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Network Contract Directed Enhanced Service

Investment and Impact Fund 2020/21: guidance

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Contents

1. Introduction

1.1 The Investment and Impact Fund (IIF) has been introduced as part of the amended 2020/21 Network Contract Directed Enhanced Service (DES). In 2020/21, the IIF will run for six months, from 1 October 2020 until 31 March 2021. 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*. The IIF in 2020/21 will resource PCNs to play a leading role in the ongoing response to COVID-19, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

1.2 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 (eg through improvements in medicines safety)
- improving the quality of care for people with multiple morbidities (eg through increasing referrals to social prescribing services)
- helping to make the NHS more sustainable.

1.3 The IIF will be worth £24.25 million in 2020/21, rising to at least £150 million in 2021/22, £225 million in 2022/23 and £300 million in 2023/24. Content for 2021/22 and beyond will be agreed as part of contract negotiations with the BMA.

Purpose of this document

1.4 This document provides guidance on the structure of the IIF for 2020/21, including details of the individual indicators on which performance is being focused. Information on how performance and achievement will be calculated is also included, and should be read alongside the relevant sections of the 2020/21 Network Contract DES specification (Section 9.8 and Annexes C and D).

2. Structure of the IIF

2.1. This section introduces the key elements of the IIF in 2020/21:

- domains, areas and indicators
- indicator structure, performance and personalised care adjustments
- achievement points
- achievement payments, prevalence adjustment and list size adjustment
- total achievement payments and preparation payments
- monitoring IIF performance.

Domains, areas and indicators

2.2 In 2020/21, 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. Six indicators are included in 2020/21.

2.3 The domains, areas and indicators for 2020/21 are set out in the summary table below:

Domain	Area	Indicators
Prevention and tackling health inequalities	Prevention	PR01: Percentage of patients aged 65 and over who received a seasonal flu vaccination
	Tackling health inequalities	HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check
Providing high quality care	Personalised care	PC01: Percentage of patients referred to social prescribing
	Medicines safety	MS01: Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine MS02: Percentage of patients aged 18 and over currently prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant) and an antiplatelet without a gastro-protective medicine MS03: Percentage of patients aged 18 and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine

Indicator structure, performance and personalised care adjustments

2.4 A PCN's performance in relation to each 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.

2.5 The denominator of each indicator is equal to the size of the target cohort for the intervention in question. In 2020/21, the target cohort for all indicators is a group of patients eligible for an intervention. For example, for indicator HI01 the target cohort is people on the learning disability register aged 14 and over.

2.6 Personalised care adjustments (PCA) may be made in relation to two indicators only: PR01 and HI01. Applying a PCA to a patient removes them from the denominator of that indicator. A PCA may be applied for two reasons in relation to indicator PR01: when the patient declined the offer of a seasonal flu vaccine; and when it was not clinically appropriate to administer a seasonal flu vaccine. One reason is permitted for applying a PCA in relation to indicator HI01: when a patient refused the offer of a learning disability health check.

2.7 An example of how PCAs would be applied to PR01 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 PR01 would be 75% (= 600/800), not 60% (= 600/1,000).

2.8 For all indicators, performance will capture the percentage of a target cohort receiving an intervention.

Achievement points

2.9 The IIF operates in a similar way to QOF, albeit with calculation of achievement at the network level rather than practice level.

2.10 The IIF is a points-based scheme. In 2020/21, each PCN can earn a maximum of 194 IIF points and the value of a point will be £111.00 (adjusted for list size and prevalence – see paragraph 2.14). Each indicator is worth an agreed number of points, and the points each PCN earns for each indicator will depend on how their

performance relates to an upper performance threshold and a lower performance threshold.

2.11 The upper performance threshold for each indicator is based on clinical or other expert opinion on good practice. Reflecting the aim of reducing unwarranted variations, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2018/19 (thresholds for social prescribing referrals have been based on expectations of the resource available to PCNs).

2.12 If a PCN's performance for an 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. If a PCN's performance is 70%, it will earn 80% of the points available for that indicator – that is, 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).

Achievable payments

2.13 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£111.00), multiplied by a prevalence adjustment, multiplied by a list size adjustment. The value of an IIF point will be subject to annual revision.

2.14 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 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. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

Total achievement payments

2.15 In 2020/21, PCNs are entitled to one type of payment under the IIF, namely a total achievement payment, which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive a total achievement payment, a PCN must comply with the conditions set out in the 2020/21 Network Contract DES specification (section 9.9A.13). Crucially, the PCN must commit in writing to the commissioner that it will reinvest the total achievement payment into additional workforce and/or primary medical services.

Monitoring IIF performance

2.16 Each PCN will be able to monitor its indicative performance against IIF indicators on a new network dashboard. This dashboard will be available through an online platform. Every PCN will be able to see the benefits it is achieving for its patients, with performance against each IIF indicator available quarterly by PCN and constituent practice from autumn 2020. The network dashboard will help PCNs to identify opportunities to reduce unwarranted variation in performance within their PCN and between PCNs, and to improve services for patients.

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.

Prevention area

3.2 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.

PR01: Percentage of patients aged 65 and over who received a seasonal flu 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). To support the ongoing response to COVID-19, government has set out ambitions for a significantly expanded seasonal flu vaccination for at-risk groups, including the over 65s. This indicator directly supports delivery of this ambition. NHS operational planning guidance and contracting guidance for 2020/21 reaffirms a system-wide commitment to the implementation of the national public health annual influenza immunisation programme. NICE Quality Standard 190 on improving flu vaccine uptake was published in January 2020.
Numerator	Number of patients aged 65 and over who received a seasonal flu vaccination In addition to counting flu vaccines provided during the IIF's six-month period of operation between 1 October 2020 and 31 March 2021, flu vaccines provided between 1 September 2020 and 30 September 2020 will also count towards the numerator. The flu vaccine can be provided in any patient setting (eg general practice, community pharmacy), provided provision is coded in GP IT systems.
Denominator	Total number of patients aged 65 and over.
Personalised care adjustments allowed	Patients who have declined a flu vaccine. Situations in which it is not clinically appropriate to provide a flu vaccine.
Desired direction	Upwards
Upper threshold	77%
Lower threshold	70%
Points available	72
Data source	General Practice Extraction Service (GPES)
Additional information	Responsibility for providing flu vaccines in primary care is currently shared between general practice and community pharmacy, and there is a parallel indicator for delivery to the over 65s in the Pharmacy Quality Scheme (PQS). To

PR01: Percentage of patients aged 65 and over who received a seasonal flu vaccination	
	encourage collaboration and discourage competition across a network, achievement for both the IIF and PQS flu incentives will be based on the total number of vaccines provided within the network, irrespective of who delivers the vaccine. The lower and upper thresholds for both indicators are set at the same rate. The IIF flu vaccine incentive supplements the existing influenza vaccine Directed Enhanced Service contract in general practice, which makes an item of service payment of £10.06 for each flu vaccine provided. This IIF indicator will also be complemented by the parallel incentive in PQS, which will reward community pharmacy for flu vaccine uptake by patients aged 65 and over. By incentivising both PCNs and community pharmacies in this way, we expect to achieve: • a collaborative approach across each PCN's footprint, leading to increased uptake of flu vaccinations in the eligible population • quality improvement, by more timely transfer of notifications of vaccine provision from community pharmacy to general practice, and prompt update of the patient record in general practice, reducing the risk of patients receiving multiple flu vaccinations. Clinical leadership at a PCN level can promote uptake, identifying areas for improvement and disseminating good practice to increase vaccination rates and reduce variation across eligible patient cohorts. PCN clinical directors should, in partnership with the identified CCG flu lead and national commissioners, engage with: • general practices in the PCN to agree how they will collaborate with each other, and discuss how they will collaborate with community pharmacies in relation to seasonal flu vaccine uptake • the pharmacy PCN lead, where available, to agree how general practices will collaborate with community pharmacies in relation to seasonal flu vaccine uptake. NHS England: 2020/21 annual flu letter

Tackling health inequalities area

3.3 The NHS was founded to provide universal access to healthcare, yet 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. IIF indicators in the tackling health inequalities area will help to ensure that everyone gets access to the care they need by focusing on specific patient groups who experience health inequalities.

HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check	
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. 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. NICE Quality Standard 187 provides the quality standard for learning disability health checks.
Numerator	Number of patients on the learning disability register aged 14 years and over who received an annual learning disability health check. In addition to counting annual learning disability health checks provided during the IIF's six month period of operation between 1 October 2020 and 31 March 2021, annual learning disability health checks provided between 1 April 2020 and 30 September 2020 will also count towards the numerator.
Denominator	Total number of patients on the learning disability register aged 14 years and over.
Personalised care	When a patient refused the offer of a learning disability health check.

HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check	
adjustments allowed	
Desired direction	Upwards
Upper threshold	80%
Lower threshold	49%
Points available	47
Data source	General Practice Extraction Service (GPES)
Additional information	This IIF indicator supplements the £140 item of service payment for annual Learning Disability health checks, which is paid as an Enhanced Service. This IIF incentive complements the 2020/21 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. 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 GPs need to review and update their register and also identify patients who may have a learning disability. The IIF supports case identification by employing a prevalence adjustment and list size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. NHS England: Learning Disability Annual Health Checks Mencap charity: Leaflets and resources to encourage people to take up an annual health check Contact (charity): Annual health checks: Factsheet for parents Public Health England: Annual Health Checks and people with learning disabilities guidance includes evidence for an annual heath check and further resources including videos on how to complete an annual health check

4. Providing high quality care domain

4.1 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

4.2 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.

PC01: Percentage of 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 the 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. 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.
Numerator	Number of patients referred to social prescribing. In addition to counting social prescribing referrals made during the IIF's six month period of operation between 1 October 2020 and 31 March 2021, social prescribing

PC01: Percentage of patients referred to social prescribing	
	referrals made between 1 April 2020 and 30 September 2020 will also count towards the numerator.
Denominator	PCN list size
Personalised care adjustments allowed	None
Desired direction	Upwards
Upper threshold	0.8%
Lower threshold	0.4%
Points available	25
Data source	General Practice Extraction Service (GPES)
Additional information	Welcome and induction pack for link workers in PCNs. NHS England: Social prescribing Reference guide for PCNs – information on setting up social prescribing services, including support for recruitment, induction and supervision. This guide also outlines quality assurance measures and explains how to gather information to develop a consistent evidence base for social prescribing. NHS England: Summary guide – describes what a good social prescribing scheme looks like, and includes a common outcomes framework to help measure the impact of social prescribing on people, the local system and the voluntary and community sector.

Medicines safety area

4.3 The NHS England and NHS Improvement Medicines Safety Improvement Programme was launched in response to the WHO challenge **Medication without harm**, which aims to reduce severe, avoidable medication-associated harm globally by 50% by 2022. It is estimated that 237 million medication errors occur in the NHS in England every year, of which about 44 million occur at the prescribing stage in primary care setting. During the COVID-19 pandemic more people on long-term medication have moved to electronic repeat dispensing. In this context it is vital that initial prescriptions are made in line with established best practice for reducing harm to patients.

4.4 The medicines safety area of the IIF aims to (i) support local reviews of prescribing, alongside other risk factors for potential harm; (ii) minimise the use of medicines that are unnecessary and where harm may outweigh benefits; (iii) identify where the risk of harm can be reduced or mitigated, including through prescribing of alternative medicines or medicines that mitigate risk; and (iv) reduce the number of hospital admissions that may be associated with medicines.

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
Indicators	Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine.	Percentage of patients aged 18 and over currently prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant (DOAC)) and an antiplatelet without a gastro-protective medicine.	Percentage of patients aged 18 and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine.
Rationale for inclusion	Patients prescribed the specific medicines described in MS01, MS02 and MS03 without a gastro-protective medicine are at a heightened risk of hospitalisation due to gastro-intestinal bleed. These indicators, which are also reported on the NHS Business Services Authority medicines safety dashboard, aim to encourage general practice to prescribe gastro-protective medicines alongside these medicines to reduce related hospital admissions.		

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
	Indicator MS01 complements the 2019/29 QOF quality improvement module on prescribing safety, which included a focus on safe prescribing of NSAIDs.		
Numerator	Number of patients aged 65 and over currently prescribed a NSAID without a gastro protective medicine.	Number of patients aged 18 and over currently prescribed an oral anticoagulant and an antiplatelet without a gastro-protective medicine.	Number of patients aged 18 years and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine.
Denominator	Number of patients aged 65 and over currently prescribed a NSAID.	Number of patients aged 18 and over currently prescribed an oral anticoagulant and an antiplatelet.	Number of patients aged 18 and over currently prescribed aspirin and another antiplatelet.
Personalised care adjustments allowed	None		
Desired direction	Downwards		
Upper threshold	30%	25%	25%
Lower threshold	43%	40%	42%
Points available	32	6	12
Data source	NHS Business Services Authority primary care prescribing data		
Additional information	The following contextual indicators are available to support monitoring. They will not be used to calculate IIF achievement. Indicators available through the medicines safety dashboard: • In relation to MS01: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 65 and over who were prescribed a NSAID without a gastro-protective medicine. • In relation to MS02: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 18 and over		

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
	who were prescribed an oral anticoagulant and an antiplatelet without a gastro-protective medicine • In relation to MS03: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 18 and over who were prescribed aspirin and another antiplatelet without a gastro-protective medicine. Indicators available through the network dashboard: • In relation to MS01: Percentage of patients prescribed an NSAID and a gastro-protective medicine who were prescribed a gastro-protective medicine above the licensed prophylactic dose. Use of gastro-protective medicines has been associated with *Clostridium difficile* infection (CDI). The risk of CDI is thought to relate to the dose at which the gastro-protective medicine is prescribed. Therefore, prescribing of gastro-protective medicines above the licensed prophylactic dose is a marker of increased risk of CDI.[1]		

[1] While gastro-protective (proton pump inhibitor and H_2 receptor antagonist) product licences state a dose or indication for prophylaxis while on NSAIDs, they do not do so for patients on anticoagulants or antiplatelets, nor are recommended doses given in national guidance. For this reason, the network dashboard will only report patients prescribed above the licensed prophylactic dose in relation to MS01, and not in relation to MS02 or MS03. CCGs often have local prescribing guidance on recommended lower doses for prophylaxis for anticoagulants/antiplatelets.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment and list size adjustment are applied when calculating IIF achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex D of the 2020/21 Network Contract DES specification.

Prevalence adjustment

A.2 Prevalence refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every IIF indicator – it equals the denominator (that is, the size of the target cohort) divided by the PCN list size. For instance, for indicator PR01, 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 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 (ie achieve a given percentage point improvement in performance).

A.4 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.

A.5 For one indicator, PC01, the target cohort 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.

A.6 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages case finding for indicators whose denominator is

under the control of the PCN. Consider indicator HI01, 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. In the absence of a prevalence adjustment, this indicator could introduce a perverse incentive for PCNs to improve their performance by not adding people to the learning disability register if they are perceived as unlikely to consent to receiving an annual health check. Applying a prevalence adjustment both eliminates any such perverse incentive and incentivises PCNs to expand their registers, as earning potential is proportional to the size of the denominator.

List size adjustment

A.7 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.8 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (ie 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.9 The net effect of applying a prevalence adjustment and a list size adjustment is to make payment proportional to the amount of activity undertaken (eg 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.