

D050-1 Ascent Detailed Business Case Lite NORS Workforce Transformation Board – Scout Function

PORTFOLIO/PROGRAMME	ODT	SUBMISSION BOARD	ODT CPB
SRO NAME	Karen Quinn	DATE OF MEETING	12/03/18
ACCOUNTABLE EXECUTIVE	Sally Johnson	AUTHOR/ROLE	John Stirling

To commence "Initiation" stage label as "OBC" To commence "Delivery" stage label as "DBC"

PURPOSE – approval of Projects Outline/Detailed Business Case

£9.4m	Project Budget
Standard	Project Size
<x>	Prioritisation score
18-24 Months	Project Duration

APPROVAL AUTHORITY – approval is required from the following :	✓	Approval date
SMT		
Directorate Change Portfolio Board		
WFTB	x	28/02/2018

1 EXECUTIVE SUMMARY

A brief outline description of the project; option plus recommended option and financial position.

This report summarises the findings and recommendations of the National Organ Retrieval Service (NORS) Workforce Transformation Board (WFTB).

The WFTB defined:

1. the functions of the scout
2. the attendance criteria
3. the training and competencies required

and explored various workforce and delivery options.

Recommendations are:

- Establish a national scout service utilising non-medical clinical practitioner from the existing cardiothoracic NORS workforce
- Set down the functions of the scout to incorporate initial donor assessment, a number of clinical interventions and on-going donor optimisation and management
- Set an attendance criterion to maximise the potential for heart donation.
- That there should be developed a national scout training program led by a national education faculty.

2 BACKGROUND

Describe what the drivers are behind the project being started, the problem to be solved ,approach, summary of the current/future state

An external review of the Scout Pilot and Scout II studies was carried out between 2013-14 and 2015-176 and the subsequent report, published in 2017, recommended that a national donor management service should be implemented, but there were no specific recommendations regarding who or how this would be delivered.

A sub-group of the NORS Workforce Transformation Project Board (WFTB) was established with the aim of defining the potential options for delivery, taking into consideration attendance criteria, required functions and competencies, before recommending a preferred option.

The sub-group was chaired by Mr Steven Tsui (Chair of the Cardiothoracic Advisory Group) and membership was drawn primarily from UK Cardiothoracic transplant centres plus representation from an abdominal centre nominated by the National Retrieval Group (NRG), and representation from NHS Blood and Transplant, including a Regional Manager and a Clinical Lead for Organ Donation

The sub-group primarily focused on developing a sustainable early donor management service that would maximise the potential for heart donation; this included scout functions, attendance criteria and recognition of training and competencies.

Additionally, they explored the potential to develop this function in the future to include optimisation of some abdominal-only donors and for the scout to manage DBD donors in the operating theatre during multi-organ retrievals, thus making NORS independent of donor hospital anaesthetists.

The Scout sub-group report, findings and recommendations were approved by the NORS WFTB and are detailed in this paper.

The Scout sub-group recommended the following:

1. Scout Functions

The sub-group agreed that the functions of the scout incorporate initial donor assessment, a number of clinical interventions and on-going donor optimisation and management. The scout also has a key role in communication between the referring hospital staff, Specialist Nurses in Organ Donation (SNODs) and staff from the recipient hospitals, ensuring that accurate and timely information is available to assist in clinical decision making. The agreed recommended functions are summarised in Table 1 below.

Table 1:

Initial Donor Assessment	Check completeness of documentation including blood test results and results of other investigations
Procedures	Peripheral IV line, central IV line, arterial line, fiberoptic bronchoscopy, pulmonary artery catheterisation (SwanGanz), trans-oesophageal echocardiogram
Donor Management / Optimisation	Thermodilution cardiac output monitoring, fluid management, ventilation and airway management, haemodynamic management and use of vasoactive drugs, urine output management
Communication	Donor ICU staff, SNOD, NORS teams, recipient centres
Management of Donor in Theatre	Management of donor during transfer from ICU to theatre and maintenance of donor during organ retrieval – freeing donor hospital of requirement to provide Anaesthetist
Education / Professional Development	Work in collaboration with the intensive care community to support education of SNODs, donating hospital staff, NORS and other professionals on donor assessment, optimisation and management
Audit and Research	In collaboration with Intensive Care clinicians, support relevant audit and research functions in donor assessment, optimisation and management

These interventions and processes can be extended in the future to include management and optimisation of abdominal-only donors if required.

The sub-group acknowledged that ability of the scout to independently manage the donor during transfer from ICU to theatre and during the organ retrieval procedure is out of scope for this report but recognises this capability as a key benefit as it provides consistency of care for the donor during the whole process. This should therefore be a recommended part of the role as it relieves the pressure from the referring hospital to provide an anaesthetist and potentially minimises any delays between organ acceptance and organ retrieval. This approach was supported by the National Organ Donation Committee.

2. Attendance Criteria

The sub-group agreed that to maximise the benefit of a national scout service, all potential adult DBD donors in the UK who meet the criteria for heart donation should be attended by a scout. Donation following circulatory death (DCD) is excluded as NORS should not be involved in patient care until after death has been confirmed.

To ensure that the scout can function effectively once they have arrived at the donor, only potential DBD donors within three hours' road travel from a scout base should be attended by a scout.

The attendance criteria recommended by the sub-group are summarised as follows:

- Consent/authorisation has been obtained for donation of heart
- Donor age less than 65 years
- Donor height equal to or greater than 145cm
- No history of previous cardiac disease
- No evidence of previous cardiac surgery or interventions
- Referring hospital within three hours road travel of scout base

3. Training and Competencies

The sub-group recommends that a national competency-based training programme is developed, modelled on existing local training programmes.

To achieve this, the sub-group recommends that a national faculty should be established, made up of Surgical and Intensive Care Doctors who are expert in donor assessment, management and optimisation.

The sub-group recommends that validation of the Scout Training Program should be sought from bodies such as the Royal College of Anaesthetists and/or Society of Cardiothoracic Surgeon as formal recognition will add credibility and value to the role. The cost of validation will need to be explored.

Incorporating an academic component to training was recognised by the sub-group as advantageous but not an absolute requirement. It potentially makes the role more attractive but is likely to require longer training period and may also increase cost.

Appraisal of workforce options to fulfil the scout function

Having defined the function, attendance criteria and the training/competencies required of the scout function, discussions took place as to which professions could deliver this role.

1. *Clinical Fellow from Cardiothoracic NORS team:*

Although a number of NORS teams utilised Surgical Clinical Fellows to undertake scouting during the pilot phases, the sub-group recognised that this would not produce a sustainable or reliable service. Scouting was felt to have a negative impact on the training of surgical fellows as providing this service significantly limited their exposure to elective and transplant surgery which made scouting unpopular amongst middle-grade trainees. This was recognised from the feedback in the Scout survey and could lead to problems with recruitment, retention and rota sustainability.

2. *Donor ICU Clinician:*

It was recognised by the sub-group that although the clinical skills and specialist equipment required for complex interventions and manouvers for scouting does exist in a limited number of large teaching hospitals, the majority of referring ICU's do not possess the necessary skills and equipment to support donor scouting independantly. It was also recognised that it is not possible or desirable for most referring ICU's to train and maintain the competence of their own clinicians to undertake scouting based on a relatively small number of potential DBD donors per annum.

3. *Specialist Nurse in Organ Donation:*

The current role of the SNOD was assessed for its suitability to deliver the scout function.

The sub-group acknowledged that as most SNODs have a clinical background in critical care, they could be trained to undertake the scout function. However, the sub-group did feel that when donor management was added to their existing responsibilities, despite the HUB taking on offering responsibilities their workload would remain challenging.

In addition, due to the size of the overall SNOD workforce it was deemed less practicable for all SNODs to be trained and maintain competence based on the skillset required to deliver this developing specialist role. (e.g swann ganz catheterisation procedure)

However, the sub-group acknowledged that there could be potential for the Organ Donation Service Team workforce to be restructured to undertake more specialised duties, such as the Specialist Requester role which has been successfully piloted, but this was not explored by the sub-group.

The potential to bring this function in-house was discussed at the Organ Donation Workforce Stategic Planning Workshops in January 2018 where a willingness to bring this initiative in house was expressed and discussions took place about how the scout function could be developed and implemented in a similar way to the Specialist Requester role. The longer term vision would be to develop this role as a highly specialised clinical role working in strong collaboration/ partnership with the cardiothoracic transplant units.

4. *Dedicated Non-medical clinical practitioner from NORS*

A number of teams have utilised this approach during the pilot phases, most notably in Papworth, Birmingham and Manchester with the use of Donor Care Physiologists (DCPs). These practitioners are trained as expert in all the competencies required of the scout. Given the current frequency of retrieval activity and the fact that cardiothoracic NORS teams work a week on/week off rota, non-medical clinical practitioners based in a NORS centre with exposure to routine and complex cardiothoracic surgery will have ample opportunity to acquire and maintain the relevant skills and competence.

Summary of Workforce Options

The sub-group agreed that Clinical Fellows from Cardiothoracic NORS teams and Donor ICU Clinicians were not favourable options and were disregarded.

The sub-group agreed that the scout functions should not be added to the existing functions of SNODs but scouting could be undertaken by this staff group should a specialist role be developed to fulfil this function.

The sub-group therefore recommends a dedicated non-medical clinical practitioner from NORS as the preferred workforce model for the delivery of the scout function.

Current State	Target State
People	
There is broad support from within the Donation and Cardiothoracic communities regarding the introduction of the Scout function but there is currently no national program to support this. Some Cardiothoracic NORS teams provide a scout service on an ad-hoc basis using a variety of personnel. This produces	To provide a national scout service for the UK where there is consistency in the availability, competence and training of the personnel fulfilling this function.

inconsistencies and variability across the UK in the ability to provide a scout.	All scout teams will adhere to a national protocol for scouting which includes donor criteria and specific duties to be carried out.
Process	
Donor management is not standardised or routinely undertaken for potential heart donors.	Optimal Cardiothoracic donor management processes are clear and consistently undertaken, to improve the number and quality of hearts available for transplant, thus maximising the potential for donation.
There is often insufficient data available to heart transplant centres, which leads to a limitation in utilisation because of hearts being declined due to uncertainty of the organ quality.	Heart transplant centres are provided with improved data regarding the quality of the heart available for transplant, which will minimise risk and maximise utilisation.
Technology	
Current information technology systems do not support the effective provision of information to inform heart transplant centres' ability to make clinical decisions regarding organ quality, resulting in a negative impact on organ utilisation.	Improved and enhanced quality of information available to provide reassurance to heart transplant centres regarding organ quality which underpins clinical decision making allowing maximum utilisation
There is a variability in availability of equipment in referring ICU's to perform specialist diagnostic procedures such as Transoesophageal echocardiogram and cardiac output monitoring	All scout teams will provide all equipment and consumables to support specialist diagnostic procedures and interventions.

3 STRATEGIC ALIGNMENT

How the scope of the proposed project/bids fits within DH/NHSBT's strategy; what is needed and why

This project is aligned with the following aims within the NHSBT strategy:

'ensure every donor's care, prior to retrieval, optimises organ quality'

This will be delivered through the introduction of this dedicated scout function, which will provide optimum donor management for potential cardiothoracic donors.

'increase the number and quality of organs that can be retrieved from both DBD and DCD donors'

This will be delivered through the dedicated scout function for multiorgan DBD donors

'review and improve the workforce, IT, systems and processes which operate throughout the donation and transplant pathway'

This will be delivered through work aligned to ODT Hub and the donation pathway review, via enhancement of information available to heart recipient teams.

4 KEY STAKEHOLDERS

Clinical; Communications; Regulatory (e.g.MHRA)/Accreditation(e.g. RCI); DH, etc

External Clinical – NORS Clinical Leads, Perioperative leads and all NORS teams.

External Non-Clinical – Transplant Managers, UK Health Departments, Professional training and accreditation bodies

Internal Clinical – National Retrieval Group, Clinical Retrieval Forum, Cardiothoracic Advisory Group ; National Organ Donation Committee, Quality Assurance

Internal Operational - SNODs ; Commissioning ; finance, HR, Stats and Audit, Procurement

5 BENEFITS/DISBENEFITS (see Appendix A for Benefits Realisation Plan)		
Financial Benefits	Anticipated Value (£k)	Anticipated Realisation Date
1.		
2.		
3.		
Non Financial Benefits	Anticipated Value & Measure (specify e.g. %)	Anticipated Realisation Date
Maximise the number and quality of hearts available for transplant	Data from the Scout pilot suggested there was a strong association between the presence of a Scout and a 15% - 20% increase in hearts transplanted in comparison to non-scouted donors.	2020
Introduction of targeted donor assessment using highly specialised techniques allowing optimisation of donor organ management.	Accurate and timely clinical information is available to recipient centres increasing enhanced decision leading to improved organ quality and recipient safety.	2020
Improve the ability to adopt new process and procedure changes across NORS teams through the introduction of standard operating procedures	Improved consistency of donor management and optimisation allowing for key performance indicators to monitor quality.	2020
Improve engagement with referring hospitals through enhanced support in donor optimisation and freeing ICU of requirement to provide intensive clinical support.	Reduced burden on referring ICU and clinicians leading to improved referral rates and enhanced support for training ICU clinicians in donor management and optimisation.	2020
Ability of the scout to independently transfer donor from ICU to theatre and manage donor during organ retrieval procedure will free referring hospital of requirement to provide an anaesthetist thus reducing potential delays and streamlining donation pathway.	Reduced burden on referring hospitals and minimise delays in donation pathway. Retrieval surgery takes place at clinically optimal time.	2020
Dis-Benefits	Anticipated Impact	Anticipated Realisation Date
Impact on mobilisation of NORS teams	Options A,B and C all had the potential to impact on availability of NORS teams as	

	mobilisation of the Scout would render the remainder of the NORS team unavailable. This would impact approximately 4% of potential donors if the preferred delivery option was adopted.	
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6 OPTIONS CONSIDERED	
Option Title	Description / Cost of option / Primary Benefit
<p>Option A: The organ preservation practitioners from the three on-call cardiothoracic NORS teams undertaking the Scout functions in addition to their existing function.</p>	<p>This model will have all NORS teams participating in scouting on alternate weeks, mirroring the NORS on-call rota detailed in Table 2. This model will ensure that three scouts are on-call at all times. The primary benefit of this option is that it is the cheapest at £0.767M in year one rising to £1.134M in year five.</p>
<p>PREFERRED OPTION</p> <p>Option B: The organ preservation practitioners from the three on-call cardiothoracic NORS teams undertaking the Scout functions in addition to their existing function and the organ preservation practitioners from the off-call NORS teams undertaking only the scout function.</p>	<p>This model will have all NORS teams participating in scouting on a 24/7 basis. This model will ensure that six scouts are on-call at all times. This option provides the best coverage in terms of number of potential donors and geography. The cost of this option is £1.627M in year one rising to £2.012M in year five. This option has minimal impact on the ability to mobilise NORS teams.</p>
<p>Option C: The organ preservation practitioners from the three on-call NORS team undertake the Scout functions in addition to their existing function and one organ preservation practitioners from one of the off-call cardiothoracic NORS teams undertake scout-only function.</p>	<p>This model will have all NORS teams participating in scouting on a 2/3 rotational basis. This model will ensure that the minimum optimum number of four scouts are on-call at all times. The cost of this option is £1.053M in year one rising to £1.427M in year five. This model has significant negative impacts on the ability to mobilise NORS teams if the scout is called out.</p>
<p>Option D: A commissioned Scout service provided by a workforce independent of NORS but commissioned from the NORS teams.</p>	<p>This option ensures the minimum optimum number of four scouts would be on-call with all six NORS teams providing cover on a rotational basis. This option has no negative impacts on the ability to mobilise NORS teams but coverage will be variable on a week to week basis dependant on the geographical location of the scouts on-call. The cost of this option is £2.12M in year one falling to £2.013M in year five.</p>

Option E: A scout service provided directly by NHS Blood and Transplant	During the earlier workforce appraisal, it was acknowledged that the scout function could be directly provided by NHS Blood and Transplant by specially trained personnel based within the Organ Donation Services Team, similar to the Specialist Requestor role. This has been modelled as a comparator to the commissioned options. The cost of this option is £2.135M in year one falling to £2.031 in year five.
Option G – Do Nothing	This would be contrary to the advice of the external review of the pilot with no clear evidence for doing so. No additional cost, but also no increase organ availability or utilisation realised. This option would be not be welcomed by the Donation or Cardiothoracic communities

7 OUTCOME OF OPTIONS APPRAISAL

Outline the reason for selecting the preferred option.

The sub-group recognised that the scout functions could be delivered by either incorporating the into the existing cardiothoracic NORS workforce model or by the establishment of a new workforce working alongside NORS.

The current cardiothoracic NORS structure can be summarised as six teams each consisting of lead and assistant surgeons, scrub practitioner and an organ preservation practitioner/transplant technician.

The current cardiothoracic NORS rota has provision for three teams to be available at all times with each NORS team providing on-call cover on a week-on and week-off rota basis as illustrated in Table 2 below.

Table 2

	On-call	Off-call
Week 1	Glasgow, Manchester, Papworth	Newcastle, Birmingham, Harefield
Week 2	Newcastle, Birmingham, Harefield	Glasgow, Manchester, Papworth

The sub-group recognised that the organ preservation practitioner role could be developed to incorporate the scout functions. This would require existing practitioners to complete additional training and competencies for the additional functions. It is the opinion of the sub-group members that the addition of these new competencies will require the Agenda for Change pay scale banding for the organ preservation practitioners to be increased from the current band 5 to band 7.

Statistical modelling of the options was undertaken to establish the optimum number and location of Scouts and any potential impact on the mobilisation of NORS teams.

It was established that 4 scouts could provide cover for up to 94% of DBD potential donors (rising to 96-100% for 6 scouts and dropping to 76% for 3 scouts). The sub-group therefore recommends that a minimum of four scouts is required to be on call at any time to provide adequate coverage of potential donors.

Based on the distribution of DBD donors during 2016-17, locating scout teams at Glasgow, Birmingham, Manchester and Harefield would provide the greatest geographical coverage.

The sub-group appraised the above delivery options by rating each against 18 agreed measures (appendix two), including coverage of potential donors, overall costs, impact on other services such as NORS and ODT Hub, likely attractiveness of the role to the workforce and availability of current and future workforce.

Objective data was used where it is available (such as costs and statistical modelling) to inform ratings. In the absence of objective data, a subjective rating approach was utilised with the majority view of the sub-group members informing final scores.

Each measure listed has been given equal weighting, by summing grades to give an overall score. This means that the importance of one measure over another has not been accounted for, and assumes each measure has equal importance.

For subjective rating, the views and opinions of each sub-group member was given equal weight to the final score against each measure.

Each option was awarded points based on perceived favourability against each measure (1 point for most favourable to 5 points for least favourable). The most favourable possible score possible therefore is 18 and least favourable possible is 90. As summary of the options rating is summarised in Table 3 below.

Table 3

Option	Score	Summary of rationale
B	29	Offers greatest coverage of potential donors, favourable in terms of availability of existing workforce, ease of ability to recruit, train and retain, frequency of ability to gain and maintain clinical competencies, good relationships with transplant community. Provide opportunities for all cardiothoracic centres to participate in scouting.
C	38	Not as good coverage of potential donors, greater impact NORS unavailability, provides less flexibility.
A	44	Poorest overall coverage as only 3 Scouts available, greatest impact on NORS availability, least flexibility and least attractive to current workforce.
D	48	Limited access to specialist equipment and limited opportunities to gain and maintain competencies. Will require duplication of these equipment in terms of purchase and maintenance. Expensive option
E	51	No access to specialist equipment and limited opportunities to gain and maintain competencies. Will require duplication of these equipment in terms of purchase and maintenance. Limited exposure to organ retrieval and most expensive option.

Option B scored most favourable overall among the sub-group members with options D and E scoring least favoured.

Considering the objective data measures only (cost, impact on NORS and geographical coverage) did not affect the overall final rating.

The sub-group therefore has identified Option B, where the organ preservation practitioners from the on-call cardiothoracic NORS teams undertaking the Scout functions in addition to their existing function and organ preservation practitioners from the off-call NORS teams undertaking only the scout function as the recommended delivery option.

Although Options A and C are the most cost-effective options overall, they were viewed by the sub-group as the less favourable than option B due to the negative impacts on the ability to mobilise NORS teams when the scout is being utilised.

Option B was perceived as the most favourable option by the sub-group as is substantially more cost effective than Options D and E and has significantly less negative impacts on the ability to mobilise NORS teams than Options A and C.

8 PROCUREMENT

Explain the procurement approach taken and list any frameworks.

Options D and E only require the purchase of hardware equipment in year one as the service is separate from NORS and therefore key equipment such as TOE, bronchoscopes and cardiac output monitors would need to be purchased. The projected costs for the preferred options are in Table 4 (financial summary).

9 Financial Summary

Tables below provided by the NHSBT Finance department: Complete for the preferred optio. NOTE: Tolerances should be recorded.

Finance Lead	Belinda Wright
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Financial modelling was undertaken for all potential delivery options. This financial modelling included workforce, transport, consumables, initial training, supervision and appointment of a professional lead for scouts. Costs for the preferred delivery model are laid out below with full caost for all options contained in the attached financial costs tracker.

C030-172 Ascent Business Case Lite Template
NHS Blood and Transplant (NHSBT)

1		Year 1	Year 2	Year 3	Year 4	Year 5	Year 0-5
		2018/19	2019/20	2020/21	2021/22	2022/23	Total
	Total Costs	£'000	£'000	£'000	£'000	£'000	£'000
	Total Capital Costs	0	0	0	0	0	0
	Total Non-Recurring Revenue Costs	-153	0	0	0	0	-153
	Total Recurring Revenue Costs	-1474	-1912	-1935	-1979	-2012	-9312
	Less Non-recurring Savings (from Benefits)	0	0	0	0	0	0
	Less Recurring Savings (from Benefits)	0	0	0	0	0	0
	Less Income Generation	0	0	0	0	0	0
	Total Cash Cost	-1627	-1912	-1935	-1979	-2012	-9465

2		Year 1	Year 2	Year 3	Year 4	Year 5	Year 0-5
		2018/19	2019/20	2020/21	2021/22	2022/23	Total
	Funding Source	£'000	£'000	£'000	£'000	£'000	£'000
	DH Capital Funds	0	0	0	0	0	0
	DH Grant in Aid	0	0	0	0	0	0
	NHSBT Funds	0	0	0	0	0	0
	Reserves/Development funds	0	0	0	0	0	0
	Baseline Budget	0	0	0	0	0	0
	Income Generation	0	0	0	0	0	0
	Other (describe)	0	0	0	0	0	0
	Total Funding secured	0	0	0	0	0	0

3		Year 1	Year 2	Year 3	Year 4	Year 5	Year 0-5
		2018/19	2019/20	2020/21	2021/22	2022/23	Total
	Differential Case	£'000	£'000	£'000	£'000	£'000	£'000
	Base Case (current)						
	Existing recurring costs						0
	Anticipated non-recurring costs						0
	Total Base Case Cash Flow	0	0	0	0	0	0
	Investment Case						
	Non-recurring Costs	-153	0	0	0	0	-153
	Capital Costs	0	0	0	0	0	0
	Existing Recurring Costs						0
	New Recurring Costs	-1474	-1912	-1935	-1979	-2012	-9312
	Capital Receipts						0
	Other (describe)						0
	Total Investment Case Cash Flow	-1627	-1912	-1935	-1979	-2012	-9465
	Differential Cash Flow	-1627	-1912	-1935	-1979	-2012	-9465
	Cumulative Differential Cash Flow	-1627	-3539	-5474	-7453	-9465	-9465
	NPV @ 3.5%						-8,521

9 IMPLEMENTATION

Provide summarised information on the implementation approach.

It is anticipated that it will take approximately 6 months to establish a national competency and training framework for scout and to ensure that all NORS teams have sufficient practitioners in post to train for this function.

Based on the experience of NORS centres who have trained non-medical clinical practitioners to undertake scout functions, an average training time of 12-18 months is required for practitioners to competently and independently fulfil the scout role.

Therefore is anticipated that it will take approximately 24 months to establish a functioning national scout service.

10 KEY DELIVERABLES / OUTPUTS

Key Deliverables, Milestones (M), Outputs (O)	Target Date	Tolerance (if relevant)
M1 – Establishment of a national scout faculty and	April 2018	+/- 3 months
M2 – Commencement of Scout training	November 2018	+/- 3 months
O1 – A national training and competency framework	October 2018	+/- 3 months
O2 – Functioning national scout service established	April 2020	+/- 3 months

11 RESOURCES REQUIRED TO DELIVER THE NEXT STAGE

Provide a summary of the resources required to deliver the next stage (i.e Start-Up, or Initiation - depending on size of project). Summarise the role(s) required, days, availability and expected timescale (date of delivery) to deliver the Project Brief/OBC or DBC/PID.

Resource and Estimated Effort Plan

Resource Role	Name	Capacity to support
SRO	Karen Quinn	Y
Accountable Exec	Sally Johnson	Y
project lead	John Stirling	Y
Subject Matter Expert	Emma Billingham	Y
Subject Matter Expert	Steven Tsui	Y
Subject Matter Expert	Rutger Ploeg	Y
Quality Assurance	Vicky Gauden	Y
Subject Matter Expert	NODC representative	Y
Finance Lead	Belinda Wright	Y
Statistics	Kate Martin	Y
Organ Donation Team	Senior ODT representative	Y

Estimated Project Management Effort Plan

Resource Role	Name	Estimated % Allocation of effort	Capacity to support
<i>Obtain the % Allocation figure by discussing with the Head of Portfolio (HoP)</i>			
Project Manager	National Scout Lead will be responsible for the implementation of the project	100%	Y

12 QUALITY ASSURANCE

If the agreed PRF indicated a change to data or operational processes (critical processes are defined in MPD10) and required a QMS change control to be raised then outline brief detail below and indicate the QMS Change control number raised and agreed QA representative aligned to the work.

QA input may be required to support implementation.

QMS Change Control Number	<nnnnnn>
QA representative aligned to the project.	<enter name>

13. KEY DELIVERY CHALLENGES – RISK / ASSUMPTIONS / ISSUES / DEPENDENCIES /CONSTRAINTS

Overall project risk profile	Comment
Low	There is a planned approach which involves a formation of a training and education faculty who will be responsible for development of a national training structure and competencies and a Standard Operating Procedure. There is with broad agreement among stakeholders regarding workforce and delivery model.

13.1 Risks

	Description of KEY Risks	Consequence	Severity Score	Mitigation Strategy/Owner
1	Stakeholder unrest if preferred delivery model is not adopted	Lack of engagement the Scout resulting in no benefit		Continue to engage and consult widely and closely involve key stakeholders.
2	Failure to train individuals to undertake the Scout function safely or to a high standard	Loss of opportunity to increase potential for retrieval		Utilise existing competency training models to develop a National curriculum and competence based training and accreditation programme
3	NORS teams will be unable to continue to support unfunded scouting	Existing limited scouting will cease resulting in fewer heart donations		Continue to engage with donating ICU's to maximise opportunities for heart donation

13.2 Issues

	Description of KEY Issues	Consequence	Severity Score	Mitigation Strategy/Owner
1	There is no National Scout lead.	Lack of national leadership will result in silo working and variation in practice		Appoint a National professional lead for Scouts within NHSBT.
2	Reliance on Scouts with other clinical commitments results in delays/ disruption.	Work is delayed/ duplicated/ ineffective as clinical practice between providers is variable.		Utilise National professional lead to coordinate training, education and clinical practice
3				

13.3 Assumptions

Include any material impact to NPV from Sensitivity Analysis.

The successful delivery of the preferred model assumes any on-going training and certification elements for Scout function will fall to individual employing organisations to deliver once they become business as usual. This will be underpinned by the national training curriculum, competence and certification framework.

13.4 Dependencies

Include reference to other Directorates that may be impacted.

Delivery of this programme will depend on support from the following teams:

- Statistics & Clinical Studies – support during implementation and ongoing QA
- Organ Donation & Nursing – on-going support from SNOD and wider donation community.
- Procurement – For delivery of new hardware and consumables if required
- Transplant Support Services – Options for making Scout function operational and links to the ODT Hub
- Finance – To review and advise on potential financial implications
- Stakeholder participation – successful Scout service will also depend on robust stakeholder engagement and external experts.

13.5 Constraints

Delivery is dependent on availability of finances. Limited financial support will result in a phased approach leading to delay in realising benefits.

If the project is not prioritised for financial support no benefit to will be realised. is dependant Stakeholder availability and engagement– This is often very limited due to operational and clinical demands on some stakeholders. Successful delivery will depend on engagement from these key stakeholders.

14 OTHER IMPACTS: (High/Medium/Low Impact)

*Consider the level of impact that the Project will have against each of the areas below and comment briefly for high impacts only
Under advice from HoP/AE a more detailed Impact Assessment Form (C010.118) may need to be re-reviewed and added to Appendix C*

Is a PRF Impact Assessment Form (C010.118) included in Appendix C ?

Y/N

Areas		Brief Description (if High)
Estates	H/M/L	
Staff	H/M/L	
Technology / IT systems	H/M/L	
Equality & Diversity	H/M/L	
Privacy / Data Protection	H/M/L	

15. APPENDICES

Reference	File	Commentary
A	<Insert/Object/CreatefromFile/Browse to file/click display as an icon>	Benefits Realisation Plan
B	 DRAFT Scout Business Case Financi	Financial Costs Tracker
C	 Appendix Two- Options rating.pdf	Delivery Options Appraisal

D		
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Document Control

Version History			
Version	Date	Author	Brief Description of Key Changes

Document Reviewed By

Version	Date	Reviewer	Reviewer Role
V2	06/03/18	Emma Billingham	Senior Commissioning Manager
V3	07/03/18	Karen Quinn	Assistant Director, UK Commissioning / Co-Chair, NORS WFTB
V4		Emma Billingham	Senior Commissioning Manager
V4	08/03/18	Karen Quinn	Co-Chair, NORS WFTB
V4	08/03/18	Belinda Wright	Finance Business Partner
V4	08/03/18	Rutger Ploeg	Co-Chair, NORS WFTB
V4	08/03/18	John Forsythe	Associate Medical Director
V4		Vicky Gauden	Quality Assurance

Document Approved by

Version	Date	Approver Name / Body	Approver Role



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