PCPIP – Plan for Economics

Summary of plans for Economic Evaluation components of PCPIP

Supporting better quality health and social care for everyone in Scotland

Economic plan

- Economic evaluation looks at the value of interventions. We compare both the costs & benefits (and any risks reducing the extent of the benefits etc).

For PCPIP we're planning to explore this in 2 ways:

- A cost-consequence analysis (CCA) evaluating costs against range of (disaggregated) benefit measures regarding patients and/or staff working under the new GMS contract (quantitative data).

- Work to better understand MDT and GP staff efficiencies (e.g. time taken) for typical clinical practice tasks (pre-specified/standardized hypothetical caseload) and preferences for delegating/requiring supervisory support.

Cost consequence analysis

Data required include:
- Costs (local site data and insights, wider literature, routine national data sources) measured in GBP (£).
- Quantitative outcome measures pursued by each demonstrator site.
- Information on unintended consequences/risks & likelihood of events occurring.

Benefits/Challenges:
- Flexibility given need for demonstrator sites to prioritise their own areas for improvement/Can't predict what they will choose.
- Models specific to each demonstrator site/May need multiple bespoke models and unable to aggregate across demonstrator sites.
- Data expected from demo sites/Granularity is dependent on how well data have been collected.

Cost-consequence analysis – example(s)

Table 1: Possible consideration of costs and consequences

Team	Outcomes collected	Direction of change (disaggregated)	Potential options for aggregation at scale
Team 1	Costs Joy at Work Polypharmacy reviews OT appointments	£+ + 20% improvement in scores + 10% increase + 15% direct rather than referral elsewhere	Cost per acute referral avoided
Team 2	Costs Acute referrals Vaccines administered Training hours	£- -18% referred to acute -50% down compared to 2021 + for GP (5%) - for pharmacotherapist (10%) -for practice manager (5%)	Cost per unit change/minimum important difference in Joy at work
Team 3	Costs Joy at work Acute referrals Medicine reconcilliations	£+ 0% change in scores -20% referred to acute +10% patients whose medicines have been reconcilled in last year	Cost per medicine review

Value of improvement and efficiency

Potential range of outcome measures is huge – primarily patient focused:

- clinical measures (HbA1c levels and blood pressure), medication, process of care, service related (e.g. number of primary care appointments).
- Comparator is baseline.
- Generalisability may be poor at scale.

Efficiency can also focus on how staff roles are changing with MDTs:

- greater focus for GPs on patients with complex care needs.
- but delegating more tasks also = increased GP supervisory responsibilities.
- Possible shorter or longer GP staff/MDT working hours.
- Concerns around deskilling GPs/other effects of altering the range of cases they see (e.g. burnout) vs not sufficiently upskilling MDT roles or overburdening MDTs.

Exploring service design efficiencies #1

CMO Annual Report 2021-22 method to estimate the capacity gain associated with MDTs contribution to General Practice (Edinburgh HSCP).

Enhancing General Practice capacity indirectly and directly

Making the most of the MDT ensures time is used more effectively, reduces multiple appointments for the same issue, and frees up time for longer appointments, where required. Evaluation of MDT contribution (where MDT members are prescribers) in Edinburgh[13] has resulted in the following expectations emerging:

- One WTE practice-embedded Physio can augment workload capacity by the equivalent of five GP sessions (half days) per week;

- One WTE practice-embedded Community Link Worker can augment workload capacity by the equivalent of one GP session per week;

- One WTE practice-embedded Advanced Nurse Practitioner can augment workload capacity by the equivalent of six GP sessions per week;

- One WTE practice-embedded Mental Health Nurse can augment workload capacity by the equivalent of five GP sessions per week;

- One WTE practice-embedded pharmacotherapy team member can augment workload capacity by the equivalent of three GP sessions per week (average across a skill-mixed team); and

- One WTE practice-embedded qualified pharmacist would augment workload capacity by more than three sessions, and make indirect impact on workload through prescribing system improvement.

Exploring service design efficiencies #2

- We'll have week of care audit data, can talk to different groups of staff to understand typical (anonymised) caseloads.

- Health economics has methods that can be used to explore people's preferences about caseloads, using specific (hypothetical) scenarios.

- These methods used to ask people to choose between service options and choose the one they'd most like to attend (informing future service design) but can also be used with staff (e.g. retirement options).

- Can be questionnaires or face to face.

Discrete choice experiment example

	"A 45 year old patient comes to the clinic complaining about a cough they had for more than two weeks, and they also fell off a chair and hurt their back around the same time and were complaining about pain in their ribs"	
	Clinic A	Clinic B
Person who sees patient	You	MDT
Case is supervised	No	Yes, by another senior member of team
Time available to see patient	5 mins	15 mins
Site of appointment	Off-site	On-site
Patient queue at site	3 patients	5 patients
Choose (tick one box) where patient to be seen:	☑·	☐·

Contingent valuation example

Scenario 1: Consider
"If a 45 year old patient came to your clinic and was complaining about a cough they had for more than two weeks, and they also fell off a chair and hurt their back around the same time and were complaining about pain in their ribs"
How much time would it take you to see this patient? Prompts: Would you see them or delegate entirely, even triage in case they should be seen outwith Primary Care (0 mins?) Or triage but delegate to someone else/send patient elsewhere (2 mins?) Or supervise/sign off but not do the whole consultation (5 mins?) Or do the consultation but delegate any onward referrals or tests etc (10 mins?) Or conduct all aspects of consultation including onward referrals (15 mins?) Or would it be atypically long for a consultation (?>=20 mins) Any other factors (e.g. travel to a hub needed if on duty, staff absence/shortages, quality (would prefer to spend more time than that if I could but we'd probably be too busy)

Understanding staff preferences and efficiencies

Benefits/Challenges

- Expect there to be a % of caseload for Primary Care staff that is common to both GP and MDT staff, but different band/grade competencies could complicate this.

- Need core set of good examples, common in clinical practice (?exam questions, week of care audit, expert panel, qualitative data).

- Method can be used repeatedly but initial design phase is complex (scenarios need to vary widely to maximise information received from respondents). Validating estimates of time v actual time taken for similar case to scenario could be difficult.

- Staff may be receptive to talking about their preferences, but we also may get pushback from staff re: labelling their work in terms of the % of a GP WTE.