BUSINESS CASE

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| Business Case Title / NIAP application |  |
| CONTACT DETAILS: | |
| Full name |  |
| Title |  |
| Phone number |  |
| Email |  |

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| 1. FINANCIAL COSTS – complete all that are relevant   *If you need assistance with estimating costs, contact your local business manager.* |
| * 1. **Equipment** |
| **🞏 Not applicable for this application**  Direct and indirect i.e. additional imaging equipment   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Description** | **Source of funds** | **Leased? If yes, lease expiry period** | **Expected lifespan** | **Units** | **$ Cost per unit** | **Total upfront costs** | **Ongoing service & maintenance costs p.a** | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | | Total | | | | | |  |  |  * + 1. **Where will the equipment be stored?**     2. **How will it be used and by whom?**     3. **Any considerations required? i.e. security of the equipment, need to move existing equipment etc..**     4. **Is additional space required for the new equipment?** |
| * 1. **Additional Staffing:** |
| **🞏 Not applicable for this application**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Type**  (clinical, administrative and support services**)** | **Industrial Classification As Per Award** | **Award Salary** | **Time required (6, 12 months, ongoing etc)** | **Number / count of staff** | **FTE** | **Expected costs**  **(inc. 15% oncosts - if an ongoing position p.a. cost)** | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | | **Total** | | | |  |  |  |  * + 1. **Are the ongoing costs the same amount as identified above? In not, outline:** |
| * 1. **Implications to other services** |
| **🞏 Not applicable for this application**  Are there any service implications for other departments in the hospital, such as Medical Imaging, CSSD, other medical specialties?  **Outline the expected impact / activity** |
| * 1. **Consumables / Prosthesis / High cost disposables** |
| **🞏 Not applicable for this application**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Description** | **Expected count per year** | **Expected cost per unit** | **If a prosthesis is it on the rebate list?** | **Rebate amount** | **Expected total cost (minus any rebates)** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | **Total** | | | | |  |   **Additional information:**   * + 1. **Are additional consumables, prosthesis, disposables listed on a state or local contract? 🞏 No 🞏 Yes** **Is yes, which contract.** |
| * 1. **Education and / or staff training** |
| **🞏 Not applicable for this application**   |  |  |  |  | | --- | --- | --- | --- | | **Description of education / training** | **Expected cost per person** | **Expected number of staff requiring training** | **Total cost** | |  |  |  |  | |  |  |  |  | | **Total** | | |  |   **Additional information:**  *If new equipment, consider whether biomedical engineering will need education on care of the equipment.* |
| * 1. **Space - including beds, theatre time, imaging, clinics physical space** |
| **1.6.1. Inpatient:**  **🞏 Not applicable for this application**  **Identify the patient journey through the hospital**   |  |  |  |  | | --- | --- | --- | --- | |  | | **Ward / Location** | **Preference** | | **MON** | **AM**  **PM** |  |  | | **TUE** | **AM**  **PM** |  |  | | **WED** | **AM**  **PM** |  |  | | **THUR** | **AM**  **PM** |  |  | | **FRI** | **AM**  **PM** |  |  |   **Additional beds**   |  |  |  | | --- | --- | --- | | **Day of the week** | **Number of beds** | **Ward location** | |  |  |  |   **Additional theatre time**   |  |  |  | | --- | --- | --- | | **Count of sessions per month (half day/full day)** | **Expected number of cases** | **Expected time per case** | |  |  |  |   **Additional slots for imaging**   |  |  | | --- | --- | | **Imaging type (MRI, CT etc)** | **Number of slots per month** | |  |  |   **Is additional space required for the service? Ie a specific treatment space**  **1.6.2. Outpatient: Number of consult / treatment rooms required:**  **🞏 Not applicable for this application**   |  |  |  |  | | --- | --- | --- | --- | | **Type of Rooms Required** | | **Occupants** | | | 🞏 Consult  🞏 Procedure | 🞏 Treatment | List the occupants of each room:  *e.g.*  *Room 1 – Staff Specialist*  *Room 2 - Registrar* | | | **Number of Rooms** | | | 🞏 1  🞏 2  🞏 3 | 🞏 4  🞏 Additional (please list) | | **Estimated number of patients per session** | | |  | | **Estimated number of *New* patients seen per session** | | |  | | **Estimated number of *Review* patients seen per session** | | |  | | **Maximum number of patients per session** | | |  | |
| **Total** |
| |  |  |  | | --- | --- | --- | | **Cost** | **Up-front (in first year)** | **Ongoing p.a.** | | **Staffing** |  |  | | **Equipment** |  |  | | **Consumables / prosthesis / high cost disposables** |  |  | | **Education / training** |  |  | | **Space** |  |  | | **Total** |  |  | |

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| 1. IMPACT & BENEFITS |
| * 1. **Length of Stay** |
| **🞏 Not applicable for this application**   |  |  |  |  | | --- | --- | --- | --- | | **Expected count of interventions p.a** | **Current LOS prior to intervention** | **Predicted LOS** | **Total expected LOS impact per patient** | |  |  |  |  | |
| * 1. **Bed Day Savings** |
| |  |  |  | | --- | --- | --- | | **Total expected bed day savings per year** | **Current bed day costs\*** | **Total expected bed day savings p.a.** | |  |  |  |   \* to calculate bed day costs use the ABM portal to identify current similar patients and include the average bed day costs of allied health, medical, nursing, critical care, ward and non-clinical costs (as advised by the Ministry of Health Program Management Office for calculating the cost of a bed day for roadmaps). |
| * 1. **Impact on activity and NWAU** |
| **🞏 Not applicable for this application**   * + 1. Will the intervention increase or decrease acute, outpatient or sub-acute activity?   Yes No   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Acute / Outpatient or Sub-acute** | **Class code (DRG, Tier 2 or SNAP)** | **NWAU19** | **Count of expected activity p.a.** | **Expected total NWAU** | | *Acute* | *I03A – Hip replacement for trauma, major complexity* | *6.7153* | *10* | *67.153* |   2.3.2 Will the intervention keep the same activity but result in a different DRG? Yes No   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Acute / Outpatient or Sub-acute** | **Current Class code (DRG, Tier 2 or SNAP)** | **Current NWAU 19** | **Expected Class code** | **Expected NWAU 19** | **Count of expected activity p.a.** | **NWAU change** | | *Acute* | *I03A – Hip replacement for trauma, major complexity* | *6.7153* | *I03B – Hip replacement for trauma, minor complexity* | *4.0509* | *10* | *- 26.644* | |
| * 1. **Patient safety and outcomes** |
| **🞏 Not applicable for this application**  Outline all the benefits to patient outcomes including reduced clinical variation, harms and/or Hospital Acquired Complications (HACs) etc. Include evidence.   * **.** |
| * 1. **Surgical or Medical Waitlist reduction – acute or outpatient** |
| **🞏 Not applicable for this application**  Outline whether the intervention will assist with the reduction of any waitlists. Include expected impact and trends over time. |
| * 1. **Revenue** |
| **🞏 Not applicable for this application**  Outline if the intervention will have an impact on revenue and estimate the impact ie. Reduced LOS, use of a prosthesis not on the rebate list, reduce outpatient activity etc. |
| * 1. **Other** |
| **🞏 Not applicable for this application**  Will the intervention attract advanced trainees, will be the firstof its kind etc   * **.** * **.** |

**NOTE:** This business case is for use as an attachment to a NIAP application and does not require separate approval but will be considered as part of the overall application approval process.

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| COMMENTS ON THE BUSINESS CASE |
| *To be completed by those assessing the business case ie. Clinical Streams, Tier 2s and CQC.* |