Preface

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Since the publication of our last volume of the *Unit Costs of Health and Social Care* in December 2014, the challenges facing local authorities and the NHS have increased, with a renewed drive to improve productivity. For example, *The Five Year Forward View* set out some fundamental principles about how the provision of health services needs to adapt: "to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding" (NHS, 2014, p.5, para.13).

The Five Year Forward View also suggests that the funding gap between resources and patient needs could be as much as £30 billion. If the NHS is to provide the service to which it aspires and introduce some of the recently proposed changes, such as seven-day working, it is clear that decision-makers will need access to good-quality cost-related data.

England is not alone in facing such demands, and in recent years many countries have made efforts to improve the availability of data collection across the health care system to inform planning and to support health services evaluation (http://www.who.int/healthmetrics/en/). We are fortunate in England to have the relatively new *data.gov.uk* which holds a vast amount of data and from which we draw some information for our unit cost calculations. However, although this has made some data easier to find, data availability and the increased demand for cost-related information continue to provide us with challenges.

As usual in this preface, we describe the contents of this volume and the changes made in the light of requests from readers, new data and research findings, and our own analyses. One change certain to catch people's eye is the new layout used in some sections. We believe this supports our aim of making unit cost estimates easily accessible to policy-makers, commissioners, service providers and practitioners, as well as other members of our broadening audience and it is encouraging for us to note that the report was cited in 65 per cent of health economic evaluations in England. We discuss these changes in more detail below, but first introduce a guest editorial and three short articles published in this year's *Unit Costs of Health and Social Care*, and the new schema we have developed.

Articles

Stephen Allan's guest editorial discusses some of the implications of the 2014 *Care Act*. The legislation, which came in to force in April 2015, puts the individual at the heart of the adult social care system and this clear summary assesses the potential impacts for social care markets. Staying with the social care theme, Raphael Wittenberg and colleagues discuss the development of a new survey tool to gather self-reported data about respondents' care needs, use of formal care, and their use and provision of informal care. Such data would add substantially to the evidence base for policy-makers.

For the first of our research-based articles, Kate Baxter and Parvaneh Rabiee from the Social Policy Research Unit at York University identify the costs of vision rehabilitation services in England: these are rarely studied supports. One component links well with a recent theme in the *Unit Costs of Health and Social Care* volumes. The authors identify time spent by staff in the sample sites on client- and non-client-related activities.

Finally, Colin Ridyard and Dyfrig Hughes from the University of Bangor discuss their review of resource-use questionnaires used in trial-based economic evaluations. Service use data are used to calculate the costs of support and underpin any cost-effectiveness analysis. In turn, findings from such analyses are key to informing commissioning.

New unit costs

Dentist information

In last year's volume, we included unit costs for performer and provider performer dentists. This year we have carried out a survey in collaboration with the Department of Health and the General Dental Council to fill some of the information gaps. Over ten thousand dentists practising in England were contacted, and one response per dental practice was requested. Dentists with registration dates earlier than 1975 were excluded, and so too were suspended dentists and those without an e-mail address. Three hundred dentists responded (11.3% response rate, taking into account the number of dentists per

practice) and the results have been incorporated into the schema this year (see chapter 10). We are hoping to repeat this survey in the near future.

Environmental costs

Building on the guest editorial in the 2013 *Unit Costs of Health and Social Care*, we have included some initial figures for environmental costs alongside the unit costs for inpatient and outpatient days, and for GP and dentist appointments, based on the 2015 guidance. Carbon impacts include direct energy use for buildings and travel, as well as indirect or embedded emissions in the goods and services used in the delivery of healthcare (http://www.sduhealth.org.uk/policy-strategy/reporting/hcs-carbon-footprint.aspx).

Acute medical units

Acute medical units (AMUs) are the first point of entry for patients who are admitted for urgent investigation or care by their GP, an outpatient clinic or the Emergency Department. Schema 8.12, based on a study carried out by Matthew Franklin and colleagues (2014), provides a summary of patient resource-use and costs over three months, and data on service and average weekly/monthly cost for very high-cost patients.

Level 3 rehabilitation services

To extend the information we currently hold on rehabilitation services for patients with highly complex rehabilitation needs, in schema 7.6 we have added the costs of a new service (hyper-acute specialist rehabilitation services) created since the development of the Major Trauma Networks (https://www.networks.nhs.uk/nhs-networks/major-trauma-networks). This year, the schema includes a mean cost per weighted occupied bed day, as well as the mean cost per occupied bed day, which takes into account the number of days patients spend at five identified levels of complexity.

GP and nurse-led triage

As a result of the escalating demands on UK primary care, to support the evidence for using triage in primary care, a multi-centre cluster-randomised controlled trial and economic evaluation was carried out between 2011 and 2013, coordinated by the Pensinsula Medical School, in collaboration with the Universities of Bristol, Warwick and East Anglia. Drawing on the 2014 paper by John Campbell and colleagues, in schema 10.9 we present the costs relating to GP- and nurse-led triage compared with usual care for patients seeking same-day consultations in primary care.

Adults with autism

Thanks to the Autism Alliance http://autism-alliance.org.uk/about-us/the-alliance, we have been able to expand on the information we provide on services for adults with autism and complex needs (see chapter 4). While previous research (schema 8.3.4.) estimated aggregated and support costs for adults with high-functioning and low-functioning autism, new information provides a detailed breakdown of expenses incurred in the running of residential services. These include staff training costs, travelling and medical expenses, and also other costs relating to maintenance. These costs have been collected from three member organisations.

Routine information

Time use

Our basic unit cost for health and social care professionals is the cost per working hour. However, for many purposes, in both research and commissioning, other ‘units’ are more useful, perhaps an hour of patient contact or an hour of patient-related activity. For these calculations we need to allocate time spent on other activities to patient contact (or patient-related) time but, to do this, we need detailed information on how professionals spend their time. In last year’s volume, we drew the reader’s attention to new surveys which had recently been published, and also discussed the poor response rate we had received from our initial attempts to collect the information from an on-line survey of professionals. This year, after further attempts, we have slightly improved the response rate, but are not confident that these results reflect nationally applicable working patterns of all staff in a particular professional group. We have reported the data in section V (Other useful information) alongside the number of survey respondents.

For next year's publication, we are hoping to draw on data collected as a result of the Productive General Practice programme, a programme first trialled in 2011 to help practices use resources more efficiently and therefore ultimately spend more time with patients.
http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_community_services.html. Work will also be carried out to analyse data from the Client Record Interactive Search (CRIS), a project supported by the National Institute for Health Research (NIHR), http://www.slam.nhs.uk/about/core-facilities/cris, to provide time-use information for a range of professionals involved in the provision of services for people with mental health problems.

NHS overheads

Since 2011, we have based our estimates of NHS overheads on the NHS (England) Summarised Accounts, using the collated expenditure data from 121 NHS Trusts for 2012/13. We found that management and other non-care staff costs were 19.31 per cent of direct care salary costs and include administration and estates staff. Non-staff costs were 41.97 per cent of direct care salary costs. They include costs to the provider for office, travel/transport, publishing, training courses and conferences, supplies and services (clinical and general), utilities such as water as well as gas and electricity.

As a result of the changes made to the way NHS services are organised, the NHS (England) Summarised Accounts are no longer produced but have been replaced, in the main, by the NHS Foundation Trusts: Consolidated Accounts. This year we have undertaken work to assess whether it is appropriate to draw on these accounts for our overheads' estimates, given that most community trusts had not attained foundation trust status and most of the unit costs we report are for community-based services.

Expenditure data from ten community trust accounts (60% of the total number) were compared with data from the NHS Foundation Trusts: Consolidated Accounts, which included 147 organisations for 2013/14. We found that total overheads (non-staff and administration and estates) as a percentage of care staff costs were 7.1 per cent higher in foundation trusts (69.8% compared with 62.7%). One important difference was that the accounting guidance for NHS Trusts (now mainly community trusts) requires expenditure on drugs to be included with 'supplies and services – clinical' whereas, in the foundation trusts' accounts, drugs are shown as a separate expenditure line. When comparing the foundation and community trust data for these two expenditure lines, we found that 'supplies and services – clinical' amounted to a similar proportion of care-staff costs for both types of organisations, but the separate 'drugs' expenditure line for foundation trusts added a further 15 per cent of care-staff costs. Higher spend on drugs in acute (hospital only) trusts is likely to be driving this figure.

Therefore, our approach for this year is to use the figures derived from the financial accounts of the community trusts to estimate overheads of NHS community-based services. Unit costs for hospital-based services include an overhead percentage calculated from the NHS Foundation Trusts: Consolidated Accounts. This has meant a slight increase in the percentage for community-based services' total overheads (from 61.3% to 62.7% of care staff costs), but a larger increase for hospital-based services to 69.8 per cent of care staff costs. Further work will be undertaken next year to identify the overheads for different groups of trusts.

Superannuation

Every second year, we verify and update the employers' superannuation contribution rate for local authorities and the NHS. The rate paid by employers of NHS staff has remained at 14 per cent for a number of years, regardless of pay level (http://www.nhsbsa.nhs.uk/Pensions.aspx). This year, we have drawn on work published by the Local Government Pension Scheme Advisory Board, which suggests that the average rates for 23 local authorities for 2014-2017 is 20 per cent, ranging from 18.5 per cent to 24 per cent (http://www.lgpsboard.org/index.php/fund-actuarial-valuations-2013). The next scheme valuation is due in 2016, and the new rates will be included in the 2017 *Unit Costs of Health and Social Care* volume.

Qualification costs

This year, in response to a request from the Department of Health for more detail on the costs of professionals' education and training, we have included the number of years over which the benefits of the training are delivered, equal to the working life of the professional. We have also separated the placement fee for postgraduate training from other costs, and provided an additional table showing the costs before allowing for their distribution over time.

Equipment costs

Work is currently underway to provide additional staff-related costs to table 7.3 on the costs of equipment and adaptations. We will make these data available on the PSSRU website as soon as possible.

Inflators

Responsibility for children's social care services was moved to the Department for Education in 2007. Since then, we have used the Personal Social Services (PSS) indices for adults to adjust the costs of children's social care services. Next year, we are hoping to address this gap and to create a new inflator for children's social care services, using the same method as that used for the adult services.

Presentation of estimates

As outlined in our Christmas 2014 blog, we have been giving careful consideration to the presentation of unit costs in the *Unit Costs of Health and Social Care* (Curtis, 2014). Chapters 9 and 13 provide examples of this work in progress. In these chapters, we have provided unit costs for more grades of hospital nurses and community allied health professionals, but in a more condensed format. Thus, users can still find a particular unit cost quickly, but we have made sure that information on the methods used to arrive at the unit costs are still easily visible. Responding to user feedback, these tables will also be available in Excel format on our website.

Finally, we would like to take this opportunity to remind our readers that when the base data for any single schema is ten years old and we cannot find newer information, our policy is to delete the schema. This year, several schema have reached the ten-year deadline. As with other out-of-data unit costs, these are listed in the 'other sources of information' section at the back of the volume. We encourage readers to let us know about any studies that may help us reinstate schema where the service is still relevant; noticeable gaps in information are services for disabled people and people with intellectual disabilities. We would welcome contact from any organisations willing to work with us to provide unit costs for these services.

Acknowledgements

I would like to thank all my readers who have sent feedback on these blogs we have published this year:

Christmas festivities or publication of the Unit Costs Report? http://www.pssru.ac.uk/blogs/blog/christmas-festivities-or-publication-of-the-unit-costs-report/

Unit Costs in Use – Mental Health Services http://www.pssru.ac.uk/blogs/blog/unit-costs-in-use-mental-health-services/

Unit Costs of Health and Social Care makes the news http://www.pssru.ac.uk/blogs/blog/category/unit-costs/

There is a form on the website or you can e-mail directly: L.A.Curtis@kent.ac.uk or A.L.Burns@kent.ac.uk. Finally, I would like to extend my special thanks to Jennifer Beecham, who is always an invaluable source of advice in the preparation of this volume; and also to second author Amanda Burns, who has been able to devote more time this year to the Unit Costs Programme. I would also like to extend my gratitude to Alan Dargan, Jane Dennett and Ed Ludlow, for their administrative and technical assistance prior to publication. Thanks too to all those who have provided articles and information for new schema, and particularly to Stephen Allan for his guest editorial.

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References

Campbell, J., Fletcher, E., Britten, N., Green, C., Holt, T., Lattimer, V., Richards, D., Richards, S., Salisbury, C., Calitri, R., Bowyer, V., Chaplin, K., Kandiyali, R., Murdock, J., Roscoe, J. Varley, A., Warren, F. & Taylor, R. (2014) Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis, *The Lancet,* 384, 9957, 1859-1866.

Curtis, L. (2014), *Christmas festivities or publication of the Unit Costs report?* http://www.pssru.ac.uk/blogs/blog/christmas-festivities-or-publication-of-the-unit-costs-report/ [accessed 22 October 2015].

Department of Health (2014) *The Care Act*, The Stationery Office, London.

Franklin, M., Berdunov,V., Edmans, J., Conroy, S., Gladman, J., Tanajewski, L., Gkountouras, G. & Elliott, R. (2014) Identifying patient-level health and social care costs for older adults discharged from acute medical units in England, *Age & Ageing,* 43, 703-707.

NHS England (2014) *Five Year Forward View*, NHS, Monitor.