LMC Report on general practice webinar Thursday 12 November.

Dr Nikki Kenani Medical Director for Primary Care at NHSEI admitted to doubt, uncertainty and even worry that surrounded the proposed CV19 vaccination campaign and primary care's role in it. She promised to bust some myths.
Dr Jonathan Leach NHSE Associate Director for Armed Forces & Veterans and a GP in Worcestershire had taken the lead for vaccination spoke next pointing out neither the Pfizer nor Astra Zeneca candidate vaccines were licensed but would give what was known currently. Licensing was expected in a few weeks. They had very different presentations and requirements. He had personally given 200 vaccines in the trials. Vaccinators would have to be familiar with the different vaccines and lay vaccinators to undergo training.

Pfizer's has been designated Courageous (mRNA) and the other Talent (adenovirus vectored). Both required drawing up and two doses.
Courageous was being manufactured in Belgium and required ultra-low temperature storing before defrosting and diluted. Each vial would provide five doses presented in a "pizza box" of vials.
Talent was somewhat less demanding of storage requirements but would also come in multi dose vials.

The JCVI cohort prioritisation with age stratification was outlined.

Phase III trials had not yet been published. There was no data on how long protection would last or need for boosters. Adverse effects so far were typical for other vaccines and mild.
The post vaccination observation period had been changed by PHE to simol6 recommending not driving for 15 minutes in case of a vasovagal.
Consent would need to be obtained in advance and so those without capacity in care homes would have to relatives consulted, or if not possible, action taken in best interests as with any other vaccine.

Mark Sanford-Wood of deputy chair of GPC spoke next about the rapidly evolving situation. He said GPs were uniquely placed to give this vaccine and all wanted it to work. A contract had been drawn up necessarily quickly. He settled that this was not a Directed Enhanced Service but an Enhanced Service as the former would be harder to change contractually as would be needed. The contract required practices to work together to help better stratify delivery to the target groups. PCNs were not the only practice groupings that could be used. Non registered patients could be vaccinated such as Care home and practice staff who might live in another area. The JCVI cohorts were likely to be finalised soon.
The 8-8 7/7 Delivery at vaccination hubs had worried many but MSW stressed this was intended to be an ability rather than an expectation. The point was not to waste vaccine that would expire over a weekend or bank holiday. Local flexibility to prevent wastage would be allowed.
Prioritisation of other work was next with LTC management in QOF suspended. In conjunction with RCGP the BMA had produced guidance on prioritisation and indeed deprioritisation of normal work.
On call and recall practices/PCNs could use the national system or devise its own.

CNSGP would indemnify all those involved in vaccination. NHS Resolution had confirmed earlier that voluntary workers would also be covered.

Nikki Kenani and Ed Waller addressed the matter of why one site per PCN and this was largely due to the presentation of the vaccine and a need to simplify the supply chain. As understanding of these factors changed so might the number of sites.

The 8-8 7/7 question was again raised and it was stressed that there was no expectation that this was to be the case unless there was vaccine to give. It would depend on vaccine supply. A staff rota for potential extra shifts was suggested.
How patients would know that vaccine was suddenly available at a given site through any call and recall service was not covered.

General practice would be a part of the process, given its wonderful record in giving vaccinations, but other sites like mass vaccination centres would be set up. Local systems would have to agree the division of labour.

The £150m of re-prioritised capacity funding (£1.43m) was ring fenced for general practice. NHSE had directed CCGs to modify LESs to release capacity as they had enhanced and improved access. ARRS staff could be redeployed e.g. clinical pharmacists as vaccinators.

Access to other workforce would be detailed later but these would include vaccinators, “drawers-up”, HCAs, volunteer stewards. St John’s Ambulance was likely to be involved.

The supply chain was, as we had seen, integral to the process. The designation of the PCN site was to help with regional planning and the assumption was that vaccines would be given at the site to which they had been delivered.
How the housebound and those in care homes - the first JCVI priority cohort - would be vaccinated was therefore obscure. (But we do know that defrosted, diluted and drawn up vaccine can last for some hours so could surely be taken away by visiting staff?)

All staff would have to undergo free online PHE/HEE training suited to qualification.

There will be centrally produced information for patients including a consent form in printed and online form. Practices would not have to print things out.

Funding was £12.58 per vaccination paid on the final dose of the same vaccine making £26.16 (with exemptions allowed). Consumables and PPE would be provided. Local commissioners would be able to help with one-off costs such as venue hire. This did not appear to be part of the £150m.

Site designation and declaration of interest deadlines had been pushed back to Tuesday 17th November at the latest with submission by 19th.

The ES was like childhood vaccinations, offered to all practices and could not be amended locally.

However local requirements like rurality could mean there was more than one site per PCN without their going over the 100,000 population number. Equally more than one PCN could share a site.

CQC had published information on its website about new site registration. GPC had agreed that a lead practice could simply submit a change to its statement of purpose as it was the service that was regulated.

Returning to the £150m Fund EW said that CCGs should not have “overly onerous” administrative processes to make a claim. The seven priority goals were recounted including CV oximetry. Work on long CV as well as backfill and “additional salaried roles” at least in the short term temporarily. Flexible pools of GPs like returners would also be supported. NHSEI was well aware that staff were in short supply but wanted to be helpful.

Towards the end the question of housebound patients was considered and NHSEI wanted to support this within the vaccine characteristics but this “needed to be worked on and thought through collectively.”

NK felt that staff working over Xmas was “very, very unlikely” unless a sudden glut of vaccine appeared but then went on to say she’d be happy to work that day after Dwali was over and other community groups might not mind either. Nevertheless we all deserved a rest and a celebration.

Dr Barry Moyse

12.11.20