NHS

COPD Commissioning Toolkit

Costing Model Guidance: Spirometry and Pulmonary Rehabilitation Costing Model

Contents

Introduction 5
Pathway Costing 5
Cost–benefit Analysis 7

Introduction

The contents page of the model sets out brief descriptions of each worksheet in the model which covers the Spirometry and Assessment, and Pulmonary Rehabilitation, elements of the COPD Commissioning Toolkit, together with a full list of data and a work sheet covering COPD disease progression analysis.

The summary page is the main control panel which allows users to select their PCT, then summarises the main results and allows the user to flex certain key inputs to reflect local circumstances and various scenarios.

The costing tools have two key functions:

i. Pathway costing – This section of the model provides a means with which to calculate the total cost, on a per patient basis, of:

- the Spirometry and Assessment Service
- the Pulmonary Rehabilitation Service

This section will help to determine the affordability of local commissioning requirements for each element or combinations as appropriate, and enable the value-for-money evaluation of providers' quotes.

ii. Cost–benefit analysis – The model also enables cost–benefit analysis of implementing the Service(s) and this can be used in the business case.

The Hospital Episode Statistics (HES) data analysis used in the costing tool is currently at Primary Care Trust (PCT) level.

The costing tool includes a full list of assumptions in both the pathway costing and the cost–benefit analysis sections, to highlight the key drivers for the calculations.

Pathway Costing

This section sets out the process that Commissioners should follow in determining the cost of implementing the Service(s) set out in the COPD Commissioning Toolkit. The purpose of the model is to enable commissioners to determine the affordability of local requirements and enable the value-for-money evaluation of providers' price quotes.

The indicative per-patient costs calculated in the costing model cover staff costs only and are based on a series of assumptions that are embedded within the costing model. Additional commissioner costs and set-up costs must be entered locally. This model has been completed using the appropriate clinical specification in the COPD Commissioning Toolkit. The example values have been populated based on the consensus view of the clinicians who advised on the specifications. They are provided as a guide and should be modified to reflect the services discussed with providers and to suit local circumstances.

Commissioners need to understand that the staff cost per patient will be similar to the indicative cost in the model only if their actual local circumstances and the respective service specifications match the assumptions in the model. If local circumstances and specification requirements differ to any degree, then the staff cost per patient will be different.

The costing model represents the activities required to run a generic service as set out in the appropriate specification. Any variation on patient requirements must be considered separately. The elements of the COPD Commissioning Toolkit must be designed in agreement with the providers so that patients' specific needs are adequately met.

Key principles that must be adhered to in implementing the COPD Commissioning Toolkit are as follows:

- Payment currency – The payment will be due only on patients completing the service element or combination of elements of the pack in full. However the commissioner may wish to incentivise providers by setting KPIs for different stages of the pathway and providing funding according to them meeting these KPIs.

- Payment trigger – Costs assume that payment will be on completion of the relevant pathway.

- Pathway divisibility – The service elements are defined in the model. The commissioners, in agreement with their providers, can modify individual service elements.

- Pathway status – The costs assume contracting for each element of the pack on a completed pathway basis. The indicative costs are not mandatory but are evidence based using expected inputs.

- Pathway variations – The costing is based on specific staff bands, to meet minimum standards. The providers may have different costs for individual elements but still work within the overall pathway costs.

- Geographical costing differences – The calculated costs are for England and exclude any regional variations. These need to be considered locally, as do other assumptions detailed in the packs. In implementing the COPD Commissioning Toolkit or any element of it,

commissioners may incur additional specific local costs or initial set-up costs, which they should include in their pathway costing, and business case exercises. Commissioners will also need to input these additional costs into the costing model to calculate the full cost reflecting local needs and conditions.

The following data sources were used in creating the costing model:

- HES, The Information Centre for Health and Social Care
- NHS Staff Earnings Estimates January 2010, The Information Centre for Health and Social Care.

The main structure of the model calculates the central costs of running a Spirometry and Assessment Service and/or a Pulmonary Rehabilitation Service for one year.

The model includes four main types of cost:

- Staff costs – salary costs and on costs (employer National Insurance contributions etc.)
- Direct revenue overheads – resources required to deliver the service and which are related directly to the level of service activity (all office costs, uniforms, stationery etc.)
- Indirect overheads – costs of support services that are required for services to carry out their main functions, such as human resources and finance departments
- Capital overheads – venue and equipment costs, based on the new-build and land requirements of community health facilities, but adjusted to reflect shared used of both treatment and non-treatment space[1]

All overheads in the model are based on the estimated overheads for a Community Nurse in "Unit Costs of Health and Social Care 2010"[2]. The allowance for capital overheads varies by PCT, according to the Market Forces Factor (MFF), in order to take into account geographical variation in the cost of providing services.

These four types of cost are combined to generate a per-minute staff cost, which is then multiplied by the amount of staff time required to provide the service (including travel and administration time).

However, it is possible that providers will incur certain locally specific additional costs, which are not taken into account in the model's main structure. The model therefore includes a facility to allow commissioners to enter estimates of these specific costs themselves. These costs might include, for example:

- staff training
- booklets and patient information packs
- interpreters for non-English speaking patients
- interpreters for patients with impaired hearing

[1] Capital costs have been annuitised over 60 years at a discount rate of 3.5 per cent.
[2] http://www.pssru.ac.uk/pdf/uc/uc2010/uc2010.pdf

Cost-benefit Analysis

When using the cost-benefit section of the tool, commissioners should complete entries in respect of the appropriate Service(s), for the following assumptions to reflect their local circumstances:

- **Selecting your PCT** – Commissioners should select their PCT in the 'Select your PCT drop down box' tab, by clicking on the pull-down list. This will drive the calculations for PCT patient population numbers, which in turn will drive much of the cost–benefit calculations and the charts in the model.

- **Choose services to commission**

- **Key inputs for Spirometry and Assessment specification**
    - Percentage of GP practices which agree to participate
    - Percentage of those invited likely to turn up
    - Proportion of population over 35 who smoke
    - Proportion of population over 35 who are ex smokers
    - Percentage of current smokers who quit on diagnosis

- **Key input PR**
    - PR completion rate

- **Additional local costs – top right of Summary worksheet**