

## Preface

### Lesley Curtis

This is the latest in a series of volumes which presents unit costs for a wide range of health and social care services using a standardised methodology based in economic theory. Each volume reflects our current knowledge and over time we seek to refine and improve the estimates as new information becomes available. Moreover, we always cite our sources and assumptions so users can adapt the information for their own purposes. Since 1993, the unit costs programme and the annual publication of *the Unit Costs of Health and Social Care* has been funded by the Department of Health. Over the last two years we have had additional inputs from the Department for Education to allow inclusion of unit costs for a wider range of children's services.

Work over the past year has focused on updating many of the processes we use to provide these estimates and to ensure they are as close as possible to today's service costs. We have overhauled the databases which underpin many of the calculations, transferred to more flexible publication software and, of course, re-designed the front cover.

We have added schema where new information about services has become available, commonly through the research community but also from data collected by central government. We have also updated some of the 'routine' aspects of our unit cost estimations – those which span several schemas – such as NHS Trust overheads and time use data (see below). Again as in previous years, we have excluded information which is more than ten years old and which we can no longer be confident reflects today's services. This has two types of impact. First, where unit costs have been based entirely on a particular research project and we have no new information to update the schema, such as for some of the staffed accommodation facilities for people with mental health problems. In these cases the schema has been deleted from this volume. A list of these services can be found in section V and these unit costs can be retrieved from previous volumes. The second type of impact is where our ten-year rule affects just part of the calculation, perhaps the way professionals spend their time. This does not affect our basic unit cost – per (working) hour – but it does mean that some of the weighted unit costs (per client contact, for example) cannot currently be estimated.

Many different sources of information are needed to create the unit costs in these volumes. While every effort is made to reflect current practice and to keep abreast of policy and practice requirements, there is always a pressing need for contemporary information. In particular, we would like to hear from readers who have access to information on occupancy rates in residential and day care services, and information on how professionals use their time. Please contact me, Lesley Curtis, at [L.A.Curtis@kent.ac.uk](mailto:L.A.Curtis@kent.ac.uk) if you would like to draw our attention to forthcoming studies or other information which may improve our estimates.

Before we outline the changes and additions in this year's volume, we would like to take this opportunity to express our enormous thanks to Professor Ann Netten. Ann has guided the unit cost volumes from their inception through to the 2011 volume. In that time, the *Unit Costs of Health and Social Care* has become a prime source of information for central government departments, local commissioners and provider organisations, as well as researchers. Although no longer the chair of the advisory group, Ann is still a valuable source of advice on the unit costs programme, and takes a keen interest in its direction. The advisory group continues to be supported by Department of Health personnel and SCIE representatives, as well as some of the foremost academics working in health and social care economics. It will now be chaired by Professor Jennifer Beecham, an expert advisor on the group since it was formed.

## What's new in the publication this year?

### Articles

This year we have included three articles. The first is from Theresia Bäumker and Ann Netten from the PSSRU at the University of Kent, which provides some of the first information on the costs of extra care housing. Between 2004 and 2010, £227 million was made available by the Department of Health to local authorities and their housing partners to

stimulate provision of a wide variety of innovative extra-care schemes. This article presents the findings from an evaluation of 19 new-build extra care housing schemes located across England.

The second article has been provided by John Dickinson from Shared Lives Plus (formerly NAAPS UK). Shared Lives Plus is the UK network for Shared Lives carers, home-share programmes and other community-based micro-enterprises. The article discusses the complexity of funding Shared Lives placements (formerly known as Adult Placements), and presents information about their cost and quality based on evidence produced by the Care Quality Commission (CQC) and Improvement and Efficiency South East.

In our third article Lisa Holmes from the Centre for Child and Family Research at Loughborough University reports findings from a study commissioned by the Local Government Association. The study explored the cost and the capacity implications for local authorities of implementing Lord Laming's (2009) recommendations on the protection and safeguarding of children and young people. A national survey was completed by 46 of the 152 local authorities in England, and in-depth research conducted in nine. The article summarises the findings. It identifies workers' concerns as well as the additional time requirements and costs of implementing six of the recommendations.

## **New unit costs**

### **Care packages**

Two recent documents summarise the government's commitment to personalised services, *Shaping the Future of Care Together* (Department of Health, 2009) sets out a vision for a new care and support system in England, and more recently *Building the National Care Service* (Department of Health 2010a). Both advocate an increasing emphasis on self-directed care using Direct Payments, Individual Budgets and Personal Budgets. Consequently, there has been greater interest in the cost of care packages, and in recent years we have drawn on several studies to expand the range of care packages shown in these volumes. For example, last year we extracted information from two studies (Knapp et al., 2009; Barrett et al., 2010) to show the care package costs for children with autism, and a study by Beecham et al. (2009) was used to present information on supports for young adults with acquired brain injury. This year, we have drawn on the national evaluation of the Individual Budget Pilot Projects (Glendinning et al., 2008) to extend this section. The study provided information on the packages of care received by more than a thousand service users representing four client groups: older people, people with learning disabilities, people with mental health problems and people with physical disabilities. For the study, the service users' needs were categorised as critical, substantial and moderate and information was collected on a pre-specified set of services; the type of accommodation in which they usually lived, the number of hours of home care and day care received each week and the social security benefits they received. These care packages have been summarised by client group and need category and the costs are provided in chapter 8.

### **Public health interventions**

Estimations of the economic burden of preventable disease and disability are becoming increasingly frequent in the health sector in the UK. In schema 7.9, we present summary information from two recent reports on the costs of such interventions (Matrix Evidence & Bazian, 2008; North West Public Health Observatory, 2011). We selected information from UK cost studies to ensure that the costs would reflect services available in the UK including interventions that may reduce long-term workplace absence, help manage high-risk drinking and reduce harm caused by smoking.

In schema 2.11, we present costs for public health interventions that have an impact on mental health. These have been drawn from a study commissioned by the Department of Health which presents the key findings from a detailed analysis of the costs and benefits of fifteen different interventions (Knapp et al., 2011). This report underpinned the recent cross-government strategy *No Health without Mental Health* (Department of Health, 2011.)

### **Mindfulness-based cognitive therapy**

This year, we have included a schema (1.10) provided by Barbara Barrett and Sarah Byford from the Centre for Economics of Mental Health (CEMH) on the costs of mindfulness-based cognitive therapy. This intervention is a manualized, group-based skills training programme designed to enable patients to learn skills that prevent the recurrence of depression.

### Multi-systemic therapy

We have also included a schema (6.8) provided by Maria Carey from the Centre for Economics of Mental Health on the costs of multi-systemic therapy (MST). MST is an intensive family and community based treatment programme that takes a holistic approach to working with chronic and violent juvenile offenders by looking at their homes and families, schools and teachers, neighbourhoods and friends.

### Resource panels

In last year's *Unit Costs* volume, we included an article by Lisa Holmes and Samantha McDermid on the costs of short break provision and the linked social care processes. As part of that study, but not reported in the article, the costs of resource panels for short break services were also calculated. Two of the three participating authorities used panels to decide how resources may be most usefully deployed to support families. The costs are presented in schema 6.10. This focus on a *care process* is a departure from our usual focus on *services*, although we have addressed this in some of our articles in earlier volumes. It is an area of unit cost estimations we hope to extend as more information becomes available.

### Palliative care for children

Following the Government's 2006 manifesto commitment to improve palliative care, the Secretary of State for Health commissioned an independent review of children's palliative care services (Department of Health 2007). This review was based on findings from a wide consultation with stakeholders and included research commissioned from the York Health Economics Consortium (Lowson et al., 2008). The York research provided examples of illness trajectories and the associated costs for children using palliative care. A summary of this information, including costs at current prices, can be found in the care package section of the report (section 8).

### Deprivation of Liberty Safeguards in England: implementation costs

Following the provision of an additional £10 million for local authorities and the NHS to fund the implementation of Deprivation of Liberty Safeguards, we have included a schema (2.9) that identifies the costs. Again a *process* rather than a service, the schema covers costs from the assessment stage through to provision of court protection. Information was drawn from a study by Shah and colleagues (2011).

### Improvements to routine data

#### Overheads

In last year's publication, we discussed the difficulty of estimating the level of overheads required to support any one type of professional and noted that there has been a dearth of studies that identify these costs. Last year, however, we used data from two new research studies to improve estimates for local authority overheads (Selwyn et al, 2009; Glendinning et al, 2010). In turn, this increased the unit cost of many social care services by around 30 per cent.

Over the last decade we have based our estimates for NHS overheads on routine data returns to the Department of Health and information provided by Trusts participating in the Ready Reckoner project (Netten et al., 1998). However, long-standing concerns about the data were addressed this year and information has been drawn from the NHS (England) Summarised Accounts, 2009-2010 to provide new estimates (The National Audit Office, 2010). The Summarised Accounts collate expenditure data from Strategic Health Authorities (SHAs), 121 NHS Trusts (including NHS Direct) and 152 Primary Care Trusts (PCTs). Given current and proposed changes to the way the NHS is organised we have based our calculations on the NHS Trust accounts as these are the bodies mainly responsible for providing health and social care staff.

In previous volumes we have made a distinction between two categories of overheads. Direct overheads cover the resources required to deliver services to users or patients and are directly related to the level of service activity. Indirect overheads include functions of the organisation which support the services and allow the organisation to operate; examples would be the Human Resources or Finance Departments. Unfortunately, the information provided in the Summarised Accounts does not identify these categories separately, and we have adapted our estimation method to obtain a percentage figure that reflects the relationship between all overheads and direct salary costs. The Summarised Accounts show the number of care (direct) and non-care (indirect) staff and costs for the latter group were estimated using the average salary for NHS management and administrative staff ([www.official-documents.gov.uk/document/hc1011/hc04/0410/0410.pdf](http://www.official-documents.gov.uk/document/hc1011/hc04/0410/0410.pdf)). The calculation resulted in an additional 19.1 per cent on care staff costs to cover

management, estates and administrative staff. The remaining overheads include the costs to the provider (office costs, travelling subsistence, leased and contract hire, advertising, transport and moveable plant, telephone rentals etc.), supplies and services (clinical and general), utilities and premises costs (water, sewerage, electricity and gas, cleaning, air conditioning) and education and training costs for the professional staff. These accounted for an additional 41.6 per cent of direct care staff salary costs, making a total of overheads 'multiplier' for direct salary costs of 60.7 per cent. More information on NHS accounting procedures can be found in the NHS Costing Manual (Department of Health, 2010b).

This approach brings our estimate for NHS overheads more in line with the new figure for social services. Of course, it is much higher than that used in earlier volumes and has therefore raised the unit costs of many health care professionals. We have used this new figure when updating schemas taken from previous volumes and for some of the new schemas. However, where more recent studies have calculated overheads from local data, as in the case of the re-ablement study, we have retained these figures.

### Qualifications

In last year's publication, we included new information on the cost of obtaining social work qualifications, following research undertaken to calculate the estimated working life of a social worker and the cost of providing the social work degree. This year, in collaboration with the Department of Health and the Higher Education Funding Council for England (HEFCE), we have reviewed our estimates for the qualification costs for health professionals to bring them in line with current funding arrangements and assumptions about the benefits for service providers during clinical placements. As in previous volumes, where no information is available on the cost of providing placements to higher education establishments or service providers we have assumed that the funding available covers the cost. More information about the changes to funding arrangements in health care is available from the Department of Health (2010c). Future editions of the *Unit Costs* publication will keep abreast of these changes.

### Time use

For many professionals we provide *weighted* unit costs alongside the cost per (working) hour. These have been adjusted in line with the time professionals spend undertaking certain tasks. For example, a cost per hour of patient contact would include recognition of the other tasks that are linked to contact, perhaps updating case notes, or liaising with other professionals. We use 'multipliers' which are applied to the basic hourly cost derived from time use studies for the different professional groups. However, such studies are rare so it is difficult to ensure that all time is appropriately allocated. Our underlying assumption is that all working time relates directly or indirectly to patient care, unless we have clear evidence otherwise. Thus, for example, study days, attendance at conferences, trade union activities and general administrative tasks are all assumed to be linked to patient care.

Given the economic climate, health providers seek the best skill mix for any service. Over the years, this has meant that some professionals (such as nurses) have taken on more responsibility, which in turn has meant that the balance of activities undertaken by other staff (such as healthcare assistants) has also changed. For example, a recent study found that healthcare assistants now carry out twice as much direct patient care on the wards as nurses, and are now deemed to be at the heart of patient care (Clover, 2010). In order to reflect this in the unit costs, this year we have replaced the time-use multipliers used in previous volumes with figures calculated from more recent studies.

### Cost of travel

Another task undertaken this year was to try to improve our travel estimates for both NHS and local authority staff, which have been drawn from a PSSRU study carried out in the early 1990s (Netten, 1992). We searched for studies that would provide some guidance on the number of miles covered by nurses for home visits and discussed the issue with members of the Royal College of Nursing (RCN). There was no relevant literature available and the RCN told us that costs could vary considerably depending on locality. We concluded that no nationally-applicable figure could be derived at this time. Instead, we have included the NHS guidance on travel costs in the relevant schemas. For local authority staff, we have cited the HM Revenue and Customs mileage rates for 2010/11.

### Community pharmacy

This year, following the *Community Pharmacy Cost of Service Inquiry* undertaken by PricewaterhouseCoopers and published in July 2011, we have been able to update the information on community pharmacy in schema 9.6.

### Clinical psychologist

This year, we have based the cost of a Clinical Psychologist on a higher salary point; Agenda for Change Band 8a rather than Band 7. We have learnt that Band 7 is considered to be a transition grade to full specialist practitioner status.

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As always, if you are aware of other sources of information which can be used to improve our estimates or if you have any other comments, please contact Lesley Curtis on 01227 827193 or e-mail [L.A.Curtis@kent.ac.uk](mailto:L.A.Curtis@kent.ac.uk).

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