To:
- GP practices
- Primary care networks
- NHS England and NHS Improvement regions:
  - directors
  - directors of commissioning
- Clinical commissioning groups:
  - clinical leads
  - accountable officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

7 December 2021

Dear Colleagues

Temporary GP contract changes to support COVID-19 vaccination programme

1. In our letter of 3 December, NHS England and NHS Improvement set out plans for an acceleration of COVID-19 vaccination following the emergence of the Omicron variant. This letter sets out further details of the actions we are taking to support GPs, primary care networks (PCNs) and their teams to progress this expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter.

2. We recognise that balancing your resources this winter between the urgent needs of your patients, the management of long term conditions, and the vital task of vaccination and public health is a daily challenge. The measures in this letter seek to support your professional clinical judgement in balancing these considerations.

The Quality and Outcomes Framework (QOF)

3. The evidence-based care provided via QOF continues to be important in minimising health inequalities and securing the best outcomes for those with long term conditions. However, to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we are making the following changes to QOF in 2021/22 – applying to all practices – which will be reflected in an amended statement of financial entitlement (SFE):

   a. Practices should focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators and the eight prescribing

indicators (see Appendix 1). These will continue to operate on the basis of practice performance in 2021/22.

b. Forty-six QOF points for new indicators where there is no historic performance to use as the basis for income protection (the eight points associated with the new for 2021/22 cancer indicators, 20 points from the new for 2021/22 mental health indicators and 18 points from the non-diabetic hyperglycaemia indicator that was introduced for 2020/21) will be reallocated. These will increase the total points available for the eight prescribing indicators, reflecting the continued importance of effective prescribing in the management of long term conditions. We appreciate the work you will have undertaken in these domains to date and that you will continue to clinically prioritise care.

c. The remaining indicators will be income protected using a methodology very similar to the one applied in 2020/21: most income-protected indicators for 2021/22 will be paid based on achievement in 2018/19, while the income-protected indicators relating to diabetes and hypertension will be based on 2019/20 achievement, given some indicators in those domains were new for the 2019/20 year (see Appendix 2). Points will be subject to a list size and prevalence adjustment calculated in the usual way at year end. Practices are expected to continue to apply their clinical judgement and deliver as much patient care in these areas as they can, with a focus on the highest risk patients, but their income will not be dependent on recorded QOF achievement this year for the income-protected indicators.

d. The quality improvement (QI) domain will be paid to practices in full.

e. To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible, but with priority according to clinical risk and accounting for inequalities. We will be working with the Royal College of GPs (RCGP) and the British Medical Association (BMA) to provide some guidance to systems and practices.

4. All activity undertaken should continue to be coded. The Calculating Quality Report Service (CQRS) will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Aspiration payments will continue as at present. Payment for QOF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

5. QOF will recommence in full from April 2022.

Investment and Impact Fund (IIF)

6. The following changes will apply to IIF for 2021/22, implemented via a forthcoming Variation to the Network Contract Directed Enhanced Service (DES):

    a. The three flu immunisation indicators, and the appointment categorisation indicator (as the work is complete), will continue to operate on the basis of PCN performance in 2021/22 (see Appendix 3).

    b. The remaining indicators will be suspended and the funding allocated (worth £112.1m) repurposed (see Appendix 4).

    c. £62.4m of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN support payment, to be paid on a weighted patient basis, subject to a simple confirmation from the PCN that it will be reinvested into services or workforce.

    d. £49.7m will be allocated to a new binary IIF indicator, paid on the basis of all practices within a PCN being signed up to phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, remaining signed up until 31 March 2022, and actively delivering the programme. Given the opt-in deadline of **10 December 2021**, practices not signed up to the phase 3 Enhanced Service would need to opt in by 10 December 2021, be assured to go live in early January, and continue to participate in the enhanced service until 31 March 2022 to be eligible for this indicator. Payment for this indicator will be made on a registered list size basis after the end of the financial year. Where, in exceptional circumstances, the commissioner agrees with one or more practices that they should not participate in the COVID-19 Vaccination Enhanced Service (as a result of wider access, performance or patient safety issues) then the PCN may still receive payment with those practices excluded from consideration. The payment will not apply if any practice in the PCN otherwise declines to participate in the programme.

7. As with QOF, CQRS will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Recording of activity should continue. Payment for IIF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

8. IIF will recommence in full from April 2022.

Wider measures

9. If participating in the vaccine programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners

should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

10. From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate and they are participating in the vaccine programme, routine health checks on request for those over 75 who have not had a consultation in the last 12 months, and for new patients may be deferred.

11. The Dispensary Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Additional telephony support

12. As a component of the NHS England and NHS Improvement Winter Access programme, NHSX have agreed a time-limited offer with Microsoft for general practice to utilise MS Teams telephony functionality. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. Practices will keep their current telephony supplier and associated number in place to support the receiving of calls. This national offer is an additional component to the Microsoft Teams application currently provided and will increase telephone capacity at no additional cost to the practice. The additional outbound only call functionality will expire on 30 April 2023.

13. If you have already responded to the baselining questionnaire indicating interest, this functionality will be enabled for all Teams users in your practice. Further communications will follow from the NHSmail Team confirming the date of availability and providing links to the support site which contains details of how to access including training and support.

14. Contact the team on scwcsu.nhsei.winterpressures.advancedtelephony@nhs.net if you no longer wish to progress with this offer, or if you did not complete the original questionnaire, but wish to take up this offer.

Next steps

15. The sign-up window for the phase 3 GP COVID-19 Vaccination Enhanced Service has therefore been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

Yours sincerely,

Ed Waller
Director of Primary Care
NHS England and NHS Improvement

Dr Nikita Kanani MBE
Medical Director for Primary Care
NHS England and NHS Improvement

Appendix 1: QOF performance-based indicators 2021/22

Table 1: Performance-based public health indicators with unchanged points values 2021/22

Indicator ID	Indicator wording	Points	Payment thresholds	Points at the lower threshold
VI001	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
VI003	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	-
CS005	The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%	-
CS006	The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%	-
			Total	**75**

Table 2: Performance-based prescribing indicators with changed points values 2021/22

Indicator ID	Indicator wording	Original points	Updated points	Payment thresholds
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	25	40-70%
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	15	56-96%
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	12	60-92%
HF006	The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	12	60-92%
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	8	57-97%
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	8	57-97%
DM022	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	7	50-90%
DM023	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	4	50-90%
			Total	**90**

Table 3: Disease register indicators

Indicator ID	Indicator	Points
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	5
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease	4
HF001	The contractor establishes and maintains a register of patients with heart failure	4
HYP001	The contractor establishes and maintains a register of patients with established hypertension	6
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease	2
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA	2
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4
COPD009	The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia	5
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6

Indicator ID	Indicator	Points
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1
LD004	The contractor establishes and maintains a register of patients with learning disabilities	4
OST004	The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3
OB002	The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months	8
	Total	**81**

The points allocated to these indicators in Table 4 are reallocated to the prescribing indicators in Table 2.

Table 4: Indicators without historic performance

Indicator ID	Indicator wording	Points	Payment thresholds
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White]) or preceding 24 months for all other patients	8	50-90%
MH012	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%
CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50-90%
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis	2	70-90%
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50-90%
	Total points to be reallocated		**46**

Appendix 2: QOF income-protected indicators 2021/22

Table 5: Indicators to be paid based on performance in 2018/19 (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12
CHD009	The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
HF005	The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6
HF007	The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7
STIA010	The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2
AST006	The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15

Indicator ID	Indicator description	Points
AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6
COPD010	The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9
COPD008	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2
DEM004	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4
RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25

Indicator ID	Indicator description	Points
SMOK004	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25
	Total	**244**

Table 6: Indicators to be paid based on 2019/20 performance (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
DM0012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11
DM019	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10
DM020	The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCCHbA1c is 58 mmol/mol or less in the preceding 12 months	17
DM021	The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
	Total	**71**

Table 7: Indicators awarded in full for 2021/22

Indicator ID	Indicator description	Points
QIECD005	The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance.	27
QIECD006	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10
QILD007	The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27
QILD008	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10
	Total	**74**

Appendix 3: Performance-based IIF indicators 2021/22

Indicator	Thresholds	Valuation
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts
CVD-01: Percentage of patients aged 18 years or over, not on the QOF hypertension register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 >= 140/90mmHg or (ii) a blood pressure reading >= 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022	20% (LT), 25% (UT)	£12.0m / 53 pts
CVD-02: Percentage of registered patients on the QOF hypertension register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts
EHCH-01: Number of Patients recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident	3 (LT), 4 (UT)	£2.9m / 13 pts
ACC-02: Number of online consultations on or after 1 October per 1000 registered patients	130 over 6 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts

Indicator	Thresholds	Valuation
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.	n/a Binary indicator	£12.6m / 56 pts
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO2e)	22.5kg (LT), 19.4kg (UT)	£6.1m / 27 pts

Appendix 4: Suspended IIF indicators 2021/22

Indicator	Thresholds	Valuation
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts
CVD-01: Percentage of patients aged 18 years or over, not on the QOF hypertension register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 >= 140/90mmHg or (ii) a blood pressure reading >= 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022	20% (LT), 25% (UT)	£12.0m / 53 pts
CVD-02: Percentage of registered patients on the QOF hypertension register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts
EHCH-01: Number of Patients recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident	3 (LT), 4 (UT)	£2.9m / 13 pts
ACC-02: Number of online consultations on or after 1 October per 1000 registered patients	130 over 6 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts

Indicator	Thresholds	Valuation
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.	n/a Binary indicator	£12.6m / 56 pts
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO2e)	22.5kg (LT), 19.4kg (UT)	£6.1m / 27 pts