Costing statement: Multiple sclerosis: management of multiple sclerosis in primary and secondary care
Implementing the NICE guideline on multiple sclerosis (CG186)

Published: October 2014
1 Introduction

1.1 This costing statement considers the cost implications of the recommendations made in Multiple sclerosis: management of multiple sclerosis in primary and secondary care (NICE clinical guideline 186).

1.2 A costing statement has been produced for this guideline because of variation in current clinical practice across the country. Therefore, we encourage organisations to evaluate their own practices against the recommendations in the NICE guideline and assess the resource impact locally. Some of the resource effects to be considered locally are discussed in this statement.

1.3 NHS England commissions adult specialist neuroscience services provided by adult neuroscience or neurology centres, including services delivered on an outreach basis as part of a provider network. NHS England also commissions GP services. Community health services and inpatient and outpatient neurology services provided at acute hospitals that are not adult neuroscience or neurology centres are commissioned by clinical commissioning groups.

1.4 Organisations are advised to assess the resource implications of implementing the recommendations in the guidance locally. Costs likely to be incurred include providing support, coordinating care and comprehensive review; recruiting additional staff or training to implement the recommendations (depending on current practice); and providing exercise programmes if they are not currently commissioned. Savings may be achieved through offering oral steroids, and through fewer relapses and hospital admissions with improved management of Multiple Sclerosis (MS).
2 Background

2.1 MS is an acquired chronic immune-mediated inflammatory condition of the central nervous system (CNS), affecting both the brain and spinal cord. It affects approximately 89,000 people in England\(^1\). Symptoms typically develop in people’s 20s and 30s and it is the commonest cause of serious physical disability in adults of working age. People with MS may live for many years after diagnosis.

2.2 MS is managed with disease-modifying therapies and symptom alleviation.

2.3 Most disease-modifying therapies aim to reduce the frequency and severity of relapses. These therapies are covered in NICE technology appraisals and are therefore not covered in the guideline.

2.4 There is currently wide regional variability in access to specialist services and access to neurological rehabilitation services is particularly poor. Services are poorly integrated for people with MS. Coordinating assessment and treatment of often complex needs and symptoms is pivotal for high-quality care.

3 Recommendations with potential resource impact

Providing support, coordination of care and comprehensive review

Recommendations

3.1 Offer the person with MS a face-to-face follow-up appointment with a healthcare professional with expertise in MS to take place within 6 weeks of diagnosis. [Recommendation 1.2.4]

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\(^1\) Multiple Sclerosis Trust – Key facts - adjusted to reflect England only
3.2 Care for people with MS using a coordinated multidisciplinary approach. Involve professionals who can best meet the needs of the person with MS and who have expertise in managing MS including:

- consultant neurologists
- MS nurses
- physiotherapists and occupational therapists
- speech and language therapists, psychologists, dietitians, social care and continence specialists
- GPs. [Recommendation 1.3.1]

3.3 Ensure all people with MS have a comprehensive review of all aspects of their care at least once a year. [Recommendation 1.6.1]

Background

3.4 Expert opinion suggests that people with MS often don’t receive a follow-up appointment within 6 weeks of diagnosis or with a healthcare professional with expertise in MS. This depends on local service arrangements.

3.5 It is not current practice in all areas for people with MS to have a comprehensive review of all aspects of their care as frequently or thoroughly as set out in the recommendations. Additionally, some people may currently have a review of their care with a healthcare professional in primary or secondary care who does not have adequate understanding of MS. Healthcare professionals with an expertise in MS may include a specialist nurse, neurologist, or a GP or therapist with experience in treating MS or its complications.

3.6 Expert opinion suggests that some areas of England currently do not have enough healthcare professionals with an expertise in MS in order to meet the guideline recommendations.
Costs

3.7 Based on the prevalence of MS in England, it is assumed that 89,000 people (see section 2.1) would need a comprehensive review each year. Local data should be available to determine the number of people who currently receive a review.

3.8 The unit costs to the commissioner for an appointment for a follow-up or review are shown in table 1. It is not possible to quantify the resource impact of an increase in follow-up or review appointments because the national baseline data is not available.

Table 1 Cost of consultant-led neurology outpatient appointments

<table>
<thead>
<tr>
<th>Neurology outpatient attendances</th>
<th>Unit cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WF01A Follow-up attendance – Single professional</td>
<td>126</td>
</tr>
<tr>
<td>WF02A Follow-up attendance – Multi-professional</td>
<td>132</td>
</tr>
</tbody>
</table>

Source: The 2014/15 National Tariff Payment System: National Tariff Information Workbook

3.9 There will be costs for providers where additional staff are needed or where current staff need training to increase their expertise in MS. Table 2 shows the annual costs to providers of the different types of staff. Training costs would need to be assessed locally.

Table 2 Provider cost of specialist staff

<table>
<thead>
<tr>
<th>Specialist staff</th>
<th>Annual costs for provider including overheads (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant neurologist</td>
<td>109,058&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Neurologist (associate specialist)</td>
<td>95,849&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Specialist nurse (band 7)</td>
<td>43,337&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Allied health professional (band 6)</td>
<td>36,151&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Psychologist (band 7)</td>
<td>43,337&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> Curtis L (2013) Personal Social Services Research Unit. Unit costs of health and social care 2013. Cost includes salary plus on-costs for employer’s national insurance and superannuation contributions.

<sup>b</sup> Agenda for Change pay scales 2014/5 – midpoint of bands used.
Savings and benefits

3.10 Providers may achieve savings if outpatient appointments are conducted by members of the multidisciplinary team. See table 2 for annual costs associated with different specialist staff.

3.11 The symptoms and progression of MS may improve as a result of better management of the condition from regular comprehensive reviews. This should lead to improved health and quality of life for the person with MS, their carer and/or family, as well as savings for commissioners from a reduced number of episodes of MS. Table 3 shows the unit cost savings that may be achieved based on the payment by results tariff costs for hospital spells. It is not possible to quantify the potential savings with reasonable certainty because of the lack of data available. Savings should be assessed locally.

Table 3 Cost of inpatient episodes for the care of people with MS

<table>
<thead>
<tr>
<th>National tariff 2014/15</th>
<th>Cost of non-elective spell (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA30A Medical care of patients with multiple sclerosis with CC²</td>
<td>3,741</td>
</tr>
<tr>
<td>AA30B Medical care of patients with multiple sclerosis without CC²</td>
<td>1,881</td>
</tr>
</tbody>
</table>

Source: The 2014/15 National Tariff Payment System: National Tariff Information Workbook

3.12 There may be efficiency savings for organisations locally because of coordinating of services for people with MS provided by the NHS and local authorities. There may be a reduction in the number of appointments required and assessments carried out by different services and improved access to services such as social care and exercise programmes. This will lead to an improved level of care for people with MS.

Complications and Comorbidities

Costing statement: Multiple sclerosis (October 2014)
Treating acute relapse of MS with steroids

Recommendation

3.13 Offer treatment for relapse of MS with oral methylprednisolone 0.5 g daily for 5 days. [Recommendation 1.7.7]

Background

3.14 When a person with MS has a relapse, they may receive treatment with steroids, which usually includes oral or intravenous (IV) methylprednisolone.

3.15 It is estimated that there are between 6,700 and 8,300 relapses in a year in England\(^3\).

3.16 Currently, a significant number of people are treated with IV steroids, either at home by visiting community nurses, or as day cases or inpatients in acute hospital settings. Some relapses are treated with oral methylprednisolone.

Savings and benefits

3.17 Expert opinion suggests that implementing the recommendation would reduce the number of people who receive IV steroids either as day cases or at home, because they will take oral steroids. The number of people who receive steroids as inpatients is not anticipated to change.

3.18 Methylprednisolone is taken orally for 5 days or by IV over 3–5 days. The cost of the steroid is similar for oral and IV preparations, at £60 and £52 respectively\(^3\).

3.19 However, it is more expensive to administer IV methylprednisolone. Home administration is estimated to cost £213 based on a 3.5-hour home visit by a community nurse, including travel\(^3\). The commissioner cost of this service will depend on local negotiations.

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\(^3\) NICE full guideline on multiple sclerosis.
of services. The cost to the commissioner for administering IV methylprednisolone as a day case is shown in table 4.

**Table 4 National tariff for day-case medical care of people with MS**

<table>
<thead>
<tr>
<th>National tariff 2014/15</th>
<th>Cost of day case (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA30A Medical care of patients with multiple sclerosis with CC⁴</td>
<td>847</td>
</tr>
<tr>
<td>AA30B Medical care of patients with multiple sclerosis without CC⁴</td>
<td>452</td>
</tr>
</tbody>
</table>

Source: The 2014/15 National Tariff Payment System: National Tariff Information Workbook

3.20 It is not possible to quantify the resource impact of implementing this recommendation because of difficulties in establishing an accurate baseline. It is anticipated that clinical commissioning groups will achieve savings locally from a reduction in the number of people receiving IV steroid treatment either as a day case or at home, thus avoiding administration costs.

**Supervised exercise programmes**

**Recommendations**

3.21 Consider supervised exercise programmes involving moderate progressive resistance training and aerobic exercise to treat people with MS who have mobility problems and/or fatigue.

[Recommendation 1.5.11]

**Background**

3.22 Expert opinion indicates that there may be a shortage of supervised exercise programmes.

3.23 Exercise programmes should be supervised by a person with experience of providing exercise programmes for people with MS.

⁴ Complications and Co-morbidities
Costs

3.24 The guideline does not make recommendations about the length of each class, duration of programme or the number of people in each class. Costs of providing supervised exercise programmes are likely to vary and should be considered locally. It is anticipated that the programme would be conducted by a physiotherapist or occupational therapist.

Savings and benefits

3.25 Treating mobility problems and fatigue associated with MS may help avoid costs of treating problems such as anxiety, depression, and difficulty in sleeping. Therefore, initial investment made by commissioners is likely to lead to savings in the longer term.

3.26 Providing exercise programmes may lead to savings for NHS commissioners and local authorities by reducing the need for adapting properties, ordering specialist equipment and designing individual care packages for people with MS with poor mobility.

4 Conclusion

4.1 Due to variation in clinical practice the costs of implementing this clinical guideline should be assessed locally. Local costs for commissioners and providers are anticipated for assessing the number of MS specialist staff needed and the training requirements to implement the recommendations on providing follow-up appointments and comprehensive review and coordinating care. Costs for commissioners are also anticipated for implementing services for supervised exercise programmes. Commissioners and providers are encouraged to assess these costs locally and collaborate to ensure that MS services are appropriately funded.

4.2 Savings may be achieved by using oral steroids, which reduces the costs associated with administering IV steroids either at home or as day cases. Savings may also be made by reducing the number of
relapses and hospital admissions by improving the management of MS.
About this costing statement

This costing statement accompanies Multiple sclerosis: management of multiple sclerosis in primary and secondary care (NICE clinical guideline 186).

Issue date: October 2014

This statement is written in the following context

This statement represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. It should be read in conjunction with the NICE guideline. The statement is an implementation tool and focuses on those areas that were considered to have potential impact on resource utilisation.

The cost and activity assessments in the statement are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.

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