How to Write a Business Case – Non Medical Prescribing

Introduction

The purpose of this document is to provide a generic tool to enable new pharmacist independent prescribers to draft a business case for new services. With the changing landscape of the NHS, there will be opportunities to improve patient care by providing innovative services in different settings using the skills of non-medical prescribers and it will be important to influence decision makers, in order to secure funding for services.

In simple terms, a business case is a supported argument that a business-related concept (in this case, a non-medical prescribing service) is both practical and ‘value for money’ or profitable. For example, you could make a business case for investing in a frozen yogurt shop in central London, but it might be harder to make a good business case for opening your shop in the Outer Hebrides.

Not to be mixed up with a business plan, which contains and demonstrates the financial steps necessary to create or grow a successful business or successfully carry out a business activity.

Top Tips

- **Know your audience** – Who are you pitching the case to? What is important to them?
- **Identify clinical allies to support the business case** – e.g. GPSIs; clinical nurse specialists, local hospital specialists.
- **Do your ‘homework’** – Research into the service, care pathway, clinical area. Who are the stakeholders and key decision makers? How can you influence them?
- **Tailor to the level of investment** – for example, a three month pilot of a service in one practice may not warrant a full length business case, whereas a multi-disciplinary service covering a whole hospital would require a full detailed business case.
- **Use your organisation’s Business Case Template,** if one is in place you will be required to complete that, otherwise follow these guidelines
- **Attention to detail** - Make it concise and accurate with enough detail to inform decision makers. It should reflect a sense of professionalism, assumptions must be realistic and the projections credible.
- **Review** - Once you have completed your case, have it independently reviewed. Select someone detached from the process who can offer constructive criticism on all aspects of the plan. This review should prompt further questions that will need to be addressed in a revised draft.
- **Focus on the opportunity** - If you are seeking investment in your service, it is important to clearly describe the investment opportunity, i.e. what the investor will get in return. What is the unique selling proposition (USP) of this service or of using pharmacists?
- **Link benefits to policy drivers/gaps in the system** – e.g. care closer to home (policy driver) would warrant changes to the anticoagulant care pathway, identifying the need for community based services (gap), hence the case for an anticoagulant pharmacist prescriber.
- **Tools to help structure business cases** – There are a number of management tools that may help you structure your thoughts, in order to write your business case, e.g. SWOT analysis, SPIN®.
- **Look for statistics to support you particular circumstances** – See important medicines statistics on page 3.
## Contents of a Business Case

A typical business-case will include the following 12 headings outlined below:

- Executive Summary
- Background
- Reasons
- Business Options
- Expected Benefits
- Scope and Exclusions
- Constraints and Assumptions
- Timescale
- Major Risks
- Costs
- Investment Appraisal
- Recommendations
A wide range of services could be provided by non-medical prescribers, so it is not possible to write a specific business case that could be used in every scenario. This is a guide to what might be included under each section. Where it has been possible to write some generic supporting information, this text has been highlighted in grey boxes (on pages 3 & 6) and can be edited as required.

1. **Executive Summary**
   This section should highlight the key point of the business case, including the important benefits and the return on investment (see section 11). Arguably the most important component. This is a summary of the entire case and is usually contained at the start of the plan. It also tends to act as a key qualifier for time-pressed people—if they like it, they will read on, if not they will go no further.

2. **Background**
   This section should include background information:
   - Strategic Intent or Case – How does the service support the organisational strategy?
   - The priorities for the organisation.
   - Specific information on the setting, locality, therapeutic area or practice.
   - Evidence to support the proposal. The text below (page 3) provides some background information and outlines the evidence to support non-medical prescribing.
   - Current policy drivers that support this service development, e.g. Care closer to home, QIPP, redesigning care pathways, reducing unnecessary hospital admissions.

Listed below are policy drivers used in a business case for NMPs to improve quality of care in hypertension management of patients with previous poor blood pressure control.¹

- **Care closer to home:** Delivered in primary care setting.
- **Value for money:** By focusing on uncontrolled patients only, the skills of the clinical pharmacist in prescribing rational and cost-effective regimens, identifying and addressing concordance issues and dealing with adverse effects were best utilised to maximize outcomes for the investment made.
- **Improving quality:** Addressing QOF/NSF targets, achievement of which within the clinic populations rose from a baseline of 26% to 57% in clinic one and from 36% to 69% in clinic two over 6 months.
- **Reducing unnecessary hospital admissions:** By improved blood pressure (BP) management.
- **Access:** The service encouraged those patients less engaged with GP services to access healthcare via the pharmacist, longer appointment times than the GPs/practice nurses allowed greater discussion of health beliefs etc. to encourage longer term engagement.
- **Choice:** Patients were given the opportunity to access the pharmacist-led service or see their usual GP/nurse. Uptake of the service was high, with low DNA rates, indicating that the additional service was well received.
- **Reducing health inequalities:** The focus on practices failing to meet QOF targets has enabled the local practices and CCGs to tackle areas of greatest need in the areas of greatest deprivation.
- **Personalisation:** The success of the service in addressing BP management and CV risk reduction has been built around the tailoring of therapy and lifestyle advice to meet the needs of the individual patients.
Evidence for NMPs

An evaluation of the nurse and pharmacist independent prescribing was commissioned and reported by the Department of Health in 2010, in order to inform planning for current and future non-medical prescribers. 

Key findings of the study were:
- Overall the results indicated that nurse and pharmacist independent prescribing is both safe and clinically appropriate.
- Acceptability of non-medical prescribing to patients is high.
- Non-medical prescribing was generally viewed positively by other health care professionals.
- Nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient’s condition and giving him/her access to medicines.
- Key issues for further expansion of non-medical prescribing may include preparing nurses and pharmacists to prescribe across conditions for patients with co-morbidities.

Evidence has shown that the benefits of non-medical prescribing include:
- Faster access to medicines.
- More flexible patient orientated care.
- Time Savings.
- Improved Service Efficiency.

Important Medicines Statistics

- Medicines are the most frequent treatment intervention and cost the NHS over £14.4 Billion in 2013-4.
- In 2008/9 over 542,000 bed days in England and Wales were attributed to adverse drug events.
- In 2007, over 86,000 medication errors were reported to the NPSA: 100 of these caused death or severe harm.
- Research has shown that at least 6% of emergency admissions are a direct result of problems with medicines.
- Research demonstrates that up to 50% of patients do not take their prescribed medicines as intended.
- Supporting healthy living and better care via pharmacies may prevent disease development and reduce medicines use.
- In 2008/9, 1% of admissions were coded as due to adverse events related to medicines used therapeutically at a cost £4.4 million. Extrapolating using Pirmohamed’s research (6% of emergency admissions are due medicines related problems) suggests that the financial cost could actually have been six times greater at £26million with a huge, potentially avoidable human cost in terms of mortality and morbidity.

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3. Reasons
This section should define the reasons for the business case. It should outline the known current situation, problems and implications and also explain how the proposed service will help to achieve any corporate strategies and objectives.

You might find the SPIN\(^4\) model a helpful way to structure this section. It is used by organisations involved with sales, negotiating and influencing. SPIN stands for:
- **Situation** – What is the situation that your proposal seeks to address or change? This is simply a statement of the situation as it is.
- **Problems** – The problems that this situation creates. The more detailed you can be, the more impactful your proposal will be.
- **Implications** – What will happen if the situation continues? You may want to project the situation 6 or 12 months into the future and consider the implications over these timelines. Again, the more detailed you can be, the more effective your proposal will be. Any evidence or research that you can refer to is critical at this point.
- **Needs** – What needs to happen? This is essentially the crux of your proposal. This is where you will detail your proposal and include details on costs, timelines, personnel (internal and external) that need to be involved, etc.

4. Business Options
This section should outline the different options available for addressing the identified need(s). Showing that you have seriously considered all the possibilities will strengthen your business case. Providing senior management with all the available information will also maximise the chances for somebody to suggest an improvement.

Include all options, even those that you would not favour or support. Your reader will think of these anyway and it is a good idea to present the reasons why your proposal is the best. For example, you may choose to include nurse independent prescribers vs. pharmacists or employed staff vs. outsourcing the service. All business cases involve at least two options:
- Doing nothing
- Doing something.

5. Expected Benefits
These can be qualitative or quantitative and should be measureable. This may include clinical outcomes or financial benefits– for example:

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Financial</th>
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<tbody>
<tr>
<td>Reducing medicines incidents</td>
<td>Savings on budgets</td>
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<tr>
<td>Improving medicines optimisation</td>
<td>Saving GP or nursing time</td>
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<tr>
<td>Improving adherence</td>
<td>Increase in QOF points for GP</td>
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<tr>
<td>Improved patient care</td>
<td>Reduction in outpatient appointments</td>
</tr>
<tr>
<td>Patient Outcomes – Control of INR, BP…..</td>
<td>Reducing readmission rates</td>
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<tr>
<td>Care closer to home</td>
<td>Medicines Wastage</td>
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<tr>
<td>Improved patient access to medicines</td>
<td>Number of drugs stopped or changed</td>
</tr>
<tr>
<td>Patient Experience – quantified by a patient satisfaction service</td>
<td></td>
</tr>
<tr>
<td>Patient Choice – of seeing a GP; Nurse or Pharmacist</td>
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</tbody>
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This is where you persuade your audience that your service is worthwhile. Every possible benefit can be considered, tangible and intangible. Just make sure that you justify the benefits that you project. If your service will reduce costs, then present calculated figures as evidence. If the primary benefit is improved patient care or staff efficiency, then explain how this will happen and what the effects will be.

**Benefits vs. Features**
A feature is a factual statement about the product or service being promoted. But features aren't what entice customers to buy. That's where benefits come in. A benefit answers the question "What's in it for me?" meaning the feature provides the customer with something of value to them. For example, pharmacists are the experts in medicines and can prescribe (feature of the pharmacist), thereby saving GP's valuable time or increasing QOF points (benefits)

**Features of pharmacists**
- General management skills
- Evaluating evidence and putting into practice
- Controlling and monitoring prescribing budgets
- Formulary and guidelines management
- Source of up-to-date medicines information
- Counselling, influencing and securing behavioural change

These features may help to support a more patient focussed and efficient service, however, it is still important to link the benefits that are important to the investor, e.g. for GPs it might be increasing their QOF points or savings on the prescribing budget.

**How can Non-Medical Prescribing be monitored?**
It may be useful to include how the service will be monitored to provide assurance of safety and effectiveness. Organisations which employ non-medical prescribers use a range of mechanisms to monitor the quality, safety and effectiveness of the service. These mechanisms include:
- Prescribing data
- Clinical outcomes data
- Clinical supervision
- Significant event monitoring
- Audit
- Patient satisfaction questionnaires

**6. Scope and Exclusions**
This should outline the scope of practice for the non-medical prescribing service, e.g. therapeutic area, setting, status of patients. Where appropriate should also state any exclusions, e.g. paediatric patients.

**7. Constraints and Assumptions**
Assumptions are events that a business case assumes will happen. For example, a business case might assume that an independent prescriber will be qualified. Critical assumptions must occur for a service development to succeed, e.g:
- Access to the GP prescribing budget
- Access to consulting rooms
- Access to the GP computer systems

Constraints are schedule, resource, budget, staffing, technical, and other limitations that may impact the success of a service development. For example, access to a prescribing budget, staff on sick leave, IT software not working, funding for training or access to clinical mentor.
8. **Timescale**
   This should state the period of the service – e.g. fixed term or on-going. It can also detail the activities and goals of each stage, and explain why the specified length of time is needed. Services can be set up as time limited projects, which can be evaluated to provide evidence of value or ‘return of investment’. Successful projects can then become long-term ‘business as usual’ services.

9. **Major risks**
   This section should include a summary of the key risks and likely impact and plans should they occur. Transparency will gain the confidence of senior managers and will demonstrate your foresight, realism and capability.

10. **Costs**
    This is a summary of the on-going operations and maintenance costs and funding arrangements.

    Senior managers need to know the total projected cost before they can authorise any proposal. Justify each area of expenditure, so that nobody is in any doubt that the budget you have forecast is as accurate as possible. Costs should include staff time; training and resources. Resources can include equipment, IT or clinical; use of facilities, including overheads and insurance.

    Benefits should also be costed where possible, for example:
    - Savings on budgets
    - Saving GP or nursing time
    Some benefits can be costed, e.g. Cost of a hospital admission is approximately £2000; Hospital outpatient appointment is approximately £90. Hourly rate of a GP; nurse or pharmacist’s time.

    Other costs may be more difficult to translate into monetary terms.
    - Reducing medicines incidents
    - Improving medicines optimisation
    - Improving adherence

    The costs can then be used to assess ‘return on investment’ -See section 11 – Investment Appraisal.

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**Is commissioning services with NMP cost-effective?**

Investing in NMP is an example of invest to save. Services which use NMP will include the employment costs of the non-medical prescriber, costs of mentoring and clinical supervision, as well as clinical governance, practical and CPD support once the non-medical prescriber qualifies. If these costs are considered against those for alternative mechanisms of access to personalised prescribing (e.g. the employment costs of using and supporting medical prescribers of equivalent experience, costs in health service inefficiencies from duplication, time or medicines wasted, and lost organisational savings or income from payment by results), it is clear that NMP can represent value for money.

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11. **Investment appraisal**
    This section should include a comparison of all the benefits and on-going operations/maintenance costs. This is where you review the cost and benefits against one another in order to demonstrate that your proposal is better than the other business options (highlighted in section 4). Before senior management can authorise your project, they need to know what they are getting for their money, i.e. the return on investment (ROI).
The investment appraisal, by detailing the costs and benefits over a fixed period of time, is the most direct way of quantifying "value for money." Value for money is based not only on the minimum purchase price (economy) but also on the maximum efficiency and effectiveness of the purchase.

12. **Recommendations**

The recommendations summarise the main points of a business case and offer suggestions on how to proceed. Make sure to consider your own business case in an objective light.

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**Key References**


3. Optimising medicines use into care pathways- NHS Specialist Pharmacy Service  


6. Maintaining competency in prescribing: An outline framework to help pharmacist prescribers - second edition. National Prescribing Centre - October 2006 which was replaced by A Single Competency Framework for all Prescribers:  


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