Appendix C1 Economic evidence

Transition from children's to adults' services for young people using health or social care services

Completed methodology checklists: economic evaluations

Review Question 4

What is the effectiveness of support models and frameworks to improve transition from children's to adults' services?

COMPLETED METHODOLOGY CHECKLISTS: ECONOMIC EVALUATIONS

Study identification: Munro E, Lushey C (2012) Evaluaton of the Staying Put: 18 Plus Family Placement Program: final report. UK Government Department for Education	
Guideline topic: Transition from children's to adults' services for young people using health or social care services.	
Economic priority area: What is the effectiveness of support models and frameworks to improve transition from children's to adults' services?	**Q:** 4
Checklist: Section 1	
Yes/No/Partly/ Not applicable	Detail
1.1 Is the study population appropriate for the review question?	
Yes	Care leavers with an established familial relationship, although not strictly defined, was considered to include 'young people who have lived with their current foster carers for some time and thus had an opportunity to develop an attachment to them'. Exclusions: 'those with placement instability and change as they approach adulthood, as well as those who are placed with parents, or in secure units, children's homes or hostels. These groups may be more vulnerable and have more complex needs than those who are eligible to stay put' (Munro et al. 2011a; Sinclair et al. 2007) (p25).
1.2 Are the interventions appropriate for the review question?	
Yes	'Staying Put 18+ Programme'. Young people with 'established familial relationships' are able to choose to stay with foster carers until age 21.
1.3 Is the current social care system in which the study was conducted sufficiently similar to the current UK social care context?	
Unclear	Conducted between July 2008 and March 2011.
1.4 Are the perspectives clearly stated and what are they?	
No	Cost case studies take perspective of public sector (p94).
1.5 Are all direct effects on individuals included?	
No	There were significant limitations in collection of outcomes and costs, which meant that no analysis could be done. Outcomes measured included engagement in education, training, employment, or not in education, training or employment (NEET) but the ability to measure impact of the intervention is limited in that these are also requirements for being in the programme. Qualitative data is available on a smaller sample for health and social care outcomes, experience and processes of care. In relation to costs, it was originally planned to collect information on the use of local authority services, but collecting this information was not possible. Instead, authors provided cost case studies to understand the intervention's impact (p24).
1.6 Are all future costs and outcomes discounted appropriately?	
No	See above – in relation to cost case studies, these were measured costs over a 5-year time horizon but do not appear to be discounted.
1.7 How is the value of effects expressed?	
Natural units	Measured as engagement in education, training, and employment, or NEET over a 2-year period.

1.8 Are costs and outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?	
Partially	Impact on outcomes and costs on families is assessed through qualitative interviews on a sub-set of the sample.
General conclusion	
Not applicable due to the lack of a robust comparison group and lack of information on impact of the intervention on outcomes and on health and social care service use. No conclusions can be drawn about the intervention's cost-effectiveness as there were significant limitations in the study design, i.e. that there was no comparison group and the lack of information on the effect of the intervention on individual's outcomes and on health and social care service use.	

Transition from children's to adults' services for young people using health or social care services

Completed methodology checklists: economic evaluations

Review Question 5

What is the effectiveness of interventions designed to improve transition from children's to adults' services?

COMPLETED METHODOLOGY CHECKLISTS: ECONOMIC EVALUATIONS

Study identification: Prestidge C, Romann A, Djurdjev O, Matsuda-Abedini M (2012) Utility and cost of a renal transplant transition clinic. Pediatric Nephrology 27: 295–302	
Guideline topic: Transition from children's to adults' services for young people using health or social care services.	
Economic priority area: What is the effectiveness of support models and frameworks to improve transition from children's to adults' services?	**Q:** 4
Checklist: Section 1	
Yes/No/Partly/Not applicable	Detail
1.3 Is the study population appropriate for the review question?	
Yes	Adolescents undergoing transition usually referred at 16.
1.4 Are the interventions appropriate for the review question?	
Yes	Tertiary children's hospital with multidisciplinary transition clinic and transition team.
1.3 Is the current social care system in which the study was conducted sufficiently similar to the current UK social care context?	
Unclear	Study was conducted in Canada and covers a period from 2000 to 2007.
1.4 Are the perspectives clearly stated and what are they?	
Partially	Not stated explicitly. It includes the cost of the intervention. Individual patient-level data was not available, therefore, costs were estimated only on the basis of outcomes – those requiring dialysis or transplant. Costs associated with dialysis or transplant were taken from published sources which included hospitalization, inpatient and outpatient physician care, laboratory and diagnostic testing and medications (p297).
1.5 Are all direct effects on individuals included?	
Partially	Focuses on clinical outcomes: death, allograft loss, biopsy-proven acute rejection, serum creatinine levels. No social care outcomes or other individual-level outcomes but this is due to the nature of the study design (matched comparison, using prospective design for intervention and using retrospective case notes for control group) and due to the aims of the intervention, which was to test impact on clinically important outcomes.
1.6 Are all future costs and outcomes discounted appropriately?	
Unclear	Not clearly stated.
1.7 How is the value of effects expressed?	
Natural units	Clinical outcomes are expressed in natural units however the changes in resource use are based on outcomes of dialysis and transplant, but this is reported in monetary units.
1.8 Are costs and outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?	
No	Impact on carers is not included.
General conclusion	

The study is applicable but has some limitations. The perspective of the analysis, while not explicitly stated, includes a very limited range of healthcare costs and focuses very specifically on key clinical outcomes. This may be appropriate given that the aims of the study are to reduce adverse health consequences, which are captured through outcomes of mortality and those needing dialysis and transplants. However, it is important to note that the study is limited in that it does not measure all-important changes in health and social care service use. The study also does not consider other outcomes such as wellbeing or social care related outcomes; however, this may be a minor point given the objectives of the study.

Section 2: Study limitations (the level of methodological quality) This checklist should be used once it has been decided that the study is sufficiently applicable to the context of the social care guidance [a].	
2.1 Does the model structure adequately reflect the nature of the topic under evaluation?	
NA	Not a model. This is a cost-consequence analysis.
2.2 Is the time horizon sufficiently long to reflect all-important differences in costs and outcomes?	
Yes	Two-year time horizon.
2.3 Are all important and relevant outcomes included?	
Partially	See Sections 1.4 and 1.5
2.4 Are the estimates of baseline outcomes from the best available source?	
Yes	Trial data.
2.5 Are the estimates of relative intervention effects from the best available source?	
Yes	Trial data.
2.6 Are all important and relevant costs included?	
No	See Section 1.4.
2.7 Are the estimates of resource use from the best available source?	
Partially	See Section 1.4.
2.8 Are the unit costs of resources from the best available source?	
Unclear	The authors rely on published studies to estimate costs.
2.9 Is an appropriate incremental analysis presented or can it be calculated from the data?	
Partially	An incremental analysis can be calculated on the basis of outcomes measured – number of deaths or allograft losses averted.
2.10 Are all-important parameters whose values are uncertain subjected to appropriate sensitivity analysis?	
Yes	Standard statistical analyses were carried out.
2.11 Is there any potential conflict of interest?	
No	No financial or ethical conflicts of interest. No funding was used for this study.
2.12 Overall assessment	

It is not possible to say whether the intervention is or is not cost-effective, as it would require further analysis to take into account differences in institutional context and unit costs between Canadian and UK settings. But more than that, given that there was not a comprehensive collection of healthcare resource use nor does social care resource use require that an assumption be made about likely impacts on these services when drawing conclusions about cost-effectiveness alongside reported outcomes.

Transition from children's to adults' services for young people using health or social care services

Completed methodology checklists: economic evaluations

Review Question 7

How can the transition process (including preparing the young person, making the transfer and supporting them after the move) be managed effectively for those receiving a combination of different services?

COMPLETED METHODOLOGY CHECKLISTS: ECONOMIC EVALUATIONS

Study identification: Bent N, Tennant A, Swift T, Posnett J, Scuffham P, Chamberlain M (2002) Team approach versus ad hoc health services for young people with physical disabilities: a retrospective cohort study. The Lancet 360: 1280–86	
Guideline topic: Transition from children's to adults' services for young people using health or social care services.	
Economic priority area: What is the effectiveness of support models and frameworks to improve transition from children's to adults' services?	**Q:** 4
Checklist: Section 1	
Yes/No/Partly/ Not applicable	Detail
1.5 Is the study population appropriate for the review question?	
Yes	Young adults with physical and complex disabilities (in the target diagnostic groups of cerebral palsy, spina bifida, traumatic brain injury or degenerative neuromuscular disease) with mild or no learning disability.
1.6 Are the interventions appropriate for the review question?	
Yes	Young adult team approach (coordinated multidisciplinary teams).
1.3 Is the current social care system in which the study was conducted sufficiently similar to the current UK social care context?	
Unclear	Study conducted between 1999 and 2000.
1.4 Are the perspectives clearly stated and what are they?	
Partially	Perspective not clearly stated but takes view of NHS and social services. Only community health and social care costs are measured. Excludes respite care and acute care services. It is unclear why these aren't included and no explanation is given so as to understand the appropriateness of excluding these categories.
1.5 Are all direct effects on individuals included?	
Partially	Social care-related quality of life measures somewhat captured through participation and psychosocial measures. 1. Participation restriction (London Handicap Scale – measuring mobility, self-care, work and leisure, getting on with people, awareness of surroundings, and being able to afford the things they require). 2. Body function impairment (Nottingham Health Profile sub-scales – pain, energy, sleep). 3. Activity limitation (Barthel). 4. Health status (Euroqol Visual Analogue Scale). 5. Psychosocial measures (self-esteem, self-efficacy, proactive attitude, stress).
1.6 Are all future costs and outcomes discounted appropriately?	
Not necessary	Six-month time horizon.
1.7 How is the value of effects expressed?	

Natural units	Resource use is expressed in natural units.
1.8 Are costs and outcomes from other sectors (including the value of unpaid care, where relevant) fully and appropriately measured and valued?	
No	Carer outcomes and costs not measured.
General conclusion	
The study is applicable although has potentially minor limitations. The perspective of the analysis is that of the NHS and social care services, although limited to the perspective of community health and social care. Acute care and respite social care services were not measured and the rationale for this is not provided. Resource use was measured over a 6-month period based on self-report retrospective resource use and unit costs were appropriately based on national unit cost publications. The authors conducted a cost–consequence analysis that included health outcomes and aspects of social care-related outcomes such as participation restriction and psychosocial measures. The study does not include impact on carers, which would be very relevant for this population group. The authors do not mention issues with the time horizon and therefore it is assumed that it is sufficient to capture important differences.	

Section 2: Study limitations (the level of methodological quality) This checklist should be used once it has been decided that the study is sufficiently applicable to the context of the social care guidance [a].	
2.1 Does the model structure adequately reflect the nature of the topic under evaluation?	
Not applicable	This is not a model. It is a cost-consequence analysis.
2.2 Is the time horizon sufficiently long to reflect all-important differences in costs and outcomes?	
Yes	Study is measured over a 6-month time horizon. The aims of the study were to increase individual participation in the community and the hypothesis was that community health and social care costs would not be different.
2.3 Are all important and relevant outcomes included?	
Partially	See Sections 1.4 and 1.5.
2.4 Are the estimates of baseline outcomes from the best available source?	
No	Baseline measures not taken.
2.5 Are the estimates of relative intervention effects from the best available source?	
Yes	From the trial.
2.6 Are all important and relevant costs included?	
Partially	See Section 1.4.
2.7 Are the estimates of resource use from the best available source?	
Partially	Self-report, retrospective over 6 months.
2.8 Are the unit costs of resources from the best available source?	
Yes	National unit costs from PSSRU unit costs compendium.
2.9 Is an appropriate incremental analysis presented or can it be calculated from the data?	
Partially	It can be calculated from the data but it is not presented.

2.10 Are all-important parameters whose values are uncertain subjected to appropriate sensitivity analysis?	
Partially	Sensitivity analyses were carried out only via scenario analysis on total costs by increasing intervention costs under the assumption of longer team meetings per week as opposed to using bootstrapping techniques on service use and costs more generally.
2.11 Is there any potential conflict of interest?	
None declared	
2.12 Overall assessment	
A formal cost-effectiveness analysis was not undertaken but the intervention improves outcomes with no differences in costs to the NHS and social care services although this is restricted to the use of community health and social care services and it is unclear how the intervention impacts on the use of acute and respite social care services. The study is limited to some extent by the absence of baseline measurements of costs and effects and the fact that there was no bootstrapping of cost estimates. Only scenario sensitivity analyses were conducted on total costs by increasing intervention costs under the assumption of longer hours per team meeting per week.	

Economic evidence tables

Transition from children's to adults' services for young people using health or social care services

Completed evidence tables: economic evaluations

Review Question 4

What is the effectiveness of support models and frameworks to improve transition from children's to adults' services?

Munro E, Lushey C (2012) Evaluaton of the Staying Put: 18 Plus Family Placement Programme: final report. UK Government Department for Education

Country, study type and intervention details	Study population, design and data sources	Outcomes, resource use	Results: cost-effectiveness, costs	Summary
Country: UK **Date** July 2008–March 2011 **Internal/external validity** (-/-) **Follow-up period** Outcomes measured from age 18 to 19 years old. **Study type** Case study. This is not a full economic evaluation. **Intervention** 'Staying Put 18+ Programme', young people (YP) w. 'established familial relationships' are able to choose to stay with foster carers until age 21'. Model type 1: 'Pure Familial' (8 LA, p26)	**Population** Care leavers with an established familial relationship, although not strictly defined. Was considered to include 'young people who have lived with their current foster carers for some time and thus had an opportunity to develop an attachment to them'. Exclusions: 'those with placement instability and change as they approach adulthood, as well as those who are placed with parents, or in secure units, children's homes or hostels. These groups may be more vulnerable and have more complex needs than those who are eligible to stay put (Munro et al. 2011a; Sinclair et al. 2007)' (p25). **Study design** Case study. Total n=not clear (see p62). **Source effectiveness data** Trial data. **Source of resource use data** Trial data. Implementation cost = local authorities' Management Information System data (MIS) (p24).	**Primary Outcomes** Significant limitation in collection of outcomes as outcomes being measured were also requirements for eligibility in the programme in most intervention sites. Outcomes included: Education, employment, training (relates to self-efficacy). Qualitative data is available on a smaller sample for health and social care outcomes, experience and processes of care. **Resource use** Significant limitations in collection of outcomes and costs, which meant that no analysis could be done. However, the authors conducted cost case studies in an effort to provide some information of the intervention's impact (p24). Case studies supplied following information, where relevant • Local authority social care services and YP's use of psychologist, housing, education and benefits. • Public sector via 'Supporting People' grants (where applicable). • Private costs to YP. Intervention costs • Measured using bottom-up approach based on time–use survey and following standard costing approaches.	**Findings on cost-effectiveness** Not possible to determine due to limitations of study design. **Costs** Intervention costs were reported but it is not possible to examine impact of the intervention on changes in health and social care resource use due to limitations of the study.	**Applicable** Not applicable as this was not a full economic evaluation (no comparison group). **Quality** Moderate reporting unclear in relation to unit costs and sample size. **Summary** No conclusions can be drawn about the intervention's cost-effectiveness as there were significant limitations in the study design, i.e. that there was no comparison group and the lack of information on the effect of the intervention on individuals' outcomes and on health and social care service use.

<u>Model type 2</u>: 'Hybrid'. Removes the condition that YP must have had an established relationship w. their carer prior to age 18 to be entitled to 'stay put' (3 LA, p26).	YP's care pathway cost = qualitative in-depth interviews + findings from CCFR's research programme (p23) to create 'cost case studies' (p24) as a result of pilot sites not recording data in MIS or not recording data properly. **Source of unit costs** Not clearly stated.	**RESULTS** Significant limitations in collection of outcomes and costs, which meant that no analysis could be done.		

Prestidge C, Romann A, Djurdjev O, Matsuda-Abedini M (2012). Utility and cost of a renal transplant transition clinic. Pediatric Nephrology 27, 295–302

Country, study type and intervention details	Study population, design and data sources	Outcomes, resource use	Results: cost-effectiveness, costs	Summary
Country: Canada **Internal/external validity**: (-/++) **Date:** Intervention = 2007 Comparison = 2000–6 **Follow-up period:** Two-year period. **Study type**: Cost-consequence analysis. **Intervention:** Tertiary children's hospital with multidisciplinary transition clinic and transition team. • One dedicated paediatric nephrologist, renal nurse, youth health specialist, renal pharmacist, renal dietician and social worker. • Goals include health and medication education, behavioural strategies for self-management. • Email, telephone and text message between patient and youth health, dietician and nursing staff. • Timing of transfer is made at	**Population** Adolescents undergoing transition usually referred at 16. **Study design** Prospective collection of intervention group and retrospective matched control group n=45, intervention, n=12, control, n=33. **Data sources** Trial data. **Sources of effectiveness data** Information taken from computer database (includes demographic and laboratory results). **Sources of resource use data** Trial data but only measures resource use as associated with outcomes – those requiring dialysis or transplant (p297).	**Primary outcomes** Death, allograft loss, biopsy-proven acute rejection, serum creatinine levels. **Resource use** Individual patient-level data was not available, therefore costs were estimated only on the basis of outcomes – those requiring dialysis or transplant. These covered: hospitalisation, inpatient and outpatient physician care, laboratory and diagnostic testing and medications (p297). **RESULTS** <u>Deaths</u>: Intervention: 0. Control: 3 (9%). <u>Allograft losses</u> Intervention: 0. Control: 7 (21%). <u>Serum creatine level</u> Not provided for control and intervention groups. <u>Biopsy-proven acute rejection</u> Not provided for control and intervention groups.	**Findings on cost-effectiveness** Apart from limitations in the study design, the intervention is associated with improvements in outcomes. The intervention costs less than the comparator group, inclusive of programme costs. Lower costs are driven by fewer but costly adverse events. **Total costs** <u>Price year</u> Unclear, perhaps 2010/11. Average yearly cost based on 2 years post-transfer (low/upper cost estimates). <u>Intervention</u> $11,380–$34,312 <u>Control</u> $17,127– $38,909 **Cost of the intervention** $6,650 per person.	**Applicable** Applicable with some limitations. **Quality** Good quality reporting. **Summary** Prestidge et al. (2012 -/++) is a Canadian study that also conducted an economic evaluation. It was rated as having good applicability to the UK with some limitations with respect to economic methodological quality. The economic analysis is an outcome-based model where differences in costs are estimated based on the difference in the proportion of individuals with key clinical outcomes: those needing dialysis and transplants. Only direct costs associated with dialysis and transplants are included and cost data are not taken from the study directly but rather from the wider literature. The economic analysis is limited in that it takes a very limited healthcare perspective and does not measure all-important changes in health and social care service use. However, this type of analysis may be appropriate given that the

individual's discretion (generally before 20th birthday). • Duration of TC is as long as necessary, can be as long as 3 hours. Meeting at TC, on average, 4 to 6 months. <u>Transition to adults' services</u> • Letter and verbal handover from nurse specialist, social worker, dietician to adult unit colleagues. • No adult nephrologist involved in TC. **Control:** People transferred to adults' services before the introduction of the transition team.	**Sources of unit cost data** Published studies.			aims of the study are to reduce adverse health consequences. However, it is likely that the analysis underestimates cost savings to the healthcare sector as individuals with dialysis or kidney transplant are likely to have greater healthcare needs and may have higher use of healthcare services than those without dialysis or kidney transplant. Apart from limitations in the study design, the intervention is associated with improvements in outcomes for reduced cost (inclusive of programme costs). Lower costs are driven by costly adverse events. Average intervention costs were estimated on 2 years' participation (Canadian $6,650 per person). Inclusive of intervention costs, the total costs per person for the intervention group ranged between $11,380 and $34,312 versus the control group, between $17,127 and $38,909. The price year of costs is unclear but may be 2010/11. It is not possible to say whether the intervention is or is not cost-effective in the UK setting, as it would require further analysis to take into account differences in institutional context and unit costs.

				However, insofar as the intervention reduces adverse clinical outcomes that are costly, there is potential for the intervention to be cost-saving and cost-effective.

Transition from children's to adults' services for young people using health or social care services

Completed evidence tables: economic evaluations

Review Question 5

What is the effectiveness of interventions designed to improve transition from children's to adults' services?

Bent N, Tennant A, Swift T, Posnett J, Scuffham P, Chamberlain M (2002). Team approach versus ad hoc health services for young people with physical disabilities: a retrospective cohort study. The Lancet, 360: 1280–6

Country, study type and intervention details	Study population, design and data sources	Outcomes, resource use	Results: cost-effectiveness, costs	Summary
Country: England **Internal / external validity** (++/++) **Date**: 1999/2000 **Follow-up period** Six months. **Study type** Retrospective case-control study, 4 sites. **Intervention** Young adult team approach (coordinated multidisciplinary teams) = team meetings held once per week between 1 to 2 hours attended by all professionals in the team, including secretarial support. **Comparator** Standard ad hoc	**Population** Young adults with physical and complex disabilities (in the target diagnostic groups of cerebral palsy, spina bifida, traumatic brain injury or degenerative neuromuscular disease) and mild or no learning disability. • Age: 20 (17–28) years • n=134 male; n=120 female • 23% communication difficulties Use of screening or targeting: Individuals were selected by reviewing case notes. Excluded individuals who only had sensory or learning disability. **Sample size** n=254 Intervention sites Leeds, n=74. Stoke-on-Trent, n=45. Matched control sites Leicester, N=76	**Primary outcomes** 6. Participation restriction (London handicap scale – measuring mobility, self-care, work and leisure, getting on with people, awareness of surroundings, and being able to afford the things they require). 7. Body function impairment (Nottingham Health Profile sub-scales – pain, energy, sleep). 8. Activity limitation (Barthel). 9. Health status (Euroqol Visual Analogue scale). 10. Psychosocial measures (self-esteem, self-efficacy, proactive attitude, stress). **Resource use** Excludes − Acute care service use. − Respite care. Includes 1. Intervention costs: − Full cost approach (salary, oncosts, overheads, training, travel). 2. Community health and social care: − Family doctors, other doctors, physiotherapists, occupational therapists, physiotherapist, psychologist or counsellor, social workers, speech therapists, and other healthcare professionals.	**Findings on cost-effectiveness** Improved outcomes with no difference in costs from perspective of community health and social care services. **Costs** Price year: 1999. Total mean costs (low/high estimate, 6 months) Intervention group: Leeds: £678/£707 Stoke-on-Trent: £694/£738 Control group: Leicester and Birmingham: £798 Community health and social care services − Intervention: £650/6 months. − Control: £798/6 months. − Health and social care service use not different between groups (using Mantel-	**Applicable** Applicable with minor limitations. **Quality** Moderate reporting quality. **Summary** Bent et al. (2002 +/++) is rated as having good applicability with minor limitations with respect to economic methodological quality. The results were presented as a cost–consequence analysis (presenting changes in costs alongside changes in outcomes). The perspective of the analysis is that of the NHS and social care services, although it is limited to community services and does not measure changes in acute healthcare services and respite social care services. It is not clear why they are not measured and the authors do not provide any rationale. The results indicate that the intervention improves outcomes with no differences in costs to the NHS and social care services from the perspective of community services. Findings of no difference in costs

service approach with respect to individual professionals working in isolation (consultant in rehabilitation medicine, psychologist, therapist, social workers), and links between them being of an ad hoc nature.	Birmingham, N=59 **Data sources** **Sources of effectiveness data** Trial, interviews. **Sources of resource use data** Trial, based on interview information, healthcare service use and cost in the previous 6 months. **Sources of unit cost data** National unit costs provided by PSSRU.	**RESULTS** Improvements favouring intervention 1. <u>Participation in society</u>: Intervention = 2·54 times more likely to participate in society than those faced with ad hoc services (95% CI 1·30–4·98), after adjusting for variables as specified in the conceptual model (pain, energy, health status, independence, self-esteem, self-efficacy, stress, proactive attitude, age, sex, income). 2. <u>Activity limitation</u> Intervention=19 (16-20) vs control=17 (12.5–20) (p<0.013). No differences 3. <u>Body function impairment</u> (although trending to improvement for pain, I=0 (0-12.1), C=5.8 (0-22.6) (p=0.066) and sleep, I=0 (0-34.4), C=12.6 (0-34.3) (p=0.062). 4. <u>Health status</u>, no difference, I=72.5 (50-90), C=70 (50-80), (p=0.078) 5. <u>Psychosocial measures</u> Pain, fatigue, and stress also affected participation in society. Individuals with severe communication difficulties are less likely to participate than even those who report more pain.	Haenszel χ 2 statistic). *Costs were only slightly higher for the control group because of slightly higher mean contacts with professionals. *Confidence intervals were not provided. <u>Intervention costs per person</u> - Leeds: £28 and £57 per client for the 6-month duration. - Stoke-on-Trent: £44 to £88 (higher because the cost of weekly meetings is spread among fewer clients than in Leeds).	depend on the assumption that the use of acute and respite care services is similar between groups. The authors report costs using 1999 prices. Mean intervention costs are presented using low and high estimates although it is not clear how those low and high estimates were derived, but they are likely based on the varying team size. Mean intervention costs per person (for the 6-month period) ranged from £28 to £57 at one site and between £44 and £88 in another site. Mean cost associated with use of community health and social care services was similar between intervention and control groups (and was not statistically different) but it was marginally lower for the intervention group (£650 vs £798 over a 6-month period). The evaluation is limited to some extent by the absence of baseline measurements of costs and effects and the fact that there was no bootstrapping of cost estimates. Bootstrapping is a method to estimate uncertainty associated with cost estimates (using a probability distribution). Even though the authors did not undertake bootstrapping methods they did undertake sensitivity analyses on intervention costs. They doubled the duration of team meetings (from 1 to 2 hours per week) and found that this did not change the finding that

				the intervention was still marginally cost-saving compared to the comparison group.