**COVID Vaccine Site Collaboration Agreement**

**DRAFT AGENDA**

1. Introduction
2. Site profile
3. Population and cohorts
4. Staffing
5. Financial arrangements
6. Data sharing agreements
7. Indemnity
8. Future meetings

NOTES – (Decide whether you want to forward this to practices, or walk them through it in the meeting then let them have it)

1. **Introduction.**Cover that this is a legal agreement between practices, not PCNs, that DOES NOT amend any primary medical services contracts, but it is a formal agreement with both duties and benefits attached for all practices. Give the positive case for doing it!
2. **Site profile:**This section will give you the info you’ll need for Schedule 1 of the Collaboration Agreement.
- Cover likely patient throughput per week.
- Cover that it is practices acting as one to deliver the vaccine
- Cover who is clinical lead, admin lead and other key contacts.
- Cover that it may be necessary to have extended working over seven days depending on supplies.
- Cover short and mid term plans. Do you intend to ramp up capacity if proven successful, or are you starting at 100%?
3. **Population and cohorts**This section will give you the info you’ll need for Schedule 2 of the Collaboration Agreement.
- Cover the list of cohorts and that they are likely to be released nationally rather than locally. Share the cohort definitions if the practices haven’t seen it.
- Cover what that means for this site. Share the per-PCN cohort breakdown provided
- Discuss how you’ll handle care homes and housebound when vaccine allows
- How will you cover care home staff?
- How will you fit in your practice staff based on their risk profile? Will you phase them through due to likely side-effects of vaccine, or do as many as possible as early as possible?
- Discuss how you’ll handle the phasing between dose 1 and 2, and what this means for the site if you start at 100% capacity immediately (Weeks 4-7 are likely to be primarily dose 2)
- How will you allocate appointments to practices given supply limitations? First-come, first-served? Fixed allocations, with waiting lists?
- What anti-wastage plans do you have? If you’re overbooking, discuss overbooking ratio. If you’re having standby lists, show how you’ll justify this within the cohorts for payment.
4. **Staffing**It is important to cover this BEFORE you get to the financial section.

Meeting pre-work required:
Have you done a vaccine line calculation of the staff you need from first appointment booking, to site reception, to consent, to physical vaccine, to second dose appointment, and so on? How will this work for your site?

Have you scaled your line to meet 300+ vaccines/day from your site? Do you plan multiple simultaneous supply drops (600+ vaccines/day)

Have you worked out a rota (without names attached) to show the clinical, non-clinical and admin staff needed to meet that?

Meeting discussion:
How do you propose to staff this? The three scenarios are:
- completely staffed by practice staffed
- completely staffed by locum/temp staff
- hybrid model

The practice staffing model is the cheapest, but it is likely to put significant staffing pressure on practices. It’s also the most patient-friendly model as the patients know these people, and these people know the area and residents.

The locum/temp model is the most expensive, but will stretch the per-dose payment and reduce the local knowledge you can apply to both the residents and area.

You can create a hybrid model of both, planning to staff internally where you can but topping up with locum/temp. For example, how will you cover evenings/weekends?

**PAUSE** there, do not complete this with firm agreements. Come back to it after the next section.
5. **Financial arrangements**This section will give you the info you’ll need for Schedules 3-8 of the Collaboration Agreement.
This is the bit that will make the agreement come together. Significant pre-work is needed.

Meeting pre-work required:
Have you calculated a per-vaccine cost based on the above staffing options? Make sure this is split into costs incurred by the host site and the practices themselves.

Have you got example locum/temp costs? EXAMPLES ONLY are:
- GP at £85-£95/hr
- Pharmacist at £50-£60/hr
- Nurse at £40-£50/hr
- Highly skilled HCA (or equiv) at £20-£30/hr
- Lower skill HCA at £20/hr
- Admin at £15/hr

Do you propose to pay practices flat open-book costs for their staff sent to the vaccination site? Do you propose to pay a premium to the practices to compensate for disruption? Do you propose to pay all practices the same higher locum/temp cost to allow them to backfill as needed?

Do you know how much GROSS payment practices can expect per-dose? This is per dose payment of £12.58 minus the host site staffing and site costs.

Do you know how much NET payment practices can expect per-dose? This is the GROSS payment minus expected practice direct vaccine costs. This is the raw surplus per-dose practices can expect.

(Note, GROSS and NET are all capitals to highlight their importance)
Meeting plan:
Start by walking the practices through your plan for funding your costs. Describe the NHSE funded bits, including all vaccine and consumable costs and that these are not the practices’ costs.

Walk them through how you got to your per-dose costs for both their practice work and the host site work. Encourage discussion here as they may help you improve it or cover things you’ve missed.

Discuss the GROSS payment to practices and likely NET income. Challenge practices to work in their own practices using their own practice-specific circumstances to make this more efficient, if they can.

Remind practices that payments will be made to one agreed practice for the entire vaccination site but only after the second dose is given. It will be distributed from there to all practices as agreed above.

Discuss who is paying for locum/temp staff. How will you fund any cash-flow shortages while waiting on the per-dose funding to arrive? What other funds do you have to cover this, and how will you pay/repay it? Remind practices that any cash-flow issues are going to be very short-term only.

Will you retain some of the GROSS or NET payments to build a fund for costs? Or will it all be distributed in full as it arrives?

Now, step back to the staffing arrangements (4 above) and see if they still agree with the plans. Allow time for a discussion.

Finish with a summary.

You will now have the information needed for Schedule 3 to 8 of the Collaboration Agreement, as follows:
- it will allow you to define the service in Schedule 3. Keep to bullet points
- it will allow you to complete the staffing section in Schedule 4.1. Overwrite parts of this as needed
- it will allow you to define the financial arrangements in Schedule 5.
- it will allow you to clarify if any formal sub-contracting in Schedule 6. As a minimum, you are sub-contracting the physical vaccination process to the host site. Document this but keep it generic where possible to entire groups rather than overly specific. Define whether it’s only on-site vaccinations or are housebound/care homes being kept to practices?
- document your governance arrangements in as few bullets as possible. Who is clinical lead, how will you assure practices about finances, staffing and clinical safety? Standard stuff, but critical.
- Schedule 8 is a blank, but is meant for agreements you have with third parties, be it other NHS bodies, local authorities, volunteer agencies, and so on. You could even put in bits around transparency including agreements with individuals.
6. **Data sharing agreements**Walk through your existing data sharing platform between practices and any clinical systems you use. How can you safely share data? This will be fine for most as they’ll already be in place, but it is your responsibility to ensure they work as intended. If you need a new data sharing agreement then place it in Annex 1 of the collaboration agreement. If you don’t, simply refer to the existing agreements for completeness.
7. **Indemnity**General liability is in clauses 34-40 of the draft collaboration agreement (pages 5-6). Staffing liability is in the draft parts of Schedule 4.1 (page 24-25)

Walk this through with the practices and ensure they’re aware of their liabilities
8. **Future meetings**What do your practices want here? Do they want to be heavily involved? Do they want to be left to get on with their patients? Are they happy to delegate items to their PCN CD or clinical lead?