

Virtual Kidney Clinics are Cost-effective to the System

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Introduction

Rising NHS demand and an annual NHS settlement below health inflation has seen urgent care prioritised over elective. Out-patient waiting times are long, clinic processes wasteful and duplicative, and health care value low.

The Long Term Plan recommends using technology to improve care integration, waiting times and clinical outcomes. Four local CCG's introduced a virtual CKD (vCKD) Service with our inner city Trust to improve equality of access, access times for specialist opinion, patient education and case-finding for progressive CKD.

We here examine the financial consequences of a traditional and our new model of care.

Methods

A comparative costing exercise of face-to-face (F2F) CKD clinics versus vCKD looking at different models of provider reimbursement on provider finances. A bottom-up costing exercise obtained direct, indirect and overhead costs for first F2F and virtual Nephrology appointments. Reimbursement was calculated using the national tariff (TFC 361 for first attendance F2F, non-F2F, and an existing Trust block contract) and applying the local market forces factor (MFF).

Results

Total costs per first F2F appointment in general nephrology were calculated at £134.62 per patient (Table 1). The national 18/19 tariff for a consultant-led first F2F appointment was £248, with Trust MFF (1.2128) resulting in total income per patient of £307.77, generating a surplus per attendance of £173.15.

Bottom-up first non-F2F costs per patient were calculated at £37.92 per patient (Table 1). The 19/20 first non-F2F national tariff was £84, with MFF income per patient was £101.88, generating a surplus per attendance of £63.96.

There is a commissioner saving of £205.89 per non-F2F (virtual) patient, with an associated provider loss of £109.19 per patient. The system cost saving is £96.70 per patient.

Our virtual programme is currently funded under block contract. Using total contract value (first attendance and follow up virtual appointments) we calculate a first virtual appointment income of £182.22 and follow up income of £91.11 on average.

The under consultation 20/21 TFC 361 first attendance tariff is set at £168 for F2F, suggesting (for fixed costs) our provider surplus for traditional clinic models will fall to £69.13, now comparable to F2F, so incentivising a switch to non-F2F (Table 1).

Conclusions

Virtual clinics are associated with significant system cost savings, potentially allowing unmet need to be better served (increased demand tolerated within a given cost envelope), or commissioner opportunity to invest elsewhere in the kidney care pathway.

With the coming establishment of integrated care systems, we would expect system value to drive the move to non-F2F models. We emphasise the need for Nephrology providers to undertake true costing exercises to explore their specific models of care in this environment. We cannot cost the benefit to patients of earlier review, a reduction in inequality and duplication of investigation, and wasted patient and clinician time.