NHS
National Institute for
Health and Clinical Excellence

Chronic fatigue syndrome/
myalgic encephalomyelitis
(or encephalopathy)

Costing report

Implementing NICE guidance

August 2007

NICE clinical guideline 53

This costing report accompanies the clinical guideline: 'Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children' (available online at www.nice.org.uk/CG053).

Issue date: August 2007

This guidance is written in the following context

This report represents the view of the Institute, 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 report and templates are implementation tools and focus on those areas that were considered to have significant impact on resource utilisation.

The cost and activity assessments in the reports are estimates based on a number of assumptions. They provide an indication of the likely impact of the principal recommendations and are not absolute figures. Assumptions used in the report are based on assessment of the national average. Local practice may be different from this, and the template can be amended to reflect local practice to estimate local impact.

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Executive summary

This costing report looks at the resource impact of implementing the NICE clinical guideline 'Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children' in England. The costing report includes service provision for adults and children.

The costing method adopted is outlined in appendix A; it uses the most accurate data available, was produced in conjunction with key clinicians, and was reviewed by clinical and financial professionals.

Supporting implementation

The NICE clinical guideline on chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy) (CFS/ME) is supported by a range of implementation tools available on our website www.nice.org.uk/CG053 and detailed in the main body of this report.

Significant resource-impact recommendations

Because of the breadth and complexity of the guideline, this report focuses on recommendations that are considered to have the greatest resource impact and therefore require the most additional resources to implement or can potentially generate savings. They are:

- Healthcare professionals responsible for caring for people with CFS/ME should have appropriate skills and expertise in the condition.
- Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET) should be offered to people with mild or moderate CFS/ME.
- If a full CBT or GET programme is inappropriate or not available, components of CBT or GET should be offered, either individually or more effectively in combination with activity management strategies, sleep management and relaxation techniques.
- People with severe CFS/ME should be offered an individually tailored activity management programme as the core therapeutic strategy.

Total cost impact

The costing model is based on recurrent annual costs for newly diagnosed patients. Non-recurrent costs for patients who are already diagnosed have also been considered.

The changes in revenue costs arising from fully implementing the guideline are summarised in table 1. The total costs (including a phased-in implementation for newly diagnosed and already diagnosed patients) over a 5-year period are modelled in graph 1.

Table 1 Changes in revenue costs

Recommendations	Change in recurrent annual costs (newly diagnosed patients)	Change in non-recurrent costs (patients who are already diagnosed)
	£000	£000
Cognitive behavioural therapy	1,034	7,298
Graded exercise therapy	581	4,098
Activity management strategies	916	6,467
Activity management programmes	1,217	8,590
Total cost increase of implementing CFS/ME guidance	3,747	26,453

There may also be costs relating to training that will need to be assessed locally.

It is not anticipated that services will be provided for the backlog of patients and newly diagnosed patients immediately.

Benefits and savings

CFS/ME can cause profound, prolonged illness and disability, which has a significant impact on patients and their families. Providing early and appropriate intervention could reduce disease progression and have a positive impact on health related quality of life. It is not possible to quantify the impact of these changes.

Local costing template

The costing template produced to support this guideline enables organisations in England, Wales and Northern Ireland to estimate the impact locally and replace variables with ones that depict the current local position. A sample calculation using this template showed that additional costs of recurrent costs of £7,000 and non-recurrent costs of £53,000 could be incurred for a population of 100,000. However, because there is significant geographical variation in service provision, it is important to adapt the template to local circumstances.

1 Introduction

1.1 *Supporting implementation*

1.1.1 The NICE clinical guideline on chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy) (CFS/ME) is supported by the following implementation tools available on our website www.nice.org.uk/CG053:

- costing tools
  - a national costing report; this document
  - a local costing template; a simple spreadsheet that can used to estimate the local cost of implementation.
- a slide set; key messages for local discussion
- implementation advice; practical suggestions on how to address potential barriers to implementation
- audit criteria.

1.1.2 A practical guide to implementation, ‘How to put NICE guidance into practice: a guide to implementation for organisations’, is also available to download from the NICE website. It includes advice on establishing organisational level implementation processes as well as detailed steps for people working to implement different types of guidance on the ground.

1.2 *What is the aim of this report?*

1.2.1 This report provides estimates of the national cost impact arising from implementation of guidance on CFS/ME for adults and children in England. These estimates are based on assumptions made about current practice and predictions of how current practice might change following implementation.

1.2.2 This report aims to help organisations plan for the financial implications of implementing NICE guidance.

1.2.3 This report does not reproduce the NICE guideline on CFS/ME and should be read in conjunction with it (see www.nice.org.uk/CG053).

1.2.4 The costing template that accompanies this report is designed to help those assessing the resource impact at a local level in England, Wales or Northern Ireland. NICE clinical guidelines are developmental standards in the Department of Health's document 'Standards for better health'. The costing template may help inform local action plans demonstrating how implementation of the guideline will be achieved.

1.3 Epidemiology of CFS/ME

1.3.1 Evidence suggests a diagnosed incidence of 0.04% and a population prevalence of 0.2% to 0.4% in the UK (Department of Health 2002).

1.3.2 The wide range in the prevalence figures creates a significant degree of uncertainty in the costing work.

1.3.3 For the purpose of this report a midpoint of 0.3% has been used to calculate the population prevalence of CFS/ME. The upper and lower estimates of the population prevalence have been investigated in the sensitivity analysis.

1.4 Models of care

1.4.1 Currently, there is wide geographical variation in provision. Some patients are managed by specialised services using CBT, GET, activity management or aspects of these. However, provision of formal CBT or GET is limited.

1.4.2 Therapy can be provided individually or in a group format. While some services offer both, others can only provide either group therapy or individual therapy. In general, group therapy is more common.

1.4.3 There is limited availability of home delivery of care for the majority of people with severe CFS/ME.

1.4.4 As models of care vary, service plans for secondary and primary care services should be considered locally.

1.4.5 Uptake of this guideline may also be affected by patient choice. Like all people receiving care in the NHS – people with CFS/ME have the right to refuse or withdraw from any component of their care plan without this affecting other aspects of their care, or future choices about care'

1.4.6 The variable of patient choice creates uncertainty in the costing work. It would seem reasonable to assume that not all patients offered interventions for the treatment of their CFS/ME would accept, the costing has attempted to take a pragmatic and realistic approach but uptake predictions may want to be investigated further at a local level.

1.4.7 The costing model is based on new patients presenting with CFS/ME and is supported by clinicians who say that few patients require re-intervention. However, there will also be non-recurrent costs attached to providing care to patients who are already diagnosed. Clinicians anticipate that it will take at least 2 years for services to treat these cases.

1.4.8 The availability of clinical psychologists, physiotherapists and occupational therapists at a local level will be a determining factor in the time it takes to implement this guideline

2 Costing methodology

2.1 Process

2.1.1 We use a structured approach for costing clinical guidelines (see appendix A).

2.1.2 Little information has been systematically collected about CFS/ME, and this led to problems in building a comprehensive bottom-up model for costing (a costing methodology in which the unit cost of individual elements and number of units are estimated and added together to provide a total cost). To overcome this limitation, we had to make assumptions in the costing model. We developed these assumptions and tested them for reasonableness with members of the Guideline Development Group (GDG) and key clinical practitioners in the NHS.

2.2 Scope of the cost-impact analysis

2.2.1 The guideline offers best practice advice on the care of people aged 5 years and older who are suspected of having, or are diagnosed with, CFS/ME.

2.2.2 The guidance does not cover the management of people for whom CFS/ME has been excluded as a diagnosis. Therefore, these issues are outside the scope of the costing work.

2.2.3 Because of the breadth and complexity of the guideline, we worked with the GDG and other professionals to identify the recommendations that would have the most significant resource impact (see table 2). Costing work has focused on these recommendations.

Table 2 Recommendations with a significant resource impact

High-cost recommendations	Recommendation number	Key priority?
Healthcare professionals responsible for caring for people with CFS/ME should have appropriate skills and expertise in the condition.	1.1.3.1	
Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET) should be offered to people with mild or moderate CFS/ME and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit.	1.6.2.4	✓
If a full CBT or GET programme is inappropriate or not available, components of CBT or GET should be offered, either individually or more effectively in combination with activity management strategies, sleep management and relaxation techniques.	1.6.2.5	
CBT should be offered on a one-to-one basis if possible.	1.6.2.9	
GET should be offered on a one-to-one basis if possible.	1.6.2.12	
People with severe CFS/ME should be offered an individually tailored activity management programme as the core therapeutic strategy, which may be delivered at home, or using telephone or email if appropriate, and may incorporate the elements of activity management recommendations and draw on the principles of CBT and GET.	1.9.3.1	

2.2.4 Ten of the recommendations in the guideline have been identified as key priorities for implementation. One of these is also among the six recommendations considered to have significant resource impact.

2.2.5 Several of the remaining key priority recommendations have little or no financial impact. This includes shared decision-making, the

patient's right to refuse care, supportive and collaborative relationships, advice on symptom management and diagnosis. Other key priority recommendations are likely to have no additional costs, including referral for specialised care, tailoring diagnostic and therapeutic options to the individual, and individualised person-centred programmes of care. Finally, the financial impact of one key priority recommendation (proactively advise about fitness for work and education) has proved impossible to determine.

2.2.6 We have limited the consideration of costs and savings to direct costs to the NHS that will arise from implementation. We have not included consequences for the individual, the private sector or the not-for-profit sector. Where applicable, any realisable cost savings arising from a change in practice have been offset against the cost of implementing the change.

2.3 General assumptions made

2.3.1 The model is based on annual incidence estimates (see table 3).

Table 3 Incidence and prevalence estimates of CFS/ME

	England population aged 5 years or older	Percentage of patients	Number of patients
Incidence	47,024,038	0.0425%	19,985
Prevalence	47,024,308	0.3%	141,072

2.3.2 Estimates on the prevalence of CFS/ME range from 0.2% to 0.4% (Department of Health 2002). This range creates a significant degree of uncertainty when calculating the resource impact. For the purpose of this report a midpoint of 0.3% has been used, the resource impact of using the upper and lower estimates of prevalence are investigated in the sensitivity analysis.

2.3.3 Approximately 19,985 people are newly diagnosed with CFS/ME each year in England. We have estimated annual recurrent cost changes based on incidence.

2.3.4 Some of the prevalent population will not have received one of the recommended interventions previously. Clinicians estimate that most patients would be unlikely to need the same intervention more than once. Consequently, costing figures are also provided for this group of patients, for information.

2.3.5 An estimated 90% of people with CFS/ME have mild to moderate levels of the condition. Estimates about the number of people with severe CFS/ME vary between 10% and 25%, but the weight of clinicians' opinion supports the 10% figure. Sensitivity analysis will look at the impact of varying the estimate.

2.4 Basis of unit costs

2.4.1 Hourly rates have been calculated for several key healthcare professionals in discussion with relevant clinicians.

2.4.2 Hourly rates for a clinical psychologist are based on the midpoint of NHS pay band 8a, assuming 40% client contact. See table 4 for details.

2.4.3 Hourly rates for specialist physiotherapists and occupational therapists are both based on the midpoint of band 7, assuming 60% client contact. See table 4 for details.

Table 4 Hourly rate calculations for healthcare professionals

Clinician	Clinical psychologist	Physiotherapist/ occupational therapist
Band (midpoint)	8a	7
Salary	38,828	32,704
Oncosts	8,465	7,129
Overheads	1,941	1,635
Total costs per whole time equivalent	49,234	41,468
Working hours per whole time equivalent	1,635	1,635
Hours of client contact	40%	60%
Number of hours of client contact	654	981
Cost per hour of client contact	**£75.28**	**£42.27**

3 Cost of significant resource-impact recommendations

3.1 Healthcare professionals should have appropriate skills and expertise

Background

3.1.1 Healthcare professionals responsible for caring for people with CFS/ME should have appropriate skills and expertise in the condition (recommendation 1.1.3.1).

Resource impact

3.1.2 We were not able to estimate the resource impact of this recommendation because training differs according to local circumstances.

3.1.3 Personal communication from clinicians indicates that the following types of training would be needed: general awareness training (covering symptoms, diagnosis and general approach for management) for primary healthcare professionals such as general practitioners; basic training for new staff working within CFS/ME services; and basic training for healthcare professionals who work outside CFS/ME services.

3.1.4 It is postulated that training will need to be built into existing regular half day continuing professional development allowances for healthcare professionals. However there may be additional cost requirements depending on local circumstances.

3.1.5 We recommend current provision is considered locally.

3.2 CBT and GET for mild or moderate CFS/ME

Background

3.2.1 CBT and/or GET should be offered to people with mild or moderate CFS/ME and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit (recommendation 1.6.2.4).

3.2.2 CBT should be offered on a one-to-one basis if possible (recommendation 1.6.2.9).

3.2.3 GET should be offered on a one-to-one basis if possible (recommendation 1.6.2.12).

Assumptions made

3.2.4 Clinicians estimate that 5% of people with mild or moderate CFS/ME are currently treated with CBT and 5% with GET.

3.2.5 Following implementation of the guideline, clinicians estimate that these percentages will increase to 15% for each intervention.

3.2.6 According to data provided by service providers, 63% of people with mild or moderate CFS/ME are currently estimated to receive group intervention, and 37% individual intervention. Clinicians expect this to change to 66% receiving individual therapy and 34% receiving group interventions following implementation of the guideline.

3.2.7 The cost of individual CBT is based on nine 1-hour sessions delivered by a clinical psychologist (a midpoint of the 6 to 12

sessions that have been offered in randomised controlled trials). This equates to £678 per patient.

3.2.8 The cost of group CBT is based on eight, 2-hour sessions for eight patients with a clinical psychologist (based on a randomised controlled trial). This equates to £150 per patient.

3.2.9 The cost of GET is based on similar individual and group formats, delivered by physiotherapists (based on randomised controlled trials). This equates to £380 per patient for individual GET and £85 for group GET.

Cost summary

3.2.10 The annual recurrent cost of CBT and GET for people with mild or moderate CFS/ME is summarised in table 5.

3.2.11 The non-recurrent cost of CBT and GET is summarised in table 6.

Table 5 Change in annual recurrent cost of CBT and GET for people with mild or moderate CFS/ME

	Current number of patients	Cost (£000)	Proposed number of patients	Cost (£000)	Change in number of patients	Cost (£000)
Individual CBT	333	226	1,781	1,207	1,448	981
Group CBT	566	85	917	138	351	53
Individual GET	333	127	1,781	678	1,448	551
Group GET	566	48	917	78	351	30
Cost	–	486	–	2,101	–	1,615

Table 6 Change in non-recurrent cost of CBT and GET for people with mild or moderate CFS/ME

	Current number of patients	Cost £000	Proposed number of patients	Cost £000	Change in number of patients	Cost £000
Individual CBT	2,349	1,592	12,570	8,516	10,221	6,924
Group CBT	3,999	602	6,475	975	2,476	373
Individual GET	2,349	893	12,570	4,782	10,221	3,889
Group GET	3,999	338	6,475	547	2,476	209
Cost	–	3,425	–	14,820	–	11,396

Other considerations

3.2.12 It is expected that benefits of implementation will include reduced likelihood of disease progression.

3.2.13 Because of the significant backlog of patients who already have a diagnosis, it is anticipated that it will take a number of years to fully implement the guideline and reach a stage where only newly diagnosed patients require treatment.

3.3 Activity management for mild or moderate CFS/ME

Background

3.3.1 If a full CBT or GET programme is inappropriate or not available, components of CBT or GET should be offered, either individually or more effectively in combination with activity management strategies, sleep management and relaxation techniques (recommendation 1.6.2.5).

Assumptions made

3.3.2 Clinicians estimate that approximately 10% of people with mild or moderate CFS/ME are currently treated with components of CBT or GET in combination with activity management strategies.

3.3.3 After implementation of the guideline, clinicians estimate that around 30% of people with mild or moderate CFS/ME will be treated with components of CBT or GET in combination with activity management strategies.

3.3.4 According to data supplied by service providers, 63% of people with mild or moderate CFS/ME are currently estimated to receive group intervention, and 37% individual intervention. Clinicians expect this to change to 66% receiving individual therapy and 34% receiving group interventions following implementation of the guideline.

3.3.5 The cost of individual activity management is based on an example service model of six to eight 1-hour sessions (we have used the midpoint of 7 for our calculations). The cost of group activity management is based on an example service model of eight 2-hour sessions. Both types of intervention are with delivered by occupational therapists. This equates to £296 per patient for individual GET and £85 for group GET.

Cost summary

3.3.6 The annual recurrent cost of activity management strategies is summarised in table 7.

3.3.7 The non-recurrent cost of activity management strategies is summarised in table 8.

Table 7 Change in annual recurrent cost of activity management strategies for people with mild or moderate CFS/ME

	Current number of patients	Cost £000	Proposed number of patients	Cost £000	Change in number of patients	Cost £000
Individual activity management strategies	666	197	3,561	1,054	2,895	857
Group activity management strategies	1,133	96	1,835	155	702	59
Net cost	–	293	–	1,209	–	916

Table 8 Change in non-recurrent cost of activity management strategies for people with mild or moderate CFS/ME

	Current number of patients	Cost £000	Proposed number of patients	Cost £000	Change in number of patients	Cost £000
Individual activity management strategies	4,698	1,390	25,139	7,439	20,441	6,049
Group activity management strategies	7,998	676	12,950	1,095	4,952	419
Net cost	–	2,066	–	8,534	–	6,467

Other considerations

3.3.8 It is expected that benefits of implementation will include reduced likelihood of disease progression.

3.3.9 Because of the significant backlog of patients who already have a diagnosis, it is anticipated that it will take a number of years to fully implement the guideline and reach a stage where only newly diagnosed patients require treatment.

3.4 Individually tailored activity management programmes for people with severe CFS/ME

Background

3.4.1 People with severe CFS/ME should be offered an individually tailored activity management programme as the core therapeutic strategy, which may be delivered at home, or using telephone or email if appropriate, and may incorporate the elements of the activity management recommendations and draw on the principles of CBT and GET (recommendation 1.9.3.1).

Assumptions made

3.4.2 Discussions with clinicians indicate that 1.5% of people with severe CFS/ME are currently treated with an individually tailored activity management programme. This estimate is based on an extrapolation from figures provided by eight out of a possible 31 services.

3.4.3 Following implementation of the guideline, this figure is expected to rise to 80% (based on clinicians' opinions).

3.4.4 Because there is no standard package of care for people with severe CFS/ME, the cost of an activity management programme is based on a combination of two packages of care provided in England. This allows for variation between service models that often involve input from several members of the multidisciplinary team. One model involves care delivered by a clinical psychologist and nurse and the other involves care delivered by a team of occupational therapists. The estimated care package consists of an initial joint assessment by a clinical psychologist and occupational

therapist for 1.5 hours, followed by five domiciliary appointments of 1 hour and five telephone appointments of 1 hour undertaken by either professional. Hourly rates for the clinical psychologist and occupational therapist have been calculated as outlined in the 'Unit costs' section, with an average of costs calculated for the ten follow-up appointments. This equates to £776 per patient.

Cost summary

3.4.5 The annual recurrent cost of individually tailored activity management programmes is summarised in table 9.

3.4.6 The non-recurrent cost of individually tailored activity management programmes is summarised in table 10.

Table 9 Change in annual recurrent cost of individually tailored activity management programmes

	Current number of patients	Cost £000	Proposed number of patients	Cost £000	Change in number of patients	Cost £000
Individually tailored activity management programmes	30	23	1,600	1,240	1,570	1,217
Cost	–	–	–	–	–	1,217

Table 10 Change in non-recurrent cost of individually tailored activity management programmes

	Current number of patients	Cost £000	Proposed number of patients	Cost £000	Change in number of patients	Cost £000
Individually tailored activity management programmes	212	164	11,286	8,754	11,074	8,590
Cost	–	–	–	–	–	8,590

Other considerations

3.4.7 Service models for people with severe CFS/ME may vary and should be tailored around the needs of patients locally.

3.4.8 Due to a significant backlog of patients who already have a diagnosis, it is anticipated that it will take a number of years to fully implement the guideline and reach a stage where only newly diagnosed patients require treatment.

4 Sensitivity analysis

4.1 Methodology

4.1.1 There are a number of assumptions in the model for which no empirical evidence exists. Because of the limited data, the model developed is based mainly on discussions of typical values and predictions of how things might change as a result of implementing the guidance, and is therefore subject to a degree of uncertainty.

4.1.2 We discussed with healthcare professionals possible minimum and maximum values of variables, and calculated their impact on costs across this range.

4.1.3 It is not possible to arrive at an overall range for total cost because the minimum or maximum of individual lines would not occur simultaneously. We undertook one-way simple sensitivity analysis, altering each variable independently to identify those that have greatest impact on the calculated total cost.

4.1.4 Appendix B contains a table detailing all variables modified and the key conclusions drawn are discussed below.

4.2 Impact of sensitivity analysis on costs

CFS/ME severity – recurrent costs

4.2.1 Clinicians' opinions vary as to the proportion of the CFS/ME population with severe CFS/ME. Estimates of 10% to 25% have been reported.

4.2.2 Varying the estimate from 10% to 25% resulted in implementation costs ranging from £3.7 million to £5.2 million.

People with mild or moderate CFS/ME to be treated with group CBT - recurrent costs

4.2.3 Average figures were used to calculate the cost of implementing this recommendation based on 34% receiving group CBT. Clinicians' opinions varied widely as to the appropriate future split between group and individual CBT. We have looked at the impact of such wide variation. As the proportion of patients receiving group CBT increases the cost estimate decreases. The range was between £3.9 million (20%) and £3.2 million (75%).

People with mild or moderate CFS/ME to be treated with individual CBT - recurrent costs

4.2.4 CBT sessions can vary from approximately 6 to 12 sessions. We have assumed eight sessions when calculating the cost of implementing this recommendation.

4.2.5 Varying the estimate from 6 to 12 sessions resulted in implementation costs ranging from £3.3 million to £4.1 million.

Population prevalence of CFS/ME – non-recurrent costs

4.2.6 Limited data are available on the population prevalence of CFS/ME, published data suggested prevalence of between 0.2% and 0.4% (Department of Health 2002). For the purpose of this report a midpoint of 0.3% was used.

4.2.7 Varying the estimated population prevalence from 0.2% to 0.4% resulted in non-recurrent implementation costs ranging from £17.6 million to £35.3 million.

5 Impact of guidance for commissioners

5.1.1 Additional CBT, GET and activity management will be required for people with mild or moderate CFS/ME. Additional domiciliary activity management programmes will be required for people with severe CF/ME.

5.1.2 As a consequence, commissioners may need to commission additional services from the following healthcare sectors: primary care and mental health (which fall outside the national tariff) and acute secondary care (which falls within the national tariff).

5.1.3 Outpatient activity is likely to fall under programme budgeting category 7X (neurological). It may also fall under 5X (mental health) or 'other' (primary care) depending on where the service is delivered.

6 Conclusion

6.1 Total national cost for England

6.1.1 Using the significant resource-impact recommendations shown in table 2 and assumptions specified in section 3 we have estimated the annual recurrent cost impact of fully implementing the guideline in England to be £3.7 million. The non-recurrent cost impact of implementing the guideline in England is estimated to be £26 million. Table 11 shows the breakdown of costs of each significant resource-impact recommendation.

Table 11 Changes in revenue costs

Recommendations	Change in recurrent annual costs (newly diagnosed patients) £000	Change in non-recurrent costs (patients who are already diagnosed) £000
Cognitive behavioural therapy	1,034	7,298
Graded exercise therapy	581	4,098
Activity management strategies	916	6,467
Activity management programmes	1,217	8,590
Total cost increase of implementing CFS/ME guidance	3,747	26,453

6.1.2 Possible additional costs for training need to be considered locally.

6.1.3 It is acknowledged that full implementation of this guideline may take a number of years particularly where additional staff training is required. This will need to be investigated at a local level.

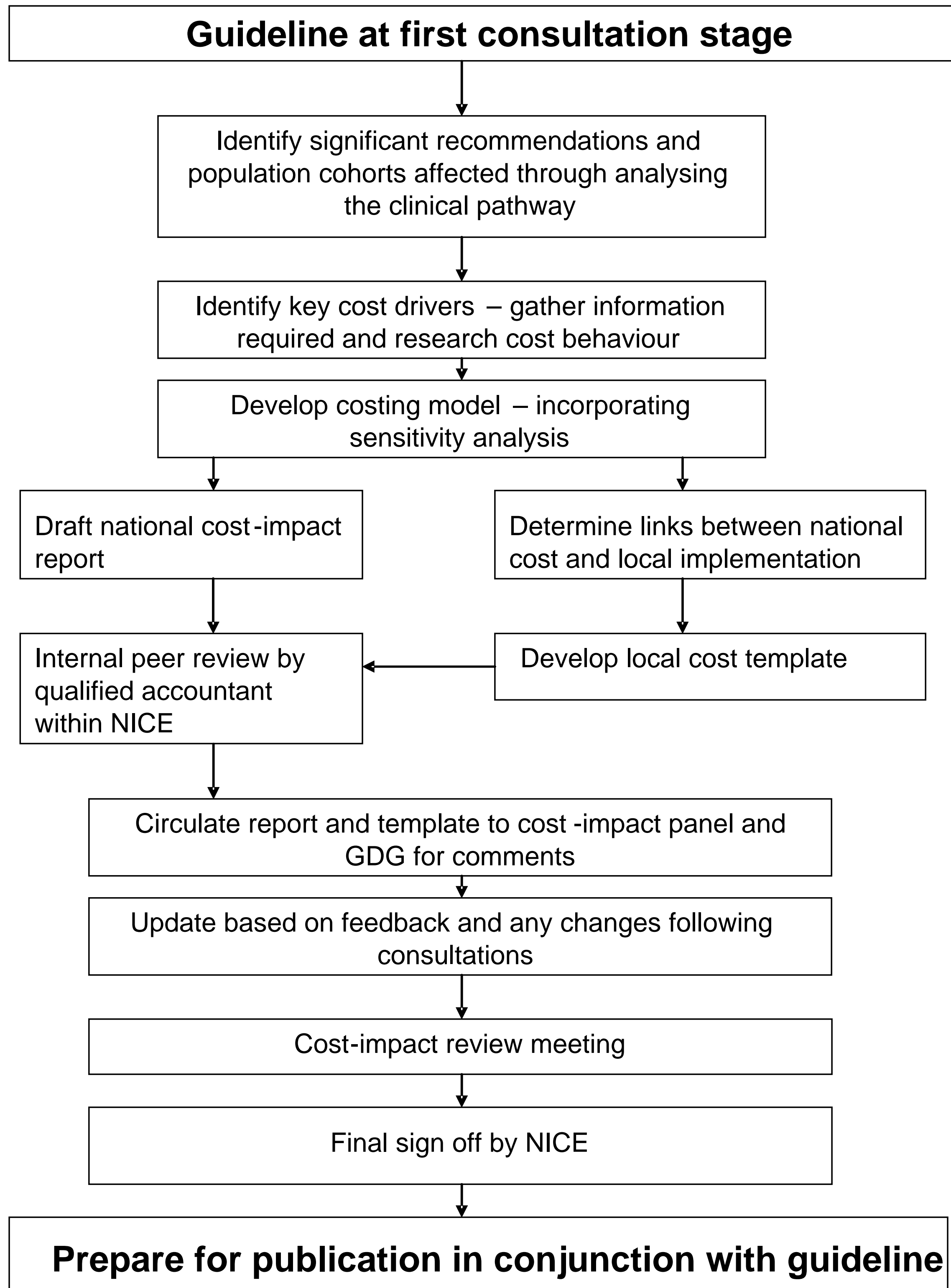
6.1.4 The implementation of this guideline could be limited by the local availability of therapists with the experience and training necessary to deliver the recommended interventions. Local incidence and the current provision of care for this patient group will determine the resource required.

6.1.5 We applied reality tests against existing data wherever possible, but this was limited by the availability of detailed data. We consider this assessment to be reasonable, given the limited detailed data on diagnosis and treatment paths, and the time available. However, the costs presented are estimates and should not be taken as the full cost of implementing the guideline.

6.2 Next steps

6.2.1 The local costing template produced to support this guideline enables organisations such as primary care trusts (PCTs) or health boards in Wales and Northern Ireland to estimate the impact locally and replace variables with ones that depict the current local position. A sample calculation using this template showed that a population of 100,000 could expect to incur additional annual recurrent costs of £7,000. Use this template to calculate the cost of implementing this guidance in your area.

Appendix A. Approach to costing guidelines



Appendix B. Results of sensitivity analysis

Assessment of sensitivity costs to a range of variables – recurrent costs							
Parameter varied	Baseline value	Minimum value	Maximum value	Baseline costs £000	Minimum costs £000	Maximum costs £000	Change £000
Population incidence	0.04%	0.036%	0.044%	3,747	3,174	3,879	705
Patients with severe CFS/ME	10%	10.00%	25.00%	3,747	3,747	5,151	1,404
Mild or moderate patients to be treated with cognitive behavioural therapy (CBT)	15%	13.5%	16.5%	3,747	3,612	3,882	270
Severe patients to be treated with individual activity management (AM)	80%	50%	95%	3,747	3,282	3,980	698
Mild or moderate patients to be treated with individual CBT (no. of sessions varied)	£678	£452	£903	3,747	3,346	4,149	803
Mild or moderate patients to be treated with individual graded exercise therapy (GET) (no. of sessions varied)	£380	£254	£507	3,747	3,522	3,973	451
Mild or moderate patients to be treated with individual AM (no. of sessions varied)	£296	£254	£338	3,747	3,598	3,897	299
Mild or moderate patients to be treated with individual AM (unit cost varied)	£296	£329	£434	3,747	3,865	4,239	374
Severe patients to be treated with individual AM (unit cost varied)	£776	£697	£875	3,747	3,622	3,906	284
Mild or moderate patients to be treated with group CBT	34%	20%	75%	3,747	3,946	3,165	-781
Mild or moderate patients to be treated with group GET	34%	20%	75%	3,747	3,859	3,420	-439
Mild or moderate patients to be treated with group AM	34%	20%	75%	3,747	3,907	3,280	-627

Assessment of sensitivity costs to a range of variables – non-recurrent costs							
Parameter varied	Baseline value	Minimum value	Maximum value	Baseline costs £000	Minimum costs £000	Maximum costs £000	Change £000
Population prevalence of CFS/ME	0.3%	0.20%	0.40%	26,453	17,634	35,269	17,635

Appendix C. References

Department of Health (2002) A report of the CFS/ME working group: report to the chief medical officer of an independent working group. London: Department of Health. Available from www.dh.gov.uk

Peninsula Medical School (2006) CFS/ME service investment programme report 2004–2006. London: Department of Health. Available from www.dh.gov.uk