North & South Essex
Local Medical Committees Ltd

Investment & Impact Fund (IIF) 2021/22

A Guidance Document for Practices

Dated: 6 April 2021

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Investment and Impact Fund (IIF)

Introduction

Investment and Impact Fund Introduction	Guidance
● The Investment and Impact Fund (IIF) forms part of the Network Contract Directed Enhanced Service (DES). In 2021/22, the IIF will run for 12 months, from 1 April 2021 until 31 March 2022. It will support primary care networks (PCNs) to deliver high quality care to their population, and the delivery of the 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 initial content of the IIF 2021/22 has been designed to provide stability and support to PCNs during their ongoing support to the COVID-19 pandemic. This includes focusing on preventative activity for cohorts at particular risk of poor health outcomes, and in tackling health inequalities more directly and proactively. Additional arrangements for 2021/22 - including any further funding to be earnable through additional IIF indicators - will be confirmed later in 2021/22. ● The IIF is an 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 medicines safety) * 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. ● Last year's update to the GP Contract 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 set out in this guidance will run from 1 April 2021 to 31 March 2022 and are worth £50.7m in total. Following further discussions with the BMA General Practitioners Committee England, further 2021/22 indicators will be introduced no earlier than October 2021, informed by circumstances of the COVID-19 pandemic.	IIF Guidance 2021/22

*For further information on this section of IIF, please see the attached guidance – page 2.

Structure of the IIF

Structure of the IIF	Guidance
● This section introduces the key elements of the initial phase of the IIF in 2021/22 * Domains, areas and indicators. * Indicator structure, performance and personalised care adjustments. * Achievement points. * Achievement payments, prevalence adjustment and list size adjustment. * Monitoring IIF performance.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – page 4.	

Domains, areas and indicators

<table>
<tr><th>Domains, areas and indicators</th><th>Guidance</th></tr>
<tr><td>
● In 2021/22, the initial phase of the IIF is divided into two domains: (i) prevention and tackling health inequalities and (ii) providing high quality care. Both contain areas and these in turn contain indicators. An initial six indicators are included in 2021/22.
● The domains, areas and indicators for the initial phase of the IIF in 2021/22 are set out in the summary table below:
<table>
<tr><th>Domain</th><th>Area</th><th>Indicators</th></tr>
<tr><td rowspan="4">Prevention and tackling health inequalities</td><td rowspan="3">Prevention</td><td>VI-01: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March</td></tr>
<tr><td>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</td></tr>
<tr><td>VI-03: Percentage of children aged 2 to 3 who received a seasonal influenza vaccination between 1 September and 31 March</td></tr>
<tr><td>Tackling health inequalities</td><td>HI-01: Percentage of patients on the Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and a completed Health Action Plan</td></tr>
<tr><td rowspan="2">Providing high quality care</td><td>Personalised care</td><td>PC-01: Percentage of patients referred to social prescribing</td></tr>
<tr><td>Access</td><td>ACC-01: Confirmation that, by 30 June, 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</td></tr>
</table>
</td><td>IIF Guidance 2021/22</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">*For further information on this section of IIF, please see the attached guidance – page 4.</td></tr>
</table>

Indicator structure, performance and personalised care

Indicator structure, performance and personalised care adjustments	Guidance
● IIF indicators can be either 'Binary' or 'Standard'. For Binary indicators, performance is equal to either 0 or 1 (equivalent to 0% and 100% performance) and depends on a criterion or set of criteria that must be met. ● A PCN's performance in relation to a Standard indicator is equal to a numerator divided by a denominator. The desired direction of performance may be upwards or downwards. If it is upwards, a higher indicator value means better performance and a 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 Standard indicator is the target cohort for the intervention in question. In 2021/22 IIF, the target cohort for all Standard 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 learning disability register aged 14 and over. ● Personalised care adjustments (PCA) may be applied to some Standard indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator. The exact conditions under which a PCA can be applied will mirror the description provided in the 2021/22 QOF Guidance, section 6. ● 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 flu vaccine. If GP IT systems record that 100 of the 1,000 patients were offered a seasonal flu vaccine but refused and it was deemed clinically inappropriate to administer the seasonal flu vaccine to a further 100, then PCN performance in relation to indicator VI-01 would be 75% (= 600/800), not 60% (= 600/1,000). ● For all Standard indicators, performance will capture the percentage of a target cohort receiving an intervention.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – page 5.	

Achievement points

Achievement points	Guidance
● The IIF operates in a similar way to QOF, albeit with calculation of achievement at the network level rather than practice level. ● The IIF is a points-based scheme. In the initial phase of the IIF for 2021/22, each PCN can earn a maximum of 225 IIF points and the value of a point will be £200.00 (adjusted for list size and prevalence – *see below in Achievement payments section). Each indicator is worth an agreed number of points, and the points each PCN earns for each Standard indicator will depend on how their performance relates to an upper performance threshold and a lower performance threshold. For Binary indicators, each PCN will either not earn or fully earn the agreed number of points by meeting specified criterion or criteria. ● The upper performance threshold for each Standard indicator is based on clinical or other expert opinion concerning good practice. Reflecting the aim of reducing unwarranted variations, where baseline data is available, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2019/20 (thresholds for social prescribing referrals have been based on expectations of the resource available to PCNs). ● If a PCN's performance for a Standard 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, 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 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 % 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 further information on this section of IIF, please see the attached guidance – pages 5 & 6.	

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 Standard but not Binary 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 make to earn IIF points. The points-based system means that, for each Standard indicator, every PCN will earn the same number of points for a given percentage point improvement in performance. However, differences in prevalence and in list size mean that PCNs may have to make different levels of effort to achieve a given percentage point improvement in performance (and for Binary indicators, no points or the same number of agreed points depending on whether the criterion or criteria 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. In the initial phase of the 2021/22 IIF, Indicator ACC-01 will be eligible for an In Year Achievement Payment as performance will be based on the period 1 April 2021 to 30 June 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 10.6.16). Crucially, the PCN must provide a written commitment to their commissioner that any money earned through achievement payments will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice that will support patient care (e.g. equipment or premises). The written commitment does not have to detail the precise areas of spend.	IIF Guidance 2021/22

*For further information on this section of IIF, please see the attached guidance – pages 6 & 7.

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 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 and constituent practice from Summer 2021.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – page 7.	

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. **Prevention area** ● The aim of the prevention area is to help people stay healthy, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Indicators in the prevention area will contribute to government's ambition to add five years to healthy life-expectancy by 2035. Relevant indicators will also support the prevention-focused ambitions of the NHS Long Term Plan, such as ensuring access to vaccines. Preventative activity is particularly vital to protect those most vulnerable from COVID-19. **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.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – pages 8 - 12.	

Providing high quality care domain

Providing high quality care domain	Guidance
● The Providing high quality care domain aims to ensure that the NHS continues to provide a world-leading quality of care for those with the greatest need, through the Personalised care area and the Medicines safety area. **Personalised care area** ● Personalised care is one of the five major practical changes to the NHS service model 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. **Access Area** ● Improving access to general practice services is a core aim of both the NHS Long Term Plan and the five-year GP contract framework, as outlined in 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 this aim by helping more patients access the right care, in the right place, at the right time.	IIF Guidance 2021/22
*For further information on this section of IIF, please see the attached guidance – pages 13 - 16.	

Annex A: Prevalence adjustment

Annex A: Prevalence adjustment	Guidance
● This annex explains why a prevalence adjustment (for standard 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 refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every IIF indicator – usually this will be the size of the target patient cohort divided by the PCN list size. The target patient cohort 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 flu 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). ● Formally, the prevalence adjustment for an indicator is equal to the PCN prevalence divided by the national average 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. ● In the initial phase of the IIF for 2020/21, the target cohort for one indicator, PC-01, is all the PCN's patients. Therefore, the denominator equals the PCN list size, and 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 this indicator. ● 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.	IIF Guidance 2021/22

*For further information on this section of IIF, please see the attached guidance – pages 17 & 18.

Annex A: List size adjustment

Annex A: List size adjustment	Guidance
● 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 further information on this section of IIF, please see the attached guidance – page 18.	

Summary

Summary	Guidance
● The net effect of applying a prevalence adjustment (for standard 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 further information on this section of IIF, please see the attached guidance – page 18.	

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