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Network Contract Directed Enhanced Service

Investment and Impact Fund 2022/23: Updated Guidance

March 2022

Contents

1. Introduction

1.1 The Investment and Impact Fund (IIF) forms part of the Network Contract Directed Enhanced Service (DES). It supports primary care networks (PCNs) to deliver high quality care to their population, as well as supporting the delivery of priority objectives articulated in the NHS Long Term Plan and in *Investment and Evolution; a five-year GP contract framework to implement the NHS Long Term Plan*.

1.2 In line with the wider Network Contract DES, the IIF for 2022/23 has been designed to support PCNs during their ongoing response to and recovery from the COVID-19 pandemic. This includes focusing on preventative activity for cohorts at particular risk of poor health outcomes from COVID-19, and in tackling health inequalities more directly and proactively.

1.3 The IIF is a financial incentive scheme. It focuses on rewarding high quality care in areas where PCNs can contribute significantly towards the 'triple aim':

- Improving health and saving lives (e.g. through increased diagnosis of hypertension)
- Improving the quality of care for people with multiple morbidities (e.g. through delivering Structured Medication Reviews and increasing the number of asthma patients who are regularly prescribed inhaled corticosteroids)
- Helping to make the NHS more sustainable.

1.4 While the IIF is a PCN-level incentive scheme, there are overlaps between it and the Quality and Outcomes Framework (QOF), which operates at practice level. Some indicators across both schemes incentivise similar activity and practices may find they can make progress towards both simultaneously. This document notes any linkages between IIF indicators and QOF indicators where relevant.

1.5 *Investment and Evolution* set out that the IIF would be worth at least £225 million in 2022/23, rising to at least £300 million in 2023/24. The 2022/23 scheme is worth £260m, following additional funding of £35m to support new indicators in 2022/23.

1.6 Elements of the IIF were suspended in late 2021/22 in response to the emergence of the Omicron variant of COVID-19 and the need to accelerate

the delivery of booster vaccinations. Where indicators were planned to run across both 2021/22 and 2022/23, these will be restarted from 1 April 2022 and PCNs will be paid on the basis of performance for the 2022/23 financial year.

1.7 This document provides guidance on the IIF for 2022/23, including key details of the individual indicators. Information on how performance and achievement will be calculated is also included, and should be read alongside the relevant sections of the 2022/23 Network Contract DES specification (Sections 10.6 and Annexes C and D). For indicators sourced from the GP Extraction Service (GPES), the business rules published by NHS Digital provide full details of how the indicators are constructed from information in GP systems. For Indicators that are not sourced from GPES, more technical details are provided (or links provided for) in this guidance. In addition, CQRS guidance provides details on the submission and reporting of data for all indicators.

2. Structure of the IIF

2.1. This section introduces the key elements of the IIF in 2022/23:

- Domains, areas, and indicators
- Indicator structure, performance, exclusions and exceptions (personalised care adjustments)
- Achievement points
- Achievement payments, prevalence adjustment and list size adjustment
- Monitoring IIF performance.

Domains, areas, and indicators

2.2 The IIF is divided into three domains: (i) prevention and tackling health inequalities, (ii) providing high quality care and (iii) a sustainable NHS. Each domain consists of several areas, which in turn consist of a number of indicators.

2.3 The domains, areas, and indicators for the IIF in 2022/23 are set out in the summary table below, along with respective start dates for each indicator.

Summary of indicators

Domain	Area	Indicators
Prevention and tackling health inequalities	Vaccination and immunisation	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-02: Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-03: Percentage of patients aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
	Tackling health inequalities	**HI-01:** Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan

Domain	Area	Indicators
		HI-02: Percentage of registered patients with a recording of ethnicity on their GP record
	CVD prevention	**CVD-01:** Percentage of patients aged 18 or over with an elevated blood pressure reading (≥140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension
		CVD-02: Percentage of registered patients on the QOF Hypertension Register
		CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins
		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 cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia
		CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist
		CVD-06: Number of patients that are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC)

Domain	Area	Indicators
Providing high quality care	Personalised care	**PC-01**: Percentage of registered patients referred to a social prescribing service
	Enhanced health in care homes	**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 aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service
		EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed
		EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over
		EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over
	Anticipatory Care	**AC-02:** Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient
	Cancer	**CAN-01:** Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral
	Access	**ACC-02:** Number of online consultation submissions received by the PCN per registered patient
		ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into

Domain	Area	Indicators
		account demographic information including levels of deprivation
		ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance
		ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less
		ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient
	Structured medication reviews and medicines optimisation	**SMR-01A:** Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review
		SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review
		SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review
		SMR-01D: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
		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 last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant
		SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral

Domain	Area	Indicators
		anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID
		SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date 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
		SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date 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-acting oral anti-coagulant (DOAC), who received a renal function test and have a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed)
	Respiratory care	**RESP-01:** Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months
		RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months

Domain	Area	Indicators
A Sustainable NHS	Environmental sustainability	**ES-01:** Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over
		ES-02: Mean carbon emissions per salbutamol inhaler prescribed (kg CO_2e)

Indicator structure and performance calculation

2.4 IIF indicators are either 'Qualitative' or 'Quantitative'. Quantitative indicators are further divided into four assessment categories: Binary, Standard, Improvement or Composite. In addition, Quantitative indicators can be standardised.

2.5 **Qualitative** indicators consist of a criterion or set of criteria. A PCN can either earn all the points available, or no points, based on whether the criterion or set of criteria are met. Where there are multiple criteria, failure to meet any one of the criteria means that no points are earnt.

2.6 **Quantitative** indicators are constructed from the ratio of a numerator and denominator. For **Binary** and **Standard** Quantitative indicators, this represents the indicator performance (Performance X = Numerator (N)/Denominator (D)). For **Improvement** Quantitative indicators, performance is based on the change in this ratio relative to a base period (Performance X = N/D – N0/D0).[1] For **Composite** Quantitative indicators, both of the above approaches are used to measure performance, with the best performance used as the basis for IIF achievement.

2.7 The desired direction of performance may be upwards or downwards. If it is upwards, a higher indicator value means better performance and a lower one means worse performance; and if it is downwards, a lower indicator value means better performance and a higher one means worse performance.

[1] N0/D0 represents the ratio of a PCN's numerator and denominator from an earlier period e.g. the previous year.

2.8 The denominator of each Quantitative indicator is the target cohort for the intervention in question. In 2022/23 IIF, the target cohort for all Quantitative indicators is a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients. For example, for indicator HI-01 the target cohort is people on the QOF Learning Disability Register aged 14 and over.

2.9 In addition to the assessment categories described above, Quantitative indicators can be standardised. This process adjusts each PCN's indicator performance to account for differences in patient demographics that would otherwise, and unjustly, impact on the indicator performance. Annex B provides further details of the methodology used.

Exclusions and Exceptions (Personalised Care Adjustments)

2.10 Exclusions may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator. Exclusions are applied prior to assessment of 'success' and are therefore removed even if action or intervention that the IIF indicator seeks to reward has happened. The exact circumstances in which Exclusions apply to IIF indicators are provided in the tables below.

2.11 Personalised care adjustments (PCAs), previously known as 'Exceptions', may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator – unless the action or intervention being incentivised by the indicator has occurred, in which case they will be retained. The exact circumstances in which PCAs apply to IIF indicators are provided in the tables below.

2.12 An example of how PCAs would be applied to VI-01 is as follows: A PCN has 1,000 patients aged 65 and over, of whom 600 received a seasonal influenza vaccination. If a practice's clinical system records that 100 of the 1,000 eligible patients were offered a seasonal influenza vaccination but refused and it was also deemed clinically inappropriate to administer the seasonal influenza vaccination to a further 100, then PCN performance in relation to indicator VI-01 would be 75% (= 600/800), not 60% (= 600/1,000).

Achievement points

2.13 The IIF is a points-based scheme. For 2022/23, each PCN can earn a maximum of 1153 IIF points and the value of a point will be £200.00 (adjusted for list size and prevalence – see paragraphs 2.18-2.19). Each indicator is worth an agreed number of points, and how these are achieved depends on whether the indicator is Qualitative, Binary Quantitative, Standard Quantitative, Improvement Quantitative or Composite Quantitative.

2.14 A PCN can earn either all the points or no points for Qualitative indicators, based on whether they meet all the criteria, and for Binary Quantitative indicators, based on whether performance meets the indicator performance threshold.

2.15 The points a PCN can earn for Standard and Improvement Quantitative indicators will depend on how their performance relates to an upper performance threshold and a lower performance threshold.

2.16 The points a PCN can earn for Composite Quantitative indicators will depend on both how their 'standard' performance relates to an upper performance threshold and a lower performance threshold, and how their 'improvement' performance relates to an upper performance threshold and a lower performance threshold.

2.17 The upper performance threshold (or single threshold for Binary Quantitative indicators) for each Standard Quantitative indicator (specifically the 'standard' component to Composite Quantitative indicators) is based on clinical or other expert opinion concerning good practice. Reflecting the aim of reducing unwarranted variation, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2019/20 (where baseline data is available).

2.18 Upper and lower thresholds for Improvement Quantitative indicators (and specifically the 'improvement' component to Composite Quantitative indicators) represent changes from each PCN's baseline e.g. 1 and 2 percentage point increases from the percentage performance recorded in the previous year. These may also be based on clinical/expert opinion but may also factor in previous trends over time or natural variation.

2.19 If a PCN's performance for a Standard or Improvement Quantitative indicator is better than or equal to the upper performance threshold, it will earn all the points available for that indicator; if a PCN's performance is worse than or

equal to the lower performance threshold, it will earn zero points; and if performance is between the upper and lower thresholds, it will earn some but not all of the points available for that indicator. Consider a hypothetical Standard Quantitative indicator worth 50 points with an upwards desired direction, a lower performance threshold of 50% and an upper performance threshold of 75%. Then, two IIF points are earnt for every percentage point improvement in performance (50 points/ (75%-50%) = 2 points per percentage point). If a PCN's performance is 70%, it will earn 40 of the 50 available achievement points – because 70% is 4/5ths of the way from 50% (the lower performance threshold) to 75% (the upper performance threshold).

2.20 For Composite Quantitative indicators, the same approach as in 2.19 is used for assigning points for each of the 'standard' and 'improvement' components of performance, with the points earned based on the best of the two. Consider a composite indicator with the same standard thresholds and performance as the hypothetical example in 2.19, with an additional lower Improvement threshold of 0 percentage points (no change from baseline) and an upper Improvement threshold of 10 percentage points (increase from baseline). With the 70% achievement the PCN would be assigned 40 points against the standard thresholds. Then, five points are assigned for each percentage point improvement in performance from baseline (50 points/ (10 percentage points – 0 percentage points). If a PCN's baseline performance (e.g. performance in the 12 months prior to current scheme) is 65%, it will be assigned 25 of the 50 available achievement points – because the 5 percentage point improvement from 65% to 70% is half way from 0 percentage points (the lower improvement performance threshold) to 10 percentage points (the upper improvement performance threshold). The PCN earns 40 points as this is the greater of the two assigned point values (40 and 25).

Achievement payments

2.21 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£200.00 in 2022/23), multiplied by a list size adjustment, and in the case of Quantitative indicators, multiplied by a prevalence adjustment. The value of an IIF point will be subject to annual revision.

2.22 The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must undertake to earn IIF points. The points-based system means that, for Standard, Improvement and Composite Quantitative indicators, every PCN will earn the same number of *points* for a given 'absolute' improvement in performance. And in addition, for Qualitative and Binary Quantitative indicators, every PCN will earn either no points or the same number of points depending on whether the criterion or criteria, or performance threshold have been met. However, differences in prevalence and in list size mean that PCNs may have to make different levels of effort to achieve a given percentage point (absolute) improvement in performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

2.23 In 2022/23, PCNs are entitled to one type of payment under the IIF: a Total Achievement Payment which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive achievement payments, a PCN must comply with the conditions set out in the 2022/23 Network Contract DES specification (section 10.6.17). Crucially, the PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice that support patient care (e.g. equipment or premises). The written commitment does not have to detail the precise areas of spend: this is for PCNs to determine.

Monitoring IIF performance

2.24 Each PCN is able to monitor its indicative performance against IIF indicators on the PCN Dashboard, which is now available through the NHS England Applications platform (having moved from NHS ViewPoint in late 2021).

2.25 The dashboard supports PCNs to understand their local population health priorities and the benefits that they are delivering for their patients. It also helps PCNs to identify opportunities to reduce unwarranted variation in performance within their PCN and between PCNs, to improve services. Performance against each 2022/23 IIF indicator is expected to be available monthly by PCN from summer 2022.

3. Prevention and tackling health inequalities domain

3.1 The prevention and tackling health inequalities domain aims to support delivery of the ambitions outlined in Chapter Two of the NHS Long Term Plan. A key focus of the Network Contract DES is prevention – the aim being to help people stay healthy, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Indicators in this domain will contribute to the Government's ambition to add five years to healthy life expectancy by 2035.

Vaccination and immunisation area

3.2 Indicators in the vaccination and immunisation area support the ambitions of the NHS Long Term Plan to ensure and expand access to vaccines.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Rationale for inclusion	Improving the coverage and uptake of vaccinations is a key public health priority and was a NHS Long Term Plan commitment (p15, p39). Securing high coverage is even more important in the context of COVID-19.		
Indicator type	Standard Quantitative		
Indicator	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**VI-02:** Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**VI-03**: Percentage of children aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
Running period	1 April 2022 – 31 March 2023		
Denominator	Number of patients aged 65 and over	Number of patients aged 18 to 64 and in a clinical at-risk	Number of children aged two or three

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
		group (as defined in the cohorts outlined in the 2022/23 NHS Seasonal Influenza Programme – see here)[2]	years on 31 August 2022
Numerator	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
	The flu vaccine can be provided in any patient setting (e.g. general practice, community pharmacy), provided provision is coded in GP IT systems.		
Prevalence numerator	Indicator denominator		
Exclusions	Patients on end of life care		
Personalised care adjustments	1. Patients who declined the offer of a seasonal influenza vaccination 2. Situations in which it is not clinically appropriate to provide a seasonal influenza vaccination. 3. Patient did not reply to two separately coded invites to receive a seasonal influenza vaccination using their preferred method of communication		

[2] Including the following at-risk groups eligible for a free influenza vaccination:
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; Morbidly obese; People in long stay residential or homes.
Excluding the following at-risk groups eligible for a free influenza vaccination, on the basis that membership of these groups is not reliably recorded in GP systems:
Pregnant women; Household contact of immunocompromised individual; Household contact of person on NHS shielded patient list; Social care worker; Hospice worker.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Desired direction	Upwards		
Thresholds	80% (LT), 86% (UT)	57% (LT), 90% (UT)	45% (LT), 82% (UT)
Points	40	88	14
Data source	General Practice Extraction Service (GPES)		
Subject to declaration?	Yes		
Additional information	NICE Quality Standard 190 on improving seasonal influenza vaccination uptake was published in January 2020. Responsibility for providing seasonal influenza vaccinations in primary care is currently shared between general practice and community pharmacy. Achievement for the IIF seasonal influenza vaccination incentives will be based on the total number of vaccines provided within the network, irrespective of who delivered the vaccine. The IIF seasonal influenza vaccination indicators supplement the existing seasonal influenza vaccination Enhanced Service in general practice, which makes an item of service payment of £10.06 (at the time of publishing this guidance) for each seasonal influenza vaccination provided. Clinical leadership at a PCN level can promote uptake, identifying areas for improvement and disseminating good practice to increase vaccination rates and reduce variation across eligible patient cohorts. • PCN clinical directors should, in partnership with the identified CCG flu lead and national commissioners, engage with: • General practices in the PCN to agree how they will collaborate with each other, and discuss how they will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake • The pharmacy PCN lead, where available, to agree how general practices will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake.		

Tackling health inequalities area

3.3 The social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves, have a significant impact on our health. The COVID-19 pandemic has also highlighted the imbalance in health outcomes and differential experiences of healthcare services between different groups, communities, and regions. IIF indicators in the tackling health inequalities area are designed to help to ensure that everyone gets access to the care they need and focus interventions on groups who experience health inequalities.

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
Rationale for inclusion	To tackle the causes of morbidity and preventable deaths in people with a learning disability and/or autism, the NHS Response to COVID Phase 3 letter reiterates the importance of people with a learning disability being identified on their local register and having annual health checks completed.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Learning Disability register aged 14 years or over.
Numerator	Of the denominator, the number who received a learning disability Annual Health Check and have a completed Health Action Plan
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Patient refused the offer of a learning disability health check.

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
Desired direction	Upwards
Thresholds	60% (LT), 80% (UT)
Points	36
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	People with a learning disability often have poorer physical and mental health and are four times more likely to die of preventable illnesses than the general population (Disability Rights Commission, 2006). Groups who already experience disproportionately poor health outcomes have also been seen to have additional risks from COVID-19. An annual health check can help to improve the health of people with a learning disability by identifying health concerns at an early stage. The health action plan is an integral part of the requirements around a learning disability health check and so encouraging this requirement will ensure that the Health Check Scheme is seen as a required two-part process, necessary for supporting individuals in any actions or follow up to support their health and well-being. NICE Quality Standard 187 provides the quality standard for learning disability health checks. All checks should be auditable against this standard. This IIF indicator supplements the item of service payment (£140 at the time of publishing this guidance) for annual Learning Disability health checks, which is paid as an Enhanced Service. In providing the annual health check, clinicians are reminded that discussing the Health Action Plan is an essential component of the check and integral to its overall efficacy. Patients should leave their health check with a copy of the action plan discussed, to support them in managing their health and wellbeing. PCNs should also ensure patients with a learning disability are accurately coded. Improving identification of people with a learning disability; guidance for general practice, published in October 2019, states GP practices need to review and update

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
	their register and also identify patients who may have a learning disability. The IIF supports case identification by employing a prevalence adjustment and list size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI-01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. PCNs and practices are also asked to ensure that patient's ethnicity status and their level of learning disability is recorded in the GP system. In addition to increased levels of health inequality, increasing levels of premature mortality are noted in people with a learning disability aged 18-49 from an ethnic minority. GPs are reminded that in order for a patient to refuse the offer of an annual health check, their capacity should be assessed using the Mental Capacity Act framework. Where the individual does not have capacity a best interest process should be followed. **Further Information** NHS England: Learning Disability Annual Health Checks Mencap charity: Leaflets and resources to encourage people to take up an annual health check Contact (charity): Annual health checks: Factsheet for parents Public Health England: Annual Health Checks and people with learning disabilities guidance includes evidence for an annual heath check and further resources including videos on how to complete an annual health check. RCGP Toolkit NDTI resources

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
Rationale for inclusion	COVID-19 has highlighted and exacerbated significant health inequalities in the delivery, experience, and outcomes of care. In response, NHS England and NHS Improvement (NHSEI) committed in Autumn 2020 to a number of short-term actions which aimed to urgently address these inequalities. One such action is to dramatically improve the recording of patient ethnicity data in

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
	primary care, to support local and national analytical work, and enable services and outreach work to be targeted at individuals and communities who may benefit most. This indicator supports this aim by recognising PCNs for the accurate and complete recording of patient ethnicity information in clinical systems.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number with a recording of ethnicity on their GP record
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None – note that, for the purposes of this indicator, a patient recorded as having chosen not to state their ethnicity after having been given the opportunity to do so will be counted as a valid recording of ethnicity (and therefore as a 'success', *not* as a Personalised Care Adjustment).
Desired direction	Upwards
Thresholds	81% (LT), 95% (UT)
Points	45
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
Additional information	This indicator recognises PCNs for recording ethnicity information for patients for which this information is missing in GP records. Patients should not feel obligated to state their ethnicity if they prefer not to do so. In accordance with this principle, this indicator recognises PCNs for giving patients the opportunity to state their ethnicity, irrespective of whether they choose to do so. This means that, for this indicator, the following are treated as a successful recording of ethnicity: • Ethnicity recorded as not stated (Z code in NHS Data Dictionary ethnic category field) • 1024701000000100 Ethnicity not stated • 763726001 Refusal by patient to provide information about ethnic group (situation) The NHS Data Dictionary states that "National code Z should be used where the person has been given the opportunity to state their ethnic category but chose not to." As such, it should **not** be used in situations where patient ethnicity data is simply missing or unknown.

Cardiovascular disease prevention area

3.4 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 cardiovascular disease (CVD) risk factors. CVD is strongly associated with health inequalities – the most deprived quintile of the population is four times more likely to die from CVD than the least deprived. Of the A, B, C of CVD risk factors (atrial fibrillation, high blood pressure, and cholesterol), hypertension (high blood pressure), has the highest level of undetected prevalence. According to modelling by Public Health England, more than 30% of hypertension cases remain undiagnosed, with the prevalence gap (difference between prevalence and diagnosis) increasing in younger age groups. This is expected to have worsened over the past year due to the impact of COVID-19 on routine blood pressure (BP) monitoring. One of the central aims of the Network Contract DES Cardiovascular Disease Prevention & Diagnosis service requirements is to facilitate actions

to reduce the gap between identified and estimated prevalence in order to minimise population-level CVD risk.

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
Rationale for inclusion	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, which has seen a significant reduction in blood pressure readings taking place in primary care. This indicator 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 Blood Pressure Monitoring.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over, not on the QOF Hypertension Register as of 31 March 2022, and who have (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
Numerator	Of the denominator, those patients for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2023 for cohort (i) and within six months of first elevated blood pressure reading after 1 April 2022 for cohort (ii). Clinically appropriate follow-up includes: 1. Initial BP reading < 140/90 mmHg (only relevant for patients in (i)) OR 2. Initial BP reading ≥ 140/90 mmHg AND a. (Subsequent change of medication AND subsequent blood pressure reading of <140/90 mmHg) OR b. Subsequent occurrence of Ambulatory Blood Pressure Monitoring OR

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
	c. Subsequent occurrence of Home Blood Pressure Monitoring OR d. (Addition to QOF Hypertension Register AND same day referral for specialist assessment) OR e. (Addition to QOF Hypertension Register AND (subsequent commencement of antihypertensive therapy OR patient declined antihypertensive therapy)).
Prevalence numerator	Number of patients on the QOF Hypertension Register as of 31 March 2022
Exclusions	Patients receiving end of life care
Personalised care adjustments	1. Patients included in part (ii) of the denominator with an initial elevated BP recorded between 1 October 2022 and 31 March 2023 inclusive, who are not followed up by the end of the financial year (patients will carry over to the denominator of CVD-01 in 2023/24). 2. Patient declined ambulatory/home blood pressure testing (Patient chose not to receive intervention). N.B. Patients declining a BP reading alone will **not** trigger a PCA.
Desired direction	Upward
Thresholds	25% (LT), 50% (UT)
Points	71
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	BP readings and clinical follow up can occur in general practice or in a community pharmacy and will still count towards achievement of this indicator, provided this activity is coded in GP clinical systems in accordance with the business rules.

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
	See guidance for the Network Contract DES CVD Prevention and Diagnosis service requirements for further information and advice on PCN actions to improve hypertension diagnosis. These service requirements are based on the Hypertension diagnosis and management NICE guidelines – particularly Section 1.2. The improved identification of hypertension risk will also be pursued by the Community Pharmacy Hypertension Case Finding service, which will provide increased opportunities for people to have their blood pressure managed in pharmacies. The intention is to update the thresholds for CVD-01 in 2023/24 and beyond, in line with NHSEI's ambition to prevent 150,000 strokes, heart attacks and dementia cases by 2029 through the earlier detection and treatment of CVD risk factors.

CVD-02: Percentage of registered patients on the QOF Hypertension Register	
Rationale for inclusion	This indicator further recognises PCNs for the hypertension diagnoses which can be expected from CVD-01 and the addition of these patients to the QOF Hypertension Register, along with the addition of other patients to the register who did not meet the requirements of CVD-01.
Indicator type	Improvement Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number on the QOF Hypertension Register
Baseline (Improvement)	Percentage of patients on the QOF Hypertension Register on 31 March 2022
Prevalence numerator	Indicator denominator

CVD-02: Percentage of registered patients on the QOF Hypertension Register	
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.6 percentage point increase (LT), 1.2 percentage point increase (UT)
Points	35
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Hypertension diagnosis can occur in general practice or as a result of blood pressure monitoring in a community pharmacy, but must be coded in GP clinical systems. This indicator recognises PCNs on the basis of improving their performance relative to a base period – in this case, PCNs will be recognised for increases in the percentage of registered patients on the QOF Hypertension Register, as compared with 31 March 2022. CVD-02 is intended as a complement to CVD-01. While CVD-01 is a process indicator recognising PCNs for undertaking actions that should lead to increased hypertension diagnosis, CVD-02 is an 'outcome' indicator that recognises PCNs for actually achieving those increased diagnoses. Thresholds for this indicator have been chosen to ensure that (i) they align with the number of new hypertension diagnoses expected to arise from achievement of CVD-01, and (ii) they do not incentivise more diagnoses than are known to be needed based on estimates of the size of the prevalence gap.

CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	
Rationale for inclusion	Statin use has been shown to significantly reduce morbidity and mortality in patients at risk of cardiovascular disease. This indicator rewards practices for identifying and treating with statins the highest risk population for primary prevention of CVD, in line with NICE guideline CG181.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 25 to 84 years inclusive and with a CVD score (QRISK2 or 3) greater than 20 percent
Numerator	Of the denominator, the number who are currently treated with statins (who were prescribed statins in the six months to the end of the reporting period)
Prevalence numerator	Indicator denominator
Exclusions	• Patients with established CVD • Patients at end of life
Personalised care adjustments	1. Patient declined 2. Not clinically suitable
Desired direction	Upwards
Thresholds	48% (LT), 58% (UT)
Points	31
Data source	General Practice Extraction Service (GPES)

CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	
Subject to declaration?	Yes
Additional information	The NHS Long Term Plan sets out ambitions to reduce the number of heart attacks, strokes and dementia cases by 150,000 by 2029/30. Statin use has been shown to significantly reduce morbidity and mortality in patients at risk of cardiovascular disease. High intensity statins are recommended as a cost-effective intervention by NICE. This indicator does not exclude treating people who have a QRISK score of 10% of higher, in line with CG181. However, it emphasises the need as a minimum to ensure that those with the highest need are treated, whilst allowing some flexibility on treatment options for those with a QRISK score of 10-19%. **Links to further resources** NICE Guidance: • Cardiovascular disease: risk assessment and reduction, including lipid modification • Statin intensity - Appendix A: Grouping of statins Accelerated Access Collaborative: • Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD

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 cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
Rationale for inclusion	The NHS Long Term Plan commits to increasing the diagnosis of familial hypercholesterolaemia (FH) from 7% to 25% by 2024/25. This indicator recognises PCNs for systematically searching their patient list to identify those with possible FH, and then referring for specialist assessment and/or genetic testing for FH in line with local pathways.
Indicator type	Standard Quantitative

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 cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 29 years or under with a total cholesterol greater than 7.5 OR aged 30 years or over with a total cholesterol greater than 9.0.
Numerator	Of the denominator, the number referred for assessment for familial hypercholesterolemia
Prevalence numerator	Indicator denominator.
Exclusions	• Patients already with a genetically confirmed diagnosis of familial hypercholesterolemia • End of life patients • "Secondary hyperlipidaemia/ hypercholesterolemia (disorders)" WITHOUT subsequent "History of Secondary hyperlipidaemia/ hypercholesterolemia" coded
Personalised care adjustments	Referral for assessment for familial hypercholesterolemia declined
Desired direction	Upwards
Thresholds	20% (LT), 48% (UT)
Points	18
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Familial hypercholesterolaemia (FH) is a genetic disorder which increases the likelihood of coronary artery disease, heart attacks and sudden cardiac death. It affects at least 150,000 people in England. The NHS Long Term Plan commits to increasing the

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 cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
	diagnosis of familial hypercholesterolaemia from 7% to 25% by 2024/25. Early detection and genetic diagnosis to enable early intervention will reduce risk and enable better outcomes for FH patients. This indicator recognises PCNs for systematically searching their patient list to identify those with possible FH, excluding any potential secondary causes, assessing further using Simon Broome or Dutch Lipid Network criteria, and then referring on for specialist assessment and/or genetic testing for FH in line with local pathways. The intention is to update the thresholds for CVD-04 in 2023/24, to align with NHSEI ambitions to align with the ambition to diagnose 25% of FH by 2024/25. **Links to further resources** • NICE FH guidance CG71 • Simon Broome Criteria • Dutch Lipid criteria – resource linked via Heart UK • Dutch Lipid criteria – Australian guidelines – Royal Australian College of General Practitioners • Accelerated Access Collaborative: Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
Rationale for inclusion	This indicator recognises PCNs for increased DOAC prescribing to patients with Atrial Fibrillation (AF), in line with 2021 NICE guidance (NG196) establishing DOACs as first-line treatment for patients with AF.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
Denominator	Number of patients on the QOF Atrial Fibrillation register and a with CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female).
Numerator	Of the denominator, the number who in the 6 months to the reporting period end date were either: • Success criterion 1: Prescribed a direct-acting oral anticoagulant (DOAC), or • Success criterion 2: Where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist. Success criteria are evaluated sequentially. For more information, please consult NHS Digital Business Rules.
Prevalence numerator	Indicator denominator.
Exclusions	• Resolved AF diagnosis • A subsequent CHA_2DS_2-VASc score of less than 2 for females and less than 1 for patients that are not female • Mechanical prosthetic valve replacement (counts as an exclusion for success criterion 1 [DOAC prescribing] – see business rules for more information)
Personalised care adjustments	As this indicator has multiple success criteria that are evaluated sequentially, a PCA for the first success criterion (i.e. DOAC prescribing) will simply shift the patient into the pool for evaluation against the second criterion (i.e. Vitamin K antagonist prescribing), rather than removing them from the denominator altogether. Possible grounds for exception reporting in the traditional sense (i.e. removal from the denominator altogether, unless a success is registered) are: 1. First AF diagnosis in 3 months to reporting period end date 2. Oral anticoagulant clinically unsuitable 3. Oral anticoagulant declined 4. A combination of PCAs applying to success criteria 1 and 2 individually.

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
	PCAs for success criterion 1 (moves the patient to evaluation under success criterion 2) • DOAC clinically unsuitable (includes recordings of antiphospholipid syndrome). • 'DOAC not indicated' plus last recording of 'Time in Therapeutic Range' >= 65% in the six months to the reporting period end date. • DOAC declined. **PCAs for success criterion 2** • Vitamin K antagonist/ Warfarin clinically unsuitable. • Vitamin K antagonist / Warfarin declined.
Desired direction	Upwards
Thresholds	70% (LT), 95% (UT)
Points	66
Data source	GPES
Subject to declaration?	Yes
Additional information	The NHS Long Term Plan commits to reducing stroke in England in three ways: • Diagnosing more patients with undiagnosed AF (the "detect" gap) • Ensuring patients diagnosed with AF are offered anticoagulation where appropriate (the "protect" gap) • Optimising the anticoagulant pathway to ensure patient outcomes are optimised (the "perfect" gap) This indicator has been developed to support LTP ambitions on the "protect" gap and complement QOF indicator AF007, which

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
	rewards practices for ensuring that up to 70% of patients on their AF register are anticoagulated. It has two objectives: 1. To increase the overall percentage of AF patients who are prescribed an anticoagulant 2. To increase the use of DOACs as a proportion of anticoagulants prescribed Anticoagulation therapy can prevent around two thirds of strokes caused by AF. However, 16% of patients with AF are not on any form of anticoagulant. Likewise, 14% of patients currently receiving anticoagulation therapy are prescribed Warfarin. NICE guidance was updated in 2021 (NG196) to recommend that clinicians prescribe DOACs, rather than Warfarin as first-line treatment for patients with AF. Warfarin is associated with a more significant risk of serious bleeding (particularly intracranial haemorrhage) than DOACs. DOACs also do not require as much monitoring, freeing up capacity in primary care and improving quality of life for patients. Other benefits of DOACs over Warfarin include: • Fixed dosing with predictable pharmacokinetics and pharmacodynamics • Low drug–drug and food interactions, and no dietary restrictions • Rapid onset and offset and shorter half-life • Predictable effects on clotting, so routine monitoring of clotting factors is not needed • Wide therapeutic window In line with NG196, practices may achieve against this indicator by working to switch patients who are currently prescribed Warfarin or by prescribing patients who are newly diagnosed with AF a DOAC. However, it is important that switching patients who are currently prescribed Warfarin is done in a clinically appropriate way and as the result of a shared decision-making conversation. Recognising the importance of this, the indicator has been designed to accommodate patients who are unsuitable for a switch to DOACs or who declined to do so after a conversation with their clinician. PCNs will not be penalised for continuing to prescribe Warfarin where a patient has declined a DOAC or where a DOAC is clinically unsuitable. In these circumstances, the prescription of Warfarin will count as a “success”. Please consult above and business rules for more information.

CVD-06: Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC).	
Rationale for inclusion	This indicator been introduced to support recent NHSEI Commissioning Guidance which recommends that clinicians should use Edoxaban where this is clinically appropriate. Any savings released will allow more patients with AF and other cardiovascular disease (CVD) to be diagnosed and treated.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Atrial Fibrillation register with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and are currently prescribed a direct-acting oral anticoagulant (DOAC)
Numerator	Of the denominator, the number who are currently prescribed Edoxaban (who were prescribed Edoxaban in the 6 months to the reporting period end date)
Prevalence numerator	Indicator denominator
Exclusions	• Resolved AF diagnosis. • A subsequent CHA_2DS_2-VASc score of less than 2 for females and less than 1 for patients that are not female.
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	25% (LT), 35% (UT)
Points	66
Data source	General Practice Extraction Service (GPES)

CVD-06: Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC).	
Subject to declaration?	Yes
Additional information	DOACs are the highest spend medicines category in primary care, costing the NHS in England over £500m per annum. If patient numbers grow and no action, annual expenditure is expected to more than double. In 2021, NHSEI completed a transparent and compliant national procurement to give all DOAC suppliers an opportunity to update their value proposition to the NHS. All suppliers who responded to the procurement have been awarded national framework agreements, effective from 1 January 2022 to 31 March 2024. A single discounted price per product (irrespective of the volume used) is now available across primary and secondary care. NHSEI will manage the contracts to ensure that the rebates are paid in full back to CCGs (less any deduction to recover the NHSEI investment), and also to ensure supply meets demand. Daiichi Sankyo offered the most significant discount for their product, Edoxaban. Overall, the NHS can now treat significantly more patients using Edoxaban than any other DOAC, where clinically appropriate. In line with NG196, practices may achieve against this indicator by prescribing Edoxaban to patients who are newly diagnosed with AF or, depending on local policy, those who are currently prescribed a different brand of DOAC. NICE also supports affordability being taken into account as a differentiation between drugs. It is important that switching patients who are currently prescribed a different brand of DOAC to Edoxaban is done in a clinically appropriate way and as the result of a shared decision-making conversation. To emphasise this, this indicator excludes anyone who is prescribed warfarin because DOACs are contraindicated or because they have declined to switch. The thresholds for this indicator recognise that it can be difficult for primary care clinicians to switch patients from a medication they were originally prescribed in secondary care, even when the new medication is clinically appropriate. NHSEI has engaged with Trusts and CCGs, and will continue to do so, to ensure that DOAC prescribing in secondary care is also aligned to the procurement outcome.

4. Providing high quality care domain

Personalised care area

4.1 Personalised care is one of the five major practical changes to the NHS service model set out in the NHS Long Term Plan. The Long Term Plan commits to (i) rolling out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade; (ii) widening, diversifying and making more accessible the range of support available to people across the country; (iii) ensuring the delivery of person-centred care; and (iv) expanding the choice and control that people have over the care that they receive.

PC-01: Percentage of registered patients referred to a social prescribing service	
Rationale for inclusion	Social prescribing is one of six key components of the NHS England comprehensive model for personalised care, and is a way for primary care staff and local agencies to refer people to a link worker. The NHS Long Term Plan commits to achieving 900,000 social prescribing referrals by 2023/24. Since 2020/21, PCNs have been required to provide access to a social prescribing service. Funding for employment of social prescribing link workers is been available to PCNs via the Additional Roles Reimbursement Scheme.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number referred to a social prescribing service
Prevalence numerator	Indicator denominator
Exclusions	None

PC-01: Percentage of registered patients referred to a social prescribing service	
Personalised care adjustments	Patient declined referral to social prescribing service
Desired direction	Upwards
Thresholds	1.2% (LT), 1.6% (UT)
Points	20
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Social Prescribing Link Workers give people time to talk and focus on what matters to them as a person, as identified through shared decision-making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support. In the context of COVID-19, and ongoing self-isolation for some individuals, provision of high-quality social prescribing services can help prevent loneliness, or worsening physical health for at risk individuals. Capacity of the social prescribing service should be considered when making referrals. Where the social prescribing service is provided within the practice/PCN, individual Social Prescribing Link Worker caseloads are recommended to be between 200-250 annually. **Coding** Please note: Where a valid referral has been made (i.e. to a social prescribing service provided in fulfilment of the Network Contract DES requirements relating to social prescribing), the following SNOMED code should be used: • 871731000000106 | Referral to social prescribing service (procedure) This indicator **only** counts referrals made to a social prescribing service**,** as captured by the SNOMED code provided above. This SNOMED code, denoting referral to a social prescribing service,

PC-01: Percentage of registered patients referred to a social prescribing service	
	should be used even when the social prescribing service is provided within the practice or PCN – e.g. if a Social Prescribing Link Worker is employed under the Additional Roles Reimbursement Scheme. In this case, the referral is internal to the practice/PCN, but it is still a referral to a distinct service. This indicator does **not** count **offers** of social prescribing because it is necessary to know whether the offer has been accepted. It therefore only counts completed **referrals** to a social prescribing service. The purpose of this indicator is to count referrals to a service, **not** unique patient contacts. As such, this indicator does not count recording (by any means) of unique patient contacts by Social Prescribing Link Workers or any other type of health care professional (e.g. Care Coordinators or Health and Wellbeing Coaches). **Further Information** Welcome and induction pack for link workers in PCNs. NHS England: Social prescribing Reference guide for PCNs – information on setting up social prescribing services, including support for recruitment, induction and supervision. This guide also outlines quality assurance measures and explains how to gather information to develop a consistent evidence base for social prescribing. NHS England: Summary guide – describes what a good social prescribing scheme looks like, and includes a common outcomes framework to help measure the impact of social prescribing on people, the local system and the voluntary and community sector. Future NHS Social Prescribing Workspace – a space for social prescribing link workers and PCNs to access resources and updates about social prescribing, including national webinars, case studies, forums and contacts for local peer support and development opportunities. Social Prescribing - e-Learning – programme hosted by E-learning for Health and Health Education England aimed at link workers in PCNs. PCN reference guide technical annex

Enhanced health in care homes area

4.2 The Enhanced Health in Care Homes (EHCH) Vanguards programme demonstrated that outcomes for care home residents can be improved by provision of a coordinated care model delivering clinical support in care homes. The NHS Long Term Plan committed in 2019 to rolling out this framework across England between 2020 and 2024.

4.3 The Network Contract DES Enhanced Health in Care Homes Service Requirements embed this framework into the clinical support provided for care homes by PCNs. Indicators in this area support the implementation of the EHCH service requirements by recognising PCNs for strong delivery of key elements of the care model.

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 aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	
Rationale for inclusion	The successful delivery of the Enhanced Health in Care Homes service by PCNs requires the accurate and complete recording of care home resident status in GP systems. However, a significant number of care home residents in England are not recorded as being care home residents in GP clinical systems. This indicator recognises PCNs for more completely recording resident occupancy in care homes which are aligned to them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service
Numerator	Number of patients aged 18 years or over and recorded as living in a care home
Prevalence numerator	Indicator denominator

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 aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	30% (LT), 85% (UT)
Points	18
Data source	Denominator: Manual submission via the Calculating Quality Reporting Service (CQRS) Numerator: General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	The denominator of this indicator will be populated by manual submission via CQRS of the number of care home beds for which the PCN is paid the care home bed premium, as defined in the Network Contract DES. The numerator of this indicator will count the number of registered patients aged 18 years or over and recorded as living in a care home by looking for the presence of one of the following four SNOMED codes: • 160734000 Living in nursing home • 394923006 Living in residential home • 248171000000108 Lives in care home (finding) • 1240291000000104 Living temporarily in care home (finding) The first three codes can have been added at any point in the past, provided that no alternative code has since been added denoting that the patient is no longer a care home resident. The fourth code must have been added in the previous twelve months.

EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	
Rationale for inclusion	This indicator rewards PCNs for strong delivery of Personalised Care and Support Plans (PCSPs), a key element of the Network Contract DES Enhanced Health in Care Homes (EHCH) service requirements.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Indicator	Percentage of care home residents aged 18 years or over who had a Personalised Care and Support Plan (PCSP) agreed or reviewed.
Denominator	Number of care home residents aged 18 years or over.
Numerator	Of the denominator, the number who had a Personalised Care and Support Plan (PCSP) agreed or reviewed.
Prevalence numerator	Indicator denominator.
Exclusions	Patients not living in care home at end of reporting period.
Personalised care adjustments	1. Patient chose not to receive the intervention 2. Registration with general practitioner practice aligned to care home declined Care home residents are eligible to receive the additional support provided via Network Contract DES Enhanced Health in Care Homes service when they are registered at a practice that is part of the PCN that their care home is aligned to. When a care home resident is registered at a practice that is part of a different PCN, they should be offered the opportunity to re-register at a practice that is part of the PCN that their care home is aligned to. If they decline this offer, they are not eligible to receive this additional support and a Personalised Care Adjustment may be recorded by application of the above SNOMED code to their patient record at the general practice of registration.

EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	
Desired direction	Upwards
Thresholds	80% (LT), 98% (UT)
Points	18
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Information and best practice advice guidance for the delivery these interventions can be found in the full guidance for the Network Contract DES EHCH Service Requirements. Further advice can also be found here: • Care Provider Alliance: EHCH - A guide for care homes. • Animation: "The care home weekly round: What does good look like?" Ensuring consistent and comprehensive coverage of Enhanced Health in Care Homes was highlighted as a key ambition for systems in 2022/23 national priorities and operational planning guidance.

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
Rationale for inclusion	Provision of a weekly care home round lies at the heart of the Network Contract DES EHCH service requirements. This indicator will recognise delivery of the weekly care home round, as recorded in practice appointment books.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of care home residents aged 18 years or over

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
Numerator	Number of general practice appointments categorised as 'patient contact as part of weekly care home round'.
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Registration with general practitioner practice aligned to care home declined • See EHCH-02 for further information about this Personalised Care Adjustment. • As EHCH-04 uses a different data source for the numerator and the denominator, this indicator does not apply the usual principle of Personalised Care Adjustments (PCAs), by which patients are retained in the denominator if they receive the intervention in question. Rather, care home residents to whom this PCA is applied are subtracted from the denominator, irrespective of the extent to which they have received the intervention in question.
Desired direction	Upwards
Thresholds	Mean of 6 patient contacts per care home resident (LT), Mean of 8 patient contacts per care home resident (UT)
Points available	13
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: General Practice Appointments Data (GPAD)
Subject to declaration?	Yes
Additional information	A new set of national appointment categories was announced in March 2021 – one of these categories is “Patient contact as part of weekly care home round”. In 2021/22, IIF indicator ACC-01 recognised PCNs for mapping appointment slot types to these new national categories, as well as for confirming compliance with the August 2020 guidance on *More accurate general practice*

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
	appointment data, published by NHSEI and the British Medical Association. A key principle of the August 2020 guidance is that each patient contact should be recorded as a separate appointment. This indicator builds on these improvements in the quality of general practice appointment data by recognising PCNs for delivery of the weekly care home round, as captured by the number of appointments that are mapped to the "Patient contact as part of weekly care home round" appointment category. This category should only be used to record patient-facing contacts – it should not be used, for example, to record instances where a patient is discussed at a Multi-Disciplinary Team meeting when the patient is not present. The thresholds for this indicator have been calculated based on the expected number of patient-facing contacts that will occur as part of the weekly care home round over a 12 month period. This indicator will count any appointment mapped to the "Patient contact as part of weekly care home round" category, irrespective of appointment mode – the appointment need not necessarily be face-to-face. Any appointment with the status "Attended", "Booked" or "Did Not Attend" will be counted towards the numerator of this indicator. No age restrictions are applied to the indicator, even though the denominator only counts care home residents aged 18 years or over. It is recognised that different patients have different needs – there is no expectation that each individual patient should receive a particular number of contacts as part of the weekly care home round. To reflect this recognition, the numerator for this indicator will be calculated by adding up all the appointments delivered as part of a weekly care home round, across all care home residents. Signing up to the GPAD Data Provision Notice (DPN) has since October 2020 been a core GMS contractual requirement. If a practice is signed up to the Network Contract DES but is not signed up to the GPAD DPN, any patient contacts recorded in its appointment books will not be extracted as part of the GPAD collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice and recorded as living in a care home **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to the GPAD DPN, so that all patient contacts delivered as part of weekly care

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
	home rounds are properly counted for the purposes of this indicator. **Further information** In addition to the PCN Dashboard discussed in paragraphs 2.22 and 2.23 above, a breakdown of appointment volumes by each of the new appointment categories will be made available via an interactive General Practice Appointments Data (GPAD) private dashboard hosted by NHS Digital. This private dashboard will display a range of appointment data to practices and PCNs, with access to be controlled via the user's NHS smartcard. Practice-level appointment data has been available since September 2021, with PCN-level appointment data to be made available in 2022. Click here for a user guide to the NHS Digital GPAD private dashboard, which contains details on how to obtain access; for further information, email ssd.nationalservicedesk@nhs.net.

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	
Rationale for inclusion	Admission to hospital on an emergency basis is widely recognised as a negative marker of health outcomes. Evaluation of the Enhanced Health in Care Homes Vanguards found that the enhanced care offer provided by the programme resulted in lower rates of emergency admission to hospital. This indicator will recognise PCNs for improvements in care home resident health outcomes resulting from high quality delivery of the Network Contract DES EHCH service requirements.
Indicator type	Composite Quantitative
Running period	1 October 2022 – 31 March 2023
Denominator	Number of care home residents aged 18 years or over
Numerator	Age and sex standardised number of emergency admissions on or after 1 October for patients in the denominator (see Additional Information section for specification details, and see Annex B for standardisation details)

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	
Baseline (Improvement)	1 October 2021 – 31 March 2022
Prevalence numerator	Indicator denominator
Exclusions	See additional information for specification details
Personalised care adjustments	None
Desired direction	Downwards
Thresholds	Improvement: Reduction of 0 (LT), 0.02 (UT) Absolute: 0.15 (LT), 0.1 (UT)
Points	27
Data source	Denominator: General Practice Extraction Service (GPES) (patient level extract identifying patients recorded as living in a care home). Numerator: Hospital Episode Statistics (number of emergency admissions experienced by patients in the denominator).
Subject to declaration?	No – if a PCN believes that their data for this indicator is incorrect, they are advised to contact their commissioner to query the discrepancy.
Additional information	This indicator does not target a specific subset of emergency admissions but broadly all emergency admissions. This takes into consideration the broader drivers of emergency admissions from care homes, incentivising a system approach to delivering the required change through, for example primary and community MDTs. It is considered appropriate to target all-cause admissions for the care home population because the EHCH framework goes beyond general practice, bringing in community services and other primary care partners. Absolute performance against this indicator will be influenced significantly by the population that a PCN serves – for example

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	

	PCNs with older care home populations can expect to see higher emergency admission rates. In recognition of this, the indicator is standardised by age and sex (see Annex B for details), meaning that the admission rates calculated across PCNs are adjusted to show performance based on every PCN having the same age-sex demographic. This goes some way to make rates more comparable against the same absolute thresholds. However, partly in recognition that adjusting for age and sex differences will not account for all differences in performance driven by patient characteristics (both observed and unobserved), improvement thresholds are also applied to this indicator (year-on-year changes in emergency admission rates are less influenced by the characteristics of a PCN's registered patients than the emergency admission rate within a given year).
	
	Detailed data specification
	
	The following numerator and denominator details are relevant for both current year performance (1 October 2022 to 31 March 2023) and base year performance (1 Oct 2021 to 1 March 2022 (the latter being relevant to 'improvement' performance assessment).
	
	1. Denominator
	
	• Count: Patients recorded in GP systems as living in a care home (see EHCH-01 for SNOMED codes).
	  • Filters applied:
	  • [AGE] ≥ 18.
	
	2. Numerator
	
	• Data source: Patient level linkage of GPES and HES APC.
	
	• Count: Finished Admission Episodes ([EPISTAT] = 3, [EPIORDER] = 1)
	• Filters applied:
	  • Patients recorded in GP systems as living in a care home (see EHCH-01 for SNOMED codes).
	  • [ADMIMETH] = 21, 23, 24, 28, 2A, 2B, 2C, 2D.
	  • [ADMIDATE] (admission date) between 01/10/22 and 31/03/23
	  • [EPITYPE] = 1; General episodes (excludes birth and delivery episodes)
	  • [SEX] = 1 or 2: The sex of patient is male or female

Anticipatory care area

4.4 Anticipatory Care is a Long-Term Plan commitment to provide proactive and personalised health and support for multimorbid and frail individuals who would benefit most from integrated evidence-based care. Operational Planning Guidance for 2022/23 set out the requirement for ICSs to design, plan for and commission Anticipatory Care for their systems, working with relevant health and care providers and in line with the Anticipatory Care Operating Model. Indicators in this area are designed to support delivery of the AC model by encouraging PCNs, in partnership with other providers, to proactively identify and provide care for individuals through this multidisciplinary model of care.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	
Rationale for inclusion	Ambulatory Care Sensitive Conditions (ACSCs) are conditions that can be managed effectively at home and within the community but are susceptible to exacerbation and potential admission to secondary care. Although such admissions can be unavoidable, there are many instances where conditions could have been managed better, earlier in the community. Through joint work with other system partners, PCNs can improve outcomes for patients with these conditions to achieve a moderation in the rate of ACSC admissions. A subset of ACSCs have been included in the scope of this indicator on the basis that they are amenable to high quality, timely provision of care in general practice.
Indicator type	Composite Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Age and sex standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions for patients in the denominator (see Additional Information section for specification details, and see Annex B for standardisation details)
Baseline (Improvement)	1 April 2021 – 31 March 2022

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	
Prevalence numerator	Indicator denominator
Exclusions	See Additional Information for details of data specification
Personalised care adjustments	None
Desired direction	Downwards
Thresholds	Reduction: 0 (LT), 0.001 (UT) Absolute: 0.01 (LT), 0.008 (UT)
Points	111
Data source	Numerator: Hospital Episode Statistics (HES) – Admitted Patient Care dataset Denominator: NHAIS/PDS
Subject to declaration?	No – if a PCN believes that their data for this indicator is incorrect, they are advised to contact their commissioner to query the discrepancy.
Additional information	Ambulatory care sensitive conditions (ACSC) are conditions where hospital admissions may be prevented by interventions in primary care (Purdy et al, 2009). NHS Digital describes the most commonly used set of ACS conditions. The conditions included for this indicator (see full details below) are a subset of this set of conditions, considered to be particularly amenable to: • Effective long-term condition management in general practice (Group 1 below). • Rapid primary care response to an acute presentation (Group 2 below) The numerator of this indicator will be standardised by age and sex – see EHCH-06 Additional Information for rationale, and see Annex B for details of standardisation methodology.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	

	Detailed data specification
	
	The following numerator and denominator details are relevant for both current year performance (1 April 2022 to 31 March 2023) and base year performance (1 April 2021 to 1 March 2022 (the latter being relevant to 'improvement' performance assessment).
	
	1. Denominator
	
	• Total number of registered patients.
	
	2. Numerator
	
	• Data source: Hospital Episode Statistics (HES) – Admitted Patient Care dataset).
	
	• Count: Finished Admission Episodes ([EPISTAT] = 3 & [EPIORDER] = 1)
	
	• Filters applied
	  • [ADMIMETH] = 21, 23, 24, 28, 2A, 2B, 2C, 2D.
	  • [ADMIDATE] (admission date) between reporting period start and end dates
	  • [EPITYPE] = 1: It is a General episode:
	  • [STARTAGE] (age at start of episode) between 0 and 120
	  • [MYDOB] (Patient date of birth) not 01/01/1900 or 01/01/1901 representing unknown
	  • [SEX] = 1 or 2: The sex of patient is male or female
	  • [MAINSPEF] is not 501, 560 or 610: The Main specialty is not Obstetrics, Midwifery or General Practice with Maternity Function:
	  • [DIAG_01] does not begin with 'O': The primary diagnosis does not relate to Obstetrics, unless otherwise stated
	  • **Diagnosis and procedural coding for Group 1 and 2 – see bottom of table for full details** (DIAG_01 refers to primary diagnosis, OPERTN_01 refers to primary procedure).
	
	Group 1 – Amenable to effective long-term condition management in general practice
	
	• Asthma: DIAG_01 = J45, J46
	• Congestive heart failure: DIAG_01 = I110, I50, J81.
	  • Exclude where OPERTN_01 = K0-K3, K4, K50, K52, K55-K57, K60, K61, K66-K69, K71, K73, K74
	• Diabetes complications: DIAG_01 = E100-E108, E110-E118, E120-E128, E130-E138, E140-E148.
	• COPD: DIAG1 = J20, J41-J44, J47.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	

	• Only accept DIAG_01 = J20 if a secondary diagnosis code = J41-J44, J47
	• Hypertension: DIAG_01 = I10, I119
	  • Exclude where OPERTN_01 = K0-K4, K50, K52, K55-K57, K60, K61, K66-K69, K71
	• Convulsions and epilepsy: DIAG_01 = G40, G41, R56, O15.
	
	Group 2 – Amenable to rapid primary care response to an acute presentation
	• Influenza & Pneumonia: DIAG_01 = J10, J11, J13, J14, J153, J154, J157, J159, J168, J181, J188.
	  • Exclude if secondary diagnosis = D57.
	• Pyelonephritis: DIAG_01 = N10-N12, N136.
	• Cellulitis: DIAG_01 = L03, L04, L080, L088, L089, L88, L980, I89.1, L01, L02.
	  • Exclude if OPERTN_01 = A-R, S1-S3, S41-S45, S47-S49, T, V, W, X0-X2, X4, X5.
	• ENT infections: DIAG_01 = H66, H67, J02, J03, J06, J312, J04.0.

Cancer area

4.5 Indicators in this area support efforts to reduce the backlog of cancer care caused by the pandemic. They also support the NHS Long Term Plan ambition that the proportion of cancers diagnosed at stages 1 and 2 will rise from around half to three quarters of cancer patients by 2028.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
Rationale for inclusion	Evidence suggests that more effective implementation of Faecal Immunochemical Testing (FIT) could support the recovery of cancer waiting times and patient throughput by significantly reducing: 1. Referrals into secondary care, by providing a clear threshold under which patients can be safety-netted in primary care.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
	2. Demand for colonoscopy, by reducing the proportion of LGI 2WW referrals sent for colonoscopies which do not ultimately identify any pathology. This indicator will recognises PCNs for increasing the proportion of LGI referrals accompanied by a FIT test result.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of lower gastrointestinal two week wait (fast track) referrals for suspected cancer.
Numerator	Of the denominator, the number of referrals accompanied by a faecal immunochemical test, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.
Prevalence numerator	Indicator denominator.
Exclusions	None
Personalised care adjustments	Provision of faecal immunochemical test kit declined, without a subsequent recording of a FIT test result
Desired direction	Upwards
Thresholds	40% (LT), 80% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
Subject to declaration?	Yes
Additional information	There has been an eightfold increase in the colonoscopy backlog (number of patients waiting over six weeks for a colonoscopy) during the pandemic, from which services have yet to fully recover. Lower gastrointestinal (LGI) patients now account for more than a quarter of all patients who do not meet the 62-day standard,[3] with almost all breaching because of colonoscopy waits. It will be impossible to reduce the backlog to pre-pandemic levels unless LGI waiting times are improved. FIT has been introduced into the LGI urgent cancer pathway as a triage tool to support prioritisation of colonoscopy capacity for those at highest risk of colorectal cancer. FIT was first introduced through NICE guidance DG30 as a "rule in" test to the LGI urgent cancer pathway. At the start of the COVID-19 pandemic, FIT was introduced for all patients on the LGI urgent cancer pathway through NHSEI Clinical Guidance on triaging LGI patients. There are a number of steps a PCN may take to ensure that FIT is implemented across all practices: 1. **Encouraging patient uptake of FIT:** Make sure the patient is aware of the importance of completing a FIT test and returning it as quickly as possible. This could include sending instant text message reminders to patients. Cancer Research UK has materials to support patient uptake available on their website. 2. **Working closely with secondary care:** Utilise e-RS pre-referral specialist advice (or 'advice and guidance') where it is unclear if a patient requires an urgent referral based on their FIT result and symptoms. 3. **LGI urgent cancer forms:** Include information on FIT on the LGI 2WW referral form. If primary care is using the FIT result to decide whether a 2WW is appropriate, the numerical result for FIT should be included on the referral form to support secondary care to triage patients appropriately. If the FIT is

[3] 85% of patients diagnosed with cancer after an urgent (two week wait) referral should begin their first definitive treatment within 62 days of the initial referral.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
	given to accompany the referral it should be noted that a FIT kit has been given to the patient to complete. The lower threshold for CAN-01 will increase to 65% in 2023/24, to align with expected increased uptake of FIT over the next 12 months.

Access area

4.6 Improving access to general practice services is a core aim of both the NHS Long Term Plan and *Investment and Evolution*, the five-year GP contract framework. COVID-19 has also resulted in rapid and widespread changes in how patients access general practice services. IIF indicators in this area are designed to support improvements in access to general practice by recognising PCNs for helping more patients to access the right care, in the right place, at the right time.

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
Rationale for inclusion	PCNs have been encouraged over the last few years to put in place digital access routes for patients – known as 'online consultation systems'. Having an online access route in place for patients via an online consultation system will become a contractual requirement from 1 October 2021 The purpose of this indicator is to recognise PCN member practices for providing and promoting online access for those patients who choose to use it and who find it beneficial, and to recognise that effective implementation of online systems takes time and effort.
Indicator type	Binary Quantitative
Running period	1 April 2022 to 31 March 2023

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
Denominator	Total number of registered patients
Numerator	Number of online consultation submissions received by the PCN
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Threshold	0.26 (single threshold)
Points	18
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: OCVC Extended Collection (from OCVC suppliers)
Subject to declaration?	No – Data for this indicator will be provided on behalf of practices by Online Consultation System suppliers. If a PCN believes that their data for this indicator is incorrect, they are advised to contact their Online Consultation system supplier to query the discrepancy.
Additional information	The numerator will count all online consultation submissions received by all Core Network Practices of the PCN, irrespective of whether they relate to a clinical issue or an administrative issue. Online access is not a replacement for other access routes and will not be suitable for all patients' needs or circumstances. Online access should, therefore, always be available alongside other access options. PCNs should agree their models of access and how their Core Network Practices' online consultation

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
	system is used alongside other access routes, taking into consideration the needs of their local community. The activity level called for by this indicator has been set at a **minimal** level, as its purpose is to demonstrate that practices in the PCN have a functioning online route to access care, for those patients that choose to use it. As such, this IIF indicator is based on a single activity threshold for online consultation submissions received by the PCN – this threshold has been set at a modest level, corresponding to five online consultation submissions received by the PCN per 1000 registered patients per week. This constitutes the minimum activity level needed to be able to demonstrate that member practices have an online access route, that they promote it to their patients and that patients are able to use the system to seek care or advice. To earn points in relation to this indicator, PCNs must ensure that member practices sign up to the Data Provision Notice (DPN) that has been issued in relation to the OCVC Extended Collection that will be used to provide the numerator of this indicator. If a member practice does not sign up to this DPN, any online consultation submissions it receives will not be provided by online consultation platform suppliers as part of this data collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to any DPN that is issued in relation to the OCVC Extended Collection, so that all online consultation submissions received by the practice can be properly counted for the purposes of this indicator. **Further information** • Guidance on implementing an online consultation system: NHS England » Using online consultations in primary care: implementation toolkit. • Guidance on implementing a 'total triage' process using online consultation systems: Report template - NHSI website. • Further guidance and resources are available on the Digital Primary Care - FutureNHS Collaboration Platform (requires login). • Data Provision Notice (DPN) Online and Video Consultation in General Practices

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
Rationale for inclusion	This indicator will recognise PCNs for taking practical and measurable steps to improve access to general practice for patient groups who experience inequalities and who are at greater risk of experiencing poor access.
Indicator type	Qualitative
Running period	1 April 2022 to 31 March 2023
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	48
Data source	Manual confirmation of completion via CQRS
Subject to declaration?	No

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
Additional information	This indicator asks that, by 31 March 2023, PCNs should make use of the 2021/22 General Practice Patient Survey (GPPS) results for member practices to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop and implement a plan to improve access for these patient groups. We particularly suggest that PCNs review the following GPPS questions, as well as considering feedback directly from their patient population: • Q16 – why patients who wanted an appointment did not receive one • Q19 – patients who avoided making an appointment • Q20 – patients' overall experience of making an appointment • Q30 – overall experience PCNs are strongly encouraged to also make use of other data and sources of evidence when identifying groups experiencing inequalities in access, particularly those which provide information on local demographics and levels of deprivation. PCNs should also consider Core20PLUS5[4], which is aimed at supporting the reduction of health inequalities at both national and system level. This plan should take the form of a written document, based on SMART principles,[5] prepared by the PCN with input from all member practices submitted to their CCG, which sets out: • The patient groups being targeted • A plan for improving access for these patient groups • How that improvement will be measured Plans will then be published by the CCG. PCNs should consider developing and sharing their plans with local interested partners, for example, their constituent practices' Patient Participation Groups (PPGs) and local Healthwatch England.

[4] For more information on Core20PLUS5, click here
[5] See Section 5 of QOF Guidance 2022/23 on Quality Improvement for further information about SMART principles.

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
	Improvement should be aimed at reducing health inequalities and improving patient experience. In developing and implementing their improvement plan, PCNs should also consider any points of overlap or synergies with the 2022/23 QOF Quality Improvement module on improving access to general practice.

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
Rationale for inclusion	Planning Guidance for 2021/22 and 2022/23 has required that all systems continue to increase utilisation of Specialist Advice in support of elective recovery. It is recognised that these services have a key role to play in supporting the provision of effective and co-ordinated management of care in key specialty areas, preventing unnecessary referrals to secondary care, and freeing up capacity to address the elective care backlog. This indicator has been introduced to reward PCNs for the utilisation of pre-referral Specialist Advice services (sometimes known as Advice and Guidance) in twelve specialties identified for accelerated uptake.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of outpatient first attendances across twelve specialties identified for accelerated delivery (Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat).
Numerator	Total number of processed pre-referral Specialist Advice (e.g. Advice and Guidance) requests across the twelve specialties identified for accelerated delivery

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
Prevalence numerator	Number of registered patients (i.e. no prevalence adjustment)
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.066 (LT), 0.19 (UT)
Points	44
Data source	Numerator: System Elective Recovery Outpatient Collection (S-EROC) Denominator: Outpatient HES/SUS
Subject to declaration?	Yes – If PCNs believe that their S-EROC data is incomplete, they will have the opportunity within CQRS to decline to declare their achievement, and to provide evidence to their commissioner of any pre-referral Specialist Advice activity undertaken but not included in S-EROC. Commissioners will then be able to update the PCN's indicator data within CQRS.
Additional information	**e-RS configuration** Most SA activity takes place via the NHS e-Referral Service (e-RS). e-RS SA pathways should be designed and commissioned locally in collaboration with both primary and secondary care. Commissioned pathways should then be configured on e-RS in order to enable submission of processed SA requests. PCNs are recommended to raise any technical issues relating to e-RS configuration with the IT/Application Support Team in their ICS. ICSs should have a named Registration Authority Manager who has e-RS access rights and the authority to process smart card role changes. Where Specialist Advice (or Advice and Guidance) is expected from secondary care (as is required by Planning Guidance) but not available, PCNs are recommended to contact the elective care

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
	commissioning teams in their CCG or ICS to explore whether or how these services may be accessed. Additional information on e-RS for referrers and referring clinician teams is available here. **Data collections and third-party providers** This indicator will measure the number of processed pre-referral SA requests using the System Elective Recovery Outpatient Collection (S-EROC). This national data collection can include SA activity generated through the use of third-party providers where measures have been taken at a local level for data from these providers to be included in submissions to the overall S-EROC collection. Inclusion of data on processed SA requests from third party platforms in S-EROC submissions is an ICS responsibility. It is recognised that there may be some PCNs who use third party SA platforms whose data is not currently included in their system's S-EROC submission. In this instance, it is recommended that PCNs contact the Commissioning or Outpatient Transformation Lead responsible for Referral Optimisation in their ICS. They will be able to engage with Business Intelligence or Information Analysts to understand and influence what is included within ICS submissions in line with S-EROC guidelines. In addition to manual ICS submission of third-party platform SA data into S-EROC, NHSEI has also established a facility for SA data from some third party platforms to flow on an automated basis into S-EROC. NHSEI intends to expand the range of third-party platforms with this automated extraction facility over the coming months. To participate in this automated extraction, the local data controller (typically this will be the CCG) must provide authorisation and consent to the third-party platform to release their data to S-EROC. While participation in this automated extraction facility is typically a CCG responsibility and is not the responsibility of individual PCNs, if a PCN wants to know whether their CCG has signed up to participating in this automated extraction for their third party platform, or wants to ask that they do so, it recommended that they contract their CCG's Performance and/or Analytics Lead within their CCG, who should be able to signpost them on to the data controller for SA platforms. **Raising queries relating to local SA provision** The named roles responsible for SA may vary between CCGs. NHSE/I Regional Leads, Heads of Primary Care and Regional

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	

	Leads for Referral Optimisation should all be able to support the navigation of queries relating to SA to the relevant contacts.
	
	Contact details for Regional Leads for Referral Optimisation can be found through the Referral Optimisation Community of Practice, accessible via FutureNHS.
	
	Guidance and further resources
	
	More information and resources can also be found through the Referral Optimisation Community of Practice portal, accessible via FutureNHS.
	
	Detailed data specification
	
	1. Denominator
	
	• Data source: Secondary User Services (SUS) Outpatient dataset
	• Count: Total number of outpatient first attendances across twelve specialties identified for accelerated delivery (Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat).
	• Filters applied:
	  • [Administrative_Category] = 1 (NHS funded)
	  • [Attendance_Status] = 5, 6 (attended and was seen)
	  • [First_Attendance] = 1, 3 (first attendance)
	  • [Treatment_Function_Code] = 101, 301, 320, 330, 400, 502, 120, 302, 303, 340, 410, 420
	
	2. Numerator
	
	• Data source: System Elective Recovery Outpatient Collection (SEROC)
	• Count: Total reported processed requests for pre referral specialist advice across twelve specialties identified for accelerated delivery
	• Filters applied
	  • [Type of Referral Optimisation Interaction] = 01 (specialist advice)
	  • [Treatment Function Code for request] = 101, 301, 320, 330, 400, 502, 120, 302, 303, 340, 410, 420
	  • [Request status] ≠ 02 (Still Open / Ongoing)
	  • [Outcome of interaction] ≠ 40 (Rejected)

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
Rationale for inclusion	Improving access to general practice is one of the most significant challenges facing primary care in England, with challenges accessing GP appointments recognised as one of the reasons for public dissatisfaction with the NHS. This indicator recognises PCNs for increases in the percentage of patients whose time from booking to appointment is two weeks or less. It will serve as a 'lead in' to an updated indicator in the 2023/24 IIF which better enables the measurement of the true excess wait time between booking and appointment by introducing 'appointment exception reporting' functionality.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of appointments delivered by the general practice under eight national appointment categories[6]
Numerator	Of the denominator, the number for which the time from booking to appointment was two weeks (14 days) or less
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)

[6] General Consultation Acute; General Consultation Routine; Unplanned Clinical Activity; Clinical Triage; Walk-in; Home Visit; Care Home Visit; Care Related Encounter but does not fit into any other category.

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
Points	71
Data source	GP Appointments Data (GPAD)
Subject to declaration?	Yes
Additional information	Improving access to general practice is one of the most significant challenges facing primary care in England, with challenges accessing GP appointments long recognised as one of the reasons for public dissatisfaction with the NHS.[7] At least three government manifesto commitments – to deliver 50 million extra appointments in general practice; deliver 6,000 new GPs; and deliver 26,000 new clinicians in general practice via the Network Contract DES Additional Roles Reimbursement Scheme – aim to tackle this challenge. In spite of being a high policy priority, there is not currently a robust way of measuring progress in tackling some of the key ways that that patients experience poor access to general practice – namely, having to wait a long time for an appointment or to get through to the GP practice on the phone. This indicator makes a start in measuring the excess wait time between booking and appointment in general practice, by rewarding PCNs for increases in the percentage of patients with a time from booking to appointment of two weeks or less. GPAD includes a set of 17 national appointment categories which enable one to distinguish between appointments for which patients will frequently want the first available appointment (so that timely availability is valued by the patient), and appointments such as reviews and check-ups that are typically scheduled in advance. ACC-08 only includes appointments mapped to national categories in the former group, i.e.: • General Consultation Acute • General Consultation Routine • Unplanned Clinical Activity

[7] The 2021 GP Patient Survey results showed that 67% of patients were satisfied with the appointment times available to them, while 58.9% received an appointment at a time they wanted or sooner. While the results represent an increase relative to the 2020 results (when the corresponding results were 63% and 56.5% respectively), the fact remains that a third of survey respondents or more report an inability to obtain a timely appointment.

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	• Clinical Triage • Walk-in • Home Visit • Care Home Visit • Care Related Encounter but does not fit into any other category. Any appointment mapped to one of the above eight national categories is in scope of ACC-08, irrespective of: • The mode (method) by which the appointment was delivered (e.g. face-to-face, telephone). • Whether the appointment is recorded as 'Attended', 'Booked', or 'Did Not Attend'. **Are general practice waiting times still relevant in a post-pandemic world?** The way that general practice provides care and advice to patients has changed dramatically in response to COVID-19, and some of the positive innovations prompted by the pandemic – for example, a greater focus on triage and online consultations – will become enduring features of general practice. ACC-08 is intended to take account of these changes to general practice. The August 2020 definition of an appointment (namely, appointments are "discrete interactions between a health or care professional and a patient, or a patient's representative") encompasses both triage and online consultations, including asynchronous communications such as a written exchange over an app. Where these interactions are recorded in general practice appointment books, and provided they occur within two weeks of the patient making the request – which would presumably be the case in the vast majority of instances – the interaction would be in scope of ACC-08 and would count as 'success'. **Measuring 'true waiting times' – introducing appointment exception reporting** There are at least two reasons why time from booking to appointment might not capture 'true' waiting time for an appointment in general practice (which might be defined as the difference in time between when a patient wanted an appointment and when they received one). 1. Some patients may explicitly request an appointment on a defined future date, or express a preference concerning the appointment that has the same effect. Alternatively, there may be a clinically defined interval between encounters – e.g. the GP may say "come back and see me in four weeks".

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	2. Patients may struggle to make contact with their practice at the first time of asking (e.g. the telephone may be engaged), meaning that, even if they request the first available appointment, time from booking to appointment will underestimate the true length of time they waited. To address the first point, which has the potential to negatively affect a PCN's achievement of this indicator, from 2023/24 a new system of appointment exception reporting will be introduced within GP IT systems. This will enable construction of a better measure of waiting times in general practice, by enabling restriction of attention to appointments for which time from booking to appointment is a better proxy for 'true' waiting time. From 2023/24, if one of a number of extenuating circumstances is flagged as applying to an appointment (e.g. patient requests appointment on a defined future date more than two weeks in advance), that appointment will be omitted from 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 two weeks or less, the appointment would still be included in calculation of ACC-08 and would count as a success. **Thresholds** In 2022/23, the thresholds for ACC-08 have been set at a relatively modest level – the lower threshold of 85% corresponds to the 20th percentile of current national performance, while the upper threshold of 90% corresponds to the 50th percentile (i.e. median performance). This means that PCNs will need to ensure that performance is at the currently median to earn all available points. The 2022/23 thresholds provide ample headroom for PCNs to continue to book appointments more than two weeks in advance if there are no appointments available in the next two weeks, if the patient requests an appointment in the future, or if there is a clinically indicated interval between appointments. PCNs should continue to make appointments available more than two weeks in advance, and should continue to book patients into these appointments where it is in the patient's best interests to do so. Commissioners are expected to closely monitor the rollout of this indicator to ensure that practices are not closing their appointment books more than two weeks in advance, as part of their assurance that general practice is meeting their contractual requirements. From 2023/24, when appointment exception reporting functionality is introduced in GP IT systems, this indicator will revert to the thresholds originally announced in August 2021 – i.e. a lower

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	threshold of 90% and an upper threshold of 98%. These more ambitious thresholds reflect the view that, unless one of the five above grounds for exception reporting applies, every patient whose needs would best be met by an appointment in general practice, should receive that appointment within two weeks.

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
Rationale for inclusion	The NHS Community Pharmacist Consultation Service (CPCS) was launched by NHSEI in 2019. Under the CPCS, practices can refer patients with a minor illness for a same day appointment with a community pharmacist. CPCS supports improved access to services, utilises the skills and medicines knowledge of pharmacists, and provides convenient treatment close to patients' homes.
Indicator type	Binary Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Number of referrals to the Community Pharmacist Consultation Service for patients in the denominator
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
Thresholds	0.034 (single threshold)
Points	27
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	**Coding** Two new SNOMED codes have been created for practices to use when they have offered to refer a patient to the CPCS: • 1362511000000107 | Referral to Community Pharmacist Consultation Service • 1362521000000101 | Referral to Community Pharmacist Consultation Service refused The numerator of ACC-09 will count the number of times the first code (1362511000000107) is applied to the records of registered patients. **Activity** The activity level called for by this indicator has been set at a **minimal** level, as its purpose is to demonstrate that practices in the PCN have a functioning referral pathway to community pharmacy under the CPCS. As such, this IIF indicator is based on a single activity threshold for CPCS referrals – this threshold has been set at a modest level, corresponding to 0.65 CPCS referrals per 1000 registered patients per week. **Further support and resources** Additional practice support is available nationally (between March and June 2022) to engage directly with practices and PCNs on the implementation of referrals to CPCS. Regional CPCS team contact information and other resources for general practice, PCN and pharmacy staff can be found here. **NHSEI Pharmacy Integration Fund website: CPCS resources** • The Toolkit for pharmacy staff provides a practical guide on providing the NHS CPCS service. • The GP/PCN toolkit provides a practical guide to implementing the minor illness referral pathway from general practice to community pharmacy via CPCS.

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
	• This briefing note explains how the GP referral pathway works and how to implement it in PCNs and practices. • The full CPCS service specification is available here: Advanced Service Specification – NHS Community Pharmacist Consultation Service.

Structured medication reviews and medicines optimisation area

4.7 Indicators in this area focus on structured medication reviews, a National Institute for Health and Care Excellence (NICE) approved clinical intervention that help people who have complex or problematic polypharmacy.

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of patients at risk of harm due to medication errors, as defined by any of the following: • Patients aged 65 or over prescribed an oral NSAID and not prescribed a gastroprotective. • Patients aged 18 or over with a history of peptic ulceration prescribed an oral NSAID • Patients aged 18 or over with a history of peptic ulceration prescribed an anti-platelet • Patients aged 18 or over prescribed both an oral anticoagulant and an oral NSAID within 28 days of each other

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	
	• Patients aged 18 or over prescribed both an oral anticoagulant and an anti-platelet within 28 days of each other. • Patients aged 18 or over prescribed both an aspirin and another type of anti-platelet within 28 days of each other • Patients aged 18 or over with an unresolved heart failure diagnosis prescribed an oral NSAID. • Patients aged 18 or over with an eGFR of less than 45ml per minute prescribed an oral NSAID. • Patients aged 18 or over with an unresolved asthma diagnosis prescribed a non-selective beta-blocker.
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	26
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	**Links to resources and further guidance** • Network Contract DES: Structured Medication Review Guidance • Royal Pharmaceutical Society: Polypharmacy best practice guide

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	

	• SMR Principles – NHS England Pharmacy Integration Programme – FutureNHS Collaboration Platform
	• Shared Decision Making guidance:
	  • NICE
	  • Keele University SDM Package
	  • CPPE Training

SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients living with severe frailty.
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards

SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review	
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of patients using potentially addictive medicines, defined as patients falling into either one or both of the following sub-cohorts: • Cohort 1: Patients with 2 or more prescriptions over a 3-month period for any of the following four classes of medicine: a. Gabapentinoids. b. Benzodiazepines. c. Z-drugs. d. Any oral or transdermal opioid other than: i. Weak opioids (Codeine, Dihydrocodeine, Meptazinol). ii. Heroin substitutes (including Methadone, Buprenorphine).

SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review	
	• Cohort 2: Patients with a single prescription for an oral or transdermal opioid with > 120 mg oral morphine equivalent
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator

Exclusions	The following exclusions apply to each cohort:
	• Cohort 1: Any opioid prescribed to cancer patients (patients with a cancer diagnosis recorded in the previous 6 months, irrespective of whether this diagnosis is a first/new occurrence, a recurrence, or continuing condition).
	• Cohort 2:
	  • Codeine, Dihydrocodeine, Meptazinol, Heroin alternatives (including Methadone, Buprenorphine).
	  • Cancer patients (patients with a cancer diagnosis recorded in the previous 6 months, irrespective of whether this diagnosis is a first/new occurrence, a recurrence, or continuing condition).

Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

SMR-01D: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of permanent care home residents aged 18 years or over
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient declined offer of a Structured Medication Review 2. Registration with general practitioner practice aligned to care home declined
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

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 last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over concurrently prescribed a non-steroidal anti-inflammatory drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed an NSAID OR 2. Prescribed a gastro-protective in addition to an NSAID.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)

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 last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

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 last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 65 years or over prescribed a non-steroidal anti-inflammatory drug (NSAID) without a concurrent oral anticoagulant in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either:

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 last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	
	1. No longer prescribed an NSAID OR 2. Prescribed a gastro-protective in addition to an NSAID.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date 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.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i)

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date 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.	
	stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over concurrently prescribed an oral anticoagulant and an anti-platelet in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed an anti-platelet OR 2. Prescribed a gastro-protective in addition to an anti-platelet.
Prevalence numerator	Indicator denominator.
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	75% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date 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.	
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

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 last three months of the previous financial year, who in the three months to the reporting period end date 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.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over prescribed both aspirin (irrespective of dose/strength) and another anti-platelet in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed aspirin and/or no longer prescribed an anti-platelet OR 2. Prescribed a gastro-protective in addition to both aspirin and another anti-platelet.

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 last three months of the previous financial year, who in the three months to the reporting period end date 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.	
Prevalence numerator	Indicator denominator.
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	75% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

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 recording that their DOAC dose was either changed or confirmed (not changed).	
Rationale for inclusion	SMR-03 supports the dose optimisation of DOACs based on current renal function, with the aim of reducing the risk of unintentionally prescribed overdoses.

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 recording that their DOAC dose was either changed or confirmed (not changed).	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients prescribed a direct-acting oral anticoagulant (DOAC)
Numerator	Of the denominator, the number who received a renal function test and have a recording of weight and Creatinine Clearance Rate (CCR), along with a recording that their DOAC dose was either changed or confirmed (not changed)
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	Patients whose first DOAC prescription is in the last 3 months of the financial year
Desired direction	Upwards
Thresholds	50% (LT), 75% (UT)
Points	13
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	The most frequent serious adverse event associated with DOACs is a major bleed. The most common modifiable causes of major bleeds associated with DOACs are:

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 recording that their DOAC dose was either changed or confirmed (not changed).	
	• Co-prescription of DOAC and a gastro-toxic drug such as a Non-steroidal anti-inflammatory drug (NSAID), aspirin and/or anti-platelets (affecting an estimated 12,500 patients) • An unintentional prescribed overdose (affecting an estimated 155,200 patients). The Orbit II-AF Registry found that 1 in 25 patients on the incorrect dose of DOAC suffered a major bleed. To prevent people being prescribed an overdose, patient renal function must be regularly monitored (generally once or twice a year) and the dose adjusted based on creatinine levels and weight. Further information on the background to SMR-03 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants - Medicines Safety Improvement Programme - FutureNHS Collaboration Platform.

Respiratory area

4.9 Asthma patients in England experience worse outcomes than those in comparable health systems. Indicators in this area encourage PCNs to develop effective medicines regimes for asthma patients by making sure they are prescribed ICS inhalers on a regular basis, in order to support effective self-management and help prevent disease exacerbation and deterioration.

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Rationale for inclusion	Inhaled corticosteroids (ICS) are the most effective and first choice preventer drug for adults and older children with asthma. However, prescribing rates remain low in England. Regular use improves symptoms and reduces reliance on short acting beta agonists (SABA), exacerbations and mortality. This indicator recognises PCNs for an increase in the percentage of patients regularly prescribed an inhaled corticosteroid. Combination ICS/LABA inhalers, including maintenance and reliever therapy (MART), are included.

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Asthma Register
Numerator	Of the denominator, the number who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient added to QOF Asthma Register in last 9 months of the financial year. 2. Not clinically suitable – as measured by: • Presence of 'Inhaled corticosteroid not indicated' SNOMED code. • A recording of mild asthma, without a subsequent recording of moderate or severe asthma. • Fewer than 3 SABA prescriptions in the same 12-month period (fewer than 4 for patients aged under 18).
Desired direction	Upwards
Thresholds	71% (LT), 90% (UT)
Points	31
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Additional information	NICE guidelines on the management of asthma recommend inhaled corticosteroids to be used as first-line maintenance therapy. For very mild asthma in patients with infrequent, short-lived wheeze and normal lung function, it may be that an ICS is not required as per NICE guidelines. A personalised care adjustment is available to use in these situations, as detailed above. Most inhaled corticosteroids can be delivered via dry powder inhalers which have a significantly lower carbon footprint than metered dose inhalers. Efforts made towards meeting this indicator should also be complementary in helping to meet asthma indicators in the Quality and Outcomes Framework (QOF), particularly AST005 and AST007. It is important that any decision to switch or start an inhaler is made as the outcome of a shared decision-making conversation. Good inhaler technique is essential for treatment to be effective, irrespective of drug or device. Appropriate training and regular technique checks are required to ensure patients use their inhalers optimally. Poor adherence with inhaled corticosteroids is correlated with poor asthma-related outcomes. Therefore it is important that patients are educated on the importance of regular use, particularly the difference between use of preventers and relievers. ICS is often used with LABA in combination inhalers, which can either be used as preventers or in MART regimes where they act as both reliever as preventer. Current guidance is that MART should be considered in patients who have a history of asthma attacks on medium dose ICS or ICS/LABA. From 2023/24, this indicator will shift to counting inhalers rather than prescriptions, rewarding PCNs based on the percentage of asthma patients prescribed five or more ICS inhalers over 12 months. The thresholds will also be revised to align with NHSEI's ambition that, by 2024/25, 90% of asthma patients should be regularly prescribed an ICS. **Further information for clinicians** • Further resources are available in the "Tools & Resources" section of the Greener NHS programme's FutureNHS workspace: https://future.nhs.uk/sustainabilitynetwork (for any

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
	access queries, please email sustainabilitynetwork-manager@future.nhs.uk). • NICE: Patient decision aid • British Thoracic Society Position Statement: The environment and lung health • UK Inhaler Group: Inhaler standards and competency document: Guidance on optimal inhaler technique • Greener Practice: How to Reduce the Carbon Footprint of Inhaler Prescribing. • PrescQIPP bulletin 295 and resources: Inhaler carbon footprint. • Asthma and Lung UK: answers to common patient concerns about asthma medications **Further information for patients** • Asthma UK & British Lung Foundation • What does good asthma control look like? • Your personalised asthma action and support plan • Asthma review: Guidance on how to use your inhaler most effectively, tailored to your device **Other references** • **NICE guideline NG80: Asthma: diagnosis, monitoring and chronic asthma management** • Relationship between adherence to inhaled corticosteroids and poor outcomes among adults with asthma

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
Rationale for inclusion	Overuse of short acting beta agonists (SABA) in asthma is higher in the UK than in other European countries and is associated with an increased risk of exacerbations and mortality. This indicator recognises PCNs for a reduction in the percentage of patients receiving six or more SABA prescriptions per year.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
Denominator	Number of patients on the QOF Asthma Register
Numerator	Of the denominator, the number who received 6 or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions in the previous 12 months.
Prevalence numerator	Indicator denominator.
Exclusions	Patients with dual diagnosis of COPD and asthma.
Personalised care adjustments	N/A
Desired direction	Downwards
Thresholds	25% (LT), 15% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Overuse of short acting beta agonists (SABA) in asthma is higher in the UK than in other European countries and is associated with an increased risk of exacerbations and mortality, as seen in the SABINA observational program[2,3]. Therefore, addressing this is key in improving asthma outcomes. SABA may be perceived by the patient to be controlling the disease, but it does not treat the underlying airways inflammation and therefore overreliance puts patients at greater risk of a severe attack. SABA inhalers contribute the largest proportion of greenhouse gas emissions of all inhaler types, so reducing SABA overuse is both desirable for patient outcomes and helps to reduce carbon emissions.

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
	Efforts made towards meeting this indicator should also be complementary in helping to meet asthma indicators in the Quality and Outcomes Framework, particularly AST005 and AST007. It is important that any decision to stop, change or start an inhaler is made as the outcome of a shared decision-making conversation. This indicator is designed to support a gradual process over the whole time period to allow such changes to be made in the appropriate way. A plan for how to reduce SABA use should be personalised for each patient and accompanied by optimising preventer treatment and regular review of changes. Overuse of SABA is correlated with poor asthma-related outcomes. Therefore it is important that patients are educated on the role of SABA in symptom relief but not disease control. The importance of reporting when their SABA use increases and ensuring their asthma management is reviewed, should also be emphasised. Case finding and prioritisation of patients with the highest volume of current SABA use may help to meet this indicator. From 2023/24, this indicator will shift to counting inhalers rather than prescriptions, rewarding PCNs based on the percentage of asthma patients prescribed five or fewer SABA inhalers over 12 months. The thresholds will also be revised to align with NHSEI's ambition that, by 2024/24, no more than 10% of asthma patients should be prescribed 6 or more SABA inhalers per year. **References** • Overuse of short acting B2 agonists in asthma is associated with increased risk of exacerbation and mortality: a nationwide cohort study of the global SABINA programme. • SABINA: An Overview of Short-Acting β_2-Agonist Use in Asthma in European Countries See RESP-01 Additional Information for further resources.

5. A sustainable NHS domain

Inhalers area

5.1 Medicines account for 25% of emissions within the NHS.

5.2 Inhalers alone are responsible for 3% of the NHS carbon footprint. Most of these emissions come from the propellants used in metered dose inhalers (MDIs) to deliver the medicine, rather than the medicine itself. Optimising the choice of inhaler, as part of a shared decision making conversation between the patient and the clinician, can play a significant role in achieving the NHS net zero target.

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
Rationale for inclusion	People with asthma (3.9 million) are the largest patient group using MDIs in England. Patterns observed in other healthcare systems across the world demonstrate that it is possible to significantly reduce the use of MDIs, and therefore the associated carbon emissions, while maintaining high standards of care. This indicator recognises PCNs for a reduction in the number of MDI prescriptions, as a percentage of all non-salbutamol inhaler prescriptions.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of non-salbutamol inhaler prescriptions issued to patients aged 12 years or over
Numerator	Of the denominator, the number of Metered Dose Inhaler (MDI) prescriptions
Prevalence numerator	Indicator denominator
Exclusions	Prescriptions to patients to whom the “Dry powder inhaler not indicated” SNOMED code has been applied

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
Personalised care adjustments	None – but note that "Dry powder inhaler not indicated" will function similarly to a "not clinically suitable" PCA.
Desired direction	Downwards
Thresholds	44% (LT), 35% (UT)
Points	27
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Dry Powder Inhalers (DPI) and Soft Mist Inhalers (SMIs), for example, offer a lower-carbon clinical alternative to MDIs. For most patients, MDIs do not confer any additional clinical advantages over DPIs. Efforts made towards meeting this indicator should also be complementary in helping to meet asthma and COPD indicators in the Quality Outcomes Framework (QOF), particularly AST005, AST007, COPD009 and COPD010. It is important that any decision to change a patient's asthma inhaler is clinically appropriate and done as the outcome of a shared decision-making conversation. This indicator is designed to support a gradual process over the whole time period to allow such changes to be made in the appropriate way. Moving a patient from an MDI to an alternative type of inhaler may not be appropriate for some patients and may disrupt disease control or threaten their safety. Good inhaler technique is essential for inhaler treatment to be effective, irrespective of the type of device. Appropriate training and regular technique checks are required to ensure patients use their inhaler optimally and maximise the benefit of their medication. This is especially important when patients are prescribed a different type of inhaler. Case finding and prioritisation of patients with the highest volume of current SABA use helps to identify which patients would benefit most from a

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
	change of inhaler, and would also help in meeting the RESP-02 indicator. Feedback 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. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New Medicine Service consultation focused on improved adherence and an inhaler technique check for patients who are prescribed an inhaler for the first time, or who are changing or have changed to a new inhaler device. The intention is to update the thresholds for ES-01 in 2023/24, to align with NHSEI's aim that, in line with best practice in other European countries, by 2023/24 only 25% of non-salbutamol inhalers prescribed will be MDIs. See RESP-01 Additional Information for further resources.

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
Rationale for inclusion	Salbutamol Metered Dose Inhalers (MDIs) are the single biggest source of carbon emissions from NHS medicines prescribing. Where a salbutamol inhaler is required, this indicator encourages PCNs to consider prescribing a lower carbon option. This does not necessarily mean changing the type of inhaler that the patient receives (e.g. MDI to Dry Powder Inhaler or DPI), since different salbutamol MDI inhalers can have different carbon emissions. If an MDI is required for the patient, for instance because a DPI is not indicated, prescribing a lower carbon salbutamol MDI will reduce overall carbon emissions from salbutamol inhalers without compromising patient safety or disease control. A table providing the manufacturer-reported or estimated whole lifecycle carbon emissions from each type of salbutamol inhaler is provided below. This table will be used to calculate the numerator of this indicator and can therefore be used by PCNs as a guide to what they can do to reduce the carbon intensity of their salbutamol prescribing.

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of salbutamol inhalers prescribed
Numerator	Total carbon emissions from all inhalers in the denominator (kg CO_2e)
Prevalence numerator	Number of patients prescribed salbutamol inhalers
Exclusions	None
Personalised care adjustments	None
Desired direction	Downward
Thresholds	22.1 kg CO_2e (LT), 18.0 kg CO_2e (UT)
Points	44
Data source	Business Services Authority (BSA) prescribing data, combined with manufacturer-reported or estimated carbon emissions from each type of salbutamol inhaler, compiled by a manufacturer survey and literature review conducted by PrescQIPP.
Subject to declaration?	No – PCNs who believe that ES-02 data collected in respect of them is incorrect are advised to consult the following link, which provides further information about how they may pursue any queries or concerns they have about BSA prescribing data collected in respect of them (see final paragraph of webpage): https://www.nhsbsa.nhs.uk/prescription-data/understanding-our-data/prescription-requests

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)

Additional information

Efforts made towards meeting this indicator should also be complementary in helping to meet asthma and COPD indicators in the Quality Outcomes Framework (QOF), particularly AST005, AST007, COPD009 and COPD010.

Any decision to change a patient's inhaler, including switching brands, should be taken as part of a shared decision-making process.

Case finding and prioritisation of patients with the highest volume of current SABA use may help to meet this indicator.

The numerator of this indicator will be calculated by multiplying the number of each inhaler type prescribed, by the carbon emissions per inhaler for that inhaler type. For example, if a PCN only prescribes two inhaler types, A and B, then

Numerator = Count of inhaler A × Emissions per inhaler A +
Count of inhaler B × Emissions per inhaler B

The following table shows the variation in estimated life cycle carbon emissions for different salbutamol inhaler types, based on a manufacturer survey and literature review conducted by PrescQIPP, and commissioned by NHSEI. Life cycle inhaler emissions include propellant emissions as well as emissions from all other stages in the product life cycle (e.g. transportation, energy and water use, and waste disposal). These estimates are based on manufacturer survey responses where available, and on information in the literature where survey responses were not provided – see below links for further information. These estimated inhaler carbon emissions values will be combined with BSA prescribing data to calculate the ES-02 indicator numerator.

Prescribing term	Carbon emissions per inhaler (kg CO_2e)
Airomir 100 microgram	9.72
Airomir Autohaler 100 microgram	9.72
Easyhaler Salbutamol 100 microgram	0.62
Easyhaler Salbutamol 200 microgram	0.62
Salbutamol CFC free breath actuated inhaler 100 microgram (GENERIC)	11.79

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)

Salbutamol CFC free Inhaler 100 microgram (GENERIC)	25.24
Salamol CFC-Free Inhaler 100 microgram	11.95
Salamol Easi-Breathe 100 microgram	12.08
Salbulin Novolizer 100 microgram	3.75
Ventolin Accuhaler 200 microgram	0.58
Ventolin Evohaler 100 microgram	28.26

We advise PCNs to also consider local prescribing guidance when considering how to make use of this information to reduce the carbon emissions from salbutamol prescribing.

This table contains two entries for generic salbutamol MDI prescribing – one for a breath-actuated MDI (BAI) ("Salbutamol CFC free breath actuated inhaler 100 microgram"), and the other for a conventional pressurised MDI (pMDI) ("Salbutamol CFC free Inhaler 100 microgram").

As it is not currently possible to know which inhaler is dispensed each time a generic salbutamol inhaler is prescribed, carbon emissions associated with generic salbutamol prescribing have been inferred based on IQVIA data which indicates that:

- When a generic salbutamol pMDI is prescribed ("Salbutamol CFC free Inhaler 100 microgram"):
  - Ventolin Evohaler 100 microgram is dispensed 81.5% of the time.
  - Salamol CFC-Free Inhaler 100 microgram is dispensed 18.4% of the time.
  - Airomir 100 microgram is dispensed 0.1% of the time.
- When a generic salbutamol BAI is prescribed ("Salbutamol CFC free breath actuated inhaler 100 microgram"):
  - Airomir Autohaler 100 microgram is dispensed 12.5% of the time.
  - Salamol Easi-Breathe 100 microgram is dispensed 87.5% of the time.

We use this information to impute a carbon intensity to generic salbutamol MDI prescribing, as a weighted average of the

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
	carbon intensities of the inhalers that tend to be dispensed when generic salbutamol MDI is prescribed, i.e. Carbon intensity of generic salbutamol pMDI prescribing = . (28.26 × 81.5%) + (11.95 × 18.4%) + (9.72 × 0.1%) = 25.24 kg Carbon intensity of generic salbutamol BAI prescribing = . (12.08 × 87.5%) + (9.72 × 12.5%) = 11.79 kg The calculation of these weighted averages will be reviewed annually. The intention is to update the thresholds for ES-02 in 2023/24, to align with NHSEI's ambition to reduce the mean life-cycle carbon intensity of salbutamol inhalers to 13.4kg by 2023/24. **Further information** Click here for the Greener Practice Guide: How to Reduce the Carbon Footprint of Inhaler Prescribing. Click here for a direct link to the PrescQIPP inhaler carbon emissions data and resources to support lowering the inhaler carbon footprint.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment (for Quantitative indicators) and list size adjustment are applied when calculating IIF achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex C of the 2022/23 Network Contract DES specification.

Prevalence adjustment

A.2 Prevalence refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every Quantitative IIF indicator, equal to a prevalence numerator divided by the number of registered patients at the PCN. The prevalence numerator will usually, but not always, be equal to the indicator denominator (the denominator may be a count of eligible patients or a count of interventions e.g. medications delivered to a set of eligible patients). For instance, for indicator VI-01 prevalence is equal to the percentage of a PCN's patients who are aged 65 and over.

A.3 Consider two PCNs that are identical other than one has twice as many patients aged 65 and over. This would mean that PCN has to deliver twice as many seasonal influenza vaccinations to earn the same number of points. Applying a prevalence adjustment compensates that PCN for the extra effort required to earn a given number of points (i.e. achieve a given percentage point improvement in performance).

A.4 An example where the prevalence numerator is not equal to the indicator denominator is ES-02. For ES-02, the indicator denominator is a count of salbutamol inhalers prescribed, whereas the prevalence numerator is a count of the number of patients prescribed salbutamol inhalers. If ES-02 prevalence had been defined using the indicator denominator, this would have made earnings ability proportional to the number of salbutamol inhalers prescribed, which would be contrary to the clinical and environmental policy objectives of reducing unnecessary salbutamol prescribing.

A.5 The prevalence adjustment for an indicator is equal to PCN prevalence divided by national prevalence. For instance, if 20% of the residents of

England registered at practices signed up to the Network Contract DES are aged 65 and over, then a PCN with 30% of registered patients aged 65 and over would have a prevalence adjustment of 1.5 – that is, it would be paid 50% more for each additional achievement point than an otherwise identical PCN with a prevalence equal to the national average prevalence.

A.6 The target cohort for some indicators is the total number of patients registered in the PCN e.g. PC-01. In this case, the denominator equals the PCN list size, and when prevalence is defined as being equal to the indicator denominator, prevalence (denominator divided by PCN list size) is equal to one for all PCNs. As prevalence is equal to one for all PCNs, national average prevalence for this indicator is also equal to one. Therefore, effectively there is no prevalence adjustment for these indicators.

A.7 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages appropriate case finding for indicators whose denominator is under the control of the PCN. Consider indicator HI-01, the denominator for which is the number of patients on the learning disability register aged 14 and over. PCNs and their constituent practices are responsible for adding patients to this register. The prevalence adjustment encourages efforts to identify patients with a Learning Disability and to add them to the register, as case finding increases earnings ability.

List size adjustment

A.8 The list size adjustment is based on a similar principle to the prevalence adjustment. If two PCNs are identical (including having identical prevalence for every IIF indicator) other than one has double the list size, that PCN would have to change its treatment of twice as many patients to earn the same number of points. The list size adjustment compensates larger PCNs for this situation by making the payment per achievement point proportional to list size.

A.9 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (i.e. the total number of patients registered that are a Core Network Practices that are part of a PCN, divided by the total number of PCNs). Thus, if the national average PCN list size is 49,000 and a PCN has 98,000 patients, that PCN's list size adjustment would be 2. In other words, that PCN would be paid twice as

much for each additional achievement point as an otherwise identical PCN with a list size equal to the national average.

Summary

A.10 The net effect of applying a prevalence adjustment (for Quantitative indicators) and a list size adjustment is to make payment proportional to the amount of activity undertaken (e.g. number of patients treated). The effort required to deliver one unit of activity is not fixed, but may vary according to patient demographics, socio-economic status and other characteristics. Likewise, there may be economies of scale, so that treating 200 patients does not require twice as much effort as treating 100 patients. Thus, applying a prevalence adjustment and a list size adjustment does not ensure an exact correspondence between effort and reward, but does bring the two closer together.

Annex B: Indicator standardisation

B.1 Some IIF indicators are standardised. Standardised indicators are indicators with the word ‘standardised’ in the indicator wording. This annex describes the methodology used to standardise IIF indicators.

B.2. Standardised IIF indicators are standardised using Direct Age-Sex Standardisation. Directly age-sex standardised rates express an indicator in terms of the overall rate that would occur in a standard population age-sex structure if it experienced the age-sex specific rates of the observed population.

B.3 The directly standardised rate (DSR) is given by:

$$DSR = \frac{1}{\sum_i w_i} \times \sum_i \frac{w_i O_i}{n_i}$$

where:

- w_i is the number of individuals in the standard population in age and sex group *i*.
- O_i is the observed number of events in the local or subject population in age and sex group *i.*
- n_i is the number of individuals in the local or subject denominator population in age and sex group *i*.

B.4 The standard population used will be the relevant national (aggregated) registered population, usually from the end of the baseline period e.g. 31 March 2022 for indicators running in 2022/23. This is fixed for both baseline and performance periods to ensure that the standardised rates are comparable and allows improvement to be correctly calculated.

B.5 The age-sex groups can vary between indicators – for example, indicators based on smaller numbers may require fewer age-sex groupings to ensure that standardised rates are sufficiently stable. The default approach however is to use five-year age bands up to 95 i.e. 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-120.