Are you ready for World-Class Commissioning in the NHS?

How do you go about calculating costing and productivity of community occupational therapy services? **Dr Sidney Chu** presents a caseload-based approach to explain the process

The 2008 NHS Next Stage Review (DH 2008) emphasised the increasing importance in the future of services being provided close to the patient and also underlined the need for services to develop and innovate.

World-Class Commissioning is seen as the way to raise quality, but provider organisations also need to be fit for purpose to deliver the transformed services (DH 2009a; NHS Confederation 2009).

Department of Health (DH) guidance issued since the NHS Next Stage Review has outlined a future where community services will adopt new governance models, where some services may be opened up to competition, and where there will be more emphasis on contracting and understanding the quality and cost of service (NHS Confederation 2009).

That means effective commissioning is a crucial part of transforming community services.

The DH has said that the contracting and costing structure will change radically over the next two years as commissioners and providers move towards a payment system which rewards improvements in quality and value, ultimately improving health and well-being outcomes.

This move will require a far better understanding, gained through improved information, of what the provision of a service actually costs (DH 2009b).

Much of this work will take place locally and decisions about which currencies (the units of healthcare for which a provider is funded) to use will be made at local level. But in some areas (for example, child health promotion and end-of-life care), the DH will explore the potential for national currencies (DH 2009b).

New currencies and better pricing are keys to transforming community services, enabling commissioners to incentivise improvements in quality and value. Currently, around 90 per cent of community services are funded on block contracts.

Contracting and currency options for service payment

There is a range of currencies that could be used to determine pay for community services. The term 'currency' refers to the unit of healthcare for which a provider is funded. At one extreme is a block budget, which is not related to the number of patients; at the other is a system based on fees for individual services (such as payments for vaccinations).

In between are systems based on capitation payments, payments for a year of care and payments per procedure or per day. Each of these will create different incentives and will have implications for efficiency, quality and equity (DH 2009b).

Commissioners will consider which currency is likely to be most appropriate for each service and what they want to achieve. But they need to understand the patterns of risk and associated behaviours created by each currency.

But much work on pricing will have to be done at local level through co-operation between commissioners and providers and an 'open book' approach.

Historically, community services have not had good data. Lack of good data could undermine attempts to introduce currencies as they could lead to unsustainable pricing models which either underprice or overprice services.

For example, reference cost has been used to examine the costing of different services for many years. However, significant variation exists in how reference costs for community services are calculated. And also, reference costs are reported on the basis of professional groups and numbers of contacts which may not fit with the chosen currency model.

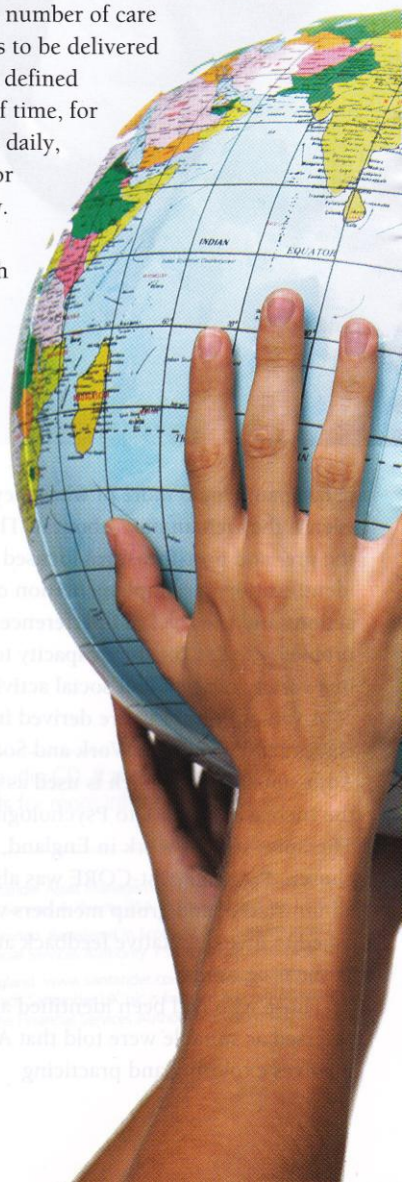
Commissioners are strongly encouraged to develop appropriate local currencies for most community services. The eventual price that is paid per unit of currency should, wherever possible, be derived from a bottom up costing approach (DH 2009b).

Approaches used in calculating costing and productivity of services

Traditionally, there are several different approaches used in the NHS to define caseload, calculate unit cost and the productivity of a clinical service. Information generated may be used to calculate staffing levels and also set standards for performance management.

For occupational therapy services in the community, the caseload-based approach is more appropriate. It involves calculating the available 'clinical input hours' per whole time equivalent (wte) staff and matching it with the number of care packages to be delivered within a defined period of time, for example daily, weekly or annually.

This approach



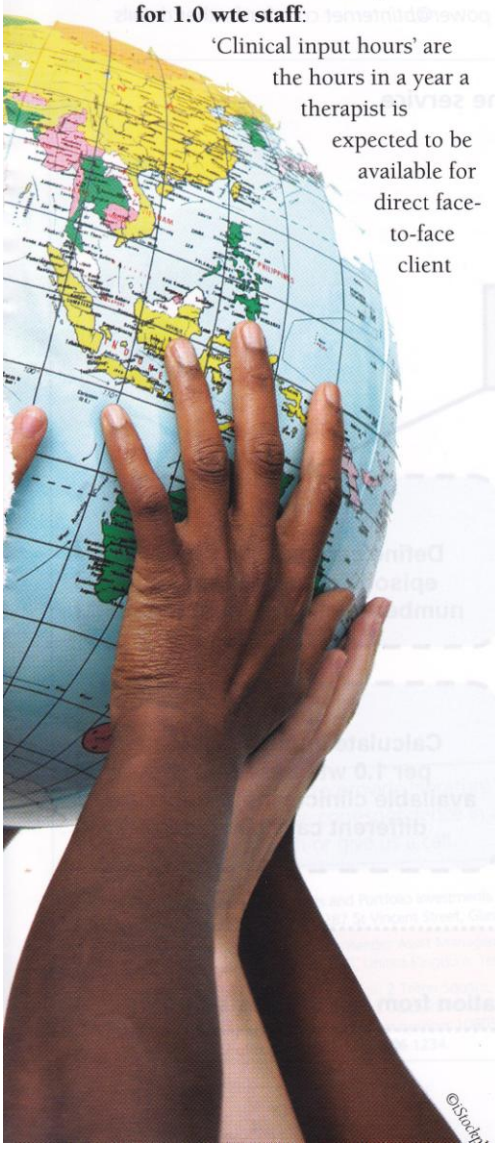
provides a better description of the ranges of clinical work carried out by occupational therapy services at different locations in the community.

Figure one (page 34) illustrates the schematic structure of the caseload-based method and steps involved in calculating the unit cost, caseload and productivity of the service (the actual calculation is not shown here).

Step one: Calculate 'on duty hours' for 1.0 wte staff:
'On duty hours' are the hours in a year a therapist is expected to be available for work after deducting the annual leave and other variable leaves (*eg* sickness or study) from the contracted hours: on duty hours = contracted hours – (annual leave + variable leaves).

For the available 'on duty hours', staff will spend time on direct face-to-face client contact (that is, clinical input hours) and other related activities.

Step two: Calculate 'clinical input hours' for 1.0 wte staff:
'Clinical input hours' are the hours in a year a therapist is expected to be available for direct face-to-face client contacts. The calculation of clinical input hours is based on the percentage of on duty hours used by a therapist for direct face-to-face client contact as distinct from related activities (for example, team meetings, clinical governance activities, documentation, liaison and supervision etc).



> New currencies and better pricing are keys to transforming community services, enabling commissioners to incentivise improvements in quality and value.

It is important for the service to have information on the proportion of time spent on direct face-to-face client contacts and other related activities. A time and motion analysis should be carried out if the information is not available. Alternatively, the service can set the defined proportion of time; for example, 40 per cent time for face-to-face contacts and 60 per cent for other related activities.

Once the number of 'clinical input hours' is calculated, it can be used to calculate the number of client contacts that could be made by a full-time (or pro-rata) staff per year (see step three), the unit cost (see step four) and also caseload (see steps five, six and seven).

For a larger service, calculation for different bandings/pay scales of staff should be done in order to reflect the level of skills required for different level of clinical work.

Step three: Calculate number of face-to-face contacts that could be made by 1.0 wte staff per year:
'Face-to-face client contact' is defined as a contact made by a staff in seeing a client for direct clinical work. The contact needs to be clearly defined in minutes or hours.

In calculating the number of contacts per year (or per week and month) it is important to use the figure of 'on duty hours' as the staff is actually on duty for about 41 weeks per year.

Step four: Calculate the 'unit cost' per one 'clinical input hour' for a staff on a particular banding/pay scale:
'Unit cost' is defined as the amount of money required for a staff to deliver a clinical input hour. The calculation of unit cost should consider figures of different costs, which include staff cost, over-head cost and other expenses in running the service, for example management cost, administrative support and non-pay expenditures.

Costing for specific equipment could be added as a separate item as it does not apply to all clients being seen by the service. Unit cost could be worked out for individual staff group at different bandings/grades if more precise costing figure is needed.

Steps five, six and seven: calculate the costing of each defined care package and also the caseload based on number of care packages completed:
'Care package' is a set of interventions designed to deliver specified benefits for a group of clients who have similar needs and who are expected to respond to a particular set of intervention in a similar way.

A care package should be capable of being accurately cost and should indicate the time scale within which the target benefits should normally be achieved (NHS Executive 1997).

'Costing per care package' is defined as the cost in completing a care package for an episode of care; that is, multiplied the number of clinical input hours required for a care package to the unit cost of the staff involved. The number of 'clinical input hours' required for each care package should be defined.

'Annual caseload based on care package' is defined as the number of clients that can be dealt with by 1.0 wte staff by completing a defined care package. It is important to note that a staff could have a mixture of new and long-term cases going through different care packages. It is necessary to do separate calculation for different care packages that may be delivered by the staff.

Step eight: Calculate the annual productivity of the whole service by combining information from the whole staff group:
'Productivity' refers to the average amount of work completed by the whole service in a defined period of time. It represents a relationship between the amount of time paid and the amount of work completed; that is, the relationship between input and output (AOTA 1992).

The figures for total face-to-face contacts and/or number of care packages delivered could be used as an annual standard of productivity. The standards set could be used to measure performance of the service. Information generated could be used for annual report.

Further information in the costing and commissioning of NHS services

Contracts for services may be for a fixed term, rather than open-ended, to allow periodic market testing. One of the mechanisms likely to achieve greater competition in community services is the 'any willing PCT-accredited provider' (AWPP) model of primary care trusts accrediting more than one organisation to provide a particular service.

Commissioners will indicate which services are likely to be opened up to AWPP and in what timescale. They can include specific service and access requirements in any accreditation process. It is most likely to be used for services where there is a well-developed payment regime and there are no high start-up or fixed costs.

The government is also committed to piloting individual budgets, with a view to rolling them out nationally should they prove successful. An individual budget is designed to provide individuals who currently receive services with greater choice and control over their support arrangements.

It is likely that individual budgets, if successful, would have an impact on the current model in the commissioning of community services.

Guidance or tool has been developed by the DH for commissioning specific community services, for example the currency options for the 'Healthy Child Programme' (DH 2010).

The caseload-based method outlined in this short article will also be useful to examine the demand and capacity of the service, including the identification of changes needed to be made in order to improve the delivery of the service.

References

AOTA (1992) *Managing productivity in occupational therapy.* Bethesda, Maryland: The American Occupational Therapy Association, Inc

Department of Health (2008) *NHS Next Stage Review: our vision for primary and community care*

Department of Health (2009a) *Transforming community services and world class commissioning – resource pack for commissioners of community services*

Department of Health (2009b) *Transforming community services: currency and pricing options for community services*

Department of Health (2010) *Currency options for the Healthy Child Programme – Transforming community services*

NHS Confederation (2009) *Primary Care Trust Network Briefing Issue 181: The future for community services*

NHS Confederation (2009) *Primary Care Trust Network Discussion Paper Issue 5: Commissioning in a cold climate*

NHS Executive (1997) Leaflet on care packages (Ref. A1084). *Enabling information management and technology for primary healthcare*

● **Dr Sidney Chu**, Paediatric Occupational Therapy Service Manager, Ealing Service for Children with Additional Needs and Honorary Fellow, Brunel University. A one-day course has specially been designed for managers and clinical leads of different therapy and nursing services to learn the concepts and calculation steps used in this method. Please contact: *kid.power@btinternet.com* for further details

Figure 1: Steps for calculating the unit cost, caseload and productivity of the service