University Hospitals Bristol and Weston NHS Foundation Trust

COUNCIL OF GOVERNORS

Meeting to be held on Friday, 28 January 2022 at 14:30-15:45
Via videoconference (Webex) and livestreamed online for public viewing

AGENDA

FOCUSED AGENDA – ITEMS FOR APPROVAL AND COVID-19 ASSURANCE ONLY					
NO.	**AGENDA ITEM**	**PURPOSE**	**SPONSOR**	**TIMINGS**	**PAGE NO.**
1. Preliminary Business					
1.1.	Introduction and apologies	Information	Chair	14:30	verbal
1.2.	Declarations of Interest	Information	Chair		verbal
1.3.	Minutes of previous meetings - Minutes of Council of Governors meeting held on 30 November 2021 - Minutes of Extraordinary COG held on 9 December 2021	 Approval Approval	Chair		p.3
1.4.	Matters arising (Action Log)	Infromation	Chair		p.14
1.5.	Chair's Report	Information	Chair	14:35	verbal
2. Performance Update and Strategic Outlook					
2.1.	Chief Executive's Report	Information	Chief Executive	14:45	verbal
2.2.	COVID-19/ Service Restoration update	Information	Deputy Chief Executive and Chief Operating Officer	14:55	verbal
3. Items for Decision					
3.1.	Nominations and Appointments Committee report	Approval	Director of Corporate Governance	15:20	p.15
3.2.	General Intensive Care Unit business case	Approval	Director of Strategy and Transformation	15:25	p.17
4. Concluding Business					
4.1.	Foundation Trust Members' Questions	Information	Chair	15:40	verbal
4.2.	Any Other Urgent Business	Information	Chair		verbal
	Date and time of next meeting • **Friday 27 May 2022, 2pm-4pm**	Information	Chair		

We are supportive respectful innovative collaborative. We are UHBW.

Papers Circulated for Information		
Governor Activity Report (including Annual Cycle of Business for Council of Governors meetings)	Information	Membership Manager
Membership Engagement Report including Governor Elections Plan	Information	Membership Manager
Governors Log of Communications	Information	Membership Manager

Minutes of the Council of Governors Meeting of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) held in public on Tuesday 30 November 2021 at 15:00-17:00 by videoconference

In line with social distancing guidance at the time of this meeting due to the COVID-19 Coronavirus pandemic, this meeting was held as a videoconference.

Present

Name	**Job Title/Position**
Jayne Mee	Interim Chair of the Board and Chair of the Council of Governors
Hessam Amiri	Public Governor
Ashley Blom	Appointed Governor, University of Bristol
Charles Bolton	Staff Governor, Non-clinical Staff
Graham Briscoe	Public Governor
John Chablo	Public Governor
Carole Dacombe	Public Governor
Aishah Farooq	Appointed Governor, Youth Involvement Group
Tom Frewin	Public Governor
Chrissie Gardner	Staff Governor, Non-clinical Staff
Paul Hopkins	Appointed Governor, Joint Union Committee
Debbi Norden	Staff Governor, Nursing and Midwifery
Mo Phillips	Public Governor, Lead Governor
Ray Phipps	Public Governor
Annabel Plaister	Public Governor
Mohammad Rashid	Public Governor
John Rose	Public Governor
Martin Rose	Public Governor
John Sibley	Public Governor
Audrey Wellman	Appointed Governor, Youth Involvement Group
Others in attendance:	
David Armstrong	Non-executive Director
Sue Balcombe	Non-executive Director
Paula Clarke	Director of Strategy and Transformation
Deirdre Fowler	Chief Nurse and Midwife
Neil Kemsley	Director of Finance and Information
Alex Nestor	Interim Director of People
Jane Norman	Non-executive Director
Emma Redfern	Interim Medical Director
Eric Sanders	Director of Corporate Governance
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-executive Director
Steve West	Non-executive Director
Robert Woolley	Chief Executive
Natashia Judge	Head of Corporate Governance
Sarah Murch	Membership Manager
Rachel Hartles	Membership and Governance Officer (Minutes)

Jayne Mee, Interim Chair, opened the meeting at 15.00

Minute Ref:	Item	Actions
1.0 Preliminary Business		
COG1.1/11/21	**1.1 Chair's Introduction and Apologies**	
	The Chair, Jayne Mee, welcomed everyone to the meeting. Apologies had been received from Governors Sofia Cuevas-Asturias, Khushboo Dixit, Jocelyn Hopkins, Sue Milestone, Graham Papworth, Barry Parsons and Garry Williams. Apologies had also been received from Bernard Galton and Julian Dennis, Non-executive Directors.	
COG1.2/11/21	**1.2 Declarations of Interest**	
	There were no new declarations of interest from Governors relevant to items on the agenda.	
COG1.3/11/21	**1.3 Minutes from Previous Meeting**	
	Governors considered the minutes of the meetings of the Council of Governors held on 29 July 2021 and the Annual Members Meeting held on 16 September 2021. **Members RESOLVED to:** • **Approve** the minutes of the Council of Governors meeting held on 29 July 2021 as a true and accurate record of the proceedings. • **Note** the minutes of the Annual Members Meeting held on 16 September 2021.	
COG1.4/11/21	**1.4 Matters Arising/Action Log**	
	Governors noted updates on the actions from previous meetings as follows: **COG2.1/07/21:** *Plans for integrated Trust identification badges to be investigated, and a communications update for staff on the Medway Patient Administration System integration to be arranged.* A response was added to the action log and Robert Woolley reiterated that there was an intention for only one identification badge to be used as soon as possible. **Action completed.** **COG2.2/07/21:** *Paula Clarke to investigate the alignment of the Trust's strategy for Trauma and Orthopaedics with the work on the Fracture Liaison Clinic and report back to the Governors.* A response had been added to the action log. **Action completed.** **COG4.2/07/21:** *Robert Woolley to investigate the follow up for treatment for patients in Clevedon Minor Injuries Unit to ensure there was no misdirection happening.* A response had been added to the action log. **Action completed.** Members resolved to: • **Approve** the updates to the action log.	
COG1.5/11/21	**1.5 Chair's Report**	
	Jayne Mee, Interim Trust Chair, gave a brief update to Governors on her recent activity. Key points were as follows: • Her visits to clinical areas had continued since the last report in July.	

	• She had noticed that Bristol Royal Hospital for Children's Emergency Department had been very busy and staff had been suffering a lot of abuse from parents. • She had visited St Michael's Hospital and conversations were held with midwives relating to ongoing issues. • She had continued to meet with Staff Network leads. • Conferences had been held for Black History Month and Menopause Awareness, which Jayne Mee had chaired. • Further recruitment panels for Consultants had been held with Jayne Mee as Chair. • A partnership workshop for the new Integrated Care System (ICS) had been held recently, with an additional two workshops due shortly. • Jayne Mee had visited the South West Ambulance NHS Foundation Trust along with Mark Smith, Deputy Chief Executive and Chief Operating Officer, to discuss the ongoing issue with ambulance waits. **Members RESOLVED to:** • **Receive** the Chair's Report for Information.	
2.0 Performance Update and Strategic Outlook		
COG2.1/11/21	**2.1 Chief Executive's Report**	
	Robert Woolley, Chief Executive, provided an update on the main issues facing the Trust. Key points included: • The Trust and the entire health and care system was still in a state of escalation due to unrelenting pressures. • The Trust was waiting to understand the implications of the new COVID-19 variant (Omicron) and how this could affect care. • The number of attendees to Emergency Departments in the Trust was still extremely high and had caused long waits in the departments. The public was asked for their understanding while they were waiting to be seen. • A new initiative was being started to help decrease the number of patients waiting for outpatient procedures in the Trust. • The Care Quality Commission (CQC) had released their report on their visit to the Trust in July 2021. • A new set of integrated values had recently been launched in the Trust. Governor questions included: • Ray Phipps, Public Governor, asked whether community care providers produced reports that were available to view by the public. Robert confirmed that all health and social care partners within Bristol, North Somerset and South Gloucestershire provided updates within their remits. He added that Chief Executives from the system met once a week to discuss the ongoing pressures within all parts of the system, and it was well understood that these were due to workforce constraints particularly affecting the social care sector • In response to a question from Mohammad Rashid, Public Governor, Robert Woolley, Chief Executive, described the range of work going on in the Trust to mitigate the ongoing pressures, including initiatives focussing on staff wellbeing, elective recovery, urgent care, estate maintenance and transforming services. Robert also advised that although the mitigations in place within the wider system were not	

	adequate, the Trust was doing all it could to help staff through the winter period within the Trust. • Chrissie Gardner, Staff Governor, asked about the Trust's response to mandatory vaccinations being implemented in April 2022. Alex Nestor, Interim Director of People, provided an overview of the health promotion work that was being prepared which included frequently asked questions and increased numbers of vaccinators. • Charles Bolton, Staff Governor, asked how the values would be implemented in the Trust. Robert described how the new values would be embedded through working with teams across the Trust and helping staff to live the values in their everyday lives. Steve West, Non-executive Director, further emphasised the importance of Governors and Board demonstrating that they were living the values • Paul Hopkins, Appointed Governor, questioned how the Trust planned to retain staff after the mandatory vaccinations took effect in April 2022 and whether there was any information on the number of staff already vaccinated. Alex Nestor, Interim Director of People confirmed that the full extent of staff vaccinated was unclear; however 55% of frontline staff had received their flu vaccine and 50% of frontline staff had received their COVID vaccine through the Trust, though it was not known how many had accessed vaccines by other means It was not always appropriate to ask staff their vaccination status which was the issue with gaining true figures but this was being looked into so that the Trust could understand where there were staff who had not yet been vaccinated. Aishah Farooq, Appointed Governor, suggested that the NHS App might be useful in this regard. • Carole Dacombe commented on the high level of pressure on the health service which she had experienced first hand recently. She further commented that the extent of the pressure needed to be made more publicly available so that members of the public could understand where and how they could help the situation. • John Rose suggested the public perhaps required more specific and distinctive information on what was causing the pressures. Robert provided reassurance that the communication professionals within the system were working together to devise messages that would have the necessary impact. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for Information.	
COG2.2/11/21	**2.2 Integration Update**	
	Paula Clarke, Director of Strategy and Transformation, provided the Governors with an update on the integration between the Bristol and Weston hospital sites following the merger in April 2020. It was highlighted that: • All corporate services had now been integrated; although the Communications team integration was still being finalised. • Clinical services integration was moving forward with 13 out of 20 clinical services integrated. • Intensive Care and Anaesthetics were due to integrate in December 2021.	

	• The Trust had increased senior leadership presence on-site at Weston General Hospital, which had helped with the structure and direction of the Division of Weston. • The Urology Department would transfer to North Bristol NHS Trust from 1 December 2021; however there would be no difference in the care patients would receive. • The timeline for the Healthy Weston programme had been extended by three months. Governor questions included: • John Rose, Public Governor, discussed the importance of staff on the Weston site feeling included and involved in integration and asked whether there was any feedback from teams already integrated. Paula Clarke described some of the ways in which newly integrated teams were involving everyone, and confirmed that learning gained from teams already integrated was being used. • Annabel Plaister, Public Governor, commended the Trust on the changes to the Weston General Hospital estate to make the hospital more inviting, including the refurbishment of the public toilets at the main entrance. She asked that the transfer of Urology services be monitored to ensure that patient care was not affected. Paula Clarke agreed that patient care should not be affected by the change; however agreed to monitor Friends and Family Test feedback to ensure no issues were revealed in the coming months. **ACTION: Paula Clarke to monitor the Friends and Family Test feedback from Urology to ensure continuity of care of patients remained stable.** • Chrissie Gardner, Staff Governor, referred to the Risk Management section of the Integration report and asked whether there was any further information that could be shared in relation to the risks identified with a high risk-rating score. Paula responded that the detail of the risks was not included in the report but agreed to look at how this detail could be shared with Governors. **ACTION: Paula Clarke to share the Integration Risks with Governors.** **Members RESOLVED to:** • **Receive** the Weston Integration Update report for Information.	Paula Clarke Paula Clarke
COG2.3/11/21	**2.3 COVID-19/ Service Restoration update**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, updated the Governors on the COVID-19 pandemic, its ongoing effect on the Trust's hospitals, and the efforts to restore services that had been impacted by it. Highlights included: • Due to the new COVID-19 variant recently been discovered, the Trust was increasing the vaccine rollout options for staff. • COVID-19 patients had taken up approximately 5% of the bed base over the last three months. • High proportions of Respiratory Syncytial Virus (RSV) were being seen in the Children's Emergency Department and the Trust had invested additional funds into the department to help to prepare for more admissions. Governors received the update. Questions included:	

	• John Rose, Public Governor, asked whether there was an update on the restoration of Orthopaedic service which had recently seen high levels of waiting lists. Mark Smith confirmed that there was now a cross-organisational approach to develop a common orthopaedic waiting list to make sure that any capacity across the system was being utilised for the service. Some activity was also being outsourced to the independent sector. Thirdly, UHBW and North Bristol NHS Trust had recently visited Knightstone Ward at Weston General Hospital to discuss whether they could jointly staff it, but this may not be possible in the short term. **Members RESOLVED to:** • **Receive** the COVID-19/ Service Restoration update for Information.	
COG2.4/11/21	**2.4 Patient Experience Report and Patient Complaints Report**	
	The Trust's Quarterly Patient Experience Report and Patient Complaints reports were provided to Governors in order to inform on the Trust's activities in these areas. John Rose, Public Governor, advised that three Governors had attended the Trust's recent Patient Experience Group meeting as new members, where an interesting report from Healthwatch was discussed. It was agreed that this would be circulated to Governors. **ACTION: Membership Team to obtain and circulate the Healthwatch report from the recent Patient Experience Group and circulate to Governors.** **Members RESOLVED to:** • **Receive** the Patient Experience and Complaints reports to note.	Membership Team
3.0 Governor Decisions and Updates		
COG3.1/11/21	**3.1 Nominations and Appointments Committee Report**	
	David Armstrong left the meeting. Eric Sanders, Director of Corporate Governance, presented the Nominations and Appointments Committee report. The main points of the report covered the reappointment of Non-executive Director David Armstrong, the appointment of two members to the Committee and an update on the involvement of the Committee in recruiting a new Trust Chair. Non-executive Director, David Armstrong, had reached his final year in his final term of office and as per the NHS Foundation Trust Code of Governance, the Council of Governors were requested to approve his reappointment. There were no dissenting voices. *David Armstrong re-joined the meeting.* Two vacancies had arisen on the Committee recently for one staff governor and one appointed governor. Governors had been asked to come forward to fill those vacancies. Jocelyn Hopkins (Staff Governor) and Paul Hopkins (Appointed Governor) had come forward. Governors were therefore asked to approve their appointment to the Committee. There were no dissenting voices. In terms of Trust Chair recruitment, the Council of Governors noted that interviews were held on Monday 29 November 2021 and a paper was due	

	to got to the next Nominations and Appointments Committee on Friday 3 December 2021 with as extraordinary Council of Governors meeting to approve the appointment s for 9 December 2021. **Members RESOLVED to:** • **Approve** the reappointment of David Armstrong for his final year of his final term of office. • **Approve** the appointment of Jocelyn Hopkins and Paul Hopkins to the Nominations and Appointments Committee. • **Note** the update to the recruitment of the Trust Chair.	
COG 3.2/11/21	**3.2 Governor Activity Report**	
	Sarah Murch, Membership Manager, presented the report on the Governors' recent activity which demonstrated that Governors had continued to carry out their duties. They had continued to hold Non-executive Directors to account and to raise issues on behalf of their members. It had been a busy period for governors, with a number of additional meetings and a lot of information to digest. Sarah thanked governors for their engagement in this period. **Members RESOLVED to:** • **Receive** the Governor Activity report for Information.	
COG3.3/11/21	**3.3 Membership Engagement Report**	
	Sarah Murch, Membership Manager, presented the Membership Engagement Report to the Governors, which reported current membership numbers and a summary of recent membership engagement. The Membership team had continued to contact longstanding members to ensure they would like to remain members of the Trust. Any that had not responded to the request or responded asking to be removed would be done so during December 2021. Upcoming opportunities for Governors to discuss membership included the next Membership and Constitution Group which would look at the breakdown and representation of membership, and a governor seminar would follow to look at how governors engage with the members of the Trust, both in January 2022. **Members RESOLVED to:** • **Receive** the Membership Engagement report for Information.	
COG3.4/11/21	**3.4 Council of Governors Register of Interests**	
	Sarah Murch, Membership Manager, presented the Council of Governors Register of Interests report. The Register of Interests would be published on the Trust website for public to view and it was requested that if any of the interests were incorrect that the Governors contact the Membership team as soon as possible. **Members RESOLVED to:** • **Receive** the Council of Governors Register of Interests report for Information.	
COG3.5/11/21	**3.5 Governors Meeting Dates for 2022/23**	

	Sarah Murch, Membership Manager, provided the Governors with the set of meeting dates for the financial year 2022/2023. Eric Sanders, Director of Corporate Governance, advised the governors that some dates for the Public Boards were being reconsidered to ensure there was more time to follow up reports between the Committees and Boards and this might affect Council of Governors meeting dates. Further information would be provided to the Governors once the dates had been considered. **Members RESOLVED to:** • **Receive** the Meeting dates 2022/2023 for Information.	
COG3.5/11/21	**3.5 Governors' Log of Communications**	
	Governors noted the report of the most recent questions that Governors had asked directors via the Governors' Log of Communications. Sarah Murch, Membership Manager, advised the Governors that some new questions had been sent to the Membership Team and would be added to the log shortly, which included questions relating to public access to the hospitals. **Members RESOLVED to:** • **Receive** the Governors' Log of Communications for Information.	
4.0 Concluding Business		
COG4.1/1121	**4.1 Foundation Trust Members' Questions**	
	One question had been raised by a Foundation Trust Member: 'Given that it has recently been publicised that the BRI had the longest delays in the country for ambulance staff waiting to hand on patients, what is causing these long delays and what are UHBW doing to reduce the waiting times?' Robert Woolley advised that the delays were mainly due to the number of patients that were medically fit for discharge but unable to leave the hospital due to capacity constraints in community and social care. This was leading to delays in unloading ambulances and in admitting patients from the Emergency Department into inpatient beds,	
COG4.2/11/21	**4.2 Any Other Business**	
	None	
COG4.3/11/21	**4.3: Meeting close and date of next meeting** The Chair declared the meeting closed at 16:35. The date and time of the next meetings would be: • Extraordinary Council of Governors: **Thursday 9 December**, from 13:00 – 14:00 • Council of Governors: **Friday 28 January 2022**, from 14:00 – 16:00.	

Minutes of the Extraordinary Council of Governors Meeting of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) held in public on Thursday 9 December 2021 at 13:00-14:00 by videoconference

In line with social distancing guidance at the time of this meeting due to the COVID-19 Coronavirus pandemic, this meeting was held as a videoconference.

Present

Name	**Job Title/Position**
Martin Sykes	Vice-Chair of the Board and Non-executive Director
Hessam Amiri	Public Governor
Ashley Blom	Appointed Governor, University of Bristol
Charles Bolton	Staff Governor, Admin and Clerical
Graham Briscoe	Public Governor
John Chablo	Public Governor
Sofia Cuevas-Asturias	Staff Governor, Medical and Dental
Carole Dacombe	Public Governor
Tom Frewin	Public Governor
Chrissie Gardner	Staff Governor, Admin and Clerical
Sally Moyle	Appointed Governor, University of the West of England
Graham Papworth	Public Governor
Mo Phillips	Public Governor
Ray Phipps	Public Governor
Annabel Plaister	Public Governor
Mohammad Rashid	Public Governor
John Rose	Public Governor
Martin Rose	Public Governor
John Sibley	Public Governor

Others in attendance:

David Armstrong	Non-executive Director
Sue Balcombe	Non-executive Director
Paula Clarke	Director of Strategy and Transformation
Julian Dennis	Non-executive Director
Alex Nestor	Interim Director of People
Jane Norman	Non-executive Director
Eric Sanders	Director of Corporate Governance
Robert Woolley	Chief Executive
Sarah Murch	Membership Manager
Rachel Hartles	Membership and Governance Officer (Minutes)

Martin Sykes, Vice-Chair, opened the meeting at 13.00

Minute Ref:	**Item**	**Actions**
COG1/12/21	**1. Chair's Introduction and Apologies**	
	The Vice-Chair, Martin Sykes, welcomed everyone to the meeting. He explained that he was Chairing this meeting due to the only item on the agenda, the Appointment of the Substantive Chair of the Trust, being a conflict of interest for the Interim Trust Chair, Jayne Mee.	

	Apologies had been received from Governors Khushboo Dixit, Paul Hopkins, Debbi Norden, Sue Milestone, Malcolm Watson and Garry Williams. Apologies were also received from Steve West, Non-executive Director. The meeting was confirmed as being quorate.	
COG2/12/21	**2. Declarations of Interest**	
	There were no new declarations of interest from Governors relevant to items on the agenda.	
COG3/12/21	**3. Appointment of Trust Chair**	
	Eric Sanders, Director of Corporate Governance, presented the report on the Appointment of Trust Chair to the Governors. The report summarised the steps taken to recruit a Trust Chair following Jeff Farrar's confirmed departure from the role and asked the Council of Governors to approve the appointment of the selected candidate, Jayne Mee, following endorsement by the Governors' Nominations and Appointments Committee. Jayne Mee had been serving as Interim Chair of the Trust since 1 April 2021. Eric Sanders reminded governors that it was part of the formal role of the Council of Governors to appoint the Trust Chair. He explained the process for the recruitment and the timeline that was used to appoint the Chair and thanked all governors who had been involved. Martin Sykes, Vice-Chair, invited any Nominations and Appointments Committee members to contribute. Mo Phillips, who was a Committee member and had been involved in shortlisting and interviewing candidates for the role, confirmed that the Trust's process for the appointment of the Chair was largely followed, though with a condensed timeframe to ensure a Chair was in place in time for the recruitment of the Chief Executive. Two candidates had been shortlisted for interview. Mo confirmed that the candidates attended focus groups before the interview and feedback from the focus groups was used to inform the questions asked in the interviews. She added that there were three Governors on the interview panel who were assisted by Trust representatives to help guide the discussions. Governors discussed the report and the recommendation to appoint at length. One objection was raised: Mohammad Rashid, Public Governor, commented on the low number of applications that had been received and asked governors to consider starting afresh and advertising the role again. All other comments from governors were supportive of the recommendation to appoint Jayne Mee. Governors who had been involved (John Rose, Carole Dacombe and Mo Phillips), provided reassurance that the process had been robust with a good level of governor challenge and involvement. The decision to select Jayne as the preferred candidate had been made after thorough consideration of both of the shortlisted candidates. The decision had been discussed at a Nominations and Appointments Committee meeting on 3 December and had been supported by all Nominations and Appointments Committee members present. Martin Rose, Public Governor, queried the proposed term of office. Eric	

	Sanders explained that Jayne had technically served as Chair since 1 April, albeit as Interim Chair, so any appointment should consider that as time served. The usual term of office for a Chair was three years. As she would have served eight months in role as Interim Chair, should governors approve the appointment today, she would therefore be appointed for the remainder of the three-year term. Martin Sykes, Vice-Chair, confirmed the Council of Governors meeting was quorate and called for a vote to appoint Jayne Mee as the Chair of the Trust. Only one governor did not vote in favour, and so the motion was passed. **Members RESOLVED to:** • **Approve** the appointment of Jayne Mee as substantive Chair of University Hospitals Bristol and Weston NHS Foundation Trust for a three-year term of office (including eight months already served as Interim Chair).	
COG4/12/21	**4. Any Other Urgent Business**	
	There was no other urgent business discussed.	
COG4/12/21	**Meeting close and date of next meeting** The Vice-Chair declared the meeting closed at 13:44 The date and time of the next meetings would be: • Council of Governors: **Friday 28 January 2022**, from 14:00 – 16:00.	

University Hospitals Bristol and Weston NHS Foundation Trust

Council of Governors meeting – 28 January 2022 - Action Log

Actions following Council of Governors meeting held on 30 November 2021 and Extraordinary Council of Governors meeting on 9 December 2021					
No.	**Minute reference**	**Detail of action required**	**Responsible Officer**	**Completion date**	**Additional comments**
1.	**COG2.2/11/21**	**Integration Update:** Paula Clarke to monitor the Friends and Family Test feedback from Urology to ensure continuity of care of patients remained stable.	**Director of Strategy and Transformation**	Jan 2022	**Action Completed** Update from Paula Clarke, Director of Strategy and Transformation**:** *The Quarterly Patient Experience Report will be reviewed over the next 6 months to monitor any feedback from the Weston Urology service.*
2.	**COG2.2/11/21**	**Integration Update**: Paula Clarke to share the Integration Risks with Governors.	**Director of Strategy and Transformation**	Feb 2022	**Work in progress** Update from Paula Clarke, Director of Strategy and Transformation: *The Integration Risk Register is undergoing a refresh to ensure the most up-to-date version is available to governors. This will be sent to governors in February 2022.*
3.	**COG2.4/11/21**	**Patient Experience/Patient Complaints Reports:** Membership Team to obtain and circulate the Healthwatch report from the recent Patient Experience Group and circulate to Governors.	**Membership Team**	Jan 2022	**Action Completed**: Healthwatch report circulated to governors.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Council of Governors on 28 January 2022

Report Title	**Item 3.1 - Nominations and Appointments Committee Report**
Report Author	**Sarah Murch, Membership Manager**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

This report provides a summary of the recent business of the Governors' Nominations and Appointments Committee and asks governors to approve an appointment to the committee.

This is a formal committee of the Council of Governors to enable governors to carry out their duties in relation to the appointment, re-appointment, removal, remuneration and other terms of service of the Chair and Non-executive Directors.

2. Key points to note

There are two items to note, one of which requires a decision.

1. Appointments to the Committee – APPROVAL ITEM

According to the Nominations and Appointments Committee's Terms of Reference, there should be 12 governors on the committee: 8 public governors, 2 staff governors and 2 appointed governors.

Garry Williams, Public Governor, stepped down from the Committee in January 2022. All public governors were therefore contacted and were invited to consider joining the committee to fill this vacancy. Mohammad Rashid was the only public governor to come forward in response. **The Council of Governors is therefore asked to approve Mohammad Rashid's appointment to the committee.**

2. Report of meeting on 3 December 2021 – to note

There has been one meeting of the Nominations and Appointments Committee since the previous Council of Governors meeting. The meeting on 3 December 2021 was attended by 7 Committee members. Martin Sykes, Vice-Chair, chaired the meeting for the items relating to the Chair's appointment, appraisal and remuneration, and Jayne Mee, Chair, chaired all other items. The following items were discussed:

- **Chair Appointment: Recommendation to Appoint:** The committee received a paper which described the process for recruitment of a Trust Chair, the outcome of the selection process, and an appointment recommendation. The Committee discussed this at length and decided to recommend the appointment of Jayne Mee to the substantive role of Trust Chair. Their recommendation was agreed by an Extraordinary meeting of the full Council of Governors on 9 December 2021.

- **Chair remuneration – Annual Review:** The Committee discussed Chair remuneration. As UHBW's remuneration rate for the Chair matched the average nationally-recommended remuneration rate for Trusts of its size, the Committee took the view that no change should be made this year.
- **Chair Appraisal Outcome:** The Committee received on the outcome of the most recent appraisal of Jayne Mee as Interim Chair.
- **Non-Executive Director Appraisals:** The Committee received appraisal outcome reports for Non-Executive Directors Bernard Galton, Steve West, Sue Balcombe, David Armstrong and Martin Sykes.
- **Six-Month Non-Executive Director Activity Reports**: The Committee discussed written reports that they had received from the Chair and the Non-Executive Directors describing their activity in the past six months and their current areas of focus.
- **Non-Executive Director remuneration – Annual Review:** The Committee discussed Non-Executive Director remuneration. As governors had agreed an increase last year to bring this into line with other Trusts of a similar size, the Committee decided not to recommend no further increase at this time.

Next Meeting: Time and Date TBC: There will be a meeting of the Nominations and Appointments Committee in February 2022 to consider a proposal and process for the recruitment of Non-Executive Directors during 2022.

3. Recommendations requiring Council of Governors approval

The Council of Governors is asked to:

- **Approve** the appointment of Mohammad Rashid to the Nominations and Appointments Committee.
- **Note** the report of the meeting on 3 December 2021.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Council of Governors on Friday, 28 January 2022

Report Title	***Item 3.2: GICU Stage 2 Expansion Full Business Case (FBC)***
Report Author	*Kirstie Corns, AD Strategy & Business Planning (interim)*
Executive Lead	*Paula Clarke, Executive Director of Strategy & Transformation* *Neil Kemsley, Executive Director of Finance*

1. Report Summary

The purpose of this paper is to ask the Council of Governors to approve the General Intensive Care Unit (GICU) Stage 2 Expansion Full Business Case (FBC). The Trust Capital Investment Policy requires major investment decisions defined as over 1% of our Trust turnover or that have a capital expenditure including VAT over £10.119m, to be approved by Trust Board and Council of Governors.

The Governors' role in the approval of this transaction will be to seek assurance that the Board of Directors has followed an appropriate process in deciding to undertake the transaction, and that it has taken account of the interests of members and of the public in that process.

The adult GICU at the Bristol Royal Infirmary (BRI) is a specialist ward that treats patients who are the most seriously ill patients in the hospital. This unit is staffed by specially trained healthcare professionals who deliver intensive levels of care and treatment.

These patients present as both medical and surgical emergencies and following major planned surgery; with around 40% of all patients requiring treatment only available at a specialist tertiary hospital such as the BRI.

The key drivers behind the case for expansion can be summarised as:

Supporting our population

- Addressing current inequity in bed provision for the South West and BNSSG populations i.e. 'levelling up'. The South West region has the lowest number of critical care beds per head of population. UHBW has one of the lowest number of adult critical care beds per 100k population within the South West Region.
- Improving access for local generalist critical care and regional, specialist critical care (e.g. cancer, cardiac)
- Ability to respond to surges in demand and minimise risk on elective pathways

Supporting elective recovery

- Additional capacity to increase elective activity and recover cancer and cardiac pathways within the acute, multi-year recovery phase

Supporting our people

- Provision of modern, appropriately sized facilities to retain and attract highly skilled staff into the Trust and BNSSG

Sustaining and growing our services

- Ensure BNSSG has appropriate services and capacity to continue its success in securing contracts for specialist Tertiary and Quaternary services. The expansion of the GICU is a key deliverable within the Trust's Clinical Strategy Programme, supporting both the consolidation and growth of our specialist portfolio and elective recovery.

The Phase 1 GICU Expansion completed in April 2020 as part of the transfer and integration of services between Weston and Bristol expanding capacity by a net 3 beds. Phase 2 would expand the GICU by a further 11 beds to 40 GICU beds in total (across the Bristol and Weston sites). Should the Trust decide to proceed to construction in line with the current programme schedule, 11 additional critical care beds would be available by June 2023.

2. Key points to note

(Including decisions taken)

This business case been developed following approval of the Outline Business Case by Trust Board on 27th November 2020. The FBC and the capital and revenue affordability have been considered through Capital Programme Steering Group, Senior Leadership Team, Finance and Digital Committee and Trust Board. A summary of the key points are;

Capital affordability

The capital allocation for this case as per the approved Medium Term Capital Programme was £12.7m. The case is being internally funded from within the Trust's available cash reserves.

The Guaranteed Maximum Price (GMP) negotiations for the main works will have been confirmed before the Board meets on 28th January 2022. At the point of submitting papers, the overall capital cost is £12.9m. This figure will not increase and has the potential to further decrease. The current £0.2m over-allocation is considered low risk.

Revenue affordability

The recurring revenue required for the 11 bed expansion is a cost to the Trust of £6.5m, £0.6m per bed. It is assumed that the investment will be funded through an agreed increase in our block income that matches the additional cost in full. Under the previous Payment by Results (PBR) regime, the 11 bed expansion would have resulted in an increase in variable income of £6.5m per annum.

The FBC remains subject to ongoing discussions with the local CCG Commissioner and NHSE Regional Specialised Commissioners to consider how the recurring revenue should be funded in the context of current uncertainty regarding the medium-term revenue financial regime for the NHS. BNSSG Clinical Commissioning Group (CCG) and the regional Specialised Commissioners have however formally approved the clinical case for change at their Clinical Executive meeting 11th November 2021.

In making the recommendation to approve the business case, the Trust process has considered the fact that a number of recently commissioned or expected extensions to specialised services that will contribute towards the required revenue for GICU expansion. These include;

- The recently commissioned South-West V-V Extra Corporeal Membrane Oxygenation (ECMO) service.
- CAR-T (chimeric antigen receptor T-cell) therapy. Currently there are 3 NHSE approved products for 3 indications and 2 trial products at UHBW; this is expected to increase to 4 NHSE products with 4 indications and 3 trial products in 2022.
- The detailed costings for these business cases are currently in development, however, it is estimated that circa 25%-30% of the £6.5m recurring revenue costs associated with the GICU Expansion would be funded via these two developments.

In addition to these recurrent funding sources, it is expected that there will be substantial non recurrent revenue resources over the next 1-3 years associated with elective recovery (as has been the case for the past 2 years). As a major provider for specialist acute services for the SW region, accessing this funding will facilitate utilisation of the extended ICU capacity.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with the FBC that have been considered in making the recommendation to proceed include:

Risks of proceeding at this time

Risk ID 5499: Commissioners have advised that they do not have the ability to confirm full revenue funding at this point in time until receipt of national guidance and confirmation of the financial regime and funding arrangements for 2022/23. The business case assessment process has considered this risk and recommends that the Trust proceed with the build, mitigating the risk by:

- Securing Commissioner support that the scheme must be prioritised highly against competing priorities within the System and confirmed in system plans for 2022/23
- Phasing the introduction of the additional beds in line with recruitment and workforce development and:
  a) utilising the confirmed funding contribution for ECMO services
  b) utilising the expected funding contribution from additional CAR-T therapy delivery
  c) utilising non-recurrent elective recovery funding
- Building the unit flexibly for temporary utilisation for alternative use such as additional escalation beds to manage increased demand and support recovery of the Trusts' elective programme or for decant space to enable other strategically important schemes or mothballing the unit and using only to increase capacity in response to spikes in demand and future Covid surges.

Risks of not proceeding at this time

Clinical risks

There is a clear clinical need for additional critical care beds on the UHBW site. The very high scoring risks as referenced in section 1.4 of the FBC include:

- Unacceptably high rates of cancellations for cancer and cardiac patients that require specialist surgery at the BRI;
- High occupancy rates driving poor efficiency in elective and non-elective pathways;
- Unmet need, particularly in the areas of fractured neck of femur and emergency laparotomies, where clinical guidelines are not being met;
- Lack of resilience and ability to effectively manage future surge scenarios;
- Delayed admission or transfer in to the unit for emergency patients.

Reputational risk

Failure to learn from the lessons of Covid-19 and create a more resilient critical care bed base to adequately respond to any future surge would cause significant reputational damage to the Trust and wider NHS.

Autonomy of capital decision making

Trust capital investment decisions are now subject to a system capital spend constraint and delaying spend on GICU expansion will impact on future years capital devolved expenditure limits (CDEL).

4. Advice and Recommendations

- This report is for **Approval.**
- The Council of Governors is asked to approve the General Intensive Care Unit (GICU) Stage 2 Expansion Full Business Case (FBC).

5. History of the paper
Please include details of where paper has previously been received.

- *Finance & Digital Committee, 25th January 2022*
- *Public Trust Board, 28th January 2022*

University Hospitals Bristol and Weston NHS Foundation Trust

General Intensive Care Unit (GICU) Stage 2 Expansion

Full Business Case

Version	Status	Version notes	Author/ Updated by	Date
0.1	Draft	Creation	Sarah Nadin	May 2021
0.2	Draft	Second Draft	Amy Worsfold	July 2021
0.3	Draft	Third Draft	Claudia Bisetto	November 2021
0.4	Draft	Fourth Draft	Kirstie Corns	November 2021
0.5	Draft	Fifth Draft	Amy Worsfold	December 2021
0.6	Draft	Sixth Draft	Amy Worsfold	January 2022
0.7	Draft	Seventh Draft	Amy Worsfold	January 2022
0.9	Draft	Eighth Draft	Amy Worsfold	January 2022
0.9	Draft	Ninth Draft	Amy Worsfold	January 2022
0.10	Draft	Final revenue updates, title update and updates to appendices	Kirstie Corns	19th January 2022
1.0	FINAL	Moved to final version and submitted to Finance & Digital Committee	Kirstie Corns	20th January 2022
1.1	FINAL	Appendices update. Submitted to Trust Board	Kirstie Corns	20th January 2022
1.2	FINAL	Update to page 2	Kirstie Corns	21st January 2022

This Business Case is supported by:

The clinical case for change has received formal support from the following external groups / committees:

Name	Organisation	Date
Critical Care Network / Peer review	Critical Care Network	06/07/21
Bristol, North Somerset & South Glos Clinical Commissioning Group Clinical Executive	BNSSG CCG NHSE Specialised Commissioning	11/11/2021

The full business case has been discussed and received support from the following committees through its development stages:

Name	Organisation	Date
Acute Services Review Programme Board	UHBW & NBT	02/08/2021
Surgery Divisional Board	UHBW	03/08/2021 02/12/2021
Specialised Services Divisional Board	UHBW	01/09/2021
Critical Care Executive	UHBW	03/11/2021
Strategic Estates Development Programme Board	UHBW	09/12/2021
Capital Programme Steering Group	UHBW	22/12/2021
Senior Leadership Team	UHBW	19/12/2021

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I. Executive Summary

The adult General Intensive Care Unit (GICU) at the Bristol Royal Infirmary (BRI) is a specialist ward that treats patients who are the most seriously ill patients in the hospital. This unit is staffed by specially trained healthcare professionals who deliver intensive levels of care and treatment.

These patients present as both medical and surgical emergencies and following major surgery; with around 40% of all patients requiring treatment only available at a specialist tertiary hospital such as the BRI. Around 31% of patients enter critical care following elective treatment, of which 85% are cancer patients.

The University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) GICU is a 25 bedded Critical Care facility for patients requiring level 2 (high dependency) and level 3 (intensive) care. The unit is configured to use a mix of level-2 and level-3 beds flexibly.

The Trust is well positioned to develop and expand its GICU bed base as part of the increased and integrated offer within the South West:

There is a clear need

The South West region has the lowest number of critical care beds per head of population. UHBW has one of the lowest number of adult critical care beds per 100k population within the South West Region, as well as looking after an above average acuity of patients indicated by numbers of organs supported. This is despite 40% of the work being highly specialist and only deliverable at the BRI.

There are currently risks associated with this shortfall in capacity

These risks include:

- Unacceptably high rates of cancellations for cancer and cardiac patients that require specialist surgery at the BRI and capping the rates of elective scheduling and waiting list growth as a consequence
- High occupancy rates driving poor efficiency in elective and non-elective pathways
- Unmet need, particularly in the areas of fractured neck of femur and emergency laparotomies, where clinical guidelines are not being met
- Lack of resilience and ability to effectively manage future surge scenarios
- Delayed admission or transfer in to the unit for emergency patients

We have clear strategic ambitions to expand our specialist clinical services and to draw patients back into the South West who are currently travelling outside of the region to access care.

UHBW is established as the specialist provider in the South West for the following services that require the provision of associated specialist critical care facilities;

- Specialist Cardiac Services
- Specialist Cancer Surgery
- Specialist Oncology

We hold specialist clinical expertise in these areas and are well placed, with the adequate capacity and infrastructure in place, to drive innovation and access in these areas to draw South West patients, who are currently travelling outside of the region, back to Bristol. Additional capacity would contribute to the management of a future pandemic surge and would be well utilised for elective cases when not required for this purpose, providing the capacity for specialised care.

Our plans can be reasonably translated into physical capacity

We have existing plans to develop and expand our critical care facilities. Our preferred option describes the requirement to expand the current adult general ICU by 11 beds. UHBW is also making plans to invest in other aspects of our specialist services infrastructure as part of our Strategic Clinical Capital programme; including specialist theatres and Cath labs.

Our critical care teams have already made significant progress in driving innovation and efficiency despite capacity constraints

Our teams have consistently demonstrated that despite operating at the limits of the available capacity, they continuously look for opportunities to drive innovation and efficiency in the care delivered. This is clearly evidenced in clinical benchmarking data (ICNARC)[1] and includes the recent integration of the general and cardiac critical care units.

Consequently this paper describes the urgent need to open 11 additional beds within the GICU at the BRI, as a result of the known and demonstrable historic deficit in the area and wider region. This paper presents the additional capacity need defined by four key drivers:

	Driver:
1.	Patient safety risks associated with under provision A. Unacceptably high rates of patient cancellations and elective back log requirements B. Increasing levels of out of hours discharges from critical care and high readmission rates C. Unmet need - Patients unable to access GICU
2.	A lack of resilience and ability to effectively manage future surge scenarios
3.	Increased demand at a local level
4.	Inability to repatriate clinical services

This case builds on the work undertaken as a part of the:

- 'Phase 1' GICU expansion – The Phase 1 expansion delivered a net gain of 3 critical care beds on the Bristol site and completes the transfer of 2 level 3 beds from Weston to Bristol. This total increase of 5 level 3 beds on the Bristol site took place in the context of the transfer and

[1] Intensive Care National Audit & Research Centre

integration of services between Weston and Bristol, as part of the UHBW merger, which took effect from April 2020. The Phase 1 GICU expansion is completed and this case outlines the requirements and plans in addition to this development.

- 'Phase 2' GICU expansion Outline Business Case (OBC) – as outlined above this case is focused on the next stage of expansion (Phase 2), following the delivery of Phase 1. Phase 2 OBC was approved at Trust Board in October 2020.
- Acute Services Review partnership work ongoing with North Bristol NHS Trust – the demand requirements have been assessed from a joint cross-city perspective then attributed to each Trust for the purpose of business case development and delivery plans within each organisation. Development plans have been presented jointly between both Trusts to the local and regional system and both Trusts are mutually supportive in the approach taken. It is planned that future opportunities for mutual aid across the two Bristol units will be explored and implemented, particularly in relation to staff recruitment, retention and training.

The purpose of this Full Business Case is to provide a clear plan for improving the quality and safety of critical care services at UHBW through eliminating the Trust's (and reducing the regional) critical care underlying capacity deficit.

II. Strategic Case

1.1 Strategic Context

National Context:

The national planning guidance for 2021/22 clearly outlines the expectations for local systems and providers in the planning and delivery of effective and resilient critical care facilities for our local and regional populations.

The H1 Priorities and Operational Planning Guidance published on the 25th March 2021 outlines the priorities for the year ahead against a backdrop of the challenge to restore services; 'meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.' The document sets out six clear priorities for 2021/22, of these Priority B, 'Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19,' states the intention, nationally to, 'conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service.'

Additionally, Priority C is clear that we should be 'Building on what we have learned during the pandemic to transform the delivery of services, **accelerate the restoration of elective and cancer care** and manage the increasing demand on mental health services' The guidance explicitly states that Systems should 'plan to recover towards previous levels of activity and beyond' for the recovery and restoration of both elective care and specifically cancer care for which systems are expected to 'return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower) and meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022'.

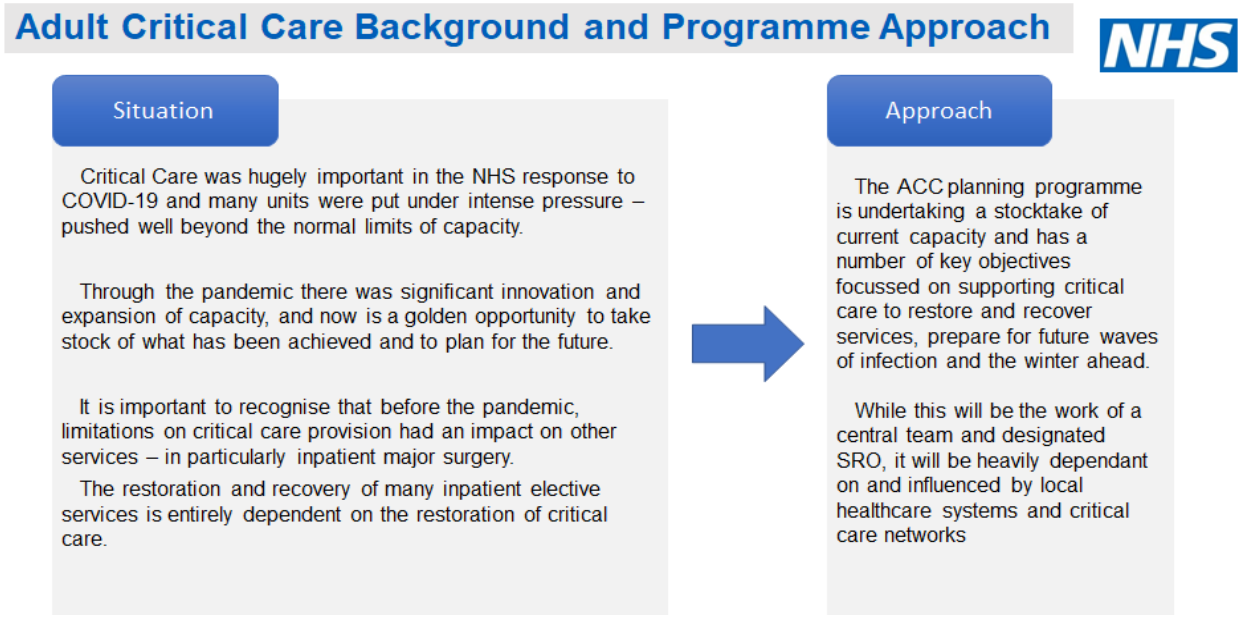
The H2 Priorities and operational planning guidance published on 30th September 2021, reiterates the priorities set out in H1. The guidance recognises that elective recovery progress has been slowed

'more recently, [by] non elective pressures, including rise in Covid-19 admissions as well as workforce supply constraints due to staff needing to isolate'. To mitigate the impact on elective recovery, NHS England & NHS Improvement have made a £700m targeted investment fund available to further support elective recovery through 2021/22 to 2024/25. The guidance states that 'proposals should focus on delivering the highest priority elective recovery reforms, and / or on systems and providers facing the greatest challenges in restoring activity to pre-pandemic levels', with a continued priority focus on restoring 'full operation of all cancer services'.

The 2022/23 national priorities and operational planning guidance published on 24th December 2021 (issued when we are again operating within a Level 4 National Incident) states that 'The new Omicron variant reminds us that we will need to **remain ready** to rise to new vaccination challenges and **significant increases in Covid-19 cases'**. The priorities set out in the guidance are a continuation of 2021/22 priorities: Priority B requires us to 'Respond to Covid-19 ever more effectively' and Priority C that we 'Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards'.

In addition to this, the NHSE/I Critical Care Programme outlines the following planning and programme approach;

(Figure 1)



With the following expectation on how this programme will be translated into delivery through regional and local planning mechanisms;

(Figure 2)

This FBC is underpinned by the national drive to ensure critical care facilities are adequate to meet the current needs of our population and support recovery of elective activity as well as ensuring future resilience.

Local Context (System and Regional):

The UHBW GICU provides critical care services for both our regional and local population. As we move towards the strengthening and formalising of our local Integrated Care System (ICS), the needs of our regional and specialist population will become increasingly the focus of our local planning and delivery mechanisms.

NHSE Specialised Commissioning South West have confirmed that ensuring adequate and resilient critical care capacity is in place is the second of their top priorities for 2021/22. This is second only to the recovery and future resilience of elective services within the region, of which adequate critical care facilities and capacity is clearly a significant factor.

This builds on the context of the South West Region Critical Care Capacity and System Operation Final Report (Appendix 1.1) which was published in June 2020, demonstrating the requirement for additional Critical Care beds across the South West. The case outlined that there is a clear need for 'investment targeted at supporting improved quality of care, outcomes for patients and improved efficiencies across elective and non-elective pathways of care'.

The case aimed to address historic capacity deficits that have become particularly visible during the urgent response to the Covid-19 pandemic. It evidenced that the South West has historically operated on a smaller number of critical care beds when compared to other regions. (Further detail provided in Section 3.3 Demand and Capacity).

It also highlights that the required response to Covid-19 in the South West has exposed the fragility of critical care capacity and associated services, despite the South West having experienced the lowest level of infection rates compared to other regions to date. It outlines that the response put in place to respond to Covid-19 has led the South West to take stock of critical care services. More recently, Specialised Commissioners have signalled that there is likely future growth for CAR-T services which will result in demand for ICU beds.

Our Local BNSSG ICS outlines its strategic priorities for the acute sector and transformation plans to deliver through the Acute Care Collaboration Programme, under the Healthier Together Executive. The vision of the programme is to;

> *'deliver exceptional health outcomes for the people we serve through provision of the full range of acute services from general to specialist, working collaboratively within an integrated care system to make the most effective use of the expertise of our staff and our acute resources for the benefit of the whole health community'*

It is intended that this vision will be delivered through three key themes, the first of this is,

> *'Collaborating for excellence in delivery of specialist acute services, working together to make best use of the specialist skills of our whole workforce, our physical facilities and equipment. We will deliver exceptional quality and outcomes by developing consistent and aligned services. We will reduce cost through better use of estate and reduced service duplication. We will improve clinical sustainability and the experience of our workforce by working as one network'*

The objectives of this case will clearly and directly contribute to the delivery of this local system priority and the overall vision for the acute sector within BNSSG.

Adult ICU has also been identified as a priority workstream within our local system provider collaborative, the Acute Services Review (ASR). This business case has been developed with NBT and it directly drives the aim of this partnership within our local ICS of;

> *'Creating a single ambition and delivery plan for our specialist networked services and define Bristol as a centre of excellence for tertiary clinical care, education and research.'*

The System focus on elective recovery remains a top priority for the populations we serve both locally, within BNSSG, and regionally, as part of our tertiary and quaternary service provision. The BNSSG System and the NHSE/I South West Regional Team have supported two Targeted Investment Fund (TIF) bids for additional critical care capacity at UHBW. The capital investment element of this GICU expansion business case has been supported to proceed to national submission of the Wave 2 TiF bids in recognition of the criticality that sufficient critical care capacity has on our ability to recover elective pathways, particularly cardiac and cancer. Following an initial review, the bid successfully progressed to the next stage and we subsequently submitted a short form business case and Value for money (VFM) template to the Regional Team. As of 18th January 2022, we await the outcome of our TiF submission. For the purposes of this case however, our working assumption is that this bid does not

require national funding and will not be funded nationally. In the event national funding becomes available in the future, this would reduce the value of the Trust's cash required by the project and provide a beneficial increase in the Trust CDEL.

The second TIF bid supported to proceed to national submission was a bid in response to a request from the South West Regional Specialised Commissioners on 17th September 2021. Systems and providers were asked to 'identify the potential opportunities for expanding critical care / enhanced care across the region. The criteria to be met is capacity which, with funding (capital and revenue), could stand up quickly and support increased elective activity over winter'. This is the second consecutive year that the Trust has been asked to increase critical care capacity at short notice to support winter pressures, further highlighting the need to increase critical care provision within the BNSSG System to; a) respond to surges and b) support elective recovery. System Directors of Finance have approved mobilisation of the first wave of TiF bids which includes the critical care expansion in response to winter pressures.

This FBC will directly contribute to the implementation of the BNSSG System Plans for maximising elective recovery for both our local population accessing generalist services and our regional population who rely on us for provision of specialised elective cardiac and cancer services. It also delivers on the priorities related to elective recovery in the 2022/23 operational planning guidance.

Trust Strategic Context:

UHBW published its new five year strategy, *Embracing Change, Proud to Care; our 2025 Vision* in April 2020. Our five year strategic vision is to;

- Anchor our future as a major specialist service centre and a beacon of excellence for education;
- Work in partnership within an integrated care system, locally, regionally and beyond;
- Excel in world-class clinical research and our culture of innovation.

Our Strategy outlines 6 Strategic Priorities which set the direction for the organisation over this 5 year period. The organisation has also recently tested these strategic priorities against the new operating context presented by the Covid-19 pandemic and the associated impact on services. In order to complete the process of refreshing our strategy in this context, a set of new world drivers were developed by our Board and Senior Leadership Team. The table below outlines our six Strategic Priorities tested against our New World Drivers

UHBW Strategic Priorities tested against the new COVID-19 context:

(Table 1)

Our Current Strategic Priorities (as per 2025 strategy)	Our New World Drivers (June 2020)
1. Our Patients We will excel in consistent delivery of high quality, patient centred care, delivered with compassion	• Backlog in non-Covid-19 services which needs to be managed and recovered, with the risk of widening health inequalities and a significant number of people not accessing health care when they ought to be. • New internal operating model alongside IPC safety measures, driving the need for different solutions to create capacity and supporting staff wellbeing , new ways of working and safety considerations.

Our Current Strategic Priorities (as per 2025 strategy)	Our New World Drivers (June 2020)
2. Our People We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future	• People Focused: creating innovative, flexible and resilient workforce models through system approaches (Terms and Conditions/passporting/training etc.), maximising our role as an anchor institution in supporting economic recovery through local employment and volunteering and managing the implications of a changing global workforce supply
3. Our Portfolio We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focusing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.	• Recognition of general and acute and critical care bed shortfalls in SW Region.
4. Our Partners We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.	• Accelerated collaboration/mutual aid and pan-system clinical leadership – Further enabled by Weston integration and Bristol acute services review with NBT • Increasing importance of system perspective and opportunity to drive common cross sector goals across our STP and beyond, including accelerated implementation of consistent community service model (Sirona) and discharge from hospitals
5. Our Potential We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation	• Virtual-by-default and digital approach in clinical and non- clinical communications, training and service delivery with changed public expectations • New opportunities for research and innovation with AHSC designation, partnership with Universities and internal innovations.
6. Our Performance We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.	• Changes to our commissioning and planning environment; • Probable changes to FT autonomy, financial regime and IS sub-contracts. National approach to acute consolidation (group models) and SW region Partnership Boards in North and Peninsula

On 20th October 2021, the Trust's Senior Leadership Team approved six core planning priorities to guide the organisation through the winter, whilst providing clarity of the expectation on what the organisation should be focussing on in terms of delivery. The six priorities are:

1. Staff first
2. Elective Restoration & Redesign
3. Urgent Care Redesign
4. Weston renewal
5. Estate development
6. Continuous Improvement culture

The priorities will also guide the operating planning process (OPP) this year and next, allowing Divisions to plan against a discrete set of objectives that should benefit all, align and allocate resources

and streamline the actual OPP itself. The GICU FBC remains strongly aligned to the Trust's strategic priorities and directly supports the core planning priorities 1, 3 and 5.

It is clear from both our strategic priorities as an organisation, and the recent testing of these within the context of the Covid-19 pandemic, that both the expansion of critical care services and the development of our specialised services portfolio are core to our strategic ambitions.

This is particularly relevant to our ambitions to expand our specialist service portfolio. However, it is also key to our ambitions regarding education and research.

1.2 Objectives and planned Benefits of the Business Case

Quality:

- Patient Experience: Ensure each patient and family has access to multi-disciplinary input where required
- Patient Safety: Ensure patients all have parity of access to GICU regardless of time of year or overall unit demand and create a more resilient workforce
- Clinical Effectiveness: Improve shared learning across the multi-disciplinary team with increased workforce and improved compliance with evidence based standards of care for a unit of our size

Performance:

- Responsiveness: The major barrier to effective use of the Critical Care beds at the BRI is capacity which significantly impacts patient flow
- Cancer and RTT targets: Ability to admit all elective patients requiring GICU, throughout the year

Financial:

- Bank and Agency: a more resilient workforce will reduce the reliance on bank and agency staffing
- Clinical pathways: to ensure there is always capacity to support all clinical pathways of care, for related RTT (both urgent and routine) and cancer performance

1.3 Current State and Case for Change

Current State – Cross-City Capacity:

The consolidated total of critical care capacity across the three local sites (Southmead, BRI and WGH) is as follows:

(Table 2)

Site	BNNSG commissioned %	Specialist Commissioned %	Other commissioners %	Total
NBT	44%	54%	2%	100%
UHBW (GICU + CICU)	31.4%	61.7%	6.9%	100%
UHBW (GICU only)	57.3%	34.1%	8.6%	100%

The expansion requirements focus on GICU beds and the references to Cardiac in the case relate to the impact of general demand and the Covid-19 pandemic on the cardiac capacity. Whilst the expansion is not specifically targeted to address cardiac capacity requirements, it will indirectly mitigate some of their capacity constraints by reducing the overall level of pressure on the bed base and the need to utilise cardiac capacity for non-speciality patients.

It should also be noted that both UHBW and NBT provide a range of regional specialist services aside from Cardiac and Neurosurgery (e.g. thoracics, gynaecology, liver, oncology etc.), all of which form part of the 'general' demand for critical care. For further context, the total critical care bed days consumed for year ended 31.03.20 have been analysed below:

(Table 3)

Critical Care Unit	Location	Bed Numbers	L3	L2	L 1.5
General ICU	A600	25	17	8	0
Cardiac ICU	CICU	19	11	8	0
Weston	Weston General	4	2	2	0
Cardiac High Care	C708	6	0	0	6
	TOTAL	54	30	18	6

Current State - UHBW Capacity:

UHBW currently (July 2021) has a total of 48 adult critical care beds across the UHBW sites. The distribution and associated levels of care are outlined below.

(Table 4)

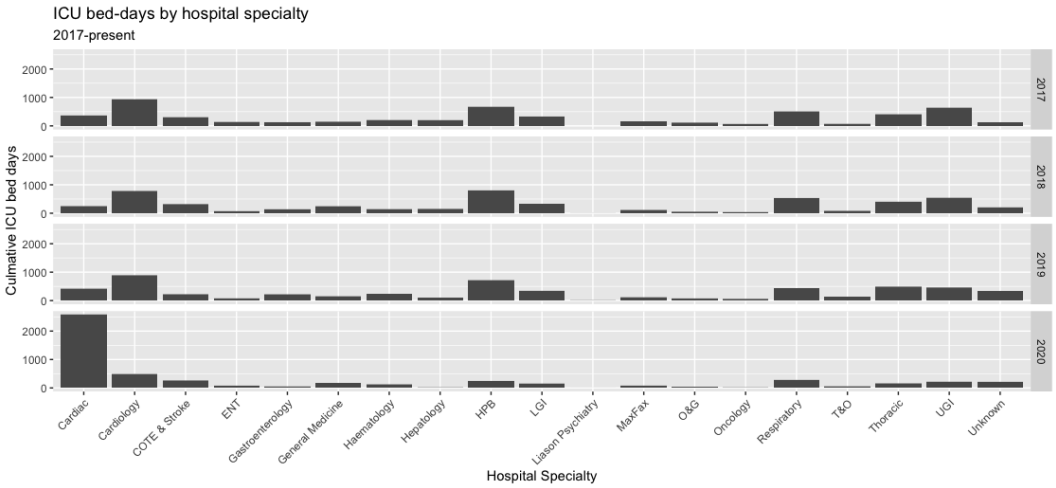
Site	Critical Care beds	Neurosurgery / Cardiac	Total commissioned beds	Un-commissioned beds	Total physical bed spaces
NBT	28 (61%)	18 (39%)	46	2	48
UHBW	29 (55%)	24 (45%)	53	0	53
Combined	57 (58%)	42 (42%)	99	2	101

It should be noted that operationally the levels of care are flexed in all units dependent on demand and staffing, so the above numbers represent an average for planning purposes.

A600 – General Intensive Care Unit (GICU):

- 25 bed spaces
- Provides general Level 2 and Level 3 critical care to emergency and elective patients, including patients having major cancer procedures, and patients with acute complex medical and cardiac conditions including out of hospital heart attacks
- Source of admission is consistent with similar units although it receives a greater proportion of patients from other critical care units and acute hospitals
- Managed by consultant intensivists, with full registrar and junior trainee tiers beneath

General ICU bed days by specialty: (Figure 3)



The table above outlines the usage of critical care beds at UHBW. Usage is spread across a range of services. However, the highest usage of beds is in the following services;

- Cardiology (including out of hospital cardiac arrests)
- Respiratory Medicine and Stroke
- Hepatobiliary and Upper GI Surgery (Both almost entirely cancer based services)
- Thoracic Surgery (almost entirely cancer based service)
- Cardiac Surgery

This demonstrates the extent to which our specialist services in these areas are supported by our critical care facilities. (*Note – the cardiac increase in 2020 is due to the inclusion of the Cardiac Intensive Care Unit in 2020).*

C604 – Cardiac Intensive Care Unit (CICU):

- 19 bed spaces
- The unit provides care for post-operative cardiac surgery patients
- The majority of the medical cover is carried out by consultant cardiac anaesthetists

- Anaesthesia junior doctors provide a single tier on-call, but with significant input from nurse practitioners

Weston General Hospital:

- Weston General Hospital and UH Bristol merged to become UHBW on the 1st April 2020 and at this point the Weston ICU bed base, became part of a combined unit with the BRI's GICU.
- The current bed base at Weston General Hospital is 2X level 3 and 2X level 2 beds
- These provide care for a range of general medical and surgical patients

The three critical care units of UHBW work closely together on a daily basis. This includes daily joint capacity meetings, to ensure equal access to specialist services in the right place, at the right time.

The GICU, CICU and Weston units meet monthly at the Critical Care Executive Meeting. The purpose of the meeting is to provide a regular multi-disciplinary forum for the discussion of strategy, performance, finance, workforce, education, governance and patient safety issues relating to critical care. The forum works well to establish integrated working and consistent application of systems and processes across all three units; to effectively manage and develop the critical care agenda 'as one', rather than in isolated units.

'Phase 1' Expansion and the Implementation of Healthy Weston Critical Care Model of Care

During 2019/20 two programmes of work were agreed internally and with local and specialist commissioners which impact on the planned critical care capacity. These were the 'Phase 1' critical care expansion and the Healthy Weston Programme.

In March 2020, NHSE Specialised Commissioning supported the decision to commission three additional critical care beds on the Bristol site. In practice this is two physical beds spaces, as there was one existing unfunded bed within General ICU routinely in use and therefore within the activity baseline.

(Table 5)

Critical Care Unit	Location	Bed Numbers	L3	L2	L 1.5
General ICU	A600	20	12	8	0
Cardiac ICU	CICU	24	10	9	5
Weston	Weston General	5	5	0	0
	TOTAL	49	27	18	6

As part of the development of a new model of care for clinical services at Weston General Hospital and as part of the Weston and UH Bristol merger, a new model for critical care was approved; the equivalent of X2 level 3 beds were transferred from Weston to the BRI GICU, whilst X2 level 2 and X2 level 3 critical care beds remained on the Weston site.

Post 'Phase 1' Expansion and Healthy Weston Capacity:

(Table 6)

Critical Care Unit	Location	Bed Numbers	L3	L2	L 1.5	Net change:
General ICU	A600	25	17	8	0	+5
Cardiac ICU	CICU	19	11	8	0	-5
Weston	Weston General	4	2	2	0	-1
Cardiac High Care	C708	6	0	0	6	6
	TOTAL	54	30	18	6	5

UHBW strategic capital funding was made available to support this development and the physical build to accommodate these beds was delivered in February 2021. This case confirms that both the 'Phase 1' expansion and the Weston transfer have been fully implemented.

Case for Change:

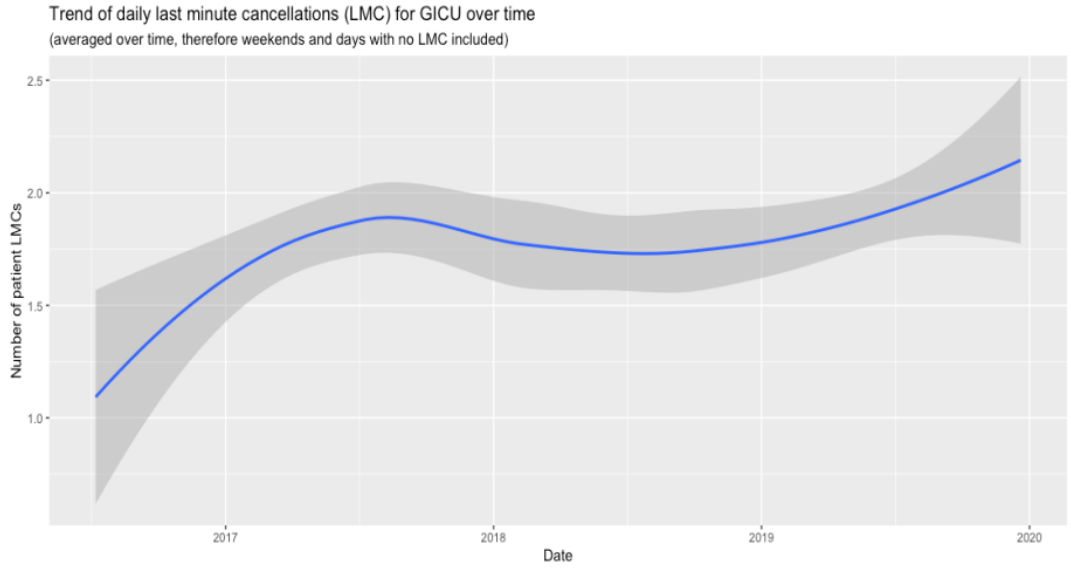
1. Patient safety risks associated with under provision

A. Unacceptably high rates of patient cancellations and elective back log requirements

Overall, elective demand on the GICU represents 31% of occupied bed days and is a fundamental part of unit demand. The most obvious impact of the capacity shortfall can be seen in the unacceptably high levels of patient cancellations, particularly pre-pandemic when activity levels were higher overall, taking into account the reduced scheduling during the pandemic. This clearly has a significantly negative impact on the quality of care provided for these patients, as well as reducing the efficiency and productivity of our elective services for major cases.

The figure below demonstrates the increase in the cancellation of patients on the day of surgery over the last four years (2021 data excluded as a result of the COVID-19 pandemic).

(Figure 4)



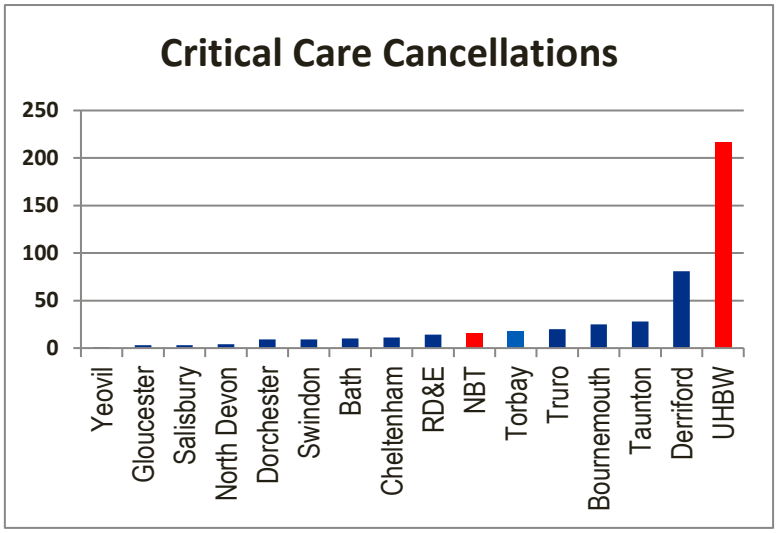
Regional benchmarking data for 2019 (Appendix 1.2), i.e. pre-pandemic, shows that 216 critical care patients had major surgery cancelled at short notice due to a lack of critical care bed at UHBW, the highest of 16 trusts in the report. This represents 48% of the reported regional figure. This has resulted in an inability to support the elective programme resulting in cancellations and an inequity of access for our elective patients.

As well as these highly visible short notice cancellations, the low bed base also results in:

- An underlying rate of 'under-scheduling' or 'pacing' of general elective work due to capacity constraints
- Delays for inpatients awaiting critical care-dependent surgery, that impact across the region; this not only has a clear negative impact on the patients involved and on the efficiency of the service, but it also impacts the reputation of the cardiac unit as a regional service provider of choice and drives referring organisations to send patients out of area where access can be assured
- Other inefficiencies due to high occupancy such as late theatre starts and lost second cases, where ICU capacity is not the recorded reason for cancellation, but often the root cause

The table below demonstrates that UHBW has the highest number of cancellations for no critical care capacity of any provider in the South West.

(Figure 5)
(Y/E 31.03.20)



The NHS as a whole is facing very substantial challenges in terms of elective backlogs, with 3 million fewer elective procedures delivered in 2020 than in 2019. In a recent BMA report (British Medical Association, 2021) they estimate that even if the NHS returned to pre-pandemic levels of elective activity (i.e. the 2019 average), waiting lists would continue to grow, and if elective activity increased to 110% of 2019 levels, the backlog would take up to five years to come back down to pre-pandemic levels.

Critical care forms a key part of the trusts recovery strategy and investing in resilient levels of critical care capacity is vital to sustaining recovery efforts. It is recognised that any estates-dependent expansions could not be completed in a feasible timescale to impact this backlog in a timely manner. However, there will be temporary surge options that could be considered as short term measures to support elective care recovery whilst the proposed capital scheme is ongoing.

It is important to note that elective cancellations for critical care beds are multi-factorial. On the day cancellations for non-clinical reasons are not limited to capacity constraints, and may be attributable to other factors, including logistical reasons such as unplanned staffing issues or equipment failures. Whilst the additional capacity will go a long way to radically reduce the high numbers of elective cancellations we currently experience, a small amount of cancellations will remain as a result of the sometimes rapidly changing, unpredictable nature of critical care capacity management (e.g. future Covid surges or unprecedented emergency demand). We would anticipate that the small number of elective cancellations would be more comparable to that of our peers, as described in the above graph (figure 5).

B. Increasing levels of out of hours discharges from critical care and high readmission rates

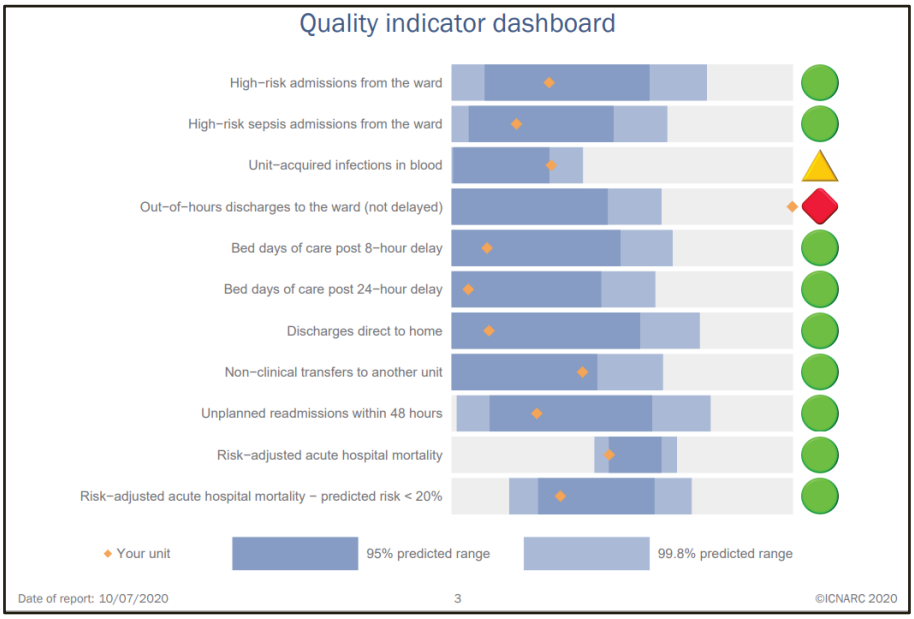
The Critical Care unit must protect the provision of an 'Emergency bed' to accommodate emergency admissions, which average 2.5 patients per day. This is an essential service requirement. The availability of these beds has been compromised on many occasions in the past (outside of Covid-19 surges) due to increasing acuity and high occupancy levels.

(Table 7)

Year	Total admissions	Total Unplanned & Emergency (U&E) Admissions	Avg U&E admit per day	Occupied % U&E
2016	1232	814	2.23	66.07%
2017	1277	812	2.22	63.59%
2018	1300	862	2.36	66.31%
2019	1318	913	2.50	69.27%

The pressure on the unit to ensure timely admission of daily emergency demand is managed via holding elective patients in recovery and identifying patients suitable for discharge on the 8pm ward rounds and discharging patients to the wards overnight. The following extract from the ICNARC Quality Report (March 2020), shows that the BRI ICU is a significant outlier in the comparator for out of hours discharges, clearly reflecting the capacity deficit.

ICNARC Quality Indicators (Figure 6)



C. Unmet need - Patients unable to access Critical Care

Prompt admission to critical care leads to lower mortality for patients assessed and recommended to critical care (Harris et al., 2018). Recent policy stresses the importance of identifying and responding to the deteriorating ward patient and the current guidelines recommend that critical care admission should be delivered within four hours. (Guidelines for the Provision of Intensive Care Services (GPICS), 2019). Delay to admission at the BRI is common, a proportion of patients recommended for critical care are not offered a bed within the GPICS four hour standard, and this proportion increases when capacity is limited. Because of the current lack of critical care beds at UHBW, we know that there are certain patient groups where critical care input is recommended, but is not currently being provided. These are specifically:

- Fractured neck of femur (NOF) pathway - UHBW will need to increase capacity to meet expected increase in demand for fractured NOF patients. We currently admit around 1% of fractured NOF patients, compared to a national benchmark of 3%. We need to increase critical care capacity to meet increases in demand and to be able to increase the quality of service we offer.
- Emergency laparotomy - The National Emergency Laparotomy Audit (NELA) guidelines include a recommendation for best-practice which includes admission to Critical Care for high-risk patients. UHBW currently admits about 70% of patients to GICU who should be admitted under the guidelines.

2. A lack of resilience and ability to effectively manage future surge scenarios

The national focus on critical care services in England has increased because of Covid-19. The Critical Care Units have been at the front line in the local level response and UHBW has taken short-term, unsustainable action to increase critical care capacity to cope with the Covid-19 pandemic. Despite

this, the risk of critical care services being overwhelmed remains and has been cited as a major factor behind repeated regional and national lockdowns in England.

The Covid-19 pandemic has had a significant impact on all three units (GICU, CICU and Weston) and their ability to provide for their local and tertiary populations, further exposing the deficit in local provision. During planning for the pandemic, maximum COVID surge capacity was planned at up to 80 critical care beds across the Bristol and Weston sites. During the first wave of the pandemic, UHBW followed national directives to reduce non-urgent surgery in order to limit the demand for critical care beds after complex surgery and increase the number of ward beds available.

After Covid-19 cases had fallen from their initial peak this situation improved in quarter 3 of 2020 but deteriorated as pressures from the second wave of Covid-19 grew later in the year. This was compounded by the need to assist other worse-hit regions with mutual aid for critical care transfers.

The excess demand for GICU beds at UHBW during the pandemic, resulted in a reduction in GICU admissions of 35%. This was mostly accounted for by a shift in 'elective' activity to CICU (most post-operative elective patients, both non-cardiac and cardiac were assigned to CICU rather than a proportional split between GICU and CICU). 353 non-cardiac patients have received their planned surgery during the pandemic, of these:

- 272 general patients were admitted to CICU following surgery (prior to the pandemic these patients post-operative destination would have been GICU)
- Only 81 were admitted to GICU following surgery
- In addition to the above, 40 non-cardiac emergency surgical patients were admitted to CICU during this period

This equated to a 15% reduction in elective general cases in comparison to the previous 3 year average. The repurposing of the regional Cardiac Intensive Care Unit (CICU) at UHBW lead to 243 fewer elective cardiac surgery cases being performed between April and January 20/21, a reduction of 35% compared to the previous year. This led to a significant increase in both clinical risk and waiting times. In January 2020, 4 cardiac patients were waiting over 40 weeks. By January 2021, this had exponentially increased to 130 patients.

In order to generate sufficient surge capacity to deal with the pandemic, the regional Coronary Care Unit (CCU) was also converted into a critical care area. This resulted in the CCU being relocated to a general ward area rather than a purpose-built Coronary Care Unit. The area was not adjacent to the catheter laboratories and the relocation also resulted in the displacement of 11 general ward beds in the Bristol Heart Institute.

The pandemic further highlighted the notable lack of resilience within the current bed base to respond to peaks in demand or to manage a surge of any kind. This presents a risk in terms of our ability to mobilise the critical care capacity needed to adequately respond to any future surge.

It should also be noted that failure to learn from the lessons of Covid-19 and create a more resilient bed base would cause significant reputational damage to the Trust and wider NHS in the event of future surge events.

3. *Increased demand at a local level*

ONS Population Change

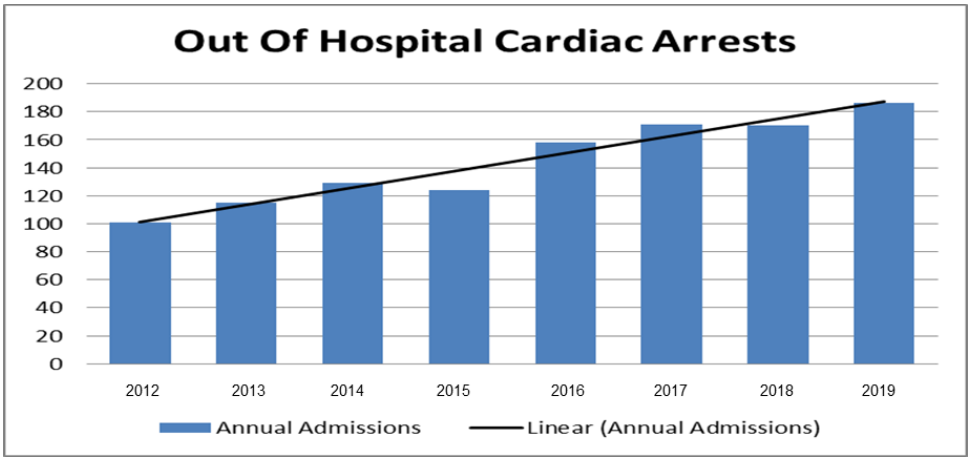
The Office for National Statistics data for population projections (www.ons.gov.uk, n.d.) indicates an increase in demand in Bristol of 0.6% per annum.

Out of Hospital Cardiac Arrest

Growing emergency and non-elective demand, specifically patients who suffer an out of hospital cardiac arrest is driving an increase in demand for critical care within our current patient group.

This is driven by patients surviving longer, as they reach hospital more quickly and are treated more effectively, as well as the wider increases in life expectancy. Admissions have risen from 101 in 2012 to 180 in 19/20. (Extrapolated from 6 months data).

(Figure 7)



Increased demand for CAR-T therapy patients

In 2019 UHBW was commissioned as one of nine centres nationally to deliver CAR-T (chimeric antigen receptor T-cell) therapy. This new treatment is a type of immunotherapy where a patient's immune system cells can be modified to destroy cancer cells in their body. This treatment has the potential to completely cure some types of cancer, but it is complex and potentially high risk. Approximately 25% of patients who receive CAR-T therapy will require admission to a critical care bed to support them while they undergo treatment. 24 CAR-T patients are treated annually, with expected increases as the therapies become more widely available.

Impact on Regional Cardiac Service

The high demand in UHBW also impacts on the Cardiac Intensive Care Unit (CICU), which serves both the BNSSG catchment and wider Severn region (the nearest cardiac centres second to Bristol are Plymouth, Oxford and Southampton). In the 24 months to March 2020 (i.e. prior to the impact of Covid-19) an average of 0.6 cardiac critical care beds were occupied by non-cardiac patients. This rose significantly as a result of the pandemic and impacted on elective capacity and the wider regional bed flow by delaying inter-hospital transfers for cardiac surgery. (See further detail described in monetisable benefits Appendix 2.1) number MB9)

Expanding GICU will significantly reduce reliance on Cardiac ICU (CICU) to accommodate non-cardiac patients, thereby improving access for cardiac surgery admissions. The BHI aims to perform c.1,400 cardiac operations per annum (pre-Covid). Of these, c.40% are in-patients (i.e. transfers from other Trusts or own general bed base), equating to 560 patients per annum. Around 50-60 cases per year would be full emergencies and warrant immediate out of hours operating, reducing the transfer figure to c.500 p.a. The target for transfer is 72 hours from referral. Inpatient transfer times in Q3 2021/22 average 7 days. Based on the 72 hour transfer target, this means that on average patients wait 4 days longer than target which equates to 2,000 bed days lost around the Region whilst patients wait for transfer. Assuming that patients waiting for transfer occupy a cardiology ward bed at a cost of approximately £195 per day, the potential benefit to the region is c.£390,000 presenting a significant improvement in access for patients and as well as a productivity opportunity for Commissioners.

4. Inability to repatriate clinical services

There are a number of critical services at UHBW that are interdependent with critical care, which are well placed to further develop, but are currently constrained by our existing critical care capacity. We have seen significant growth in our core specialist services over the past five years and supporting further growth would deliver the regional ambition to drive local access for South West regional patients and to reduce the number of patients currently travelling out of area to access these services.

We know that for each of these services there are patients travelling out of the South West who could be treated at UHBW; limiting access and causing unnecessary travel for patients and relatives, but also causing funding to flow out of the region into neighbouring health systems and notably London. It is proposed that an expansion of critical care beds would support the achievement of the Trust and the System strategic ambition to deliver specialist care within the region, specifically in the following areas;

- Gynaecology - As chemotherapy is improving, we expect to see an increase in gynaecology patients with operable cancer who require a post-operative critical care bed.
- Liver resection transfer - Transfer from the Royal United Hospital, Bath for liver resection work which would repatriate work to BNSSG from Basingstoke. This would provide a service closer to home for Bath patients and would further strengthen the BNSSG health system by retaining and developing clinical skills and services within the BNSSG region as well as attracting additional income.
- Thoracic surgery transfer - Transfer thoracic surgery work from Cheltenham to the BRI to repatriate work from Birmingham. We currently have a resection rate of around 12% and national rates are closer to 20% so the rate of resection is assumed likely to increase.
- There is also potentially future further demand associated with Pancreatitis management (benign, but provided by HPB cancer surgeons).
- ECMO – There has been a long-standing strategic aim to develop a respiratory ECMO (Extra Corporeal Membrane Oxygenation) service for the South West.

  ECMO is an extracorporeal (performed outside the body) life support technique for providing cardiac and respiratory support for patients whose heart and/or lungs are unable to provide enough gas exchange or blood supply to organs to sustain life. It is most similar to the heart lung machine technology used for cardiac bypass surgery. Blood is pumped out of the body and through a machine where carbon dioxide is removed and red blood cells are oxygenated. There are two broad types of ECMO which can be provided; V-A ECMO (veno-arterial) and V-V ECMO (veno-venous). UHBW already provides V-A ECMO for paediatric and adult cardiac

surgery patients. The paediatric service is well-developed and largely delivered by nursing staff after the initial set-up, supported by the on-site cardiac perfusion team. Historically, there has been no service in the south west for either cardiogenic shock V-A ECMO or for V-V ECMO.

In November 2021 the national highly specialised commissioning team announced a plan to make a substantial investment in the existing nationally commissioned ECMO centres. Three of the regional specialised commissioning teams, including the South West, raised concerns with the national team and requested the opportunity for providers not currently commissioned to also bid for investment.

In December 2021 we received confirmation from Commissioners that the proposal was supported and a funding envelope identified, consisting of both set up costs and recurrent revenue funding for the service. An ECMO working group has been set up, with focus on defining and finalising the details of the clinical model and costs associated with this.

As we are in the early stages of service implementation, the full revenue costs of providing an ECMO service in Bristol are not included within this case. These costs extend beyond the critical care area to include services such as cardiac perfusion.

However, the ECMO development has been articulated in the context of the wider capacity expansion plans at UHBW. The ECMO development includes provision for nursing, medical and AHP cover for ECMO patients on GICU, so there will undoubtedly be a contribution to the GICU revenue from this development. Any duplication of revenue costs associated between the two cases (ECMO and Adult Critical Care Phase 2 Expansion) will be worked through over the coming months. Any amendments to the revenue request included in this case will be changed to reflect these ongoing developments and escalated via the appropriate approval routes.

1.4 Risks the Business Case is Addressing

The table below outlines the risks currently on the risk management tool Datix associated with the current shortfall in Critical Care capacity at UHBW. The primary driver of this case is to mitigate these risks to an acceptable level.

(Table 8)

Datix Ref:	Area	Title	Rating (current)
1417	UHBW – GICU	Risk that patients will be harmed as major elective procedures are cancelled on the day, due to lack of availability of GICU beds	8
1035	UHBW - GICU	Risk that operations are cancelled and performance targets breached	20
1777	UHBW - GICU	Risk that cross contamination of patients could occur due to insufficient side room capacity	9
3650	UHBW - GICU	Risk that a patient may be discharged from GICU out of hours	6
5116	UHBW - GICU	Risk that there is a lack of standardised clinical practice and approach to workforce development in adult critical care	3
3128	UHBW - GICU	Risk that a lack of an equipment technician is leading to patient harm through faulty equipment	12
1514	UHBW – GICU	Risk that emergency admissions to GICU are delayed due to lack of capacity	16
3423	UHBW – GICU	Risk that quality of care is compromised due to the prioritisation of GICU beds for elective treatments being inconsistent	12
3895	UHBW – BHI	Risk of compromised care quality for patients requiring elective, routine cardiac treatment during COVID-19	20
4811	UHBW – BHI	Risk that timescales for non-elective cardiac pathways are not achieved	16
1511	UHBW – CICU	Risk to patient safety due to limited provision of veno-arterial ECMO in UH Bristol adult services	12

A Quality Impact Assessment (QIA) has been completed to support this case and is attached in Appendix 3. The QIA provides a clear and urgent case to support the expansion of critical care in the domains of patient safety, clinical effectiveness, patient experience, workforce and operational impact.

Patient Safety

A number of significant patient safety risks relating to critical care capacity are currently held by GICU. The modelling for future critical care demand (as described in Section 3.3) suggests that these risks will increase as demand for scarce beds increases. The most obvious patient safety risks relate to the failure to be able to admit a critically ill patient. This is evidenced by high cancellation rates for elective patients. It is also a problem for emergency patients but is less straightforward to quantify. As demand increases we will see an increasing number of critical incidents relating to the inability to admit a deteriorating patient as an emergency. These patients will impact on the emergency department and theatre capacity as we overflow from GICU with critically unwell patients.

The GPICS standards recommend that patient discharge should occur as early as possible in the working day and must occur between 0700hrs and 2159hrs. Discharging patients that are not fit for the ward at night due to capacity constraints exposes patients to increased risk. This is current practice at the BRI and again will become more common as GICU demand increases. These patients are at a higher risk of readmission and suffer poorer outcomes. Also, out-of-hours discharge from critical care is strongly associated with both in-hospital death and readmission. (Vollam et al., 2018) They are also likely to have an increased overall length of stay. (Priestap and Martin, 2006) It is also a very poor patient experience to be discharged early from GICU at night.

It should be noted that outcomes are driven by multiple factors, so it is not possible to conclude that time of discharge is a definitive cause of poorer outcomes or excess mortality in individual cases. All patients are reviewed prior to discharge by an ICU consultant and all deaths after admission to intensive care have been reviewed as part of standard morbidity and mortality procedures and there is no evidence that the time of ICU discharge has contributed to poor outcomes in individual patients.

This proposal will provide more side rooms which will improve our ability to operate with optimal infection control practice.

As of December 21, recurrent funding has been agreed for the Critical Care Outreach Service and we have been asked to now proceed with full implementation. The lack of a Critical Care Outreach team is a longstanding deficit on the Bristol site. Whilst critical care outreach will improve patient experience and support ward teams, we do not anticipate any impact on critical care capacity. Therefore the revenue costs of providing an outreach service are not included within this case. These benefits of the Outreach Service extend beyond the critical care area, for example, patient flow; length of stay; patient and staff experience.

Clinical Effectiveness

Our constrained GICU capacity impacts on a number of planned care pathways and performance targets. Our demand case suggests further pressure on elective and non-elective pathways and continued lack of GICU capacity will further impair our performance.

Improving GICU capacity will enable us to deliver the right care at the right time for the right patient. Optimising the critical care pathway by admitting patients earlier in their illness and discharging them when they are fit to leave is dependent on sufficient critical care capacity. Defects in this pathway compromise patient care and often result in longer length of stay in hospital. As demand for critical care increases, it is likely that we will see increasing compromise in the critical care pathway leading

to early critical care discharge, early readmission, longer lengths of stay, poorer outcomes and poorer patient experience.

Patient Experience

Cancellation of high risk major surgery is extremely distressing for patients. A large proportion of our cancelled patients are undergoing treatment for cancer which compounds this distress with the fear of metastatic disease always present. Clearly reducing our day of surgery cancellation rate with increased capacity will improve patient satisfaction with the service.

Discharging patients at night who are not deemed fit for the ward also offers poor patient experience. We have undertaken several patient surveys as part of audit work on optimising patient discharge and it is clear that discharge from GICU is a stressful time. This is compounded when undertaken at night with minimal prior planning and chance for patient involvement in the process.
At times of GICU strain, we have to look after critically unwell patients in both the emergency department and theatre recovery. These areas are not configured to look after unconscious or rehabilitating critically unwell patients and the poor environment impacts on our ability to offer dignified and respectful care. If our current critical care capacity is not improved we will need to utilise these inappropriate areas more often as a matter of routine.

Workforce

A critical care unit under significant strain is an intensely stressful environment as was experienced and widely demonstrated during the Covid-19 pandemic. These working conditions risk becoming normalised if insufficient critical care capacity continues as demand increases. We are currently risking a cycle of burn out, stress, absenteeism and the inability to recruit, causing further impacts on capacity (Howell, 2021), (Imperial News, n.d.). This will be difficult to recover from without urgent action. Our proposal offers a resilient workforce model working in an optimal environment to mitigate these threats.

Operational Impact

The operational benefits of expanding critical care mirror the domains outlined above.

A critical care unit with appropriate capacity will enhance the patient pathway, reduce cancellation rates, improve performance, improve staff wellbeing and improve patient outcomes. Reduced critical care capacity impacts on the efficiency of multiple downstream and upstream pathways including theatres and the emergency department.

The case for expansion of critical care will significantly improve the quality of care offered at UHBW. When considering the risks already held around insufficient capacity and the demand projected in the next few years, the “do nothing option” poses a significantly increased risk to quality.

1.4 Patient and Public Involvement, and Consultation in re-design

The Trust is committed to involving our patients and members of our population in their care and delivery of services. Under the NHS Constitution (Patient and public participation in commissioning health and care, n.d.) commissioners, supported by their providers and local partners, have a statutory

duty to involve the public in their work in a meaningful way and specifically when there is a proposal to change services (e.g. location of services of the way in which a service is delivered).

The scope of this proposal is limited to an expansion of existing services and does not constitute a change in the way in which services would be delivered or accessed. We are therefore satisfied that there is no legal obligation to consult or involve patients and the public in this development. However, aside from the legal duty, it is always important to consider whether some form of public involvement would be beneficial. The Trust has considered whether this would be beneficial to the clinical team designing the model of care and to the population we serve. We have concluded that a simple expansion and duplication of existing service provision with no additional impact on patients and the public would not present an opportunity for meaningful involvement. We will keep this under continuous review as the business case develops.

2 Economic Case - Development of Options

2.1 Summary of Options & Options Appraisal

BAM Construction were commissioned to undertake an initial design feasibility study for the Phase 2 expansion of GICU to maximise the creation of additional critical care bed capacity. Stretto Architects were appointed to provide architectural advice, supported by Hulley & Kirkwood and WSP to provide Mechanical & Electrical and Structural designs respectively. A final feasibility report was issued in September 2020.

The preferred option outlined in the OBC approved in November 2020 was to expand the adult critical care bed base by 14 beds, with 11 beds located within the current critical care unit on A600, 2 beds developed as surgical high care beds and 1 bed located within the critical care unit in Weston. As the FBC developed, the Medical Director recommended that the Trust did not proceed with high care beds that were not co-located with critical care and subsequently these 2 beds were removed from the case. The bed at Weston does not require capital spend and was therefore removed from this case. A case for enhanced care areas may be developed in the future but is out of scope for this Phase 2 expansion case.

Non-financial options appraisal for physical location of additional Critical Care beds on UHBW site:

(Table 9)

Scheme:	Status:	Detail:
Expand GICU into CICU	Rejected	This option was discussed with the wider stakeholder team early in the process however, was quickly discounted as being unviable due to the displacement of CICU beds with no viable options to re-provide across the existing BRI/BHI estate.
Expand GICU beds at Weston	Rejected	Expanding beds in Weston is a contradiction of the Healthy Weston solution agreed, which is to provide 4 beds in Weston. With an ED closed for 10 hours overnight and no overnight operating there is a reduction in demand at Weston. The surgical case mix at Weston is also limited relative to the BRI, where the majority of our specialised and tertiary surgery takes place. A development at WGH would therefore have been of

Scheme:	Status:	Detail:
		limited utility in terms of supporting these services, which was a further factor considered.
Create extension to A600 and redesign existing GICU footprint		Three initial options were prepared for high level costing to determine the feasibility of significantly increasing the number of GICU Cubicles on the existing unit and the likely cost of each. The scope was focussed on the GICU in Terrell Street Building (TSB) but also explored any potential space efficiency gains by combining the GICU and CICU. • Option 1 – X11 additional beds • Option 2 – X8 additional beds • Option 3 – X10 additional beds

(Further described in Appendix 4)

The evaluation criteria:

- Maximum increase in bed spaces
- Corresponding increase in support spaces - storage and staff facilities
- Maintaining the patient environment
- Providing rooms with different air regimes including additional lobbied rooms to meet the demand of individual patient needs
- Reconfiguration of both GICU and CICU to allow departments to operate as one unit (NB any modification to the Queens Building is outside the scope of this study.)
- Providing a new physical link between the GICU and CICU is the most space efficient way.
- Combining staff spaces where possible to encourage integration
- Minimise disruption to the existing unit which will need to continue operating throughout construction.
- Timescale - due to the pressures of the current pandemic and future predications of patient numbers the increase in bed base is required urgently.
- Affordability/Value for Money - the proposal will need to be both affordable and demonstrate good value for money.

The options were reviewed by key stakeholders, Infection Prevention and Control, and leading clinicians and Option 1 was proposed as the preferred option:

- The preferred option increased the current bed base by X11 patient cubicles to provide a unit total of X32 beds.
- The proposed link to the adjacent CICU at the north end, along with the southern link, combined the GICU and CICU into one unit operating as one for increased flexibility and efficiency.
- Seven of the new cubicles located in the new build extension on the north side of the existing floor, offers the opportunity to provide a new ventilation plant.
- The unit divided into two halves for fire separation (as is the existing unit) with a staff base on either side. These were retained and extended to improve visibility and provide more space for the increase in staff.

- Clinical and bulk stores centrally located with access form both halves of the unit and also from the Goods Lift lobby.
- A second patient WC/ shower located at the North West corner of the unit.
- The proposed shared staff room for both GICU and CICU staff centrally located on the new link corridor. The existing WC/shower in the Queens Building displaced by the corridor is also re-provided.
- Three of the proposed additional cubicles would be lobbied with an en-suite sluice. This will allow a degree of isolation but the room ventilation will not be totally compliant (refer to MEP report). Ventilation for these rooms will be provided from new plant at roof level and will require a ductwork route through the atrium.
- The consultants' office is relocated to the atrium space (above the level 5 staff rest room) and is co-located with other admin areas behind the existing reception.
- The resource room is re-provided in the vacated staff room of the Queens Building to enable a better configuration of cubicles and clean utility.
- The two roof areas formed by the new build extension will provide the opportunity for an accessible roof garden (between the two wings) and for external plant on the roof between the TSB Ward Block and Queens Building/ BHI.
- An undercroft area also formed between the TSB Ward Block and Queens Building/ BHI at level 5.

Further steps

In Nov 2020, the Capital Projects Steering Group (CPSG) approved the design fee funding to proceed with the preferred option, working design up to OBC stage. Approval to progress design to FBC stage was granted by CPSG in May 2021 and a full design and GMP (Guaranteed Maximum Price) for construction is expected in Jan 2022 for Trust Board approvals.

Appendix 5 outlines the high level drawings of the preferred option and the visual of the external elevation of the preferred option. The Trust commissioned Archus report (Appendix 6) was received in October 2021 providing an independent assessment which supported the Trust's preferred option in terms of the scale and location of the Stage 2 expansion.

2.2 Development of Preferred Option

In reviewing the options available to expand the unit buy 11 beds and to mitigate the risks associated with the lack of capacity, four options have been identified to be described in the FBC.

1. Outline Business Case Model: Increase GICU bed base by X5 level 3s, X6 level 2s (Preferred Option)
2. Enhanced Care Model: Increase GICU bed base by X5 level 3s, X2 level 2s & X4 Level 1s
3. Regional Demand Model: Increase GICU bed base by X11 level 3s
4. Do nothing

Summary of options appraisal:

(Table 10)

Option 1: Outline Business Case Model (Preferred Option)
Pros: • Significantly reduce delays in admitting critically ill patients to the GICU and commencing treatment • Improvement in clinical performance and quality of care • Ensure minimal length of stay on unit • Staffing model more accurately reflects acuity and occupancy and ensures that GICU capacity remains consistent • Elective surgery not compromised due to limited GICU capacity • Improved staff morale and workforce sustainability, enhanced multidisciplinary working • Units reputation improved, unit be seen as investor in care to all national standards • Addresses CQC, GIRFT and Peer Review actions and recommendations
Cons: • Capital and Revenue costs • Requires additional GICU trained workforce in a limited market

Option 2: Enhanced Care Model
Pros: • As described in Option 1 • Inclusion of enhanced care unit • Model of care reflective of national guidance to include co-located enhanced care beds • Patient safety and quality of care improved as patients will be cared for on the GICU by appropriately trained staff and the appropriate level of care (including at level 1)
Cons: • Capital and Revenue costs • Requires additional GICU trained workforce in a limited market

Option 3: Regional Demand Model
Pros: • As described in option 2 • Unit funded to accommodate future growth
Cons: • As described in option 2 • Capital and Revenue costs associated with funding all beds at level 3 • Increased staffing requirements poses significant risk in terms of our ability to recruit

Option 4
Pros:

• No financial support required (both in capital and revenue terms) • No recruitment requirement
Cons: • Unable to deliver against Trust agreed strategic themes • Compromised patient safety • Deterioration in clinical performance and quality of care • Delays in admitting critically ill patients to the GICU and commencing treatment • On-going cancellation of elective surgery • Poor staff morale, increased staff turnover and sickness absence • Failure to consistently address CQC / GIRFT / Peer Review recommendations and comply with national Critical Care Standards • Missed income associated with the inability to repatriate services • Failure to meet national recommendations around ensuring resilience in critical care to cope with future surge scenarios

Model of Care of the Preferred Option

We require an additional 11 critical care beds; X5 level 3s and X6 level 2s, based on regional and local demand modelling. The detail of the demand and capacity analysis is further described in section 3.3.

Bed configuration and levels of care for preferred option

(Table 11)

Critical Care Unit	Location	Bed Numbers	L3	L2	L 1.5	Net Change:
General ICU	A600	36	22	14	0	+11
Cardiac ICU	CICU	19	11	8	0	0
Weston	Weston General	4	2	2	0	0
Reprovide + 1 re CICU	C708 enhanced care	6	0	0	6	0
	TOTAL	65	35	24	6	0

The detailed breakdown of the demand case and the model of care are detailed below. We have attributed the split between Level 3 and Level 2 beds based on analysis of existing acuity and activity data and on clinical assessment of the proposed additional case mix.

(Table 12)

Area:		**No. of Beds**	**Level of care:**	**Model of Care Rationale:**
Cancellations	Cancellations – UHBW	2.09	L3 0.09 L2 2	The "cancellations" cohort will mirror our current general surgical elective throughput. The L3 and L2 numbers are also based on analysis of current activity in ward watcher.

Area:		No. of Beds	Level of care:	Model of Care Rationale:
Unmet need	#NOF – UHBW	0.1	L2 0.1	These patients are currently managed inappropriately in recovery or on wards and require L2 care.
	Laparotomy – UHBW	0.4	L2 0.4	The unmet need to admit patients after emergency laparotomy will be skewed towards the lower acuity end of the spectrum and so will be L2 rather than any additional L3.
	Unmet need in BRI	2.5	L3 1.36 L2 1.14	This demand is generated by unmeasured demand on wards, early discharges from GICU and the need to improve efficiency by running at a lower occupancy rate. As such there is a broad case mix of patients here. There are 1.36 L3 and 1.14 L2 beds to accommodate emergency admissions. This reflects the mix of acuity seen in these patients based on current patterns in existing data.
Existing growth	ONS Growth – UHBW	1.0	L3 0.6 L2 0.4	ONS growth represents an extension of current activity which is managed at a ratio of 60% L3 and 40% L2.
	OOHCA – UHBW	1.4	L3 1.14 L2 0.28	These numbers reflect average bed utilisation by acuity over entire length of stay.
	CAR-T cells	0.1	L3 0.1	CAR-T patients have complex needs (including the need for isolation) and will be managed as L3.
	Cardiac	0.6	L3 0.6	Patients in this cohort are currently L3 and have been decanted to CICU as an emergency.
Future growth / developments	ECMO	1.1	L3 1.1	These are complex patients and will require level 3 care in this model..
	Gynaecology growth	0.1	L2 0.1	Based on analysis of current gynaecology work, we can accommodate this additional work as L2.
	Specialist oncology growth	0.2	L2 0.2	This projection is likely to require predominantly level 2 care. There will be a spectrum of acuity as this is a broad case mix but by flexing within our existing L3 capacity we can accommodate the additional work.

Area:		No. of Beds	Level of care:	Model of Care Rationale:
	Liver resection repatriation	0.1	L2 0.2	When considered as part of our entire liver resection workload we can accommodate these additional patients as L2.
	Thoracic transfer & growth	0.2	L2 0.2	When considered as part of our overall thoracic workload, we can accommodate additional work as L2.
Total		**9.9**		

As a part of the options appraisal, the development of a model of care including an enhanced care option (Option 2) was considered. Although the development of an enhanced care model has been encouraged centrally, it is important to note that this business case proposes an expansion of critical care capacity in order to mitigate and address the risk associated with the shortfall in critical care beds. Recent peer review by the Southwest Critical Care network acknowledged that the current shortfall in critical care capacity cannot be accommodated by an enhanced care model in the first instance. Once the critical care capacity shortfall is addressed, the GICU would look to review the benefits of the enhanced care model to further improve patient access to the right care in the right place at the right time. (Appendix 7)

Whilst Option 3 would solve the capacity constraints and provide resilience going forward, it poses significant risks in terms of staff recruitment strategy. We have considered our model of care carefully as a part of the local level review of existing acuity, activity data and clinical assessment of the proposed additional case mix, it was concluded that we can deliver the service required with less level 3 beds.

The 'do nothing' option (4) is not acceptable in the light of the current risks the trust holds in relation to the lack of Critical Care capacity at the BRI and the future demand for critical care outlined by both the internal and external demand case. The risks for adopting the 'do nothing' option are described in Section 1.4 and within the QIA.

3 Financial Case

The financial case describes the capital costs and the recurring revenue costs of the preferred option of an overall increase of 11 Adult Critical Care Beds, of which 5 beds are level 3 and 6 beds are at Level 2.

3.1 Capital Costs

The capital cost has been provided by BAM Construction Limited our ProCure22 Preferred Supply Chain Partner (PSCP). ProCure22 (P22) is a Construction Procurement Framework administrated by NHS England and NHS Improvement for the development and delivery of NHS and Social Care capital schemes in England. It is consistent with the requirements of Government Policy including the Productivity and Efficiency agenda; the Government Construction Strategy; the Public Contracts Regulations 2015; the National Audit Office guidance on use of centralised frameworks; and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector.

The full capital cost estimate of the preferred option is £12.96m. The Guaranteed Maximum Price (GMP) negotiations for the mains works costs are at an advanced stage and are scheduled to conclude 24th January 2022. The status of the current negotiated GMP figure for the main works is £9.69m. At the draft FBC stage in July 2021 the capital cost was estimated at £12.68m and was budgeted for at this level in the Trust's approved Medium Term Capital Programme. At Outline Business Case (OBC) stage as received at the Finance & Digital Committee 24th November 2020 the capital cost was £11.6m. The increase of £1.1m from OBC to the draft FBC is due to additional scope having been identified during the clinical meetings held as part of the FBC design process. It became apparent that additional staff support areas were required to enable the expanded unit to function. The additional works / areas include:

- Level 5 office & storage (below the link being created from GICU to CICU);
- New build at levels 7 & 8 infill (above consultant office being created at level 6 to re-provide and increase staff change facilities);
- Conversion of store into pantry within Queens Building; and
- Increased footprint for link / bridge between GICU and CICU to create combined staff rest.

Since the capital cost estimate as per the draft FBC in July 2021 at £12.68m, GMP has been received and the total final project cost is £12.96m, an increase of £0.28m. An explanation of this increase is provided in table 13 below.

(Table 13)

	Estimated Cost (Inclusive of VAT)	Revised / Final Cost (inclusive of VAT)	Variance	Comments
	Draft FBC July 2021	Final FBC Jan 2022	FBC	
	£	£	£	
Total project costs	**12,681,297**	**12,964,209**	**282,912**	
BAM Costs (Final GMP)	8,869,810	9,695,133	825,323	Market costs increases from estimate to actual price (e.g. Covid, Brexit)
Other Works and enabling costs	270,000	270,000	0	Fire damper allowance and chiller - no change from Draft FBC
Professional Fees	114,055	124,013	9,958	Cost consultant, NEC supervisor and associated planning fees - no material change from Draft FBC
Contingency (Main Works)	1,185,108	534,361	(650,747)	Contingency now at 5% due to reduced risk as now have received GMP
Non Works Costs	70,000	385,000	315,000	The inclusion of traffic marshalls cost at £300k driving majority of the £315k variance from Draft FBC
Internal Recharges	40,000	65,500	25,500	Revised estimate
Equipment	1,824,000	1,575,600	(248,400)	Fully costed equipping schedule opposed to estimated costs at Draft FBC
Internal Fees (2.5%)	308,324	314,603	6,278	Internal Estates fees - no material change from Draft
Total Project Costs	**12,681,297**	**12,964,209**	**282,912**	

The Gross Internal Area (GIA) is 1595sqm, with approximately 58% (935sqm) being refurbishment of the existing area and 42% (660sqm) being new build.

(Table 14)

Total (£)	Total GIA	Cost per m/2	Total bed gain	Cost per bed
12,964,210	1595 sqm	7,951	11	£1.18m

Table 15 below provides a detail breakdown of the capital costs as per the completed budget estimate form provided by the Trust's independent cost adviser and the construction project manager.

Of the £12.96m, the estimate for main works, enabling costs and fees are £10.1m, non works costs are £0.38m, internal recharges (IM&T) are £0.07m, equipment costs estimated at £1.57m and other internal fees at £0.31m. A contingency sum of 5% of the mains works cost at £0.53m.

Capital Cost Plan Summary (Table 15)

Description of Building / Equipment	Cost (Excluding VAT)	VAT 20%	Gross Capital Cost	VAT Recovery	Capital Cost
	£'000	£'000	£'000	%	£'000
Main Works Costs					
BAM	6,837	1,367	8,204	20%	7,931
BAM Risk	0	0	0	0%	0
PSCP Fees	1,499	300	1,799	100%	1,499
BAM Below the line items	200	40	240	0%	240
Void detection	21	4	25	0%	25
Contractor / BAM Costs	**8,557**	**1,711**	**10,268**		**9,695**
Other Works Costs & enabling costs	225	45	270	0%	270
Trust's Professional Fees	124	25	149	100%	124
Contingency @ 5%	445	89	534	0%	534
Sub-total works and professional fees	**9,351**	**1,870**	**11,222**		**10,624**
Equipment					
Equipment & Furniture	993	199	1,192	0%	1,192
Pendants	993	64	384	0%	384
Sub-total equipment	**1,986**	**263**	**1,576**		**1,576**
Non works	385	0	385	0%	385
Internal Fees					
IM&T			66	0%	66
Other	0	0	0	0%	315
Total Capital Cost	**11,722**	**2,133**	**13,248**		**12,964**

The main assumptions underpinning the capital costs are:

- The capital costs are priced at 2022/23 prices;
- Construction inflation is included in the GMP value above at £0.1m following review and discussion with the Trusts Cost Advisor;
- The capital costs have been independently assessed and signed off by the Trust's independent cost advisor;
- Trust Contingency has been calculated and included at 5% (£0.5m). This contingency at GMP stage is in line with the Cardiac / GICU Stage 1 scheme which had an allowance of 5% at GMP stage and the project was delivered within budget;
- The Contractor has a provision for risk at £0.2m;
- The VAT paid on professional fees is recoverable at 100%;
- It is likely that there will be some VAT reclaim which will be confirmed after GMP stage.

Capital Equipment

A detailed, fully costed capital equipment schedule has been completed and was signed off at the GICU working group in September 2021. The total value of the capital equipment is £1.6m including VAT, £0.14m per bed. This value includes a contingency of £0.2m, circa 17%. The capital equipment budget included in the July 2021 draft FBC budget estimate form was £1.8m, showing a favourable variance of £0.24. A summary of the equipment breakdown is shown in table 16 below with further detail shown in Appendix 2.2 attached.

Table 16 – Capital Equipment

Equipment Category 1	Equipment Category 2	Sum of Total Cost (Excl VAT)	Sum of Total Cost (Incl VAT)
Bed Space	Beds	£83,600	£100,320
	Cleaning and Linen	£3,687	£4,424
	General Equipment	£29,575	£35,468
	IT Equipment	£46,376	£55,651
	Medical Equipment	£805,939	£967,126
Bed Space Total		**£969,177**	**£1,162,990**
Unit Space	Cleaning and Linen	£3,698	£4,438
	General Equipment	£16,172	£19,406
	IT Equipment	£18,800	£24,320
	Medical Equipment	£32,512	£39,015
	Staff and Other Unit Support Equipment	£3,858	£4,630
	Pharmacy Equipment	£9,884	£11,861
Unit Space Total		**£84,924**	**£103,669**
Physio Equipment	Physio Equipment	£59,688	£71,625
Physio Equipment Total		**£59,688**	**£71,625**
Staff Space	Staff and Other Unit Support Equipment	£8,035	£9,642
Staff Space Total		**£8,035**	**£9,642**
Contingency	Contingency	£189,445	£227,673
Contingency Total		**£189,445**	**£227,673**
Grand Total		**£1,311,269**	**£1,575,600**

***Note** - In addition to the above equipping detail - BAM construction have confirmed that included in the overall construction costs is the cost to supply and install 17 hoists, of which 7 are existing hoists and 10 are new - the estimated cost of this is £53.9k. There will also be some pantry goods required which will be purchased using a small sum from the contingency balance.*

Capital Affordability:

This scheme forms part of the Category 1 schemes as prioritised in the recent Strategic Capital Review. The capital affordability and capital charges assessment has been based on the FBC cost of £12.96m. This includes a GMP at £9.69m.

Despite being one of the few Trusts in the country to have built up significant capital resources under the previous Payment by Results (PbR) financial regime, we are no longer able to make decisions about how we access and spend this money autonomously. Nationally there is a limit on the amount of capital investment a Trust can make in a single financial year. This is known as Capital Departmental Expenditure Limit (CDEL).

The capital cost of £12.96m is a call on the Trust's CDEL limit. This means that this scheme consumes 21% of the Trust's limit.

It has been confirmed that the capital cost will be internally funded from within the Trust's available cash reserves as shown in the Source and Applications table 17 below

Capital Cost – Source and Application of Funds

(Table 17)

Source and Application of Funds	
	£'000
Source of funding	
Internally generated cash	12,964
Application of funds	
Capital cost	(12,964)
Total capital funding	**-**

Capital Charge Estimates:

The recurring capital charges are estimated at £0.67m per annum, £0.39m for depreciation and £0.28m for PDC as shown in Table 18 below.

(Table 18)

Capital Charges	£'000
Depreciation	387
Public Dividend Capital (PDC	283
Total Capital Charges	**670**

The following assumptions have been used to calculate the capital charges and are in accordance with the Trust's accounting policies:

- Buildings depreciated over a 30 year life;
- Equipment depreciated over a 10 year life;
- PDC calculated on the written down value (WDV) at 3.5%;
- New builds are impaired at 25%; and
- Refurbishments are impaired at 50%.

Capital charges are an annual cost and are included in the recurring revenue assessment described in section 3.2.

3.2 Revenue Affordability

This section describes the recurring affordability of the preferred option being the 11 bed expansion of 5 Level 3 beds and 6 Level 2 beds. It describes annual recurring cost in terms of the workforce to deliver the agreed model of care, the associated non pay costs, estates costs, capital charges and a provision for Trust overheads. The non-recurring costs associated with the phased implementation of the build and phased recruitment plan are described in section 3.2.1 below.

The main assumptions underpinning the revenue assessment are as follows:

- All workforce has been priced at mid-point of scale at 2021/22 prices which includes the 3% pay award for all NHS staff;
- The Hard and Soft FM Costs are based on GIA of 1595sqm provided by Estates and are based on the 2021/22 inflated cost per sqm of the BRI Building;
- Capital charges calculated using UHBW accounting policies as described in the capital cost section above;
- The formally approved workforce model including nursing, medical staff, allied healthcare professionals and necessary support staff have been costed in accordance to the required Guidelines for the Provision for Intensive Care Services (GPICs), with some benchmarked investment in the required support staffing for the department; and
- The financial assessment has been carried out under the assumption that the affordability can be judged by comparison to the income that PbR would have brought to the Trust. This has been based on the local agreed critical care tariff of £1,485 per critical care bedday. It is assumed that additional block funding is sought from the commissioners and that they will base their assessment of the reasonable cost of the service development on what they would have expected to fund using the locally agreed critical care tariff of £1,485 per bedday; and
- The recurring revenue costs have been phased in line with the phased construction plan, recruitment strategy and aligned to the time of opening the beds. It is assumed that +3 beds will open in November 2022, a further +7 beds in March 2023 and the remaining +1 bed in May 2023.

A summary of the phased recurring revenue costs is shown in table 19 below with further detail provided in Appendix 2.3.

Recurring Revenue Costs

(Table 19)

Revenue Phasing	Year 0-2021/22		Year 1-2022/23		Year 2 - 2023/24	
Recurring	**WTE**	**£'000**	**WTE**	**£'000**	**WTEs**	**£'000**
Pay Costs						
Medical Staff			10.28	(401)	10.28	(968)
Direct Nursing Staff			57.13	(1,097)	57.14	(2,537)
Nursing Support Staff			5.54	(146)	5.54	(212)
Ancillary Staff			1.00	(26)	1.00	(31)
Allied Healthcare Professionals			12.36	(147)	12.36	(569)
Memo Engineer			0.50	(2)	0.50	(21)
Sub Total Pay Costs	**0.00**	**0**	**86.81**	**(1,818)**	**86.81**	**(4,339)**
Non Pay Costs				(152)		(1,004)
Estates Costs				(44)		(390)
Overheads				(24)		(145)
Total operating costs		**0**		**(2,039)**		**(5,877)**
Capital Charges Costs				0		(670)
Total recurring cost	**0.00**	**0**	**86.81**	**(2,039)**	**86.81**	**(6,547)**

The Payment by Results financial regime was suspended on 1st April 2020 in response to the Covid-19 pandemic, therefore service developments requiring recurring revenue funding from Commissioners are presented on a costed service basis.

The recurring revenue cost assessment shows that for the 11 bed expansion, there is a cost to the commissioner of £6.5m or £0.6m per bed. It is assumed that the investment would be funded through an agreed increase in our block income that matches the additional cost in full and is aligned with the activity and growth assumptions included in the case. Under the previous Payment by Results (PBR) regime, the 11 bed expansion would have resulted in an increase in variable income of £6.5m per annum.

Discussions with local and Specialised Commissioners have been ongoing since 2017.
More recently, BNSSG Clinical Commissioning Group (CCG) considered support in principle for the clinical case at their Clinical Executive meeting 11th November 2021 with Specialised Commissioning present during which both Commissioners formally approved the clinical case for change.

The FBC remains subject to ongoing discussions with the local CCG Commissioner and NHSE Regional Specialised Commissioners to consider how the recurring revenue should be funded. The case will also be considered in the BNSSG System and Specialised Commissioning prioritisation processes (currently pending) alongside understanding the BNSSG System 2022/23 funding allocation.

The current uncertainty regarding the medium term revenue financial regime means that securing full recurrent revenue funding beyond 2022/23 is challenging. However, the case has had the support of the BNSSG System as a priority bid as part of the H2 Planning Round and Targeted Investment Fund (TiF) process. As of 18th January 2022, we await the formal outcome of our TiF submission. For the purposes of this case however, our working assumption is that this bid does not require national funding and will not be funded nationally. In the event of national funding becomes available in the future, this would reduce the value of the Trust's cash required by the project and provide a beneficial increase in the Trust CDEL.

In addition to potential non-recurrent funding related to elective recovery, and in the context of: the last two years; underlying growth; and planned/proposed commissioned developments in specialist services; under any form of variable payments this business case would proceed.

In further support of the revenue affordability presented above we have undertaken a further benchmarking exercise using 2018/19 reference costs for UHBW state that the cost of a Critical Care Bed Day (Adults, excluding Cardiac) cost £1,333. The additional beds are more expensive at £1,485 due to higher capital costs and staffing all new beds fully to GPICS standards. (The existing legacy bed base does have a GPICS deficit particularly with relation to Therapies and Pharmacy staff of circa £1.3m, this case does not seek to address this deficit and these costs are therefore not included in the proposed workforce model).

Having reviewed a sample of the trusts that were identified as Peers for the Model Hospital reporting; these costs are from 2018/19 reference costs, the most recent available. A table sets out the costs per Critical Care Bed Day (Adults, excluding Cardiac) below. UHBW costs are not an outlier and the new beds, whilst more expensive at £1,485 per bedday are also within these norms. The lowest cost per bed day is seen in Sheffield Teaching Hospitals NHS Foundation Trust. It is noted in their report that 61% of their recorded bed days report have only 1 organ support, only 11% of UHBW bed days report with this low dependency. We would therefore not consider Sheffield to be a relevant benchmark for Critical Care costs.

(Table 20)

2018/19 Reference Cost	**£**
University Hospitals Bristol NHS Foundation Trust	1,333
North Bristol NHS Trust	1,473
Southampton University Hospital NHS Foundation Trust	1,510
Sheffield Teaching Hospitals NHS Foundation Trust	1,055
Plymouth Hospitals NHS Trust	1,671
University Hospitals Birmingham NHS Foundation Trust	1,253

It is important to note that there are a number of recently commissioned or expected extensions to specialised services that will contribute towards the required revenue for GICU expansion. These include;

- The recently commissioned South-West V-V ECMO service needs to be considered in tandem with the GICU Stage 2 Expansion case. The two developments are mutually complementary as ECMO will be one of the sources of recurrent revenue for the GICU expansion, and the expansion provides the long-term capacity mitigation for ECMO as the service develops. The target expected ICU capacity required for ECMO is 30 patients per annum (allowing for 4 patients concurrently but based on an average length of stay equating to 1-2 on average across the year).

- CAR-T therapy. Currently there are 3 NHSE approved products for 3 indications and 2 trial products at UHBW; this is expected to increase to 4 NHSE products with 4 indications and 3 trial products in 2022. This will include an element of ICU funding as 30-40% of patients are likely to require some ICU support.

- The detailed costings for these business cases are currently in development, however, it is estimated that circa 25%-30% of the £6.5m recurring revenue costs associated with the GICU Expansion would be funded via these two developments.

In addition to these recurrent funding sources, it is expected that there will be substantial non recurrent revenue resources over the next 1-3 years associated with elective recovery (as has been the case for the past 2 years). As a major provider for specialist acute services for the SW region, accessing this funding will facilitate utilisation of the extended ICU capacity.

Medical Staff

The medical staff model of care has been based on the direct requirement of staffing the junior doctor rota for the 11 beds at 6.0wtes.

The consultant direct clinical care and supporting programmed activities (PA) time required for the 11 beds is 3.65WTE in total with their remaining PA time providing other services across the hospital for example in respiratory or anaesthesia. The expectation is that this service is provided by recruitment of 6.0wte or equivalent to 60 Pas with the balance of job plans being elsewhere once the on call requirement for Critical Care is delivered. This is in line with existing job plans in the department. In addition 0.63wte consultant radiology time has been included at a cost of £0.07m.

Nursing Staff

The Nursing staff model of care has been based on the direct nursing requirement for the additional 11 beds and includes the support staff to deliver the specific GPICs roles. Overall, the nursing is an increase of 57.14WTE direct nursing staff plus 6.54WTE of supporting staff at a cost of £2.78m as shown in the table 5 below. Of the support staff, 2.31WTE are nursing staff with the remaining 4.23WTE being other AFC grade posts. The allocation of housekeeping resource is scaling up for the new capacity. The administration and procurement posts are new posts, because the department is now at a scale that these roles need an additional supervisory role. This has been considered after review of, and comparison with, other Critical Care departments in the region. The Equipment Technician funding is pro-rated against the net increase of beds. This case does not seek to fund the discrepancy or shortfall associated with the existing GICU beds for these two roles.

Nursing and Nursing Support Staff

(Table 21)

Staff	Band	wte	Unsocial %	*Cost of 1 WTE (£)*	£
Nursing	**Band 7**	5.19	24.00	*53,064*	275,400
Nursing	**Band 6**	5.19	24.00	*53,064*	275,662
Nursing	**Band 5**	41.56	24.00	*43,634*	1,813,401
Nursing	**Band 4**	0.00	0.00		0
Nursing	**Band 3**	0.00	0.00		0
Nursing	**Band 2**	5.19	35.00	*33,216*	172,557
Subtotal		**57.14**			**2,537,020**
A&C	**Band 3**	1.00	0.00	*26,664*	26,664
A&C	**Band 2**	1.23	27.00	*31,174*	38,344
Ancillary (HK)	**Band 2**	1.00	27.00	*31,174*	31,174
Ancillary	**Band 1**	0.00	0.00	*24,280*	0
Subtotal		**3.23**			**96,182**
Equip Tech	**Band 5**	0.31	0.00	*34,380*	10,505
Admin	**Band 4**	1.00	0.00	*30,645*	30,645
PEF	**Band 7**	1.00	0.00	*52,741*	52,741
Supervisor	**Band 7**	1.00	0.00	*52,741*	52,741
Subtotal		**3.31**			**146,632**
AFC Subtotal		**63.67**			**2,779,833**

The additional nursing costs have been costed using standard nursing rotas and have also been approved by the Surgery Division Head of Nursing and the Matron for Critical Care within the Surgical Division.

Given the additional nursing resource and capacity increase, consideration has been given to additional requirement for senior nursing support within the unit. As a result of the changing landscape of the critical care unit at this time (outreach development, ECMO implementation, and non-medical consultant practitioner recruitment), the Division of Surgery will aim to review the additional senior nursing resource support required in a years' time rather than including any funding request for resource within this expansion case.

There is an acknowledgement of the requirement to support and strengthen the nursing leadership in Critical Care once we have clarity of the position.

Allied Healthcare Professionals

The required allied healthcare professionals have been costed as set out below. The WTEs below are the WTE for all professions from GPICS, per bed:

(Table 22)

Physio	0.25WTE
OT	0.22WTE
SLT	0.1WTE
Dietetics	0.1WTE
Psychology	0.04WTE

This provides a 44 week of the year service, and therefore is adjusted by 20% to provide a '52 weeks of the year' service. This is for the core delivery of services – Physiotherapy six days per week plus on-

call cover on Sundays, Occupational Therapy six days per week, Dietetics and Speech and Language Therapy (SLT) five days per week.

The basis of the staffing assessment is broadly to GPICS (where this is clearly indicated) and other relevant publications as follows;

- Physiotherapy is defined in GPICS guidelines as being required to 0.25 WTE per level 3 bed. This ratio has been applied to all 11 beds following review with the lead for the service. However, level 2 patients actually receive a higher level of input from the physiotherapist on the ward and therefore this was not reduced for the level 2 beds in the case.
- Occupational Therapy is partly defined in the GPICS with a ratio of 0.22 WTE per level 3 bed. However, it also admits that there is little firm evidence for this. This has been used to calculate the investment required as it is a reasonable basis and supports patients' rehabilitation from delirium and other cognitive disturbance. This is expected to deliver better outcomes, reduced length of stay and support the high volume of emergency admissions to the GICU.
- SLT is clearly set out at this 0.10WTE per level 3 bed ratio in the GPICS guidelines
- Dietetics GPICS staffing is indicated to be between 0.05WTE and 0.10WTE per bed. The higher level of staffing has been used in the model, reflecting the Trusts status as a tertiary referral centre for Liver Surgery, Pancreatic patients, Head and Neck Cancer patients, all of whom require high levels of dietician input.
- Psychology support is in line with a paper produced in 2020 by the Intensive Care Society and PINC-UK (the Psychology in Critical Care Group). This further refines the recommendation in GPICS Pathology, Radiology and Pharmacy support is provided in line with the Service Specification for Critical Care and is only to the level required for the additional 11 beds.

Table 23 shows a total investment of

→ 9.34wte for Therapies Staff at a cost of £0.40m per annum,
→ Diagnostics investment of 1.68wte at a cost of £0.06m
→ Pharmacy staff of 1wte band 8b and 0.34wte band 8a at an annual cost of £0.09m per annum.

Diagnostics and Therapies Staffing

(Table 23)

Therapies	Band	WTE Split by Band		Cost of 1 WTE (£)	£
Dietetics	**Band 6**	1.32		*42,551*	56,168
Psycologists	**Band 8a**	0.50		*60,166*	30,083
OT	**Band 7**	0.80		*52,741*	42,193
	Band 6	1.00		*42,551*	42,551
	Band 5	1.10		*34,380*	37,818
	Band 4	0.00		*30,645*	0
Physio	**Band 8b**	0.00		*71,959*	0
	Band 7	1.40		*52,741*	73,838
	Band 6	1.00		*42,551*	42,551
	Band 5	0.90		*34,380*	30,942
SALT	**Band 7**	0.20		*52,741*	10,548
	Band 6	1.12		*42,551*	47,658
Subtotal		**9.34**			**414,351**

Diagnostics	Band	WTE Split by Band		Cost of 1 WTE (£)	£
Pathology	**Band 6**	0.05		*42,551*	2,128
	Band 3	0.05		*26,664*	1,333
Radiology					
Radiographer	**Band 6**	1.00		*42,551*	42,551
Radiographer Assistant	**Band 2**	0.27		*24,370*	6,580
Nurse	**Band 5**	0.16		*34,380*	5,501
Nurse	**Band 4**	0.06		*30,645*	1,839
A&C	**Band 3**	0.06		*26,664*	1,600
A&C	**Band 4**	0.03		*30,645*	919
Subtotal		**1.68**			**62,451**

Pharmacy	Band	WTE Split by Band		Cost of 1 WTE (£)	£
Pharmacy	**Band 8b**	1.00		*71,959*	71,959
Pharmacy	**Band 8a**	0.34		*60,166*	20,457
Subtotal		**1.34**			**92,415**

MEMO	Band	WTE Split by Band		Cost of 1 WTE (£)	£
MEMO - Engineer	**Band 6**	0.50		*42,481*	21,241

Non Pay Costs

The non-pay costs have been based on the 2019/20 actual costs of Ward A600 (GICU) apportioned for 11 beds and inflated to 2021/22 prices. These are estimated at £1.0m per annum with a breakdown provided table 24 below.

Non Pay Costs

(Table 24)

Non Pay Description	£
Blood	179,902
Clinical supplies	602,756
Drugs	11,700
Establishment expenses	6,530
General Supplies	49,735
Other Expenses	56,422
Premises costs	5,612
Pathology Non Pay - Reagents & Consumables	37,000
Radiology Non Pay - Contrast Agents	19,000
Memo Equipment Maintenance Costs	35,000
Total estimated non pay	**1,003,657**

Facilities Management Costs

The facilities management costs in total are estimated at £0.39m. These have been based on the floor area of 1595sqm and includes both hard and soft FM. These costs are estimated using 2020/21 ERIC data, inflated to 2021/22 price base. The Hard FM costs are estimated at £0.13m per annum and includes security, maintenance, energy, water / sewage and rates. The Soft FM costs are estimated at £0.26m this includes cleaning, cleaning materials, cleaning supervision, portering, linen, waste and patient catering.

Overheads

The overhead costs are included at circa 3.5% of total operating costs, at £0.14m.

Capital Charges

The capital charges are estimated at £0.67m per annum, £0.39m for depreciation and £0.28m for PDC. These are calculated on the overall capital cost estimate of £12.96m.

Impairment Charge

The impairment charge is the difference between the full cost and the professional valuation of the scheme. For planning purposes, the Trust applies an impairment charge assumption of 50% for full cost and 25% for new build. The impairment charge reduces the capitalised value of the scheme and therefore the recurring capital charges, with a corresponding charge to the income and expenditure account.

The impairment charge to the income and expenditure account is estimated at £4.5m. This is a technical accounting adjustment, is non-recurring and does not impact on the decision making of the case. Technical accounting items are removed when calculating the adjusted financial performance.

3.2.1 Non-Recurring / Transitional Costs

The non-recurring (NR) costs have now been costed in full and phased over a two year period to 2023/24. These costs reflect the phasing of the beds of an increase of +3 in November 2022, a further +7 in March 2023 and +1 in May 2023.
It also reflects the planned recruitment strategy. The total revenue NR costs (excluding the technical impairment) are £1.06m and shown in the summary table 25 below. Excluding the impairment charge, the majority of the costs will be incurred in 2022/23 at £0.9m and further £0.2m is expected in 2023/24. It is assumed that non-recurring investment, as per the revenue, would be funded through an agreed increase in our block income for the relevant financial year(s). Further detail on the monthly phasing is shown in appendix 2.5a and appendix 2.5b attached.

The NR costs were signed off by the Adult Critical Care working group in October 2021.

Non Recurring Cost Schedule

(Table 25)

	2021/22	2022/23	2023/24	
Transitional / Non Recurring Costs	**Total Year 0**	**Total Year 1**	**Total Year 2**	**Total**
	£	**£**	**£**	**£**
Pay				
Project Management Costs				
Project Manager - Band 8b for 18 months (Planned from April 2022 to October 2024)	**0**	**80,644**	**40,322**	**120,966**
Consultant PA time project management support - assumed 0.5PAs	**0**	**6,000**	**0**	**6,000**
Nursing Recruitment Costs	**0**	**0**	**0**	**0**
Overseas Recruitment Costs - assumed 2/3 of total WTEs will be overseas recruits at a cost of £22.4k per WTE	**22,451**	**585,372**	**14,219**	**622,042**
Agency Costs - assumed 1/3 of total WTEs will not be filled at an assumed agency pickup rate of 35% (current rate)	**0**	**51,367**	**105,177**	**156,544**
Supernumery Costs - 50% of local recruited nurses for 6 weeks	**0**	**31,855**	**1,526**	**33,381**
Supernumery Costs - 50% of local recruited nurses for 8 weeks	**0**	**42,473**	**2,035**	**44,508**
1 WTE Band 3 - Additional Resource for Local Recruitment	**2,216**	**24,377**	**0**	**26,593**
1 WTE Band 3 - Additional Resource for Local Recruitment	**2,216**	**24,377**	**0**	**26,593**
Relocation packages and costs for 10% of the 1/3 wte local nursing	**0**	**6,293**	**633**	**6,927**
Other Pay Costs		**0**	**0**	**0**
Removal costs - 1wte Band 2 and 1wte Band 7 (assume 3 weeks for each phase)	**0**	**12,129**	**0**	**12,129**
Non pay	**0**	**0**	**0**	**0**
Storage Costs - purchase 30 crates at circa £30 each	**0**	**900**	**0**	**900**
Total Transitional / Non Recurring Costs	**26,883**	**865,786**	**163,913**	**1,056,581**
Impairment Charge - Technical Item	**0**	**0**	**4,498,501**	**4,498,501**
Total Transitional / Non Recurring Costs	**26,883**	**865,786**	**4,662,413**	**5,555,082**

The assumptions underpinning the NR cost estimate above are as follows:

- Agency costs assumes 35% pickup rate which reflects the actual current pickup rate;
- Each agency nurse requirement is costed at £5.1k which is the difference between the Tier 4 rate at £9.1k per month and a monthly cost of an RN Band 5 at £4k per month;
- The case assumes 100% appointment to substantive posts by November 2023;
- 2 WTE Band 3 administration support for nursing recruitment - 2 separate posts for overseas and local nursing recruitment - assumed required for 1 year from March 2022 to February 2023;

- Assumed that two thirds of the recruits will be from overseas recruitment at a cost of £22.5k per 1wte with an assumed lead time of 6 months. One third of the nurses will incur relocation costs at £5k per wte;
- Department commissioning (removal) costs - assumed requirement is 1wte Band 7 and 1 wte Band 2 for 3 weeks for each phase of opening.

3.2.2 Impact on Primary Financial Statements

The impact of the proposed investment on the Trust's primary financial statements at 2023/24 is referenced in Appendices 2.4a, 2.4b, 2.4c. Table 26 below shows the incremental impact of the revenue costs of £6.5m (recurring) and £1.05m (non-recurring) and the non-recurring technical impairment charge of £4.5m on the Trust wide Statement of Comprehensive Income. As with all the primary financial statements presented, this statement excludes matching funding the Trust is seeking from commissioners.

(Table 26)

Statement of Comprehensive Income and Expenditure - Incremental Bridge	Year 0	Year 1	Year 2
	2021/22	2022/23	2023/24
	£'000	£'000	£'000
BAU Net Surplus/(Deficit)	0	0	0
Increased costs (included assumed impairment)		(2,039)	(5,877)
Non Recurring Costs			
Non recurring costs	(27)	(866)	(164)
Non Recurring costs - Impairment Charge (Technical)			(4,499)
Effeciency savings			0
Capital charges			(670)
Preferred Option Net Surplus/(Deficit)	**(27)**	**(2,905)**	**(11,210)**
Adjust for technical items (exclude impairment charge)	**0**	**0**	**(4,499)**
Preferred Option Net Surplus/(Deficit)	**(27)**	**(2,905)**	**(6,711)**

3.2.3 Efficiency and Productivity Assumptions

The case is planned to improve the overall efficiency of the hospital by ensuring that patients receive their care in an appropriate setting in a timely manner. This is expected to deliver benefits to overall length of stay of both emergency and elective patients and to support referral to treatment and cancer pathways and targets. These improvements will be measured through usual performance KPIs reporting to Division of Surgery Board. A benefits plan is attached in Appendix 2.1 which captures monetisable and non-monetisable benefits.

3.3 Demand and Capacity

The unit demand has seen steady, albeit not sharp, growth over the last 5 years (6.98%).

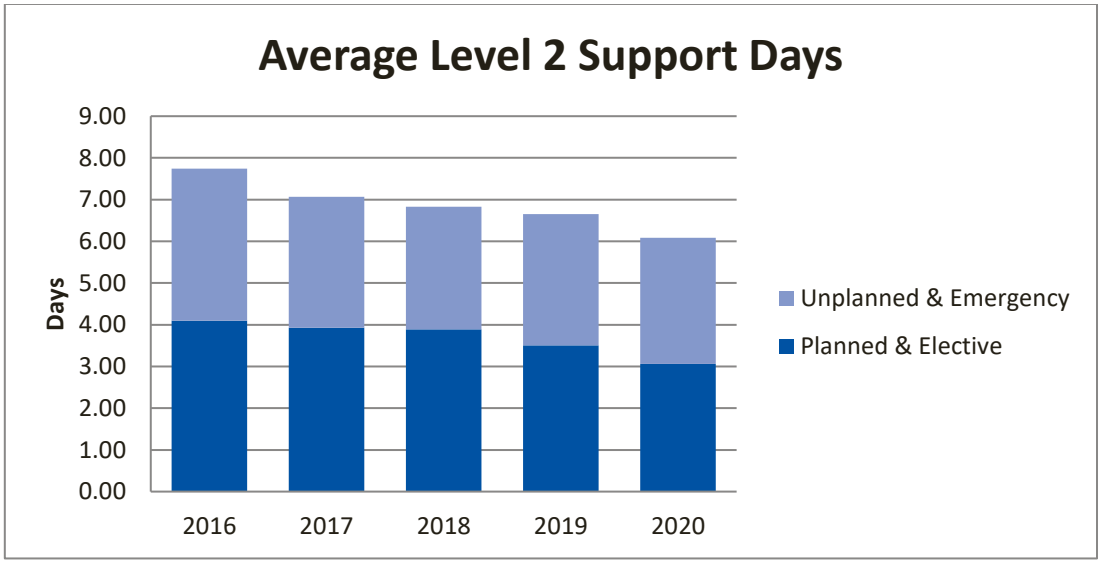
(Table 27 & 28)

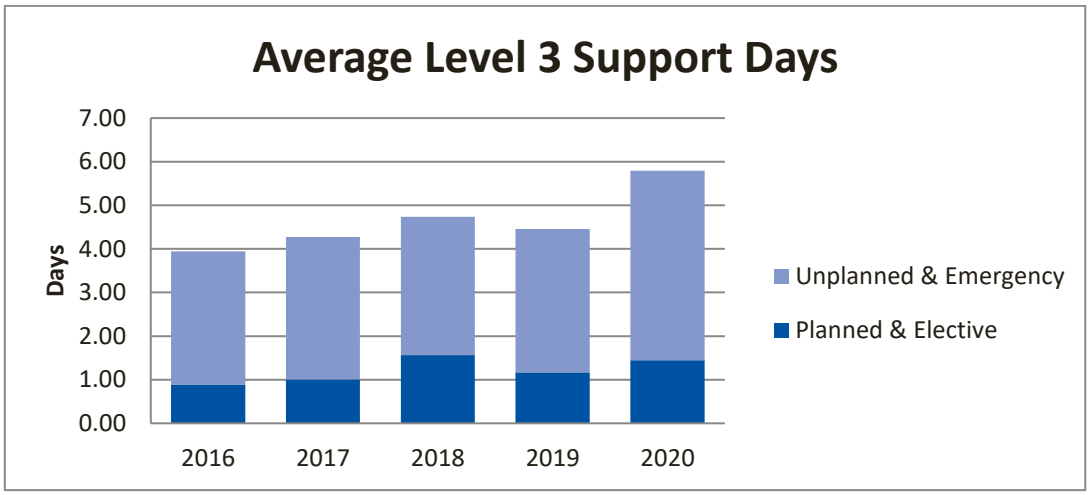
Year	Total admissions	Year on Year growth
2016	1232	
2017	1277	3.65%
2018	1300	1.80%
2019	1318	1.38%
Growth 2016 to 2019:		6.98%

Year	Bed occupancy
2016	86.7%
2017	85.5%
2018	87.2%
2019	91.0%
2020	88.9%

On average, the GICU has seen a marked increase in level 3 patients per day and a slight reduction in level 2 patients per day reflective of the high levels of acuity within the unit. This means that the patients within the available beds are more complex and require more input and support. These figures might have been higher if the unit had accommodated all patients that would have benefited from higher dependency care.

(Figure 8 & 9)



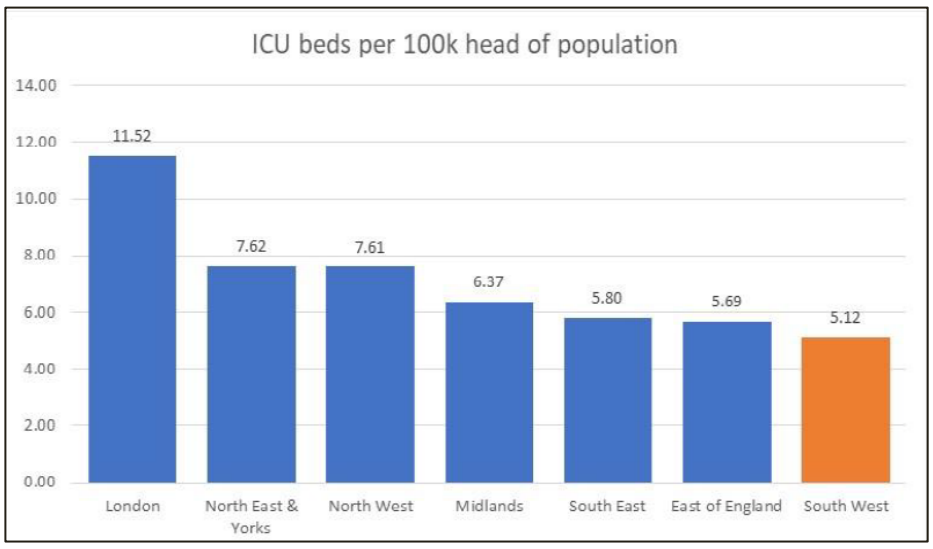


The bed capacity requirements have been considered from two perspectives: a regional, population-based approach based on recommended beds per 100,000 population and a local, 'bottom up' approach, building up the picture based on the four factors driving demand. Both methods lead to similar conclusions in terms of the bed deficit, estimated at 10-18 beds.

Taking into consideration the national picture, the South West as a whole[2] is the least well-provisioned English region in terms of critical care beds per head of population.

The number of critical care beds per 100k population in the South West is 5.12, compared to an average of 7.48 across the other English regions. Provision in London is arguably skewed by the level of quaternary services and inflows from neighbouring regions, so excluding London from the analysis, the average number of critical care beds per 100k population outside the South West is 6.61.

(Figure 10)



The ratio for UHBW is 4.4 per 100k population. NBT are also below the recommended level with 5.9 beds and the combined current position is a follows:

[2] Cornwall, Devon, Dorset, Somerset, BNSSG, Gloucestershire and N. Wilts

(Table 29)

Current position	General critical care beds	Provider catchment population[3]	Beds/100k
NBT	28	472,828	5.92
UHBW	29	652,781	4.44
Combined	57	1,125,609	5.06

An extensive report coordinated by regional Specialist commissioning (Appendix 1.1-1.3) identified a target for the South West region to achieve 6.7 general critical care beds per 100,000 population. Taking the Severn sub –region[4] as a whole, the regional report identified a shortfall of 66 beds in all. In order to achieve the regional aspiration of 6.7 beds per 100k, this would require 75 beds across Bristol and Weston, an increase of 18 beds in total. This investment would bring the region into line with the regional average (excluding London).

(Table 30)

	Critical care beds	Catchment	Beds/100k current	Beds/100k target	Beds required:
NBT	28	472,828	6.56	6.70	31.7
UHBW	29	652,781	4.44	6.70	43.7
Combined	**57**	**1,125,609**	**5.33**	**6.70**	**75.4**

The local approach calculated a shortfall of 10 beds, broken down as follows:

(Table 31)

Area:		**Beds**
Cancellations	Cancellations – UHBW	2.09
Unmet need	#NOF – UHBW	0.1
	Laparotomy – UHBW	0.4
	Unmet need in BRI	2.5
Existing growth	ONS Growth – UHBW	1.0
	OOHCA – UHBW	1.4
	Car -T cells	0.1
	Cardiac	0.6
Future growth / developments	ECMO	1.1
	Gynaecology growth	0.1
	Specialist oncology growth	0.2
	Liver resection repatriation	0.1
	Thoracic transfer & growth	0.2
Total		**9.9**

[3] The provider catchments for NBT and UHBW are larger than the BNSSG locality population, reflecting the tertiary nature of both Trusts
[4] BNSSG, Somerset, Gloucestershire, Bath, Swindon & N. Wiltshire

Based on the demand analysis at a regional and local level, the current footprint and possible expansion of the GICU and predictable workforce ratios the case seeks to request investment of an additional 11 beds.

3.4 Productivity

The implementation of this scheme is intended to improve productivity in terms of how the Trust best utilises the wider bed base, enabling delivery of elective pathways whilst maintaining support for emergency patient admissions. The productivity benefits are further described in the benefits realisation log (Appendix 2.1).

As referenced in section 3, expanding GICU will significantly reduce reliance on Cardiac ICU (CICU) to accommodate non-cardiac patients, thereby improving access for cardiac surgery admissions. We anticipate a regional productivity saving of around 2,000 bed days per annum (equating to £390,000) by reducing in-patient transfers from an average of 7 days to the transfer target of 72 hours.

3.5 Workforce

Critical care services rely on highly trained specialised staff who deliver intensive levels of care. A wide variety of staff support or work in Critical Care; including medical doctors, nurses and allied health professionals.

Because patients in Critical Care Units need constant monitoring and specialist support, clinical guidelines require a high level of expert staff to be available in these units.

Nurses:

According to national service specifications for adult critical care, it is expected that Critical Care Units should have minimum nursing establishments that allow one registered nurse per patient staffing levels for level-3 (intensive care) patients; and one nurse for every two patients for level-2 (high dependency) patients.

Doctors:

Critical care is a consultant-led service, with a consultant in intensive care medicine immediately available to attend patients, and substantial consultant-level input into key decisions on the admission, care and discharge of patients.

Allied health professionals:

Some patients in critical care units will experience extended periods of time when they are immobile and given support to breathe. Allied health professionals play essential roles in ensuring these patients receive the care they need during treatment and recovery. For example:

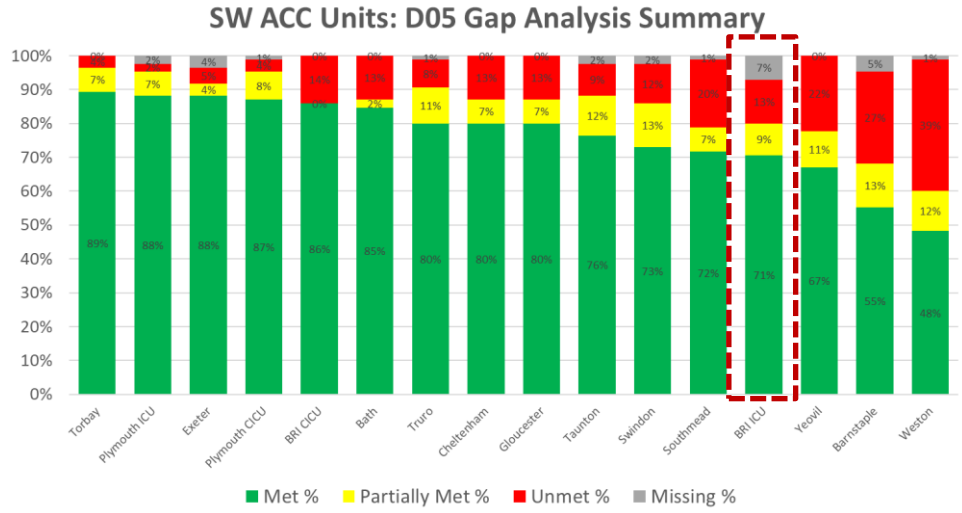
- physiotherapists help maintain or strengthen the muscles of patients who spend long periods in bed
- occupational therapists assess and support the ability of critical care patients to carry out activities of daily living such as bathing and feeding,

- pharmacists provide expert advice on medicines for treatment and recovery
- dieticians support patients' nutritional needs, including through advice on how to feed patients through feeding tubes and drips
- speech and language therapists can assist patients recover their ability to speak after being on breathing tubes or receiving tracheostomies
- psychologists help meet the emotional and psychological needs of patients who have gone through periods of critical illness

The graph below demonstrates the use of GPICS as a metric for performance of standards with the Severn regions unit's performance collected for comparison. The BRI unit is in the bottom quartile for fulfilling these standards, given the size of the unit and complexity of pathways it supports, this has a negative impact on reputation on the unit.

One of the key failures in the BRI is the requirement to be able to admit emergency and elective patients in a timely fashion. We will be unable to meet this without improving our capacity.

(Figure 11)



There is a requirement for the unit to be working towards compliance with NICE Clinical Guideline 83 and Quality Standard 158 and while several cost pressure requests have been put in to redress the deficit as a part of the Division of Surgery Operating Plan, they currently remain unfunded.

The proposed workforce model (including nursing, medical staff, allied healthcare professionals and necessary support staff) is defined the by GPICS and the NICE guidelines. These standards are used to assess and rate the unit and in particular guide CQC assessments. The workforce model has been costed in accordance to the required GPICs, with some benchmarked investment in the required support staffing for the department. The financial assessment of the workforce model is detailed Section 3.2.

Overall, this investment toward the GPICS and NICE standards would:

- Improve patient and family experience on the unit with increase specialist input

- Improve our responsiveness to patients' needs improving rehabilitation and long term recovery outcomes
- Support a minimal length of stay on the unit with a comprehensive multi-disciplinary team
- Ensure the unit is seen as an attractive employer with adequate staffing in all disciplines, improving recruitment and retention
- Improve the units reputational assessment and continued delivery of CQC outstanding rating

There is a local and national shortage in the supply of medical and nursing staff and within UHBW there are high vacancy rates in certain specialisms of nursing. The increased demand for these additional roles will add to the current workforce challenges we face, therefore, pre-emptive planning will be undertaken to manage this workforce increase.

The GICU would aim to undertake recruitment to the posts described but recognise the challenge of this in the context of the current limitations in attracting and retaining clinical professionals. Attempting to address the recruitment without a clear strategy would create significant challenges from an operational perspective as a result in the required step change in specialist staffing levels (84.16WTE Net increase on baseline staffing levels).

The detail of the workforce recruitment strategy is being developed with trust workforce leads in line with the phasing plans. (A draft recruitment phasing plan is included in Appendix 8). A GICU Recruitment task force group will be set up to develop and drive forward the detailed activities which will deliver the workforce strategy. It will be lead and chaired by the Workforce Strategy Project leads and membership will be drawn from members of the ICU Working Group with expert knowledge on the workforce requirements and milestone activities that need to be achieved at each stage of the project. This group will report routinely into the main ICU Working Group.

As a part of the GICU Recruitment task force group, resource will be allocated from the existing talent team to pull together a robust recruitment plan to support the expansion of GICU. The plan will have three key strands for the nursing recruitment plan:

- international
- domestic
- internal

With regards to the international plan, discussions with NHS Professionals (UHBW key supplier) have already commenced, specifically raising anticipated and required international critical care nurse supply and planned lead time for internal training.

For domestic recruitment we will develop a dedicated recruitment webpage to showcase this service expansion and will drive traffic through a robust social media campaign targeting nurses migrating from the large national centres in the post-covid period. An internal recruitment campaign will be lighter touch to avoid destabilisation of the wider workforce.

For all other non-nursing roles in the business case we will develop a lighter touch recruitment plan for these roles given the smaller volumes required, but will keep this under review to address any recruitment challenges as and when they arise.

Timely recruitment into administration and management roles for resourcing, included in both the non-recurring and recurring costings, will be undertaken at the earliest opportunity to enable focussed

support for the GICU Recruitment task force. The expertise of a Talent Acquisition Manager and the wider (Business As Usual) Resourcing Team will also be drawn on to support the delivery of the Recruitment Strategy.

It is expected that it could take up to November 2023 to recruit to all posts, however, benefits could be realised before full recruitment is achieved.

3.6 Support from other Organisations (including Commissioners)

UHBW benefits from a well-established relationship with both local and Specialised Commissioners, which has consisted of regular opportunities to meet and discuss investment proposals. Historically, these regular communications were conducted via the contractual management arrangements with a schedule of regular meetings in place to discuss financial, quality and performance matters.

The need to address the capacity deficit within our BNSSG critical care service has been a longstanding discussion item with Commissioning colleagues with both local and Specialised Commissioners verbally signalling support in principle to address these capacity concerns. A Commissioner engagement log is available in Appendix 9.1. In response to the Covid-19 outbreak, these traditional contractual meetings were stood down in order to free up System capacity and focus resource and effort on dealing with the outbreak and the recovery of services. At the same time, the financial regime changed from the historic activity based Payment by Results (PbR) model to a blended model whereby the majority of the Trust's activity was moved to a block contract and this remains the case for 2021/22. There is a very heavy focus on financial balance being achieved at system level, and there is non-recurrent support in place to cover the on-going costs of the Pandemic, but there is ongoing uncertainty in terms of the level of recurrent funding in place moving into 2022/23. This uncertainty around the future financial regime, coupled with a change in the meeting schedule with Commissioners and the transition from CCGs to Integrated Care Systems, has resulted in a slower pace of decision making within the BNSSG System particularly when it comes to recurrent investments. UHBW is in regular discussions with Commissioners and other System Partners about these challenges via the following Healthier Together Groups: Directors of Finance; Deputy Directors of Finance; System Planners and Deputy Directors of Finance.

More recently, BNSSG Clinical Commissioning Group (CCG) considered support in principle for the clinical case at their Clinical Executive meeting 11th November 2021 with Specialised Commissioning present. Both Commissioners formally approved the clinical case for change and an extract from the minutes of this meeting is included within Appendix 9.2.

The FBC remains subject to ongoing discussions with the local CCG Commissioner and NHSE Regional Specialised Commissioners to consider how the recurring revenue should be funded. The case will also be considered in the BNSSG System and Specialised Commissioning prioritisation processes (currently pending) alongside understanding the BNSSG System 2022/23 funding allocation.

The current uncertainty regarding the medium term revenue financial regime means that securing full recurrent revenue funding beyond 2022/23 is challenging. However, as referenced in section 1.1, the case has had the support of the BNSSG System as a priority bid as part of the H2 Planning Round and Targeted Investment Fund (TiF) process. As of 18th January 2022, we await the formal outcome of our TiF submission. For the purposes of this case however, our working assumption is that this bid does not require national funding and will not be funded nationally. In the event of national funding

becomes available in the future, this would reduce the value of the Trust's cash required by the project and provide a beneficial increase in the Trust CDEL.

Therefore, the FBC cannot at this stage confirm full revenue funding support. This position applies to all service developments, reflecting the general uncertainty in the commissioning landscape and requiring providers to take risk-based decisions.

3.7 Contingencies

The following contingencies have been included in the financial case

- There is no revenue contingency included in the FBC
- Capital – main works cost - contingency at 5% £0.3m
- Capital Equipment – contingency of £0.2m

4 Management case

4.1 Project Plan

The Scheme project plan sets out the proposed timescales for delivery to establish resource inputs, tasks and related target dates. The construction programme included in Appendix 10 provides the detailed critical path through the project.

The construction project has been phased to ensure bed numbers are maintained and the existing department can continue to function. The phasing plan (included in Appendix 5) has been developed in conjunction with the ICU clinical and construction project teams.

Please see the below summary of key milestones:

(Table 32)

FBC Process	April 21 – December 21
GMP received	13th December 21
Review GMP	13th December 21 – 6th January 22
Approval of GMP/FBC through Trust Board Governance	January 22
Construction Contract Approved and Signed	End January 22
Contractor Mobilisation Period	February 22
Construction Period (detail contained within Construction Programme Appendix 9)	March 22 – April 23

4.2 Project Management

Project management support will be provided by both the Trust's Corporate Team and Capital Team, sitting within the Estates & Facilities Division. Recognised Project and Programme management methodology (e.g. MSP and PRINCE2) has and will continue to be provided throughout the lifespan of this scheme.

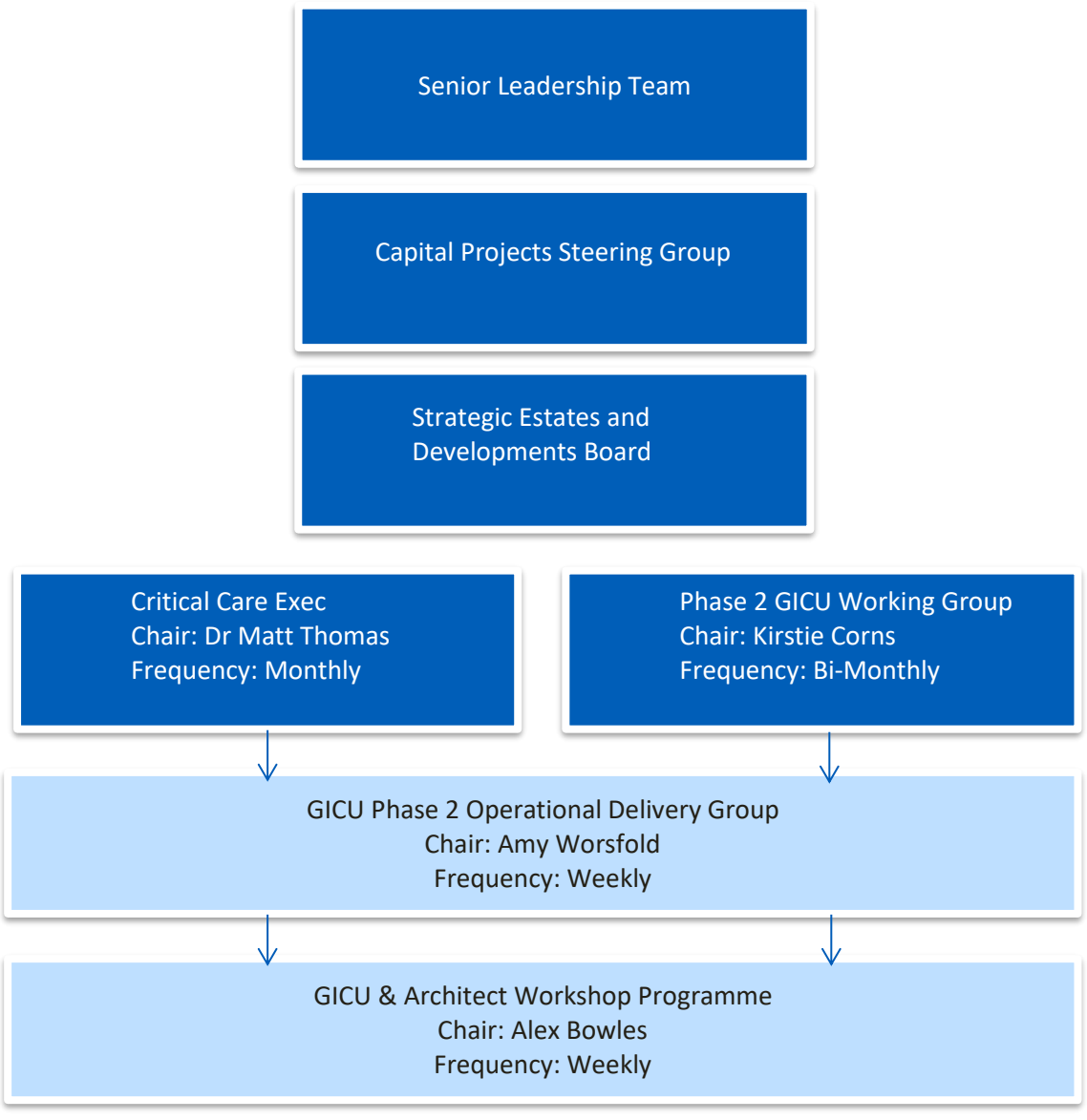
Business case development and coordination has been led by the Corporate Team with support from key stakeholders from Finance, Capital Team and the Surgical Division. The majority of stakeholders have undertaken Better Business Case training, in line with HM Treasury guidance.

The Capital PM will chair the Project Team and be responsible for the oversight of the construction design and delivery. They are a qualified PRINCE2 practitioner and will manage their area of responsibility using formal project management methodology in terms of governance, reporting and risk management through the consistent use of actions and decision logs, formal project team minutes, highlight reporting into Surgery Project Board.

The Capital PM and Planning PM hold joint responsibility for project programme maintenance, updating and changes or additions to design & construction and operational activities respectively.

This Project Team sits specially under the Surgery Project Board in the form of a with a variety of working groups established below, reporting and escalating upwards as required in line with the standardised approved Terms of Reference (Appendix 11) formally approved by Strategic Estates Development Project Board.

The ongoing work is monitored and reviewed via the below reporting structure:
(Figure 12)



4.3 Risk Management

Risks have been identified as a part of the project and have been articulated throughout the narrative of the case. These are monitored via the project risk register (Appendix 12) and Capital Scheme risk register (Appendix 13). The GICU Phase 2 Operational Delivery Group is responsible for the register.

There are two main risks to delivery of the business case at this stage:

Risk nº	Category	Risk description	Mitigation of risk	Risk likelihood after mitigation	Risk impact after mitigation
36	Finance	Financial risk of not securing recurring and non-recurring revenue support from commissioners	Formal Commissioner support for clinical case for change secured November 2021. Other mitigations include: ▪ Securing Commissioner support that the scheme must be prioritised highly against competing priorities within the System ▪ Phasing the introduction of the additional beds in line with recruitment and workforce development. A phased opening with also be supported through incremental confirmation of funding, for example, as with the ECMO service. ▪ Utilising non-recurrent elective recovery funding to support phased opening. Given the relatively low asset specificity of the proposed development, there is also the opportunity to mitigate the revenue funding risk via consideration of alternative, temporary utilisation of the additional beds such as: ▪ Using the beds as Enhanced Care Area ▪ Additional escalation beds to manage increased demand and support recovery of the Trust's elective programme ▪ Decant space to enable other strategically important schemes ▪ Mothballed critical care beds to increase capacity in response to spikes in demand and future Covid surges.	Medium	Medium

Risk nº	Category	Risk description	Mitigation of risk	Risk likelihood after mitigation	Risk impact after mitigation
39	Workforce	Recruitment risk – the case assumes that we will be able to recruit to 100% of the required workforce	▪ Recruitment plan developed with and assured by the Trust's Clinical Talent Acquisition Manager ▪ Planned international recruitment to supply two thirds of the required ICU nurses with the remaining third coming from internal movement and the domestic market ▪ 2 WTE Band 3 administration support for nursing recruitment included within the non-recurrent cost schedule to support recruitment drive ▪ Phased recruitment plan based on phasing of build i.e. not all 11 beds come on board at the same time.	Medium	High

4.4 Communication and Engagement Plan

The GICU Phase 2 Operational Delivery Group recognises that the involvement and support of a range of multi-disciplinary staff is vital to the success of the FBC, both to determine the requirement and scope of the investment, and also to participate in subsequent stages of planning. The group has identified and involved key stakeholders who have a direct interest in the impact the scheme and upon whom the realisation of benefits from the investment will depend, for example; leading clinicians, nurse managers, Allied Health Professionals, Infection Prevention and Control leads, Estates and Facilities representatives, Manuel Handling experts and Information and Technology leads.

It is vital that all Trust staff who may be affected by the proposed capital investment are consulted and given appropriate opportunities to participate in the decision-making process. The GICU Phase 2 Operational Delivery Group recognise that the realisation of the benefits of a capital investment will be more fully achieved as the staff involved as users of the new facilities participate in the design process. A full and comprehensive communication and engagement strategy for project delivery will follow upon completion of the design phase.

4.5 Post Project Evaluation

The Trust has decided to use the Department of Health P22 Framework for delivery of projects within the Strategic Programme to improve project appraisal at all stages of the project from the FBC through design, management and implementation.

As part of the P22 Framework process a Post Project Evaluation is required to be undertaken and reported internally and to DoH P22 team.

4.6 Impact assessments

In addition to the QIA, the following impact assessments have been completed and can be located within the appendices:

- Appendix 14 – Equality Impact Assessment Screening Tool
- Appendix 15 – Sustainability Impact Assessment
- Appendix 16 – Carbon Assessment Tool

5 Recommendations

- It is recommended to Trust Board that the Full Business Case (FBC) for the preferred option to create additional 11 adult critical care beds at the BRI campus is approved and that the planned expansion is delivered in a phased manner, to enable the required building works and staff recruitment to be completed.

Appendices

Appendix 1 – South West Region Critical Care Capacity and System Operation Final Report (including regional benchmarking data)

App 1.1 NHSE_SW_Region_CC

App 1.2 NHSE_SWRegion_Data

App 1.3 NHSE_SWRegion_ICU

Appendices 2.1-2.5 – Financial Case

App 2.1_Finance_Benefits a

App 2.2_Finance_Full equipment schedule_(

App 2.3_Finance_Full revenue costing_phas

App 2.4a_Finance_Incr_SoC

App 2.4b_Finance_Incr_SoF

App 2.4c_Finance_Incr_SoC

APP 2.5a_Finance_Monthly

APP 2.5ab_Finance_Monthl

Appendix 3 – Quality Impact Assessment

App 3 Draft_QIA_GICU2 20.0

Appendix 4 – Development of Options

App 4 Development of options_GICU2 19.0

Appendix 5 – Construction Phasing Plan (including high Level Drawings)

App 5 Construction Phasing Plan_GICU2 1

Appendix 6 – Archus Report

App 6 Archus Report Oct21_GICU2 19.01.22

Appendix 7 – South-West Critical Care Network: Peer Review Report

App 7_SW_CCNetwork Pee

Appendix 8 – Phased Recruitment Plan

App 8 Phased_Recruitment_F

Appendices 9.1-9.4 – Commissioners Engagement

App 9.1 Commissioner Engag

App 9.2 BNSSG_CCG_ClinicalEx

App 9.3 Letter to Commissioners 1June

App 9.4 Letter to Commissioners 1JDec

Appendix 10 – Construction Programme Plan

App 10 Construction Programme Plan_GICU

Appendix 11 – ICU Working Group Terms of Reference

App 11 ICU Working Group TOR_Apr21_GIC

Appendix 12 – ICU Working Group Risk Register

App 12 ICU_Working_Group_R

Appendix 13 – Capital Scheme Risk Register

App 13 Capital Scheme risk register_C

University Hospitals Bristol and Weston NHS Foundation Trust

Appendix 14 - Equality Impact Assessment (EIA) Screening Tool

Name of the Proposal: *General Critical Care Unit Refurb and Extension*

What is the main purpose of the Proposal? *To expand the current GICU by an additional 11 beds.*

Who is it likely to have an impact on? (Please circle or tick all that apply.) Staff / Patients / Visitors / Carers / Other – *ALL*

Could the Proposal have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		X	The expansion of critical care beds would support all adults regardless of age
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	The expansion of critical care beds would support all adults regardless of other disabilities
Gender reassignment		X	The expansion of critical care beds would support all adults regardless of whether they are transitioning or transitioned
Pregnancy and maternity		X	N/A
Race (includes ethnicity as well as gypsy travelers)		X	The expansion of critical care beds would support all adults regardless of race
Religion and belief (includes non-belief)		X	The expansion of critical care beds would support all adults regardless of religion or belief or no belief
Sex (male and female)		X	The expansion of critical care beds would support all adults regardless of sex
Sexual Orientation (lesbian, gay, bisexual, other)		X	The expansion of critical care beds would support all adults regardless of sexual orientation
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		x	The expansion of critical care beds would support all adults regardless of social status
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	The expansion of critical care beds would support human rights by providing dignity and respect for the most seriously ill patients in the

			hospital and possibly add years to life

You will need to ask yourself:
Will the Proposal create any problems or barriers to any community or group? NO
Will any group be excluded because of this Proposal? NO
Will the Proposal result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment (Form B).

Could the Proposal have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?	X		The expansion of critical care beds would support all adults from all groups
Will it help to get rid of discrimination?	X		The expansion of critical care beds would less discrimination in service provision to some extent
Will it help to get rid of harassment?		X	Unknown
Will it promote good relations between people from all groups?		X	Unknown
Will it promote and protect human rights?	X		The expansion of critical care beds would support human rights by providing dignity and respect for the most seriously ill patients in the hospital and possibly add years to life

On the basis of the information / evidence so far, do you believe that the Proposal will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact						**Negative Impact**
Significant	Some	Very Little	X None	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: 17th November 2021
Person completing the assessment: Trust Equality and Diversity Lead
Person responsible for the Proposal: Dr Matthew Thomas & Amy Worsfold

Appendix 15 – Sustainability Impact Assessment

App 15 Sustainability Impact Assessment_GI

Appendix 16 – Carbon Assessment Tool

App 16 Carbon Assessment Tool_GICI

Appendix 17 – Proceeding at risk SBAR

App 17 Proceeding at risk SBAR Nov21_GI

Appendix 18 – CAR-T SBAR

App 18 CART SBAR_GICU2 19.01.22.

Bibliography:

A. Service Specifications Service Specification No. (n.d.). [online] . Available at: https://www.england.nhs.uk/wp-content/uploads/2019/05/Adult-Critical-Care-Service-Specification-FINAL.pdf. [Accessed 26 Jul. 2021].

British Medical Association (2021). Rest, recover, restore: Getting UK health services back on track. [online] Available at: nhs-staff-recover-report-final.pdf (bma.org.uk) [Accessed 26 Jul. 2021].

GUIDELINES FOR THE PROVISION OF INTENSIVE CARE SERVICES Intensive Care Medicine. (2019). [online] . Available at: https://www.ficm.ac.uk/sites/default/files/GPICs-v2.pdf. [Accessed 26 Jul. 2021].

Harris, S., Singer, M., Sanderson, C., Grieve, R., Harrison, D. and Rowan, K. (2018). Impact on mortality of prompt admission to critical care for deteriorating ward patients: an instrumental variable analysis using critical care bed strain. Intensive Care Medicine, [online] 44(5), p.606. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6006241/ [Accessed 26 Jul. 2021].

Howell, B.A.M. (2021). Battling Burnout at the Frontlines of Health Care Amid COVID-19. AACN Advanced Critical Care, pp.e1–e9.

Imperial News. (n.d.). Many ICU staff have experienced mental health conditions in COVID-19 pandemic | Imperial News | Imperial College London. [online] Available at: https://www.imperial.ac.uk/news/226513/many-icu-staff-have-experienced-mental/ [Accessed 26 Jul. 2021].

www.ons.gov.uk. (n.d.). Population projections for local authorities - Office for National Statistics. [online] Available at: Population projections for local authorities: Table 2 - Office for National Statistics. [Accessed 26 Jul. 2021].

Patient and public participation in commissioning health and care. (n.d.). [online] . Available at: patient-and-public-participation-guidance.pdf (england.nhs.uk) [Accessed 26 Jul. 2021].

Priestap, F.A. and Martin, C.M. (2006). Impact of intensive care unit discharge time on patient outcome. Critical Care Medicine, 34(12), pp.2946–2951.

Vollam, S., Dutton, S., Lamb, S., Petrinic, T., Young, J.D. and Watkinson, P. (2018). Out-of-hours discharge from intensive care, in-hospital mortality and intensive care readmission rates: a systematic review and meta-analysis. Intensive Care Medicine, 44(7), pp.1115–1129.