NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care COVID-19 Response

Primary Care Cell – Dr Martin Jones, Medical Director

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Overview

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1. Key Focus Areas

- **Care Homes** – working group continues to oversee BNSSG delivery of the national guidance on the primary and community care model for care home support and implementation of the PCN DES Enhanced Health in Care Homes from 1st October. Key areas this month have included planning distribution of additional pulse oximeters to care homes (see virtual covid ward slides) and asking PCNs to complete a short template about their MDT arrangements.
- **Capacity planning-** primary care escalation plan in development supported by Opel status reporting for practices. Currently in testing with practice managers before rolled out. Escalation plan to support system-wide approach to escalation reporting and action planning. Capacity modelling tool developed, to be updated and shared with primary care
- **Flu planning** - standing agenda item at the primary care cell, update included in quality report and flu report to PCCC.
- **Workforce support –** CCG confirmation of approach to contracting and income for Q3 and Q4 included support for continued backfill for isolating staff in line with national guidance received in August. Workforce to support covid vaccination programme to be a key priority.
- **111 First** - standing agenda item at weekly primary care cell
- **Communications** – continued twice weekly bulletins with ad hoc additional bulletins to mirror increased need to summarise key information for practices
- **Cell Terms of Reference** – review of Terms of Reference planned to revisit key objectives for this year, seek opportunities to minimise duplication and clarify governance

2. Digital Sub-Group

- **111 Direct Booking/111 First:**
  All practices are configured and receiving direct bookings from CCAS and 111. Weekly monitoring is in place to ensure configuration continues to be in place correctly and to monitor utilisation of the 1 per 500 population contractually required allocation. The risk remains that this is not actual additional capacity and if demand was at this level it would not be manageable. This work is essential to support the 111 First Programme.
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- **Remote Consultations**
  - Work continues to review suppliers of video consultation capability and SMS services to provide continuity of functionality for practices and value for money
  - The practices yet to implement online consultations have been asked to submit assurance plans in preparation for the 1st April 2021 deadline. A final implementation training session will take place on 25th November.

- **Digital Inclusion:** A piece of work is underway to support practices in management of patients with visual impairment including training resources and supporting compliance with the accessible information standard. This work will feed into the Prevention, Health Inequality & PHM steering group for wider system sharing.

- **Digital Support has also been provided for:**
  - Care Homes EMIS Proxy Access
  - Care Homes Virtual MDT EMIS templates
  - Elemental for Social Prescribers
  - EMIS searches for LD
  - EMIS searches for identification of vulnerable patients
  - EMIS ethnicity coding protocol

3. Community Phlebotomy - Background and Case for Change

- **Pre-Covid Phlebotomy**
  - Primary care responding to secondary care requests informally without resources
  - Blood results are returned to GP – interpretation, communication, risk and time
- **Response to Covid-19**
  - COVID response in outpatients; virtual consultations and need for phlebotomy out of hospital -> increased delegated bloods into GP
  - General practice, Trusts, CCG and One care have met regularly to progress project
  - South Bristol Hub pilot (x1) and proof of concept to use a WEB ICE system in N&W
- **Going Forwards**
  - An agreed way of processing delegated phlebotomy with robust governance
  - GP to be resourced for the work being done already and any future work
  - COVID OP changes likely to stay (transformation in OP) -> pts coming to community or their bloods

Work so far

- Monthly community phlebotomy strategic group
- Weekly community phlebotomy operational group
- Acute Trust and Locality Lead representation, Sirona, CCG
- Pilots – Hub in South Bristol and pilots in practices across BNSSG
- Feedback from membership was to develop an offer to practices using Covid-19 funding which we have secured until March 2021, and to continue to fund the hub alongside
- Build resilience into the offer – practice/PCN
- Use the next 4 months to test referral process, volumes, ability of practices to deliver phlebotomy, assess financial model

Engagement

- Primary Care Cell – Tues 13th Oct / Tues 20th Oct
- GP Collaborative Board Thursday 22nd October
- Clinical Cabinet – Weds 14th Oct
- Locality Meeting – Thurs 8th or Thurs 22nd Oct
- Outpatient Board – Tues 6th Oct
- GP Membership - Tues 10th/Weds 11th Nov

Next steps

- Feedback from membership
- Consistent coding in GP
- Funding agreement from November
- Continued engagement of trust medical directors from Martin Jones and Peter Brindle
- SOPs continue to be refined
- Continued work with OOH and trusts to confirm process
- All practices have access to ICE for trusts they face
- IT roll out of primary care resources
- EIA/QIA

4. Proactive Care for Our Vulnerable and Shielded Population

- **Approach to vulnerable and shielded patients discussed at PCCC in September**
  - Restore service levels and face to face appointments
  - Protect the most vulnerable
  - Better engage those who need most support
  - Ensure datasets are complete to understand and address inequalities
  - QoF 20/21 **-** Agree with commissioners how to risk stratify your QoF population – clinical prioritisation

- **Stage 1 - developed a pragmatic risk guide for practices to support this prioritisation**
  - Priority groups
  - Priority areas of QOF work
  - Influenza QOF targets
  - Trial high risk Covid groups (multi-factorial risk model – currently based on the ALAMA Covid-age model. Deprivation is one of our best proxies for need/unmet need – the combined risk score e.g. ALAMA, QCovid will help go some way to prioritising people based also on deprivation.)

Next Steps

- **Stage 2 - wider system wide programme of work that will include:**
  - An inclusive communication and engagement plan for co-design
  - Having clear definitions and aligning vulnerable, health inequalities, medical vs non-medical and social determinants of health
  - Building on the integrated ways of working and scaling up as part of a preventative, proactive, personalised approach to integrated care.

- **Governing Body seminar around the risk stratification work and the Covid age adjusted approach (1st December 2020)**

5. Covid Virtual Ward

- NHS E/I with the Academic Health Science Network (AHSN) to support the continued set-up of 'COVID Oximetry @home' services (also known as 'COVID virtual wards')
- This is one of the priority goals for the additional £150m General Practice COVID Capacity Expansion Fund
- Detect earlier deterioration of people with COVID-19, both in the community and in care homes.
- In BNSSG initial tranche of the VW will be deployment into care homes - GPs/Sirona are actively leading and coordinating this work, acute clinicians also collaborating
- Building on existing but isolated work in BNSSG to ensure effective system coverage

Covid Virtual Ward Continued

- Current focus is to support specific cohorts at risk of silent hypoxia and reduce pressure on step-up processes
- Aiming for a coordinated deployment into care homes, with a plan to deploy further into community shortly after that
- Key benefits from early diagnosis are shorter (and less intensive care required during) hospital stays
- Clinical and logistical are risks currently being flagged and resolved through daily stand-ups
- VW for discharge processes once this initial deployment is in place – already NBT pilot we need to learn from
- AHSN supporting with learning from other areas

6. Mass Vaccination – Primary Care Enhanced Service

- The vaccines being developed **require two doses per patient, with a 21-28 day gap between doses.**

- **Eligible patients will be confirmed soon,** but are expected to be in line with the latest JCVI (joint committee on vaccination and immunisation) recommendations.

- **Similar to the flu groups,** they include:

✓ all over the age of 50
✓ those at high risk
✓ care home residents and staff
✓ all health and care workers (although it is unlikely that general practice will be required to deliver to all health and care staff who may get it from their employer).
✓ the high priority groups will be vaccinated first, and as the vaccine becomes more available, practices will be able to provide this to increasing numbers.

What the Service Involves - Based on the Information Currently Known

This interim ranking of priorities is a combination of clinical risk stratification and an age-based approach, which should optimise both targeting and deliverability. A **provisional ranking of prioritisation for persons at-risk** is set out below:

- older adults' resident in a care home and care home workers[1]
- all those 80 years of age and over and health and social care workers[1]
- all those 75 years of age and over
- all those 70 years of age and over
- all those 65 years of age and over
- high-risk adults under 65 years of age
- moderate-risk adults under 65 years of age
- all those 60 years of age and over
- all those 55 years of age and over
- all those 50 years of age and over
- rest of the population (priority to be determined)[2]

[1]The final decision on the prioritisation for health and social care workers will be dependent on vaccine characteristics and the epidemiology at the start of any programme.

[2]A risk-benefit assessment would likely be undertaken in advising on vaccination in group

What the Service Involves - Based on the Information Currently Known

- The ES includes provision of vaccinations to housebound patients via home visits, as well as staff and residents of care homes. Community service providers will be expected to play a role in this service, **particularly with housebound patients, as many do with flu immunisations using practice stocks.**

- Practices will **be able to vaccinate their own staff and be paid for doing so**.

- **Alongside the general practice-led service, other providers (likely to be NHS trusts) will be commissioned to provide the programme through other means, probably via regional vaccination centres** in a similar way to the testing centres.

- Local pharmacies may be commissioned where general practice coverage is not enough.

- National and local public campaigns **will advertise the services on offer, and which patients are eligible.**

How the Service Will Operate

- **Due to the logistics of delivery and characteristics of the vaccines, the service needs to be delivered at scale. The current assumption is that it will need to be done through groups of practices working together (likely along PCN (primary care network) geographies)**, with one designated vaccination site (ideally to be a GP practice). That would be determined by the practices involved.

- As vaccines become more widely available **it is possible that more than one site could be possible within each grouping.**

- **Working together, practices will need to be prepared to offer vaccinations seven days a week so that the vaccine is delivered within its short shelf-life** and so patients receive it as soon as possible. **Specifics around delivery of the service will depend on matching patient demand and vaccine availability**.

Call and Recall System

- **A national call and recall system will be used, in addition to practices operating their own call and recall systems** if they wish to do so.
- **Patients can choose to attend either their local general practice-led designated site, or a regional immunisation service.**
- If patients choose the local site, **practices will need to contact patients to book an appropriate time.**
- **Practices will be able to use the national booking system** instead of their local booking system if they choose.

Administering the Vaccine

- A **registered healthcare professional will need to carry out the clinical assessment and consent.** A **suitably trained non-registered member of staff will be able to administer the vaccine itself under clinical supervision.**

- This **could include staff from the relevant practices, from the PCN, as well as volunteers and other NHS staff** – as decided by the relevant practices. There is an **expectation that staff will be required to undertake appropriate training in advance**. Other **staff assisting in an administrative capacity would not be required to undertake the training**, but an information pack will be provided.

- **It will be for practices to determine how they work together to deliver the programme**. For instance, practices could operate a rota using their teams to immunise their own registered patients in different sessions during the week. Or, they may wish to employ a dedicated team to do this on behalf of all practices, or for some practices to act on behalf of others.

- Once the vaccine has been administered, **patients must remain under clinical observation for 15 minutes.**

- Patients would need to be **contacted again to book in their second appointment** (or this could be done at the time of administering the first) allowing for the appropriate gap. **Patients will need to receive the second dose from the same provider**.

Finance Update – Enhanced Service

- Practices will be provided with the vaccines, needles, syringes, diluents and PPE.
- A **£12.58 IOS (item of service) fee will be provided per dose.**
- This will be provided through a single payment of **£25.16 upon completion of the second dose.**
- Should it **not be possible to administer the second dose, one IOS can be claimed.**
- We **anticipate additional local funding, in line with the additional funding for the flu programme arrangements** (for example for hire of venues, additional storage etc). This is currently being worked through
- We have been **informed that nationally there will be £150 Million, locally this is £2.4 million of further support from NHSEI** for **additional capacity, ring fenced for general practic**e until the end of March 2021. **This funding is not part of the CVP** (COVID-19 vaccination programme) service, but will sit alongside it and should ease other pressures in general practice to allow prioritisation of the CVP. Further detail provided on the next set of slides

7. Covid Capacity Expansion Fund

- 2.4 million allocated to BNSSG – funding is ring-fenced for use in general practice
- ICSs and CCGs to determine how best it is spent within general practice - with a focus on simplicity and speed of deployment, within the following parameters.
- CCGs should not introduce overly burdensome administrative processes for PCNs and practices to secure support.
- Accessing the fund will be conditional on practices and PCNs continuing to complete national appointment and workforce data in line with existing contractual requirements.
- **Where an individual practice is not yet accurately recording activity that is broadly back at its own pre-COVID levels, it is expected to do so as part of accessing the fund** - CCGs should seek to understand and support the relatively small number of practices that are finding restoration of their activity most difficult.
- ICSs to confirm the 7 goals have been achieved (next slide) money is non re-current and should not be used to fund commitments beyond 31 March 2021.
- Covid vaccine delivery is additional to this funding

Parameters – Expectations/7 Priority Goals

1. Increasing **GP numbers and capacity**

2. Supporting the **establishment of the simple COVID oximetry@home model**

3. First steps in **identifying and supporting patients with Long COVID**

4. Continuing to **support clinically extremely vulnerable patients and maintain the shielding list**

5. Continuing to make inroads into the **backlog of appointments including for chronic disease management and routine vaccinations and immunisations**

6. On inequalities, making **significant progress on learning disability health** hecks, with an expectation that all CCGs will without **exception reach the target of 67% by March 2021** set out in the inequalities annex to the third system letter; and **actions to improve ethnicity data recording in GP records**

7. Potentially **offering backfill for staff absences where this is agreed by the CCG**, **required to meet demand, and the individual is not able to work remotely.**