Rotherham CCG - Principles for balancing general practice capacity and delivery of the Covid-19 vaccination programme phase 1 to 31st March 2021.

Introduction

The covid-19 vaccination programme is going to be reliant on delivery at practice grouping level for at least the initial, most vulnerable patient cohorts in our community. Whilst it is acknowledged that funding (for delivery of the vaccine) is being provided to enable practices to increase their staffing to facilitate the programme, it is acknowledged that there is unlikely to be sufficient appropriately trained workforce without the need to limit some tasks within practices. Whilst delivery of the vaccine is essential, it is also acknowledged that patient care has only just started to return to some kind of normality and therefore it is also important to sustain as far as possible existing care during this intense period.

An additional £150m funding has been announced (expected to be in the region of £450k for Rotherham) to support general practice during this second wave of covid and to increase capacity to sustain activity whilst delivery the covid-19 vaccine. There are caveats with this funding and it is therefore important that the principles do not impact the ability to receive this funding into Rotherham general practice. Further discussion is required with LMC officers and Primary Care Networks in relation to this funding.

NHSE/I expectations

1. Local enhanced services should where possible be re-purposed by agreement with CCGs to make funded capacity available for COVID 19 vaccination.

2. Extended Access and hours capacity should similarly be reprioritised to provide additional capacity [as above].

3. QOF has been significantly income protected around long term condition management activity. Practices should approach the management of long term conditions on the basis of clinical prioritisation and should continue to record patient contact but this will not impact payment.

4. QI modules in QOF have been significantly revised, supporting essential activity.

5. Additional Roles Reimbursement Scheme (ARRS) staff can be deployed as required to vaccination as integral members of PCN teams. ARRS recruitment should continue with full funding entitlements remaining in place to continue to support practice teams.

6. PCNs should note that the Structured Medication Review and Medicines Optimisation service requirements in the Network Contract DES are very clear that the number of SMRs to be delivered will be determined and limited by PCN clinical pharmacist capacity. Depending on local clinical prioritisation it is likely to be the case that COVID vaccination is considered a priority for deploying available clinical pharmacists in the short term.

7. A PCN may use its Additional Roles Reimbursement Sum to reimburse extra hours worked by PCN staff, at plain time rates only, as long as the increase in WTE hours worked is clearly recorded on the PCN's claim form and National Workforce Reporting System.

8. Further information will follow in due course about how PCNs can access further support from local systems to bring in additional workforce to support the Covid-19 vaccination programme.

9. Whilst a restart of a new, more supportive appraisal model was described in a letter from Stephen Powis earlier this year, we fully recognise the current pressures on the system and the need for a flexible and sympathetic approach - many areas will not be in a position to carry out appraisals at this time but we will maintain the ability to access support for those who need it.

10. CQC have separately communicated about their approach to ease burden on providers in this period.

RCCG Proposal

1. In a similar way to the income guarantee for QOF, RCCG propose to pay the quality contract at 100% this financial year with the only exception that the Quality standards related to access and cancer must be achieved. It is key that our patients can access general practice at these difficult times and that when they are being referred onto the 2ww pathway, they are fully briefed of the importance of their appointment. This does not impact the existing arrangements for managing these contractual requirements. The quality contract was paid at 100% from 01 April to 30 September, and then reverted to payment by activity (i.e. 83% /standard 7 to be earned) for October and November. As it will be paid at 100% again from 01 December to 31 March, there is no way practical way to assess whether standard 7 has been achieved in two months; the KPIs rely on achievement over the year and some are cumulative and can't be reviewed in isolation. Payment of the 17% for these two months equates to £40,653.42.

2. Many of our local enhanced services are essential for our patients and without their delivery, the patient would default into secondary care who are also severely impacted by COVID-19, with many patients currently unwilling to attend appointments in hospitals. As detailed in the above NHSE/I briefing, RCCG has considered the LES which could reduce/be postponed to facilitate staff being 'repurposed' and consider that all LES offers need to be maintained and will be paid on an actual activity basis.

3. Extended access capacity has already been repurposed this year to provide a home visiting service to release capacity in all practices. The home visiting service is understood to be valued by all the practices and some PCNs will be utilising innovation fund monies to increase this further. There are sessions at weekends which could be 'repurposed' to support the vaccine programme however this is likely to impact practices detrimentally on Mondays therefore it is not proposed to do this.

4. ARRS – There are currently an additional 41.8wte ARRS staff employed across the network of which 15.85wte could be released to support the vaccine programme, it is for the PCNs to determine if these staff are best utilised on current duties or if they can be released to support the vaccine programme. For example, is identified that the structured medication reviews can be reprioritised and Clinical Pharmacists prioritised to vaccine delivery. Also, where posts have not been recruited to, PCNs can utilise the underspend on ARRS to fund additional hours which is more flexible than the advice to date (noting the caveats required)

5. RCCG will be supporting the practice groupings to encourage staff who have retired to return to support the delivery of the vaccine programme. RCCG have already been contacted by individuals who are interested in this but acknowledge that initial training will be required.

Covid capacity expansion fund

The fund is ring-fenced for general practice for spend in this financial year. There is a requirement for practices and PCNS to complete the appointment and workforce data returns and for activity to be at

pre-covid levels or for the additional funding to be utilised to support achievement of the activity levels. In Rotherham, as part of the review of activity only a small number of practices identified that they were not 'restored' with the main area minor surgery.

RCCG proposes, subject to receipt of funding from the ICS that the above proposed repurposing of LES do not significantly impact activity overall and therefore the practices and PCNs, subject to the above caveats should be eligible for funding. There are restrictions (as follows) on how the monies can be utilised and more discussion is required on how this fund is utilised:

- Additional support for LD health checks to achieve the minimum 67% expectation
- Establishing the covid oximetry@home service
- Supporting patients with long covid issues
- Increasing GP numbers and capacity
- Continuing to support clinically extremely vulnerable and maintain the shielded list
- Continuing to reduce the backlog of appointments
- Potentially offering backfill for staff where agreed by the CCG where it is required to meet demand and the individual cannot work remotely

Approval

Due to the speed at which decisions needed to be made regarding this proposal, a discussion took place with LMC Officers on 23 November 2020 who were supportive of the approach. The Executive Place Director, therefore approved the proposal within his delegated responsibilities following a full briefing via video conference to the Chair of the Primary Care Committee. The paper will be received for information at the next Primary Care Committee.