NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Resource impact report:
Abortion care (NG140)

Published: September 2019

Summary

This report focuses on the recommendations from NICE's guideline on abortion care that we think will have the greatest resource impact nationally (for England), and will need the most additional resources to implement or potentially generate the biggest savings. They are:

- Commissioners should work with providers to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay **(recommendation 1.1.5)**.
- Do not offer anti-D prophylaxis to women who are having medical abortion up to and including 10^{+0} weeks' gestation **(recommendation 1.3.2)**.
- Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy **(recommendation 1.7.1)**.

Financial impact

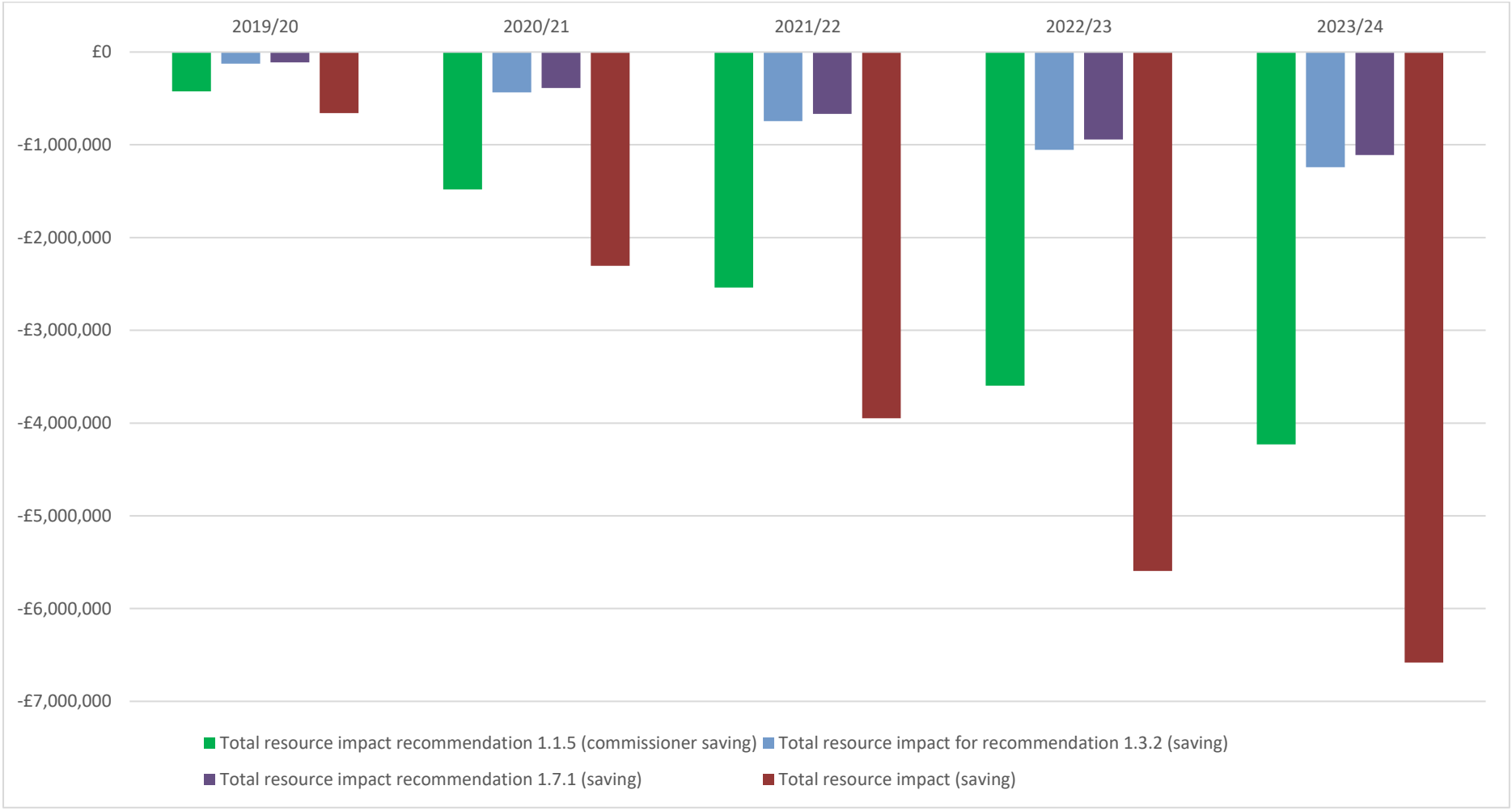
The estimated financial impact of implementing this guideline for England in the next 5 years is a saving of around £658,000 in 2019/20 rising to a saving of around £6.6 million in 2023/24 as set out in table 1 and figure 1 below. The savings result from:

- a reduction in waiting times
- a reduction in rhesus status testing
- a reduction in anti-D prophylaxis
- a reduction in the number of ultrasound scans.

Table 1 Estimated budget impact of implementing the guideline

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)
Implementation rate	10%	35%	60%	85%	100%
Total resource impact recommendation 1.1.5 (commissioner saving due to minimal delays) (£m)	-0.4	-1.5	-2.5	-3.6	-4.2
Total resource impact recommendation 1.3.2 (provider saving due to reduction in anti-D prophylaxis) (£m)	-0.1	-0.4	-0.7	-1.1	-1.2
Total resource impact recommendation 1.7.1 (commissioner saving due to reduced waiting times) (£m)	-0.1	-0.4	-0.7	-0.9	-1.1
Savings for commissioners	-0.5	-1.9	-3.2	-4.5	-5.3
Savings for providers	-0.1	-0.4	-0.7	-1.0	-1.2
Total savings for England	**-0.7**	**-2.3**	**-3.9**	**-5.6**	**-6.6**
	(£000)	**(£000)**	**(£000)**	**(£000)**	**(£000)**
Total saving per 100,000 population for commissioners	**-1.0**	**-3.4**	**-5.8**	**-8.2**	**-9.6**
Total saving per 100,000 population for providers	**-0.2**	**-0.8**	**-1.3**	**-1.9**	**-2.2**
Total saving per 100,000 population	**-1.2**	**-4.1**	**-7.1**	**-10.0**	**-11.8**

Figure 1- The budget impact of guideline



1 Introduction

1.1 The guideline offers evidence based advice on abortion care.

1.2 This report discusses the resource impact of implementing our guideline on abortion care in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.

1.3 A resource impact template accompanies this report to help with assessing the resource impact at a local level in England, Wales or Northern Ireland.

1.4 We have considered direct costs and savings to the NHS and not those for the individual the private sector. Any cost savings arising from a change in practice have been offset against the cost of implementing the change.

1.5 Abortion care services are commissioned by clinical commissioning groups. Providers are NHS hospital trusts and independent providers. Contraceptive services are commissioned by local authorities and provided by GP's, community providers and NHS trusts.

2 Background

2.1 Abortion is a common procedure. Each year around 185,000 women have an abortion in England.

2.2 Most abortions are carried out because the pregnancy was unintended, and the majority of procedures (80% of abortions in England and Wales in 2018) are conducted in the first 10 weeks of pregnancy as shown in the figures in abortion statistics for England and Wales 2018.

2.3 Abortion is a safe procedure and can be carried out medically (taking mifepristone followed by misoprostol) or surgically.

2.4 The guideline makes recommendations on how to organise services and on how to conduct abortions within the legal framework set out by the Abortion Act 1967(as amended by the Human Fertilisation and Embryology Act 1990) and its related guidance. It does not repeat things already covered by the legislation, Department of Health guidance or other statutory regulations, and practitioners should therefore ensure they are adhering to all other applicable requirements when using this guideline.

3 Significant resource impact recommendations

There are 3 recommendations that are expected to lead to a significant resource impact. These recommendations are considered in turn in sections 3.1, 3.2 and 3.3.

3.1 **Commissioners should work with providers to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay (recommendation 1.1.5).**

Background

3.1.1 The earlier women are referred for to abortion services, the more choice there will be about the type of procedure they can have. This will include women who choose to pass the pregnancy at home.

Assumptions made

3.1.2 As a result of the recommendation it is assumed that on average, abortions will be performed 4 days earlier than they are in current practice.

3.1.3 It is assumed, for England, there will be an increase of around 7,900 medical abortions. This has a corresponding reduction in two areas. The first is a reduction in surgical abortions by around 7,400, and the second is a reduction of around 500 abortions after 20

weeks (which can be either medical or surgical) , as per the health economic model that underpins the recommendation (Evidence review A).

3.1.4 As a result of the recommendation there will be a small decrease in the number of abortions that take place between 14 and 20 weeks and over 20 weeks gestation. There will also be an increase in the number of abortions that take place before 14 weeks gestation.

Costs

3.1.5 The average cost of an abortion in current practice is £556. This is based on the average case mix in the health economic modelling and prices in the national tariff 19-20. The national tariffs for these procedures are shown in table 2.

3.1.6 In future practice, if abortions are performed 4 days earlier than they are currently, the average cost will be £534. This is based on a change in case mix as modelled in the economic modelling and the prices in the national tariff 19-20 as shown in table 2.

Table 2 abortion (termination of pregnancy) national tariffs for 2019-20

Procedure name	HRG code	2019-20 tariff	Current practice %	Future practice %
Surgical termination of pregnancy less than 14 weeks gestation	MA17C / MA19A	£783	24.44%	20.83%
Surgical termination of pregnancy 14 to 20 weeks gestation	MA17D / MA19B	£1,212	3.98%	3.65%
Medical termination of pregnancy, less than 14 weeks gestation	MA18C	£394	68.85%	73.15%
Medical termination of pregnancy, 14 to 20 weeks gestation	MA18D	£874	1.36%	1.25%
Medical or surgical termination of pregnancy, over 20 weeks gestation	MA20Z	£2,425	1.37%	1.12%
Average tariff			**£556**	**£534**

3.1.7 The net saving of recommendation 1.1.5 is summarised in table 3.

Table 3 Estimated annual saving of recommendation 1.1.5

	Current practice	2019/20	2020/21	2021/22	2022/23	2023/24
Implementation rate		10%	35%	60%	85%	100%
Activity						
Surgical termination of pregnancy, less than 14 weeks gestation	45,988	45,310	43,613	41,917	40,221	39,203
Surgical termination of pregnancy, 14 to 20 weeks gestation	7,486	7,424	7,269	7,115	6,960	6,867
Medical termination of pregnancy, less than 14 weeks gestation	129,569	130,378	132,399	134,421	136,443	137,656
Medical termination of pregnancy, 14 to 20 weeks gestation	2,557	2,538	2,489	2,440	2,391	2,362
Medical or surgical termination of pregnancy, over 20 weeks gestation	2,587	2,538	2,416	2,294	2,172	2,099
Costs						
Surgical termination of pregnancy, less than 14 weeks gestation (£m)	36.0	35.5	34.1	32.8	31.5	30.7
Surgical termination of pregnancy, 14 to 20 weeks gestation (£m)	9.1	9.0	8.8	8.6	8.4	8.3
Medical termination of pregnancy, less than 14 weeks gestation (£m)	51.1	51.4	52.2	53.0	53.8	54.2
Medical termination of pregnancy, 14 to 20 weeks gestation (£m)	2.2	2.2	2.2	2.1	2.1	2.1
Medical or surgical termination of pregnancy, over 20 weeks gestation (£m)	6.3	6.2	5.9	5.6	5.3	5.1
Total cost (£m)	104.6	104.2	103.2	102.1	101.0	100.4
Total resource impact (commissioner saving) (£m)		-0.4	-1.5	-2.5	-3.6	-4.2

Benefits and savings

3.1.8 Implementing the recommendations will lead to a reduction in the number of surgical abortions as well as a reduction in abortions between 14 and 20 weeks' gestation and after 20 weeks. This will lead to a cost saving for commissioners, as shown in table 3.

3.1.9 There also may be a saving for providers as an increase in numbers in earlier medical abortions may mean that more women will be able to have the option of expulsion at home which would lead to more women seen as outpatients rather than as day cases.

3.1.10 There may also be a reduction in abortion related adverse events. For example, there is evidence that morbidity and mortality increase for women with every additional week of gestation and therefore earlier abortions are safer (Bartlett 2004).

3.1.11 Expert clinical opinion is that earlier abortions may also lead to a reduction in outpatient appointments and tests. The savings are not expected to be cash releasing but may free up clinical staff time and further contribute to reductions in waiting times.

Other considerations

3.1.12 In order to reduce delays in abortions some providers may need to invest in their services. In some regions this may mean installing a dedicated phone and booking system. This would need initial investment and potentially need some ongoing investment. There may however be some efficiency savings arising from a better booking system that may offset some of these costs, such as reduced administration costs for some centres. Providers may also need to consider this in combination with **recommendation 1.1.2** (commissioners and providers should allow women to self-refer to abortion services) which may lead to an increase in early referrals.

3.1.13 Other areas may need to work with neighbouring providers to operate an abortion care hub, in order to offer women access to all

types of abortion at the different stages of gestation. This may also be needed for **recommendation 1.6.1** (offer a choice between medical or surgical abortion before 23^{+6} weeks gestation).

3.1.14 In regions where fewer surgical abortions are currently provided, staff may need extra training and there may be a need for greater access to operating theatres in order to increase access to surgical abortions. Providers may need to consider the impact of **recommendation 1.1.13**, (for specialities that include training in abortion as part of the core curriculum should ensure all trainees have the training), as this may impact upon the structure of their services and the range of services that they can provide.

3.2 Do not offer anti-D prophylaxis to women who are having a medical abortion up to and including 10+0 weeks' gestation (recommendation 1.3.2).

Background

3.2.1 Current practice in the NHS is to give anti-D prophylaxis to all women who are having an abortion and are rhesus D negative. However, testing for rhesus status and then administering anti-D can result in significant delays for women.

3.2.2 The primary reason for anti-D prophylaxis being administered is for the prevention of sensitisation to RhD antigen which could result in haemolytic disease in a new-born baby in any subsequent pregnancies.

3.2.3 Anti-D is a blood product and therefore has theoretical risk of transmission of infective agents.

Assumptions made

3.2.4 It assumed that currently around 67% of abortions are before 10^{+0} weeks and are medical abortions (Abortion statistics England and Wales 2018 Table 7ab).

3.2.5 It is assumed that around 27% of medical abortions before 10^{+0} weeks are performed by NHS providers and 73% are performed by independent providers (Abortion statistics England and Wales 2018 table 3a).

3.2.6 Currently 60% of women's rhesus status is known by NHS providers because of previous pregnancies. The remaining 40% of women have a rhesus status test.

3.2.7 Currently 100% of women receive a point of care rhesus status test at independent providers according to clinical expert opinion.

3.2.8 In current practice, 15% of women attending a medical abortion before 10^{+0} weeks are rhesus negative and receive anti-D prophylaxis (NCT).

3.2.9 In future practice none of these women will have a rhesus status test or receive anti-D prophylaxis.

Costs

3.2.10 It is assumed that the cost of a rhesus status test is £24 (NICE DG25).

3.2.11 It is assumed that the average cost of a point of care rhesus status test is around £0.50 according to clinical expert opinion.

3.2.12 It is assumed that the dose of anti-D prophylaxis is 1,500/2 ml solution which costs £46.50 (BNF).

3.2.13 The net saving of recommendation 1.3.2 is summarised in table 4.

Table 4 Estimated annual saving of recommendation 1.3.2

	Current practice	2019/20	2020/21	2021/22	2022/23	2023/24
Implementation rate		10%	35%	60%	85%	100%
Activity						
Number of people receiving Rhesus status testing (NHS providers)	13,229	11,988	8,658	5,328	1,998	0
Number of people receiving point of care Rhesus status testing (independent providers)	92,220	82,998	59,943	36,888	13,833	0
Number of people receiving anti-D prophylaxis	18,828	16,945	12,238	7,531	2,824	0
Costs						
Rhesus status testing (£m)	0.3	0.3	0.2	0.1	0.0	0.0
Point of care Rhesus status testing (£m)	0.0	0.0	0.0	0.0	0.0	0.0
Treatment with anti-D prophylaxis (£m)	0.9	0.8	0.6	0.4	0.2	0.0
Total cost (£m)	1.2	1.1	0.8	0.5	0.2	0
Total resource impact (provider saving) (£m)		-0.1	-0.4	-0.7	-1.1	-1.2

Benefits and savings

3.2.14 Implementing the recommendations will lead to a reduction in the number of rhesus status tests performed and a reduction in the numbers of women given anti-D prophylaxis. Therefore, this recommendation is expected to result in a cost saving for providers of abortion care services.

3.2.15 As a result of women not being offered anti-D prophylaxis, there may also be a reduction in the number of additional outpatient appointments which may also lead to a cost saving for providers of abortion care services.

3.2.16 Clinical expert opinion is that it is highly likely that providers may implement these recommendations much more quickly than the other recommendations which need investment and service development.

Other considerations

3.2.17 There may also be a saving in staff time as a result of implementing the recommendations. These savings are not likely to be cash releasing (and not included in the calculations).

3.2.18 Implementing these changes will result in savings for the providers of abortion care services but not for clinical commissioning groups. This is because the cost of rhesus status testing and anti-D prophylaxis are included as part of the payment covered by the national tariff.

3.3 Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy (recommendation 1.7.1).

Background

3.3.1 Some providers do not currently provide an abortion before there is definitive ultrasound evidence of pregnancy.

3.3.2 As a result, the recommendation may make abortion available earlier than it is provided currently. This may make it easier for women to access services and may reduce waiting times. There may be a greater impact on providers of surgical abortion, as this is not always offered as early as medical abortion.

3.3.3 Services providing surgical abortion before ultrasound evidence will need to have systems to confirm that the pregnancy has been aspirated. For example, they will need to have staff trained to

inspect the products of pregnancy and provide the necessary equipment to do this or immediate access to ultrasound.

Assumptions made

3.3.4 Based on expert clinical opinion, it is assumed that at present around 20% of women having an abortion will have an additional ultrasound to provide definitive ultrasound evidence of an intrauterine pregnancy. This additional ultrasound usually occurs one week after the initial ultrasound scan.

3.3.5 In future practice, expert clinical opinion is that around 5% of women will have an additional ultrasound scan to provide definitive ultrasound evidence of an intrauterine pregnancy.

3.3.6 The most relevant ultrasound from a cost perspective is an antenatal ultrasound scan (dating scan).

3.3.7 It is assumed that the cost of the ultrasound scan and the necessary blood tests will be covered by the ultrasound tariff.

3.3.8 Expert clinical opinion is that in future practice, because most women will no longer need an additional ultrasound to provide definitive ultrasound evidence before an abortion, they will be seen one week earlier.

Costs

3.3.9 The average cost of an abortion in current practice is £556. This is based on the change in average case mix in the health economic modelling and prices in the national tariff 19-20. The national tariffs for these procedures are shown in table 5.

3.3.10 These savings are as a result of a further change to the pathway not considered in section 3.1 and are assumed to be independent of the changes modelled as a result of implementing recommendation 1.1.5.

Table 5 abortion (termination of pregnancy) national tariffs for 2019-20

Procedure name	HRG code	2019-20 tariff	Current practice %	Future practice %
Dilation and evacuation, less than 14 weeks gestation/Vacuum aspiration with cannula, less than 14 weeks gestation	MA17C/ MA19A	£783	24.44%	18.13%
Dilation and evacuation, 14 to 20 weeks gestation/Vacuum aspiration with cannula, 14 to 20 weeks gestation	MA17D/ MA19B	£1,212	3.98%	3.40%
Medical termination of pregnancy, less than 14 weeks gestation	MA18C	£394	68.85%	76.37%
Medical termination of pregnancy, 14 to 20 weeks gestation	MA18D	£874	1.36%	1.18%
Medical or surgical termination of pregnancy, over 20 weeks gestation	MA20Z	£2,425	1.37%	0.92%
Average Tariff Price			£556	£517

3.3.11 The average tariff, based on the health economic modelling and the prices in the national tariff 19-20, for these women who will no longer have an additional ultrasound will be £517. Prices per procedures are shown in table 5.

3.3.12 The net saving of recommendation 1.7.1 is summarised in table 6.

Table 6 Estimated annual saving of recommendation 1.7.1

	Current practice	*2019/20*	*2020/21*	*2021/22*	*2022/23*	*2023/24*
Implementation rate		10%	35%	60%	85%	100%
Activity						
Surgical termination of pregnancy, less than 14 weeks gestation	9,134	8,958	8,515	8,073	7,631	7,366
Surgical termination of pregnancy, 14 to 20 weeks gestation	1,487	1,471	1,430	1,390	1,350	1,326
Medical termination of pregnancy, less than 14 weeks gestation	25,736	25,946	26,473	27,000	27,528	27,844
Medical termination of pregnancy, 14 to 20 weeks gestation	508	503	490	477	465	457
Medical or surgical termination of pregnancy, over 20 weeks gestation	514	501	469	438	406	387
Costs						
Surgical termination of pregnancy, less than 14 weeks gestation (£m)	7.2	7.1	6.7	6.4	6.0	5.8
Surgical termination of pregnancy, 14 to 20 weeks gestation (£m)	1.8	1.8	1.7	1.7	1.6	1.6
Medical termination of pregnancy, less than 14 weeks gestation (£m)	10.2	10.3	10.5	10.7	10.9	11.0
Medical termination of pregnancy, 14 to 20 weeks gestation (£m)	0.4	0.4	0.4	0.4	0.4	0.4
Medical or surgical termination of pregnancy, over 20 weeks gestation (£m)	1.2	1.2	1.1	1.1	1.0	0.9
Total cost (£m)	20.9	20.8	20.5	20.3	20.0	19.8
Total resource impact (Commissioner saving) (£m)		-0.1	-0.4	-0.7	-0.9	-1.1

Benefits and savings

3.3.13 The cost of an ultrasound scan is included as part of the tariff for providing an abortion, therefore savings as a result of fewer ultrasound scans are not expected to be cash releasing but may free up staff time and reduce waiting times. It is estimated that this will save around 15 minutes per scan for around 28,000 scans per year.

3.3.14 It is also likely to lead to a reduction in associated additional appointments and blood tests that would be performed at the same time as the additional ultrasound, this also would be a saving for providers.

3.3.15 Further savings for providers may result from a reduction in abortion related adverse events leading to fewer outpatient appointments and tests.

3.3.16 A reduction in waiting times, as result of not needing definitive ultrasound evidence before performing an abortion will lead to a more favourable case mix for service commissioners because of a reduction in the numbers of abortions performed after 14 and 20 weeks gestation.

3.3.17 Earlier abortions are also more likely to be medical abortions. This will result in a lower average tariff being paid to the provider and therefore a saving for the commissioner.

Other considerations

3.3.18 Medical staff in providers of surgical abortions may need some additional training and equipment to acquire the skills in inspecting the aspirated products of pregnancy.

4 Resource impact over time

4.1 The estimated annual saving of implementing this guideline for the population of England based on the uptake in the resource impact

assumptions is shown in table 7. The saving from year 5 is £6.5m per year in England. This is equivalent to around £11,751 per 100,000 population.

Table 7 Resource impact of implementing the guideline using NICE assumptions

	2019/20 (£m)	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)	2023/24 (£m)
Implementation rate	10%	35%	60%	85%	100%
Total resource impact recommendation 1.1.5 (commissioner saving due to minimal delays) (£m)	-0.4	-1.5	-2.5	-3.6	-4.2
Total resource impact recommendation 1.3.2 (provider saving due to reduction in anti-D prophylaxis) (£m)	-0.1	-0.4	-0.7	-1.1	-1.2
Total resource impact recommendation 1.7.1 (commissioner saving due to reduced waiting times) (£m)	-0.1	-0.4	-0.7	-0.9	-1.1
Savings for commissioners	-0.5	-1.9	-3.2	-4.5	-5.3
Savings for providers	-0.1	-0.4	-0.7	-1.0	-1.2
Total savings for England	**-0.7**	**-2.3**	**-3.9**	**-5.6**	**-6.6**
	(£000)	**(£000)**	**(£000)**	**(£000)**	**(£000)**
Total saving per 100,000 population for commissioners	**-1.0**	**-3.4**	**-5.8**	**-8.2**	**-9.6**
Total saving per 100,000 population for providers	**-0.2**	**-0.8**	**-1.3**	**-1.9**	**-2.2**
Total saving per 100,000 population	**-1.2**	**-4.1**	**-7.1**	**-10.0**	**-11.8**

5 Implications for commissioners

5.1 Abortion care falls under programme budgeting category 18X maternity and reproductive health.

5.2 Although many abortions are provided by independent providers they are funded by clinical commisoning groups. Any savings for commissioners will therefore fall to clinical commisoning groups.

5.3 As a result of the recommendations around contraception services in section 1.15 this may lead to a transfer of costs in contraceptive services from local authorities to clinical commissioning groups.

5.4 The savings resulting from recommendation 1.1.5 and 1.7.1 will lead to a combined saving of £5.3 million per year for clinical commisoning groups by year 5.

5.5 The savings resulting from recommendation 1.3.2 will result in savings of around £1.2 million per year by year 5 for providers of abortion care services.

6 Assumptions made

6.1 The resource impact template makes the following assumptions:

- That the numbers of abortions (adjusting for England only) as per the 2018 Abortion statistics for England and Wales is assumed to be representative for the activity in England.
- The number of NHS funded abortions is around 98%.

6.2 If a national tariff price or indicative price exists for an activity, this has been used as the unit cost. The resource impact template can be used to amend unit costs to account for any local market forces factor.

6.3 Using these prices ensures that the costs in the report are the cost to the clinical commissioning group of commissioning predicted changes in activity at the tariff price but may not represent the actual cost to individual trusts of delivering the activity.

7 Other considerations

The following recommendations do not have significant resource implications but may need to be assessed locally. These are:

- Do not routinely offer antibiotic prophylaxis to women who are having a medical abortion (recommendation 1.4.2).

- When using metronidazole for antibiotic prophylaxis in medical or surgical abortion, do not routinely offer it in combination with another broad-spectrum antibiotic such as doxycycline (recommendation 1.4.5).
- Improving access to contraception (recommendations 1.15.1-1.15.5).

7.1 Not routinely offering antibiotic prophylaxis to women having a medical abortion will lead to savings for providers, however as the cost per dose is low this saving will not be significant.

7.2 Not routinely offering metronidazole in combination with other broad-spectrum antibiotics such as doxycycline will lead to savings for providers. However, as the cost per dose is low this saving will not be significant.

7.3 The recommendations around improving access to contraception after an abortion may lead to some additional costs for providers of abortion care although it is not thought that this cost will be significant. This is because the recommendations around offering a range of contraceptive services immediately after an abortion are broadly in line with the NICE clinical guideline CG30 Long-acting reversible contraception.

7.4 The recommendation may lead to an increase in overall numbers of women having long-acting reversible contraception fitted by abortion care providers although some of these women may have previously had this fitted at their GP surgery or at a local family planning clinic. This is likely though to provide some saving through a reduced need for abortions in the future.

8 Sensitivity analysis

8.1 There are some assumptions in the model for which no empirical evidence exists, so we cannot be as certain about them. Appropriate minimum and maximum values of variables were used

in the sensitivity analysis to assess which variables have the biggest impact on the net cost or saving. This enables users to identify the significant cost drivers.

Appendix A is a table listing all variables modified. The key conclusions are discussed below.

8.2 Changing the number of days of delays saved when reconfiguring abortion care services from 2 to 7 days leads to a saving ranging from £4.5 to £9.8m. Savings are due to a reduction in the number of surgical abortions as well as a reduction in abortions before 14 and 20 weeks' gestation.

8.3 Changing the number of days to wait saved for an additional ultrasound scan to show definitive evidence before an abortion from 4 days to 10 days leads to a saving ranging from £6.1m to £6.9m. Savings are due to a reduction in the number of surgical abortions as well as a reduction in abortions before 14 and 20 weeks' gestation.

8.4 Changing the number of women having an additional ultrasound for definitive evidence before an abortion in current practice from 15% to 25% leads to a saving ranging from £6.3m to £6.9m.

Appendix A. Results of sensitivity analysis

Individual variable sensitivity

				Recurrent resource impact				
	Baseline value	**Minimum value**	**Maximum value**	**Baseline resource impact (£000s)**	**Minimum resource impact (£000s)**	**Maximum resource impact (£000s)**	**Change (£000s)**	**Sensitivity ratio**
Number of days waiting saved because of reduced waiting times	4	2	7	-6,581	-4,467	-9,754	-5,287	0.64
Number of days waiting saved because of no ultrasound rescan	7	4	10	-6,581	-6,106	-6,938	-832	0.15
Change in the price of rhesus status testing	24	18	30	-6,581	-6,501	-6,661	-160	0.05
Change in number of women having an ultrasound in current practice	20%	15%	25%	-6,581	-6,304	-6,859	-555	0.17
Change in the current number of women having rhesus status testing in NHS providers	40%	30%	50%	-6,581	-6,501	-6,661	-160	0.05
Change in the current number of women having rhesus status testing in independent providers	100%	60%	100%	-6,581	-6,562	-6,581	-19	0.00

About this resource impact report

This resource impact report accompanies the NICE guideline on Abortion Care and should be read in conjunction with it. See terms and conditions on the NICE website.