## Opposition policy costing – New GP Hubs – Labour

| Description of policy |
|---|
| **Labour would introduce new 'GP Hubs'.** Under the plans, every part of the country would trial "neighbourhood health centres" bringing together a wide range of services – including doctors, dentists and treatment of minor injuries – and treating millions of patients currently seen in overloaded A&E units. Wes Streeting said: "*I want the future of the NHS to be as much a neighbourhood health service as a National Health Service. I think this is a model that will save patients' time, save taxpayers' money and fix the front door to the NHS*."<br><br>Under the new policy, each of England's 42 "integrated care systems" – responsible for the running of local healthcare – would be asked to design a neighbourhood health centre, to meet the needs of specific communities (*Daily Telegraph,* 1 December 2023, link). |
| Additional policy assumptions |
| - This should assume that each of England's 42 "integrated care systems" – responsible for the running of local healthcare – would be asked to design a neighbourhood health centre.<br>- This should therefore take into account the costs of setting up 42 new hubs over the forecast period, including capital and set up costs and all associated staffing costs.<br>- Can assume these will be open for 7 days a week and 12 hours a day.<br>- 'While each of Labour's neighbourhood health centres would be designed locally, they are based on the system being introduced across Australia, which offers walk-in services, 7 days a week, from 8am to 8pm' (*The Daily Telegraph,* 1 December 2023, link). |
| Additional technical modelling assumptions or judgements required |
| All figures have been inflated to the year in which they are expected to be incurred. This has been done using the GDP deflator and where applicable, Personal Social Services Research Unit (PSSRU) NHS Cost Inflation Index up to 2021/22. From 2022/23, the GDP deflator was used.<br><br>The territorial extent of these policies is England only so Barnett consequentials are presented in the costing tables.<br><br>This is a trial and costings are presented on a total and annual basis.<br><br>As we understand it, the system being discussed in Australia is very similar to our existing model of urgent treatment centres (UTCs). UTCs are expected to be open 7 days a week, 12 hours a day, see both booked and walk-in patients and see minor injuries and minor illnesses. UTCs already work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to emergency departments for patients who do not need to attend hospital.<br><br>UTCs must be led and governed by an appropriate named senior clinical lead who will take responsibility for general oversight, governance, audit, staff training and the strategic development of the service. While GPs have often been the default, this leadership can be provided by a GP, Emergency Department consultant or other appropriate senior clinical lead. |

While the current direction of travel is to move towards collocation with emergency departments, many of the existing UTCs will be on standalone sites.

Wider economic benefits/cashable savings from increased preventative care not currently included. No assumptions have been made about behavioural impacts.

**Assumed Scenario**

The assumptions in the scenario are based on the establishment of 42 new hubs, over and above the existing UTC infrastructure. The costings below reflect these assumptions. For ease, it is assumed that implementation occurs immediately in 2024. In practice, there is likely to be a time-lag given the need for capital investment and building time.

An alternative (lower cost) scenario would be to adapt existing UTC sites, potentially with the addition of services such as dentistry. In such a scenario, the costs would reflect the additional costs of providing those services, as capital investment would not be required.

**Staffing cost estimates (non-dental)**

We have made some broad assumptions on staffing based on previous business case for a UTC. These are very high-level assumptions rather than a robust estimate. Staffing would come from existing workforce so the creation of new hubs could exacerbate existing vacancy pressures. Local areas would need to make a choice about the most appropriate resourcing for their needs.

| Spend type | Band | WTC | Salary | Employer NI | Employer Pension | Estimated cost to employ | Total annual cost based on estimated WTE |
|---|---|---|---|---|---|---|---|
| Employed GP | NA | 2.5 WTE | £86,530 | £10,685 | £17,894.40 | £115,109 | £287,774 |
| Advanced nurse practitioner | 7 | 4 WTE | £45,996 | £5,091 | £9,511.97 | £60,599 | £242,396 |
| Nurse or AHP | 5 | 5 WTE | £30,639 | £2,972 | £6,336.15 | £39,947 | £199,736 |
| Healthcare assistant | 2 | 3 WTE | £22,383 | £1,833 | £4,628.80 | £28,845 | £86,535 |
| Admin | 3 | 3 WTE | £24,336 | £2,102 | £5,032.68 | £31,471 | £94,412 |
| **Total** | | | | | | | **£910,853** |

**Salary cost estimates:**

**GP**: For salaried GPs, the recommended range is £68,974 to £104,086 in 2023. For the purpose of costing, we have taken a mid-point of the range = £86,530.

**Agenda for change staff**: Assumed national pay bands without high cost weighting.

- **Band 2:** taken a mid-point estimate of 2+ years: £22,383
- **Band 3:** Assumed an average of band 3 staff with 2+ years experience: £24,336
- **Band 5**: taken a mid-point estimate of 2-4 years experience: £30,639
- **Band 7:** taken a mid-point estimate of 2-5 years experience**:** £45,996

**Cost to employ estimates**

**Pension costs:** NHS employers pay 20.68% of staffing salary as employer contribution to the NHS Pension scheme. This has been included within the cost to employ figure.

**Employer NI costs:** Estimates have been calculated using online payroll calculators.

Costs for education and training and other employee benefits have not been included. Given the range of staffing groups (ranging from receptionists to GPs), we did not have a high level of confidence in determining an appropriate figure. In addition, such costs would be marginal to the overall estimate given the highest proportion of cost would come from capital spend (see below), followed by salary and associated costs.

**Dental costs**

These costs are based on the assumption that running a dentist chair would likely require a separate NHS dental contract and so we assume there would be two Whole Time Equivalent (WTE) dentists, one providing-performer dentist, and the other an associate dentist.

Based on 21/22 data on dental earnings relevant expenses to provide a contact might include the following. This is excluding premises costs on the assumption that the service is making use of an existing facility. There may well be additional capital costs on top to re-fit an existing treatment room to be suitable for dentistry.

| | **Providing performer** | **Associate** | |
|---|---|---|---|
| Office and General Business | £20,800 | £4,000 | £24,800 |
| Employee | £90,800 | £3,200 | £94,000 |
| Car and Travel | £2,100 | £1,000 | £3,100 |
| Interest | £5,300 | £100 | £5,400 |
| Lab and material costs | £40,400 | £8,800 | £49,200 |
| Dentist salary | £135,000 | £64,900 | £199,900 |
| | **£294,400** | **£82,000** | **£376,400** |

- It is assumed that the total expenses for an NHS dentist in this setting would largely reflect the expenses recorded in the 2021-22 dentist earning and expenses publication (Dental Earnings and Expenses Estimates, 2021/22 - NHS Digital).
- It is assumed that Premises, Net Capital Allowances and the majority of Other costs (including business advertising, etc.) will not apply to an NHS dentist in this setting.
- It is assumed that lab costs for an NHS dentist would be 4.2% of their gross income, and the material costs would be 5.2% of their gross income.
- It is assumed that to provide dental cover for a year, 2 WTE dentists would be required, including a providing performer dentist, to hold the NHS contract, and an associate dentist.

- We have not made an assessment on the feasibility of delivering this additional dental activity.

This would provide an approximate annual cost of £376,400**.** If this approach was taken in all 42 ICS areas there would be an approximate annual cost of £15.8m.

**In 2024/25 prices that would be: £433,000 for one site (£448,000 annual average over 5 years) or £18.8m for 42 sites**.

**Capital building costs and operational costs**

We have seen costings for 3 new health hubs which range in size from 1479m2 to 2,632m2. These figures have come from internal benchmarking information on the costs of new build health centres based on three current schemes either recently operational, under construction or in the advanced stages of development by NHS Property Services to clinical specifications. The three centres were based in Devizes (Wiltshire), Kings Lynn (Norfolk) and Weybridge (Surrey). These facilities provide for a range of primary care and community facilities but not dentistry. We picked 3,000m2 assuming the facility may need to be slightly larger to accommodate dentistry but these facilities would be smaller than Cavell Centres (a scheme previously proposed by NHSE). Estimates for the size of Cavell centres were higher, suggesting a 'neighbourhood' size of 3,250m2 but could go up to around 6000m2. These figures are all taken from internal documents so would not be in the public domain.

At this stage we have not considered rental options and have also not factored in length of build time/construction: capital costs have been front-loaded. These costings are based on the assumption that centres would be additional to existing capacity.

We have used benchmarking costs for new health hubs. Construction costs have a £/square metre gross internal area range (excluding VAT) of £6,500 to £7,500. Using a midpoint figure of £7,000 we have worked out approximate costs for a 3,000 m2 facility. This would give an approximate build cost of **£21m.** After accounting for inflation, gives a cost of **£21.4m** in 2024/25 prices.

Benchmark running costs for a 3,000 m2 facility would be in the region of **£660,000** excluding VAT (and excluding any rental charges that may be applied). After accounting for inflation, gives an average annual cost of **£694,000.**

**Consumables**

We have taken an estimate from a previous UTC business case for a 24 hour centre and re-calculated based on likely attendances over time to give an estimated figure for a 12 hour timeframe. In 2021/22, 83% patients not arriving by ambulances arrived between 8am – 8pm. Inflationary uplifts have been applied to give an average annual estimate of **£164,000** over the next five years.

**In 2024/25 prices:**

For one centre this would therefore give an approximate cost of **£21.4m** in capital build, **£694,000** in annual operational costs, **£958,000** in annual staffing costs, **£448,000** in dental and **£164,000** in annual consumable costs.

For 42 centres this would give an approximate cost of **£897m** in capital costs, **£29m** in annual operational costs, **£40m** in annual staffing costs, **£18.8m** in dental and **£6.9m** in annual consumable costs.

| DEL (annual average over 5 years) | One site | 42 sites |
|---|---|---|
| Resource | £2.3m | £95m |
| Capital (24/25) | £21.4m | £897m |

Cost/Revenue to the Exchequer over five years

**Assumed Scenario : Establishment, staffing and running of 42 new hubs**

| | DEL per site (£m) | | | | |
|---|---|---|---|---|---|
| | 2024-25 | 2025-26 | 2026-27 | 2027-28 | 2028-29 |
| Resource | 2.2 | 2.2 | 2.3 | 2.3 | 2.3 |
| Capital | 21.4 | | | | |
| **Total** | **23.5** | **2.2** | **2.3** | **2.3** | **2.3** |

| | DEL for 42 sites (£m) | | | | |
|---|---|---|---|---|---|
| | 2024-25 | 2025-26 | 2026-27 | 2027-28 | 2028-29 |
| Resource | 92 | 94 | 95 | 97 | 99 |
| Capital | 897 | | | | |
| **Total England** | **989** | **94** | **95** | **97** | **99** |
| **Total Barnett** | 185 | 18 | 18 | 18 | 19 |
| **Total Cost** | **1172** | **112** | **113** | **115** | **118** |

All prices here are considered nominal and so each year’s costs have been inflated to the same year prices in which they are expected to be incurred.

Comparison with current system (if applicable):

As above, an alternative (lower cost) scenario would be to adapt existing UTC sites, potentially with the addition of services such as dentistry. In such a scenario, the costs would reflect the additional costs of providing those services, as capital investment would not be required.

Other comments (including other Departments consulted):

This note sets out the costs of the delivery of the policy, it does not include estimates of any benefits or potential cost savings that may flow from it.

This costing was produced by DHSC.

| *To be completed by Permanent Secretary’s Office*<br>Date costing signed off: | |
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| *[If applicable]*<br>Date revised costing signed off: | |
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