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# Network Contract Directed Enhanced Service

## Investment and Impact Fund 2021/22: Updated Guidance

**01 October 2021**

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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 will support 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 2021/22 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 IIF indicators for 2021/22 have been introduced in phases, with an initial set of indicators commencing in April 2021. In order to give PCNs the opportunity the full £150m IIF funding for 2021/22, as their capacity allows, further indicators have been introduced from October 2021.

1.4 The 2021/22 IIF has been designed as a preparatory package which serves as a 'lead-in' to commencement of a more comprehensive IIF from 2022/23. The 2022/23 IIF will focus on five objectives: (a) improving prevention and tackling health inequalities; (b) supporting better patient outcomes in the community through proactive primary care; (c) supporting improved patient access; (d) delivering better outcomes for patients on medication; and (e) helping create a more sustainable NHS. The details of the 2022/23 IIF have been announced early, to provide clarity and certainty to practices and PCNs about the direction of travel. Annex B provides further details.

1.5 The original version of this document, published in March 2021, provided guidance for the initial set of indicators that commenced in April 2021. These indicators remain unchanged. This updated guidance incorporates all information in the March 2021 guidance document. This updated guidance document also now includes further information on the second set of 2021/22 IIF indicators, which will run from 1 October 2021 to 31 March 2022. Some 2021/22 IIF indicators will continue into the 2022/23 scheme, while others will be retired at the end of 2021/22. Start dates for all IIF indicators

can be found below, and the details of the 2022/23 scheme can be found in Annex B.

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

- Improving health and saving lives (e.g. through improvements in the uptake of seasonal influenza vaccinations)
- Improving the quality of care for people with multiple morbidities (e.g. through increasing referrals to social prescribing services)
- Helping to make the NHS more sustainable.

1.7 *Investment and Evolution* set out that the IIF will be worth £150 million in 2021/22, rising to at least £225 million in 2022/23 and £300 million in 2023/24. The indicators outlined in this guidance which run from 1 April 2021 to 31 March 2022 are worth £50.7m in total. The set of indicators which will run from 1 October 2021 to 31 March 2022 bring the total value of the 2021/22 IIF to £150.2 million.

1.8 This document provides guidance on the IIF for 2021/22, 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 2021/22 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. 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 2021/22:

- 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 2021/22 are set out in the summary table below, along with respective start dates for each indicator.

| Domain | Area | Start | Indicators |
|---|---|---|---|
| **Prevention and tackling health inequalities** | Prevention | **Apr 21** | **VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March |
| | | **Apr 21** | **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 and 31 March |
| | | **Apr 21** | **VI-03**: Percentage of children aged 2 to 3 who received a seasonal influenza vaccination between 1 September and 31 March |
| | Tackling health inequalities | **Apr 21** | **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 | Start | Indicators |
|---|---|---|---|
| | | **Oct 21** | **HI-02:** Percentage of registered patients with a recording of ethnicity |
| | CVD prevention | **Oct 21** | **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 |
| | | **Oct 21** | **CVD-02:** Percentage of registered patients on the QOF Hypertension Register |
| **Providing high quality care** | Personalised care | **Apr 21** | **PC-01**: Percentage of registered patients referred to social prescribing |
| | Enhanced health in care homes | **Oct 21** | **EHCH-01:** Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service |
| | | **Oct 21** | **EHCH-02:** Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed |
| | | **Oct 21** | **EHCH-03:** Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review |
| | | **Oct 21** | **EHCH-04:** Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over |
| | Access | **Apr 21** | **ACC-01:** Confirmation that, by 31 July 2021, all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments |

| Domain | Area | Start | Indicators |
|---|---|---|---|
| | | **Oct 21** | **ACC-02:** Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients |
| | | **Oct 21** | **ACC-03:** By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions. |
| | | **Oct 21** | **ACC-04:** Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacy Consultation Service by no later than 31 March 2022. |
| | | **Oct 21** | **ACC-05**: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups. |
| **A Sustainable NHS** | Environmental sustainability | **Oct 21** | **ES-01:** Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October |
| | | **Oct 21** | **ES-02:** Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg $CO_2e$) |

## Indicator structure and performance calculation

2.4 IIF indicators are either 'Qualitative' or 'Quantitative'. Quantitative indicators are further divided into 3 assessment categories: Binary, Standard, or Improvement.

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]

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.

2.8 The denominator of each Quantitative indicator is the target cohort for the intervention in question. In 2021/22 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.

## Exclusions and Exceptions (Personalised Care Adjustments)

2.9 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 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.

2.10 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.

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

2.11 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

2.12 The IIF is a points-based scheme. For 2021/22, each PCN can earn a maximum of 666 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 or Improvement Quantitative.

2.13 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.

2.14 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.

2.15 The upper performance threshold (or single threshold for Binary Quantitative indicators) for each Standard Quantitative indicator 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).

2.16 Upper and lower thresholds for Improvement 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.

2.17 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).

## Achievement payments

2.18 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£200.00 in 2021/22), 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.

2.19 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 and Improvement Quantitative indicators, every PCN will earn the same number of *points* for a given percentage point improvement in performance (and for Qualitative and Binary Quantitative indicators, no points or the same number of agreed 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 improvement in performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

2.20 In 2021/22, PCNs are entitled to two types of payment under the IIF: 'In Year Achievement Payments' and 'Year End Achievement Payments'. Payments will in most cases take the form of Year End Achievement Payments based on performance covering the period 1 April 2021 to 31 March 2022. Indicator

ACC-01 (launched 1 April) is eligible for an In Year Achievement Payment as performance is based on the period 1 April 2021 to 31 July 2021.

2.21 To be eligible to receive achievement payments, a PCN must comply with the conditions set out in the 2021/22 Network Contract DES specification (section 10.6.14). 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

2.22 Each PCN is able to monitor its indicative performance against IIF indicators on the PCN Dashboard, which is available through NHS ViewPoint. To access the dashboard, please either register on the Insights Platform or log in in using your existing Insights Platform account, and then select the NHS ViewPoint product. A user guide is available to help navigate the dashboard. The Dashboard can be accessed directly via this link.

2.23 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 IIF indicator is expected to be available monthly by PCN from Autumn 2021.

# 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 and 31 March | **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 and 31 March | **VI-03**: Percentage of children aged 2 to 3 who received a seasonal influenza vaccination between 1 September and 31 March |
| **Running period** | 1 April 2021 – 31 March 2022 | | |
| **Denominator** | Number of patients aged 65 and over | Number of patients aged 18 to 64 and in a clinical at-risk group (as defined in | Number of children aged 2 to 3 on 31 August |

| VI-01, VI-02, VI-03: Seasonal influenza vaccination | | | |
|---|---|---|---|
| | | Appendix A in the national influenza immunisation programme update for 2020/21)[2] | |
| **Numerator** | Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March | Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March | Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March |
| | 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** | Patients who declined the offer of a seasonal influenza vaccination<br>Situations in which it is not clinically appropriate to provide a seasonal influenza vaccination.<br>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** | 80% (LT), | 57% (LT), | 45% (LT), |

[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 | | | |
|---|---|---|---|
| | 86% (UT) | 90% (UT) | 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.<br><br>Responsibility for providing seasonal influenza vaccinations in primary care is currently shared between general practice and community pharmacy. To encourage collaboration and discourage competition across a network, a parallel indicator for delivery to the over 65s was included in the Pharmacy Quality Scheme (PQS) for 2020/21 and continues to be included in the 2021/22 scheme. Achievement for both the IIF and PQS seasonal influenza vaccination incentives will be based on the total number of vaccines provided within the network, irrespective of who delivered the vaccine.<br><br>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.<br><br>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.<br><br>• PCN clinical directors should, in partnership with the identified CCG flu lead and national commissioners, engage with:<br>• 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<br>• 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 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.<br><br>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.<br><br>NICE Quality Standard 187 provides the quality standard for learning disability health checks. |
| **Indicator type** | Standard Quantitative |
| **Running period** | 1 April 2021 – 31 March 2022 |

| HI-01: Percentage of patients on the QOF Learning Disability register aged 14 or over, who received a learning disability Annual Health Check and have a completed Health Action Plan | |
|---|---|
| **Denominator** | Number of patients on the QOF Learning Disability register aged 14 years and 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. |
| **Desired direction** | Upwards |
| **Thresholds** | 49% (LT), 80% (UT) |
| **Points** | 36 |
| **Data source** | General Practice Extraction Service (GPES) |
| **Subject to declaration?** | Yes |
| **Additional information** | 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. This IIF indicator complements the 2021/22 QOF Quality Improvement Module Supporting people with Learning Disabilities which is focused on the quality of care that General Practices deliver for patients with a learning disability.<br><br>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 |

| HI-01: Percentage of patients on the QOF Learning Disability register aged 14 or over, who received a learning disability Annual Health Check and have a completed Health Action Plan | |
|---|---|
| | 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.<br><br>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.<br><br>**Further Information**<br><br>NHS England: Learning Disability Annual Health Checks<br><br>Mencap charity: Leaflets and resources to encourage people to take up an annual health check<br><br>Contact (charity): Annual health checks: Factsheet for parents<br><br>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.<br><br>RCGP Toolkit<br><br>NDTI resources |

| HI-02: Percentage of registered patients with a recording of ethnicity | |
|---|---|
| **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 committed in Autumn 2020 to a number of short-term actions which would aim to urgently address these.<br>One such action is to dramatically improve the recording of patient ethnicity data in 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 |

| HI-02: Percentage of registered patients with a recording of ethnicity | |
|---|---|
| **Running period** | 1 October 2021 – 31 March 2022 |
| **Denominator** | Total number of registered patients |
| **Numerator** | Of the denominator, the number with a recording of ethnicity on their patient 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 |
| **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:<br>• Ethnicity recorded as not stated (Z code in NHS Data Dictionary ethnic category field) |

| HI-02: Percentage of registered patients with a recording of ethnicity | |
| --- | --- |
| | • 1024701000000100 Ethnicity not stated<br>• 763726001 Refusal by patient to provide information about ethnic group (situation)<br>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, not on the QOF Hypertension Register as of 30 September 2021, who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR; (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022 | |
|---|---|
| **Rationale for inclusion** | From October 2021 to March 2022, the Network Contract DES Cardiovascular Disease Prevention & Diagnosis service requirements will focus solely on hypertension case finding and diagnosis. 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.<br><br>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 October 2021 – 31 March 2022 |
| **Denominator** | Number of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021 |

| **CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, who have**<br>**(i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR;**<br>**(ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021,**<br>**for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 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 2022. Clinically appropriate follow-up includes:<br>1. Initial BP reading < 140/90 mmHg (only relevant for patients in (i))<br>OR<br>2. Initial BP reading ≥ 140/90 mmHg AND<br>a. (Subsequent change of medication AND subsequent blood pressure reading of <140/90 mmHg) OR<br>b. Subsequent occurrence of Ambulatory Blood Pressure Monitoring OR<br>c. Subsequent occurrence of Home Blood Pressure Monitoring OR<br>d. (Addition to QOF Hypertension Register AND same day referral for specialist assessment) OR<br>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 |
| **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 2021 and 31 March 2022 inclusive, who are not followed up by the end of the financial year (patients will carry over to the denominator of CVD-01 in 2022/23).<br>2. Patient declined ambulatory/home blood pressure testing (Patient chose not to receive intervention).<br>N.B. Patients declining a BP reading alone will **not** trigger a PCA. |

| CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, who have<br>(i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR;<br>(ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021,<br>for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022 | |
|---|---|
| **Desired direction** | Upward |
| **Thresholds** | 20% (LT), 25% (UT) |
| **Points** | 53 |
| **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.<br>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.<br>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. |

| 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 |

| CVD-02: Percentage of registered patients on the QOF Hypertension Register | |
|---|---|
| **Running period** | 1 October 2021 – 31 March 2022 (but increases in QOF Hypertension Register size between 1 April and 30 September will count towards achievement) |
| **Denominator** | Total number of registered patients |
| **Numerator** | Of the denominator, the number on the QOF Hypertension Register |
| **Prevalence numerator** | Number of patients on the QOF Hypertension Register on 31 March 2021 |
| **Exclusions** | None |
| **Personalised care adjustments** | None |
| **Desired direction** | Upwards |
| **Thresholds** | 0.2 percentage point increase (LT),<br>0.3 percentage point increase (UT) |
| **Points** | 27 |
| **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.<br>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 2021.<br>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 |

| CVD-02: Percentage of registered patients on the QOF Hypertension Register | |
|---|---|
| | an 'outcome' indicator that recognises PCNs for actually achieving those increased diagnoses.<br>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. |

# 4. Providing high quality care domain

4.1 This domain aims to ensure that the NHS continues to provide a world-leading quality of care for those with the greatest need. Many indicators in this area are related to the Network Contract DES Service Requirements, recognising strong performance in key interventions. Others recognise PCNs for improved access to general practice services.

## Personalised care area

4.2 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 social prescribing** | |
|---|---|
| **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. 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.<br>The NHS Long Term Plan commits to achieving 900,000 social prescribing referrals by 2023/24. To help deliver this ambition, the Update to the GP contract agreement 2020/21-2023/24 states that each PCN must provide access to a social prescribing service from 2020/21. Funding for employment of social prescribing link workers has been available to PCNs via the Additional Roles Reimbursement Scheme since April 2019. |
| **Indicator type** | Standard Quantitative |

| PC-01: Percentage of registered patients referred to social prescribing | |
|---|---|
| **Running period** | 1 April 2021 – 31 March 2022 |
| **Denominator** | Total number of registered patients |
| **Numerator** | Of the denominator, the number referred to a social prescribing service |
| **Prevalence numerator** | Indicator denominator |
| **Exclusions** | None |
| **Personalised care adjustments** | None |
| **Desired direction** | Upwards |
| **Thresholds** | 0.8% (LT), 1.2% (UT) |
| **Points** | 20 |
| **Data source** | General Practice Extraction Service (GPES) |
| **Subject to declaration?** | Yes |
| **Additional information** | 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:<br>• 871731000000106 \| Referral to social prescribing service (procedure)<br>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, 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. |

| PC-01: Percentage of registered patients referred to social prescribing | |
|---|---|
| | 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.<br><br>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).<br><br>**Further Information**<br><br>Welcome and induction pack for link workers in PCNs.<br><br>NHS England: Social prescribing<br><br>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.<br><br>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.<br><br>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.<br><br>Social Prescribing - e-Learning – programme hosted by E-learning for Health and Health Education England aimed at link workers in PCNs. |

## Enhanced health in care homes area

4.3 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.

4.4 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 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 October 2021 – 31 March 2022 |
| **Denominator** | Number of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service, as reflected in the calculation of the care home bed premium. |
| **Numerator** | Number of patients aged 18 years or over and recorded as living in a care home (including a residential home or nursing home, and including both permanent and temporary residents) |
| **Prevalence numerator** | Indicator denominator |
| **Exclusions** | None |
| **Personalised care adjustments** | None |
| **Desired direction** | Upwards |
| **Thresholds** | 30% (LT), 85% (UT) |

| EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service | |
|---|---|
| **Points** | 18 |
| **Data source** | Denominator: Manual submission via the Calculating Quality Reporting Service (CQRS)<br>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.<br>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:<br>• 160734000 Living in nursing home<br>• 394923006 Living in residential home<br>• 248171000000108 Lives in care home (finding)<br>• 1240291000000104 Living temporarily in care home (finding)<br><br>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 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements | |
|---|---|
| **Rationale for inclusion** | These indicators recognise PCNs for strong delivery of key elements of the Network Contract DES EHCH service requirements, namely Personalised Care and Support Plans (PCSPs) and Structured Medication Reviews (SMRs). |
| **Indicator type** | Standard Quantitative |

| **EHCH-02 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements** | | |
|---|---|---|
| **Running period** | 1 October 2021 – 31 March 2022 (but PCSPs and SMRs delivered between 1 April 2021 and 30 September 2021 will count towards achievement) | |
| **Indicator** | Percentage of care home residents aged 18 years or over who had a Personalised Care and Support Plan (PCSP) agreed or reviewed | Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review |
| **Denominator** | Number of care home residents aged 18 years or over | Number of permanent 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 | Of the denominator, the number who received a Structured Medication Review |
| **Prevalence numerator** | Indicator denominator | Indicator denominator |
| **Exclusions** | Patients not living in care home at end of reporting period | |
| **Personalised care adjustments** | Patient chose not to receive the intervention<br>Registration with general practitioner practice aligned to care home declined<br>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. | |
| **Desired direction** | Upwards | |

| EHCH-02 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements | | |
|---|---|---|
| **Thresholds** | 80% (LT), 98% (UT) | 80% (LT), 98% (UT) |
| **Points** | 18 | 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.<br>Further advice can also be found here:<br>• Care Provider Alliance: EHCH - A guide for care homes.<br>• Animation: "The care home weekly round: What does good look like?" | |

| EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over | |
|---|---|
| **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 October 2021 – 31 March 2022 |
| **Denominator** | Number of care home residents aged 18 years or over |
| **Numerator** | Number of appointments on or after 1 October with a slot type mapped to the "Patient contact as part of weekly care home round" appointment category and with Status of "Attended", "Booked" or "Did Not Attend" |
| **Prevalence numerator** | Indicator denominator |

| EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over | |
|---|---|
| **Exclusions** | None |
| **Personalised care adjustments** | Registration with general practitioner practice aligned to care home declined<br>• See EHCH-02 and EHCH-03 for further information about this Personalised Care Adjustment.<br>• 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 3 patient contacts per care home resident over 6 months (LT),<br>Mean of 4 patient contacts per care home resident over 6 months (UT) |
| **Points available** | 13 |
| **Data source** | Denominator: General Practice Extraction Service (GPES)<br>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 recognises 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 appointment data*, published by NHS England and NHS Improvement 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.<br>This indicator builds on these improvements in the quality of general practice appointment data by recognising PCNs for |

| EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over | |
|---|---|
| | 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 six month period.<br><br>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.<br><br>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.<br><br>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 home rounds are properly counted for the purposes of this indicator.<br><br>**Further information**<br><br>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 |

| EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over | |
|---|---|
| | 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 Autumn 2021. 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. |

## Access area

4.5 Improving access to general practice services is a core aim of both the NHS Long Term Plan and *Investment and Evolution*. The response of primary care to COVID-19 has also seen 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-01: Confirmation that, by 31 July, all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments | |
|---|---|
| **Rationale for inclusion** | The development of a comprehensive and structured dataset describing access to general practice based on better and more consistent recording of appointment data via consistent established standards is a commitment set out in *Investment and Evolution* (para 5.29) and reinforced in *Update to the GP contract agreement 2020/21 to 2023/24* (para 4.3). This dataset will provide comprehensive, granular and timely information about activity in general practice. |
| **Indicator type** | Qualitative |
| **Running period** | 1 April 2021 to 31 July 2021 |
| **Denominator** | N/A |

| ACC-01: Confirmation that, by 31 July, all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments | |
|---|---|
| **Numerator** | N/A |
| **Prevalence numerator** | N/A |
| **Exclusions** | N/A |
| **Personalised care adjustments** | N/A |
| **Desired direction** | N/A |
| **Thresholds** | N/A |
| **Points** | 27 |
| **Data source** | Manual PCN submission to commissioners. Full details including value of payment were provided to PCNs and commissioners in advance of 30 June via Future NHS |
| **Subject to declaration?** | N/A |
| **Additional information** | In August 2020, NHS England and NHS Improvement and the British Medical Associated published guidance on *More accurate general practice appointment data*, to ensure all appointments are being recorded in general practice appointment books, and to fully capture the scale of work and workload in general practice. This guidance document introduced an agreed definition of an appointment, and asked general practice to start applying this systematically, as an important first step to improving data quality.<br><br>Technical system-specific advice and guidance to support practices with configuring appointment books has been published by NHS Digital.<br><br>A new standardised set of GP appointment categories across general practice in England have also been introduced. New functionality to map local slot types to this new set of standard national GP appointment categories has also been provided in GP appointment systems. Each appointment slot type needs to |

| ACC-01: Confirmation that, by 31 July, all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments | |
|---|---|
| | be mapped to one of the categories. Guidance to support practices to do this is available.<br><br>PCNs will be recognised through this indicator for completing both the mapping and improvements in overall appointment data quality and therefore confirming they are submitting high quality appointment data. The recording improvements and self-declaration should be completed by 31 July and any necessary validation will be undertaken prior to the payment deadline of 31 October.<br><br>**Further information**<br><br>More accurate general practice appointment guidance<br><br>Appointment category guidance |

| ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients | |
|---|---|
| **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 January to 31 March 2022 |
| **Denominator** | Total number of registered patients divided by 1000 |
| **Numerator** | Number of online consultation submissions received by the PCN on or after 1 January |

| ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients | |
|---|---|
| **Prevalence numerator** | Indicator denominator |
| **Exclusions** | None |
| **Personalised care adjustments** | None |
| **Desired direction** | Upwards |
| **Threshold** | 65 over 3 months (Single Threshold) |
| **Points** | 27 |
| **Data source** | Denominator: General Practice Extraction Service (GPES)<br>Numerator: OCVC 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. It will **not** count online consultation submissions by patients registered at a Core Network Practice of the PCN that are signposted away from the practice/PCN, e.g. to NHS 111.<br>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 online consultation system is used alongside other access routes, taking into consideration the needs of their local community.<br>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 |

| ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients | |
|---|---|
| | 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 and that patients are able to use the system to seek care or advice.<br><br>To earn points in relation to this indicator, PCNs must ensure that member practices sign up to any Data Provision Notice (DPN) that may be issued in relation to the OCVC Collection that will be used to provide the numerator of this indicator. If a member practice does not sign up to any DPN that may be issued, 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 may be issued in relation to the OCVC Collection, so that all online consultation submissions received by the practice can be properly counted for the purposes of this indicator.<br><br>**Further information**<br>• Guidance on implementing an online consultation system: NHS England » Using online consultations in primary care: implementation toolkit.<br>• Guidance on implementing a 'total triage' process using online consultation systems: Report template - NHSI website.<br>• Further guidance and resources are available on the Digital Primary Care - FutureNHS Collaboration Platform (requires login). |

| ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions | |
|---|---|
| **Rationale for inclusion** | Reducing unnecessary A&E attendances and emergency admissions is a key Long Term Plan commitment. Strategies for achieving this aim may encompass a variety of approaches, and data analysis and planning are important to ensure efforts are appropriately directed according to local factors. |

| ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions | |
|---|---|
| **Indicator type** | Qualitative |
| **Running period** | 1 October 2021 to 31 March 2022 |
| **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** | 56 |
| **Data source** | Manual confirmation of completion via CQRS |
| **Subject to declaration?** | Yes |
| **Additional information** | The plan developed in fulfilment of the requirements of this indicator should take the form of a written document prepared by the PCN with input from all member practices, submitted to their CCG. The plan should cover the following areas:<br>1. Ensuring that local services are comprehensively mapped and accurately recorded in the Directory of Services.<br>• This should include (but not be limited to) the following services: Urgent Community Response (UCR), Urgent Treatment Centres (UTC), Mental Health crisis and community services, Falls services, Social Care.<br>2. Ensuring that current activity and referral pathways are fully understood and documented for all services. |

| ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions | |
|---|---|
| | 3. Making use of all available demand and capacity tools in order to understand the gap between current capacity and demand.<br>4. Identifying optimal service provision on a cross-PCN / ICS wide footprint. |

| ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022 | |
|---|---|
| **Rationale for inclusion** | The Community Pharmacist Consultation Service (CPCS) was launched in 2019 to integrate community pharmacy into provision of local NHS urgent care services.<br>The CPCS provides a mechanism for patients to be referred either by NHS111 or by general practice to community pharmacy for minor illness. It provides patients with more convenient treatment closer to home by connecting them with the skills and medicines knowledge of pharmacists, which can in turn alleviate pressure on GP appointments and emergency departments.<br>This preparatory indicator recognises PCNs for engaging with their local community pharmacies and agreeing a plan to either begin or increase referrals to CPCS. PCNs are asked to have a plan in place with referrals increasing by no later than 31 March 2022. From 1 April 2022, a new indicator will be introduced which recognises PCNs for making an increased number of referrals to CPCS within the 2022/23 financial year. |
| **Indicator type** | Qualitative |
| **Running period** | 1 October 2021 to 31 March 2022 |
| **Denominator** | N/A |
| **Numerator** | N/A |
| **Prevalence numerator** | N/A |
| **Exclusions** | N/A |

| ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022 | |
|---|---|
| **Personalised care adjustments** | N/A |
| **Desired direction** | N/A |
| **Thresholds** | N/A |
| **Points** | 56 |
| **Data source** | Manual confirmation of completion via CQRS |
| **Subject to declaration?** | Yes |
| **Additional information** | PCNs are encouraged to consult this toolkit for GP and PCN staff. It is a practical guide on how patients can be referred from general practice to community pharmacy via CPCS.<br><br>Full details of the CPCS, including an Advanced Service specification, can be found here.<br><br>The plan developed in fulfilment of the requirements of this indicator should take the form of a written document prepared by the PCN with input from all member practices, submitted to their CCG. When developing and agreeing this plan, PCNs and community pharmacies may want to consider the following areas:<br>• The structure and geography of pharmacies and PCNs in the local area<br>• Who within PCNs and community pharmacies should lead on implementation<br>• Digital availability in the local area – more details on digital referral opportunities can be found on the PCN NHS Futures page here.<br>• How practice teams will be trained to deliver the referral pathway.<br>• Having a process in place where any incidents related to patient safety, near misses, or problems with the referral process or operational issues will be raised, investigated and mitigated in future.<br>• How referral volumes will increase by 31 March. |

| ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups | |
|---|---|
| **Rationale for inclusion** | This indicator will recognise PCNs for taking steps to improve access to general practice for patient groups who have historically experienced poor access. It will support preparation for commencement of the new patient experience survey, which will measure patient experience of access to general practice. |
| **Indicator type** | Qualitative |
| **Running period** | 1 October 2021 to 31 March 2022 |
| **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** | 56 |
| **Data source** | Manual confirmation of completion via CQRS |
| **Subject to declaration?** | Yes |
| **Additional information** | This indicator asks that, by 31 March 2022, PCNs should make use of the 2020/21 General Practice Patient Survey (GPPS) results for member practices to (i) identify patient groups experiencing inequalities in their experience of access to general |

| ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups | |
|---|---|
| | practice, and (ii) develop and implement a plan to improve access for these patient groups.<br><br>We particularly suggest that PCNs review the following GPPS questions, as well as considering feedback directly from their patient population:<br><br>• Q16 – why patients who wanted an appointment did not receive one<br>• Q19 – patients who avoided making an appointment<br>• Q20 – patients' overall experience of making an appointment<br>• Q30 – overall experience<br><br>This plan should take the form of a written document prepared by the PCN with input from all member practices, submitted to their CCG that states the patient groups being targeted and sets out a plan for improving access for these patient groups. Progress will contribute to reducing health inequalities and improving patient experience, which will be measured by a new real time measure of patient experience, derived from the new patient experience survey in 2022/23. |

# 5. A sustainable NHS domain

5.1 In 2019, the Long Term Plan committed the NHS to reducing its carbon footprint. "Delivering a 'Net Zero' National Health Service", published in October 2020, built on this by committing the NHS to reaching net zero carbon (and equivalent emissions) by 2040 for those emissions under the direct control of the NHS (the 'NHS Carbon Footprint'). IIF indicators in this domain support this ambition.

## Inhalers area

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

5.3 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 on or after 1 October** | |
|---|---|
| **Rationale for inclusion** | People with asthma (3.9 million)[3] 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.<br>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. 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 |

[3] QOF 2019/20.

| ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October | |
|---|---|
| **Running period** | 1 October 2021 – 31 March 2022 |
| **Denominator** | Number of non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October |
| **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 |
| **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** | 53% (LT), 44% (UT) |
| **Points** | 27 |
| **Data source** | General Practice Extraction Service (GPES) |
| **Subject to declaration?** | Yes |
| **Additional information** | 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. 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.<br><br>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 |

| ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October | |
|---|---|
| | medication. This is especially important when patients are prescribed a different type of inhaler.<br><br>Feedback, to be published later in the year, suggests that the majority of asthma patients using MDIs would change device for environmental reasons so long as the new inhaler was efficacious, easy to use and fitted their current routine, and that they could change back if needed. Additional guidance and advice will therefore be provided alongside rollout of this indicator to support shared decision making and patient choice of inhaler. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New 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 during the pandemic.<br><br>**Further information for clinicians**<br>• Further resources are available in the "Tools & Resources" section of the Greener NHS programme's FutureNHS workspace: https://future.nhs.uk/sustainabilitynetwork (for any access queries, please email sustainabilitynetwork-manager@future.nhs.uk).<br>• NICE: Patient decision aid<br>• RightBreathe: Information for clinicians on different kinds of inhalers<br>• Primary Care Respiratory Society: Position statement on the environmental impact of inhalers<br>• British Thoracic Society Position Statement: The environment and lung health<br>• UK Inhaler Group: Inhaler standards and competency document: Guidance on optimal inhaler technique<br><br>**Further information for patients**<br>Asthma UK & British Lung Foundation<br>• What does good asthma control look like?<br>• Your personalised asthma action and support plan<br>• Asthma review: Guidance on how to use your inhaler most effectively, tailored to your device |

| 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.<br>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. |
| **Indicator type** | Standard Quantitative |
| **Running period** | 1 October 2021 – 31 March 2022 |
| **Denominator** | Number of salbutamol inhalers prescribed on or after 1 October |
| **Numerator** | Total carbon emissions from all inhalers in the denominator (kg $CO_2e$) |
| **Prevalence numerator** | Number of patients prescribed salbutamol inhalers on or after 1 October 2021 |
| **Exclusions** | None |
| **Personalised care adjustments** | None |
| **Desired direction** | Downward |
| **Thresholds** | 25.1 kg $CO_2e$ (LT), 22.1 kg $CO_2e$ (UT) |
| **Points** | 27 |

| ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg $CO_2$e) | |
|---|---|
| **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):<br>• https://www.nhsbsa.nhs.uk/prescription-data/understanding-our-data/prescription-requests |
| **Additional information** | 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<br><br>Numerator = Count of inhaler A × Emissions per inhaler A +<br>Count of inhaler B × Emissions per inhaler B<br><br>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 NHS England and NHS Improvement. 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 $CO_2$e) |
|---|---|
| Airomir 100 microgram | 9.72 |
| Airomir Autohaler 100 microgram | 9.72 |
| Easyhaler Salbutamol 100 microgram | 0.62 |

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

| Inhaler | kg $CO_2e$ |
|---|---|
| Easyhaler Salbutamol 200 microgram | 0.62 |
| Salbutamol CFC free breath actuated inhaler 100 microgram (GENERIC) | 11.79 |
| 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 |

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.

| ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg $CO_2e$) | |
|---|---|
| | We use this information to impute a carbon intensity to generic salbutamol MDI prescribing, as a weighted average of the carbon intensities of the inhalers that tend to be dispensed when generic salbutamol MDI is prescribed, i.e.<br>• Carbon intensity of generic salbutamol pMDI prescribing = . (28.26 × 81.5%) + (11.95 × 18.4%) + (9.72 × 0.1%) = 25.24 kg<br>• Carbon intensity of generic salbutamol BAI prescribing = . (12.08 × 87.5%) + (9.72 × 12.5%) = 11.79 kg<br><br>The calculation of these weighted averages will be reviewed annually.<br><br>**Further information**<br>Click here for further PrescQIPP respiratory care resources and materials.<br>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 2021/22 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 47,000 and a PCN has 94,000 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: The IIF in 2022/23

B.1 To provide clarity on the onward trajectory of the Investment and Impact Fund and wider Network Contract DES after 2021/22, NHS England and NHS Improvement has published details of the thresholds and valuations for the IIF indicators expected to run in 2022/23.

B.2 The addition of new indicators to the scheme, and the increase in value of many indicators rolled over from April 2022, brings total funding for the IIF to £225 million in 2022/23. This will increase further to at least £300 million in 2023/24.

B.3 The following table summarises details of the scheme in 2022/23.

| ***Objective 1: Improve prevention and tackle health inequalities*** | | | |
|---|---|---|---|
| Indicator | Thresholds | Value | Source |
| HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan | 60% (LT), 80% (UT) | £8.1m / 36 pts | GPES |
| VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March | 80% (LT), 86% (UT) | £9.0m / 40 pts | GPES |
| VI-02: Percentage of at-risk patients aged 18 to 64 years inclusive who received a seasonal influenza vaccination between 1 September and 31 March[4] | 57% (LT), 90% (UT) | £19.8m / 88 pts | GPES |
| VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March | 45% (LT), 82% (UT) | £3.2m 14 pts | GPES |

[4] 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.

| | | | |
|---|---|---|---|
| CVD-01: Percentage of patients aged 18 or over with an elevated blood pressure reading (≥ 140/90mmHg)[5] and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up[6] to confirm or exclude a diagnosis of hypertension | 25% (LT), 50% (UT) | £16.0m / 71 pts | GPES |
| CVD-02: Percentage of registered patients on the QOF Hypertension Register | Increase 0.6pp (LT), Increase 1.2pp (UT) | £7.9m / 35 pts | GPES |
| CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins | 48% (LT), 58% (UT) | £7.0m / 31pts | GPES |
| CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia | 20% (LT), 48% (UT) | £4.1m / 18 pts | GPES |

| ***Objective 2: Support better patient outcomes in the community through proactive primary care*** | | | |
|---|---|---|---|
| Indicator | Thresholds | Value | Source |
| PC-01: Percentage of registered patients referred to a social prescribing service | 1.2% (LT), 1.6% (UT) | £4.5m / 20 pts | GPES |
| EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed | 80% (LT), 98% (UT) | £4.1m / 18 pts | GPES |
| EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over | 6 (LT), 8 (UT) | £2.9m / 13 pts | GPAD/ GPES |
| EHCH-06: Standardised number of emergency admissions per 100 care home residents aged 18 years or over | Improvement: Reduction of 0 (LT), 4 (UT) | £6.1m / 27 pts | HES-SUS APC / GPES |

[5] Either (i) a last recorded blood pressure reading in the two years prior to 1 April 2022 ≥ 140/90mmHg, or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 April 2022.
[6] Occurrence of one of the following within six months of 1 April 2022 (cohort (i)) or the first elevated blood pressure reading after 1 April 2022 (cohort (ii)): Ambulatory Blood Pressure Monitoring; Home Blood Pressure Monitoring; Change of medication followed by subsequent non-elevated reading; Same-day referral for treatment; Commencement of anti-hypertensive therapy.

| | Thresholds | Value | Source |
|---|---|---|---|
| | Absolute: 30 (LT), 20 (UT) | | |
| AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions[7] per 1000 registered patients | Improvement: Reduction of 0 (LT), 1 (UT)<br>Absolute: 10 (LT), 8 (UT) | £25.0m / 111 pts | HES-SUS APC / GPES |

| ***Objective 3: Support improved patient access to primary care services*** | | | |
|---|---|---|---|
| Indicator | Thresholds | Value | Source |
| ACC-06: Standardised percentage of survey respondents indicating that it was "easy" or "very easy" for them to make a general practice appointment, or to seek medical care or advice from their general practice | 35th (LT), 65th (UT) percentile of performance from piloting | £25.0m / 111 pts | Patient experience survey |
| ACC-02: Number of online consultation submissions received by the PCN per 1000 registered patients | **TBC** | £4.1m / 18 pts | OCVC Extended Collection / GPES |
| ACC-07: Specialist Advice utilisation rate (number of Specialist Advice requests per 100 outpatient first attendances) across twelve specialties[8] identified for accelerated delivery | 6.6 (LT), 19 (UT) | £9.9m / 44 pts | System Elective Recovery Outpatient Collection / HES-SUS OP |
| ACC-08: Percentage of patients who had to wait two weeks or less for a general practice appointment | 90% (LT), 98% (UT) | £16.0m / 71 pts | GPAD |
| ACC-09: Number of referrals to the Community Pharmacist Consultation Service per 1000 registered patients | 34 (single threshold) | £6.1m / 27 pts | GPES |

[7] ACSCs in scope: COPD, Diabetes complications, Convulsions and Epilepsy, Asthma, Congestive Heart Failure, Hypertension, Influenza and Pneumonia, Ear Nose and Throat Infections, Pyelonephritis, Cellulitis.
[8] Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat.

| *Objective 4: Deliver better outcomes for patients on medication* | | | |
|---|---|---|---|
| Indicator | Thresholds | Value | Source |
| SMR-01: Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review | **TBC** | £12.0m / 53 pts | GPES |
| SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant. | 85% (LT), 90% (UT) | £0.9m / 4 pts | GPES |
| SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID. | 85% (LT), 90% (UT) | £0.9m / 4 pts | GPES |
| SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet. | 75% (LT), 90% (UT) | £0.9m / 4 pts | GPES |
| SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet. | 75% (LT), 90% (UT) | £0.9m / 4 pts | GPES |
| SMR-03: Percentage of patients prescribed a direct oral anti-coagulant, who received a renal function test and a recording of their weight | 50% (LT), 75% (UT) | £2.9m / 13 pts | GPES |

| | | | |
|---|---|---|---|
| and Creatinine Clearance Rate, along with a change or confirmation of their medication dose. | | | |
| RESP-01: Percentage of patients on the QOF Asthma Register who were regularly prescribed* an inhaled corticosteroid over the previous 12 months<br>* 22/23: 3 or more ICS prescriptions; 23/24 onwards: 5 or more ICS inhalers. | 71% (LT), 90% (UT) | £7.0m/ 31 pts | GPES |
| RESP-02: Percentage of patients on the QOF Asthma Register who received six or more SABA inhaler prescriptions* over the previous 12 months<br>* From 23/24: who were prescribed 6 or more SABA inhalers | 25% (LT), 15% (UT) | £5.0m/ 22 pts | GPES |

| ***Objective 5: Help create a more sustainable NHS;*** | | | |
|---|---|---|---|
| Indicator | Thresholds | Value | Source |
| ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over | 44% (LT), 35% (UT)<br><br>intended 23/24 trajectory: 35%/25% | £6.1m / 27 pts | GPES |
| ES-02: Mean carbon emissions per salbutamol inhaler prescribed (kg CO2e) | 22.1kg (LT), 18.0kg (UT)<br><br>intended 23/24 trajectory:<br>18.0kg/ 13.4kg | £9.9m / 44 pts | BSA prescribing data |