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

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| **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** |
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| 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?**
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| * 1. **Additional Staffing:**
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| **🞏 Not applicable for this application**

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| **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)** |
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| **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**

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| **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)** |
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| **Total** |  |

**Additional information:** * + 1. **Are additional consumables, prosthesis, disposables listed on a state or local contract? 🞏 No 🞏 Yes** **Is yes, which contract.**
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| * 1. **Education and / or staff training**
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| **🞏 Not applicable for this application**

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| **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**

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|  | **Ward / Location** | **Preference**  |
| **MON** | **AM****PM** |  |  |
| **TUE** | **AM****PM** |  |  |
| **WED** | **AM****PM** |  |  |
| **THUR** | **AM****PM** |  |  |
| **FRI** | **AM****PM** |  |  |

**Additional beds**

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| --- | --- | --- |
| **Day of the week** | **Number of beds** | **Ward location** |
|  |  |  |

**Additional theatre time**

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| **Count of sessions per month (half day/full day)** | **Expected number of cases** | **Expected time per case** |
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**Additional slots for imaging**

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| **Imaging type (MRI, CT etc)** | **Number of slots per month** |
|  |  |

**Is additional space required for the service? I.e. a specific treatment space.****1.6.2. Outpatient: Number of consult / treatment rooms required:****🞏 Not applicable for this application**

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| **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**  |  |

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| **Total** |
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| **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
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| * 1. **Length of Stay**
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| **🞏 Not applicable for this application**

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| **Expected count of interventions p.a** | **Current LOS prior to intervention** | **Predicted LOS**  | **Total expected LOS impact per patient**  |
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| * 1. **Bed Day Savings**
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| **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 **[ ]**

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| **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* **.**
* **.**
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**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 i.e. Clinical Streams, Tier 2s and CQC.*  |