Business and Service Planning in Cardiac Physiology

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Business Management in Cardiac Physiology

• Complex systems within differing organisations
• Highly bureaucratic
• Anything from couple of sides of A4 to binded dossier!
• Anything from 5k to 5 million and way beyond
• You should start small and build with confidence and learn from your many mistakes!
Business Management in Physiology

• Those who manage clinical services are best placed to understand those services in terms of development
• Need to understand the wider context of our operating environment – internal and external
• Have an awareness of the local and national agenda in relation to local service planning
• Understanding of financial flows both within and external to your organisation
• Get to know “who you need to know”
• Look at any service development objectively – it may make good clinical sense to you………. 
Service Planning

• Revenue case, capital or both
• What are the drivers for this service development
• What is the strategic context – how does it fit with the overall Cardiology or Divisional vision?
• What is the operational context of the proposal – how does it fit with other services.
Revenue Business Case

Is this a be new service:

• Running physiology led clinics
• This could be expansion of existing service – taking on ICD/CRT follow-up in existing pacemaker service
• This could be existing service expansion delivered by different individuals – DSE/TOE
• Overall workforce expansion
• Research proposal
Ground Work

• In development of a business case (especially new revenue), research your proposal thoroughly
• Approximately 1-3 months to research and gathering info, 2-3 days to write (depending on size)
Evidence of Need

• Maximise market share
• NICE guidance
• Comply with local, national or regional standards
• Reduce waiting times – 18 week rtt
• Innovation – using staff/resource differently
• Improved pathways of care for patients
• Utilise capacity
• Increase revenue for Dept/Division
• Aligned with commissioners intentions/priorities
• Unmet need
Developing the Service model

- This will inform your business case
- Highlight inter-dependencies
- Identify the referral pathway
- Who will be involved
- How many patients – what is the evidence for this activity!
- Patient outcomes
- Clinical Governance
- Service audit and evaluation
Risk/Benefit ratio

- If this case successful what would be the strategic, operational and financial benefits (detailed in the strategy)
- If fail to support what would be the risks – loss revenue, reputation, business, reduce quality, lose staff, market share.
- Is there alternatives – option appraisals, “middle ground” solution.
Demand and capacity

• Meticulous activity recording is essential for business case development related to expansion
• Proof of activity and growth should be done of periods – upto 5 years ideally
• Data shown in quarters identifies any seasonality
• Any influencing factors should be recorded (drop-off due to consultant absence etc, increase due to new consultant starting or new guidance)
• If this is new activity what if the evidence base for your activity projections?
Activity Data
Demand and capacity

• Capacity should be detailed in terms of physical and manpower.
• The physical availability of a room, equipment, down-times etc.
• Detail of how long each element of the process is, the grade and time needed of each member of staff.
• Working time available in terms of working weeks minus holidays and study – e.g. 42 week working year.
“National guidelines suggest that echo-cardiographers should spend not less than 30 mins per echo. Practicalities of reporting and physical ergonomics suggest that an echo-cardiographer could perform up to 12 - 14 echoes per day.

The Division estimate that it is reasonable to expect 30% of each accredited member of staff clinical time to be spent performing echoes, given the other diagnostics and administrative requirements, we have 9.7WTE BSE accredited staff – resulting in 2.9 WTE dedicated echo time per week across the Division. n. 14 echoes x 5 days x 2.9 wte = 204 echoes per week across the 3 + SBH sites or 51 per site per week (including SBH) . This gives a maximum annual capacity of 9180 echos, assuming a 45 week clinical working year (6 weeks holiday and 1 week study/absence). This equates to a maximum capacity of 51 echoes per site per week during normal working hours”

Capacity to deliver on above modelling 9180 per year
Actual activity  13832 per year
Demand and Capacity

• The metric of demand and capacity is waiting times
• This is one of the loudest voices in today's NHS but proof of the validity is essential in terms of rigorous demand and capacity modelling.
Echo Waiting Times - DMH

- 6+weeks
- 3-6weeks
- 1-3weeks
- <1week

Graph showing waiting times from January 2009 to March 2010.
Financial Analysis-Cost

• Cynically – the bit that counts!!
• Consider all potential costs – better to identify a cost and don’t use than miss it and absorb in your “profit”
• Interdependency costs – other services (phlebotomy/pathology/radiology/porters/linen/pharmacy/transport)
• Staff and non-staff (consumables)
Financial considerations

Capital Costs:

- Don’t forget VAT
- Don’t forget service and maintenance
- Don’t forget capital depreciation
- Don’t forget IT dependencies
- Don’t forget associated consumables
Financial considerations

Staff:

• Don’t forget recurrency
• Don’t forget grade increase - ?cost at top assuming you will get there
• Don’t forget organisational add-ons
• Don’t forget lead times for new services
• Don’t forget training budget
Implementation Plan

• Is there a lead in time?
• Is the projected activity staggered?
• Will the costs be staggered or full financial commitment at start?
• What are the risks?
• What is the exit strategy?
• Audit considerations
• Post implementation review
Specifics of MSC

• Service expansion
• New service
• Upgrades of existing to scientist grade
• Workforce expansion - “demand and capacity case”
• Dovetailing the training period into a service development
• Better workforce planning!!
Service Planning MSC

• In business terms the grade of the job needs to be aligned to the service provision – e.g. specialist

• New services with staff follow revenue business case +/- capital element

• Service expansion, additional staff to existing with proof of activity to support.

• Upgrade – what additional revenue will be attracted with this upgrade?
Workforce Expansion

There could be a trick here:

- Business case could include the 3 year StHA funding
- This could be 3 year cost saving if existing member of staff or 3 year funding for new member of staff
- Business case to include workforce projection e.g. known retirement, Could be opportunity to “pre-fill” a vacancy
- New service with build-in for growth in 2-3 years
Future Planning

• Always have ears open to new potential opportunities
• New markets – GP commissioning, although be wary of internal trade-offs.
• Tie services in – clinical standards, accreditation, IT infrastructures in face of “any willing provider”
• Opportunities to deliver services traditionally remit of Dr’s (clinical engagement!)
• How can we make service planning take into account the new training pathway
• We need to get used to forward planning, staggering-in service delivery to match workforce plans
• Think differently and more strategically about staff resource utilisation – current and future.
“Fingleworth, stop trying to speed up reduction of staff through attrition.”