Guide to writing a business case for an epilepsy specialist nurse

Background and context
This guide has been produced by the Joint Epilepsy Council www.jointepilepsycouncil.org.uk and the Long Term Conditions Delivery Support Team www.ltc-community.org.uk. It seeks to address the identified challenges of writing a business case or influencing local decision makers to recruit an epilepsy specialist nurse as an integral member of a specialist support team.

The Epilepsy NICE guideline states that ‘Epilepsy specialist nurses (ESNs) should be an integral part of the network of care of individuals with epilepsy. The key roles of the ESNs are to support both epilepsy specialists and generalists, to ensure access to community and multi-agency services and to provide information, training and support to the individual, families, carers and, in the case of children, others involved in the child’s education, welfare and well-being.’

Epilepsy Action’s report ‘Best care: The value of epilepsy specialist nurses’ states that ESNs undertake a wide range of valuable, mainly patient-related activities in various settings. In the absence of ESNs this work would either fall to consultants or simply be overlooked.

This guide complements the ‘Commissioning Epilepsy Services Resource Pack for Commissioners’ which is one of the outcomes of ‘Best Value, Better Care – Commissioning Epilepsy Services’ conference held on 23rd February 2010 in London.

It is recognised that the potential audiences for this work will range from clinical practitioners with considerable insight into the impact of epilepsy on people’s lives and little experience of developing a business case, to those with commissioning experience and little knowledge of the specific condition. This guide draws together the intelligence from all perspectives. It will help to identify the desired outcomes and the costs and benefits accrued in achieving them.

Purpose and structure
A business case makes a proposal for change. It is desirable that the business case emerges from development work with all stakeholders as part of a process of change rather than a stand alone piece of work.

A business case needs to focus on outcomes that are of priority to key stakeholders involved, especially those who are being asked to fund the proposal. It is therefore beneficial to reflect the link between the business case and the priority in the title.
It is assumed that organisations have a template for a business case. This guide is designed to suggest sources of information to complete that template. It is important that the business case reflects the local perspective.

**Support and information**
The sources of information are current at the time of writing and are intended to stimulate thinking, however original references should always be sought.

Consultation with stakeholders will increase their engagement in the proposal. Having focused conversations and developing appropriate relationships with colleagues, service users and carers forms a sound basis for the business case and will impact on its eventual success.

Even if the business case is not ultimately successful in achieving funding it may lead to other desirable outcomes through the engagement of stakeholders.

**Long Term Conditions Delivery Support Team**
We aim to improve the services for people with long term conditions by supporting the implementation of Long Term Conditions policy and strategy. We work with the Department of Health and are funded by NHS.

Become a part of the LTC Community at [www.ltc-community.org.uk](http://www.ltc-community.org.uk)
Wellington House, 133 – 155, Waterloo Road, London SE1 8UG, Tel 0207 972 3049
Fax 0207 972 4349

**Joint Epilepsy Council**
The Joint Epilepsy Council of the U.K. and Ireland (JEC) is an umbrella organisation which exists to represent the united voice of the voluntary sector and presents evidence based views on the need to improve services for people with epilepsy, their families, and carers in the UK and Ireland.

The Joint Epilepsy Council of the U.K. and Ireland, PO Box 186, Leeds LS20 8WY, [www.jointepilepsycouncil.org.uk](http://www.jointepilepsycouncil.org.uk)  [sharon.jec@btconnect.com](mailto:sharon.jec@btconnect.com) Tel: 01943 871852

**Epilepsy Action**
Epilepsy Action has been supporting ESNs for over 15 years and has a range of expertise and resources to help a review of epilepsy services. We can provide advice on designing services, care pathways and epilepsy generally. We have a network of local branches and a large database of members to provide local input in to service redesign. To find out more contact the epilepsy services team at [services@epilepsy.org.uk](mailto:services@epilepsy.org.uk) or call 0113 210 8800.

**Feedback and Comments**
We welcome any comments and feedback. If you have an example of a business cases written using this guidance and would be prepared to share it we would be most interested to see it. To share your feedback on this guide contact the epilepsy services team at [services@epilepsy.org.uk](mailto:services@epilepsy.org.uk) or call 0113 210 8800.

Written: August 2010 Review date: August 2011
**Introductory Memo: Key considerations for non-commissioning experts**

Commissioning is the process by which local budget holders – such as Primary Care Trusts and GP consortia, identify the health and social care needs of the populations they serve, and plan for and procure the services required to meet those needs. High quality commissioning is based on a strategic and long term view, which delivers better health outcomes for patients, and is cost effective i.e. it secures the greatest possible value for the taxpayer.

Despite the decentralisation of health budgets to the local level, the process of commissioning does not take place in a vacuum – it is shaped by national political imperatives, and residual elements of ‘top-down’ command and control, as well as the wider economic climate.

The first question NHS commissioners might ask is how to get more for less. ‘More’ meaning higher quality services which meet increasing demand, increase efficiency and effectiveness and satisfy rising expectations of service users. ‘Less’ includes net savings, reduction in waste from investments, public sector cash release, and reduced budgets.

Below is a suggestion of some potential issues to be taken into account when developing a business case for the improvement of epilepsy services.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommended response</th>
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| 1. Commissioners are measured against their success in tackling local and national health priorities. | • Acknowledge the wider commissioning environment and the principal changes on the horizon.  
• Identify which national and local health priorities are of main concern for commissioners (refer to the NHS Operating Plan, the NHS Outcomes Framework with national goals, local strategic plans and any other initiatives).  
Explain how an improvement in epilepsy services, in line with the business case, can help to address other identified major priorities for the NHS (see objectives in section 1). |
| 2. All decisions meet the test of quality, innovation, productivity and prevention (QIPP). | • Highlight the short-term financial gains to be achieved as a result of the service re-design (wherever possible).  
• Explain which elements of the business case support QIPP, and quantify this wherever possible.  
Highlight evidence based outcomes and how guidance will be met. |
| 3. Commissioners are responsible for a large range of services. | • Take steps to ensure that decision makers consider your business case (which may take them time and effort to implement) amongst other pressing priorities, and similar proposals.  
- Build wider support for the business case – secure endorsements from clinicians, professional bodies, local MPs/elected representatives such as Councillors, patients for the case.  
- Ask others to be advocates for the business case – give other stakeholders (such as local MPs) the information and tools to help them call on NHS bodies to implement the business case.  
Aim to secure a face to face meeting to talk through the plan and agree next steps (identify allies within the decision makers who can help to make this happen). |
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## Objectives

Ensure it is clear how each objective will be achieved.

Not all of the objectives will be relevant to each business case. Focus on the areas of change important to the specific health economy. Expecting too much from an individual nurse would lead to inadequate service provision.

### Objectives of the service

#### Care related
- Effective Personal Care Plans for all patients with epilepsy
- Ensure patient review every year (NICE and SIGN guidance)
- First seizure support
- Support, advice and liaison with other local support for patient and carers
- Transition clinics for teenagers entering the adult service
- Clinics and advice specifically for women of child bearing age working jointly with maternity services

#### Outcome related
- Reduction in inappropriate hospital admissions
- Reduction in length of stay
- Better concordance with medication and self care
- Reduce treatment gap - 70 per cent of the population with epilepsy in the UK could be seizure free with optimal treatment. Currently only 52 per cent of the population of people with epilepsy are seizure free. Source JEC ‘Epilepsy prevalence, incidence and other statistics’ [www.jointepilepsycouncil.org.uk/Final.pdf](http://www.jointepilepsycouncil.org.uk/Final.pdf)
- Ensure equitable access to epilepsy services
- Improved and appropriate anti-epileptic medication prescribing

#### Pathway/service related
- Facilitation service between primary and secondary care
- Effective liaison and joint planning with all agencies in health, social care, education and the third sector
- Deliver nurse-led clinics
- Improve referral pathway (well timed and appropriate referral) from primary care to neurologists (secondary care) to epilepsy specialists/epileptologists (tertiary care)
- Non medical prescribing (nurse/therapy prescribing)
- Building a comprehensive database of the population with epilepsy in the area to include the capture of performance metrics and outcomes as required by commissioning organisations
- Ensuring an evidence based and standardised approach to prescribing
- Ensuring faster identification of “treatment resistant patients” and delivering treatment advice to this patient group
- Increase training, education and awareness of epilepsy across the
| 1.2. | **Measures of success**  
Outcome measures should be clearly identified together with performance metrics, clinical governance assurances and best practice.  
It is essential to quantify the benefits to be able to influence an investment or redirection of funds to the business case. This means translating the benefits into measurable, costed targets, including identified costs savings, releasing capacity (in quantifiable terms) or alternative uses of resources.  
Ensure that the data is available to prove these measures.  
**Care related**  
- Improved patient satisfaction  
- Improved compliance and appropriate use of anti-epileptic medications  
- Training of family and carers in the administration of rescue medication, so reducing clinical involvement  
**Outcome related**  
- Reduction in A&E attendances  
- Reduction in emergency admissions  
- Reduction in GP consultations  
- Reduction in out patient episodes  
- Reduce epilepsy related deaths  
- Reduce consultant led follow-up care  
**Pathway/service related**  
- Increase access to epilepsy services in the community  
- More equitable access to epilepsy services  
- Follow best evidence based practice  

\(^1\) The potential cost savings can be calculated using Payment by Results (PbR)  
\(^2\) The Office for National Statistics recorded 1,045 epilepsy related deaths in 2008. 

| 1.3. | **Target audience, referrals and discharge**  
Identify the target population of the service (adult, paediatric, learning disabilities or older people). Also define the population by geographic area.  
Consideration needs to be given to the referral process to the service. Possible options include:  
- All patients with a diagnosis of epilepsy self refer  
- GP and consultants refer to the service  
The referral method has implications on the caseload of the service. |
Discharge from the service needs to be considered to ensure a manageable caseload.

### 1.4. Examples of benefits / outcomes

How people with epilepsy will benefit from the introduction of an epilepsy specialist nurse. How primary care, consultants and other hospital departments will benefit. An attempt has been made to ensure all benefits are tangible.

**Care related**

- Healthier pregnancy outcomes for women on anti-epileptic drugs
- Better quality of life for people with epilepsy measured with satisfaction surveys
- More people with epilepsy in employment
- Number of people attending self help groups
- Reduction in the number of epilepsy related deaths
- Improved health through prompt access to specialist expertise
- People with epilepsy experiencing fewer seizures and side effects
- Increased awareness of epilepsy amongst other professionals (such as health professionals, social services, education, employers and the wider community)
- Tailored care and better self management through patient care plans
- Empowerment of people with epilepsy and signposting to other services

**Outcome related**

- Higher quality of service through improved patient experience scores
- Reduction in number of GP appointments – freeing up primary care capacity
- Reduction in number A&E attendances reducing costs to the health economy
- Reduction in emergency admissions and number non-elective admissions freeing capacity and reducing cost and less disruptive to patients
- Reduction in 999 admissions
- Higher number of people seizure free
- Reduction in misdiagnosis of epilepsy

**Pathway/service related**

- Follow best evidence based practice
- Reducing costs by using cost effective nurses time rather than consultant or GP time
- Improved liaison between primary and secondary care and therefore better patient care pathways
- More effective anti-epileptic drug prescribing

See 5.2 for the baseline cost information that can be used to demonstrate gains against outcomes.
For patient focused outcomes, an initial survey of epilepsy patients, their carers or of healthcare professionals, may be beneficial to establish a baseline of patient service satisfactions, employment difficulties and quality of life.

1.5. **Evidencing outcomes**

It is recommended that outcomes are **Specific, Measurable, Agreed, Realistic and Time-based** (or SMART).

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Example:
Target: 25% reduction in A&E attendances over one year related to baseline activity.
Baseline: If there are currently 1,000 attendances there would need to be a reduction of 250.
Assumptions: Assuming one in three of the people who see a specialist nurse could be prevented from attending A&E. 750 patients would need to be seen over the year to prevent 250 attendances at A&E. This assumption in not evidence based.

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Example of lead in time: Induction and competency based skill assessment framework. Non medical prescribing is a 6 month 2 day per week commitment at university with additional supervision from

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Issues to consider:

- Is this realistic (4.1 states that the recommended case load is 250 patients)
- The lead in time for the nurse
- Whether the data collected provides evidence of the measure
- There may be multiple attendances by the same person
- Assumed success rate of the nurse’s interventions
- Number of interventions the nurse would need to make to achieve the measure
- The length of time of intervention
- The reduction may only be visible in the following year

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It is recommended that activity projections work on an individual being productive for 42 weeks per year, unless there is a multi disciplinary team that is available for 52 weeks per year. This allows 6.5 weeks annual leave, 2 weeks study leave and 2 weeks potential loss to sickness absence. Based on Agenda For Change – Department for Health.
### 2. Finance of the service

#### 2.1. Evidence of cost effectiveness

The financial model needs to reflect the service description, measures and outcomes.

It is advisable to work with the finance team to develop the financial section of the business case. Potential sources of income will vary from organisation to organisation but may include:

- Local Operating Plan
- Primary Care GP Commissioning
- Disinvestment to Reinvest from Acute providers admission tariff – into Primary Care commissioning or PCT Commissioning
- Deprivation monies (only available in areas of high deprivation)
- Regional Innovation Fund (RIF) & Quality, Innovation, Productivity and Prevention (QIPP)
- Epilepsy Action Sapphire Scheme [www.epilepsy.org.uk/services/sapphire](http://www.epilepsy.org.uk/services/sapphire)
- Corporate sponsorship, investment and/or partnership

See 5.2 for the baseline cost information that can be used to demonstrate gains against outcomes.

#### 2.2. Service costs

The following items should be considered, listed as pay with on costs, and non pay.

**Pay** costs with 24% on costs and top of scale Agenda for Change pay rates:

- Band 5 support nurse
- Band 2 administration support
- Pension contribution (included in above 24%)
- Employers National Insurance (included in above 24%)
- Administration support (usually calculated on band 2)
- Annual leave cover
- Sickness leave cover

**Non Pay** including:

- Travel – realistic for the locality
- Uniforms or allowance
- Training
- Stationery/printing
- Leaflets and information for patients
- Computer and consumables
- Room rental and furniture

See appendix A for an example of how to display this information.
These should be projected over several years of the service to include inflation. These costs will be at least an additional 24% above salary costs and some acute trusts estimate the cost to be an additional 40% above salary costs. The costs may fluctuate over time due to set up costs and increasing the service.

2.3. **Income**
Some business cases increase revenue (through sale of goods or charges for services) that can be offset against the costs of the scheme. Whilst this is not a feature widely experience currently, in some fields it is significant and with the introduction of individual budgets or joint schemes with local authorities this could become an interesting area for inclusion future business cases.

The administration costs of collecting the revenue should be included.

2.4. **Cost data**
These data are needed to understand the savings which have been made. Direct costs of current activity include:
- Tariffs for hospital admissions
- Drug costs and uses
- Cost of doctor and nurse led clinics
- Banding of current staff costs

2.5. **Cost comparisons**
Any cost comparisons must take into account the development and the running costs of the proposal. All data should be used in context and with local interpretation.

The cost basis uses at least two comparisons:
- Before / current situation (baseline)
- Future / proposed model of service (target)
  - Direct benefits
  - Indirect, mid to long term impact, with assumptions
2.6. **Return on investment**  
This can assist in calculating the reasonableness of a scheme. See 2.7

Benefits \[= \text{return on investment}\]  
Service costs

For every £1 invested you project 'return on investment' (as calculated above) worth of benefit.

<table>
<thead>
<tr>
<th>Example:</th>
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<tbody>
<tr>
<td>If the service costs £360,000 over five years and the benefits are £650,000 over five years</td>
</tr>
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\[
\frac{\text{£650,000}}{360,000} = 1.8
\]

For every £1 invested you project £1.80 worth of benefit.

Service costs as calculated in 2.2 and Benefits as outlined in 1.4

2.7. **Test of reasonableness**  
The cost of the scheme needs to be in proportion to the outcomes achieved. One way this can be assessed is by comparing a unit cost.

To calculate a unit cost:

\[
\text{Total cost of service} = \text{unit cost per patient}\]  
\[
\frac{\text{Number of patients}}{= \text{unit cost per patient}}
\]

<table>
<thead>
<tr>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the service cost £72,000 per year and saw 250 patients per year</td>
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</tbody>
</table>

\[
\frac{\text{£72,000}}{250 \text{ patients}} = \text{£288 per patient}
\]

For example if it costs £288 to see each patient considering the assumptions regarding success and depending on the cost of tariff, consider if it is reasonable to pay for that intervention?

Total cost as shown in 2.2 and Caseload see 4.1

The reasonableness can also depends on how long it will take to pay back any initial outlay that may be required.
3. **Demographic information**

3.1. **Size of population with epilepsy**
Epilepsy is a tendency to have recurrent seizures. It can affect anyone, at any age and from any walk of life. It is the most common, serious, neurological condition.

Epilepsy is not a single condition; there are about 30 different epileptic syndromes and over 38 different seizure types.

Approximately 456,000 people in the UK have epilepsy (based on 2003 census and a total UK population of 59,554,000) This is equivalent to 1 in 131 people. The Age Standardised Prevalence Rate of Epilepsy in the UK: 7.5 per 1,000. Include reference to newly diagnosed cases. Equivalent to 27,400 new cases diagnosed per year (based on 2003 census figures).

The number of people with epilepsy within a health economy can be calculated using document produced by the Joint Epilepsy Council entitled: *Epilepsy prevalence, incidence and other statistics.*

The document can be found at [www.jointepilepsycouncil.org.uk/Final.pdf](http://www.jointepilepsycouncil.org.uk/Final.pdf)

3.2. **Specifics of the population**
Prevalence varies by age, gender and social deprivation as well as other factors. It is therefore important to include information on people with learning difficulties, children, transitional (between paediatric and adult), social deprivation, urban, rural, population age or ethnic mix and the impact this will have on the service. [www.jointepilepsycouncil.org.uk/Final.pdf](http://www.jointepilepsycouncil.org.uk/Final.pdf)

3.3. **QOF Data (Quality and Outcomes Framework)**
This data for everyone with epilepsy over 18 can be sourced from Primary Care Trusts.
Limitations of this data include:
- Variation in exception reporting
- Uncertainty of the suitability of the review (how it’s conducted and by who)

The results of the QOF data can be found at [www.qof.ic.nhs.uk](http://www.qof.ic.nhs.uk)
4. **Service Design**

4.1. **Factors to consider**
These factors need to be considered to ensure that the service is a success.
- Nurse’s workload – is the case load manageable?
- Epilepsy Action also recommends that epilepsy specialist nurses have a caseload of no more than 250 patients with active epilepsy, see [www.jointepilepsycouncil.org.uk/Wasted-Money-Wasted-Lives.html](http://www.jointepilepsycouncil.org.uk/Wasted-Money-Wasted-Lives.html)
- Urban / rural split and travel
- Administrative support
- Working with other agencies
- Realistic costing
- Probability of achievability
- Contingency plans for non delivery
- Patient consultation
- Proportion of time spent on:
  - Education of GPs
  - Education of members of the public
  - Education of other professionals
  - Patient consultation

4.2. **Option appraisal**
A business case needs to demonstrate an option appraisal. The option appraisal process shows the range of options there are to delivering the outcomes required. There should be a recommendation for the preferred option.

Whilst this is advice on developing a business case for a specialist epilepsy nurse service, it is the clinical outcome for people with epilepsy that is the critical objective. The options discuss the advantages and limitations of each option.

All options need to have the advantages, disadvantages and limitations made explicit. No option is perfect. This is where the cost and outcome differences are explicit for comparison. See 2.1 Evidence of cost effectiveness. It must be remembered that an option of ‘do nothing’ will have associated costs.

Some of the limitations might also be probability of recruitment, time to train, lack of interest (for example GPs locally). Advantages might be flexibility of nursing input, community location, and flexible working hours.

4.3. **What shortfalls there are in the current epilepsy service?**
This section should identify the current local service and include how the existing service may not meet national guidelines including the NICE Guidelines 2004, pressures and constraints on the current system. The NICE Guidelines are being consulted on in summer 2010, the remit is to update the pharmacological management sections of the guideline and include the use of ketogenic diet. [www.nice.org.uk/CG020](http://www.nice.org.uk/CG020)
Shortfalls should be measured against the outcomes that the service is aiming to achieve in 1.1. There may also be considerations that fall outside the direct scope of the service but are worth consideration. These may include access to surgery and diagnostic equipment (such as MRI and EEG), diagnosis of epilepsy by non-epilepsy specialists and differences in prescribing protocols between organisations.

4.4. **Risks**
Consider the risks faced by the people with epilepsy if the service is not sufficient and appropriate to the needs of the local population.
What risks do these constraints and pressures present?
- Sudden Unexpected Death from Epilepsy (SUDEP)
- Misdiagnosis
- Increased rate of admissions
- Uncontrolled seizures
- Unacceptable drug side effects
- Social issues such as unemployment and isolation
- Increased cost of inappropriate access to health provision by patients with epilepsy
- Impact on prescribing budgets

Consider the risks that may be faced by the service. These include lack of funding beyond initial period, staff sickness or resignation. The exit strategy at 4.7 should outline how these risks will be handled.

4.5. **Timescale**
Including milestones, such as a nurse being in post, running clinics and the period of time over which there will be return on investment.

When considering a new post an induction is required and additional training may be required if the person has not undertaken this role before. This delay in the full service being up and running should be taken into account when setting outcomes. Experience from the community matron and other specialist services models suggests at least a 9 month lead in time to full efficiency in the post; with return on investment clearly achievable within a 2 year period (Derbyshire County PCT – Parkinson’s Disease Nurse Specials Report 2010).

4.6. **Evaluation and impact assessment**
Consider:
- Metrics and performance monitoring required
- Equality impact assessment
- Time lines for reporting (often quarterly review)
- Appropriate outcome measures across the community including the patient and carer feedback, health and social care impacts.

The reporting should reflect the objectives outlined in this business case. Suggested measures of success can be seen in 1.2.
## 4.7. Exit strategy

The exit strategy should consider other options of doing things differently, especially where developments might have taken place over a period of time. The impact on other services, including demand, capacity, skills and risks need to be considered.

**Issues to consider:**

- Funding is withdrawn
- Nurse leaves, or is unable to work – is the patient’s care by default returned to Primary and Secondary care colleagues?
- Reduction in demand due to patients no longer needing the service because seizures are controlled
### Assumptions and evidence base

#### 5.1. Sources of information
Outline any assumptions made and draw on evidence of the need locally and nationally. Useful documents include:

- Epilepsy in England: time for change [www.epilepsy.org.uk/campaigns/timeforchange](http://www.epilepsy.org.uk/campaigns/timeforchange)
- Latest guidance from NICE [www.nice.org.uk/CG020](http://www.nice.org.uk/CG020)
- SIGN – Scottish Intercollegiate Guidelines Network [www.sign.ac.uk/guidelines/fulltext/70/index.html](http://www.sign.ac.uk/guidelines/fulltext/70/index.html)
- Best Value, Better Care – Commissioning Epilepsy Services February 2010 [www.ltc-community.org.uk/articles.asp?action=view&id=5794](http://www.ltc-community.org.uk/articles.asp?action=view&id=5794)

See appendix B for examples of what these articles include.

#### 5.2. Baseline data and costs / benchmarks
Include any current data on the service because this will give a good benchmark when showing the improvements over time. Include information on when the service was established the number of new diagnoses per month or year and national statistics regarding the incidence of epilepsy ([www.jointepilepsycouncil.org.uk/Final.pdf](http://www.jointepilepsycouncil.org.uk/Final.pdf)). This data acts as a baseline for ongoing monitoring and viability of the service.

Baseline data should be collected on all outcomes in 1.5 and demographic data at 3.

#### 5.3. Strategic fit
Consider the strategy from Department of Health, Long Terms Condition Team, Strategic Health Authority, Primary Care Trust, Acute Trust and GP commissioners any other local provider.

• World Class Commissioning [www.dh.gov.uk](http://www.dh.gov.uk)
• Quality, Innovation, Productivity and Prevention (QIPP) [www.dh.gov.uk](http://www.dh.gov.uk)
• National Sentinel Clinical Audit of Epilepsy-related Deaths (2002)
### Additional information to position the business case

#### 6.1. Further information about epilepsy

- Joint Epilepsy Council (JEC) [www.jointepilepsycouncil.org.uk](http://www.jointepilepsycouncil.org.uk)
- JEC Epilepsy prevalence, incidence and other statistics [www.jointepilepsycouncil.org.uk/Final.pdf](http://www.jointepilepsycouncil.org.uk/Final.pdf)
- National Institute for Health and Clinical Excellence (NICE) [www.nice.org.uk](http://www.nice.org.uk)
- Long Term Conditions Delivery Support [www.ltc-community.org.uk](http://www.ltc-community.org.uk)
- Department of Health [www.dh.gov.uk](http://www.dh.gov.uk)
- Brainwave - The Irish Epilepsy Association [www.epilepsy.ie](http://www.epilepsy.ie)
- The Daisy Garland [www.thedaisygarland.org.uk](http://www.thedaisygarland.org.uk)
- David Lewis Centre [www.davidlewis.org.uk](http://www.davidlewis.org.uk)
- Epilepsy Action [www.epilepsy.org.uk](http://www.epilepsy.org.uk)
- Epilepsy Bereaved [www.sudep.org](http://www.sudep.org)
- Epilepsy HERE [www.epilepsyhere.org.uk](http://www.epilepsyhere.org.uk)
- Epilepsy Outlook [www.epilepsyoutlook.org.uk](http://www.epilepsyoutlook.org.uk)
- Epilepsy Research UK [www.epilepsyresearch.org.uk](http://www.epilepsyresearch.org.uk)
- Epilepsy Nurses Association [www.esna-online.org.uk](http://www.esna-online.org.uk)
- Gravesend Epilepsy Network [www.gravesendepilepsynetwork.com](http://www.gravesendepilepsynetwork.com)
- International League Against Epilepsy UK chapter [www.ilae-uk.org.uk](http://www.ilae-uk.org.uk)
- Matthews Friends [www.matthewsfriends.org](http://www.matthewsfriends.org)
- Meath Epilepsy Trust [www.meath.org.uk](http://www.meath.org.uk)
- Mersey Region Epilepsy Association [www.epilepsymersey.org.uk](http://www.epilepsymersey.org.uk)
- National Centre for Young People with Epilepsy [www.ncype.org.uk](http://www.ncype.org.uk)
- National Society for Epilepsy [www.epilepsysociety.org.uk](http://www.epilepsysociety.org.uk)
- St Elizabeths Centre [www.stelizabeths.org.uk](http://www.stelizabeths.org.uk)

#### 6.2. Health economy, supporters and others involved

Be clear about who is funding the service and who can access it.

The service will impact on other professionals, these may include: Neurologists, paediatricians, learning disability psychiatrists, general practitioners, other specialist nurses in primary and secondary care, practice nurses, occupational therapists, community neurological and rehabilitation teams, community team for people with learning disabilities, community matrons, community hospitals, community nursing teams, ward staff, social workers, pharmacists, psychologists, counsellors, midwives, amongst others.

It is advisable to seek their commitment to support the service before setting up the service.

Also include if and how other organisations propose to be involved. Local authority, schools, GPs, acute trust, PCT, social care, SHA, carers, mental health professionals, public involvement forum, charities, local neurological forum, epilepsy conference providers, benefits agency, carer support groups. Access to work, local ‘condition management teams’.
6.3. **Change management**
Consider how the change will be managed and who needs to be engaged to ensure that the change is a success.
Appendix A – Service Costs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay costs</strong> based on Agenda for Change rates with 24% on costs to account for National Insurance, NHS pensions and other employing organisation overheads such as management.</td>
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<tr>
<td>Band 7 nurse</td>
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<tr>
<td>Band 5 support nurse</td>
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<tr>
<td>Band 2 administration support</td>
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<tr>
<td><strong>Non Pay Costs - Recurrent</strong></td>
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<tr>
<td>Travel – realistic for the locality</td>
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<tr>
<td>Uniform or allowance</td>
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<tr>
<td>Training</td>
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<tr>
<td>Printing and ink</td>
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<tr>
<td>Stationery</td>
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<tr>
<td>Information for patient (leaflets)</td>
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<tr>
<td>Land line rental and Mobile phone</td>
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<tr>
<td>Sickness leave cover</td>
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<tr>
<td><strong>Non Pay – non recurrent</strong> (but needs depreciation costs factored in at year 4)</td>
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<tr>
<td>Computer &amp; printer</td>
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<tr>
<td>Specialist equipment for specialist role</td>
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<tr>
<td>Room rental and furniture</td>
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<tr>
<td><strong>Total Costs</strong></td>
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</table>

It may be useful to work out these costs against the predicted savings to come up with a cost per case saving model.
Appendix B – Extracts from useful documents

Below is a selection of extracts from documents which may be useful. It is always recommended that the reference is read in full to understand the context.

**Long Term Neurological Conditions:** A good practice guide to the development of the multidisciplinary team and the value of the specialist nurse. (2009)

Misdiagnosis rates in the UK where a diagnosis of epilepsy is incorrectly made are between 20-31%. Using an assumed rate of 23%, this equates to 105,000 people with a diagnosis of epilepsy and receiving antiepileptic drugs who do not have the condition. This high misdiagnosis rate has a major impact on people’s lives, including the physical implications of the side effects of taking antiepileptic medication. One of the main reasons for the high level of misdiagnosis is the lack of training and the limited access for people with epilepsy to epilepsy specialists (1).

In 2004, the medical cost associated with misdiagnosis in England was £23 million and the non medical cost was £111 million (2). Developing the epilepsy service and having the correct workforce in place should help to improve the rates of accurate diagnosis thus reducing the amount of costs associated with misdiagnosis.

A randomised controlled trial (3) found that patients who consulted an epilepsy nurse specialist as well as their neurologist were significantly less likely to seek additional consultations with their GP or clinic doctors. This led to an annual saving of £184 per patient, as GP and clinician time was freed up by patients being able to access the epilepsy specialist nurse for advice and support.


[www.healthcareworkforce.nhs.uk/option.com_docman/task.doc_download/gid,1635/Itemid,697.html](http://www.healthcareworkforce.nhs.uk/option.com_docman/task.doc_download/gid,1635/Itemid,697.html)

**Wasted money, wasted lives** (2007)

All Party Parliamentary Group on Epilepsy inquiry into to the serious shortfalls in service provision for people with epilepsy

- 400 avoidable deaths per year
- 69,000 people living with unnecessary seizures
- 74,000 people taking drugs they do not need
- 189 million needlessly spent each year

**Best Care: The value of epilepsy specialist nurses**

**Key findings**

- ESNs act as a central cog in the care of people with epilepsy.
- Adequate resourcing of the ESN service is crucial to the delivery of high quality care for people with epilepsy – limited resources lead to compromised and fragmented care.
- ESNs undertake a wide range of valuable, mainly patient-related activities in various settings. In the absence of ESNs this work would either fall to consultants or simply be overlooked.
- The ESN service is about improving quality of care. It is an essential service, not a luxury, to ensure patients are ‘moved-on’ and receive best, not basic, care.
- ESNs are good value for money and the work ESNs do cannot be done by less experienced staff.
- ESNs reduce a consultant’s workload. This can lead to cost savings since nurse-led care does not carry the high salary costs associated with consultant-led care.
- Primary care based ESNs can optimise and standardise care for individuals with epilepsy and support and reduce the burden of care for GP colleagues.

[www.epilepsy.org.uk/sos](http://www.epilepsy.org.uk/sos)

**Epilepsy in England: time for change (2008)**

- Despite NICE guidelines that all people with suspected epilepsy should be seen by an epilepsy specialist, half of Acute Trusts (49 per cent) do not employ one.
- Despite NICE guidelines stating that all people with suspected epilepsy should be seen urgently (within two weeks), most trusts (more than 90 per cent) have waiting lists of longer than this.
- Despite NICE guidelines stating epilepsy specialist nurses (ESNs) should be an integral part of the medical team providing care to people with epilepsy, well over half of Acute Trusts (60 per cent) and PCTs (64 per cent) do not have one.

[www.epilepsy.org.uk/campaigns/timeforchange](http://www.epilepsy.org.uk/campaigns/timeforchange)

**Specialist nurses Changing lives, saving money (2010)**

In Surrey PCT, a new specialist epilepsy nurse reduced attendances at A&E by nearly half in 2005. This represents a saving of £17,136 a year. Epilepsy misdiagnosis (which happens in 20-31 per cent of cases, or over 100,000 people) in England costs £23 million and the non-medical cost was £111 million. A specialist epilepsy service could help combat this and a randomised controlled trial (NHS National Workforce Project) found that patients consulting a specialist nurse and a neurologist were less likely to visit their GP, which led to a saving of £184 per patient per year.
NHS could save millions by investing in specialist nurses – RCN (2010)

In February 2010 the Royal College of Nursing (RCN) joined forces with almost 40 of the UK’s leading health organisations to warn that cutting specialist nurse services for people with long term conditions would be a “false economy”, as they began a campaign for guaranteed access to specialist nursing care for all patients with long term conditions.
Appendix C – Structure of your business

This flow chart is intended to assist in determining the structure of your business case. The following questions will assist in your team brainstorming and discussion.

**Introduction**
- What is your rationale to improve your business case?
- Have you sourced appropriate references?
- Who needs to be engaged to ensure the project is a success?

**Objectives**
- What is your overall vision?
- What are the care related, outcome related and pathway/service related objectives?
- Have you identified the target population for this business case?

**Impact of improving epilepsy service**
- What are your proposed measures of success?
- How will you evidence outcomes? Are they SMART?
- Will the evaluation data appropriately measures your care related, outcome related and pathway/service related objectives?

**Financials**
- What are your projected costs?
- What is your financial strategy?
- Have you engaged with your financial team members?
- What are the financial risks?

**Demographic information**
- Who will benefit from the epilepsy care / service improvements?
  - Local/ National/ Both?
  - People with learning difficulties, children, transitional, social deprivation, urban, rural or ethnic mix?

**Service Design**
- What are the key building blocks to your business case?
- How will your service design address current service short falls?
- What are the options? Are they delivering the required outcome?
- What are the risks to epilepsy patients should the service not achieve the desired outcomes?

**Timings**
- What is your timeline for the activity?
- Do you have a contingency plan?
- What are your timelines for reporting?
- What are your timelines for activity evaluation?

**Conclusions**
- Have you included supporting evidence?
- Have the objectives been met?
- Do you have clear and succinct next steps?
Appendix D – Schedule for business case

A clear activity schedule can be helpful in ensuring your business case is completed in a timely manner, and to ensure it contains all the information it needs. The tracker below may assist you in dividing responsibilities and establishing a completion timeline.

<table>
<thead>
<tr>
<th>Business Case Section</th>
<th>Responsibility</th>
<th>Reviewer</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
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<tr>
<td>Objectives</td>
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<tr>
<td>Impact of improving epilepsy service</td>
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<tr>
<td>Financials</td>
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<td>Demographic Information</td>
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<td>Service Design</td>
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<tr>
<td>Timings</td>
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<tr>
<td>Conclusion</td>
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