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Annex B – Investment and Impact Fund (IIF): 2021/22 and 2022/23

Scheme description

I. Improve prevention and tackling health inequalities
IIF indicators in this area will support primary care networks (PCNs) to undertake a range of activity to address well known inequalities in rates of diagnosis for cardiovascular disease (CVD), delivery of Learning Disability Health Checks and the influenza vaccination to potentially high-risk cohorts. In 2021/22, there will be an indicator rewarding comprehensive of recording of ethnicity data in the GP record. This will help PCNs better understand their populations, plan and deliver services, and target interventions where necessary. *CVD indicators, further detail:* The NHS Long Term Plan commits to the prevention of 150,000 strokes, heart attacks and dementia cases by 2029 through the earlier detection and treatment of CVD risk factors. The IIF indicators focussing on CVD will drive relevant activity to support this ambition, with a particular focus on hypertension in 21/22: *Hypertension case finding* CVD is a leading cause of death and disability in England, but an estimated 30% of hypertension is undiagnosed. An estimated 3 million people have a recorded reading of high blood pressure (BP) on GP systems, but have not had appropriate follow up to confirm or rule out a hypertension diagnosis. This issue is expected to have been exacerbated during the pandemic. Indicator CVD-01 encourages PCNs to follow up more patients with an elevated BP reading (including through proactive outreach, where possible) to assess them for hypertension, typically through provision of Ambulatory or Home BP Monitoring. CVD-02 rewards PCNs for the corresponding rate of hypertension diagnoses which can be expected having undertaken appropriate follow up activity for individuals with high BP. CVD-01 complements quality outcomes framework (QOF) indicator BP002, which rewards practices for blood pressure recording. This QOF incentive means that a significant percentage of undiagnosed hypertension is known to general practice in the form of an elevated BP reading. CVD-01 rewards PCNs for adherence with NICE guidance on timely follow-up for patients to confirm or exclude a diagnosis of hypertension. *Familial hypercholesterolaemia (FH)* FH affects at least 150,000 people in England, but only 7% of cases were diagnosed as of 2019/20. CVD-04 will support the NHS Long Term Plan ambition to increase levels of diagnosis to 25% by 2023/24.

II. Support better patient outcomes in the community through proactive primary care

Indicators in this area will reward PCNs for:

- Delivery of high rates of coverage of key elements of the Enhanced Health in Care Homes model, as well as appropriate recording of residency in a care home in GP systems, which current data suggests is only complete for ~50% of residents;
- Mitigation of emergency admissions for care home residents and patients with a subset of Ambulatory Care Sensitive Conditions;
- Preparatory work in 21/22 including planning and engagement with system partners to lay the groundwork for delivery of the emergency admission indicators in 22/23;
- Continued expansion of social prescribing services, in line with LTP ambitions.

Emergency admissions indicators, further detail

Investment and Evolution committed to introducing financial incentives for PCNs to cover avoidable A&E attendances and emergency admissions and the 21/22 and 22/23 IIF package begins to meet that commitment.

The 2021/22 indicator ACC-03 will reward PCNs for undertaking activities that will help to identify opportunities to reduce unnecessary emergency attendances and admissions – for example, ensuring comprehensive local mapping of services is in place and making use of demand and capacity tools. These measures are expected to support systems in delivering safe alternative pathways to emergency department (ED) attendance and conveyance. Further detail on the criteria for this indicator will be provided in forthcoming guidance. To further support this work, we will make available to PCNs data relating to the number of minor acuity ED attendances per PCN.

The 2022/23 indicators AC-02 and EHCH-06 will reward PCNs for moderating the rate of all emergency admissions from care home residents and for emergency admissions relating to a subset of Ambulatory Care Sensitive Conditions, selected for their high rate of amenability to care delivered by general practice. These ACSCs[1] have been subjected to clinical review and selected on the basis of meeting either of the two following criteria:

- Amenability to effective long-term condition management in primary care
- Amenability to rapid primary care response to an acute presentation

We have removed any ACSCs which are considered to be out of the control of general practice (e.g. dental conditions), and also those that are particularly low volume.

Evidence from the EHCH vanguard programme highlighted that delivery of the key elements of the model supported a reduction in avoidable emergency admissions, when combined with effective partnership work between clinical services and care

[1] In scope ACSCs: COPD, Diabetes complications, Convulsions and Epilepsy, Asthma, Congestive Heart Failure, Hypertension, Influenza and Pneumonia, Ear Nose and Throat Infections, Pyelonephritis, Cellulitis.

home providers. Thresholds for EHCH-06 thresholds are calibrated to recognise that many admissions from care homes are clinically appropriate and unavoidable and calls to emergency services should continue to take place where clinically appropriate and in the interests of patients.

In order to maximise the incentive effect for all PCNs in relation to AC-02 and EHCH-06, these indicators will operate with a composite reward structure where PCNs have two separate opportunities to achieve the entire reward for these indicators. The first is on the basis of their relative improvement against an agreed baseline; in recognition of the fact that current low performers should have an opportunity to earn for the efforts required to improve. The second opportunity to earn is on the basis of an absolute level of performance, which ensures that those PCNs that are already high performing can access reward for maintaining that level of performance. PCNs will be rewarded on whichever of the two bases upon which they earn the greatest number of points.

III. Support improved patient access to primary care services

The GP Contract Framework commits to improving access to primary care services. Primary care plays a fundamental role as the 'front door' of the NHS: equitable and responsive access is therefore essential to better patient health. Through the IIF, PCNs will be rewarded for achieving:

- Improvements in patient experience of access to general practice, though financial incentives linked to performance in relation to the forthcoming survey-based real-time measure of patient experience (ACC-06).
- Continued delivery of online consultations. Indicator ACC-02 ensures that online consultations continue to be offered to patients consistently across the country as we exit the pandemic, relieving pressures on wider services as part of the Recovery Programme.
- Improved utilisation of Specialist Advice services – indicator ACC-07 will support the wider NHS recovery of elective care services through avoidance of unnecessary outpatient activity.

- Reductions in rates of long waits for routine general practice appointments, which are a leading cause of dissatisfaction with primary care services and can result in the escalation of clinical needs.
    - GP Appointments Data will be used to construct a measure of waiting time for an appointment, using the new national appointment categories as well as a forthcoming system of appointment exception reporting to restrict attention to appointments for which time from booking to appointment is a valid proxy for 'true' waiting time (see below for further details).
    - Using this measure, we indicator ACC-08 will be introduced to reward PCNs for reductions in the percentage of patients waiting more than two weeks for an appointment.
    - We will keep under review whether further contractual requirements are needed to guard against the creation of perverse incentives for practices to refuse to book appointment more than two weeks in advance.

IV. Deliver better outcomes for patients on medication

PCNs have been delivering SMRs as a contractual requirement via the Network Contract DES since October 2020. The 2022/23 indicator SMR-01 will reward PCNs for high rates of SMR delivery to the primary target cohorts as outlined in the DES. This recognises the expanding capacity of suitable clinicians available to PCNs via funding from the Additional Roles Reimbursement Scheme (ARRS).

The 2020/21 IIF included a series of indicators focussed on improved prescribing to support a reduction in medicines-related harm (MS01, MS02, MS03). These indicators successfully ensured that gastro protective medicines were added for between 75% and 85% of the prescriptions being targeted. In response to feedback on the suitability and positive effect of these indicators, a series of new medicines safety indicators will be introduced from 2022/23. Building on the 2020/21 performance rates, the 2022/23 indicators directly incentivise good prescribing practice for patients prescribed drug combinations that are known to have increased risk of associated harm. Along with the SMR indicator, they will support reduction of unnecessary hospital admissions due to medicines-related harm, which are estimated to cost £400m annually.

Two further indicators aimed at improving prescribing to deliver better outcomes for asthma patients are discussed in section V below.

V. Help create a more sustainable NHS

We will introduce a suite of four indicators focussed on improving inhaler prescribing to support the dual outcomes of (i) improved respiratory care and health outcomes for the 12% of the population with an asthma diagnosis, and (ii) delivering on the NHSEI and BMA ambitions to reduce avoidable carbon emissions through encouraging choice of lower carbon inhaler alternatives, where clinically appropriate. The *Delivering a 'Net Zero' National Health Service* report reinforced the Long Term Plan commitment to reduce carbon emissions from Metered Dose Inhalers (MDIs) by 403kt CO2e and committed to an additional 374kT of reductions by 2040 through further uptake of low carbon inhalers.

From 2022/23, the IIF will reward PCNs for increasing the percentage of asthma patients who are regularly prescribed an inhaled corticosteroid (ICS, or preventative inhaler), where clinically indicated. As well as improving patient health, it is envisaged that this incentive will also enable reductions in unnecessary SABA prescribing (and therefore carbon emissions) by improving disease control. A further incentive will directly reward PCNs for achieving these reductions in avoidable SABA prescribing. Our aim is that, by 2024/25, 90% of patients on the asthma register will be regularly prescribed an ICS, while only 10% will be prescribed 6 or more SABA inhalers per year (a marker of poor disease control). Pharmacies taking part in the Pharmacy Quality Scheme have been proactively identifying and referring asthma patients with markers of poor disease control.

In addition, two further indicators aimed at reducing inhaler carbon emissions will commence in October 2021.

- Dry Powder Inhalers (DPIs) and Soft Mist Inhalers (SMIs) offer a low-carbon alternative to Metered Dose Inhalers (MDIs). From October 2021, the IIF will

reward increased prescribing of DPIs and SMIs where clinically appropriate. Our aim is that, in line with best practice in other European countries, by 2023/24 only 25% of non-salbutamol inhalers prescribed will be MDIs.

- Salbutamol MDIs are the single biggest source of carbon emissions from NHS medicines prescribing. From October 2021, the IIF will also reward increased prescribing of less carbon intensive salbutamol MDIs. Our ambition is to reduce the mean life-cycle carbon intensity of salbutamol inhalers prescribed in England to 13.4 kg by 2023/24.

Feedback, to be published later in the year, suggests that the majority of asthma patients using MDIs would change device for environmental reasons so long as the new inhaler was efficacious, easy to use and fitted their current routine, and that they could change back if needed. Additional guidance and advice will therefore be provided alongside rollout of these indicators to support shared decision making and patient choice of inhaler. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New Medicines Service consultation and inhaler technique check for patients prescribed an inhaler for the first time or are changing or have changed to a new inhaler device during the pandemic.

2021/22 IIF indicators, thresholds and valuations

I. Improving prevention and tackling health inequalities			
Indicator	Thresholds	Valuation	Data source
HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts	GPES
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts	GPES
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts	GPES
VI-02: Percentage of at-risk patients[2] aged 18 to 64 years inclusive who received a seasonal influenza vaccination between 1 September and 31 March	57% (LT), 90% (UT)	£19.8m / 88 pts	GPES
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m / 14 pts	GPES
CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022[3]	20% (LT), 25% (UT)	£12.0m / 53 pts	GPES
CVD-02: Percentage of registered patients on the QOF Hypertension Register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts	GPES

[2] "At-risk" refers to patients in the following cohorts (those subject to national call and recall system): Chronic respiratory disease, Chronic heart disease, Chronic kidney disease, Chronic liver disease, Chronic neurological disease, Learning disabilities (as captured by being on the QOF Learning Disability register), Diabetes, Immunosuppression, Asplenia or dysfunction of the spleen, Morbid obesity, People in long stay residential or homes.

[3] Specifically: occurrence of one of the following within six months of 1 October 2021 (cohort (i)) or the first elevated blood pressure reading after 1 October 2021 (cohort (ii)): (1) Ambulatory Blood Pressure Monitoring; (2) Home Blood Pressure Monitoring; (3) Change of medication followed by subsequent non-elevated reading; (4) Addition to QOF Hypertension Register alongside same day referral for specialist assessment; (5) Addition to QOF Hypertension Register alongside either subsequent commencement of antihypertensive therapy or a record that the patient declined antihypertensive therapy.

II. Support better patient outcomes in the community through proactive primary care			
Indicator	Thresholds	Valuation	Data source
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts	GPES
EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts	GPES / CQRS manual entry
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts	GPES
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts	GPES
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over	3 (LT), 4 (UT)	£2.9m / 13 pts	GPAD[4] / GPES

III. Support improved patient access to primary care services			
Indicator	Thresholds	Valuation	Data source
ACC-01: Confirmation that all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments	n/a - Binary indicator	£6.1m / 27 pts	Commissioner manual submission
ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients	65 over 3 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts	OCVC Extended Collection / GPES
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts	CQRS manual entry
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase	n/a Binary indicator	£12.6m / 56 pts	CQRS manual entry

[4] GP appointment data (GPAD) at PCN level will be made available from October 2021 in alignment with introduction of this IIF indicator, and will be included in future enhanced GPAD publications.

referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.			
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts	CQRS manual entry

V. Help create a more sustainable NHS			
Indicator	Thresholds	Valuation	Data source
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts	GPES
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	25.1 kg (LT), 22.1 kg (UT)	£6.1m / 27 pts	BSA prescribing data

Total Value / Points	**£150.2m / 666 points**

IIF 22/23 indicators, thresholds and valuations

I. Improving prevention and tackling health inequalities			
Indicator	Thresholds	Valuation	Data source
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	60% (LT), 80% (UT)	£8.1m / 36 pts	GPES
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts	GPES
VI-02: Percentage of at-risk patients aged 18 to 64 years inclusive who received a seasonal influenza vaccination between 1 September and 31 March[5]	57% (LT), 90% (UT)	£19.8m / 88 pts	GPES
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m 14 pts	GPES
CVD-01: Percentage of patients aged 18 or over with an elevated blood pressure reading (≥ 140/90mmHg)[6] and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up[7] to confirm or exclude a diagnosis of hypertension	25% (LT), 50% (UT)	£16.0m / 71 pts	GPES
CVD-02: Percentage of registered patients on the QOF Hypertension Register	Increase 0.6pp (LT), Increase 1.2pp (UT)	£7.9m / 35 pts	GPES
CVD-03: Percentage of patients aged between 25 and 84 years of age inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	48% (LT), 58% (UT)	£7.0m / 31pts	GPES
CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total	20% (LT), 48% (UT)	£4.1m / 18 pts	GPES

[5] See footnote 4 for cohort definition.

[6] Either (i) a last recorded blood pressure reading in the two years prior to 1 April 2022 >= 140/90mmHg, or (ii) a blood pressure reading >= 140/90mmHg on or after 1 April 2022.

[7] Occurrence of one of the following within six months of 1 April 2022 (cohort (i)) or the first elevated blood pressure reading after 1 April 2022 (cohort (ii)): (1) Ambulatory Blood Pressure Monitoring; (2) Home Blood Pressure Monitoring; (3) Change of medication followed by subsequent non-elevated reading; (4) Addition to QOF Hypertension Register alongside same day referral for specialist assessment; (5) Addition to QOF Hypertension Register alongside either subsequent commencement of antihypertensive therapy or a record that the patient declined antihypertensive therapy.

cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia			

II. Support better patient outcomes in the community through proactive primary care			
Indicator	Thresholds	Valuation	Data source
PC-01: Percentage of registered patients referred to a social prescribing service	1.2% (LT), 1.6% (UT)	£4.5m / 20 pts	GPES
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts	GPES
EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	6 (LT), 8 (UT)	£2.9m / 13 pts	GPAD/ GPES
EHCH-06: Standardised number of emergency admissions per 100 care home residents	Improvement: Reduction of 0 (LT), 4 (UT) Absolute: 30 (LT), 20 (UT)	£6.1m / 27 pts	HES-SUS APC / GPES
AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions[8] per 1000 registered patients	Improvement: Reduction of 0 (LT), 1 (UT) Absolute: 10 (LT), 8 (UT)	£25.0m / 111 pts	HES-SUS APC / GPES

III. Support improved patient access to primary care services;			
Indicator	Thresholds	Valuation	Data source
ACC-06: Standardised percentage of survey respondents indicating that it was “easy” or “very easy” for them to make a general practice appointment, or to seek medical care or advice from their general practice	35th (LT), 65th (UT) percentile of performance from piloting	£25.0m / 111 pts	Patient experience survey
ACC-02: Number of online consultation submissions received by the PCN per 1000 registered patients	**TBC**	£4.1m / 18 pts	OCVC Extended Collection / GPES
ACC-07: Specialist Advice utilisation rate (number of Specialist Advice requests per 100 outpatient first attendances) across	6.6 (LT), 19 (UT)	£9.9m / 44 pts	System Elective Recovery Outpatient Collection (EROC) /

[8] ACSCs in scope: COPD, Diabetes complications, Convulsions and Epilepsy, Asthma, Congestive Heart Failure, Hypertension, Influenza and Pneumonia, Ear Nose and Throat Infections, Pyelonephritis, Cellulitis.

twelve specialties[9] identified for accelerated delivery			HES-SUS OP
ACC-08: Percentage of patients who had to wait two weeks or less for a general practice appointment	90% (LT), 98% (UT)	£16.0m / 71 pts	GPAD
ACC-09: Number of referrals to the Community Pharmacist Consultation Service per 1000 registered patients	34 (0.65 per 1000 per week) (single threshold)	£6.1m / 27 pts	GPES

IV. Deliver better outcomes for patients on medication			
Indicator	Thresholds	Valuation	Data source
SMR-01: Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review	**TBC**	£12.0m / 53 pts	GPES
SMR-02A: Percentage of patients aged 18 years or over prescribed **both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant** in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	85% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02B: Percentage of patients aged 65 years or over prescribed **a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant** in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	85% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02C: Percentage of patients aged 18 years or over prescribed **both an oral anticoagulant and an anti-platelet** in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet.	75% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02D: Percentage of patients aged 18 years or over prescribed **aspirin and another anti-platelet** in the 3 months to 1 April 2022, who in the 3 months to 1 April	75% (LT), 90% (UT)	£0.9m / 4 pts	GPES

[9] Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat.

2023 were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet.			
SMR-03: Percentage of patients prescribed a **direct oral anti-coagulant**, who received a **renal function test** and a recording of their weight and Creatinine Clearance Rate, along with a **change or confirmation of their medication dose**.	50% (LT), 75% (UT)	£2.9m / 13 pts	GPES
RESP-01: Percentage of patients on the QOF Asthma Register who were regularly prescribed* an inhaled corticosteroid over the previous 12 months * 22/23: 3 or more ICS prescriptions; 23/24 onwards: 5 or more ICS inhalers.	71% (LT), 90% (UT)	£7.0m/ 31 pts	GPES
RESP-02: Percentage of patients on the QOF Asthma Register who received six or more SABA inhaler prescriptions* over the previous 12 months * From 23/24: who were prescribed 6 or more SABA inhalers	25% (LT), 15% (UT)	£5.0m/ 22 pts	GPES

V. Help create a more sustainable NHS			
Indicator	Thresholds	Valuation	Data source
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over	44% (LT), 35% (UT) intended 23/24 trajectory: 35%/25%	£6.1m / 27 pts	GPES
ES-02: Mean carbon emissions per salbutamol inhaler prescribed (kg CO_2e)	22.1 kg (LT), 18.0 kg (UT) intended 23/24 trajectory: 18.0 kg/ 13.4 kg	£9.9m / 44 pts	BSA prescribing data

Total Value / Points	**£225.3m / 999 points**

Further detail: New measure of general practice waiting times

Indicator ACC-08 ('Percentage of patients who waited two weeks or less for an appointment in general practice') is based on GP Appointments Data, using the new national appointment categories as well as a forthcoming system of appointment exception reporting to restrict attention to appointments for which time from booking to appointment is a valid proxy for 'true' waiting time. Specifically, indicator ACC-08 will be based on 8 of the 17 patient-facing appointment categories. For these 8 categories, it can in many or all cases be assumed that the patient will have requested the first available appointment – therefore, time from booking to appointment can, in many or all cases, be taken as a valid proxy for 'true' waiting times.

For a subset of these 8 appointment categories, patients will sometimes request appointments on a defined future date (or express preferences concerning the appointment that have the same effect). For these appointment categories – most prominently, "General Consultation – Routine" – we will introduce a system of exception reporting whereby practices can indicate when one of the following has occurred:

1. Patient requested appointment on a defined future date.
2. Clinician-requested follow-up appointment after providing care or advice.
3. Patient asked for an appointment with a specific clinician.
4. Patient asked for an appointment at a specific time of day.

If one of these circumstances is flagged as applying to an appointment, that appointment would be omitted from the calculation of indicator ACC-08 *if* the time from booking to appointment is greater than two weeks. If on the other hand the time from booking to appointment is less than two weeks, the appointment would be included in calculation of ACC-08 irrespective of whether exception reporting was invoked.

#	Category Name	In scope of IIF waiting time measure?	Exception reporting allowed?
1.	General Consultation Acute	Yes	No
2.	General Consultation Routine	Yes	Yes
3.	Planned Clinics		
4.	Planned Clinical Procedure		
5.	Unplanned Clinical Activity	Yes	No
6.	Walk in	Yes	No
7.	Triage	Yes	No
8.	Home Visit	Yes	Yes
9.	Care Home Visit	Yes	Yes
10.	Group Consultation and Group Education		
11.	Structured Medication Review		
12.	Patient contact during Care Home Round		
13.	Care Home Needs Assessment & Personalised Care and Support Planning		
14.	Social Prescribing Service		
15.	Service provided by organisation external to the practice		

16.	Non-contractual chargeable work		
17.	Care Related Encounter but does not fit into any other category	Yes	Yes