Classification: Official

Network Contract Directed Enhanced Service

Investment and Impact Fund 2021/22: guidance

31 March 2021

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Publishing approval number: PAR486

Version number: 1

First published: 31 March 2021

Prepared by: Primary Care Group

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Equalities and health inequalities statement

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

Contents

1. Introduction

1.1 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*.

1.2 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.

1.3 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 flu 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.

1.4 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.

Purpose of this document

1.5 This document provides clear and concise guidance on the initial phase of the IIF for 2021/22, including key 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 2021/22 Network Contract DES specification (Sections 10.6 and Annexes C and D).

2. Structure of the IIF

2.1. 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.

Domains, areas and indicators

2.2 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.

2.3 The domains, areas and indicators for the initial phase of the IIF in 2021/22 are set out in the summary table below:

Domain	Area	Indicators
Prevention and tackling health inequalities	Prevention	**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
	Tackling health inequalities	**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
Providing high quality care	Personalised care	**PC-01**: Percentage of patients referred to social prescribing
	Access	**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

Indicator structure, performance and personalised care adjustments

2.4 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.

2.5 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 lower one means worse performance; and if it is downwards, a lower indicator value means better performance and a higher one means worse performance.

2.6 The denominator of each 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.

2.7 Personalised care adjustments (PCAs) 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

2.8 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 also 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).

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

Achievement points

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

2.11 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 paragraph 2.15). 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.

2.12 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).

2.13 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).

Achievement payments

2.14 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.

2.15 The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must 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 (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.

2.16 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.

2.17 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.

Monitoring IIF performance

2.18 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 in using your existing Insights Platform account, and then select the NHS ViewPoint product. A user guide is available to help navigate the dashboard.

2.19 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.

3. Prevention and tackling health inequalities domain

2.20 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

2.21 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.

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). To support the ongoing response to COVID-19 in 20/21, the government set out ambitions for a significantly expanded seasonal flu vaccination for clinical at-risk child and adult groups. In light of the ongoing pandemic, NHS providers (including GP Practices and Community Pharmacy) have been advised to plan to achieve similar levels of uptake in 2021/22. These indicators directly support delivery of this ambition. NICE Quality Standard 190 on improving flu vaccine uptake was published in January 2020.		
Indicator type	Standard		
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

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Numerator	Number of patients aged 65 and over who received a seasonal flu vaccination between 1 September and 31 March	Number of patients aged 18 to 64 and in a clinical at-risk group (as defined in Appendix A in the national flu immunisation programme update for 2020/21[1]) who received a seasonal flu vaccination between 1 September and 31 March	Number of children aged 2 to 3 who received a seasonal flu 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.		
Denominator	Total number of patients aged 65 and over.	Total number of patients aged 18 to 64 and in a clinical at-risk group.	Total number of children aged 2 to 3.
Personalised care adjustments allowed	Patients who have declined a flu vaccine Situations in which it is not clinically appropriate to provide a flu vaccine. Patient did not reply to two separately coded invites using their preferred method of communication		
Desired direction	Upwards		
Upper threshold	86%	90%	82%
Lower threshold	80%	57%	45%

[1] 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 home

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			
Points available	40	88	14
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. 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. Achievement for both the IIF and PQS flu incentives was based on the total number of vaccines provided within the network, irrespective of who delivered the vaccine. The negotiations for the contractual framework for 2021/22 including the PQS for 2021/22 have not yet started. Details will be published once the negotiations are concluded. The IIF influenza vaccine indicators supplement the existing influenza vaccine Directed Enhanced Service contract in general practice, which makes an item of service payment of £10.06 (at the time of publishing this guidance) for each flu vaccine provided. Clinical leadership at a PCN level can promote uptake, identifying areas for improvement and disseminating good practice to increase vaccination rates and reduce variation across eligible patient cohorts. PCN clinical directors should, in partnership with the identified 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.		

Tackling health inequalities area

2.22 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 Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and 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. People with a learning disability often have poorer physical and mental health and are four times more likely to die of preventable illnesses than the general population (Disability Rights Commission, 2006). Groups who already experience disproportionately poor health outcomes have also been seen to have additional risks from COVID-19. An annual health check can help to improve the health of people with a learning disability by identifying health concerns at an early stage. The health action plan is an integral part of the requirements around a learning disability health check and so encouraging this requirement will ensure that the Health Check Scheme is seen as a required two-part process, necessary for supporting individuals in any actions or follow up to support their health and well-being. NICE Quality Standard 187 provides the quality standard for learning disability health checks.
Indicator type	Standard
Numerator	Number of patients on the learning disability register aged 14 years and over who received an annual learning disability health check and have a completed Health Action Plan between 1 April 2021 and 31 March 2022.
Denominator	Total number of patients on the learning disability register aged 14 years and over.
Personalised care adjustments allowed	When a patient refused the offer of a learning disability health check.
Desired direction	Upwards
Upper threshold	80%
Lower threshold	49%

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	
Points available	36
Data source	General Practice Extraction Service (GPES)
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. PCNs should also ensure patients with a learning disability are accurately coded. Improving identification of people with a learning disability; guidance for general practice, published in October 2019, states GP practices need to review and update their register and also identify patients who may have a learning disability. The IIF supports case identification by employing a prevalence adjustment and list size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI-01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. 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. RCGP Toolkit NDTI resources

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.

PC-01: 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.
Indicator type	Standard
Numerator	Number of patients referred to social prescribing between 1 April 2021 and 31 March 2022
Denominator	PCN list size

PC-01: Percentage of patients referred to social prescribing	
Personalised care adjustments allowed	None
Desired direction	Upwards
Upper threshold	1.2%
Lower threshold	0.8%
Points available	20
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. 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. Social Prescribing - e-Learning – programme hosted by E-learning for Health and Health Education England aimed at link workers in PCNs.

Access area

4.3 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.

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	
Rationale for inclusion	The development of a comprehensive and structured dataset describing access to general practice based on better and more consistent recording via standards is a commitment set out in Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (para 5.29) and reinforced in Update to the GP contract agreement 2020/21 to 2023/24 (para 4.3) This will provide comprehensive, granular, frequent and timely information.
Indicator type	Binary
Numerator	N/A
Denominator	N/A
Personalised care adjustments allowed	N/A
Desired direction	N/A
Upper threshold	N/A
Lower threshold	N/A
Points available	27
Data source	Manual PCN submission to commissioners. Full details including value of payment to be provided to PCNs and commissioners in advance of 30 June.
Additional information	NHSEI with the BMA issued more accurate general practice appointment data – guidance in August 2020 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 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. Technical system specific advice and guidance to support practices with configuring appointment books has been published by NHS Digital. A new standardised set of GP appointment categories across general practice in England have also been introduced. New

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	
	functionality to map local slot types to this new set of standard national GP appointment categories is also being provided in GP appointment systems. Each appointment slot type needs to be mapped to one of the categories. Guidance to support practices to do this is available. PCNs will be rewarded through the IIF 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 in Q1 and any necessary validation prior to payment will be undertaken in 2021/22. More accurate general practice appointment guidance Appointment category guidance

Annex A: Prevalence adjustment and list size adjustment

A.1 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 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 – 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.

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 (i.e. achieve a given percentage point improvement in performance).

A.4 Formally, the prevalence adjustment for an indicator is equal to PCN prevalence divided by national prevalence. For instance, if 20% of the residents of England registered at practices signed up to the Network Contract DES are aged 65 and over, then a PCN with 30% of registered patients aged 65 and over would have a prevalence adjustment of 1.5 – that is, it would be paid 50% more for each additional achievement point than an otherwise identical PCN with a prevalence equal to the national average prevalence.

A.5 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.

A.6 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.

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 (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.9 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.