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Financial Guidance for consideration in developing a Women's Health Hub

- Understanding your local financial reimbursement pathways for LARC
- Centralising the model within Primary Care Networks
- Optimising the Additional Roles Reimbursement Scheme

Words by:
Dr Stephanie Cook

SITUATION | SOLUTION | SUCCESS

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INTRODUCTION

This resource highlights the importance of understanding your local financial reimbursement pathways for LARC devices, when to consider centralising the model with the Primary Care Network (PCN) and how to optimise the Additional Roles Reimbursement Scheme (ARRS).

Understanding your local financial reimbursement pathways (LARC devices)

Background

- The Health and Social Care Act 2012 divided responsibilities for commissioning sexual health and reproductive health between Local Governments, Clinical Commissioning Groups (CCGs) and NHS England. Local Authorities were directed to commission contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) under local public health contracts (such as arrangements formerly covered by Local Enhanced Services (LES) and National Enhanced Services (NES).
- Clinical Commissioning Groups were directed to commission contraception primarily for gynaecological reasons (non-contraceptive) purposes.

This fragmentation in commissioning resulted in many difficulties including contracting problems and, as a result, a number of collaborative arrangements have been developed between Local Authorities and CCGs. However, there remains significant variation in local practice and it is therefore important to understand the local financial pathway and reimbursement process when looking to improve or redesign services.

When setting up a Women's Health Hub to offer LARC provision, it is important to consider how you will order in your stock and equipment and how to claim the costs back. For example, if setting up LARC provision in general practice the options for sourcing implants and coils are different.

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Implants

For implants, the device needs to be prescribed on an FP10, the device can then be dispensed and delivered to the practice in time for the patient's appointment (or picked up from the pharmacy by the patient). Some CCGs in England will cover the cost of LARC devices, however in a few areas the local authority commissioner holds the budget for devices (in these situations, the process for how to claim the cost of devices back should be covered in the Local Service specification). Where the CCG covers the cost of the device, the money comes directly out of a prescribing budget for the local CCG (and practices don't need to bear the burden of the cost of the device upfront).

The advantage of prescribing LARC devices on an FP10 means that there is no upfront cost for the practice. Another benefit to this route is that no additional paperwork is required.

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Coils

For coils, in a general practice set up there are two main routes for obtaining stock. The first option is the FP10 route, as described for implants.

The alternative is that coils can be bought directly from a wholesaler. The cost is then claimed back through the FP34D monthly reimbursement form for personally administered items (or direct from the local authority if there is a local process in place). Historically this 'personally administered items' route may have yielded a small, but worthwhile profit for practices. However, this process has caused some confusion over the years. For example, coils are on the list of 'personally administered items' but implants aren't. Another concern is that, unfortunately, this process has led to the misunderstanding by some that practices are expected to cover the cost of the devices themselves. The profit margins for this process have fallen in recent years, and there is now some debate over whether this route leads to any worthwhile profit.

The upfront costs of buying coils can be expensive. For example, an IUS can cost between £66-£88, so 10 devices bought up front would be an initial outlay of up to £880. This potentially adds yet another obstacle to the delivery of LARC Services in primary care. However, some practices prefer this route because it enables them to keep additional stock of coils in case of an emergency or failed fit. It also avoids the patient collecting the prescription and then deciding not to turn up for the appointment. For example, if not counselled prior to picking up the prescription a patient may be put off by the size of the box the coils are packaged in. This results in wastage.

There is currently an application in place to request that contraceptive implants are included in the list of personally administered items.

In some areas a contract is held by a prime provider to deliver provision through several hubs in general practices or clinics throughout the community. In this scenario the contract holder may buy in the LARC devices in bulk and distribute directly to the hubs on demand resulting in no direct cost to the provider. This may apply to implants and coils.

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EXAMPLES OF LARC DEVICE CLAIM PROCESS

FP34D Claims Process (Coils only)

- Practice buys in stock directly from the wholesaler
- ↓
- Patient attends for LARC procedure
- ↓
- FP10 script generated for evidence of claim
- ↓
- FP10 scripts submitted with the FP34D form for personally administered items
- ↓
- Practice is reimbursed from the prescriptions prescribing authority

FP10 Process (Implants & coils)

- FP10 script is generated prior to the fitting appointment (stipulate 'deliver device to fitting surgery')
- ↓
- FP10 script sent to local pharmacy
- ↓
- Pharmacy dispenses and delivers device to fitting surgery in time for the procedure appointment
- ↓
- Some practices may prefer to ask their patients to collect the device and bring it to the appointment – however this can lead to wastage if the patient change their mind or forgets to bring the device along.

Local Authority Direct Reimbursement (Coils and implants)

Practice buys stock from a wholesaler or prescribes on an FP10

↓

Patient attends for LARC procedure

↓

Practice submits costs of device and fitting fees on a monthly return to Local Authority or Prime Contract holder

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CONSIDER CENTRALISING THE MODEL WITHIN THE PRIMARY CARE NETWORK (PCN)

In England, Long-Acting Reversible Contraception (LARC) services are commissioned by the Local Authority through a locally commissioned service (LCS) contract. A LARC service is an optional service that can be offered either at practice or at PCN level.

As these contracts are not agreed nationally, they vary across the country in scope and funding. Practices can decide whether they sign up to provide the service, it is not mandatory.

When developing a Women's Health Hub or a LARC inter-practice service, it may be advantageous to centralise the funds of the service from practice to PCN level.

Historically the contracts for LARC services are usually held at practice level. This means that the fitting practice claims the fitting fee reimbursements for the service whether it be coils, implants or both at the end of each month or financial quarter.

If a PCN were to consider developing a LARC service, it may make more financial sense for the PCN to claim the fitting fee payments (and possibly the device costs). Centralising the fitting fee claims from practice level can confer several benefits such as:

- The financial risk for the LARC service is taken away from an individual practice and instead the burden is shared across the PCN.
- The service can utilise the ARRS roles to help with workforce planning and financial viability (see next section). For example:
    - The network could advertise for one or more of the reimbursable administrative roles to help with organisation & day-to-day running of the service.
    - The network could advertise for one or more clinical roles (such as physicians associate or nursing associate) to help deliver the service.
- Profit from the LARC service can then be reinvested into the Women's Health Hub (e.g. to help develop other Women's Health Services, such as menopause care).

If a PCN claims the fitting fees, it is then important to work out how to fairly reimburse the fitting practices for their costs. These costs include:

- The cost of paying their staff (the LARC fitter and, where necessary, their assistant).
- The cost of their equipment.

One example of a reimbursement process can be found below. A spreadsheet can be developed to calculate an agreed cost for equipment & staff. The example below demonstrates how the activity codes can be easily linked to a search on the clinical system. For example, at the end of each financial quarter a search for all the codes which demonstrate activity, can be performed within the clinical systemic. Each code for a procedure can be linked to an estimate of equipment costs for that procedure (e.g. the cost of a coil fitting pack).

These numbers can then be transferred into a claim form (along with the number of hours each fitter has worked) and a spreadsheet will automatically calculate the total reimbursement for each practice. This is also a useful way of keeping an eye on the profit or loss of a service. (See below).

A2 | Quarter 1 (PCN)

	A	B	C	D	E	F	G	H
1	LARC Fitters Claims to the PCN							
2	Quarter 1 (PCN)							
3								
4	Total PCN Claims	Number	Amount claimable per item	Chaperone Cost	Total paid to practices	LES fee per procedure	Total LES Claimed	Profit/Loss of the practice service to the PCN
5	GP Session Cost (hours)	16.5	£ 100.00		£ 1,650.00			
6	Coil Insertions	14	£ 18.50	£ 8.50	£ 378.00	£ 100.00	£ 1,400.00	£ 1,022.00
7	Coil Removals	8	£ 4.50		£ 36.00	£ 38.09	£ 304.72	£ 268.72
8	Failed coil insertions	1	£ 18.50	£ 8.50	£ 27.00	£ 100.00	£ 100.00	£ 73.00
9	Failed coil removals	2	£ 4.50		£ 9.00	£ 38.09	£ 76.18	£ 67.18
10	Implant Insertions	3	£ 6.00		£ 18.00	£ 60.87	£ 182.61	£ 164.61
11	Implant Removals	2	£ 6.50		£ 13.00	£ 63.16	£ 126.32	£ 113.32
12	Failed implant insertions	0	£ 6.00		£ -	£ 60.87	£ -	£ -
13	Failed implant removals	0	£ 6.50		£ -	£ 63.16	£ -	£ -
14	DNAs	5	£ -		£ -	£ 24.83	£ 124.15	£ 124.15
15	Inter-Practice Referrals	17	£ -		£ -	£ 10.00	£ 170.00	£ 170.00
16	Total				£ 2,131.00		£ 2,483.98	£ 352.98
17								
18								
19								
20								

PCN Claims | Clinic 1 | Clinic 2 | Clinic 3 | Clinic 4 | Clinic 5 | Clinic 6 | Clinic 7 | Clinic 8 | ...

Author owned image, 2022 *Primary Care Network *Local Enhanced Services

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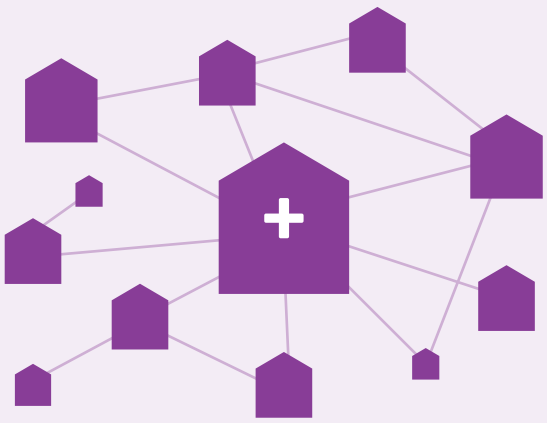
OPTIMISE THE ADDITIONAL ROLES REIMBURSEMENT SCHEME (ARRS)

Developing a Women's Health Hub is flexible and the model should be designed around the current local resources and identified needs. One model that proves popular and could be considered is to introduce inter-practice referrals within PCNs. In an inter-practice referral service, practices are set up to be a hub site and receive referrals from other practices within the PCN becoming the hubs.

PCNs have a workforce budget and are giving funding to employ additional roles for their network, the ARRS*. There are various additional roles to choose from, each of which can be recruited to support a variety of services within a PCN. These ARRS roles are 100% reimbursable, enabling extra support for a PCN and their practices. The scheme also provides a fantastic opportunity to drive down the overheads for a PCN or practice and help improve financial viability for the service.

What is a PCN?



A Primary Care Network (PCN) is a group of practices working together to focus local patient care. Through a PCN, practices can work together to help co-ordinate care for patients, share services and optimise resources.

Some of these roles can be particularly useful when developing a Women's Health Hub or LARC Service. For example:

- Nursing associates can be used to help assist with procedures.
- Pharmacists and physician's associates can be trained to fit implants and coils.
- The care co-ordinator role can give much needed administrative support to LARC clinics, for example, helping with appointment bookings, appointment reminders and equipment ordering etc.

What is the ARRS scheme?

Additional Roles Reimbursement Scheme is a summary term used to refer to a range of new, centrally funded roles which allow PCNs to establish multi-disciplinary teams to provide more integrated health and social care services locally. Designed to improve co-ordination between practices & reduce the burden on GPs, the PCNs have a workforce budget and can choose to recruit from a variety of roles.

The roles include:

- Clinical Pharmacist
- Pharmacy Technician
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Care Co-ordinator
- Physician Associate
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational Therapists
- Mental Health Practitioner
- Paramedic
- Nursing Associate

Why not arrange a meeting with your local PCN board to discuss utilising some of these roles for your service? You may be asked to develop a business case and a project development plan (these can be helpful for outlining how you plan to make the most of these roles in terms of workforce planning and financial viability).

*NHS England » Network Contract Directed Enhanced Service – contract specification 2022/23 – primary care network requirements and entitlements

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