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Generate your options



Start by pinning down the decision, using a problem from your own service.

The problem and current baseline	What you want to achieve, and by when	Who decides, and how

Five ways to vary an option

Change one or more of these to create options that are actually different

Dimension	A · Do minimum	B · Alternative	C · Alternative
Scope Who or what is covered?			
Solution How is the need met?			
Implementation When, and in what stages?			
Delivery Who delivers it, and where?			
Funding Where the money comes from; is it confirmed?			

Quick check: could you defend each of these options, or were B and C added after you had already chosen your answer?

Add more columns if you need them. If you rule an option out, note why, against minimum requirements you set in advance.

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Compare the options and make a recommendation



Agree the criteria before you score. Rate each option against the do-minimum using **++ much better** **+ better** **0 no different** **− worse**, and note the evidence, a sensible range and any assumptions behind each rating.

Criterion	A · Do minimum	B · Alternative	C · Alternative	Evidence and uncertainty
Patient outcomes, safety and quality				
Demand coverage and service capacity				
Workforce and dependencies				
Recurrent annual cost Full cost, not salary alone				
One-off (non-recurrent) cost Set-up, recruitment, equipment, estates				
Implementation time and risks				
Affordability / funding status Confirmed or still to be validated?				
Sensitivity What if key assumptions change?				

Your recommendation

Which option, and why (not simply the cheapest or the biggest)	Assumptions, open questions and what you still need to find out

Watch for: **beds freed ≠ cash saved** · **projected income ≠ confirmed funding** · **full recurrent costs ≠ salary alone**

This is a thinking aid. Larger proposals may need a fuller economic appraisal, so follow your organisation's process.

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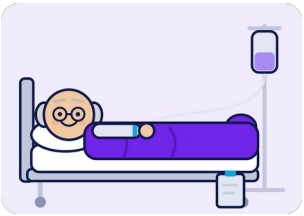
Options worksheet · page 3 of 3 · worked example

A perioperative medical service (fictional)



The problem and current baseline	What you want to achieve, and by when	Who decides, and how
About 300 emergency laparotomies a year. An estimated 35% (about 105) may need specialist perioperative review. Input is currently via ad hoc referral; frailty and delirium care can be reactive.	Every patient identified as needing review is seen within an agreed time of admission or surgery; reduce length of stay towards the national benchmark within 12 months.	Divisional board, using the Trust business case template, in the annual planning round. Finance business partner involved from the start.

Five ways to vary an option

Each option differs in more than its staffing

Dimension	A · Do minimum	B · Alternative	C · Alternative
Scope Who or what is covered?	Estimated patients needing review: about 105 a year	Wider frail emergency surgical cohort	All higher-risk emergency surgical admissions
Solution How is the need met?	Clearer referral pathways and structured risk assessment	Extend existing frailty / perioperative team	Dedicated general surgery perioperative team
Implementation When, and in what stages?	Immediate; no new staffing	Phased over 6 months, evaluate at 12	Full service from day one
Delivery Who delivers it, and where?	Existing staff, structured protocols	ACP-led, weekly consultant input	Daily consultant sessions + dedicated ACP
Funding Where the money comes from; is it confirmed?	Within existing budgets	Divisional cost pressure, with possible NELA best practice tariff income (not yet checked)	Assumes NELA best practice tariff income covers the cost (not yet checked)
Indicative annual cost Illustrative, not a funding source	**~£10k**	**~£80k**	**~£220k**

Next step: take these three options to page 2 and compare them on scope, delivery, implementation, cost and affordability, not just the staffing model.

All figures and the approval route are fictional. 105 is an estimate of patients needing review, not the number of appointments or a payment figure.