Claiming reimbursement for reasonable additional costs for flu delivery

Guidance for NHS regional teams, clinical commissioning groups and GP practices

Introduction

1. NHS England and NHS Improvement have made available an additional £15.4m to local systems and primary care providers to cover reasonable additional costs (over and above the usual fee structures) associated with this year's extended flu programme. This is in recognition of the fact that considering social distancing, some flu providers may need to adopt alternative delivery models – eg drive-in vaccination or mass vaccination clinics – as well as deliver vaccinations from alternative locations.

2. The breakdown of the additional funding is:

    - GP practices and CCG costs: £12.2m
    - Community pharmacies costs: £3.2m

3. There are two scenarios covered by this guidance:

    - Costs incurred by GP practices/primary care networks (PCNs).
    - Costs incurred by clinical commissioning groups (CCGs) on behalf of local providers (GP practices and community pharmacies).

A separate guidance document sets out the process for community pharmacy claims.

What can CCGs and GP practices claim for?

4. Funding will be restricted to contributions towards the costs of:

    - additional venue hires and associated costs (signage, external temporary shelters)
    - additional fridges/mobile cold storage.

5. Claims will not be authorised for costs that are already funded via other routes, such as other national funding streams, the vaccination Item of Service fee, existing GP contract or CCG funding or locally agreed contracts. The funding will therefore not cover:

    - additional staff costs
    - routine vaccination consumables ie syringes, disposal of sharps
    - PPE
    - communications and advertising.

6. The £12.2m funding could cover both additional expenses incurred by practices and community pharmacies, as well as costs incurred by CCGs on behalf of local providers. There may be scenarios, for example, where it is agreed locally that CCGs decide to hire additional venues and make them available as a ‘free good’ to practices/pharmacies. Applications from practices/pharmacies that demonstrate joint working and collaborative delivery approaches with other local providers will be encouraged.

How do CCGs and practices make a claim?

7. This funding can be accessed by general medical services (GMS), personal medical services (PMS) and alternative provider medical services (APMS) contract holders with a registered patient list. All claims made in respect of costs incurred from 1 October onwards will need pre-authorisation by the commissioner. Any claims from practices incurred between 1–30 September are payable at the discretion of the commissioner. All payments made under this scheme will be made to GP practices under Section 96 of the NHS Act 2006 (as amended) “Assistance and support: Primary Medical Services”.

8. Practices should submit actual claims with any associated evidence or invoices in line with the guidance to the CCG (or regional team where their CCG is not delegated) within six weeks of the date of pre-authorisation. Commissioners should aim to process actual claims promptly in line with usual processes.

Commissioner approval process for GP practices

9. Each CCG has been allocated an indicative budget for GP practices and CCG costs in annex 1. CCGs are expected to manage the claims from practices and any costs incurred by the CCG on behalf of local providers within this fixed funding envelope and in line with the guidance in our letter dated 4 August 2020. If a CCG exceeds their fixed funding envelope, this is at their own risk.

10. Commissioners may require an appropriate portion of claims to be repaid – or set off against practice global sum or such other monies due under the GP contract – if funding was outside the terms of this guidance. Commissioners should consider any exceptional circumstances in making these judgements. In accessing support, practices agree to this process.

11. Where the claim is not approved, the CCG will reject and return to the practice to review and resubmit if appropriate.

12. The commissioner should include the details of the flu programme expenses in their non ISFE submission. There will be a specific column included on the COVID worksheet within non-integrated single financial environment (ISFE) for this.

CCG payment to practice process and coding

13. Once the practice has submitted a claim for payment which has been approved the CCG needs to process a manual payment transaction with a description of **flu programme costs** which must be coded to:

    - the **CCG CORONAVIRUS A1 code**, AND:
    - the appropriate **Practice A2 code**; and broken down using the following subjective codes:

CODE	DESCRIPTION (FULL)
521610K6	Clinical And Medical Goods & Services - Supplies and Services - APMS LES Childhood Seasonal Influenza GP Enhanced Service
521610MB	Clinical And Medical Goods & Services - Supplies and Services - GMS LES Influenza
521610PX	Clinical And Medical Goods & Services - Supplies and Services - GMS LES Childhood Seasonal Influenza GP Enhanced Service
521610RY	Clinical And Medical Goods & Services - Supplies and Services - PMS LES Influenza
521610SS	Clinical And Medical Goods & Services - Supplies and Services - PMS LES Childhood Seasonal Influenza GP Enhanced Service
521610UQ	Clinical And Medical Goods & Services - Supplies and Services - APMS DES Influenza & Pneumococcal
521610VA	Clinical And Medical Goods & Services - Supplies and Services - GMS DES Influenza & Pneumococcal
521610VY	Clinical And Medical Goods & Services - Supplies and Services - PMS DES Influenza & Pneumococcal
521610K6	Clinical And Medical Goods & Services - Supplies and Services - APMS LES Childhood Seasonal Influenza GP Enhanced Service

14. The transaction once approved will be available to pay on the CCG's next scheduled payment run.

15. CCGs should ensure that all payments recorded against the fund are coded correctly in the ledger, including retrospective ones.

16. CCGs should check that all expenditure is correctly reflected each month in their non ISFE submission.

Claims process for costs incurred by CCGS on behalf of local providers

17. Claims from CCGs in respect of costs incurred on behalf of local providers are subject to the same rules and timescales which apply to practices (apart from pre-authorisation is not required). Where total claims exceed the available funding envelope, CCGs will need a transparent process for prioritising claims.

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