Business Case Template
Investment Governance Group (IGG)

Scheme Title	**Critical Care and Anaesthetics Workforce Review**
Divisional Lead	**Jamie-Rae Burgoyne; Operations Manager, Critical Care**
Clinical Lead	**Vishal Dhokia – Clinical Lead, Critical Care**
Divisional Finance Manager	**Gareth Jenkins**
Revenue funding requested for project	**21/22 H2 £558,300** **22/23 £1,776,200** **23/24 £1,610,900**
Capital funding requested for project	**£361,400**
Date project presented at COO Operations Meeting	
Executive Signature	
Type of Case:	Growth ☐ Service Development ☒ Efficiency Plan ☐ Compliance / Safety ☒

To ensure inclusion in the next IGG meeting please complete this form and return to:

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Managers should complete all sections. Any additional supplementary information should be attached as an Appendix in the **Business Case+** document

Summary of Proposal

The aim of this document is to outline a proposal for Adult Critical Care services to establish an additional 2 bed spaces within the CCU footprint and sufficient staffing to cover unplanned admission, scheduled elective and non-elective surgical activity. This will improve CCU staffing levels, On-Call and Out of Hours (OOH) which fails on many accounts to meet the current national guidelines for delivery of basic critical care services (including poor estate, GPICS2 gap analysis) and obstetric cover.

This proposal aims to achieve the following as a direct result of the additional bed spaces:

- Increased throughput of patients to allow increased capacity for both Critical Care and the wards in a number of different specialities
- Ability to keep Critical Care within its geographical footprint; reducing the possibility of surge into Recovery / Theatres
- Mitigation of risks ≥9 on the Risk Register
- Reduce pressure and stress on staffing, helping to increase their mental and physical well-being
- Reduced Critical Care length of stay
- Reduced hospital ward length of stay
- Release of resource in terms of bed days through a reduction in length of stay
- Improved functional status of patients at Critical Care and hospital discharge
- Improved quality of life in survivors of critical illness

In order to achieve the above aims, the objectives of this proposal are to:

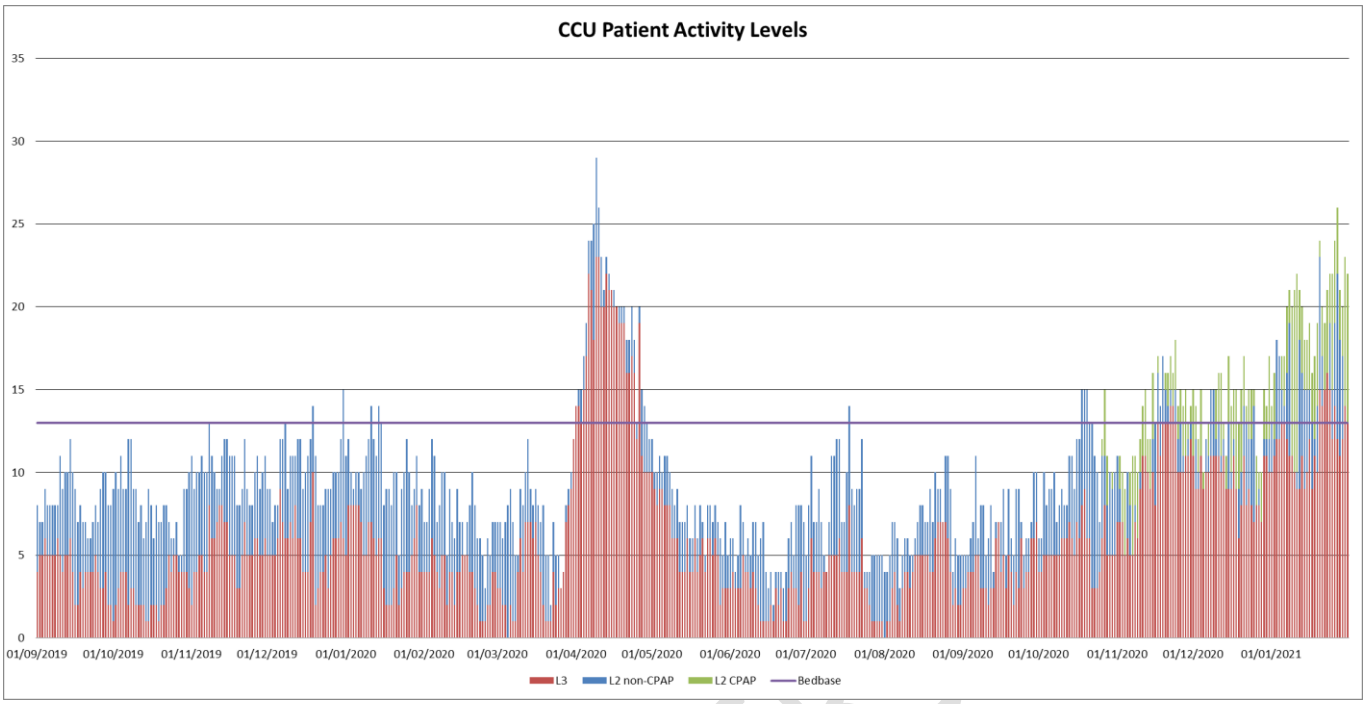
- Decrease the staffing gap analysis as set out in the GPICS2 standards
- Increase to 12 x L3 equivalent bed spaces within CCU and/or 15 beds in total in line with NHSI requests to maintain 125% capacity
- Invest in Multidisciplinary Rehabilitation and Support Services to meet service specification, improve flow and deliver quality improvement which has previously been described as a 'struggle' in our last CQC report
- Deliver 24/7 CCOT cover as described in the CQC 'should do's' through the reduction of pressures and interventions required across all ward areas and support services, providing Divisional benefits across the Trust as a whole

- **What is the issue?**

As it stands the service in unable to maintain the current level of elective activity alongside the requirements to cover the Critical Care Unit, On-Call, OOH provision and Emergency work. With the introduction of the Elective Accelerator Programme and responding to the pandemic, this has further highlighted shortfalls within the service which this proposal hopes to address.

At present there is a distinct lack of rehabilitative services on CCU except for a proportion of Physiotherapy which is distributed between CCU, Ward 31 and Ward 32. This has a direct impact on patient outcomes and could potentially increase their length of stay.

During the last 18 months CCU has been responding to the COVID-19 pandemic and has previously been recognised for its efforts. During the second wave the decision was made to continue with elective activity which had previously been stood down during the first; this coupled with the increasing request for mutual aid via the Critical Care Network for the East Midlands has resulted in an unmaintainable level of activity.



CCU days with >12 to 17 patients	2019	2020	2021 to date
January	15	7	29
February	4	1	28
March	7	2	19
April	3	29	13
May	1	1	11
June	0	0	1
July	0	4	
August	1	0	
September	1	0	
October	2	9	
November	4	21	
December	9	26	

Current Position

Estates

The Critical Care Unit (CCU) is currently located within the retained estate at Kings Mill Hospital (KMH). The unit has 13 bed spaces across two sides comprising of 8 bed spaces on A side (including 1 isolation room) and 5 on B side (including 2 isolation rooms). Currently bed spaces 7, 8 and 9 on B side are being used to store equipment and consumables as there is limited storage elsewhere on the unit.

Medical Workforce

The current medical establishment does not meet the requirements to safely meet the requirements of the unit. As it stands, the workforce currently consists of:

- Junior/Resident [Monday to Sunday, 08:00 – 08:00] – a single Registrar (second on-call) who ideally is in Theatres Monday to Friday [08:00 – 18:00] and called to CCU/ED if needed
- Monday to Friday [08:00 – 18:00] – additional Juniors/Middle grades*:
    - Specialty Doctors (from Anaesthesia)
    - ACCS Trainee (6 months of year)
    - ICM/Anaesthesia Trainees (not all parts of the year)
    - FY1/FY2 (supernumery)
    - ED CESR Doctor
- Consultants [Monday to Friday, 08:00 – 16:00], on-call is the Resident [08:00 – 21:00] with weekends covered 08:00 – 14:00 and 19:30 – 21:00

*The number on any given day is variable - last 12 months we have been working with a 'minimum of two airway trained'.

The RCoA (Royal College of Anaesthetists) have made changes to the anaesthetic curriculum which will mean a change to training and to the trainees we get at KMH. The changes include a new CT3 post which will replace two of our previous training posts. In addition to this are 5 x ST3 posts (i.e. 7 very junior registrars with little experience). Historically Registrars would normally fulfil the second on-call rota which is mainly the delivery of OOH critical care. All RCoA trainees now have to complete a mandatory duration of 4 months Obstetric on-call resulting in the OOH anaesthetic cover being provided by CT3/ST3 trainees. Due to the experience levels of the CT3/ST3 trainees, this is not deemed a safe or acceptable level of seniority cover and would require an additional tier of senior medical support OOH.

Nursing Workforce

The Francis Inquiry[1] identified a number of key areas for the nursing profession to address, including the need to determine safe staffing levels and the provision of solid nursing leadership. This message was reinforced by the Berwick Report[2], which highlighted the need for healthcare organisations to ensure that they have staff present in appropriate numbers at all times to provide safe care and to ensure that staff are well supported.
It is widely acknowledged that the intensive care workforce is costly; however, previous attempts to reconfigure this workforce in order to reduce staffing budgets have resulted in negative patient outcomes[3]. A number of systematic literature reviews have revealed evidence to suggest there are links between the nursing resources and patient outcomes and safety[4]. Furthermore, correlation has been established between nurse staffing levels in intensive care and the incidence of adverse events[4,5]. Most recently, West et al.[5] have linked higher numbers of nurses per bed with higher survival rates.
The current nursing establishment consists of the following:

- 16.29 WTE Band 6
- 53.19 WTE Band 5*
- 5.69 WTE HCSW

* The WTE was increased by 15 during COVID which supports 11 x L3 equivalents.

CCOT

The ideal Comprehensive Critical Care Outreach[6] is defined by the National Outreach Forum as a multidisciplinary organisational approach to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients, irrespective of location or pathway.

The seven core elements[6] which characterise Comprehensive Critical Care Outreach are:

- **P**atient track and trigger
- **R**apid response
- **E**ducation, training and support
- **P**atient safety and clinical governance
- **A**udit, evaluation and monitoring of patient outcome and continuing quality care
- **R**ehabilitation after Critical Illness (RaCI)
- **E**nhancing service delivery

The current establishment stands at:

- 1 WTE Band 7
- 7.4 WTE Band 6

Rehabilitation

Physiotherapists provide assessment and intervention for a range of acute and chronic respiratory pathology, including the prevention, support, and resolution of respiratory failure. Physiotherapy has a prominent role in the prevention and management of post-operative pulmonary complications, as well as supporting physical recovery following major surgery. Importantly, physiotherapists promote early mobilisation and prevention of deconditioning during periods of acute illness, in addition to providing specialist rehabilitation following critical illness or severe injury.

Patients in the critical care setting are at high risk of malnutrition[7]. Critically ill patients are likely to require enteral, parenteral or oral nutrition support (or a combination of these) to meet their nutritional needs. The dietician is best placed to provide nutritional advice to the multi-professional team on the optimal way to manage the nutritional needs of all critically ill patients[8].

People with intensive care needs who have difficulty with communication and/or swallowing require timely access to a Speech and Language Therapy (SLT) service. The specific value of SLT input within the intensive care setting and inclusion as a key member of the multidisciplinary team is now recognised in a number of national documents[9,10]. SLT assessment and intervention address the increasingly complex communication, swallowing and tracheostomy weaning needs of patients. SLT is essential for performing instrumental assessments such as FEES (Fibreoptic Endoscopic Evaluation of Swallowing) and video fluoroscopy, guiding timing for oral intake, early identification of laryngeal injuries, advising on speaking valve use, contributing to weaning assessments and specialist tracheostomy tube selection.

The only rehabilitative input that is currently available on CCU is physiotherapy; the establishment for this is also used to cover two surgical wards within the hospital and is comprised as follows:

- 0.8 WTE Band 7
- 2.8 WTE Band 6
- 1.0 WTE Band 5
- 0.6 WTE Band 3

Admin and Other Clinical Support

CCU's are reliant upon a range of support staff whose role are vital to the provision of high-quality care and form an essential part of the MDT. The importance of support staff in the provision of good intensive care, and in freeing up clinical staff time for such care should be valued. The current establishment (detailed below) presently has part time roles which do not cover core hours and means we are unable to provide a 7 day service which would be invaluable, especially in terms of the receptionist and housekeeper roles.

- 1.6 WTE Receptionist
- 1.0 WTE Housekeeper

- 0.67 WTE Secretary
- 1.0 WTE Senior Audit Clerk

Proposal

Estates

With capital investment, the conversion of the three unused bed spaces into two isolation rooms will allows us to increase CCU capacity. The enabling work required to do this includes the re-location of equipment currently stored in these spaces to old Cardiac Catheter Suite. The estate on the CCU corridor needs to be reconfigured to address the needs of the current and proposed staffing model, including adequate changing facilities and suitable rest facilities for the MDT.

According to GPICS2, it is recommended that for every 35 acute beds within a hospital there should be 1 CCU bed. On average KMH has 576 acute beds which means in order to meet this recommendation, the unit should have 16 beds. By increasing the CCU footprint by 2 beds will allow us to get closer to meeting this recommendation.

Medical Workforce

In order to provide robust and safe levels of cover across Critical Care, the organisation and a staffing model that supports sustainability and staff wellbeing, we are proposing additional substantive cover in the following areas:

- Extend weekday Consultant Resident Cover by an additional two hours [08:00-18:00]
- Splitting Consultant 24 hour on-calls into two patterns with job planned handover
- Extend weekend Consultant Cover by an additional two hours [08:00-16:00]
- Additional tier of 'Junior Critical Care Resident' staff Monday – Sunday 08:00-23:00; 6 person rota comprised of:
    - Acute Care Common Stem (ACCS) doctor(s) – currently in post, requiring change of rota
    - Junior Clinical Fellow(s) – new medical post. FY3-CT2 level with skills appropriate for Critical Care junior doctor, including at minimum basic airway skills, and motivation within the specialty
    - Qualified Advanced Clinical Practitioner(s)/Advanced Critical Care Practitioner(s) – new post. Aligned with model of staffing critical care units outside SFH, and other specialties within SFH, whereby they work on combined rota with medical staffing and perform similar duties
    - Trainee ACP/ACCP's will populate this rota when qualified
- 'Senior Critical Care Resident' cover provided by second on-call anaesthetic registrar covered by support from new anaesthetic middle grade 4th tier Mon – Friday 19:30-08:30, Sat – Sun 08:00-08:00. This will provide two tiers of 24 hour senior airway cover.

Due to the difficulty in recruiting to some of the medical posts and the cost of these posts to the Trust, we have included ACP / ACCP posts within the proposed establishment as these roles present as more cost effective without impacting patient care.

The level of staffing proposed supports a resilient service, allowing better wellbeing and creating the capacity to be continually learning and improve as a service:

- 3.5 WTE Junior Clinical Fellow
- 2.0 WTE Qualified Advanced Clinical Practitioner / Advanced Critical Care Practitioner

Nursing Workforce

In order to provide the recommended level of care as set out in GPICS2 there is a need to increase the nursing establishment further to support the additional proposed two bed spaces.

The current Nurse Educator is looking to retire in the not so distant future and so there is a need to look at succession planning; although the replacement role will be a Band 6.

To support the additional bed and nurses we require the below number of HCSW's.

- 5.2 WTE Band 5 support for an additional 2 x L3 equivalent bed spaces
- 1.0 WTE additional Nurse Educator (Band 6)
- 4.97 WTE HCSW

CCOT

As per the GPICS2 and CQC recommendations there is a need to provide a 24/7 service which cannot be operated on the current establishment. In order to address the above the following additional establishment is required:

- 3.5 WTE Band 6

Rehabiliation

In order to improve patient outcomes and meet the recommendations set out in NICE CG83 'Critical Illness Rehabilitation' we propose additional investment in the current therapy service. This service will be essential in identifying those patients deemed 'at risk' of physical and non-physical morbidity and, where identified, provide early and structured comprehensive packages of rehabilitation within Critical Care, on the wards and post discharge. This process involves starting rehabilitation much earlier in the patient's critical care stay whilst they are still receiving mechanical ventilation. With the investment in the additional rehabilitation support we would implement the following model of care:

- All patients assessed within 24 hours of admission by a physiotherapist
- Consistent physiotherapist over the weekend
- Starting rehabilitation as early as clinically possible whilst the patient is still ventilated
- For those patients deemed to be high risk / ≥ 5days ventilated:
    - Key worker assigned
    - A comprehensive assessment would then be performed
    - Following assessment, short and medium term goals would be set which would then be reviewed at weekly therapy rehabilitation meetings for each of the 4 areas of critical care
    - Structured programmes of rehabilitation would be devised and documented in the patients notes and as appropriate displayed at the bedside
- Patients with a length of stay > 10 days would be discussed at a weekly MDT meeting attended by a Consultant, Nursing staff, Physiotherapists, Dietician, Occupational Therapist, SLT, Critical Care follow up team and any other staff deemed appropriate
- On discharge from Critical Care a thorough and documented handover of care for those patients deemed high risk
- On-going therapy support from Critical Care staff for the most debilitated patients to support ward staff and ensure a seamless rehabilitation pathway
- Full functional assessment at hospital discharge, with referral into the post CCU rehabilitation programme for all patients with on-going rehabilitation needs or significantly off baseline

It is envisaged that for patients with a length of stay of > 10 days we could reduce their time on the unit by an average of 4.7 bed days, equating to £7.05k per patient (£1.5k per bed day).

A significant portion of the benefits of patient rehabilitation and reduced length of stay are realised outside of CCU and the Surgical Division; mainly in the Medicine Division, more precisely on the respiratory wards and in the community.

The following establishments are required to meet GPICS2 recommendations:

- 1.5 WTE Band 7 Speech and Language Therapist
- 1.5 WTE Band 7 Dietician
- 1.0 WTE Band 7 Occupational Therapist
- 2.0 WTE Band 6 Occupational Therapist
- 2.0 WTE Band 7 Physiotherapist

Admin and Other Clinical Support

To effectively support the 2 additional bed spaces there is a need to increase administrative and other clinical support on the unit. These roles provide assistance to all staff, especially the nursing staff, helping to maintain audit and governance whilst ensuring documentation and activity are recorded correctly.

GPICS2 recommends that that there should be receptionist/housekeeper cover 7 days per week which at present is not possible with the establishment we have. These roles enable the nursing and medical staff to focus on patient care.

An additional part time secretary will enable longer hours to be covered during weekdays to ensure core work is completed. This will also mean should there be sickness or annual leave, this could be covered.

As an Organisation we are required to submit all of our figures on ICNARC. The current member of staff is looking to retire in the not so distant future and so there is a need to look at succession planning; this will also help to cover annual leave and sickness as no other member of staff can complete the ICNARC data.

The additional establishment which is required to support the unit is detailed below.

- 0.4 WTE Receptionist
- 0.4 WTE Housekeeper
- 0.67 WTE Secretary
- 0.5 WTE Audit Clerk to support additional requirements for ICNARC

Benefits

Through the increase of CCU bed base to 15 this will safeguard elective activity as it will enable the unit to consistently offer 1 x L3 equivalent or 2 x L2 equivalent bed spaces meaning the likelihood of patient procedures being cancelled is reduced, circa. £4.7m per year.

				CCU Workforce Business Case - Do Nothing Potential Financial Impact						
Specialty	Elective Inpatient Activity			Protected Activity	Average 19/20 Tariff	Protected Income	Protected Income	Potential Income Loss	Potential Cost Savings 50%	Potential Net Income Loss
	May-21	Jun-22	Average	Month		Month	Year	Year	Year	Year
					£000					
Breast Surgery	19	17	18	16	5	71	855	(855)	428	**(428)**
ENT	17	21	19	17	2	29	347	(347)	173	**(173)**
General Surgery	67	57	62	54	4	204	2,450	(2,450)	1,225	**(1,225)**
T & O	88	85	87	75	5	406	4,875	(4,875)	2,438	**(2,438)**
Urology	65	46	56	48	2	77	920	(920)	460	**(460)**
	260	**235**	**241**	**210**		**787**	**9,448**	**(9,448)**	**4,724**	**(4,724)**

- **What is preventing progress?**

Without investment we will be unable to invest in the proposed service through the increase of staffing and ability to meet CQC and GPICS2 standards.

- **What do you need to progress?**

Approval for investment.

- **What are the consequences of not doing it?**

The implications of not approving the proposal with the current demands on the service are:

- Inability to protect the current level of elective activity due to increase geographical footprint
- Increase the potential for staff sickness which currently stands at >8% per year (25% of this is anxiety / stress / depression related as of June 2021) and increased staff turnover rates of 0.3% per year
- Reduce the potential to avoid Trust incidents / 'Never' events
- Likelihood of increased Hospital Acquired Infections due to length of stay and reduction of resources when surging into other clinical areas
- Long stay Critical Care patients requiring lengthy periods of inpatient rehabilitation
- Reduced capacity of Critical Care and wards to new admissions
- Poor long term physical and non-physical outcomes for survivors of critical illness
- Non-compliance with NICE guideline CG83 (see Appendices)

Conclusions

There is a requirement for the service to address a number of key issues:

- Increase level of clinical support at resident level
- Right-Size in and out of hours staffing resources
- Increase levels of rehabilitation support
- Plan for increase in activity and acuity of admissions
- Mitigate Junior Out of Hours Provision
- Deliver NHSI requirement of 90% elective workload whilst maintaining 125% critical care capacity

Executive support is paramount for this proposal as this work highlights the focus the Trust is placing on reducing length of stay, increased bed capacity within the Surgery Division for elective activity and improving long term outcomes for patients. TMT are asked to support the investment required within the paper.

References

1. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. [online]. Available from Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)

2. Nursing resources and patient outcomes in intensive care: A systematic review of the literature. [online]. Available from Nursing resources and patient outcomes in intensive care: a systematic review of the literature - PubMed (nih.gov)

3. European Federation of Critical Care Nursing Associations. Position Statement on Workforce Requirements in Critical Care Units 2007. [online]. Available from European Federation of Critical Care Nursing Associations (efccna.org)

4. Safety, effectiveness and costs of different models or organising care for critically ill patients: Literature review. [online] Available from Safety, effectiveness and costs of different models of organising care for critically ill patients: literature review - PubMed (nih.gov)

5. Nurse staffing and mortality in Intensive Care: An observational study. [online] Available from Nurse staffing, medical staffing and mortality in Intensive Care: An observational study - PubMed (nih.gov)

6. National Outreach Forum Operational Standards for Critical Care Outreach Services. [online]. Available from https://www.norf.org.uk/Resources/Documents/NOrF CCCO and standards/NOrF Operational Standards and Competencies 1 August 2012.pdf

7. Nutritional Status and Mortality in the Critically Ill. [online]. Available from: Nutritional Status and Mortality in the Critically Ill – PubMed (nih.gov)

8. Multi-professional framework for advanced clinical practice in England. [online]. Available from: HEE-ACP-Framework.pdf (allcatsrgrey.org.uk)

9. On the Right Trach? [online]. Available from: OnTheRightTrach_Summary.pdf (ncepod.org.uk)

10. What can you expect from Speech and Language Therapy in Critical Care? [online]. Available from: Critical care – overview | RCSLT

How does the Proposal fit with the Trust's Strategic Objectives?	
To provide outstanding care	The proposal aims to improve the quality and experience of care provided by all staff on CCU. Improving the level of patient care and enhancing their experience during a potentially difficult time is a key objective.
To promote and support health and wellbeing	The proposal aims to improve the health and well-being of all staff on CCU through reducing the possibility of work stresses which may lead to sickness. This is a key objective of the proposal.
To maximise the potential of our workforce	The proposal aims to provide a safe and sustainable workforce with the possibility of development, appropriate supervision for junior staff and training as required.
To continuously learn and improve	The on-going pandemic coupled with staff feedback has provided CCU with many opportunities to learn and to identify areas in which improvements are required. Regular reviews of processes and staff feedback will be used to continually learn and develop.
To achieve better value	The proposal aims to reduce the amount of additional spend on agency and locum staff through right-sizing the workforce and to reduce the patient LOS meaning better use of bed days.

Benefit /Risk to the Trust- If Financial Risk and Service Benefit, please summarise issues **(Including mitigations & exit strategy)** in the Business Case+ document

Financial Benefit ☐

Service Benefit ☐

Financial **Risk** and service benefit ☒

Is the proposal to commission /expand a service?

No ☐

YES ☒ - Please contact the Resuscitation Department in the initial business planning

Does the proposal mitigate a risk on the Risk Register?

No ☐ - Please expand

YES ☒

Is this in line with the Trust's risk appetite as defined in the Risk Management and Assurance Policy? ('Respond to the risk' – Section 6 of the Policy – click here)

ID	Risk title:	Description	Risk level (current)
2438	Staffing Levels Nursing - Critical Care	If available staffing within nursing roles on a shift in the service falls significantly below required levels; caused by the number of vacancies or absence, and / or difficulties with recruitment and retention of staff with the required skills and experience; it may result in noticeable disruption to essential aspects of the service with potential failure to meet individual care needs, delays in care, reduced quality of patient experience, exposure to increased risk of harm and additional staff workload.	12. High risk
2351	Staffing levels - medical (Consultants) - Critical Care	Available staffing within medical roles on a shift in the Critical Care service falls significantly below required levels; caused by the number of vacancies or absence, and / or difficulties with recruitment and retention of staff with the required skills and experience; it may result in noticeable disruption to essential aspects of the service, failure to meet individual care needs, reduced quality of patient experience with exposure to increased risk of harm, additional staff workload and increased costs. If the Critical Care service is unable to maintain continuity of safe and effective services; Caused by prolonged issues with the availability of essential resources; It may result in enforced closure of the service to admissions, impacting on the care of critically ill patients and the Trust's capacity to perform elective surgery.	12. High Risk
2328	Critical Care – Therapies – inadequate provision of support services	Inadequate provision of support services as a result of current provision being below recommended levels (national standards GPICS 2016 & Core Standards) resulting in some patients experiencing inequity in physio and rehabilitation service depending on when they are admitted to the unit, case mix and expertise of the therapist and lengthy or reduced levels of rehabilitation.	12. High risk
2011	Staff engagement & morale - Critical Care	If a member of staff within the Critical Care service becomes disengaged or disillusioned; Caused by low morale, lack of motivation and / or uncertainty over the future; It may result in poor clinical outcomes & unsatisfactory experience for patients, less effective teamwork, reduced compliance with policies and standards, increased levels of absence and high staff turnover. Update 10.09.20 Due to the recent pandemic there has been a significant surge in CCU activity of a highly stressful nature impacting staff morale	12. High risk
1708	Staffing levels - medical (Junior doctor/residents) - Critical Care	If available staffing within medical roles on a shift in the Critical Care service falls significantly below required levels; caused by the number of vacancies or absence, and / or difficulties with recruitment and retention of staff with the required skills and experience; it may result in noticeable disruption to essential aspects of the service, failure to meet individual care needs, reduced quality of patient experience with exposure to increased risk of harm, additional staff workload and increased costs.	12. High risk
2505	Reduction in Theatre Output	The use of theatres is identified within the Critical Care surge plan. This includes their utilisation of all main theatres as well as recovery in the event of CCU surge. In such times Critical Care requires to increase their bed capacity into theatres or recovery, it will impact on how theatre can work and ultimately theatre utilisation will inevitably reduce	9. Medium risk
1279	Inability to provide a Quality & timely intervention from CCOT	If an acutely ill patient does not receive a quality and timely intervention from the Critical Care Outreach Team (CCOT) when a referral is made; Caused by limited staffing capacity which affects the ability to meet unpredictable increases in demand and increasingly high levels of patient acuity; It may result in a poor clinical outcome or significant, avoidable harm. Unable to currently provide a full 24/7 service as highlighted in the CQC report (2020)and identified as a gap in the GPIC II service standards potentially leaving deteriorating patients at risk after midnight-0800.	12. High risk

Insert Options Appraisal. As a minimum, this should consider "Do Nothing" versus implementation of the project. This should also include a benefits v cost summary.

Option 1 – Do Nothing
This option works on the assumption that activity levels will remain the same and/or increase and this can be managed within the current establishment.

Advantages
- None identified

Disadvantages
- Not meeting CQC and GPICS2 standards
- Aims and benefits of the case not realised
- Risks highlighted not addressed
- Leaves patients exposed to known avoidable risks
- Failure to match capacity with demand
- On-going variable pay spend
- Reduction in the Trust's reputation due to inability to provide service to local community

Option 2 – Meet CQC and GPICS2 Standards [preferred option]
This option works on the assumption that we can recruit to the posts identified as needed to meet CQC and GPICS2 requirements. This will split the recruitment of AHP posts over a 2 year period in order to reduce the impact on revenue costs and to make the proposal more affordable.

	Year 1	Year 2
Nursing		
Band 5	5.2	0
SLT		
Band 7	1	0.5
Dietetics		
Band 7	1	0.5
OT		
Band 7	1	
Band 6	1	1
Physio		
Band 7	1	1

Advantages
- All aims, objectives and benefits fulfilled
- All risks on register mitigated

Disadvantages
- Some on-going variable pay whilst recruiting to these posts

Divisional Finance Manager to complete finance template and insert here

Category	Detail	Pay Band	Capital	21/22 PYE Revenue (H2 Oct-March)		22/23 FYE Revenue		23/24 FYE Revenue	
				WTE	£	WTE	£	WTE	£
2 x Bed Spaces - 3 x Additional L3 equivalent Patients									
Estates	Two Bed Spaces		(£361,418)						
Medical Pay	CCU Consultant	Medical		(0.83)	(£52,900)	(0.83)	(£105,700)	(0.83)	(£105,700)
Medical Pay	Junior	Medical		(3.50)	(£110,100)	(3.50)	(£220,100)	(3.50)	(£220,100)
Nursing Pay	Acute Critical Care Practitioner	Band 8A		(2.00)	(£57,500)	(2.00)	(£114,900)	(2.00)	(£114,900)
Nursing Pay	CCU Nurse Educator	Band 6		(1.00)	(£24,000)	(1.00)	(£48,000)	(1.00)	(£48,000)
Nursing Pay	CCU Nurse (Covid Funded Posts)	Band 5		(15.00)	(£315,000)	(15.00)	(£630,000)	(15.00)	(£630,000)
Nursing Pay	CCU Nurse	Band 5		(5.20)	(£107,600)	(5.20)	(£215,100)	(5.20)	(£215,100)
Nursing Pay	CCU Nurse	Band 2		(4.97)	(£68,100)	(4.97)	(£136,200)	(4.97)	(£136,200)
Nursing Pay	Covid Funding Stream	Band 5		15.00	£315,000	15.00	£630,000	15.00	£630,000
Non Clinical Pay	Audit Clerk	Band 4		(0.50)	(£7,500)	(0.50)	(£14,900)	(0.50)	(£14,900)
Non Clinical Pay	PPC Support	Band 3		(0.67)	(£8,700)	(0.67)	(£17,300)	(0.67)	(£17,300)
Non Clinical Pay	Receptionist	Band 2		(0.40)	(£4,700)	(0.40)	(£9,400)	(0.40)	(£9,400)
Non Clinical Pay	Housekeeper	Band 2		(0.40)	(£7,700)	(0.40)	(£15,400)	(0.40)	(£15,400)
	CCU Pay			**(19.45)**	**(£448,800)**	**(19.45)**	**(£897,000)**	**(19.45)**	**(£897,000)**
CQC Should Do's									
Nursing Pay	CCOT 24/ 7 Rota	Band 6		0.00	£0	(3.50)	(£216,500)	(3.50)	(£216,500)
	CCOT Pay			**0.00**	**£0**	**(3.50)**	**(£216,500)**	**(3.50)**	**(£216,500)**
Rehabilitation and Support Services									
Rehab	SLT	Band 7		0.00	£0	(1.00)	(£63,000)	(0.50)	(£31,500)
Rehab	Dietetics	Band 7		0.00	£0	(1.00)	(£63,000)	(0.50)	(£31,500)
Rehab	OT	Band 6/7		0.00	£0	(2.00)	(£123,800)	(1.00)	(£61,900)
Rehab	Physio	Band 7		0.00	£0	(1.00)	(£80,900)	(1.00)	(£40,500)
Rehab	Rehab & Follow Up Consultant Lead	Medical		0.00	£0	(0.20)	(£24,500)	(0.20)	(£24,500)
Other	Pharmacy	Band 6		0.00	£0	(0.50)	(£23,700)	(0.50)	(£23,700)
Other	Psychologist	Band 8B		0.00	£0	(0.60)	(£40,200)	(0.60)	(£40,200)
	Other Pay			**0.00**	**£0**	**(6.30)**	**(£419,100)**	**(4.30)**	**(£253,800)**
Non Pay									
Non Pay	Clinical Supplies & Drugs				(£109,500)		(£219,000)		(£219,000)
Capital Charges	Revenue implications of capital				0		(£12,000)		(£12,000)
Capital Charges	Interest costs of borrowing				0		(£12,600)		(£12,600)
	Sub Total - Non Pay				**(£109,500)**		**(£243,600)**		**(£243,600)**
	Grand Total		**(£361,418)**	**(19.45)**	**(£558,300)**	**(29.26)**	**(£1,776,200)**	**(27.26)**	**(£1,610,900)**

Has funding been identified YES ☐ NO ☒

If **YES,** please provide Budget Codes _____

If funding has **NOT** been identified where do you expect funding to be sourced/provided?

What is the nature of funding required?

Capital ☐
Revenue ☐
Both ☒

Does the scheme require any training or project management to be carried out? Please summarise any costs for training in the Business Case+ document

NO ☒
YES- Training ☐
YES- Project Mt ☐

Does the scheme require a Quality Impact Assessment (QIA)? If Yes, please include in the Business Case+ document

YES ☒
NO ☐


QIA.xlsx

The project must be considered by various corporate departments before it is able to proceed. Please complete the Corporate Services checklist. If further detail or explanation is required, please provide this within the Business Case+ document.

Corporate Services Checklist

Have you consulted with?	YES	NO	N/A	Further detail included in **Business Case+** document
Commercial- is a commercial contract or SLA with an external provider required? Are negotiations with the Commissioner required?	☐	☐	☒	☐
Procurement- if support required, Procurement Business Partner to describe procurement route option and sign off in Business Case+	☐	☐	☒	☐
NHIS- has approval been sought from Digital Strategy Group? Please evidence DSG case and outcome in Business Case+	☐	☒	☐	☐
Support Services- are there any Pharmacy, Diagnostic, Pathology, Admin, etc implications? Summarise requirements in Business Case+	☒	☐	☐	☐
Information Governance- If there are any implications, please summarise in Business Case+	☐	☒	☐	☐
Medical Devices Equipment Group- if the project involves medical equipment, please confirm MDEG approval. Summarise ranking assumptions in Business Case+	☐	☒	☐	☐
Space Management Group- does the project require additional space? Outline requirements, cost and consent in Business Case+	☐	☒	☐	☐
Estates FM Support- changes to opening times, additional FM support, cleaning, portering. Summarise PFI variation implications and costs in Business Case+	☒	☐	☐	☐
Human Resources- does the project involve recruitment of staff? If staffing change, recruitment or TUPE is required, HR Business Partner to describe costs and options in Business Case+	☒	☐	☐	☐

Business Case+	
Financial Risk AND Service Benefit- please summarise issues (including mitigations and exit strategy)	
Commercial- is a commercial contract or SLA with an external provider required? Are negotiations with the Commissioner required?	
Procurement- if support required, Procurement Business Partner to describe procurement route option and sign off	
NHIS- has approval been sought from Digital Strategy Group? Please evidence DSG case and outcome	
Support Services- are there any Pharmacy, Diagnostic, Pathology, Admin, etc implications? Summarise requirements	All additional support has been discussed with the relevant departments and any increase has been outlined.
Information Governance- If there are any implications, please summarise	
Medical Devices Equipment Group- if the project involves medical equipment, please confirm MDEG approval. Summarise ranking assumptions	
Space Management Group- does the project require additional space? Outline requirements, cost and consent	
Estates FM Support- changes to opening times, additional FM support, cleaning, portering. Summarise PFI variation implications and costs	Discussions taken place and processes to support this are underway.
Human Resources- does the project involve recruitment of staff? If staffing change, recruitment or TUPE is required, HR Business Partner to describe costs and options	Discussions taken place for if recruitment will proceed.
Project Management & Training- please summarise costs	
Quality Impact Assessment- please insert here if required	