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Network Contract Directed Enhanced Service

Investment and Impact Fund 2023/24: Guidance

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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*.

1.1. The IIF for 2023/24 has been redesigned to focus on a small number of key national clinical priorities, while at the same time providing general practice and Primary Care Networks (PCNs) with the time, funding, and flexibility to ensure patients can access good and timely care.

1.2. The IIF for 2023/24 contains five indicators worth £59 million. The remaining IIF-committed funding for 2023/24 has been put into the Capacity and Access Support Payment and the Capacity and Access Improvement Payment, which has total available funding of £246m.

1.3. This document provides guidance on the IIF Indicators for 2023/24. Information on how performance and achievement will be calculated is included, and should be read alongside the relevant sections of the 2023/24 Network Contract DES specification (Sections 10.6 and Annexes C and D). For indicators sourced from the GP Extraction Service (GPES), the business rules 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 regarding the IIF in 2023/24:

- 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 indicators are divided into two domains: (i) prevention and tackling health inequalities, and (ii) providing high quality care. Each domain consists of several areas with one or more indicators within each area.

2.3 The domains, areas, and indicators for the IIF in 2023/24 are set out in the summary table below, along with respective start dates for each indicator.

2023/24 indicators

Domain	Area	Indicators
Prevention and tackling health inequalities	Vaccination and immunisation	**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 2023 and 31 March 2024
		VI-03: Percentage of patients aged two or three years on 31 August 2023 who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024
	Tackling health inequalities	**HI-03:** 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 in addition to a recording of ethnicity

Domain	Area	Indicators
Providing high quality care	Cancer	**CAN-02:** Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral
	Access	**ACC-08:** Percentage of appointments where time from booking to appointment was two weeks or less

Indicator structure and performance calculation

2.4 All indicators in 2023/24 IIF can be classed as ‘standard quantitative’ and are constructed from the ratio of a numerator and denominator. This represents the indicator performance (Performance X = Numerator (N)/Denominator (D)).

2.5 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.

2.6 The denominator of each indicator is the target cohort for the intervention in question. In 2023/24 IIF, the target cohort for all indicators is a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients. For example, for indicator HI-03 the target cohort is people on the QOF Learning Disability Register aged 14 and over.

Exclusions and Exceptions (Personalised Care Adjustments)

2.7 Exclusions may be applied to some 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.

2.8 Personalised care adjustments (PCAs), previously known as ‘Exceptions’, may be applied to some 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.

2.9 An example of how PCAs would be applied to VI-02 is as follows: A PCN has 1,000 patients aged 18 to 64 years and in a clinical at-risk group, 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-02 would be 75% (= 600/800), not 60% (= 600/1,000).

Achievement points

2.10 The IIF Indicators are points-based. For 2023/24, each PCN can achieve a maximum of 262 IIF points and the value of a point will be £198.00 (adjusted for list size and prevalence – see paragraphs 2.14-2.15). Each indicator is worth a specific number of points.

2.11 The points a PCN can achieve for standard quantitative indicators will depend on how their performance relates to an upper performance threshold and a lower performance threshold.

2.12 The upper performance threshold 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 baseline performance (where baseline data is available).

2.13 If a PCN's performance for an indicator is better than or equal to the upper performance threshold, it will achieve all the points available for that indicator; if a PCN's performance is worse than or equal to the lower performance threshold, it will achieve zero points; and if performance is between the upper and lower thresholds, it will achieve some but not all of the points available for that indicator. Consider a hypothetical 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 achieved for every percentage point improvement in performance between the lower and upper threshold (50 points/ (75%-50%) = 2 points per percentage point). If a PCN's performance is 70%, it will achieve 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).

Achievement payments

2.14 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£198.00 in 2023/24), multiplied by a 'list size adjustment', and by a 'prevalence adjustment'. The value of an IIF point will be subject to annual revision.

2.15 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 achieve IIF points. The points-based system means that, for any indicator, every PCN will achieve the same number of *points* for a given 'absolute' level of performance. 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 e.g. to improve from 50% to 60% performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

2.16 In 2023/24, PCNs are entitled to one type of payment associated with the IIF indicators: a Total Indicator Achievement Payment which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive a Total Indicator Achievement payment, a PCN must comply with the conditions set out in the 2023/24 Network Contract DES specification (section 10.6.10). Crucially, the PCN must provide a simple written commitment to their commissioner that any money earned through the IIF indicators 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 Indicator performance

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

2.18 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 2023/24 IIF indicator is expected to be available monthly.

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-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-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 2023 and 31 March 2024	**VI-03**: Percentage of children aged two or three years on 31 August 2023 who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024
Running period	1 April 2023 – 31 March 2024	

VI-02, VI-03: Seasonal influenza vaccination		
Denominator	Number of patients aged 18 to 64 and in a clinical at-risk group[1]	Number of children aged two or three years on 31 August 2023
Numerator	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2023 and 31 March 2024
	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	None	
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	
Desired direction	Upwards	
Thresholds	72% (LT), 90% (UT)	64% (LT), 82% (UT)

[1] As defined in the cohorts outlined in the 2022/23 NHS Seasonal Influenza Programme – see here.
Includes 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-02, VI-03: Seasonal influenza vaccination		
Points	113	20
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 ICB 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. • General practices should send the invitation for the vaccination and offer to carry out the vaccination within their practice. Invitations do not include any national reminders that may be sent.	

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-03: 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 in addition to a recording of ethnicity	
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 2023 – 31 March 2024
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 in addition to a recording of ethnicity.
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Patient refused the offer of a learning disability health check or a health action plan

HI-03: 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 in addition to a recording of ethnicity	
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. Data for 21/22 showed that there was an average 10% disparity between people who had received an Annual Health Check and those who received a Health Action Plan as a consequence. Reports commissioned by NHS England regarding

HI-03: 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 in addition to a recording of ethnicity	
	Annual Health Check delivery suggested that many of the people consulted with had not received a physical copy of a Health Action Plan following their Annual Health Check. The recommendation is that a physical Health Action Plan is provided to all individuals/carers in receipt of an Annual Health Check either as a paper version or a digital version (email/text/NHS App). 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 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 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. NDTI resources

4. Providing high quality care domain

Cancer area

4.1 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-02 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral.	
Rationale for inclusion	Comprehensive use of FIT in NG12 patients is critical to improving bowel cancer survival in England, ensuring patients on the lower GI pathway can be diagnosed promptly and that available colonoscopy capacity is used in the most effective way. The risk of colorectal cancer in those with a negative result, a normal examination and full blood count is <0.1%. This is lower than the general population risk. In June 2022, the BSG and the ACPGBI published guidance on using FIT in patients with signs or symptoms of suspected colorectal cancer. This guidance recommends that all adults with symptoms of a suspected colorectal cancer diagnosis, including those with rectal bleeding, should be offered a FIT test in primary care, except those with an anal/rectal mass or anal ulceration. The BSG/ACPGBI guidance recommends referral for patients with a FIT fHb <10µg Hb/g who have persistent/recurrent anorectal bleeding for flexi-sigmoidoscopy, however this does not need to be on the Lower GI FDS pathway. By fully implementing the use of FIT in the symptomatic lower GI pathway, in accordance with the British Society of Gastroenterology (BSG) and the Association of Coloproctology of Great Britain and Ireland (ACPGBI)'s joint guidance on use of FIT in patients with signs or symptoms of suspected colorectal cancer, we will be able to spare patients unnecessary colonoscopies, release capacity to decompress the symptomatic lower GI pathway, and ensure the most urgent symptomatic patients are seen more quickly.
Indicator type	Standard Quantitative

CAN-02 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral.	
Running period	1 April 2023 – 31 March 2024
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 in the twenty-one days leading up to the referral.
Prevalence numerator	Indicator denominator.
Exclusions	None
Personalised care adjustments	Provision of faecal immunochemical test kit declined Patients with anal ulceration or with anal or rectal masses
Desired direction	Upwards
Thresholds	65% (LT), 80% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	All GPs are expected to implement the recommendations set out in the BSG/ACPGBI guidance, which is NICE accredited and

CAN-02 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral.	
	evidence-based[2]. The guidance recommends the use of FIT in primary care for patients presenting with all NG12 suspected colorectal cancer symptoms except those with an anal/rectal mass or anal ulceration. The guidance also recommends that those with a FIT of fHb <10µg Hb/g, a normal full blood count, and no ongoing clinical concerns are not referred on a lower GI urgent cancer pathway but are managed in primary care or referred on an alternative pathway. Where patients are not referred, appropriate safety netting must be in place. For safety netting, clinical teams should consider the recommendations set out in NHS England's publication on FIT implementation. Many GP practices across the country have now fully implemented use of FIT in primary care to guide referrals of those with lower GI symptoms. In North Tees & Hartlepool NHS FT, FIT implementation has contributed to a 9% increase in colorectal cancer detection, alongside a 24% fall in demand for symptomatic colonoscopies. There are a number of steps a PCN may take to ensure that FIT is implemented across all practices: • 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. • 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. • LGI urgent cancer forms: Include FIT results on the LGI 2WW referral form so that it can be used by LGI triage teams to determine the appropriate onward pathway for the patient. FIT kits should be commissioned locally through ICBs in line with expectations set out in the 2023/24 NHS Operational Planning

[2] Guidelines - The British Society of Gastroenterology (bsg.org.uk)

CAN-02 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded in the twenty-one days leading up to the referral.	
	Guidance (page 11 – implement and maintain priority pathway changes for lower GI - at least 80% of FDS lower GI referrals are accompanied by a FIT result). Where there are supply issues that are unable to be resolved locally via ICBs or Cancer Alliances, PCNs can contact england.pcn.fitsupply@nhs.net for support from the National Cancer Team at NHS England. Cancer Alliance budgets include service development funding to support FIT implementation. In the short term this funding can also be used to purchase FIT kits where there are local commissioning issues. PCNs can email england.edcancer@nhs.net if they would like an introduction to their Cancer Alliance FIT lead.

Access area

4.2 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-08: Percentage of appointments where 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.
Indicator type	Standard Quantitative

ACC-08: Percentage of appointments where time from booking to appointment was two weeks or less	
Running period	1 April 2023 – 31 March 2024
Denominator	Number of appointments delivered by the general practice under eight national appointment categories[3]
Numerator	Of the denominator, the number of appointments 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)
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

[3] 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 appointments where time from booking to appointment was two weeks or less	
	of the reasons for public dissatisfaction with the NHS.[4] 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 practices to distinguish between subsets of appointments. Categories that are within scope of ACC-08 are ones that patients will frequently want the first available appointment for. ACC-08 therefore includes appointments mapped to following national categories: • 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. 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'.

[4] 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.

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".
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 is planned to be tested. This should enable future construction (not before 2024/25) of a better measure of waiting times in general practice, by enabling restriction of attention to appointments for

ACC-08: Percentage of appointments where time from booking to appointment was two weeks or less	
	which time from booking to appointment is a better proxy for 'true' waiting time. Specifically, 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 the indicator 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 the indicator and would count as a success. **Thresholds** In 2023/24, 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 current median to earn all available points. There are good reasons why an appointment may not take place within 2 weeks. 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". 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. Appointment exception reporting functionality will be introduced and embedded in GP IT systems from 2023/24. Once it is available in all systems, this indicator is expected (for future incentivisation) to be re-specified to include exception reporting and will use the thresholds originally announced in August 2021 – i.e. a lower threshold of 90% and an upper threshold of 98%. These thresholds reflect the expectation that, unless one of the five above grounds for exception reporting applies, every

ACC-08: Percentage of appointments where time from booking to appointment was two weeks or less	
	patient whose needs would best be met by an appointment in general practice, should receive that appointment within two weeks.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment and list size adjustment are applied when calculating IIF Indicator achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex C of the 2023/24 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 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-02 prevalence is equal to the percentage of a PCN's patients who are aged 18 to 64 years and in a clinical at-risk group

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 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.5 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.6 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.7 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.8 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.

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