Rotherham CCG – Revised principles for balancing general practice capacity and delivery of the Covid- 19 vaccination programme phase 1 to 31st March 2021 following the 7 January letter

Introduction

In November, we agreed on the basis of the guidance from NHSE/I a set of revised principles for local application in relation to payment arrangements. Further to this advice, on 7 January we received a further letter in relation to freeing up additional capacity to support the vaccination programme at pace. 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 funding pot of £839,000 has already been distributed to practices to increase staff provision to maintain as far as is reasonably practicable, services during the vaccination programme. The 7 January letter goes further:

NHSE/I expectations and actions being taken

1. CCGs to take a supportive and pragmatic approach to minimise local contract enforcement across routine care, with attention and support focused on the core areas set out above (in the letter)

2. Suspend any locally commissioned services except where these relate to the vaccination programme, or other covid related support to the system e.g. where they contribute to reducing admissions to hospital or support hospital discharge. Budgeted payment against these areas should be protected to allow capacity to be deployed

3. Review whether clinical staff involved in CCG management could be deployed in support of practices or PCN work

Actions already taken by NHSE/I

1. 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.

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

3. 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.

4. 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.

5. 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

6. 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.

7. 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.

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

Additional actions by NHSE/I in the 7 January 2021 letter

1. Increase in PCN Clinical Director funding to 1wte (from 0.25wte) until 31 March

2. Minor surgery DES will be income protected until March 2021

3. Quality improvement domain of QOF will be income protected in full at 74 points per practice until March 2021

4. The 8 prescribing indicators will be protected on the same basis as the 310 points which have already been income protected

5. Appraisals can be declined but if do go ahead should be on the shortened format

RCCG Proposal

1. In a similar way to the income guarantee for QOF, RCCG has already confirmed that it will 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.

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. Following the 7 January letter, RCCG has considered the LES which could reduce/be postponed to facilitate staff being 'repurposed' and proposed the following:

Aural care (can be delayed – or utilise additional resource from the expansion pot)
Minor surgery (can be delayed – or utilise additional resource from the expansion pot)
Ring pessary insertion (can be delayed – or utilise additional resource from the expansion pot)
IUCDs (can be delayed – or utilise additional resource from the expansion pot)
Over 65s health checks (can be delayed – or utilise additional resource from the expansion pot)

Case Management – will be at the clinical judgement of the clinician to ensure that a patient does not suffer a detriment by not being reviewed again, the review can be delayed or you could use the additional resources from the expansion pot.

For **all** local enhanced services we propose to calculate a payment for Q4 based on the payment for these services made in Q1 of this financial year (as we moved to activity in Q2 and Q3). We do still require activity information submitting at the end of Q4 for all local enhanced services including those identified above which can be delayed, this is to understand the amount of 'catch up' required in Q1 of 2021/22, the CCG data quality team will support extraction.

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. We could repurpose extended hours (i.e. the individual practice extended access) however it is considered that this will cause pressure on all practices and likely impact UECC.

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, given the 7 January request to free up capacity, our expectation, in line with the guidance is that **all the 15.85wte clinicians within the ARRS roles who are able to vaccinate are deployed to vaccination unless they are supporting urgent care in practices**. 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.

5. Release of CCG clinical staff – the majority of the CCG clinical staff are employed to undertake Continuing Healthcare duties without which, discharges from hospital will be significantly delayed. A significant number of staff are also currently deployed to support the set up and development of the

vaccination centres. However we will be reviewing if any other clinical staff could be freed up for all or part of their time to support the vaccination programme without compromising the operational function of the CCG (which is also required to support practices and the vaccination programme).

Approval

Due to the speed at which decisions needed to be made regarding this proposal, discussions will be taking place at speed with LMC officers and PCN directors regarding these proposals for practical application of the 7 January letter. The Executive Place Director, therefore has been approved, within his delegated responsibilities by the Chair of the Primary Care Committee to agree the proposal. The paper will be received for information at the next Primary Care Committee.