

# **Building an effective business case to support heart failure services**

**Monday, 14 October 2013**  
**Royal College of Physicians, London**



The development of an effective business case for heart failure services was discussed at a meeting held at the Royal College of Physicians on Monday, 14 October 2013. Approximately 90 delegates attended the meeting, which was organised by Hayward Medical Communications (HMC) and the York Health Economics Consortium (YHEC). The focus of the day was to provide information and advice on how to prepare and structure a business case, what sources of data and information to use, and how to employ a business case to inform service development.

The stage was set by **Professor Theresa McDonagh** (King's College, London) who showed how the National Heart Failure Audit can be used as a tool to support business case development. Professor



McDonagh highlighted that 'data is power'. She discussed how the audit allows service providers to demonstrate to commissioners the potential gains that can be made by providing adequate services for patients admitted to hospital. In particular, the audit highlights how the best outcomes are achieved for patients who are admitted to hospital under the care of cardiologists and are subsequently followed up by a cardiologist. The next step, once a robust mechanism for risk-adjusting the data has been finalised, will be to produce hospital-level outcome data, including mortality data, in the audit.

The discussion that followed emphasised that one of the perennial weaknesses in the available data set is the ubiquitous problem of coding. For some hospitals, the discrepancy between cases reported to the audit and cases coded as heart failure in the Hospital Episode Statistics (HES) returns is almost 100%. Importantly, the audit only really covers secondary care. Data from primary care are more sparse, particularly when considering that the number of cases on Quality and Outcomes Framework (QOF) registers is almost always lower than what would be expected from epidemiological data.

**Professor John Hutton** (University Hospitals of Morecambe Bay NHS Foundation Trust) addressed the considerable problems introduced by the upheavals of the Health and Social Care Act. In some circumstances, the principles underlying the act are mutually contradictory. For example, a merger of services might improve efficiency, yet fall foul of the requirement to maintain patient choice.

Additional challenges are posed by the Quality, Innovation, Productivity and Prevention (QIPP) demand of a 20% increase in productivity by 2015 and by the shift of funding from health to social care. Nevertheless, some important principles are unarguable – performance will be best measured through patient outcomes.

The central feature of a business case must involve the demonstration of 'value for money'. Professor Hutton concluded by describing the traditional view, where the Treasury is seen as being solely interested in minimising costs, while patients, doctors and providers are interested in maximising health; the Department of Health, health technology assessment bodies such as the National Institute for Health and Care Excellence (NICE) and, crucially in this context, commissioners are interested in the value judgement. A pessimistic reading of the NHS changes sees doctors, commissioners and providers all moving into the Treasury's corner, concerned only with reducing costs and leaving the patients alone with the aim of maximising health, as shown in the table below. Conversely, the optimist pictures most aligning themselves with the 'value for money' column in the table.

|                    | Minimise costs  | Value for money   | Maximise health  |
|--------------------|---|---|--|
| <b>Traditional</b> | <ul style="list-style-type: none"> <li>• Treasury</li> </ul>  | <ul style="list-style-type: none"> <li>• Department of Health</li> <li>• NICE</li> <li>• Commissioners</li> </ul>   | <ul style="list-style-type: none"> <li>• Patients</li> <li>• Doctors (?)</li> <li>• Providers (?)</li> </ul> |
| <b>Pessimist</b>   | <ul style="list-style-type: none"> <li>• Treasury</li> <li>• Commissioners</li> <li>• Doctors</li> <li>• Providers</li> </ul> | <ul style="list-style-type: none"> <li>• Department of Health</li> <li>• NICE</li> </ul>  | <ul style="list-style-type: none"> <li>• Patients</li> </ul>   |
| <b>Optimist</b>    | <ul style="list-style-type: none"> <li>• Treasury</li> </ul>  | <ul style="list-style-type: none"> <li>• Department of Health</li> <li>• NICE</li> <li>• Commissioners</li> <li>• Doctors</li> <li>• Providers</li> </ul> | <ul style="list-style-type: none"> <li>• Patients</li> </ul>   |

The commissioners' position was then described in more detail by **Dr Nigel Rowell** (South Tees Clinical Commissioning Group [CCG]). When you are preparing a business case, it is vital to understand that commissioners want to ensure that a patient sees the right person at the right time. In the development of a model for care delivery, the clinician is the key figure who provides the evidence to underpin the business case, and for patients with heart failure, there is a wealth of evidence to underpin that process. As well as extraordinarily strong evidence for specific medical therapies, there is also strong evidence to support the value of the care delivered by heart failure specialist nurses and rehabilitation.

Dr Rowell went on to emphasise the need to provide evidence specifically tailored to local areas. Epidemiological data for individual localities is available from a variety of sources, in particular every health and well-being board, in conjunction with CCGs and local authorities, is obliged to produce a Joint Strategic Needs Assessment (JSNA). The JSNA provides a breakdown of local patient need, identifies potential gaps in service provision and provides predictions on likely future demographic changes. It is also important to be aware of resources available to commissioners, such as the 'heart failure service commissioning and benchmarking tool' available from the NICE website (<http://www.nice.org.uk/usingguidance/commissioningguides/heartfailureservice/thecommissioningtoolheartfailureservice.jsp>).



Dr Rowell summarised by emphasising the need to gather **all** the available evidence, describe the possible benefits to be gained in terms of reduction in the need for beds through reduced lengths of stay (with 'flow is capacity' being the relevant mantra!) and, very importantly, to ensure that primary and secondary care colleagues agree on the aims of the business case.

**Mike Gains** (HMC) and **Nick Hex** (YHEC) then described how to construct a business case, reminding the audience that the purpose of the document is to allow commissioners to make informed decisions. Central is the need to identify evidence that supports how any proposed change is likely to be beneficial not only in terms of cost, but also in service provision. All available information should be included, but the data provided need to be kept relevant to the fundamental 'decision problem'

of the business case. The application should contain a description of current practice and relevant pathways (the 'base case'), and it is often helpful to include a case study.

Specifically, when considering service design, the case must be outcome-orientated and patient-focused; in other words, there should be an emphasis on patient-reported outcomes (PROMS). A safety and risk assessment and a description of the time horizon over which the gains from any service redesign will accrue should be included.

In considering the health economic aspects of any business case, it is always important to remember that the business case should include a cost–benefit analysis, rather than simple accountancy. Decisions to invest can often be determined by small differences between potential interventions. When evaluating the case, commissioners will consider the cost of current practice remaining unchanged, as well as the cost of change.

The costs to be considered include not only the direct costs associated with providing care, but also the indirect costs not borne by the care provider (such as effects on patient earnings). Second-order costs may also be involved; that is, costs related to co-morbidities or implicit in improved survival. It is here that administrators should be involved in developing the case; clinicians are usually not in a position to develop the health economic case explicitly. Bear in mind that those working in the pharmaceutical and device industries are very experienced in constructing business cases. Most companies employ health economists to help in presenting evidence. It may be worth contacting companies where they have an interest in heart failure, and many will be prepared to offer help and advice.

To close the meeting, **Professor Andrew Clark** (Hull York Medical School) provided a recipe for a successful business case. Remember your audience: the CCG committee will typically include



medical, nursing and lay members who will all be involved in making decisions. It is important to remember that there is competition for limited resources, and the business case should explicitly make the case for the proposed intervention and why it should be chosen rather than any other.

Typically, a business case is approximately six pages in length, and should begin and end with an executive summary. A background exposition should outline the existing problem, summarise the existing services and consider what effects the local area demographics have on the problem. Discussing heart failure in terms of patterns across the UK is less appropriate than providing data on heart failure and how it is currently managed in the individual locality for which the case is being set out. The solutions to the present limitations of a service should then be detailed; in other words, the proposed changes should be presented, providing precise and budgeted information. Typically, when considering heart failure services, the emphasis will be on personnel rather than on equipment, although equipment may still be part of the bid.

In addition, the evidence base for the proposed changes should be provided, with, where possible, reference to specific guidelines (e.g. NICE, Scottish Medicines Consortium and European Society of Cardiology guidelines). The business case should then detail the expected benefits of making the proposed changes and describe the consequences of *not* supporting this plan. The outcome measures that will be improved by the intervention under consideration should be presented, as well as how outcomes from the intervention are going to be measured and over what time scale. Finally, an appendix illustrating a 'before and after' patient-centred scenario is often helpful.

