARE)</p>	<p>The contract cost per frequency unit of the care package.</p> <p>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 data set field; otherwise please populate the contract unit cost value accordingly.</p> <p>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.</p> <p>For Joint Funded packages completion of contract unit cost, frequency, and weekly hours is optional. Where this information is completed, it should relate to the NHS contribution to Joint Funded packages only.</p>										
<p>CONTRACT UNIT FREQUENCY CODE (NHS ALL AGE CONTINUING CARE)</p>	<p>The unit of frequency for which the CONTRACT UNIT COST applies.</p> <p>The value list includes:</p> <table border="1" data-bbox="544 1317 853 1601"> <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> <p>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.</p> <p>For Joint Funded packages completion of contract unit cost, frequency, and weekly hours is optional. Where this information is completed, it should relate to the NHS contribution to Joint Funded packages only.</p>	01	One-off cost	02	Hourly	03	Daily	04	Weekly	05	Other frequency
01	One-off cost										
02	Hourly										
03	Daily										
04	Weekly										
05	Other frequency										
<p>NUMBER OF COMMISSIONED WEEKLY HOURS OF</p>	<p>The number of hours of care per week the care provider is contracted to supply.</p>										

<p>CARE (NHS ALL AGE CONTINUING CARE)</p>	<p>Not required if CONTRACT UNIT is 'One-off cost' where recording by weekly hours is not applicable e.g. equipment.</p> <p>Please note if CARE PRODUCT TYPE (NHS ALL AGE CONTINUING CARE) is '11 NHS-funded Nursing Care Standard Rate' or '12 NHS-funded Nursing Care High Rate' this field can be left blank.</p> <p>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 = 168 hours).</p> <p>However, it is also recognised there may be scenarios in which weekly hours of care exceed 168 hours e.g. where additional one-to-one (or two-to-one etc.) care is provided over and above a 24-hour placement.</p> <p>For example, a main care provision for a commissioned bed in accommodation may be 24 hours a day (168 hours a week), and additional one-to-one is 35 hours (see CARE PACKAGE IDENTIFIER above for further information).</p> <p>Where possible, the different aspects can be captured against separate Care Package Identifiers e.g. care package ID1 = 168 hours and care package ID2 = 35 hours. Alternatively, if 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 is not possible to separate out, then both elements of care can be captured under the same Care Package Identifier and submitted as e.g. 203 hours (168 full time placement hours + 35 hours one-to-one care) with the cost for both elements.</p> <p>For Joint Funded packages completion of contract unit cost, frequency, and weekly hours is optional. Where this information is completed, it should relate to the NHS contribution to Joint Funded packages only.</p>
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6.5 AACCC103 Review

AACCC103 Review							
Description							
<p>This group contains information on care package reviews (including standard CHC/CYP, Fast Track CHC/CYP, FNC and joint funded packages of care) and associated outcomes. The collection of these data items can be used to analyse the review period, the review date, and outcome of the review.</p> <p>Providers should supply AACCC103 data as it was at the end of the reporting period.</p> <p>One occurrence of this group is permitted per review that has taken place. Reviews are linked to Service Request Identifier and individuals under multiple funding types (e.g. eligible for both FNC and Joint Funding) should have review information recorded for each component against each of the respective Service Request Identifiers e.g.:</p> <p>SERVICE REQUEST ID 1 FNC eligible > FNC REVIEW</p> <p>SERVICE REQUEST ID 2 JF eligible > Joint Funding REVIEW</p> <p>Group AACCC103 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.</p>							
Additional Notes on Data Items							
Data Item Name	Additional Notes						
SERVICE REQUEST IDENTIFIER	<p>This is the unique identifier for the AACCC101 (Referral, Assessment, and Outcome) group, and is included here to enable linkage to that group. As such this is a mandated item, and the record will be rejected if a value is not provided.</p> <p>Note that the AACCC103 Review group does not require a unique Review identifier item. AACCC103 records are uniquely identified by combining SERVICE REQUEST IDENTIFIER, CARE PACKAGE REVIEW TYPE (NHS ALL AGE CONTINUING CARE) and CARE PACKAGE REVIEW DATE (NHS ALL AGE CONTINUING CARE).</p>						
CARE PACKAGE REVIEW TYPE (NHS ALL AGE CONTINUING HEALTHCARE)	<p>The type of care package review.</p> <p>This is a mandated item.</p> <p>The value list includes:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 50px; text-align: center;">01</td> <td>Three months review</td> </tr> <tr> <td style="text-align: center;">02</td> <td>Twelve months review</td> </tr> <tr> <td style="text-align: center;">03</td> <td>Other/Ad Hoc review</td> </tr> </tbody> </table>	01	Three months review	02	Twelve months review	03	Other/Ad Hoc review
01	Three months review						
02	Twelve months review						
03	Other/Ad Hoc review						
CARE PACKAGE REVIEW DATE (NHS ALL AGE CONTINUING HEALTHCARE)	<p>The date the REVIEW of the CARE PACKAGE took place.</p>						

<p>CARE PACKAGE REVIEW OUTCOME CODE (NHS ALL AGE CONTINUING HEALTHCARE)</p>	<p>The recommended outcome of the individual's care package review.</p> <p>Note that where an outcome indicates the need for a reassessment for CHC/CYP, or a new referral for assessment (e.g. an FNC review identifies an individual may now be eligible for CHC and a referral for CHC assessment is required) a new service request record should be generated under the appropriate SERVICE REQUEST TYPE:</p> <ul style="list-style-type: none"> • Re-assessment of existing eligibility (e.g. existing CHC case requires re-assessment of CHC) should use SERVICE REQUEST TYPE '11 Referral for re-assessment of existing eligibility following a care package review'. • Referral for assessment of a new funding type (e.g. FNC case may now be eligible for CHC) should use the appropriate new referral type e.g. '01 Checklist - positive (NHS Continuing Healthcare)'. <p>See section 4.1.5 for further details.</p> <p>Individuals eligible for multiple funding types (e.g. eligible for both FNC and Joint Funding) should have separate review information recorded for each component against each of the respective service request IDs (e.g. one review group completed for the FNC service request ID and another review group completed for the Joint Funding service request ID (see 'Description' section above).</p>
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Appendix A – Care Product Types Categories and Definitions

National Code	Category	Definition
01	Care Home with nursing	<p>A Care Home is defined as a place where personal care services and accommodation are provided together.</p> <p>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.</p> <p>Examples of Care Homes with Nursing include:</p> <ul style="list-style-type: none"> • Nursing home • Convalescent home with nursing • Respite care with nursing • Mental health crisis house with nursing. <p>Note: The Care Quality Commission definition of nursing care is:</p> <ul style="list-style-type: none"> • "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."
02	Care home without nursing	<p>A Care Home is defined as a place where personal care services and accommodation are provided together.</p> <p>A Care Home without nursing is defined here to distinguish Care Home's that provide qualified nursing care (see Care Home with nursing above) from those that do not.</p> <p>Examples of Care Homes Without Nursing include:</p> <ul style="list-style-type: none"> • Residential home • Rest home • Convalescent home • Respite care • Mental health crisis house • Therapeutic communities.
03	Hospice	<p>A Hospice:</p> <ul style="list-style-type: none"> • 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

		<ul style="list-style-type: none"> will generally employ or work with a broad range of health and social care professionals to meet the needs of people using the service. <p>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.</p> <p>Examples of Hospices include:</p> <ul style="list-style-type: none"> Adult Hospice Children’s Hospice Day Hospice End of life care teams Hospice at home
04	Other Type of Placement	<p>Any placement that does not meet the definition of any of the other categories.</p> <p>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).</p>
05	NHS Continuing Healthcare Funded Home Care	<p>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.</p>
06	NHS Continuing Healthcare Funded Care in Supported Housing	<p>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.</p> <p>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.</p>
07	Day care facility	<p>Day Care Facilities may be called Day Hospitals, Centres, Facilities or Units.</p> <p>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.</p> <p>Day Care Facilities may be financed, planned and run solely by NHS organisations or solely by non-NHS organisations or jointly</p>

		<p>between NHS and non-NHS organisations. Jointly run facilities should still be managed by only one organisation.</p> <p>The facilities specifically do not have hospital beds and function separately from any ward.</p> <p>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.</p>
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	<p>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.</p> <p>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.</p>
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	<p>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.</p> <p>For further information on NHS-funded Nursing Care, see National framework for NHS continuing healthcare and NHS-funded nursing care and FNC practice guidance.</p> <p>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.</p>
12	NHS-funded Nursing Care High Rate	<p>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.</p> <p>For further information on NHS-funded Nursing Care, see National framework for NHS continuing healthcare and NHS-funded nursing care and FNC practice guidance.</p> <p>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:</p>

		<p>a) on review, it is determined that they no longer have any need for registered nursing care; or</p> <p>b) they are no longer resident in a care home that provides registered nursing care; or</p> <p>c) they become eligible for NHS Continuing Healthcare; or</p> <p>d) they die.</p> <p>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.</p>
13	Other Non-Placement Care Package not included in National Codes 05 to 12	<p>Any non-placement care package that does not meet the definition of any of the other available categories.</p> <p>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.</p>

Appendix B – 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 2025 which has associated data stored relating to patients with an active care package as at 1st April 2025 and onwards.

2. Is historical data required within the NHS AACC data set submission file/s?

In summary yes. As per the user guidance (see section 4.1 Data Set Scope) we are expecting (from 1st April 2025):

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:

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

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 section 4.4 Resubmitting Data).

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' data set items in the AACC data set 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 Identifiers. e.g. Local Patient Identifier, Organisation Identifier etc. Patient Identifiable Data (PID) items such as Forename, Surname, Address etc... can be migrated to the new/current system (if required) but these are only 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 data set fields first, followed by 'Required' data set 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 'SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE)', 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 SERVICE REQUEST 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 period will not include referrals with these historical dummy dates).

Please note that while dummy dates may be required for AACC data set 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 AACC data set 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 'SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE)' where this information is not known, and every attempt should be made to obtain the correct information.

Appendix C – Glossary

Term / Abbreviation	Definition
28 days referral time	<p>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 <i>full assessment</i> of NHS CHC eligibility is required (e.g. a <i>positive</i> checklist or other notification that full assessment is required). This is the date that should be recorded against C101040 SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE). Referral time ends at the date the ICB makes a verified decision on eligibility (ELIGIBILITY DECISION COMMUNICATED TO PATIENT DATE (NHS ALL AGE CONTINUING CARE) or the referral is discounted (C101140 REFERRAL DISCOUNTED DATE (NHS ALL AGE CONTINUING CARE)).</p> <p>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 SERVICE REQUEST RECEIVED DATE (NHS ALL AGE CONTINUING CARE) 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.</p> <p>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.</p>
Case	<p>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 data set against the activity type ‘01 NHS Continuing Healthcare’). 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 Identifier <i>and</i> a PUPoC Request with a different Service Request Identifier).</p>
Data Item	<p>A data item in the context of the All Age Continuing Care data set is the definition of a discreet unit of information to be collected. A data item can be thought of as equivalent to a field definition for a database.</p>
Group	<p>A group in the context of the All Age Continuing Care is a collection of data items that should be submitted together. A group can be thought of as equivalent to table definition for a database.</p>

<p>Referral or notification</p>	<p>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 data set 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 Identifier.</p> <p>Referrals or notifications in the data set include e.g. positive checklists, negative checklists, Fast track referrals, PUPoC requests, or Local Resolution Requests.</p> <p>Note that "referral or notification" is sometimes used interchangeably with "service request" (see below).</p>
<p>Reporting Period</p>	<p>An AACCC data set reporting period refers to the window of time in which activity should be submitted. AACCC reporting periods align to calendar month, so in a given month activity that occurred between the first and last days of the previous calendar month should be submitted.</p>
<p>Service Request</p>	<p>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 Identifier.</p>

Appendix D – Summary of Changes

Below is the summary of changes made to the AACCCDS User Guidance since the initial published version (v1.0)

Version	Date	Section	Change
1.1	20.01.26	4.1 Data Set Scope	Addition – confirmation that the AACC data set is submitted at sub-ICB location level.
1.1	20.01.26	4.1.5 Joint Funded Package of Health and Social Care	Amendment – adjusted wording in third paragraph for out-of-scope cases and link to FAQs.
1.1	20.01.26	4.1.8 When to generate a Service Request record	Amendment – minor immaterial adjustments to wording for better clarity.
1.1	20.01.26	4.1.9 Open Activity	Amendment – adjusted wording for better clarity on definition of an ‘open case’.
1.1	20.01.26	4.1.10 Closing a Case Record	Amendment – adjusted wording for better clarity on definition of a ‘closed case’. Addition – confirmation on what constitutes a ‘closed case’ in different scenarios relating to ineligible cases. Addition – confirmation on what constitutes a ‘closed case’ in different scenarios relating to eligible cases.
1.1	20.01.26	4.1.11 Out-of-scope activity	Amendment – minor immaterial adjustments to wording for better clarity.
1.1	20.01.26	4.3 Validation	Amendment – adjusted wording for better clarity on definition of a rejection.
1.1	20.01.26	4.3.1 Validation Levels	Amendment – adjusted wording for better clarity on definition of record level validations.
1.1	20.01.26	4.5 Data submission examples	Amendment – adjusted wording for better clarity on inclusion rules and what constitutes an ‘open case’.
1.1	20.01.26	6.1 AACC000 Header / ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Addition – confirmation that the AACC dataset is submitted at sub-ICB location level, with the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) identifying the sub-ICB location to which the reported data relates.
1.1	20.01.26	6.3 AACC101 Referral, Assessment and Outcome	Amendment – minor adjustment to wording (“records” changed to “data items” in second paragraph).
1.1	20.01.26	6.3 AACC101 Referral, Assessment and Outcome / NHS ALL AGE CONTINUING	Amendment – minor adjustment to wording for better clarity (“inter-agency eligibility disputes” changed to “formal inter-agency eligibility disputes”).

		CARE ACTIVITY TYPE	
1.1	20.01.26	6.3 AACC101 Referral, Assessment and Outcome / SERVICE REQUEST RECEIVED TYPE (NHS ALL AGE CONTINUING CARE)	Amendment – minor immaterial adjustments to wording for better clarity in items 11 and 12.
1.1	20.01.26	6.4 AACC102 Care Package / ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Amendment – updated link to ODS search website provided.