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Guide to Writing a Successful Business Case

This business case is an example template of what to consider when building your own case for a Women's Health Hub model to be submitted for approval to representatives of an Integrated Care System (ICS) or Primary Care Network (PCN).

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With thanks to Liverpool City Council and Commissioning Lead Sexual Health James Woolgar for granting permission to use resources resulting from their work: Primary Care Networks LARC Inter-Practice Referral Model – Liverpool 'Developing Women's Health Hubs'

SITUATION | SOLUTION | SUCCESS

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This document is intended to be used as a flexible guide to shape your own business case.

This template is based on increasing access to LARC provision, however, it could be adapted for use across any locality and range of services as required.

The following structure sets out an example of the type of information and wording that could be considered and included in a local business case.

Where variable fields appear this shows examples of names/local area/data which can be replaced with your own local area/local figures.

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1. EXECUTIVE SUMMARY

This section is a summary of the current situation in your area, which includes the need and the opportunity, using available data such as PHE fingertips data. For example:

<Primary Care Networks (PCNs)> have an opportunity to increase access to long-acting reversible contraceptives (LARCs) such as intrauterine systems and devices (IUD/S) and subdermal implants (SDI) for their patients. The <Local Authority> are currently at <less than half> the national average (PHE fingertips data/situational analysis resource) for GP-prescribed LARC (intrauterine methods and subdermal implants excluding injections). This opportunity is not only important to the public health of our network but creates the ability for the <PCN LARC service> to be financially sustainable by generating additional income.

2. BACKGROUND

This section is a list of statements to present the background (the need) for the local service that you intend to create. For example:

- Ensuring that every child is wanted and born into an environment with the emotional and material resources needed to care of her or him well is a vital public health goal. The maxim 'children by choice, not chance' is as relevant today as it was during the genesis of the UK's family planning services in the 1920s. Contraceptives enable women to control their fertility and improve their lives, as well as those of their children and partners.
- The use of long-acting reversible contraceptives (LARCs) such as IUS/Ds and implants is lower than other methods of contraception.
- LARCs are widely accepted to be the most effective and cost-efficient methods of contraception. There has been much emphasis on the provision of these methods as supported by The National Institute for Health and Clinical Excellence (NICE). (NICE 'Long-acting Reversible Contraception: The Effective and Appropriate use of Long-acting Reversible Contraception' (Clinical Guideline 30))[1].
- Many women still think that their contraceptive options are limited to condoms or the pill. However, long-acting reversible contraception (LARC) are significantly more effective in preventing pregnancy than contraceptive pills or barrier methods. They are also highly cost effective even if the duration of usage is limited to an interval of 1 year or less (K. Upadhya et al, Over-the-Counter Access to Oral Contraceptives for Adolescents (2017))[2].
- The limited time available and partial knowledge of contraception options currently possessed by GPs and other healthcare professionals are also thought to be a reason why LARCs may be being under-used. Some sources suggest that up to 50% of GPs believe themselves to have inadequate knowledge of contraceptives such as implants (Wellings et al, 2007[3]; Donnelly, 2015[4]).
- Public Health England (PHE) developed a model (PHE 'Extending PHEs contraception on investment tool July 2021')[5] to estimate the ROI for providing additional LARC fitting capacity within general practices. The benefits captured from this intervention focus on the cost savings of averted pregnancies resulting from women using no method of contraception adopting LARC as well as women switching from less effective methods of contraception, such as from the contraceptive pill to LARC.
- The model shows that investment in the provision of additional LARC in primary care is highly cost-effective, with an estimated ROI across the system of £48 for every £1 invested.

1 https://www.nice.org.uk/guidance/cg30
2 https://pubmed.ncbi.nlm.nih.gov/28314704/
3 https://pubmed.ncbi.nlm.nih.gov/17707718/
4 https://www.telegraph.co.uk/women/womens-health/11671906/Birth-control-GPs-lack-time-and-knowledge-to-prescribe-contraception.html
5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001464/ROI_LARC_maternity.pdf

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3. CURRENT SITUATION (using data taken from situational analysis)

This section is where you identify what service is currently offered to women in your local area, using local data. This creates a context for your plans. For example:

- The <Network> are developing a Primary Care Network model of LARC delivery which will feature inter-practice referral and the use of dedicated clinics rather than ad-hoc appointments for LARC. <LA> commissioners are driving this work and have recently increased the number of Primary Care LARC contracts and increased the Population Health LARC budget by <n>% as part of the strategy to increase the level of LARC provision in <area>.
- <We can see there are fewer GPs making use of LARC across Local Authority>.
- The picture of LARC/contraception in <Local Authority> can be seen below (PHE Fingertips Data 2019):
  - Total prescribed LARC excluding injections rate/1,000 = <n> in <Local Authority> versus the national average of 50.8/1000
  - GP prescribed LARC excluding injections rate/1,000 = <n> in <Local Authority> versus the national average of 30.0/1,000
  - Under 18s conception rate/1000 = <n>in <Local Authority> versus the national average of 16.7/1000 (2018 data is the most recent data available currently)
  - There were <n> abortions performed in <Local Authority> in 2019
    - Of these <n> were funded NHS abortions under 10 weeks
    - <n>% were repeat abortions in women under 25 (www.gov.uk Department of Health and Social Care, Abortion Statistics for England and Wales)

With patients struggling to access transport links, often city centre-based provision presents too many barriers and patients do not access the provision.

This following context encourages us to consider how and where we can improve our LARC practice and increase access to a wider range of treatment.

- Include treatment for Heavy Menstrual Bleeding (HMB): Additional to contraception, using a LNG-IUS versus surgical intervention (e.g. endometrial ablation/hysterectomy) is far more cost effective with less risk and complications. There were <n> admissions for HMB in <Clinical Commissioning Group> between 2015-16, resulting in <£n> estimated costs. (Bayer Heavy Menstrual Bleeding Cost Model, September 2016[6].)
- Include Menopause treatment options: Women also find it difficult to access LNG-IUS for endometrial protection for HRT with ongoing limited availability of hormone replacement therapy (HRT) preparations; the IUS offers an alternative option for HRT delivery with lower risk of VTE.
- With patients struggling to access transport links, often city centre-based provision presents too many barriers and patients do not access the provision. This presents an opportunity for general practice to respond to.

6 https://www.nice.org.uk/guidance/cg30

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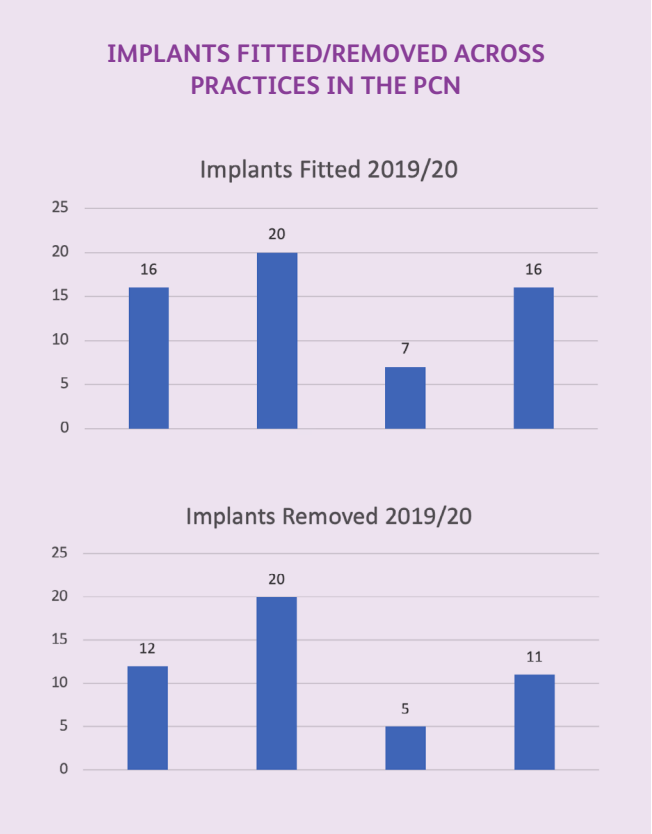
4. EXAMPLE PROPOSED PLAN

This section uses local data again to drill down into the current services available, and the alternative approaches presented by your plan for the future of service delivery via a Women's Health Hub. For example:

- <City Council> is supporting the development of a <PCN LARC> model.
- The LARC provision across the practices within <Primary Care Network> in the year <year/year> is outlined below to give an idea of the delivery across the network (the delivery across the network gives us an opportunity to provide LARC in line with national provision);

Include your own graphs, as in the example below:



Alternative approaches/Future opportunities for the service

- There are several approaches that could be considered for the provision of a service such as this in the future across <PCN>. Examples of these include:
- A number of practices delivering the LARC service from their own premises – appointments uploaded onto central booking system and bookable from across the network – in this scenario LES fees would go to the fitting practice.
- PCN to employ sexual health clinicians who act as peripatetic fitters who can travel between the practices across the network– in this scenario LES fees would go to the network (it could be that Physicians Associates are employed for this role – 100% reimbursable). It's unlikely there are any fully trained Physician Associates available as this is such a new role, however, we could recruit and develop the individual.
- Provision of premises from where the service can be delivered for the network – this could be in conjunction with peripatetic fitters.
- Hybrid model – e.g. current fitters providing a service from their own practices and receiving the LES payments for the LARC fits that they perform, alongside a network service with fitters employed by the network – for LARC fits performed by the network fitters the LES payment would be paid to the network.

Please see the Toolkit's Project Plan for full detail.
Steps include:

- Developing a key stakeholder network/network engagement
- IT interoperability – development and sustainability of system
- Workforce sustainability
  - i. Identification of additional workforce
  - ii. Workforce training if required
- Patient pathways
- Communication across network workforce
- Communication for patients
  - i. Promotional leaflet
  - ii. Promotional poster
  - iii. Clinic letter

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5. FINANCIAL VIABILITY/COSTS

This section is where you use costings for consumables and staff to present the best case scenario (green table – financially viable); the bad case scenario (yellow table – neutral viability), and the worst case scenario (red table – not financially viable). For example:

Please see the Financial Viability and Financial Planning resources in the Toolkit for detail.

The multiple scenarios below demonstrate the best to worst case scenarios based on variation in costs and potential income associated with delivering LARC 3-hour procedure clinics depending on the combination of staff employed to run the clinics. This template is based on increasing access to LARC provision, however, it could be adapted for use across any locality and range of services as required. (The below examples are reproduced with permission from the work of James Woolgar, *Primary Care Networks LARC Inter-Practice Referral Model – Liverpool 'Developing Women's Health Hubs'*.)

BEST CASE SCENARIO (6 X REPLACEMENTS) WITH 100% OF ATTENDANTS FROM OTHER PRACTICES 3 hours

PROCEDURE	TIME ALLOCATED (HOURS)	APPOINTMENT TIME REQUIRED (MINS)	NUMBER PERFORMED	CONSUMABLES PER PROCEDURE	TOTAL COST OF CONSUMABLES	STAFFING COSTS (GP)	STAFFING COSTS (CHAPERONE)	LES PAYMENTS CLAIMED PER PROCEDURE	TOTAL LES PAYMENTS CLAIMED	TOTAL REIMBURSEMENT - LES - CONSUMABLES & STAFFING COSTS
Coil fit	1.5	30	3	£17.00	£51.00	£112.50	£25.37	£100.00	£300.00	£111.14
Coil removal	0	15	3	£5.00	£15.00	£-	£-	£38.09	£114.27	£99.27
Implant fit	1.5	30	3	£3.00	£9.00	£112.50		£60.87	£182.61	£61.11
Implant removal	0	25	3	£7.00	£21.00	£-		£63.16	£189.48	£168.48
Inter-Practice Referral fee for 100% of appointments in the clinic			6	£0.00	£0.00			£10.00	£60.00	£60.00
Total income per clinic										**£500.00**
Total Yearly (48 weeks at 1 clinic/week)										**£23,999.76**

BAD SCENARIO (50% DNAS) WITH NO PATIENTS FROM OTHER PRACTICES 3 hours

PROCEDURE	TIME ALLOCATED (HOURS)	APPOINTMENT TIME REQUIRED (MINS)	NUMBER PERFORMED	CONSUMABLES PER PROCEDURE	TOTAL COST OF CONSUMABLES	STAFFING COSTS (GP)	STAFFING COSTS (CHAPERONE)	LES PAYMENTS CLAIMED PER PROCEDURE	TOTAL LES PAYMENTS CLAIMED	TOTAL REIMBURSEMENT - LES - CONSUMABLES & STAFFING COSTS
Coil fit	1	30	1	£17.00	£17.00	£75.00	£16.91	£100.00	£100.00	-£8.91
Coil removal	0	15	1	£5.00	£5.00	£18.75	£4.23	£38.09	£38.09	£10.11
Implant fit	1	30	1	£3.00	£3.00	£75.00		£60.87	£60.87	-£17.13
Implant removal	1	25	1	£7.00	£7.00	£75.00		£63.16	£63.16	-£18.84
Inter-Practice Referral fee for 50% of appointments in the clinic			0	£0.00	£0.00			£10.00	£-	£-
DNA retainer			4	£0.00	£0.00			£24.83	£99.32	£99.32
Total income per clinic										**£64.55**
Total Yearly (48 weeks at 1 clinic/week)										**£3,098.52**

WORST CASE SCENARIO (100% DNAS) WITH NO PATIENTS FROM OTHER PRACTICES 3 hours

PROCEDURE	TIME ALLOCATED (HOURS)	APPOINTMENT TIME REQUIRED (MINS)	NUMBER PERFORMED	CONSUMABLES PER PROCEDURE	TOTAL COST OF CONSUMABLES	STAFFING COSTS (GP)	STAFFING COSTS (CHAPERONE)	LES PAYMENTS CLAIMED PER PROCEDURE	TOTAL LES PAYMENTS CLAIMED	TOTAL REIMBURSEMENT - LES - CONSUMABLES & STAFFING COSTS
Coil fit	1	30	0	£17.00	£0.00	£75.00	£16.91	£100.00	£-	-£91.91
Coil removal	0	15	0	£5.00	£0.00	£18.75	£4.23	£38.09	£-	-£22.98
Implant fit	1	30	0	£3.00	£0.00	£75.00	£16.91	£60.87	£-	-£91.91
Implant removal	1	25	0	£7.00	£0.00	£75.00	£16.91	£63.16	£-	-£91.91
Inter-Practice Referral fee for 50% of appointments in the clinic			0	£0.00	£0.00			£10.00	£-	£ -
DNA retainer			8	£0.00	£0.00			£24.83	£198.64	£198.64
Total income per clinic										**-£100.07**
Total Yearly (48 weeks at 1 clinic/week)										**-£4,803.24**

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6. 6-MONTH PLAN

What are your plans for the first six months of the new Hub? Include examples of actions needed to open the existing (or proposed) service network-wide. For example:

i. Workforce Sustainability

Introduce a care-co-ordinator/admin support (this role could be funded through the Additional Roles and Responsibilities monies available).

Recruitment of a care-co-ordinator (or similar) (hours required to be confirmed) to provide admin support around the following areas;

Managing booking system (updating the appointment book, maximising clinic potential and financial viability, e.g. booking implant appointments together and coil appointments together due to the fact that the chaperone is only required for the coil appointments and therefore only in clinic for the necessary amount of time).

- Minimising DNAs through patient engagement (sending out appointment reminders etc).
- Communication with all practices to ensure engagement with and utilisation of the service.
- Promotion of the service to patients (e.g. placement of network promotional literature/posters, working with practices to identify groups of patients who would benefit from the service and directly promoting the service to these patients via accuRx).
- Standardised ordering of consumables (can consumables be bought in bulk for the network service to secure any potential discounts?).
- Identify training requirements for new fitters as well as general contraception training for practices/the network.
- Verifying procedures performed against payments made against the LES contract.

Examples of identification and recruitment of additional workforce as the service is developed further (as above could be funded through the Additional Roles and Responsibilities monies available).

Identification of workforce could include:

- Identification of lapsed fitters who could undertake a refresher course to re-certify their Letter of Competence.
- Identification of GPs/nurses willing to undertake the FSRH Letters of Competence for coils and/or implants (include the costings/income from a GP-led service against e.g. potential income from a nurse-led clinic).
- Potential for use of a Physician's Associate as an additional fitter alongside experienced fitter (include the costings/income from a PA-led clinic).

ii. Training/Education

Refer to the Training Plan resource for detail.

Option to set up one or more of the 'hub' practices as a LARC Training Centre to support workforce development and sustainability.

iii. Patient pathways – referral of patients into the service

For example, there is an expectation that all practices will support the service by identifying women who would benefit, and then refer them into the service. Support for practices and practice staff to be able to do this is necessary.

iv. Development of additional hubs and/or clinics

For example, potential additional hubs could be created to accommodate increased demand for the service and reduce inequalities ensuring improved accessibility to the service to provide more equitable provision across the entire network.

Depending on the service to be offered, consider if QoF points for payment or additional funding is available, i.e. for cervical screening.

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7. CONSIDER RISKS

What are the risks to your future plans? For example:

- Demand could escalate beyond the resource of the service. This could result in a long waiting list and impact on the quality of the patient journey.
- Interoperability across practice systems is required to enable this to work beyond the current fitting practices.
- Costs to deliver this service could leave practices out of pocket.

8. FUTURE PLANS

This section presents the longer-term ambitions of the proposed model and any development/s needed to add to the services available and further support women across the network. For example:

Consider and include the benefits and value of future development of the service to provide a holistic life course approach, and how this could impact and improve patient outcomes, i.e.:

- Ring pessary fitting/removal services
- Cervical screening
- Heavy menstrual bleeding – advice and treatment options
- Menopause advice and treatment options.

9. NEXT STEPS

What actions do you need to take next to move closer to making your plans reality? For example:

- Prepare, present and agree business case with ICS/PCN.
- Identify task group to develop a project plan.

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