North & South Essex
Local Medical Committees Ltd

Investment & Impact Fund (IIF) 2021/22

A Guidance Document for Practices

Version 3 - Dated: 4 January 2022

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Investment and Impact Fund (IIF)
Introduction (part one)

Investment and Impact Fund Introduction (part one)	Guidance
● 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. ● 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. ● In response to the emergence of the Omicron variant of Covid-19 and the need to accelerate the delivery of booster vaccinations in Q3/Q4 2021/22, NHSEI has changed the structure and approach of the IIF for 2021/22. Full details of these changes can be found in this letter to systems and in the Variation to the Network Contract DES. To summarise: • VI-01, VI-02, VI-03 and ACC-01 will continue to operate as planned (i.e. on the basis of PCN performance) in 2021/22. • All other indicators have been suspended. Funding allocated for these (£112.1m) will be repurposed as follows: o £62.4m of the allocated funding will be provided to PCNs via a PCN Support Payment, which will be administered on a weighted patient basis. o £49.7m will be allocated to a new binary IIF indicator, paid on the basis that all practice within a PCN are a) signed up to phase 3 of the Covid-19 Vaccination Enhanced Service by 31 December 2021, b) remain signed up by 31 March 2022, and c) are actively delivering vaccinations during this period. ● The previous version of this document, published in October 2021, provided guidance for both the initial set of indicators that commenced in April 2021, and a second set of indicators which commenced in October 2021. Guidance for the indicators which have not been suspended still applies. ● Guidance for those indicators which have been suspended for 2021/22 can still be found in Section 5. Likewise, the below table summarises all 2021/22 IIF indicators, including those that have been suspended, those that remain live, and the new qualitative indicator rewarding participation in the COVID19 Vaccination Enhanced Service.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – pages 2 and 3.	

Investment and Impact Fund (IIF)

Introduction (part two)

Investment and Impact Fund Introduction (part two)	Guidance
● 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. ● 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. As a result of the suspension of IIF in December 2021 to support the COVID-19 Vaccination programme, the IIF will now be worth £87.8m in 2021/22. ● 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	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – page 3.	

Structure of the IIF

Structure of the IIF	Guidance
● 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.	IIF Guidance 2021/22
*For confirmation of live and suspended indicators for 2021/22, please see the attached guidance – pages 4 to 7.	

Domains, areas and indicators

Domains, areas and indicators	Guidance
● 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. ● The domains, areas and indicators for the IIF in 2021/22, along with respective start dates for each indicator, are set out on pages 4, 5, 6 and 7 of the IIF Guidance document within the link on the right.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – from page 4.	

Indicator structure and performance calculation

Indicator structure and performance calculation	Guidance
● IIF indicators are either 'Qualitative' or 'Quantitative'. Quantitative indicators are further divided into 3 assessment categories: Binary, Standard or improvement. ● **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. ● **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 I**mprovement** Quantitative indicators, performance is based on the change in this ratio relative to a base period (Performance X = N/D – N0/D0). ● 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. ● 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.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 7 and 8.	

Exclusions and Exceptions
(Personalised Care Adjustments)

Exclusions and Exceptions (Personalised Care Adjustments)	Guidance
● 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 from page 12 in the guidance link on the right. ● 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 incentivized 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 from page 12 in the guidance link on the right. ● 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).	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – page 8.	

Achievement points

Achievement points	Guidance
● The IIF is a points-based scheme. For 2021/22, each PCN can earn a maximum of 389 IIF points and the value of a point will be **£200.00** (adjusted for list size and prevalence). 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. ● 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. ● 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. ● 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). ● 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. ● 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).	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 8 and 9.	

Achievement payments

Achievement payments	Guidance
● 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. ● 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. ● 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. ● 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.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 9 and 10.	

Monitoring IIF performance

Monitoring IIF performance	Guidance
● 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 login 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. ● 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. ● All IIF indicators, including suspended indicators, will continue to be collected and reported on the PCN Dashboard. Data on all IIF indicators drawn from GPES, including suspended indicators, will continue to be available in CQRS and published on the NHS Digital website as part of the NCD service/extract. Plans to incorporate suspended IIF indicators drawn from non-GPES data sources into CQRS have been paused, and will now take place in early 2022/23.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 10 and 11.	

Prevention and tackling health inequalities domain

Prevention and tackling health inequalities domain	Guidance
● 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** ● Indicators in the Vaccination and immunisation area support the ambitions of the NHS Long Term Plan to ensure and expand access to vaccines. Please see the tables within the attached guidance link on the right **on pages 12 to 16** for more information.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 12 to 16.	

Providing high quality care domain

Providing high quality care domain	Guidance
Access area ● 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. Please see the tables within the attached guidance link on the right on **pages 17 to 19** for more information.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 17 to 19.	

Suspended 2021/22 indicators

Prevention and tackling health inequalities domain

Suspended 2021/22 indicators – Prevention and tackling health inequalities domain	Guidance
Tackling health inequalities area ● 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. Please see the tables within the attached guidance link on the right on **pages 20 to 24** for more information. **Cardiovascular disease prevention area** ● 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. Please see the tables within the attached guidance link on the right on **pages 25 to 29** for more information.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 20 to 29.	

Suspended 2021/22 indicators

Providing high quality care domain

Suspended 2021/22 indicators – Providing high quality care domain	Guidance
Access area ● 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. Please see the tables within the attached guidance link on the right on **pages 29 to 37** for more information. **Personalised care area** ● 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-centered care; and (iv) expanding the choice and control that people have over the care that they receive. Please see the tables within the attached guidance link on the right on **pages 37 to 39** for more information. **Enhanced health in care homes area** ● 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. ● 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. Please see the tables within the attached guidance link on the right on **pages 40 to 46** for more information.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 29 to 46.	

A sustainable NHS domain

A sustainable NHS domain	Guidance
Inhalers area ● Medicines account for 25% of emissions within the NHS. ● 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. Please see the tables within the attached guidance link on the right on **pages 46 to 52** for more information.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 46 to 52.	

Annex A: Prevalence adjustment

Annex A: Prevalence adjustment	Guidance
● This annex explains why a prevalence adjustment (for Quantative 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** ● 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. ● 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). ● 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. ● 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. ● 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. ● 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.	IIF Guidance 2021/22

*For clarification of this information on this section of IIF, please see the attached guidance – pages 53 and 54.

Annex A: List size adjustment

Annex A: List size adjustment	Guidance
List size adjustment ● 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. ● 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.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – pages 54 and 55.	

***For Annex B: The IIF in 2022/23, please see pages 56 to 60 of the IIF Guidance 2021/22**

Summary

Summary	Guidance
● 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.	IIF Guidance 2021/22
*For clarification of this information on this section of IIF, please see the attached guidance – page 55.	

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