Clinical Lead Survival Guide – Business cases

As a clinical lead for ophthalmology, you will need to ensure you and your senior colleagues can formulate and present good business cases, to ensure the department obtains the resources it needs. This is a short guide to help you.

Step 1 What is a business case?

A business case is a structured written document used to obtain funding needed by the department or its patients for which they currently do not have funding. The contents normally include:

- Description of the current situation
- Explanation why something needs to change or the reasoning for initiating a new project or investment
- Captures the financial and non-financial assessment (benefits, risks, risks of not doing) of an option or range of options
- Recommends a preferred option and makes the case for why this is the best option and should proceed
- Considers the impact on other departments and people
- Considers the timescales involved

The logic of the business case is that, whenever resources such as money or effort are consumed, they should be in support of a clear and specific objective.

Step 2 When do I need a business case?

Organisations vary as to when to use business cases, particularly in terms of a financial cut off (e.g. £5K, £20K) above which it is required. Many departments have some discretion to spend extra within a certain budget, decided by a clinical lead, clinical director or manager. Some also have a planned replacement budget for equipment, so that equipment which fails or is out of date can be replaced without a new business case. Other trusts use business cases for almost anything more than small change.

Business cases are used for:

- If you are asking for capital (a one-off request for buildings or equipment also known as “fixed assets”).
- If you are asking for revenue expenditure (recurring costs, most commonly staff salary costs)
- Funding for substantially changing a service
- Funding to ensure compliance with regulations, new national guidelines or for significant safety issues.

Business cases may also be required for annual business planning (capital or expenditure planning) for some.

18 Stephenson Way, London, NW1 2HD T. 020 7935 0702 contact@rcophth.ac.uk rcophth.ac.uk @RCOphth
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Step 3 Where do I start?

There will be some sort of standard template business case form in most trusts which give you a guide of what is needed and how to structure it. If there is one, you must use it, if not structure your own sensibly with the headings below. Check carefully whether there is more than one form and make very sure you get the right one to avoid wasting a lot of time. There may be different forms for a big comprehensive cases vs a little one, or different forms for space and estates from staff.

Start by making a few notes about what the situation is, what's wrong, or why you need what you need. To get started; you can cut and paste this into the template in due course. You might need to get a list of published evidence or references together on standards or guidelines that need to be met or published evidence of why you now need to practice differently or are not doing what you ought to – e.g. you would reference NICE guidelines on AMD to ask for more staff if you are not seeing new wet AMD within two weeks. Put the references at the end in the usual format, as for a scientific paper.

The single most helpful thing is to get a couple of similar completed business cases from colleagues, ideally ones that were successful, to see what they wrote and get inspiration from it or copy the style.

Your service manager ought to be helping you; some trusts also have business, finance and performance/information managers allocated to your department who can support you with data and expertise in writing cases. It should be the managers undertake much of the data gathering and support work on:

- activity (numbers of cases in outpatients and theatres per year)
- relevant income and expenditure now, future and with the changes requested
- salary and banding details for staff; liaising with estates etc.

However, they will not be able to understand as well as you the clinical aspect and often also the quality and safety aspects, and they may not be as good at seeing the big picture, the significance or the "vision" of the case. They move around between specialties a lot or may not be familiar with ophthalmology, and you may need to supply that specialty expertise or vision, even if you think they should know. Also, for ophthalmic equipment and devices, the managers don't understand them and often want you, perhaps with your theatre or outpatient lead nurse, to look through the catalogues, contact the company reps and try out any equipment or start negotiations on costs.

You will probably need to drive the case and you may need to do more of the work than you think you ought to if you want to get the money you need. You are likely to need to remind people to supply information you have requested to maintain momentum for the business case.

Step 4 – completing the form

Commonly used headings for cases are along the lines of

- Executive Summary
- Current Service
- Reasons for Change
- Description of Proposal
- Options Appraisal
- Cost Benefit Analysis
- Risk Assessment
- Financial Summary

Remember you need enough detail to make the case convincing without so much that it overwhelms and the reader cannot face reading it to the end. Bullet points and tables help a lot.

Executive summary:

A concise punchy summary of the entire case, bringing together the key information contained in all remaining parts of the document including what's currently happening, why change is required, options considered, preferred option and headline financial and other impact of choosing the option – and of doing nothing.

- Don't put anything new in here not explained in more detail elsewhere.
- This is the most important section – time pressures may mean this is the part that gets most (or even any) attention.

Current service:

- Describe the current situation in detail
- What clinical activity is being undertaken along with the trend of that activity or future predictions – and how much are we earning (income) from it now?
- What resources are currently dedicated to operating the service in respect of staff, equipment, space and location etc? How much does that cost?
- What's the profit margin currently? (no one likes to expand a loss-making service)
- What's the history – how have we got to this point?

Reasons for change:

- Why is there a need to change anything?
- To what extent:
    - is the service operating at a sub-standard level?
    - is demand exceeding capacity?
    - has activity grown but investment lagged behind?
    - are activity levels anticipated to change?
    - is there a need to improve patient care quality or safety?
- Is there a risk to trust reputation?
- Is it a regulatory requirement (e.g. CQC, NHSI)?

Description of proposal:
General description of what's being requested or what you want to do, for which a decision is being sought, with a range of options where appropriate – but not specifically "how" under this section e.g. describe proposal to obtain three new lasers, but not which ones or whether leased or purchased (or borrowed) or how much at this stage. You might put a consultant or service timetable in here as it would look if approved or broadly describe any new service.

Options appraisal:

- This should describe all the options that have been considered
- Always include a "do nothing" option
- Sometimes a "do minimum" – describe as such
- Note the preferred option – state why
- Describe discounted options – state why not preferable.

Cost benefit analysis:

- Activity – What's the impact?
- Workforce – Change in workforce requirement? List all the staff, banding, number of WTEs (whole time equivalent) and cost for each, with overall cost.
- Equipment – What do we need to invest/divest? How much one off or recurring?
- Consumables / Maintenance – "Non- pay (i.e. non- salary) revenue costs"
- Accommodation and estates– where and when? Reconfiguration and cost?
- Income – What extra income will we earn?
- Where relevant, explain here what the benefits will be beyond money: quality, safety, morale, reputation, patient experience.

This section is key and often done badly.

Most people do not make a proper assessment of all the extra things needed to support a change, don't include and cost them, don't think if they are practical and feasible. For instance, if you appoint a consultant they need a secretary, a desk, a computer, an office, they will not work 52 weeks per year due to leave, they need nurses, HCAs, equipment for their operating lists etc. Consider depreciation of equipment and estates as a cost. It is not just the cost – are there actually office space and theatre slots available to them? If not, it won't work.

Remember – often decisions are based primarily on money. If it's profitable, it is usually fine; if it is cost neutral probably fine; but if it makes a loss you will have to make a compelling case on what other grounds it can be justified. You must make your case and can succeed, particularly if it's about patient safety.

Risk assessment:

- What might go wrong if we don't make the change e.g.:
    - NICE non-compliance
    - patient/staff dissatisfaction
    - waiting list breaches

    - breach of legislation or regulatory requirements
    - behind the times – not modern medicine
    - etc
- What might go wrong if we do make the change requested – as above plus might not recruit someone suitable, might lose money, increased activity might not materialise etc

Financial summary:
There will usually be a table for details plus a little summary in writing. This is where you really need a manager with good financial savvy or speak directly to your finance department.

- What are the capital and revenue costs?
- Income: tariff pricing + MFF (market forces factor i.e. a top up for expensive areas in the country)
- What's the contribution (i.e. profit = income – expenditure)?
- Planned implementation date and part year effect
- What types of costs to include (inclusive of VAT where appropriate or make clear if not):
    - Staff costs
    - Drugs
    - Clinical supplies and services
    - Other costs – e.g. space utilization, facilities, IT
    - Interest on capital
    - Capital Costs: depreciation and dividends
    - Overheads

All £000s	Option 1 - no new laser	Option 2 - replace existing laser, no new activity	Option 3 - replace & increase number of lasers & increase activity
NHS income	(8,632)	0	860
Non-NHS income	0	0	0
Total income	(8,632)	0	860
Staff costs	0	0	0
Drugs	0	0	0
Clinical supplies and services	0	0	0
Non-clinical supplies	0	0	0
Other costs	0	(77)	(77)
Total expenses			
EBITDA and Overheads (earnings before interest, tax, depreciation, amortisation & overheads)	(8,632)	(77)	784
Interest on Working Capital Facilities	0	(26)	(26)
Depreciation and Amortisation	0	(257)	(257)
Dividend Payable to the Department of Health	0	(31)	(31)
Total non-operating expenses	0	(314)	(314)
Surplus/(Deficit) before overheads	(8,632)	(390)	470
Overheads (30%)	0	(23)	(23)
Net surplus /(deficit)	(8,632)	(413)	447
Target contribution margin (10%)	(863)	0	86
Excess profit above target contribution/(loss vs contribution target)	(7,769)	(413)	361

You might also, especially if a complex case, need to use and justify some financial assumptions you used to populate the above table e.g. activity rise commensurate with trend over last two years, or cost improvement programme predicted to save £X etc.

Other:
As required, use appendices for the details e.g. JD of a consultant, detailed service specification, timetables for staff etc.

Step 5. Decision making

Once written, or at least something respectable drafted, and you have worked on it with your manager, get the involved colleagues to look and input or amend or advise. You may have missed something. Chat to people about what is in there – e.g. the clinic clerk may have something useful for you if there is an admin element to the case. Discuss it at consultants' meetings and team meetings. Ask other senior staff, including those not involved in the case, but who have done business cases before, for tips and advice. Bat it back and forth a bit between you and useful others. This is particularly important if it is big and complex or a lot of money. Once more honed, get input or advice as required from senior management, finance, HR etc. as needed.

Many cases benefit from a wide awareness that they are coming and what is in them well before decision day. Sometimes if the case has been around the block it helps generate a mood that this is going to happen or must be done.

Generally, the case needs to be approved within your service leads business meeting then go higher. This may be several steps including a directorate or divisional meeting before it goes to the final step of a management executive type meeting (Medical Director, CEO, Chief Finance Officer, Chief Operating Officer etc). If it's a big or risky case, it might also have to go after that to the Board. Some trusts need a very senior manager to input into it and state its ok to go to the meeting before it can even be put on the agenda. You may need to chase, to get them to look at it with many other priorities competing for their attention.

You are likely to need to go and present the case yourself, at least at some of these meetings. Take your manager, and it's fine to take key colleagues (e.g. nurse lead), especially if they can talk well or fill in the gaps in your knowledge.

You need to know the case well including the headline money information. You need to have rehearsed your arguments beforehand, ideally practised your pitch (including in front of friendly colleagues if you wish), you need to anticipate the questions. If you have multiple meetings to present at, learn from the last one and any questions that arose – redo the case, and address the question in it.

Step 6. What makes a case successful

- A clear and concise case
- A compelling reason for change
- Good exploration of alternative options
- A strong financial case (especially a financial contribution – minimum 10%)
- Clinical engagement
- Financial and manager input and approval of the details
- Wider stakeholder buy-in and advanced discussion

Melanie Hingorani, RCOphth Chair of Professional Standards
Steve Davies, Chief Financial Officer, Moorfields Eye Hospital
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