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Financial Planning

Financial viability is key when setting up a Women's Health Hub; adequate funding has been found to be a key driver when setting up and developing provision of women's health services in primary care.

Words by:
Richard Scarborough

SITUATION | SOLUTION | SUCCESS

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Financial viability is key when setting up a Women's Health Hub; adequate funding has been found to be a key driver when setting up and developing provision of women's health services in primary care. Where the funding for provision of services comes from needs to be determined along with the costs of providing various services, whether it be long acting reversible contraception (LARC) or the treatment of common gynaecological conditions, for example heavy periods, fitting of ring pessaries, and menopause services.

An illustration of what needs to be considered for inclusion when preparing a business case to develop a sustainable LARC service has been prepared by *Richard Scarborough, Commissioner for Manchester.*

GREATER MANCHESTER SEXUAL HEALTH NETWORK LARC COST MODEL

Introduction

Across Greater Manchester and nationally there is a wide variation of prices paid for primary care LARC, often based on historic arrangements that have not changed for some time. There is also a widespread assumption that payments do not generally cover costs.

The lack of information on the cost of delivering LARC within primary care is a barrier to increasing capacity and makes it difficult for commissioners and Primary Care Networks (PCNs) to build business cases for alternative delivery models and increasing capacity.

The financial return of investment for LARC methods of contraception is clear, however, services need to be funded appropriately and financially viable for providers to invest in them and opt to provide them.

The Greater Manchester Sexual Health Network is developing proposals for the delivery of LARC via Primary Care Networks. The PCN model will feature inter-practice referral and delivery via dedicated procedure clinics rather than ad-hoc appointments. As part of these proposals a cost model was required to both inform the pricing of services and to model the costs of increasing capacity.

In order to make proposals for the pricing of LARC within Primary Care we needed to establish the baseline cost of delivering the service.

Development of the model

A clinical reference group (CRG) of GP LARC fitters from across Greater Manchester was formed to advise on the costing process with information being sent to them to review and comment on alongside online focus groups.

The cost model was developed in an iterative process alongside the development of the PCN model of LARC delivery.

The reference group was consulted on staff time required for each LARC procedure, baseline costs of staff and cost of consumables which are the basis of the costing and also wider issues such as paying for failed fits, Did Not Attends (DNAs), ratio of coil checks and ratio of LARC removals that are replaced in the same appointment.

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Assumptions

The model reflects the GM delivery model and should be adapted to reflect local differences.

- Contraceptive counselling is not included in the activity and is assumed to have been completed prior to a referral for the procedure.
- The patient will have received information on the method and any pre-appointment instructions etc.
- Costs do not include anything for premises etc as these are already funded.
- Cost of implants not included as these are prescribed via FP10.
- Cost of devices not included as these can be claimed via FP34PD 'personally administered item'.
- Cost of local and topical anaesthetics and skin closure strips not included as claimed via FP34PD 'personally administered item'.
- Time has been allowed for a telephone consultation for taking consent, confirmation of counselling and suitability for the chosen method, and giving pre-appointment information.
- It is assumed that patient records, including contraceptive assessment, will be shared by EMIS/SystemOne/vision for interpractice referrals.
- For IUD/S insertion where a Clinical Support worker (CSW)/ Health Care Assistant (HCA) is required for the fitting, the CSW/HCA has been allocated for the full duration of the appointment.
- The fitting practice will provide follow-up care for 6 weeks after which the patient will be discharged to their own practice.
- Payment will be made for any attempted fit or remove.

In developing LARC capacity some providers have not been aware that LARC payments do not include the costs of implants and devices. This may explain some of the belief that services are underfunded.

Whilst in Greater Manchester the cost of implants and devices would go back to the CCG prescribing budget, in some areas the budget sits with the Local Authority and payments would need to reflect this.

Within the GM model the following assumptions are made about follow-up and IUD/S checks.

- IUD/S checks are not booked in routinely. Patients are advised as part of the fitting appointment when to contact the fitting practice for follow-up advice.
- Telephone-based follow-up advice and face-to-face appointments will be provided by the fitting practice for up to 6 weeks after LARC fitting, after which the patient will be discharged to their own practice.
- The reference group estimated that 20% of patients will require a follow-up phone call after an IUD/S fit and 50% of these will require an additional face-to-face appointment.
- Follow-up to consist of a 10 minute phone consultation followed by a 10 minute face-to-face consultation where required.
- For modelling purposes, it is estimated that this would add 20 minutes telephone consultation and 10 minutes face-to-face consultation for every 10 procedures. This figure needs to be confirmed during pilot.

For DNAs a fee will be paid for any face-to-face appointments for LARC fit, remove or replace that are missed. DNAs will be paid at a flat fee of £20.00 per missed appointment. This equates to 13.3 minutes of GP time @£90 per hour or 29 minutes of a band 8a nurse @£40.20 per hour.

The DNA payment recognises that some of the appointment time may be wasted, but there is also opportunity to make phone appointments during this time.

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Timings

The following timings for each activity were developed in consultation with a clinical reference group of GPs from the 10 Greater Manchester Boroughs. A range of timings were initially suggested by clinicians which may have reflected different levels of experience and different models of current delivery compared to the proposed delivery.

For local implementation these can be used as the basis to develop timings based on local delivery models and clinical experience.

Task	Role	IUD/S fit	IUD/S replace	IUD/S removal	Implant fit	Implant replace	Implant remove	IUD/S Phone advice	IUD/S Check appointment
Registration	Blend admin/ clerical	5	5	5	5	5	5		
Pre-consult phone	Dr/Nurse	10	10	10	10	10	10		
Consultation	Dr/Nurse	5	5	5	5	5	5		
Insertion	HCA/CSW	30	40						
Insertion	Dr/Nurse	25	25		15	10			
Removal	Dr/Nurse		10	10		20	20		
IUD Post fit advice phone	Dr/Nurse							10	
IUD Check appointment	Dr/Nurse								10
Appointment length minutes		30	40	15	20	35	25	10	10

Staffing costs

The Personal Social Services Research Unit (PSSRU) produce annual unit costs of health and social care and this has been used as a baseline for staffing costs.

- Unit costs of health and social care 2019/20[1].
- For the purposes of this analysis the net remuneration has been used. (The PSSRU also give a cost that includes direct care staff, admin and clerical, office and general business, premises, other (advertising, promotion and entertainment) and car/travel and capital premises costs.)
- The salary and on costs have been divided by productive working hours as defined by PSSRU to give an hourly rate.
- PSSRU does not give an hourly rate for band 2 or 3 so band 4 used for both clerical/admin and CSW/HCA however HCA/CSW likely to be band 2/3.

Consultation with the clinical reference group suggested that the cost per hour for a GP fitter should be £90 (£1.50 per minute) to reflect the cost of sessional backfill and this was used as a maximum staffing cost for the model.

In setting LARC pricing and building business cases consideration should be given to the staff mix that is delivering the service. This is particularly important where delivery will be via clinics with a mixed team of clinicians delivering.

1 https://www.pssru.ac.uk/project-pages/unit-costs/

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STAFFING COSTS BASED ON PSSRU UNIT COSTS OF HEALTH AND SOCIAL CARE.

GP Net remuneration £117,300 Hours 1791 Hours P/W 34.44 Per hour £65.50 Per minute £1.091 **Backfill rate** £90/hour	**BAND 8A (AFC £45,753 –£51,668)** Salary £47,915 Salary on costs £15,330 Total £63,245 Working Hours 1573 Hours P/W 30.25 Cost per hour £40.20 Per minute £0.67
BAND 7 (AFC £38,890 - £44,503) Salary £40,997 Salary on costs £12,945 Total £53,942 Working Hours 1573 Hours P/W 34.29 Cost per hour £31.85 Per minute £0.57	**BAND 6** Salary £34,250 Salary on costs £10,618 Total £44,868 Working Hours 1573 Hours P/W 30.25 Cost per hour £28.52 Per minute £0.475
BAND 5 Salary £27,350 Salary on costs £8,239 Total £35,589 Working Hours 1573 Hours P/W 30.25 Cost per hour £22.62 Per minute £0.377	**BAND 4 (AFC £21,892 – £24,157)** Salary £21,929 Salary On costs £6370 Total £28,299 Working hours 1618 Hours P/W 31.11 Cost per hour £17.49 Per minute £0.291

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STAFF COST PER PROCEDURE – STAFFING COSTS BASED ON GP AT £90/HOUR AND FOR A BAND 8 NURSE

Task	Role	IUD/S fit	IUD/S replace	IUD/S removal	Implant fit	Implant replace	Implant remove	IUC Check Phone	IUD Check Face-to-face
Registration	Band 4	£1.46	£1.46	£1.46	£1.46	£1.46	£1.46		
Pre-consult phone		£15.00	£15.00	£15.00	£15.00	£15.00	£15.00	£15.00	
Consultation	GP	£7.50	£7.50	£7.50	£7.50	£7.50	£7.50		£15.00
Insertion	Band 4	£8.73	£11.64						
Insertion	GP	£37.50	£37.50	£0.00	£22.50	£15.00	£0.00		
Removal	GP	£0.00	£15.00	£15.00	£0.00	£30.00	£30.00		
TOTAL		**£70.19**	**£88.10**	**£38.96**	**£46.46**	**£68.96**	**£53.96**	**£15.00**	**£15.00**

Task	Role	IUD/S fit	IUD/S replace	IUD/S removal	Implant fit	Implant replace	Implant remove	IUC Check Phone	IUD Check Face-to-face
Registration	Band 4	£1.46	£1.46	£1.46	£1.46	£1.46	£1.46		
Pre-consult phone		£6.70	£6.70	£6.70	£6.70	£6.70	£6.70	£6.70	
Consultation	Band 8	£3.35	£3.35	£3.35	£3.35	£3.35	£3.35		£6.70
Insertion	Band 4	£8.73	£11.64						
Insertion	Band 8	£16.75	£16.75	£0.00	£10.05	£6.70	£0.00		
Removal	Band 8	£0.00	£6.70	£6.70	£0.00	£13.40	£13.40		
TOTAL		**£36.99**	**£46.60**	**£18.21**	**£21.56**	**£31.61**	**£24.91**	**£6.70**	**£6.70**

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Consumables

The clinical reference group were consulted on the range of consumables required for LARC procedures and provided details of kits they use.

There was a wide range of initial costs which may reflect the potential for providers to make efficiencies by using different kits and suppliers.

FOLLOWING CONSULTATION WITH THE CRG THE FOLLOWING COSTS FOR CONSUMABLES WERE AGREED:

IUD/S fit	IUD/S replace	IUD/S removal	Implant fit	Implant replace	Implant remove
£17.00	£18.00	£5.00	£3.00	£9.00	£7.00

TOTAL COST (TIME PLUS CONSUMABLES)

total costs based on different staffing costs plus consumables.

	IUD/S fit	IUD/S replace	IUD/S removal	Implant fit	Implant replace	Implant remove	IUC Check Phone
GP @£90/hour	£87.19	£106.10	£43.96	£49.46	£77.96	£60.96	£15
GP @PSRRU Rate	£70.83	£85.65	£33.73	£37.19	£59.55	£46.64	
Band 8a	£53.99	£64.60	£23.21	£24.56	£40.61	£31.91	
Band 7	£49.99	£59.60	£20.71	£21.56	£36.11	£28.41	
Current GM Average	£84	£103	£19	£59	£109	£50	
Current Manchester	£80	£100	£20	£68	£123	£55	£20

The table above includes the current average LARC payment rates across Greater Manchester and the current Manchester rates for comparison. Currently no GM Areas have a price for 'replace' so separate fit + remove payments are used. Implementing a 'replace' fee has a significant impact when comparing current rates with an implant replace costed at a maximum cost of £77.96 compared to current payment rate of £123 in Manchester.

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Costing analysis

An analysis based on previous Manchester activity levels and payments compared to the model, suggests that while individual activities may be costed differently, overall the current amount paid is similar to the analysed costs even when based on the maximum costing basis of £90 per hour.

The following assumptions were made in the comparison analysis:

- 40% of LARC removes were followed by a LARC fit
- 20% of IUD/S fits will require a follow-up phone call after an IUD/S fit and 50% of these will require an additional face to face appointment.

Business case and pricing considerations

The cost model can be used to inform business cases for LARC services comparing projected income at local payment rates to the modelled costs. For example, using the cost model and assumptions around the ratio of LARC removals to fits, the model estimates that an additional £670k would be needed to increase GM, GP, LARC activity to the England rate of provision.

The basis of the costing analysis in several areas may be considered to be generous:

- Main analysis based upon delivery by a GP at a rate of £90/hour to enable backfill. Nurse provision or provision based on salary and on costs is much less.
- Health Care Assistant/Health Care Worker (HCA/HCW) and administration based on Band 4 however likely to be band 2/3.
- Timings for activities are generous compared to some estimates.
- Consumables may be obtained at more competitive prices than the costs quoted.

This work does not consider the wider benefits to the primary care economy in terms of reductions in appointments for repeat pill prescription; prescribing emergency contraception; reductions in unplanned conception and associated activity.

In developing local services, consideration should be given to the staff mix delivering LARC services which will increase the service viability.

Viability may also be increased by accessing extended access payments to support out of hours delivery.

Implementation will need to consider how to fund elements not included, such as training, LOCs and FSRH membership.

"This work does not consider the wider benefits to the primary care economy in terms of reductions in appointments for repeat pill prescription; prescribing emergency contraception; reductions in unplanned conception and associated activity "

Greater Manchester implementation

The cost model will be used to inform pricing of LARC services in Greater Manchester with each area setting prices based upon local circumstances, including the need to incentivise delivery and the range of LARC fitters.

Individual PCNs are using the model to inform business cases for the development of PCN-wide LARC services and also more holistic services including cervical screening and potentially elements of community gynae.

Summary

The cost model elements can be used to inform local business cases and demonstrate financial viability of services or amended to reflect current and proposed models of delivery and calculate the financial impact of increasing LARC delivery.

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APPENDIX 1: CONTRACEPTIVE SERVICES INCLUDED IN PRIMARY CARE CONTRACT

Guidance page 90: https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf.
As of 1st April 2019, the following changes have applied:

Additional services

From April 2019, contraception services will no longer be an Additional Service under the Regulations but will become part of Essential Services. There will be no opt-out or reduction of global sum payments as a result.

This was the wording of contraception in the 2018/19 contract when it was an additional service:

9.3.1 The Contractor shall make available the following services to all of its patients who request such services:

(a) the giving of advice about the full range of contraceptive methods;

(b) where appropriate, the medical examination of patients seeking such advice;

(c) the treatment of such patients for contraceptive purposes and the prescribing of contraceptive substances and appliances (excluding the fitting and implanting of intrauterine devices and implants);

(d) the giving of advice about emergency contraception and where appropriate, the supplying or prescribing of emergency hormonal contraception or, where the Contractor has a conscientious objection to emergency contraception, prompt referral to another provider of primary medical services who does not have such conscientious objections;

(e) the provision of advice and referral in cases of unplanned or unwanted pregnancy, including advice about the availability of free pregnancy testing in the practice area and, where appropriate, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objections;

(f) the giving of initial advice about sexual health promotion and sexually transmitted infections; and

(g) the referral as necessary for specialist sexual health services, including tests for sexually transmitted infections.

Additional considerations – Indemnity

As demonstrated, financial viability and funding the provision of women's health in primary care is a priority when looking at developing a Women's Health Hub. As part of the development, it is important to take into consideration the cost of any indemnity that may be required depending on the model that is being developed. Indemnity for nurses, in particular, is a 'frequently asked question'. In order to deal with this the following information on the Clinical Negligence Scheme for General Practice (CNSGP) scheme may be useful.

'All providers of NHS primary medical services are covered under CNSGP, including out of hours providers. The scheme extends to all GPs and others working for general practice who are carrying out activities in connection with the delivery of primary medical services – including salaried GPs, locums, students and trainees, nurses, clinical pharmacists, agency workers and other practice staff.

In addition to NHS primary medical services, any other NHS services provided by general practice are also covered under CNSGP (namely, NHS activities carried out by or for a provider whose principal activity is to provide NHS primary medical services). These 'other' NHS services are referred to in the regulations that establish CNSGP as 'ancillary health services'. This means general practices are covered for all of their NHS services, including local authority commissioned public health services.

The place at which activities are carried out, the status of the person carrying out the activity, the form of the entity responsible for the provision of the NHS services in question and the individual circumstances of the patient concerned are not relevant to the scope of CNSGP. The question is whether the services provided are NHS primary medical services, and where they are not NHS primary medical services, whether they are NHS services provided by general practice [namely, by a provider whose principal activity is to provide NHS primary medical services]. This means that different kinds of organisations are covered under the scheme for activities they carry out which are in scope of the scheme.'

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