York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

25 November 2020

York Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

The programme for the next meeting of the Board of Directors will take place:

On: 25 November 2020

In: via Webex

TIME	MEETING	LOCATION	ATTENDEES
09.30 – 11.00	**Board of Directors meeting held in public**	**Via Webex**	**Board of Directors Members of the public**

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence	Chair	Verbal	-	9.30 – 9.40
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.	Chair	A	7	
3.	**Minutes of the meeting held on 30 September 2020** To receive and approve the minutes of the public meeting held on the 30 September 2020.	Chair	B	11	
4.	**Matters Arising/Outstanding actions** To discuss any matters arising/actions arising from the action log.	Chair	Verbal	-	

Strategic Goal: To deliver safe and high quality patient care

Strategic Goal: To ensure financial sustainability

Strategic Goal: To support an engaged, healthy and resilient workforce

	SUBJECT	LEAD	PAPER	PAGE	TIME
5.	**Chief Executives Update** To receive an update from the Chief Executive • Pandemic Update	Chief Executive	C	23	9.40 – 10.00
6.	**Scarborough Capital Outline Business Case** To confirm options and approve the Outline Business Case	Head of Capital Projects/ Strategic Capital Projects Manager/ Head of Business Development	D	27	10.00 – 10.30
7.	**Quality and Resources Committees** Items for escalation to the Board. • 20.10.20 to receive and note the minutes • to receive and discuss the Escalation Logs	Committee Chairs	 E E1	 197 227	10.30 – 10.50
	Governance				
8.	**Reflections on the meeting** • BAF	Chair	 F	- 231	10.50 – 11.00
9.	**Any other business** • Question to the Board	Chair	Verbal G	- 256	11.00

SUBJECT	LEAD	PAPER	PAGE	TIME
10. Items for information:	Chair			
• Integrated Board Report		*Separate Report*		
• Continuity of Carer Report		H	259	
• Bi-annual Midwifery Workforce Report		H1	265	
• To receive the October & November 2020 Star Awards Booklet		H2	269	

11. Time and Date of next meeting

The next meeting will be held on 27 January 2021 via webex.

Items for decision in the private meeting: - None

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients).

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

Register of directors' interests
November 2020

York Teaching Hospital
NHS Foundation Trust

Additions:

Dylan Roberts, Chief Digital Information Officer
David Watson, Non-executive Director

A

Changes:

Deletions:

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Ms Susan Symington (Chair)	**Non-executive Director—**Beverley Building Society **Director** - Lodge Cottages Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member—**the Court of University of York	Nil
Jenny McAleese (Non-Executive Director)	**Non-Executive Director**—York Science Park Limited **Director**—Jenny & Kevin McAleese Limited	**50% shareholder and Director**—Jenny & Kevin McAleese Limited	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member**—Audit Committee, Joseph Rowntree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Lynne Mellor (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Position with BT (telecom suppliers)
Mr Steve Holmberg (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Dillon (Non-Executive Director)	Nil	LLP—Members Representative	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Prof Matt Morgan (Stakeholder Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Deputy Dean**—Hull York Medical School	Nil
Mr David Watson (Non-executive Director)	Battersea Dogs & Cats Home York University			**Act as Trustee** –on behalf of the York Teaching Hospital Charity		Hull York Medical School via York University
Mr Simon Morritt (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Act as Trustee** Medicinema		Nil
	Other: Member of the Independent Reconfiguration Panel (Independent Committee advising the Secretary of State on contested health service reconfiguration.					
Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Executive)	Nil		Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representative	Nil
Mrs Heather McNair (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr James Taylor (Medical Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Wendy Scott (Chief Operating Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Polly McMeekin (Director of Work-force & OD)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	HR Director—Nightingale Hospital (Yorkshire & Humber)	Nil
Mrs Lucy Brown (Director of Commu-nications)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Dylan Roberts (Chief Digital Information Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 November 2020
Public Board Minutes – 30 September 2020

Present: **Non-executive Directors**

Ms S Symington	Chair – via video conferencing
Mrs J McAleese	Non-executive Director – via video conferencing
Dr L Boyd	Non-executive Director – via video conferencing
Mr S Holmberg	Non-executive Director – via video conferencing
Ms L Mellor	Non-executive Director – via video conferencing
Mr J Dillon	Non-executive Director – via video conferencing
Prof. M Morgan	Non-executive Director – via video conferencing
Mrs J McAleese	Non-executive Director – via video conferencing

Executive Directors

Mr S Morritt	Chief Executive – via video conferencing
Mr A Bertram	Deputy Chief Executive/Finance Director – via video conferencing
Mrs W Scott	Chief Operating Officer – via video conferencing
Mr J Taylor	Medical Director – via video conferencing
Ms P McMeekin	Director of Workforce & OD – via video conferencing
Mrs H McNair	Chief Nurse – via video conferencing
Mr D Roberts	Chief Digital Information Officer – via video conferencing

Corporate Directors

Mrs L Brown	Director of Communication - – via video conferencing

In Attendance:

Trust Staff

Mrs L Provins	Foundation Trust Secretary – via video conferencing
Mrs M Lilley	Deputy COO for Phase 3 Recovery & Winter items - via video conferencing
Mr S Eames	HCV ICS Chair for ICS Item via video conferencing

Observers:

Margaret Jackson	Lead Governor – via telephone conferencing
Sheila Miller	Public Governor - – via video conferencing
Chloe Laversuch	Newsquest Media Group - – via video conferencing

Ms Symington welcomed everyone to the public Board meeting at York Hospital. The meeting was held in public via webex.

20/35 Apologies for absence

No apologies were received.

20/36 Declarations of interest

No further declarations of interest were raised.

20/37 Minutes of the meeting held on the 29 July 2020

It was noted that the minutes of the meeting held on the 29 July 2020 were approved as a correct record.

The Board:

- **Received and approved the minutes of the meetings held on the 29 July 2020.**

20/38 Outstanding Actions

There were no matters arising.

The Board:

- **Noted the action log**

20/39 Staff Story – Physicians Associate Role

Mrs Karen Cowley, Care Group Manager from Care Group 6 provided a presentation on Physician's Associates (PA's), which was deferred from the cancelled March Board due to the start of the pandemic.

There was still some concern that that there were problems retaining graduates locally and it was felt more assurance was required that local jobs were available despite the positive picture presented. There was some discussion about banding of PA's against that of senior nursing roles and where the roles were restrictive and required additional training elements. Mrs Cowley highlighted that further competency frameworks were being developed and that PA's being unable to prescribe was a limiting factor that was being picked up nationally.

It was noted that the bigger problem was a lack of career structure and people in these roles became "stuck" as progression was not clear. It was important for the Trust to sort out the organisational fit and career trajectory of all these enhanced roles.

The presentation was seen as enlightening, but further understanding was required about how this fitted in General Practice. Mrs Cowley stated that PA's spent time with GP practices and held their own sessions working alongside a GP especially in relation to patients with long term conditions. That skill set was brought back into the Trust and used to support surgical consultants as patients often have underlying conditions, however there was still more work to do.

It was anticipated that legislation would be forthcoming and quality assurance of these roles would be provided by the GMC in the next year or so.

Ms Symington thanked Mrs Cowley for the very informative presentation.

The Board:

- **Noted the presentation and supported developments**

20/40 Infection Prevention & Control Update

Dr Damien Mawer, Infection Control Doctor and Deputy Director of Infection, Prevention and Control noted that he had provided a presentation to the Board in January 2020 regarding C Dif. He planned to talk through where the Trust is with C Dif., but also in light of the current climate he will provide an update on the Covid position. Dr Mawer shared a presentation.

Dr Mawer stated that the pandemic had helped individuals engage with, and provided enhanced understanding around, IPC. It had also provided a new focus on cleaning standards and he wished to thank the Domestic Teams who needed to be congratulated on their hard work. The pandemic had also provided an opportunity to convert nightingale wards into side rooms which is a fantastic development and will also further reduce infections. The job now was to ensure improvements are sustained over winter.

Concern was expressed around the current numbers of C. Dif and the need to get antibiotic stewardship back on track. Dr Mawer was asked if there were any themes emerging from the PIRs which the Board needed to know about? Dr Mawer stated that Sepsis Group will focus on staff taking appropriate samples ie: blood, urine - as knowing what the infection was obviously helped with the management. However, the crucial thing was the review of antibiotics and the need for them to be reviewed, were they still appropriate or could treatment be simplified? Other items and trends included commode cleaning and spot check audits. Dr Mawer highlighted the challenges with cleaning the environment as much of the Trust's estate is aging and refurbishment is limited due to financial constraints.

Dr Mawer was asked about Covid transmission within wards including the risks and mitigations and what tolerance levels there are? He stated that social distancing was a concern. It works to limit the virus spread and many elderly patients have worked hard at social distancing in order to stay safe. The Trust is not able to offer the same protection within their bed space. Mitigations include drawing curtains, wearing masks etc, but none of these come without other issues. In regards to tolerance, he noted the Trust was

doing-it's-best in respect of distancing for high risk patients, but it remains a challenge. It is difficult to stop patients sitting in ED if there are no beds in the Trust and it is difficult to create extra beds. Dr Mawer stated that the Trust is doing the same as many other Trusts.

Dr Mawer stated that it was about learning to live **with** the virus and he thought the next 6 months would be difficult with the combined pressures of winter, flu, Covid and that it would be at least another 6 to 9 months before a vaccine was available, but it would also take time to roll that out.

The Board asked whether further developments with IT infrastructure could help the focus on antibiotic stewardship and Dr Mawer stated it could and that this was being looked at.

Ms Symington thanked Dr Mawer for his very helpful and informative presentation and requested a regular 6 monthly update on IPC.

Action: 6 monthly updates on IPC

The Board:

- **Noted the presentation and recognised the hard work being done**

20/41 Chief Executive Overview

The Chief Executive provided an update on the following key areas:

Integrated Care System – Stephen Eames will be joining the meeting later to provide a broader update. Mr Morritt stated that the development of Place was progressing and provider collaboratives would evolve from CCG's. Local level resources would be planned and delivered at a Place level. There is the potential to develop an integrated care vehicle or provider alliance and the first conversations were being held to explore this which included City of York Council, TEWV, GPs and Hill Dickinson.

Board Time Out - The Board time out on the 13 October would be looking at the clinical strategy and developments on the East Coast and also include a Clever Together update.

Race Equality Network - Mr Morritt stated that the Race Equality Network piece should have stated that these roles were interim positions and that these appointments would work through the methodology on how the Network can be developed going forward.

Mr Morritt was asked if the Race Equality Network would link in with other businesses in the region which already have networks set up? It was noted that the Trust is linking in with Hull Trust who are a little further ahead on this and that it was only NHS links being made at the moment.

Ms Symington stated that a NED Development Programme was being set up with other Trusts in the ICS and the University of York and would look at ways of encouraging BAME applicants to NED roles. .

Covid Update – Mr Morritt stated that the Trust had seen an increase in Covid patients which now seem to be levelling out. Mrs Scott highlighted some of the numbers stated that 13 patients up to last night had swabbed positive, but there were 4 other patients being treated as Covid +ve, but who had not yet received results. Aspen Ward at

Scarborough had been changed as part of the Surge 2 Plan and 2 wards in York have been established to treat Covid positive patients. Mr Morritt stated that there had been a slight surge in numbers last week but there does not seem to have been a significant increase. Prevalence in community is causing concern as some communities have particularly high rates, but no additional measures/restrictions have been put in place to date. Mrs McNair added that only half the patients came into the hospital with Covid symptoms and the other half came in for a variety of other conditions, but were positive on testing.

It was noted that the University students in York are back this week and that the Trust is offering a small number of tests to the university, but this is limited. City of York is developing x2 walk-in testing facilities for students which should be up and running in mid-October.

The Board:

- **Received and noted the Chief Executive's Report including the Covid update**

20/42 Phase 3 Recovery

Melanie Lilley joined the meeting.

Mrs Scott wished to highlight the following:

- HCV Phase 3 operational plan, together with supporting narrative had been submitted.
- The plan covered October 2020 to the end of March 2021
- The following was required, plans which delivered 100 % of pre-Covid OPD activity and 90% of elective activity
- Narratives around health inequalities, Mental Health, Cancer and Workforce were included in the paper.
- HCV had provided a response to the People Plan which was in the Board pack.
- The Trust's plan had been built on assumptions and the need to juggle restoring services whilst acknowledging the risks around waiting times, winter resilience and IPC guidance on social distancing
- Acknowledge the impact the guidance is having on capacity and productivity and the number of beds available.

Mrs Scott stated that the table on page 31 represented the improvements shared in July from the initial plan which was the early stages of restoring services and did not meet national requirements, but had forecast 6000 52 week breaches at the end of the year. Current activity levels do not address the backlog. The plan has been through a confirm-and-challenge process with the ICS to look at any other options to plan for more activity or outsource, but funding would need to be secured for any outsourcing. The narrative also summarises risks and mitigation which have been shared by all providers involved.

A further requirement came out on Friday that requested the need to model the impact of a number of different Covid surge assumptions which will be worked through over the next few weeks. It will be about how the Trust can protect beds and what functions can be maintained such as protecting cancer beds, assessing the clinical risk and what this would mean for elective activity. Mrs Scott mentioned the operation Minerva workshop taking place this morning.

Mrs Scott stated one of her concerns was around staffing as the Trust had been able to redeploy staff in the first wave, but unfortunately this would not be possible as the Trust needed to keep as many services as possible going during any further waves. However, obviously at different levels of surge it would be a balancing act between protecting some services like cancer and diagnostics whilst accommodating Covid patients.

It was noted the Quality Committee had also discussed this and wanted to know where the big risks were. It was felt important to sight the Board on the risks and oversight especially in terms of patients waiting a long time, there may be small numbers in some cases, but this could result in harm.

Mr Taylor stated that the Trust was in uncharted territory and needed to manage conflicting risks as things emerged as well as being proactive, for example, with the flu vaccine.

It was stressed that there is a great deal of pressure being applied nationally to maintain performance and prepare for a second wave, but that at certain tipping points maintaining this balance would become increasingly challenging to achieve. .

The Board asked where the risks were being discussed and actions agreed? Mrs Scott stated that the Trust had continued to use the bronze, silver and gold command and control system (although elements have been stepped down over the summer) and this was now being stepped back up. Lessons from the first wave of infection were also being incorporated in risk management and actions.

Staff resilience was questioned in relation to mental health and it was also noted that some patients would also need mental rehabilitation. Mrs Scott stated that staff were tired and there was a level of anxiety from staff who would be required to go back into level 3 PPE if there was another spike: she sought to reassure the board that work was being done with teams to understand and mitigate this.

Mrs McNair stated that things like the lack of adequate rest facilities to enable social distancing was a struggle and that staffing will be the limiting factor in another wave. Ms McMeekin agreed that there was a need for break-out spaces and that sickness and stress were a challenge, together with those needing to take carers leave. She noted that the Trust is constantly reviewing absence rates and learning from what others are doing.

The Board:

- **Noted the delicate risk balancing act that will be required during the winter months**
- **Supported staff and recognised the fragility of staffing**

20/43 Winter Resilience Plan

Mrs Liley provided an overview of the paper which was slightly different to the normal winter plan as it involved planning for Covid, winter, flu, norovirus and BREXIT, all of which added up to increased pressure and risks on services and staff. The plans were built on national expectations and balancing these 5 elements, recognising that the plan will not address any backlog. Mrs Liley highlighted the prioritisation of schemes and funds, noting that there were further schemes available if any more funds are made available.

Mrs Liley stated that schemes being taken forward would maximise flow and discharge and the discharge command centres were working in conjunction with the SAFER refresh. Increasing capacity, critically, was about managing length of stay down so that medically fit patients are discharged. She noted that the Trust is working with the Urgent and Emergency Care Network on patients using 111 and "talk before you walk" which should see a reduction of 20% of unheralded attendances when fully embedded. She stressed that the Trust was heavily reliant on the delivery of some reduction in attendance although this would not necessarily mean a reduction in admissions. Fewer attendances would mean better management of ED.

Mrs Liley stated that it was about understanding seasonal variations and additional bed requirements, and that there was a real level of concern around projections and this creates anxiety in the work force. Quality impact assessments have been done on both sites around easing social distancing. She also noted that operation Minerva was taking place today which looked at how the Trust managed and delivered surges.

Mrs Liley stated that a risk summary had been shared and that she was asking the Board to endorse the plan and expenditure.

It was noted that basically the Trust could not take local action over BREXIT, although Mrs Liley stated that the Trust has a steering group. Mr Bertram stated that most of the work was indeed being done nationally, but the Trust Emergency Planning Officer was part of the local resilience forums. The only red area was around how the Trust would deal with an EU citizen post BREXIT if they needed to access treatment (especially as this could be a massive training issue for finance staff).

The Board:

- **Noted and endorsed the winter resilience plan**

20/44 Integrated Care System Update

Mr Eames firstly wanted to acknowledge the collective leadership shown by the Executive Team of the Trust during the pandemic as he was conscious of all the time and effort required to lead through this as well as all the other things required of the team.

Mr Eames made the following points:

- The focus required on winter and restoration work
- The increase in the numbers waiting for treatment
- The increasing threat of Covid
- BREXIT with particular focus on the ICS port areas and remaining linked in nationally
- The NHS People Plan containing 101 actions including the wellbeing of staff and associated workforce issues
- The increased focus on challenges around BAME and health inequalities
- The hidden impact of mental health issues building up over the last 6 months
- Capital of £160m in HCV of which £15m was linked to York ED including an email received this morning committing £2m this year

Mr Eames stated that the ICS also had to keep an eye on the future, whilst all the above were going on, including transforming the way services are delivered , the integration

between health and social care and the work on devolution. He stated that a white paper was due next year. Mr Eames also highlighted the strategy work including the East Coast and the role that Trusts play in their local networks.

Mr Eames stated that there were a number of things the ICS was working on:

- The development of Place
- A focus on integration and leadership
- Setting up a programme of work in York between the Local Authority, CCG, Trust, Primary Care and Voluntary Sector which was being piloted as a pathfinder so that HCV could build momentum
- Moving to establish to distinct geographies in Humber and North Yorkshire to delegate authority from the ICS
- Delivery of a financial plan for the region by the 5 October
- A devolution model aligning health with local government
- Provider collaboratives established for acute, mental health and community and social care – as changes are made CCGs will become part of collaboratives
- Devolving resources and functions
- Waiting lists challenges
- Geography partnerships and the move to further merge CCGs including Vale of York CCG coming under North Yorkshire and York CCG.

It is likely that legislation will make ICS's more accountable and legally responsible for finance especially as NHSE/I want to see that direction of travel. It is unlikely that there will be any legislation before spring next year, but the ICS are planning to have as much in place as possible ahead of any legislation and so will be poised to move towards a difference governance framework.

Mr Morritt stated that there was a lot going on and that there was a delicate balancing act over winter whilst trying to develop a new work and managing the day job.

Ms Symington stated that it was an extraordinary amount of information to take in, but thanked Mr Eames for joining the Board meeting and setting the scene.

The Board:

- **Noted the vast amount of work being undertaken and wished to be kept updated on the development of the governance arrangements**

20/45 Quality & Resources Committees – Items for escalation

Resources Committee – Mrs Mellor highlighted the following:

- LLP – absence of the CAFM system which would monitor a number of KPIs
- LLP – blockages around the North entrance which need resolving
- Workforce – sickness levels already discussed, staff absenteeism – already covered carers leave
- Workforce – award from MoD Employers Recognition (Gold)
- Workforce – apprenticeship scheme achievements
- Digital – presentations on telemedicine, risks around roll out of N365
- Digital – the CDIO report and ensuring he has the right team to support him

- Finance – Financial position to be discussed later

Ms McMeekin stated that staff sickness is monitored on a daily basis and it is back down to within range. She is keeping a close eye on the Covid sickness which is at 29% and bang on the national and regional trends. Measures to support staff attendance and mental wellbeing are in place and practicalities such as time off lieu and adjusting hours creatively are being focused on. However, it is a daily challenge and the single biggest threat to the trust in its response to winter and a possible second wave of Covid.

Mrs Scott stated that during the first wave of the pandemic the majority of services were stepped down and staff redeployed. The Trust does not have the same luxury this time around and this will be hugely challenging.

Ms McMeekin noted that non-medical appraisal rates have gone up to 68.4% and the appraisal window extended till end of November.

Mrs McNair stated that the Trust is complying with national guidance on visiting, but it is an iterative process. She noted the changes to visiting at Scarborough and that there were currently more opportunities for visiting at York, but this is being kept under review. Obviously patients with capacity can use smart phones, but the Trust needs to ensure that there are enough tablets available and staff to help patients.

There was a discussion about communications between in-patients and relatives and whether there was some sort of charter so that patients were aware of what they could expect? Mrs McNair stated that there was more to do especially as volunteers cannot get involved in this on Covid wards. Mrs Brown stated that information was updated on the website and it was making sure people knew who to contact and that staff were also aware of the current arrangements.

It was also raised that relatives needed ways to be able to discuss care with doctors and nurses as the visiting restrictions had frustrated the process.

Mr Dillon provided some assurance around the LLP stating that the Managing Director had a significant number of challenges around cultural and motivational issues, but progress was being made. 3 new management posts were being introduced which would have a significant impact. There were challenges with absenteeism, but the level of appraisals had risen significantly. There would also be a concerted effort and focus on backlog maintenance.

Quality Committee – Dr Boyd stated that the Committee had focused on restoration and the winter plan which had been discussed at length earlier in the meeting. The Committee had received information on nurse staffing and the good news that York University came sixth in the league table for nursing student satisfaction. The Committee confirmed its focus on the CQC and improved communication links and the establishment of a Quality & Regulations Group which would provide oversight of CQC actions.

Dr Boyd stated that the Committee had received the Medical Appraisal and Revalidation Report and recommended it to the Board for approval. **Approved.**

The Board:

- **Noted the items escalated from the Committees**

- **Approved the Medical Appraisal and Revalidation Report**

20/46 Integrated Business Report

Mrs Scott highlighted the following points:

- GP referrals are down by 30%
- Cancer fast track is improving, but still down by 15% on pre-Covid levels
- ED attendance is increasing although Scarborough has bounced back to pre-Covid levels which is adding pressure to the Scarborough bed base
- Cancer waiting times is an improving picture with 93% achieved in June and July
- 62 day waits were 79.4% in July against a national target of 85%
- Improvements being made in radiology, MRI and CT to recover services
- In endoscopy there are a number of surveillance patients overdue
- Risk stratification in place to prioritise patients at higher risk
- Small numbers of patients being outsourced, but more can be done if finances allow
- A reduction in the waiting list in July
- DNA levels of 5.1%
- 52 week wait position at the end of September of 2101 of which 1700 do not have a TCI date yet.

Mrs Scott stated that there is tension around how all this will be addressed, but she was pleased to note that the September activity plan would be achieved and possibly slightly exceeded which showed that the planning processes were successful.

There was challenge around the numbers and that even with all the work that was being done the Trust was not achieving 85% and even so this left around 20% at risk of harm. Mrs Scott stated that some of the delays were due to tertiary centres, but she provided assurance that all patients are tracked especially cancer patients. Mr Taylor added that there is clinical review of all breaches at 62 days and a formal review at 104 days. Mrs Scott noted that clinical harm reviews are in the Medical Directors Report and areas of learning are looked at.

The Board asked about super-stranded patients and if they start to increase what the impact on bed availability would be? Mrs Scott stated that funding was being made available which enabled positive working with partners and this has transformed and accelerated discharges. The funding stream would continue till the end of March 2021. Mr Bertram stated that the continuing retrospective recharge arrangement for CCG's was really welcome.

The inconsistent provision of NIV cover was raised from the IBR and it was noted that this was due to staff being redeployed during the first wave returning to their substantive positions. Additional funding had been agreed but there was a period where new staff needed to be trained.

The 14 hour review standard was discussed and Mr Taylor highlighted the Scarborough vacancy rate which is a critical issue, however, he felt this was due to historical establishment and that significant work was needed in recruitment to reinforce Scarborough. He noted a time out being held in October by the Care Groups which would try to understand the gaps.

Ms Symington stated that sharp focus was required on recruitment in Scarborough and that recruitment methods needed to change and that the Board would be discussing the clinical strategy and developments on the East Coast at the Board time out in October.

The Board:

- **Noted the report and the areas raised.**
- **Was concerned about recruitment on the East Coast**

20/47 Reflections on the Meeting

BAF – Ms Symington stated that the high level risks had been discussed at the meeting and it was interesting to note the improving scores at the bottom of the grid including finance. Mr Roberts noted that he is working on a full revision of risk 5 (IT).

Concern was expressed by Prof. Morgan that the Trust had fallen seriously behind some national surveys and data collection particularly in some specialties. He noted that some of it was so out of date as to now be irrelevant. It was noted that the Medical Director is speaking with Care Groups and senior clinicians are being asked to prioritise this in their appraisal. There should be a significant improvement in data collection, but it was about understanding the barriers. It was stressed that there is a new Safety and Governance Team in place who are looking at this as a priority.

This has been a concern for the Quality Committee for some time and there was now some assurance that the position/base line was known and would be dealt with.

The Board:

- **Was assured the national survey/data collection position was now clear, but wished to see some improvements which will be monitored by the Quality Committee**

20/48 Any other Business

NED Recruitment - Ms Symington stated that the Council of Governors had ratified the appointment of David Watson on Monday 28 September following NED Recruitment held in August and September. It is hoped that Mr Watson will start on the 1 October and an induction will be provided so he will hopefully talk to every member of the Board in the next couple of months.

Chair (3rd Term) – Ms Symington noted that the Council of Governors had ratified her appointment for a 3rd term at their meeting on the 1 September.

AMM/AGM – Ms Symington stated that the Trust will hold the AMM/AGM virtually on the 13 October. She noted that this was an important date for the diary and hoped as many board members as possible would attend.

Time Out – Ms Symington stated that a board time out was scheduled for the 13 October which would cover meeting new board members, a Clever Together update and a strategic review which would include the East Coast work.

No further business was discussed.

20/49 Date and Time of next meeting

The next public meeting of the Board will be held on 25 November 2020 via Webex. Details TBC.

Outstanding actions from previous minutes

Minute No. & month	Action	Responsible Officer	Due date
19/68	Consider in discussion with new CE, PCN presentation to board. Consider in 2021 after April.	Ms Symington	~~Oct 19~~ ~~Jan 20~~ ~~Jul 20 review~~
19/93	Mortuary to be kept under review on the action list.	Board	Until completed
20/11	Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.	All	Feb 20 - ongoing
20/25	Invite Dr Jayagopal to provide an HYMS update to the Board in December 2020	Mrs Provins	Dec 2020
20/26	Clever Together feedback to the Board	Mr Morritt	~~Sept 2020~~ Oct 20 time out
20/40	IPC Presentation (every 6 months)	Mrs McNair	Mar 21

C

NHS

York Teaching Hospital

NHS Foundation Trust

Board of Directors – 25 November 2020
Chief Executive's Overview

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To provide an update to the Board of Directors from the Chief Executive on recent events and current themes.

Executive Summary – Key Points

The report provides updates on the following key areas:

- Covid-19 update
- Devolution for North Yorkshire and York
- A new name for the Trust

Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: November 2020

1. Covid-19 update

Since the last meeting of the Board of Directors the number of admissions of patients with Covid-19 has grown considerably, and case numbers in our local communities have been rising. Scarborough in particular has had a steep rise in recent weeks, and trusts in other parts of our ICS have felt the effects of some of the highest infection rates in the country.

At the time of writing this report we have over 130 confirmed positive patients in our care across the Trust, surpassing the number of positive cases at any time in wave one.

In response to the growing pressure, and in anticipation of cases rising further, we have enacted the next step in our surge plan which will release additional beds and staff to ensure that we have as many beds available as possible to care for these patients as the infection peaks for the second time.

This does mean we have postponed some planned operations, however our teams are working hard to continue to do as many operations as possible within the constraints we are facing. Day case surgery will continue, and we will carry out as many urgent operations, for example for patients with cancer, as we can. We will once again be working with our local independent hospitals to use their facilities for some urgent operations. Emergency patients will be treated as normal, and outpatient appointments will also continue.

This is, as ever, a fast-moving situation and we will have the opportunity to talk about the up-to-date position during the Board meeting.

2. Devolution for North Yorkshire and York

There have been some developments in relation to proposals for devolution in North Yorkshire and York.

The background is that long-running discussions about devolution for the Yorkshire region culminated in proposals for a joined-up deal for One Yorkshire Devolution, put forward to the Government in 2018. The response from the Government suggested it would prefer smaller devolved deals to take place first. These have since been agreed in West Yorkshire and South Yorkshire.

The Government has said any devolution deal requires local government to simplify by removing the current two-tier (County and District) structure in North Yorkshire.
York is the only unitary council in the area, and provides all the services within its boundaries, whilst for the rest of North Yorkshire service delivery is split between the County Council and the five district and two borough councils.

Discussions have been taking place between the local authorities in the region, including City of York Council and the various Borough and District Councils within the wider North Yorkshire County Council area, and North Yorkshire County Council itself.

North Yorkshire County Council has submitted its proposal to the Government for a single unitary authority for North Yorkshire based upon the current county footprint, whilst

retaining the existing City of York Council. This would be the first step towards devolution for North Yorkshire, with a view to the two unitary authorities of North Yorkshire and York working together under a single Mayor. North Yorkshire County Council and City of York Council both favour this approach.

The proposals are detailed in full in a document called A unitary council for North Yorkshire: The case for change which is on North Yorkshire County Council's website: www.northyorks.gov.uk/proposal

There is also comprehensive information on City of York Council's website: www.york.gov.uk/BackUnitarisation

The district and borough councils have developed an alternative proposal. This model would split the county in half into two unitary authorities – east (including Scarborough, Ryedale, Selby and York) and west (including Hambleton, Richmondshire, Harrogate and Craven).

The government will conduct a formal consultation about the different proposals for local government restructure in North Yorkshire in the new year.

Regional NHS leaders, including the Humber Coast and Vale Integrated Care System and local NHS organisations are supportive of City of York and North Yorkshire County Council's proposals.

3. A new name for the Trust

I have stated in previous reports that, following a pause to respond to the first wave of Covid-19, we will be starting to revisit some of the recommendations from the 'Our Voice, Our Future' workshops that we held in the last few months of 2019.

Throughout this work, and in the many conversations I have had with staff since I joined the Trust, the question of our name has been a constant theme. The need to move forward as a single organisation came across loud and clear in the workshops, and there was a specific recommendation that we should change the name of the organisation to be inclusive of all staff.

We have taken this into account, alongside the suggestions from staff and the rules and obligations around how NHS Trusts can be named, and as a result we are proposing to change our name to 'York and Scarborough Teaching Hospitals NHS Foundation Trust'.

We are now in the process of seeking feedback from our patients, staff, foundation trust members, partner organisations and local people. This feedback will be carefully considered and will help to inform a final recommendation for our Council of Governors and Board of Directors.

I believe that the change will send a strong, inclusive message to all of our staff, help us move forward as a single organisation, and better represent the communities we serve.

We are working towards being able to launch the new name in the new year, with plans being developed to enable us to do this as efficiently and cost-effectively as possible.

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 November 2020
Outline Business Case for Scarborough Hospital Transformation of Urgent and Emergency Care

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☐	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

This covering report supports the Outline Business Case (OBC) submission to Trust Board for the Scarborough Hospital Transformation of Urgent and Emergency Care Project. The Capital Team, in collaboration with Trust Finance Directorate colleagues, has now completed the process to produce the required OBC to the necessary standard required of all HM Treasury Green Book 5 Case Model investments expected for Department of Health and Social Care and NHS England and Improvement approvals.

The Trust received the letter of approval for the Strategic Outline Case in April 2020, which specifically required the Trust to clarify several issues within the Outline Business Case submission in particular the Trust's strategy for the fallow floor and whether this could be funded within the existing bid envelope of £40M.

Two options for the fallow floor were designed; traditional ward space and a Level 1, 2 and 3 Critical Care facility. In July 2020, the Trust confirmed that the Critical Care facility was the preferred option and a cost plan was developed on that basis. The fit-out of the fallow floor was costed at an additional £10M bringing the total proposed investment to £50M net. The cost of fitting out the fallow floor at a later stage (2 years after delivering the ground floor) would increase to £14.1M. Therefore, the case has been made within the OBC that the Preferred Option, which delivers the greatest Benefit to Cost Ratio (BCR), is requesting an augmented funding envelope of £50M. The funding of the £10M gap is described within the OBC and work continues to secure healthcare partner commitment to this capital expenditure.

Associated revenue consequences have been briefed and discussions held with North Yorkshire CCG who will be submitting a letter in support of the project prior to the central approval process.

Executive Summary – Key Points

The key points for discussion and approval are as follows:

Timescales

Milestone Activity	New build	Infrastructure
Award Construction Contract	26 November 2020	26 November 2020
Commencement of construction	Quarter 3 2021	Quarter 3 2021
Construction complete	January 2024	January 2024
End of Defects Liability period	January 2026	January 2026

The above table indicates the high-level programme that the teams are working to. Before commencement of construction, the OBC will pass through the central approvals process followed in quick succession by the Full Business Case (FBC). Work will commence on the FBC early January 2021 which is before the OBC approval letter is expected.

Options

Four options are described within the OBC. In summary these are as follows.

Option 1 Business as usual (Status Quo)

- Undersized accommodation & fragmented services
- No engineering infrastructure to support any capital expansion/site development

Option 2 Do minimum (£39,989M) (Preferred Option No 2)

- Two storey right-sized accommodation for the:
    - Urgent and Emergency Care facilities (ground floor), and
    - Plant room (first floor).
- Sufficient site wide engineering infrastructure to support the AMM capital build and future Site Development Plan
    - HV/LV
    - Re-provision of car parking spaces
    - Steam
    - Cold water supply and drainage

  - VIE and oxygen ring main
  - Ventilation – AHU's
  - Replacement lifts
  - Mortuary

Option 3 Do intermediate (£39,989M) (Preferred Option No 3)

- Three storey right-sized accommodation for the:
  - Urgent and Emergency Care facilities (ground floor)
  - Fallow floor to provide future Level 1,2 & 3 Critical Care (first floor)
  - Plant floor (second floor)
- Sufficient essential only site wide engineering Infrastructure support the capital build and future Site Development Plan
  - HV/LV
  - Re-provision of car parking spaces
  - Steam
  - Water storage tank.

Option 4 Do intermediate + (£49,998M) (Preferred Option No 1)

- Three storey right-sized accommodation for the:
  - Urgent and Emergency Care facilities (ground floor)
  - Level 1,2 & 3 Critical Care Unit (first floor)
  - Plant floor (second floor)
- Sufficient essential only site-wide engineering Infrastructure support the capital build and future Site Development Plan
  - HV/LV
  - Re-provision of car parking spaces
  - Steam
  - Water storage tank

The Scarborough Mortuary scheme will also be delivered within the Preferred Option (Option 4). Further design, commercial, risk management and value engineering work is

required to ensure that the full cost of this element of the project can be met from within the external funding envelope.

Delivery of the Critical Care facility will allow the Trust to re-provide ward accommodation for 3 Nightingale wards currently in the 1930's North Block of the site.

Procurement solution and appointment of the Principal Supply Chain Partner (PSCP)

Following an options appraisal a procurement report was prepared that outlined a range of procurement options available to the Trust for the new build and engineering infrastructure. This report proposed that the two elements of the project be packaged together and released as a programme of work under the ProCure 22 framework with is a fully compliant Department of Health framework.

Following approval by the Project Board of this procurement route, a formal tender process followed to appoint a Principal Contractor for the project. This process will be completed with final interviews on 20 November 2020 and will be subject to Trust Board approval on 25 November 2020.

Recommendation

- The Trust Board are asked to note the four options described within the OBC and confirm that the Preferred Option (Option 4) is taken forward within the FBC within a cost envelope of £50M net.
- The Trust Board are asked to confirm that should the Preferred Option (Option 4) not be successful, the next Preferred Option is Option 2.
- The FBC development is started in January 2021, noting that receipt of the letter of approval from the Department of Health and Social Care and NHS England and Improvement is not expected until March/April 2021.
- The Trust Board are asked to confirm the appointment of the PSCP for this project.

Author: Joanne Southwell, Project Lead, YTHFM LLP

Director Sponsor: Delroy Beverley, Managing Director, YTHFM LLP

Date: 17 November 2020

Turner & Townsend

16 November 2020

Outline Business Case

Outline Business Case (OBC)

Scarborough Hospital, Transformation of Emergency & Urgent Care

York Teaching Hospital NHS Foundation Trust

making the **difference**

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Document Quality Management

The following quality checks have been carried out on this document:

- Review by Turner & Townsend Consulting Director
- Review by Dr Andrew Bennett, Head of Capital & Project Director
- Review by Andrew Bertram, Director of Finance.

Version control will be maintained throughout the life of this dynamic document and will adhere to YTHFT control of documents and audit standards.

Project Approval to date

In September 2019, York Teaching Hospital NHS Foundation Trust (YTHFT) Board approved the SOC for submission to the Humber Coast and Vale Integrated Care System (HCV ICS) and onward for central government approval. The SOC approval letter was received from the Department of Health & Social Care and NHS England and Improvement at the end of April 2020.

This next stage Outline Business Case builds on the specific feedback from the Department of Health and Social Care and NHS England and Improvement SOC approval letter specifically requiring the Trust to clarify the following:

- The Trust to clarify how the remaining backlog maintenance is to be financed.
- The Trust should (at OBC) explore other options to fund the capital cost above allocation of some of the higher value options. The OBC should also explore as part of this the additional costs of developing the first-floor ward space as part of this programme of work and identify the cost/benefit analysis of doing so.
- The Trust explores the potential and costs of moving services out of the Nightingale Wards so that they can identify surplus land disposals.
- The Trust confirms clinical activity assumptions including growth and revenue affordability.
- The Trust confirms the ability to reclaim VAT for the preferred procurement route through York Teaching Hospital Facilities Management LLP.

Glossary of Terms

Acronym	Description
AICU	Adult Intensive Care Unit
ALOS	Average Length of Stay
AMM	Acute Medical Model
BCF	Better Care Fund
BLM	Back Log Maintenance
BREEAM	Building Research Establishment Environmental Assessment Model
CBRN	Chemical, Biological, Radiological or Nuclear
CCG	Clinical Commissioning Group
CDEL	Capital Departmental Expenditure Limits
CIP	Cost Improvement Programme
CMG	Clinical Management Group
CPEG	Capital Programme Executive Group
CRL	Capital Resource Limit
CQUIN	Commissioning for Quality and Innovation
DCP	Development Control Plan
EAC	Equivalent Annual Cost
EAU	Emergency Assessment Unit
EFL	External Financing Limit
EPR	Electronic Patient Record
EPACCS	Electronic Palliative Care Coordination System
FBC	Full Business Case
FM	Facilities Management
GAM	Government Accounting Model
GEM	Generic Economic Model (Department of Health)
GPICS	Guidelines for the provision of Intensive Care Services

Acronym	Description
ICS	Integrated Care System
I&E	Income and Expenditure
IBD	Interest Bearing Debt
ICU	Intensive Care Unit
IFPIC	Integrated Finance and Performance Investment Committee
IM&T	Information Management and Technology
JSNA	Joint Strategic Needs Assessment
LTFM	Long Term Financial Model
MDTs	Multi-disciplinary team
NHSE	NHS England
NHSI	NHS Improvement
NIHR	National Institute for Health Research
NPC	Net Present Cost
OSC	Overview and Scrutiny Committee
PCT	Primary Care Trust
PDC	Public Dividend Capital
PDS	Patient Demographics Service
PLACE	Patient led assessment of the care environment
PPR	Post Project Review
PSCP	Principle Supply Chain Partners
PSED	Public Sector Equality Duty
RTT	Referral to Treatment Time
SCR	Summary Care Record
SDEC	Same Day Emergency Care
SDMP	Sustainable Development Management Plan
SMART	Specific Measurable Achievable Realistic Time related.

Acronym	Description
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
VAT	Value Added Tax
VFM	Value for Money
YTHFT	York Teaching Hospital NHS Foundation Trust

Contents

Rev	Status	Originator	Approved	Date
1.0	For Trust Board Approval	Peter McKinlay	Claire Colgan	16 November 2020

1 Foreword

Statement of support from North Yorkshire and Vale of York CCG Clinical Chairs and York Teaching Hospital NHS Foundation Trust Chair

"Through the 'Scarborough Acute Services Review Steering Group' and supported by the work of McKinsey and Company, we have completed a strategic review of the acute clinical services for Scarborough and the surrounding areas. In recognising the challenges of clinical recruitment, geography, clinical service demand and demography of the east coast; we understood that the existing model of service would need to change and develop through the support and input from all system healthcare partners.

Our intent is to develop the Scarborough Acute Services that ensure they are sustainable, accessible and of high quality. This included a commitment to continue providing 24/7 emergency care services at Scarborough hospital through the local development of the innovative Acute Medical Model (AMM), but also recognised that the current Urgent and Emergency Care facilities at Scarborough Hospital are inadequate, too small and too disparate to be reconfigured to support the AMM.

Further development of the new site to provide clinical space to relocate the currently dispersed Level 1,2 & 3 critical care patients into an integrated compliant facility is welcomed and will allow relocation of three wards from current inadequate inpatient accommodation at Scarborough Hospital.

Over the past two years, multi-disciplinary stakeholder engagement across health and social care have contributed their time and expertise to the design of the care pathways supporting the AMM, including those outlined in this Business Case. We thank each of them for their contributions to the programme so far and to the development and assurance of this process.

We will continue to ensure that this programme is led in line with best practice throughout and will engage widely with patients, the public and our stakeholders. Above all, we will maintain our ambition to deliver, in partnership, on behalf of the people Scarborough and surrounding area".

Dr Charles Parker - North Yorkshire CCG Clinical Chair

Sue Symington - York Teaching Hospital NHS Foundation Trust Chair

James Taylor – YTH NHS Foundation Trust Medical Director.

2 Executive Summary

2.1 Introduction

This OBC describes the proposed investment in a new capital build and site-wide engineering infrastructure at Scarborough Hospital.

The project will provide redesigned acute and emergency services within a new fit for purpose, compliant, capital build which will support significant operational benefits for the Trust and wider community. The new building will facilitate the Acute Medical Model (AMM) – combining and expanding the current Emergency Department, Same Day Emergency Care (SDEC), Frailty and Acute Medical Unit.

Level 1, 2 and 3 critical care services will be combined to provide a critical care floor directly above and in support of the new AMM as well as site-wide engineering infrastructure to support the capital build and future Site Development Plan (SDP).

2.2 Strategic Case

2.2.1 Overview

Scarborough Hospital is part of York Teaching Hospital NHS Foundation Trust and is a partner in the Humber, Coast and Vale Integrated Care System, being the Trust's second largest hospital. It has an Accident and Emergency Department and provides acute medical and surgical services, including trauma and intensive care services to the population and visitors to the North East Yorkshire Coast.

The current acute care accommodation infrastructure at Scarborough Hospital dates from the mid-1980s and is no longer fit for purpose both in terms of non-elective activity, capacity and compliance with new regulations.

2.2.2 Drivers for change

The increasing size and ageing of the local population, as well as increasing demand for urgent healthcare in society, has delivered increasing attendances to Scarborough Emergency Department year on year for many years (variable but up to 6% increase per year). In the post-Covid world there is an opportunity to re-set urgent healthcare services and attempt to continue to evolve the way in which we provide these locally.

Scarborough Hospital also faces challenges around recruitment, sustainability, geography and demography as identified in the *Scarborough Acute East Coast Services Review January 2019.* This was a detailed report on Clinical Services in the Scarborough area that identified:

- The local population is ageing and has **changing health needs**
- A **different type of healthcare service is required** – one that results in decreased hospital activity
- A **new model of care** is needed.

2.2.3 Engineering Infrastructure

A Site Condition Survey carried out in July 2017 highlights the catastrophic, critical, high risk and non-compliant nature of the current infrastructure. Without investment, the current infrastructure is unable to support the proposed capital build and service transformation or any future capital expansion.

2.2.4 Patient safety

There are urgent patient safety issues that our teams deal with on a day to day basis and require to be addressed. The reality of the current situation of running an Emergency Care service in a sub-optimal facility is that:

- Our patients incur **unacceptable waiting times**
- Ambulances are **unable to off-load patients** in a timely manner and
- Dedicated practitioners are, despite their best efforts, **unable to deliver the standard of care** that our health population deserve.

2.2.5 Rationale and Investment Objectives

The main strategic objective is to design and construct an accommodation solution to implement the Acute Medical Model (AMM) incorporating compliant Level 1, 2 and 3 critical care facilities to support the local population demographic growth and complexity by completion in early 2024.

This OBC also seeks to address:

- The extensive clinical and operational challenge in providing sustainable, responsive emergency care in a department which is **too small, overcrowded, non-compliant, inflexible and no longer fit for purpose**
- The extensive clinical and compliancy challenges in providing sustainable Level 1, 2 and 3 critical care services which are currently dispersed in **five separate, non-compliant, departments across the hospital site.** Integration of the critical care services will enable re-provision of three 1930's Nightingale Wards into improved ward accommodation
- The **critical fragility of the existing engineering site infrastructure** which is **non-compliant and at maximum capacity** with major operational critical services working on non-essential power together with the burden of outstanding backlog maintenance.

2.2.6 Strategic Context

This OBC aligns and supports delivery of the following relevant Department of Health and Social Care (DHSC) policies and guidance:

- *NHS Five Year Forward View*
- *NHS Long Term Plan*
- *Findings and recommendations from the Carter review of productivity in NHS hospitals.*

2.2.7 Health Economy Strategies

At a local level, in Scarborough, this OBC is aligned with the North Yorkshire CCG's strategic aims and objectives for the region and is underpinned by our Five-Year Plan and our Estates Strategy.

In terms of the Trust's strategic direction, this OBC has been developed to support and be consistent with the delivery of the following:

- York Teaching Hospital NHS Foundation Trust (YTHFT) Our Strategy 18 – 23
- YTHFT Clinical Strategy (Nursing & Midwifery Strategy 2017 – 2020)
- YTHFT Estates Strategy v2.0
- Workforce & OD Strategy 2019 - 2024
- YTHFT Sustainable Development Management Plan 17 – 20
- YTHFT Digital Strategy 17 – 22.

2.2.8 Conclusion on Strategic Context

The proposed reconfiguration of acute and emergency services is entirely consistent with health and social care strategies at both a national level, in terms of government policy for health and social care and Department of Health and NHSE priorities and at a local level in terms of the Health & Social Care Partnership and YTHFT strategies.

2.3 Clinical Quality Case

2.3.1 Introduction

The OBC has been aligned to the Trust's Clinical Strategy to provide high quality services in a financially affordable and sustainable way. It also sets out how the investment will enable the Trust to support the delivery of a sustainable health economy in the future, strengthening the provision of urgent and emergency critical care.

2.3.2 Clinical Sustainability

The most important aspect of the project from a sustainability perspective is achieving as close as possible to complete integration of clinical services at the front door of the hospital and aligning those services with an outward-facing community focus.

The main outcome measure is managing as many patients as possible without the need for hospital admission.

The project has taken into account the changing landscape of healthcare, through the innovative design of flexible interchangeable space, which will have the ability to adapt as services develop and improve. Learning from Covid-19 has also been considered and within the new facility there is ability to successfully divide into appropriate zones to ensure patient safety and effective patient flow.

2.3.3 Overarching Principles informing the Design Brief

A number of overarching principles have influenced development of the design.

2.3.3.1 *Clinical models of care and Operational Policies*

These have been developed by the clinical stakeholders and underpinning the clinical model of care is the AMM and UEC operational policy.

2.3.3.2 *Innovative changes to service delivery*

The project has taken into account the many changing demands of acute and emergency care and has been designed throughout with the need to provide flexible working spaces with appropriately adjacent zones to allow the facility to meet the current demand, predicted growth and adjust to the innovative changes to service delivery.

2.3.3.3 *Infection Control*

The Infection Prevention Team has been involved in the design throughout. The build will comply with HBN 00-09: Infection Control in the Built Environment.

2.3.3.4 *Quality of care and experience*

The project is designed to incorporate our existing knowledge and experience gained from many years of patient feedback. There are a number of specific examples of where we have ensured that we have referenced best practice with respect to this.

2.3.3.5 *Patient Led Assessment of the Care Environment (PLACE)*

PLACE is a patient-led system for the assessment of the quality of the patient environment. The assessments are undertaken each year and the results published to help drive improvements in the hospital environment. The project will improve PLACE scores across a number of areas.

2.3.3.6 *Carer and Parent accommodation*

Patient needs and the patient environment have been at the fore front of this project and along with this, has been the consideration for carers.

2.3.3.7 *Quality of the environment*

Design quality will be achieved through the delivery of the design principles by applying, where possible, guidance, compliance and quality assurance standards. The Trust is committed to ensuring that the best possible designs are delivered, within the constraints of the footprint and cost envelope, and will be undertaking formal reviews of the design.

2.3.3.8 *Safe Design*

Safe design is imperative to the successful delivery and operation of all patient environments and important aspects have been included in the project design.

2.3.3.9 *Access*

Access is key in the development of the design for the project and there will be a site wide review of access both internally and externally.

2.3.3.10 *Security*

The Trust employs a Local Security Management Specialist (LSMS) who is being consulted during the design process. The LSMS role is to deliver a safe and secure NHS environment which allows the delivery of high-quality patient and clinical care.

2.3.3.11 *IT systems*

The project will have all relevant Trust clinical IT systems fully integrated within each area of the new build. Opportunities will be optimised to review current systems and processes to maximise technology to provide efficient, seamless transitions of patients through their episode of care.

2.3.5 Scheme Design Development

The following areas have been considered in the design of the new building:

- **Privacy and Dignity** - will be enhanced through maximising where appropriate use of single room accommodation throughout the AMM and Critical Care floor
- **Key clinical support functions** - have been planned to carefully consider optimal logistical movement of goods and services throughout the new build
- **Adaptability** - following lessons learnt from the current pandemic, it has been essential to plan and design both the AMM and Critical Care floor to adapt and operate separate flows of patients and staff by segregating infected and non-infected patients
- **Flexibility of accommodation** - operational team areas can be flexed to meet demand
- **Patient space standards** - have been achieved or exceeded by following HBN guidance for clinical environments
- **Clinical adjacencies and workflow** - the co-location and integration of currently dispersed services are brought together to maximise clinical productivity and decision making and enhance the patient experience.

2.3.6 Leadership and Stakeholder Engagement

The Acute and Emergency Care Group Director and Clinical Leads is the key sponsor of the project and has been involved since the inception. He has worked with clinical leads across services in the development and agreement of the models of care and clinical operational policies which support this project.

The following stakeholders have been engaged to date:

- Healthwatch
- Patient Partners
- Commissioners
- Overview and Scrutiny Committee (OSC)
- Internal clinical support services
- Estates and Facilities Management (FM).
- Royal College of Emergency Medicine (RCEM).

2.3.7 Workforce

The approach to workforce development planning has been aligned to the Trust's Workforce and OD Strategy 2019 to 2024 and the Trust will ensure that it uses Organisational Development (OD) input appropriately and has recognised this as a key element of the success criteria. Resources have been identified to support change through the new AMM and Critical Care.

2.3.9 Training and development in new ways of working

Our workforce plans will build on recent Covid–19 learning, developing teams to maximise the range of experience and capabilities of clinical and non-clinical members. Training and development will have renewed emphasis on the importance of flexible skills and building capabilities rather than purely traditional roles.

The Trust will continue to work closely with both national partners (e.g. HEE) and local partners (e.g. Coventry University Scarborough).

2.3.10 Workforce Plans

At the point of delivery there will be a fully established composite workforce designed to maximise the efficiency and effectiveness of the facility. This strategy is already well developed and will involve the development of a multidisciplinary workforce working towards the single goal of delivery of excellent patient care as close to home as possible.

2.4 Economic Case

2.4.1 Introduction

The economic appraisal has been undertaken in accordance with the HM Treasury Central Government Guidance on Appraisal and Evaluation (The Green Book) and the Department of Health & Social Care Comprehensive Investment Appraisal (CIA) Model and consists of six analyses:

- Capital Costs
- Recurring annual revenue costs
- Risk
- Benefits
- Net Present Social Value (NPSV) and
- Benefit Cost Ratio (BCR).

2.4.2 Critical Success Factors

The CSF's for the project have been established as follows:

- **Business Needs** - How well the option meets the agreed investment objectives, related business needs and service requirements
- **Strategic Fit** - How well the options provides a holistic fit & synergy with key elements of local, regional and national strategies & programmes
- **Benefits Optimisation** - How well the option optimises the potential return on expenditure & assists in improving overall VFM
- **Potential achievability** - The Organisation's ability to innovate, adapt, introduce, support & manage the required level of change including management of risks, capacity & capability
- **How do we procure the solution** including best practice - the ability of the marketplace & potential suppliers to deliver the required services & deliverables?

- **Affordability -** the Organisation's ability to fund the required levels of expenditure - capital & revenue consequences of investment.

2.4.3 Options Appraisal

2.4.3.1 *Long list*

The table below shows the long list of five options, which the Project Team used the HMT (2018) guidance options framework to identify.

Project	1. Business as Usual (BAU)	2. Do Minimum	3. Do Intermediate	4. Do Intermediate +	5. Do Maximum
1. Project scope – as outlined in the strategic case. Focus on scale of potential change required	1.0 Represents the business as usual and as such does not have capital spend or revenue/monetisable (cash / non-cash releasing) benefits	1.1 Under Acute Medical Model (AMM) patients will be assessed and increasingly, seen/ treated in the same day, improving recovery times. Additional costs incurred from the estates and facilities costs of serving a larger area are partially offset by savings from the closure of the existing facility and changes in ways of working under AMM. The use of the existing ED facility will form part of the wider Estates Strategy, SDP, going forward.	1.2 Includes the same benefits as the model in Option 2, with the additional benefit of clinical expansion space above the Acute Medical Model Floor. This will allow the Trust to re-provide all the current 4 Nightingale 1930's adult ward accommodation into this space in future years.	1.3 Includes the model in option 3; with the addition of further capital spend on elimination of backlog maintenance of £1m.	1.4 Includes the model in option 4; with the addition of a basement storey & roof helipad

2.4.3.2 *Long List to Short List process*

A SWOT analyses was carried out on the Long List options and they were then assessed against the project Investment Objectives (IOs) and Critical Success Factors (CSFs).

2.4.3.3 *Short List*

Based on the evaluation, a Short List of four options was approved by the Project Board to be taken forward for economic appraisal.

Option 1 – Business as Usual

This option represents the status quo:

- Undersized accommodation & fragmented services
- No engineering infrastructure to support any capital expansion/site development

Option 2 Do minimum (£39,989M)

This option represents the do minimum:

- Two storey right size accommodation - AMM (ground floor) & Plant room (first floor)
- Sufficient site wide engineering infrastructure to support the AMM capital build and future Site Development Plan.

Option 3 Do intermediate (£39,989M)

This option represents the intermediate solution:

- Three storey right size accommodation – AMM (ground floor), Fallow floor to provide future Level 1,2 & 3 critical care (first floor) & Plant floor (second floor)
- Sufficient essential only engineering infrastructure to support the capital build and future Site Development Plan.

Option 4 Do intermediate (£49,998M)

This option represents the intermediate plus solution:

- Three storey right size accommodation - AMM (ground floor), Level 1,2 & 3 integrated critical care (first floor) & Plant floor (second floor)
- Sufficient essential only engineering infrastructure to support the capital build and future Site Development Plan.

2.4.4 Economic Appraisal

The main costs and benefits associated with each of the four short-listed options, along with key assumptions, have been reconciled in a Comprehensive Investment Appraisal (CIA) to identify which option provides the greater benefits for the least cost. The following tables are extracts from the CIA and detail the evaluations which underpin the selection of the Preferred Option from a Benefit to Cost Ratio at conclusion:

2.4.4.1 *Benefits*

The benefits, per annum are summarised as follows:

	Option 1	***Option 2***	***Option 3***	***Option 4***
	£'000	£'000	£'000	£'000
Cash releasing (CRB)		£5,540	£5,540	£5,540
Non-cash releasing (NCRB)		£188,556	£188,556	£456,823
Societal Benefits (SB)		£20,618	£20,682	£25,606
Unmonetisabe Benefits (UB)	Not Quantifiable	Not Quantifiable	Not Quantifiable	Not Quantifiable
Grand Total		**£214,714**	**£214,778**	**£487,969**

2.4.4.3 *Capital Costs*

The Capital Costs of the Short List Options are as follows.

Description	Option 1 – Business as Usual	Option 2 – Do Minimum	Option 3 - Do Intermediate	Option 4 – Do Intermediate +
		£'000	**£'000**	**£'000**
Capital Build				
Construction & Infrastructure costs		28,751	29,139	34,484
Fees		2,487	2,594	3,104
Non-Works costs		90	90	90
Equipment costs		1,850	1,750	3,750
Planning contingency		2,691	2,444	2,999
Optimism Bias		2,285	1,924	2,936
Inflation adjustment		1,835	2,048	2,635
Capital Build Total		**£39,989**	**£39,989**	**£49,998**

2.4.4.4 *Revenue Costs*

The revenue costs are based on current year values and growth in costs have been applied over the life of the project.

Costs	Option 1	Option 2	Option 3	Option 4
	Business as Usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Revenue Costs				
Additional Support Staff (Radiology / Ultrasound)	£0	£175	£175	£175
Estates & Facilities running costs associated with increased floor area - AMM Unit	£0	£1,810	£2,132	£2,132
Assumed closure and mothballing of old ED area	£0	-£322	-£322	-£322
Increased FM costs on	£0	£221	£221	£221

infrastructure services				
Background running costs of empty first floor shell	£0	£0	£65	£0
Estates & Facilities running costs associated with fit out of first floor	£0	£0	£0	£1,392
Assumed closure and mothballing of Nightingale Wards	£0	£0	£0	-£501
Overheads	£0	£496	£512	£719
Total Revenue Costs	**£0**	**£2,380**	**£2,783**	**£3,816**

Note: All costs are exclusive of VAT

2.4.4.5 *Avoided Costs*

Avoided costs are as follows:

Avoided Capital Cost	Option 1 – Business as Usual	Option 2 – Do Minimum	Option 3 - Do Intermediate	Option 4 – Do Intermediate +
	£'000	**£'000**	**£'000**	**£'000**
Critical Care Unit	£20,000	£20,000	£14,100	£0
Total	**£20,000**	**£20,000**	**£14,100**	**£0**

2.4.4.6 *Avoided Backlog Maintenance*

Avoided Backlog Maintenance costs are as follows:

Option 2- Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
£'000	**£'000**	**£'000**
£24,627	**£18,353**	**£19,103**

2.4.4.8 *Lifecycle Costs*

Lifecycle costs have been calculated for the 60-year life and are outlined below.

Project life – 60 years	Option 1	Option 2	Option 3	Option 4
	Business as Usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Capital Build		£8,779	£10,123	£10,829
Lifecycle management (3%)		£173	£304	£325
Risk (5%)		£289	£506	£541
Overheads (5%)		£312	£547	£585
Profit (10%)		£655	£1,148	£1,228
Totals		**£10,208**	**£12,628**	**£13,508**

The lifecycle costs compared to the avoided backlog maintenance costs are more cost effective, as expected due to the ageing / critical condition of the current site as compared with the new capital build.

	Option 1	Option 2	Option 3	Option 4
	Business as usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Lifecycle Costs		£10,207	£12,628	£13,508
Avoided Backlog Maintenance		£24,627	£18,353	£19,103
Net Saving		**£14,420**	**£5,725**	**£5,595**

2.4.4.9 *Net Present Cost*

The net present costs of each option are as follows:

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate +
Opportunity costs	£0.00	£0.00	£0.00	£0.00
Capital costs	£32,882	£53,359	£54,392	£50,874
Capital costs optimism	£0.00	£2,091	£1,755	£2,658

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate +
bias uplift				
Capital costs + optimism bias uplift	£32,882	£55,450	£56,147	£53,532
Revenue costs	£1,999,690	£1,977,952	£1,981,821	£1,980,138
Transitional costs	£0.00	£0.00	£0.00	£0.00
Externality costs	£0.00	£0.00	£0.00	£0.00
Net Contribution costs	£0.00	£0.00	£0.00	£0.00
Total costs	**£2,032,572**	**£2,033,402**	**£2,037,968**	**£2,033,670**
Rank	**1**	**2**	**4**	**3**

From a total cost point of view Option 1 (Business as Usual) is ranked first and the Preferred Option ranked 3.

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate+
Capital costs + optimism bias uplift	£32,882	£55,450	£56,147	£53,532
Total costs	**£32,882**	**£55,450**	**£56,147**	**£53,532**
Rank	**1**	**3**	**4**	**2**

From a capital cost point of view, Option 1 (Business as usual) is the more cost effective option with a capital cost of £33m including lifecycle, avoided capital cost and optimism bias, however the Preferred Option, Option 4 (do intermediate +) is ranked 2 at £54m.

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate+
Revenue costs	£1,999,690	£1,977,952	£1,981,821	£1,980,138
Total costs	**£1,999,690**	**£1,977,952**	**£1,981,821**	**£1,980,138**
Rank	**4**	**1**	**3**	**2**

From a revenue point of view, Option 1 is the least favoured option, with Option 2 (Do Minimum) ranked 1 and the Preferred Option 4 (Do intermediate +) ranked 2.

2.4.4.11 *Cost Benefit Analysis*

The following table summarises the key results of the economic appraisals:

Detailed Economic Summary (Discounted) - £'000				
	Option 1 – Business as usual	**Option 2 – Do Minimum**	**Option 3 – Do Intermediate**	**Option 4 – Do Intermediate +**
Costs				
Incremental cost increase - capital (including optimism bias)	£0	-£22,568	-£23,265	-£20,650
Incremental cost increase - risks	£0	-£2,264	-£2,056	-£2,523
Incremental costs - total	£0	-£24,832	-£25,321	-£23,173
Benefits				
Incremental cost reduction - revenue	£0	£21,738	£17,869	£19,552
Incremental benefit - cash releasing	£0	£5,540	£5,540	£5,540
Incremental benefit - non-cash releasing	£0	£17,759	£17,759	£43,026
Incremental benefit - societal	£0	£20,618	£20,682	£25,606
Incremental benefits - total	£0	£65,655	£61,851	£93,724
Value for Money				
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio	£0	2.64	2.44	4.04
Rank	**4**	**2**	**3**	**1**

The Benefit Cost Ratio demonstrates that **Option 4 is the Preferred Option with a BCR of 4.04.**

2.4.4.12 *Options Ranking*

The results are summarised and shown in the following Table.

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs - total	£0	-£24,832	-£25,321	-£23,173
Incremental benefits – total	£0	£65,655	£61,851	£93,724
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio		2.64	2.44	4.04
Rank	**4**	**3**	**2**	**1**

Although Option 4 has the greater capital cost which exceeds the current funding allocation, it only has the 2nd highest revenue cost over the life of the project. This combined with the value of the benefits over the 60-year life results in **Option 4 having the greatest Benefit Cost Ratio of 4.04** and is therefore the Preferred Option.

2.4.4.13 *Qualitative benefits appraisal*

Unmonetisable benefits have been assessed from a qualitative base to provide a NPSV per benefit score. The results of the benefits appraisal are shown in the following table:

	Option 1 – Business as usual	Option 2 – Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
Benefit score	66	18	18	12
NPSV	£0	£40,823	£36,529	£70,551
NPSV per benefit score	0	£2,267.96	£2,029.40	£5,879.24
Rank	**4**	**2**	**3**	**1**

Option 4 has the lowest benefit score and the highest Net Present Social Value and ranks 1st on a qualitative basis, supporting the BCR as Option 4 as the Preferred Option.

2.4.4.14 *Risks*

Risk appraisal has been undertaken and involved the following distinct elements:

- Identifying all the possible business and service risks associated with each option
- Assessing the impact and probability for each option.

2.4.4.15 *The Preferred Option*

The results of investment appraisal are as follows:

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs – total	£0	-£24,832	-£25,321	-£23,173
Incremental benefits – total	£0	£65,655	£61,851	£93,724
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio		2.64	2.44	4.04
Rank	**4**	**2**	**3**	**1**

2.4.4.16 *Conclusion*

The Preferred Option is Option 4 as the value of the benefits out- weigh the capital and revenue costs and the value of the risks associated over the life of the project.

2.4.4.18 *Sensitivity analysis*

Sensitivities have been introduced to the Comprehensive Investment Appraisal (CIA) to identify how much of a change would be required to move the Preferred Option to another option.

The methods used were:

a) 'switching values'

b) scenario planning / analysis ('what if ') by altering the values of the 'uncertain' costs and benefits to observe the effect on the overall ranking of options.

2.4.4.19 *Key observations*

The effect of the sensitivity analysis work was to reduce the BCR across all options however this did not cause a switch in the preferred outcome.

Following scenario planning, 'what if' analysis and switching values, the impact on the Benefit Cost Ratio has an effect on reducing the BCR, and for some scenarios reducing this below the Absolute Value For Money threshold for health spending of 4.0.

However, in none of the scenarios is the **Preferred Option** anything other than **Option 4**, as this still gives the greatest benefit over costs of all other shortlisted options. This demonstrates that the Preferred Option is a robust proposal that does not react to moderate and realistic sensitivities.

The Preferred Option is Option 4 however it is accepted that this option breaches the current funding envelop and supplementary funding would be required.

Should funding ultimately be constrained within the original £40m envelope then the Preferred Option, following the investment appraisal, would be Option 2. The appraisal reveals that construction of the fallow floor (for later fit out and completion) scores marginally lower than removing the floor construction completely and making an investment in additional backlog maintenance.

2.5 Commercial Case

2.5.1 Introduction

This section of the OBC outlines the proposed procurement method in relation to the Preferred Option (Option 4 - Do Intermediate + (AMM + Critical Care).

2.5.2 New Build Scope

The new build project will be the acute care hub for the entire locality enabling the co-working of multiple professions in a coordinated manner. The new facility will enable patients to be managed appropriately as quickly and safely as possible without the need to travel to another healthcare facility.

The proposed capital development will provide a three storey fully integrated Acute Medical Model, Level 1, 2 & 3 integrated critical care facility, and plant floor within a single building situated to the west of the main hospital estate. The AMM and Critical Care facility will occupy a floor space of 3,100m2 per floor.

2.5.4 Site Infrastructure Scope

The Infrastructure project originally comprised 12 elements that tackle key aspects of the site backlog maintenance burden, ensuring that the existing services were fit to support future developments including the proposed capital build. Not all 12 elements are affordable within the financial envelope and have therefore been prioritised. Necessary and essential elements are included for each option.

2.5.5 Procurement Strategy and Implementation Timescales

2.5.5.1 *Requirements & drivers*

The various procurement strategies available entail fundamental differences in the allocation of risk and responsibilities between parties and the suitability of the different approaches have been considered in relation to the specific nature of this project.

The key drivers for the project focus around the requirement for cost certainty at Full Business Case submission (with the cost being substantiated via a competitive tender process), the transfer of risk and achieving a tight programme, whilst also retaining control over design and construction quality.

2.5.5.2 *Procurement Options*

A Procurement Options report was prepared by Turner & Townsend Cost Management on 24 June 2020. This report outlined a range of procurement options available to the Trust for the New Build and Infrastructure works projects.

2.5.5.3 *Preferred Procurement route*

The Turner & Townsend report recommended a **two-stage Design & Build process with Guaranteed Maximum Price** as the Preferred Option:

The following procurement two-stage Design & Build process with Guaranteed Maximum Price options has been considered the most suitable procurement solution:

- JCT Standard Form of Contract – Design & Build (D&B)
- Pagabo - Framework agreement and
- Procure22 (P22) - Framework agreement.

The appointed independent cost advisor has undertaken a review of the procurement options and proposes that the ProCure22, (P22) framework is the most favourable procurement route.

The two elements of the project (New Build and Engineering Infrastructure) will be packaged together and released as a programme of work under the ProCure 22 framework which is fully compliant with the Public Contracts Regulations 2015.

2.5.7 Timescales

The key milestones for the Procurement Plan are outlined below.

Procurement Milestone Activity	Date
Scheme registered	14/10/20
High Level Information Pack (HLIP) issued	23/10/20
Open day	04/11/20
PSCP confirm	11/11/20
PSCP expression of interest submission	13/11/20
Short listing	17/11/20
PSCP Interviews	20/11/20
Trust Board approve appointment of PSCP	25/11/20
PSCP appointment	26/11/20

2.5.8 Market Interest

The overall value of the project should generate a good degree of interest from the market and soft intelligence suggests a robust degree of interest from ProCure 22 PSCP's.

2.5.9 Commercial feasibility and deliverability

Through the monthly meetings, updates and reports submitted to the Project Board; there is a high degree of assurance that this project is viable and deliverable and Trust Board approval of the Outline Business Case in November 2020, before submission for central approvals will reinforce this view.

2.5.10 Cost Plan

At conclusion of RIBA Work Stage 2, a robust Cost Plan Summary has been developed by our external cost consultant in conjunction with the Integrated Design Team and Trust stakeholders and project managers, to ensure cost affordability is realistic and takes account of the programme in terms of inflation, optimism bias and risk contingency.

2.5.11 Programme

The programme supporting the OBC is deemed to be realistic and deliverable and is developed in conjunction with our external advisory team. The programme has been adjusted in light of our preferred procurement route of ProCure 22 and takes account of the time required by the PSCP for the commercial aspects to inform the GMP and contract.

2.5.12 Resources

Sufficient and adequate skilled resource will be made available to successfully manage the procurement, implementation and operational stages of this project.

2.5.13 Design Quality Review (DQI)

DQI is designed to set and track design quality at all key stages of a building's development and incorporates post-occupancy feedback. It plays a fundamental role in contributing to the improved design, long term functionality and sustainability of building projects.

An online workshop has been held and the team were complimented on a well-considered and coherent approach with some clear direction on where proposals could be improved. An agreed set of outcomes will be addressed during the RIBA Work Stage 3/4 design development.

2.5.14 Mandatory Government Construction Strategy

This project has been developed in line with the Government Construction Strategy policy paper 2016-2020.

2.5.15 Compliance with HBN/HTM

Whenever possible, the project will comply with Building Regulations, European Standards, British Standards and Codes of Practice, guidance on the design and construction of primary care and general medical facilities. Much of this is contained in a series of DH publications and guidance documents primarily written for the NHS.

2.5.16 BREEAM (Building Research Establishment Environmental Assessment Method)

The Trust's focus will be to achieve **BREEAM Excellent**, which is achievable based on the current design and with the potential to achieve an Outstanding rating.

2.5.17 Energy & Sustainability

2.5.17.1 *Sustainability Management Plan*

The Trust has a Sustainability Management Plan 2017 to 2020 and the commitments in it have been a reference point for this project.

2.5.17.2 *Sustainable Design Guide*

The Trust introduced the use of a Sustainable Design Guide in 2017 as part of Board commitment to sustainability and this guide has been a reference point for this project.

2.5.17.3 *Sustainable Procurement Plan*

The Trust has a Sustainable Procurement Plan prepared specifically for this project. This plan helps to support the Trust's commitment to delivering sustainable buildings and to set minimum standards that build on the Trust's Sustainable Design Guide.

2.5.18 Low and Zero Carbon

A Low and Zero Carbon Feasibility Study has been prepared for this project by specialist advisors and identifies a number of opportunities for the new build facility.

2.5.19 Travel Plan

This project takes account of requirements under the Trust's approved 'Green Travel Plan'. The Trust has also commissioned a Travel Statement in support of the development of the site.

2.5.20 Planning Permission

The feedback from the Local Planning Authority advises that in principle the proposal is acceptable, subject to detailed Planning Application.

2.5.21 Risk Transfer & allocation

An assessment of how the associated risks might be apportioned between the Trust (Public Sector), the professional design team and the construction company (Private Sector) has been carried out for each aspect of the project. Allocation of risk is very clearly defined within the ProCure 22

framework and appropriate transfer of risk to the PSCP has been one of the deciding benefits of selecting this procurement route.

2.5.22 Proposed Contract Timelines

The length of the construction and infrastructure contract will reflect the construction programme and the prescribed defects period as shown in the following table:

Milestone Activity	New build	Infrastructure
Award Construction Contract	26 November 2020	26 November 2020
Commencement of construction	Quarter 3 2021	Quarter 3 2021
Construction complete	January 2024	January 2024
End of Defects Liability period	January 2026	January 2026

2.5.23 Implications for Trust staff

There are no TUPE implications associated with the project. This is a positive impact on Trust staff which will aid recruitment and retention and has been one of the key drivers for the project. Stakeholder engagement to date has been extremely positive in terms of the new environment and facilities that are proposed to be delivered for our staff.

2.6 Financial Case

2.6.1 Introduction

The Trust has used the Long Term Financial Model (LTFM) issued by NHS Improvement to provide a set of fully integrated financial statements based on the key drivers and assumptions underpinning the Trust's financial projections for the preferred option.

2.6.2 Historical Financial Performance

Historical Surplus / Deficit April 2017 – March 2020			
	Mar - 18	**Mar - 19**	**Mar - 20**
	£'000	£'000	£'000
Income	489,240	517,602	556,539
Expenditure	(501,680)	(520,435)	(553,307)
Operating Surplus / (Deficit)	**(12,440)**	**(2,833)**	**3,232**
Non-Operating expenses	(7,692)	(7,019)	(5,877)
Surplus / (Deficit)	**(20,132)**	**(9,852)**	**(2,645)**

The table above illustrates the financial performance of the Trust for the three years preceding the current outturn year (2020/21). As a result of this performance the Trust was the subject of a licence breach investigation by NHSE&I, and subsequently had undertakings placed against it.

Following significant progress made by the Trust and dependant on agreeing a system and organisation financial plan for Phase 3 Covid-19 recovery within the North Yorkshire system envelope (which has been achieved), NHSE&I have indicated that the Trust's undertakings are likely to be removed in December 2020.

2.6.4 Elements of the Long Term Financial Model

2.6.4.1 *Capital Costs*

A robust Cost Plan summary has been developed by our external cost consultant in conjunction with the Integrated Design Team and Trust stakeholders and project managers, to ensure cost affordability is realistic and takes account of the programme in terms of inflation, optimism bias and risk contingency.

The capital costs for the Preferred Option are summarised as follows:

Item	Description	Option 4 Do Intermediate +
100	**Construction**	
101	Construction costs	£ 25,485,558
102	Fees	£ 2,534,350
103	Non-Works costs	£ 60,000
104	Equipment costs	£ 3,750,000
105	Planning contingency	£ 2,548,556
106	Optimism Bias	£ 2,382,428
107	Inflation adjustment	£ 2,314,597
108	**Construction Total**	**£ 39,075,489**
200	**Infrastructure Works**	
201	HV / LV ring main	£ 7,759,706
204	Steam main replacement	£ 313,585
207	Cold water supply and drainage	£ 250,000
211	Re-provide car parking spaces	£ 676,022
212	Fees	£ 569,750
213	Non-Works costs	£ 30,000
215	Planning contingency	£ 449,966
216	Optimism Bias	£ 553,701
217	Inflation adjustment	£ 320,082
218	**Infrastructure Total**	**£ 10,922,813**
	TOTAL	**£ 49,998,302**

2.6.5 Equipment Schedule

A considerable amount of work has already been undertaken with regard to equipment purchase for the multiple schemes within the project to ensure that the equipment cost allocation within the cost plan summary is reasonable and adequate and also to identify any long-lead items.

2.6.6 Revenue

The Trust has developed robust methodologies for this project and has deployed these alongside the LTFM, to review affordability. These methodologies include a number of key assumptions around activity, income and expenditure. These assumptions will be the subject of further review between the OBC and FBC.

2.6.7 Inflation Assumptions

Inflation for the long-term financial planning model has been applied following NHSE/I Long Term Planning implementation assumptions.

2.6.9 Predicted Activity and Capacity Demand

The following assumptions on activity and capacity demand and growth in costs have been applied to the base line costs for the economic appraisal, however costs are included in the LTFM at baseline 2020/21 prices (net of growth and inflation).

Activity demand on the Urgent and Emergency Care Department has been assumed for the next 10 years as follows:

Year	2020/21	2021/22	2022/23	2023/24	2024/25
Growth in demand	0%	6%	6%	5%	4%
Year	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Growth in demand	3%	3%	2%	2%	2%

Activity growth in years 2020 - 2023 represents the current planning assumptions agreed with the commissioners in the 5 year plan.

2.6.10 Growth in Costs

Following assessment of the Trusts Service Line Reporting, growth in costs have been applied over the life of the project as follows:

Costs	Growth
Fixed	0%
Semi Fixed	2%
Variable	In line with activity growth above

The net growth applied to all revenue costs is as follows:

Year	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Growth	2.43%	2.45%	2.32%	2.17%	2.01%	2.02%	1.85%

2.6.11 Service Developments

The Trust has analysed the capital and revenue costs associated with this project and discussions have taken place with North Yorkshire system partners and the HCV ICS, and agreement has been sought from the partners to commit to meeting the revenue implications.

The table below represents the service developments as a full year impact when the scheme is completed, based on 2020/21 real prices (i.e. net of inflation).

	Additional Revenue implications of preferred option	
	Full year impact 2024/25 at 2020/21 prices.	
	WTE	**£'000**
Additional Support Staff (Radiology / Ultrasound)	3.39	159
Estates and Facilities running costs:		
Associated costs with increased floor area - AMM Unit (Ground Floor)	36.71	1,945
Associated costs with increased floor area – Critical Care Unit (First Floor)	27.37	1,270
Increased Infrastructure Costs	2.81	201
Assumed closure and mothballing of old ED area	-6.81	-294
Assumed closure and mothballing of Nightingale Wards	-10.59	-457
Agency Savings		-670
Depreciation		1,073
Total Operating Expenditure	**52.88**	**3,227**
PDC		1,811
PDC relieve on impaired value		-660
Total Non-Operating Expenditure		**1,151**
Total increase in revenue costs		**4,378**

2.6.11.1 *Additional Support Staff*

Additional support staff have been identified for Radiology and Ultrasound due to the provision of a dedicated radiology zone within the AMM providing CT / General X-ray and Ultrasound.

2.6.11.2 *Estates and Facilities costs*

Increased estates and facilities costs shown in the table below have been identified for the increase in floor area as follows:

- **Ground floor AMM unit**, which has an increase in floor area from a current Emergency Department and Cherry Ward combined 1,395sqm to 3,120sqm in the new build.
- **First floor Critical Care Unit**, which has an increase in floor area from 1,459sqm (ICU / Beech / CCU) to 3,120sqm in the new build.

The estates and facilities costs are broken down as follows:

	AMM (Ground Floor)				Critical Care (First Floor)			
	Total	**WTE**	**Pay**	**Non-Pay**	**Total**		**Pay**	**Non-Pay**
			£'000	**£'000**			**£'000**	**£'000**
SQM	**3,120**				**3,120**			
Domestics	836	23.62	753	83	634	17.92	571	63

	AMM (Ground Floor)				Critical Care (First Floor)			
Maintenance costs	425	7.06	252	173	425	7	252	173
Utilities (excl. Energy Management)	207			207	75			75
Rates	51			51	51			51
Waste	10			10	0			
Medical Engineering	183	1.12	42	141	0			
Porters/FO's	127	3.60	115	13	85	2.40	77	8
Catering	107	1.32	31	76	0			
Total	**1,945**	**36.71**	**1,193**	**752**	**1,270**	**27.37**	**900**	**370**

2.6.11.3 *Increased Infrastructure Costs*

Domestics, maintenance and portering costs have been factored into the revenue implications to take into account the increased demand on these services following the HV / LV ring main and Cold Water Supply infrastructure schemes.

	Infrastructure Costs			
	Total	**WTE**	**Pay**	**Non-Pay**
			£'000	**£'000**
Domestics	83	2.47	74	9
Maintenance costs	99			99
Porters/FO's	19	0.34	19	
Total	**201**	**2.81**	**93**	**108**

2.6.12 Capital Charges

2.6.12.1 *Public Dividend Capital (PDC)*

PDC will only apply when the asset is brought into use and the LTFM reflects this. The financial model assumes that the programme is financed through input of additional PDC and there will therefore be a corresponding increase in the PDC charge.

2.6.12.2 *Depreciation*

Depreciation for the new build is calculated on the asset once it has come into use. Infrastructure works will be in use by January 2022 and the capital build complete and in use by December 2023.

2.6.13 Efficiency Savings

2.6.13.1 *Closure and Mothballing of the old estate*

Following the transfer of services to the new build, a number of areas will be closed. There are therefore a number of assumed savings from mothballing these.

The transfer of Emergency and Urgent Care Services to the ground floor AMM unit will allow the current Emergency Department to close. Estates and facilities savings that will be generated will be £294k per annum.

Level 1, 2 and 3 critical patients will transfer to the purpose built first floor of the new build. Following a number of subsequent moves following this transfer, three Nightingale Wards in the old 1930s block will be closed. Estates and facilities savings that will be generated will be £457k per annum.

2.6.13.2 *Agency Savings*

Following the transfer of services to the new AMM unit, savings in agency premium costs have been assessed at £670k at 2020/21 prices.

2.6.14 Quality Assurance of Financial Model

The Trust has used the Long Term Financial Model (LTFM) to provide a set of fully integrated financial statements based on the key drivers and assumptions underpinning the Trust's financial projections for the Preferred Option.

The LTFM has been reviewed and signed off by Andrew Bertram, Finance Director, on 12 November 2020.

2.6.15 Funding Options

2.6.15.1 *Revenue Funding*

Discussions have taken place with the Trust's North Yorkshire system partners and the HCV ICS and agreement has been sought from the Trust's North Yorkshire partners to commit to meeting the revenue implications.

2.6.15.2 *Capital Funding*

The Trust's preferred option requests an augmented funding envelope requiring £49.998M of capital investment. The SOC approval letter confirmed a funding bid of £39.998M subject to approval of the subsequent OBC and FBC. However, the SOC approval letter also went on to request that the OBC "*…..should….explore other options to fund the capital cost above allocation of some of the higher value options. The OBC should also explore as part of this the additional costs of developing the first-floor ward space as part of this programme of work and identify the cost / benefit analysis of doing so.*"

This exact programme work has been undertaken as part of the OBC development and has been costed at a further £10M, taking the total scheme value from the original allocation of £39.989M to £49.998M.

At the time of submission of the OBC, whilst commitment exists from the ICS to deliver the full £49.998m project, agreement has not been reached on the final funding solution. The ICS has confirmed that it prioritises this additional investment and fully supports the eradication of substandard Nightingale accommodation in its hospitals (see Appendix 29).

Work on a funding solution will continue as part of the preparation of the Full Business Case submission. The Trust is working with the ICS and with the Regional NHSE/I Team to explore the potential for a three-way funding split including exploring the potential for additional central Public Dividend Capital (should this be available), a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme.

2.6.16 Summary

Following the appraisal of the impact on I&E / Balance Sheet and Cash flows, and based on the commitment from the Trust's North Yorkshire system partners and the HCV ICS commitment to

meet the revenue implications, this scheme is affordable as can be evidenced by the financial statements below.

2.6.17 Technical checks

2.6.17.1 *Capital/Revenue split*

The split of costs between revenue and capital is accounted for in line with the current capitalisation policy, within the Government Accounting Manual (GAM).

2.6.17.2 *Ownership of the assets*

At the end of the construction phase, the Trust will own the new assts.

2.6.18 Procurement costs

The internal project management team are permanent staff within the Capital Projects Team and have allocated annual establishment budget which is re-charged to their projects at year. This project has required the procurement of external project management through Turner and Townsend Project Management Ltd for which the cost is borne from the professional fees within the Capital Cost Summary.

2.6.19 VAT treatment

The construction of the new build and infrastructure works will be contracted out to the Trust's subsidiary, YTHFM. Under the MSA, YTHFM will undertake all construction and therefore VAT is recoverable.

2.6.20 Contingencies

2.6.20.1 *Capital Funding*

Capital funding of £40m has been secured through HCV ICS Wave 4 bid. At the time of submission of the OBC, whilst commitment exists from the ICS to deliver the full £49.998m project, agreement has not been reached on the final funding solution. The ICS has confirmed that it prioritises this additional investment and fully supports the eradication of substandard Nightingale accommodation in its hospitals.

Work on a funding solution will continue as part of the preparation of the Full Business Case submission. The Trust is working with the ICS and with the Regional NHSE/I Team to explore the potential for a three-way funding split including exploring the potential for additional central Public Dividend Capital (should this be available), a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme.

Further clarity on this position is expected for the FBC, at which time the requirement for additional contingency plans will be considered.

2.6.20.2 *Revenue Funding*

Discussions have taken place with the Trust's North Yorkshire system partners and the HCV ICS and agreement has been sought from the Trust's North Yorkshire partners to commit to meeting the revenue implications. As the revenue is developed through FBC, should any increase in operating expenses arise, this will be discussed through a collaborative approach with our system partners.

2.6.20.3 *Risk Register*

The Project Team has undertaken a risk assessment to identify the major areas of risk and a fully costed Risk Register has been produced.

2.6.20.4 *Capital Contingencies*

Contingencies are included within the Capital Cost Plan in the form of optimism bias and planning contingency. There are also contingences within the equipment costs.

2.6.21 Sensitivity Analysis

A sensitivity analysis has been applied to the LTFM in order to understand what impact a change in a number of events would impact on the current financial projections.

Sensitivity 1

Should operating expenses increase by 10% between December 2023 and March 2030, the impact on the I&E is an increased deficit / reduced surplus by an average of £267k per annum.

The biggest impact of increasing non-operating expenses by 10% is the impact on the Trust's liquidity rating, reducing this from -1.09 in 2029/30 to -2.11, however the rating is still 2 overall.

The I&E margin reduces from -0.02% to -0.06% but again does not change the overall rating of 3.

It is assumed for the purpose of this sensitivity that the additional cost will be an overspend that will need to be mitigated within the Trust; however it is more likely that there will be a collaborative approach with our system partners, and a way forward agreed.

Sensitivity 2

Sensitivity 2 assumes that the impairment of assets will be 25% rather than 30%. Although in the LTFM PDC is calculated on the full value of the asset, the change increase in valuation would increase the depreciation charge.

The LTFM does not pick up the changes to the I&E following the application of the sensitivity, which will need to be addressed for the FBC, however, the output would be a minor change to the value of capital charges (Depreciation) and a reduction to the post development surplus of £1.12m in 2029/30.

Sensitivity 3

Sensitivity 3 assumes an increase in capital costs by 10%, as with Sensitivity 2, the LTFM does not pick up the changes to the I&E following the application of the sensitivity, however the effect of this change would be an increase in capital charges and reduction in I&E surplus, plus a reduction on the Trust's cash reserves by £5m.

2.6.22 Optimism Bias

The optimism bias has been based on a percentage calculation which is derived from a list of risk factors and mitigation in accordance with the HMT Green Book. The % included within the cost plan reflects the current risk factors and mitigation which have been assessed to reflect the current status of the project and will be reviewed as the project progresses.

2.6.23 Land Transactions

There are no land transactions associated with this project.

2.7 Management Case

2.7.1 Overview

The management case details the project management and governance arrangements that the Trust has put in place to support the delivery of this project.

2.7.2 Project Plan

The Project Programme is intended to deliver the project by January 2024. The milestones for the programme are set out below:

Milestone Activity	Date
Submit OBC draft to Project Board meeting	09/11/2020 - complete
Submit OBC to Trust Board	25/11/2020 - complete
Submit OBC to Humber, Coast & Vale ICS Board	01/12/2020 - complete
Set up fortnightly Infrastructure user groups	Commenced 17/03/20
Set up fortnightly AMM clinical user groups	Commenced 26/03/20
Set up fortnightly Project Team meetings	Commenced 01/04/20
Site investigation surveys undertaken	01/04/20 - complete
Set up fortnightly finance meetings for OBC and revenue business case completion	Commenced 15/06/20 - complete
Appointment of special advisors	Complete to end of OBC
Complete high-level infrastructure packages for cost advisor costing for OBC	31/08/2020 - complete
DQI workshop	08/09/2020 - complete
Pre-Planning Application	15/10/2020 - complete
Tender and Appointment of PSCP	Completion by 01/12/2020
Submit FBC to Project Board	01/07/2021
Submit FBC to Trust Board	01/07/2021
Submit FBC to HCV	01/08/2021
Construction Milestones for procurement of equipment/training etc – to be developed following appointment of the PSCP	Commence Jan 2022 - 2 Years
Benefits realisation	January 2024 onwards

2.7.3 OGC Gateway Risk Potential Assessment (RPA)

All significant public sector projects are required to complete the Office of Government Commerce (OGC) process of detailed peer review and assessment at key stages or gateways.

Guidance states that the RPA form should be completed as early as it can in a project and it has been populated for OBC stage on information currently available. The RPA has been submitted in November 2020 and is awaiting a review date (before the end of November 2020).

2.7.4 Post Project Evaluation

The capital team have a well-developed and documented guide to follow for all projects in excess of £1m capex and will use this for the project.

2.7.5 Project Management Structure

The Trust's Chief Executive is the Senior Responsible Owner (SRO). The Managing Director of YTHFM is the Project Sponsor and the Head of Capital Projects, the Project Director.

The Project Lead will manage the Integrated Design Team; Cost Advisors; Specialist External Advisors and Internal Advisors. The Project Lead will chair the Project Team Meeting Group which will be the forum to manage design and implementation.

The Project Management Structure is included within the Governance Structure chart in section 9.3.5.4.

2.7.6 Project Management Methodology

The methodologies and approach for this project rely on our internal Capital Projects Team management processes which follow the principles of PRINCE 2 and follow the construction industry standard best practice. Project direction and management will be determined by the Project Director.

2.7.7 The Project Team

Key members of the Project Team are shown in the table below:

Role	Name	Responsibilities	Full Time Equivalent
Head of Capital Projects	Dr Andrew Bennett	Project Director	0.2WTE
Strategic Capital Planning Manager	Joanne Southwell	Project Lead	0.8 WTE
Senior Capital Project Manager	Liz Vincent	Support for Project Lead	0.6 WTE
Infrastructure Project Manager	Steve Dalton T&T	Project Lead for Infrastructure	0.6 WTE
Head of Business Development	Sarah Barrow	Financial Management support for Business Case development	0.6WTE
Project Administration	Hannah Bailey	Administrative Support to Project	1.0 WTE

In addition, this team is supported by several External Advisors & Specialists.

2.7.8 Project Reporting & Monitoring

Throughout the development of the proposals, regular monthly briefings and communications have been scrutinised and reported to the Trust Executive Team and ultimately the Trust Board. The following reports will be prepared:

Report	Prepared by	Sent to	When
Project Report Summary	Project Lead	Project Board	Monthly
Project Board Report	Project Director	Project Board & Capital Programme Executive Group (CPEG)	Monthly
RIBA Work stage 2 report	Integrated Design Team	Project Board	End of OBC

2.7.9 Lessons learned

In addition to a Post Occupancy Review (POR), a Lessons Learned Workshop will be held on the completion of the FBC and all building and infrastructure works on site.

2.7.10 Benefits Strategy

The delivery of benefits will be managed through the Project Board and at FBC stage a detailed plan for realising each benefit will be developed.

2.7.11 Change Management

Change management associated with the project will be managed through the Project Board, under the chairmanship of the Project Director. Day to day change management issues will be discussed at a project level and any resultant contract and/or cost changes will need to be approved by the Project Board.

2.7.12 Users support

Users of the new facility have been involved in and are fully supportive of the project and will be included in the planning and implementation of the project.

2.7.13 Organisational/Cultural Impact

The organisational and cultural impact has been considered and built into the Trust's local Care Group and overall Human Resource and Estates strategies.

2.7.14 Risk Management

The Project Team has undertaken a risk assessment to identify the major areas of risk and highlighted the controls currently in place, or to be put in place, to mitigate the risks.

The Trust's approach to risk management, in accordance with its Board Assurance Framework, the Capital Investment Manual and HM Treasury Green Book, is designed to ensure that the risks and issues are identified, given an owner, assessed and mitigation plans developed.

2.8 Recommendation

It is recommended that:

- This Outline Business Case is submitted to the Trust Board in November 2020 for approval
- The Trust Board acknowledge that the funding envelope for Option 2 is already established within the original £40m bid proposal but is not the optimal option
- **Option 4, at a cost of £49.998m** is carried forward as the **Preferred Option** by closing the £10m funding gap through continued working with the ICS and with the Regional NHSE/I team to explore the potential for a three-way funding split including the potential for additional central capital, a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme. If this option proves ultimately unaffordable then Option 2, at a cost of £39.989M, would be the Trust's second preferred option
- That the Full Business Case (FBC) is developed without delay utilising the early drawn-down fees received whilst awaiting central approval of the OBC.

3 The Strategic Case

3.1 Structure and Content of the Document

This Outline Business Case (OBC) has been prepared using the agreed standard template and format for business cases using The Green Book, Five Case Model which comprises the following key components:

- The **Strategic Case** which sets out the strategic context and the case for change, together with the supporting investment objectives of the project
- The **Economic Case** which demonstrates that the Trust has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM)
- The **Commercial Case** which outlines the commercial and procurement strategy
- The **Financial Case** which confirms funding arrangements and affordability and explains any impact on the balance sheet of the Trust
- The **Management Case** which demonstrates that the project is achievable and can be delivered successfully to cost, time and quality.

The OBC has been built around the NHSI Business Case core and clinical quality checklists dated November 2016 Code CG14/16. (See Appendix 26).

3.2 Introduction

Building on the Strategic Outline Case (SOC), this OBC describes the proposed investment in a new capital build and site-wide engineering infrastructure at Scarborough Hospital.

The proposals focus on the provision of redesigned acute and emergency services within a new fit for purpose, compliant, capital build which will support significant operational benefits for the Trust and wider community. The new building will facilitate the Acute Medical Model (AMM) – combining and expanding the current Emergency Department, Same Day Emergency Care (SDEC), Frailty and Acute Medical Unit. Level 1, 2 and 3 critical care services will also be combined to provide a critical care floor directly above and in support of the new AMM as well as site-wide engineering infrastructure investment to support the capital build and future Site Development Plan (SDP).

This OBC outlines the context, both local and national, together with capacity and demand modelling against which the proposals have been planned. The key drivers for change will be detailed, from which the Benefits and Critical Success Factors (CSF) are derived. It will also confirm the affordability of the proposals in terms of both capital and revenue consequences.

This OBC will also address the approval conditions laid out in the SOC approval letter of 29 April 2020, from the Department of Health and Social Care and NHS England and Improvement.

3.3 Scarborough Hospital Overview

Scarborough Hospital is part of York Teaching Hospital NHS Foundation Trust and is a partner in the Humber, Coast and Vale Integrated Care System.

Scarborough Hospital is the Trust's second largest hospital. It has an Accident and Emergency Department and provides acute medical and surgical services, including trauma and intensive care

services to the population and visitors to the North East Yorkshire Coast. It comprises a range of clinical and support facilities and services which vary significantly in terms of age, compliancy and functional suitability.

Scarborough Hospital serves a core catchment population of approximately 200,000 residents which grows by 7%+ in the summer months. The hospital is a designated Trauma Unit supported by networking arrangements with South Tees, Leeds, Hull and York Hospitals. North Yorkshire Clinical Commissioning Group (CCG) is the Trust's main commissioner of services and with whom the Trust is working in support of this project.

Services provided at Scarborough Hospital are shown below.

Diagram 1 – Scarborough Hospital Services

The current Emergency Department no longer has the capacity to meet the current demand and its design and geographical position prevents any opportunity for expansion and limits implementation of new models of care delivery.

3.4 The geography

Scarborough Hospital is geographically isolated with the nearest hospital, York Hospital, 40.5 miles away as shown in the diagram below.

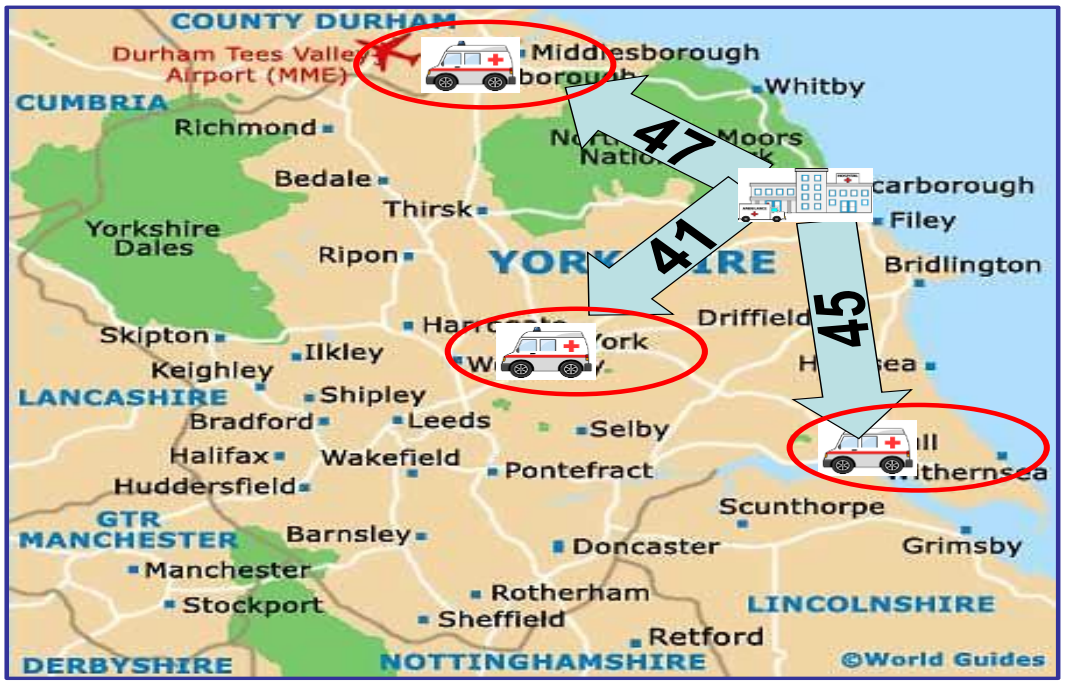

Diagram 2 – Geographical location

3.5 Catchment area

The map below shows the extensive catchment area for Scarborough Hospital by Electoral Wards for the Local Authority areas.

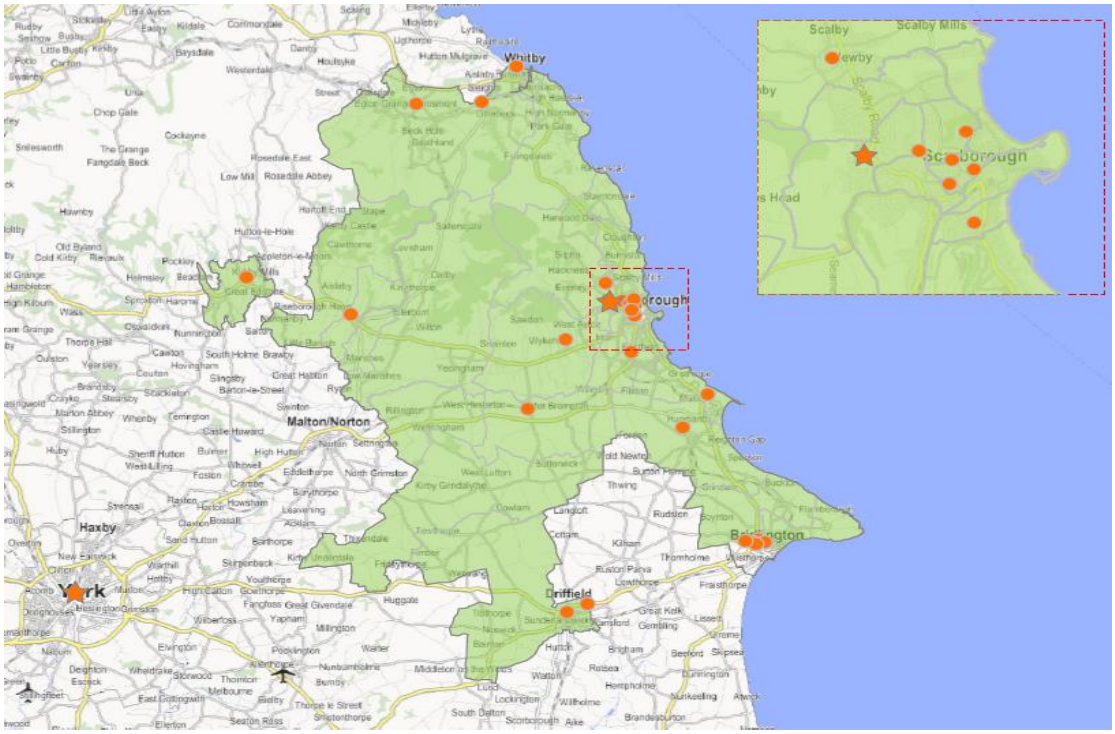

Diagram 3 – Scarborough Hospital Catchment Area

3.6 System level structure

North Yorkshire Clinical Commissioning Group (CCG) is the Trust's main commissioner of services and Humber, Coast and Vale the regional healthcare partnership.

The project outlined in this OBC is owned at a programme level by our Health Care Partner, Humber Coast and Vale, who set the strategic direction for the three Trusts, York, Northern Lincolnshire and Goole and Hull University Teaching Hospitals, focusing on acute services.

Scarborough Hospital has networking arrangements with South Tees, Leeds, Hull and York Hospitals.

The Diagram below shows the System level organisation structure.

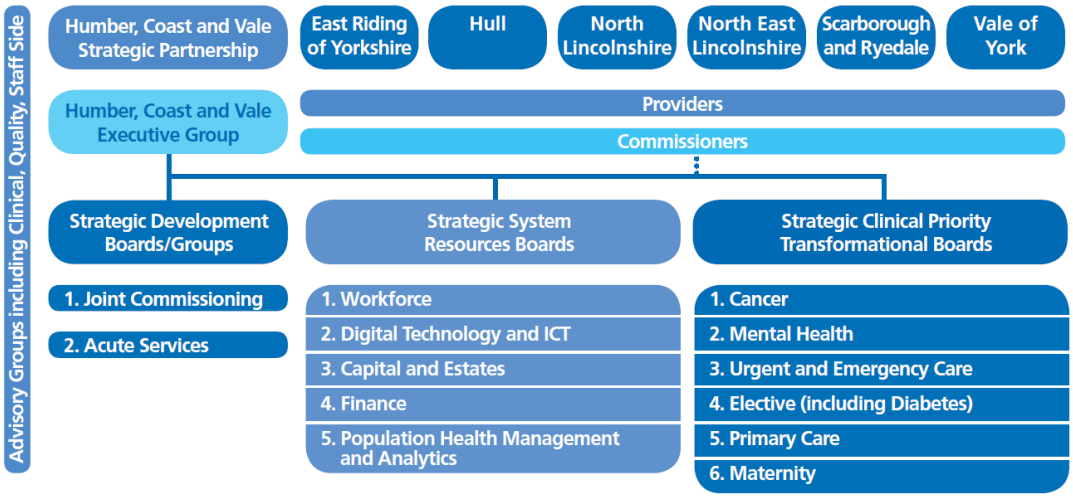

Diagram 4 – System level Organisation Structure

3.7 Approval and Support

3.7.1 Approval

This OBC seeks approval to invest an estimated £50 million of Humber, Coast and Vale Integrated Care System (HCV ICS) central funding to deliver the Scarborough Hospital Transformation of Emergency and Urgent Care and Site Engineering Infrastructure project.

Approval for this OBC will be sought from the following:

- The Project Board
- The Trust Board
- Humber, Coast & Vale Integrated Care System
- NHSEI Joint Investment Committee
- Department of Health and Social Care.

3.7.2 Support for the project

Appendix 17 – includes an article written by the Care Group Clinical Director, Consultant in the Emergency Department at Scarborough Hospital, Dr Ed Smith, for the Royal College of Physicians describing the new model of service delivery, which will be applied to this project.

A letter of support for the SOC from Amanda Bloor, Accountable Officer, North Yorkshire Clinical Commissioning Group was received by the Trust's Finance Director, Andrew Bertram on 27 February 2020.

The letter of support for this OBC was submitted on XXXXXXXX.

Part A: The Case for Change

3.8 Drivers for Change

The increasing size and ageing of the local population, as well as increasing demand for urgent healthcare in society, has delivered increasing attendances to Scarborough Emergency Department year on year for many years (variable but up to 6% increase per year). In the post-Covid world there is an urgent need to re-set urgent healthcare services and attempt to continue to evolve the way in which we provide these locally.

Scarborough Hospital also faces challenges around recruitment, sustainability, geography and demography, with the following drivers for change identified as part of the *Scarborough Acute East Coast Services Review January 2019*, which was a detailed report on Clinical Services in the Scarborough area:

Summary case for change for Scarborough Hospital	
The local population is ageing and has changing Health needs…	▪ Life expectancy in Scarborough is below the national average for men, driven by high rates of stroke and coronary heart disease ▪ The local population (within the catchment) is growing by 0.2% per year but ageing, with the number of people over 70 projected to grow over the next seven years ▪ This will result in a higher prevalence of people with long term conditions (LTCs) and frailty ▪ Scarborough has a large and seasonal non-resident population-there are 5 million nights a year spent in the Scarborough region by tourists ▪ The underlying population is projected to grow by 2.2% by 2030, in the same period demographic related activity growth in non-elective care is projected to increase by 10.4%
… requiring a different sort of care to that historically provided…	▪ Care for people with LTCs and frailty needs to be provided in a different way & in a different place than in the past ▪ It will need a more proactive approach, delivered by multi-disciplinary teams working together, with easier access to diagnostics and specialist opinion and more consistent quality of care ▪ It will also require greater use of technology, e.g. virtual outpatient clinics or remote monitoring
… which will result in decreased in hospital activity…	▪ Currently over 50% of NHS funds available for the local population are spent in the acute sector ▪ The clinical evidence base suggests that a greater focus on prevention of ill health and on caring for people with LTCs and frailty in the community can potentially reduce the need for care within the acute hospital resulting in better health status and greater independence ▪ Examples from elsewhere suggest that new models of out of hospital care could reduce the amount of acute activity by ~3.5% per year
… which is good for the local population, but will put further pressure on	▪ Scarborough Hospital is recognised as a remote site, 42 miles away from the nearest hospital, challenging collaborative working ▪ As a result of population size and demographics, acute hospital services in Scarborough have relatively low volumes and acuity, and a relatively high number of patients who could be treated in a different environment –**51% of attendances at Scarborough ED (including the UCC) were**

already fragile, low volume acute hospital services	**for minor problems** **–73% of all bed days were occupied by patients over 65, compared with 60% nationally** **–Stranded non elective patients accounted for 65% of all bed days** ▪ Services which need to be provided 24/7 are particularly difficult with relatively small numbers of patients **–Obstetrics sees ~1,400 deliveries per year, the 7th smallest consultant led obstetric unit nationally** **–There were fewer than 3,000 admissions last year to Paediatrics: the national average approaches 5,000** **–Only 70% of doctors in training report adequate experience at Scarborough; the national average is 90%** ▪ 24/7 services are more expensive to run in Scarborough: ED, women's services and children's services costs are 124%, 120% and 128% of indexed national average assessed costs respectively ▪ Staffing of services providing 24/7 care is particularly difficult to provide **–46% of posts in Emergency and Acute Medicine are not filled with a substantive appointment** **–26% of consultant workforce is over 55** **–Locum/agency/bank expenditure at Scarborough Hospital was £10.6 million in 2016/17**
The Trust therefore needs to change its model of care to continue providing high quality sustainable services	▪ Building on experiences of similar sized hospitals elsewhere, this is likely to involve: **–New forms of collaboration with neighbouring hospitals, in particular York, while remaining cognisant of travel times between the two sites** **–More integrated arrangements with local primary and community care services** **–New workforce models and potentially greater use of technology** **–Identifying opportunities to utilise the Bridlington site**

Table 1 – Case for Change

3.9 Background

3.9.1 Overview of current facilities

The current acute care accommodation infrastructure at Scarborough Hospital dates from the mid-1980s which means it is no longer fit for purpose both in terms of non-elective activity, capacity and compliance with new regulations for example; ligature free rooms for mental health patients, environments for patients with learning disabilities and isolation capacity. There is also a need for increased therapy input to prevent deconditioning and ensure the overall strategy of "Home First" (a key tenet of Acute Medical Model) can be delivered.

3.9.2 Current Level 1 beds

The current cardiology bed configuration has six Level 1 'unit' beds, with an average occupancy of five beds. The sixth bed provides the necessary flexibility to cope with peaks in demand. YTHFT have commenced (October 2020) a capital scheme on the York site to provide additional Cardiac Catheterisation Labs known as the Vascular Imaging Unit (VIU). This additional cardiac capacity in York will not impact on the demand for Cardiology Level 1-unit beds at Scarborough Hospital.

Current pathways linking services for cardiac patients who are acutely unwell and require immediate surgical intervention will remain unchanged and patients will be transferred, as at present, to the Cardiology Unit at Castle Hill Hospital in Hull.

3.9.3 Current Level 2 & 3 beds

The current Intensive Care Unit (ICU) in Scarborough Hospital does not meet building, infection prevention and environmental requirements of a modern ICU and it cannot be upgraded to meet these standards. An options appraisal was undertaken in October 2016 (see Appendix 14) and concluded that there is no other obvious area of Scarborough Hospital that could be converted to an ICU recommending that a new build solution was the only viable option.

Non-clinical transfers (transfers due to bed capacity or staffing issues) from the site to other ICU's remain low to moderate at consistently 1 per month over the same time period.

The driving focus for the proposed critical care floor is patient safety and the non-compliant nature of existing Level 1-3 areas, IPC issues around the lack of single room accommodation and the geographical separation of critical services across the hospital site.

There is no designated paediatric stabilisation area in the current unit configuration and it also does not provide adequate staff change and relative's accommodation or supporting accommodation.

3.9.4 Engineering Infrastructure

In relation to the Engineering Infrastructure, a Site Condition Survey carried out in July 2017 highlights the catastrophic, critical, high risk and non-compliant nature of the current infrastructure. Without investment, the current infrastructure is unable to support this proposed capital build and service transformation or any future capital expansion.

The table below outlines the current condition and suitability of the Engineering Infrastructure at Scarborough Hospital.

Scarborough Hospital Engineering Infrastructure – site-wide	
LV Network/Generators	LV network currently at full capacity switch wise and cannot add any additional equipment or expansion. Two of the three existing generators are ancient and obsolete and no resilience (N+1 HTM compliancy)
HV ring main	Existing 3 radials with a single point of failure which would affect the entire site. Proposal is to install a completely new ring main.
Oxygen ring main	Currently only one VIE plant in situ which is a single point of failure. A second full size oxygen VIE will be provided and a ring main created.
Air Handling Units	Operating Theatres 1, 2 & 3 are not on single theatre supply and extract thus any maintenance or repair shuts down 3 theatres at a time. Single theatre supply & extract required.

Steam mains	The steam main is 60+ years old, single pipe with no emergency connection available in the event of a single point of failure. Also runs in the ceiling void above the basement link corridor where staff and patients walk. This is a high risk to the safety of staff and patient in the event of a failure and requires re-location.
South block roof	The south block roof is 35+ years old and leaking into patient areas. Departments most affected are maternity, SCBU, Elderly Medicine Ward and medical records. Requires total new over-roof solution.
Mortuary	The current mortuary is not fit for purpose with insufficient body storage capacity, damp, roof leaking and body viewing areas in extremely poor condition.
Water, drainage, gas, utilities	Site-wide resilience issues and drain repairs required.
Vertical transportation	11 passenger lifts in situ ranging from 1968 to 2018 install with varying general conditions. Phased lift replacement programme required.
Parking	Proposed site for capital build holds 118 vehicles. Relocation of this parking will generate a total of 94 parking spaces, an overall loss of 24 spaces.
Pneumatic tube system	Current system for transporting pathology specimens is obsolete, fails on a daily basis and doesn't cover the entire site. Requires a hospital wide new installation to all wards and department areas.

Table 2 – Current Engineering Infrastructure

3.9.5 Care Quality Commission (CQC)

The Care quality Commission produced a report on 24 March 2020 which highlighted clear concerns regarding patient care in the Trust's Emergency Department, further evidencing the need to take forward the project in this OBC at the earliest opportunity.

The report found that Urgent & Emergency Care Services were Inadequate and were given a **RED** rating for being Safe, Responsive and Well Led.

The extract below from the report highlights the rating and concerns.

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Inadequate	We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by York Teaching Hospital NHS Foundation Trust required significant improvement.

Diagram 5 – CQC review of Scarborough Hospital Emergency Department

The full CQC Report is included in Appendix 18.

3.9.6 Patient safety

There are urgent patient safety issues that our teams deal with on a day to day basis and require to be addressed. The reality of the current situation of running an Emergency Care service in a sub-optimal facility is that:

- Our patients incur unacceptable waiting times
- Ambulances are unable to off-load patients in a timely manner and
- Dedicated practitioners are, despite their best efforts, unable to deliver the standard of care that our health population deserve.

The new facility that this project will deliver is crucial to reducing the clinical risk and patient safety issues within acute and emergency care and within our Level 1, 2 and 3 critical care facilities. It also supports our future transformation programme of acute services and improved patient flow that together will deliver improved patient outcomes and experience.

3.9.7 Guidelines for the Provision of Intensive Care Standards (GPICS)

Guidelines for the provision of Intensive Care Services (GPICS), published by the Intensive Care Society, requires critical care units to have adequate access to side rooms (recommendation of at least 50% of the unit being side rooms). The ICU in Scarborough Hospital currently only has one side room which has proved especially challenging in current times due to the additional Covid-19 isolation requirements.

The main building regulation for this project is HBN 04-02. This is clearly set out in the GPICS. At the last peer review in 2015 and Get It Right First Time (GIRFT) visit in 2019, the Trust was tasked with creating a plan to explain how we were going to address the lack of compliance with the GPICS. To date we have been unable to achieve any improvements and require a new build solution to provide resolution assurances.

3.9.8 Scarborough Acute East Coast Services Review

The *Scarborough Acute East Coast Services Review* phase one report of January 2019 sought to understand the clinical, operational and financial drivers that support a case for change.

The main purpose of the review was to consider the most appropriate configuration of Scarborough's acute services to ensure that they are adequately supported by other specialties, fit for purpose, sustainable, accessible and deliver the highest possible quality of care. The Trust remains committed to sustaining effective urgent and emergency, and critical care services in Scarborough and the review has focused on how to ensure that services are configured in the future to support this commitment.

The presentation of the Stage 1 Review included the commitment to provide 24/7 emergency care, ensuring specialty support and engagement. It was also evident that to meet current challenges; recruitment, geography, demand and demography of the East Coast, the existing model of service would need to change and develop together with our healthcare partners.

3.9.9 Funding

The HCV ICS Wave 4 bid for funding outlined in the Strategic Outline Case (SOC) focused on provision of a new model and clinical pathway of delivering urgent care at the front door - the

Acute Medical Model (AMM), requiring a capital build solution and investment in mechanical and electrical engineering infrastructure to support the build for the Scarborough site.

The Trust's Preferred Option requests an augmented funding envelope requiring £49.998M of capital investment. The SOC approval letter confirmed a funding bid of £39.998M subject to approval of the subsequent OBC and FBC. However, the SOC approval letter also went on to request that the OBC "…..*should….explore other options to fund the capital cost above allocation of some of the higher value options. The OBC should also explore as part of this the additional costs of developing the first-floor ward space as part of this programme of work and identify the cost / benefit analysis of doing so."* This work has been undertaken as part of the OBC development and has been costed at a further £10M, taking the total scheme value to £49.998M.

At the time of submission of the OBC, whilst commitment exists from the ICS to deliver the full £49.998m project, agreement has not been reached on the funding solution, however the ICS is prioritising this investment as mentioned in their letter of support.

This work will continue as part of the preparation of the Full Business Case submission. The Trust is working with the ICS and with the Regional NHSE/I team to explore the potential for a three-way funding split including the potential for additional central capital, a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme.

3.9.10 Clinical Strategy post SOC

In the SOC submission, the Trust had yet to define the clinical strategy for critical care on the East Coast and as such the first floor of the new capital build was referred to as a fallow floor (a floor that is not fitted out and is basically a building shell).

Following clinical and operational review, the decision has been taken to ensure our Level 1, 2 and 3 patients receive optimal care in an integrated fit for purpose, compliant unit as a further development of the AMM. This will place critical care directly above the AMM floor providing operational and clinical efficiencies with the additional benefit of freeing up ward accommodation to reduce the number of 1930's Nightingale Wards by three, namely Ann Wright, Stroke and Coronary Care.

3.10 Rationale and Investment Objectives

3.10.1 Key issues

This OBC seeks to address three key issues:

- The extensive clinical and operational challenge in providing sustainable, responsive emergency care in a department which is **too small, overcrowded, non-compliant, inflexible and no longer fit for purpose**

- The extensive clinical and compliancy challenges in providing sustainable Level 1, 2 and 3 critical care services which are currently dispersed in **five separate, non-compliant, departments across the hospital site.** This will, in turn, reduce the number of 1930's Nightingale Wards currently in the 1930's North Wing of the Hospital

- The **critical fragility of the existing engineering site infrastructure** which is **non-compliant and at maximum capacity** with major operational critical services working on non-essential power together with the burden of outstanding backlog maintenance.

3.10.2 Health Service needs

This project also addresses a number of material health service needs. The Scarborough Acute East Coast Review with York Teaching Hospitals NHS Foundation Trust, North Yorkshire CCG, East Riding of Yorkshire CCG, Humber Teaching Hospital NHS Foundation Trust (community service provider) and Humber, Coast and Vale Integrated Care System all identified that:

- The local population is ageing and has **changing health needs**
- A **different type of healthcare service is required** – one that results in decreased hospital activity
- A **new model of care** is needed.

This is further supported by the need to provide a high-quality sustainable service, delivered by a workforce that the Trust can retain and recruit to and supports delivery of financial efficiencies that help the Trust live within its means.

3.10.3 Overall objectives

The main strategic objective of the capital build project is to design and construct an accommodation solution to implement the Acute Medical Model (AMM) incorporating compliant Level 1, 2 and 3 critical care facilities to support the local population demographic growth and complexity by completion in early 2024.

This solution will also provide the ability to reduce the number of Nightingale Wards which are outdated and not fit for purpose.

3.10.4 SMART Objectives

At a workshop held on 11 June 2019, the following SMART objectives were agreed by the Project Team and Stakeholders.

	Investment Objectives
IO1	**Reduce cost**
	Reduce backlog maintenance burden from £65M to: -
	£40.4M (reduction of £24.6M) for Option 2
	£46.6M (reduction of £18.4M) for Option 3
	£45.9M (reduction of £19.1M) for Option 4
	Cost effective to build Critical Care Floor at same time as AMM (£10.3M build now & £14.1M to build at future date)
IO2	**Improve efficiency**
	Infrastructure efficiencies
	Improves Energy Performance Certificate (EPC) rating in existing buildings from a rating of D to a rating of B for the new build

	Critical Care efficiencies
	Reduce nursing staff vacancy percentage from 6.48% to <5% in first year of operation
	Reduce nursing staff turnover from 3.6% to <2.5% in first year of operation
	Reduce nursing staff sickness absence rates from 4.24% to 3.1% in first year of operation (Level 2 & 3 patient areas)
	Improved end of life care in respect of dignity & privacy utilisation of single occupancy rooms (deaths in bays/single room improves from 9% to 70%)
	Reduction in No of non-clinical external transfers to other hospital sites from 2% to 0.8% from operational start date
	Currently 50% of ICU patients are delayed longer than the ICU standard of 4 hours to transfer to downstream specialty wards. This will be reduced to 30%
	Co-location of all Level 1, 2 & 3 patients currently in 5 dispersed locations to 1 central location from operational start date
	AMM efficiencies
	Improve the time first seen from 30 mins (mean) 47% to 15 mins (mean) for 75% of attendances within 12 months of AMM opening
	Improve 2-hour decision making/patient planning from 97 mins (mean) 71% to 85 mins for 75% of attendances within 12 months of AMM opening
	Improve SDEC admissions from 12% to 33% (national target) within 6 months of AMM opening
	Improve ECS 4-hour target from 80% to 95% within 12 months of AMM opening
	Improve time to CT for head injuries from 20 minutes to 5 minutes within 3 months of AMM opening
	Reduce nurse staffing vacancy percentage from 10% to 7% within 12 months of AMM opening
	Improve capacity within diagnostics (CT, X/ray, U/S) based on 2018/19 activity and demand profile to 2023 to accommodate: CT increase of 1384/ X/Ray increase of 7566/ U/S increase of 413
	Dedicated CT provides resilience (only 1 CT on site currently) to reduce the No of times CT is unavailable from 6 to 0 from AMM opening
	Integrated CBRN improves response time from 60 to 0 mins from 2024
	Improve quality
	Design & build to provide innovative, light, fit for purpose exterior/interior with life cycle of 65 years by 2023

	Improve environment for staff, visitors and patients (measure by satisfaction surveys) by 2023
	Removal of 3 Nightingale Wards from operational start date of Critical Care Floor within 1 year from vacant accommodation being available
IO4	**Re-procurement**
	AMM
	Increase m2 from 550m2 ED and 800m2(AMU) to combined 3,100m2 by 2023 to provide capacity for current and future demand modelling
	Provide demand modelled flexible layout i.e. no of specific spaces required from 41 to 73 from 2023 28 > 24 hr inpatient beds to 12 < 24 hr patient beds/trolleys Increase 2 external ambulance parking bays to 4 bays Increase 1 shared general x/ray room to dedicated 1 general X/ray room & 1 CT & 1 U/S room
	Increase capacity to accept patients in the category dispersal model P1, P2 & P3 from 4pts, 4pts & 30pts to 6pts, 6pts & 45pts
	Critical Care
	Increase m2 from 600m2 to 3,100m2 from operational start date
	Increase number of single occupancy rooms from 2 to 19 from operational start date
	Infrastructure
	Execute & complete essential infrastructure schemes to facilitate the opening of the capital build by 2023
IO5	**Compliance & conformance**
	Comply with Carter Model Hospital recommendations - <35% non-clinical accommodation by completion 2023
	Build to HBN & HTM standards 95% compliant by completion 2023
	Build to BREEAM standards (good 45%, very good 55%, excellent 70%) Target excellent by completion 2023
	Build to Inclusive & Accessible Built Environment Policy 100% by 2023
	Comply with CQC accommodation issues in ED and Critical Care (GPIC) including RCPCH Facing the Future Documents by completion of build
	Comply with Local Planning Authority and Building Regs by completion of design
	Comply with HTA regulations for new mortuary by end of build design phase

Table 3 – SMART Objectives

3.10.5 Benefits linked to Smart Investment Objectives

During a final workshop review of the project benefits on 2 November 2020, the Project Team and Stakeholders confirmed the categorisation of each individual benefit into four distinct categories as follows:

- **Cash releasing benefits** (CRB) – benefits which will release cash from revenue budgets
- **Non-cash releasing benefits** (NCRB) – benefits which do not release cash from revenue budgets, however, do have a productivity benefit which may result in lower costs in future time periods
- **Un-monetisable benefits** (UB) – benefits which do not release cash and are more qualitative in nature
- **Societal benefits** (SB) – benefits which do not release cash, however, do have a benefit to the wider society.

The benefits were then linked to the SMART Investment Objectives derived in earlier workshops to ensure a clear and consistent approach to the strategic outputs of this project. The benefits form part of the CIA financial template which informs the overall Benefit to Cost Ratio (BCR) required to rank the four options in terms of economic value.

Main Benefits Criteria	Classification	Investment Objectives
Patient at the centre of clinical decision making by providing appropriate clinical accommodation & diagnostic support services to implement the Acute Medical Model	UB	IO2
Rapid assessment & decision making leading to shorter waiting times and improved ECS	NCRB	IO2
Avoiding unnecessary inpatient admissions	NCRB	IO2
Improved environment (age appropriate accommodation i.e. paeds/elderly/accessibility etc)	UB	IO3
Maximise single occupancy accommodation to comply with infection prevention best practice & improve privacy & dignity & lessons learnt from Covid-19	UB	IO4
Use of art to signpost & inform patients through their episode of care	UB	IO3
Centralised management of level 1, 2 & 3 critical care patients in improved, complaint, single occupancy accommodation	NCRB	IO2
Reduce % of medical outliers in surgical beds due to cohorted level 1 in new facilities. This will result in reduced cancellations of planned activity and increased theatre efficiencies	NCRB	IO2
Avoiding unnecessary inpatient transfers	NCRB	IO2

Main Benefits Criteria	Classification	Investment Objectives
Improved environment (age appropriate & accessibility) including dedicated breast-feeding room & baby changing facility	UB	IO3
Baby friendly initiative compliance	UB	IO3
Appropriate paediatric play area & adjoining consulting room	UB	IO3
Additional & improved bereavement & quiet space accommodation within the Acute Medical Model & Critical Care facility	UB	IO3
Dedicated relatives' day and night accommodation within the critical care floor	UB	IO3
Artwork & build design to promote a calm, spacious, professional environment	UB	IO3
Improved working environment including dedicated staff welfare facilities to aid recruitment & retention	NCRB	IO3
Innovative design of a range of clinical spaces to provide the required capacity to care for all acute patient attendances	UB	IO3
Improved access to diagnostics (CT, X/ray/US) & improved resilience with 2nd CT	CRB	IO2
Improved access to multi-disciplinary integrated care teams in AMM & Critical Care	UB	IO2
Reduce nursing vacancy from 6.48% to <5%	NCRB	IO2
Sufficient access to PC's & workspace	UB	IO2
Improved working environment & staff welfare facilities	UB	IO3
Consolidation of currently fragmented administration	UB	IO2
Use of technology to improve patient flow	UB	IO2
Reception area design to promote confidentiality issues on check-in	UB	IO3
Improved CQC rating - compliance	UB	IO5
Reduced backlog maintenance programme	UB	IO1
Improved infection control outcomes	NCRB	IO2
Reduction from 50% to 30% (net 20% improvement) for delays in stepping down Level 2/3 care to Level 1 care or ward specialty bed	NCRB	IO2

Main Benefits Criteria	Classification	Investment Objectives
Delivery of Site Development Plan (Estates Strategy)	UB	IO4
Carter compliance clinical/non-clinical. Trust wide currently 23.42% non-clinical space. New build will be 11% non-clinical space maximising clinical space	NCRB	IO5
Compliant level 1, 2 & 3 critical care facilities	UB	IO5
Improved YAS turnaround times and handover	NCRB	IO2
Supports integrated primary & secondary care pathways	UB	IO2
3rd sector opportunities	NCRB	IO2
Improved access for helicopter patient transfers	UB	IO5
Supports education and apprenticeships during design and construction period	SB	n/a
Potential boost to local economy during construction period & future	SB	n/a

Table 4 – Benefits linked to Smart Investment Objectives

3.10.6 Stakeholder engagement

In March 2020, a Launch Workshop was held to set the strategic direction for the project and from a capital projects and clinical team perspective, share the vision for the scheme with wider Trust colleagues and consultants. Our Architects, IBI Group, led part of the workshop session to present the stakeholder engagement journey, establish the core clinical team, their roles and responsibilities and to programme the engagement meetings to formulate the brief.

Members of the Capital/ Estates and the Core Clinical team included:

Capital Projects & Estates Team

- Andrew Bennett - Project Director
- Joanne Southwell - Project Lead
- Liz Vincent - Project Manager
- Hannah Bailey - Project Administrator
- Nigel Watkinson - Electrical Estates Manager
- Kevin Sowersby - Mechanical Estates manager
- Kevin Allen - Mechanical Clerk of Works
- Chris Blackstone - Electrical Clerk of Works Norman Addison - Mechanical Supervisor.

Core Clinical Team AMM

- Bryony Cappleman - Sister
- Lynn Merritt - ACP Heather Pickering - Operational Service Manager
- Amy Dailey - Sister
- Jan Doe - Sister
- Sally Alexander - Deputy Care Group Manager
- James Robertson - Associate Specialist ED
- Stephen Lord - Consultant
- Ed Smith - Consultant and Care Group Director
- David Thomas - Care Group Manager
- Sarah Freer - Matron ED
- Melissa Jenkinson – Sister.

In addition to establishing the above, individual Work Groups were identified and each group allocated a lead who could act as the key decision maker. A meeting schedule was drawn up which tied into the overall programme and the engagement workshops arranged with a clear understanding of the purpose and desired outcomes for each one.

A separate Launch Workshop was held for Critical Care Services and similar actions were taken from that session. A smaller Core Clinical Team was established for this Launch Workshop. IBI Group led part of the workshop session to establish the project brief and set the vision for the project as this was not as far developed as the AMM. Breakout groups were asked to report on three key questions:

- *What currently works?*
- *What currently does not work?*
- *What are the aspirations?*

Discussions captured thoughts on operational, functional, aesthetic and strategic objectives. The feedback recorded was used to set the vision and the strategic direction of development for the Critical Care floor.

A full list of Stakeholders engaged in the project to date can be found in Appendix 1.

3.10.7 Changes to SOC scope

The SOC approval letter from the Department of Health & Social Care and NHSE/I asked the Trust to explore as part of this scheme the additional costs of developing the first-floor space, identifying the costs and benefits of doing so. As such, the provision of a fallow floor within the SOC has led to a change of scope within the OBC which identifies the Trust Preferred Option to develop a Level

1, 2 & 3 critical care facility which will free up ward accommodation to reduce the number of 1930's Nightingale Wards.

The current helipad is non-compliant, and the footprint of the helipad is required for the new build solution. The re-location of the Helipad was included in the SOC scope. This will now be a separately funded stand-alone project to resolve the non-compliancy issues and is therefore excluded from the scope of this OBC.

Part B: The Strategic Context

3.11 Strategy and Policy context

3.11.1 Overarching strategy

The Trust's Strategy Pyramid for Scarborough Hospital is shown below.

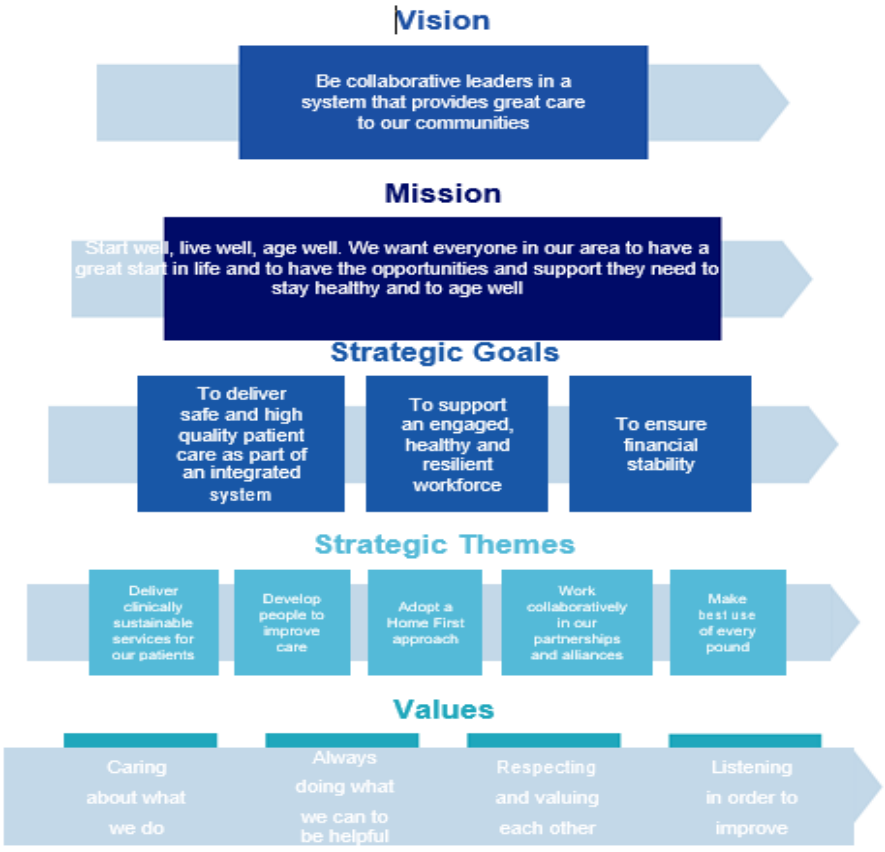

Diagram 6 – The Trust's Strategy Pyramid

3.11.2 Department of Health and Social Care Policy & Guidance

This OBC aligns and supports delivery of the following relevant Department of Health and Social Care (DHSC) policies and guidance and outlines the benefits criteria in this business case, in particular:

- *NHS Five Year Forward View*

- Upgrading hospital facilities
- Adapting models of care to the changing health needs of patients
- Modernising treatments and technical solutions for healthcare delivery
- Enhancing mental health and social care
- Addressing the Care Quality gaps
- Funding efficiencies

- *NHS Long Term Plan*
  - Helps address the out of hospital care divide of primary and community services
  - Move to integrated Care System

- *Findings and recommendations from the Carter review of productivity in NHS hospitals*
  - Focus on high quality clinical care and good resource management
  - Reducing delays in transfer of care
  - Enhances local collaboration and coordination.

The aims and objectives of the Scarborough Hospital Transformation of Emergency and Urgent Care and Site Engineering Infrastructure project are also consistent with all the above.

3.11.3 NHS Five Year Forward View

The NHS Five Year Forward View (5YFV) published by NHS England (NHSE) in October 2014 set out the government's priorities and a clear direction for the NHS, showing why change was needed and what it would look like. It set out a triple integration agenda, involving greater integration between primary and specialist care; physical and mental health care; and health and social care. The vision was one of services organised around the needs of patients rather than professional boundaries. As such there was a clear emphasis that delivering the 5YFV vision would require the input of the NHS, local communities, local authorities and employers.

This OBC has been developed in line with the 5YFV.

3.11.4 NHS Long Term Plan

The NHS Long Term Plan is a new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next 5 years.

This OBC has been developed in line with the Long-Term Plan.

3.11.6 Carter Review

Lord Carter's review of efficiency in hospitals suggests how large savings can be made by the NHS. The final report, Productivity in NHS hospitals, sets out 15 recommendations on how non-specialist acute trusts can reduce unwarranted variation in productivity and efficiency to save the NHS £5 billion each year by 2020/21.

There are several relevant Carter efficiency requirements applicable to this project:

- Creating a system that is **continuously improving** in its ability to deliver high value to patients by creating flexible space to meet surges in demand
- **Reducing or eliminating** unwarranted variation for this project - focusing on future running costs of the new build
- **Optimising** our staff resource by integrating the acute clinical response to one ground floor area of the hospital, the AMM, and integrating the Level 1, 2 & 3 critical care services within one unit directly above the AMM
- Adopting an **improved digital technology framework** with real time monitoring and reporting to enable quicker decision making i.e. e-rostering, e-prescribing, patient early warning alerts and seamless transition from primary to secondary care or vice-versa
- Continuing to **develop the model hospital metric** in order to measure what good looks like and benchmark good practice
- Compliance with the recommendation that **non-clinical accommodation should be <35% of the overall accommodation** which is an investment objective detailed in IO5 compliance and conformance.

3.11.7 Government Construction Strategy

The project is consistent with the Government Construction Strategy 2025 to promote the success of the UK Construction Sector, focusing on smart technology and green construction.

3.12 Trust's Strategic Priorities

The rationale for this project is consistent with the Trust's strategic priorities as described in the Five-Year Strategy (Our Strategy 2018-2023 – see Appendix 13) and can be mapped against the key strategic themes from the strategy as follows:

- The project will help to realise the theme of **delivering clinically sustainable services** as it will provide the environment to enable and support the development of the Acute Medical Model which will pool and deploy the Trust and interagency clinical team resource to provide the best possible standards of assessment, treatment and care
- Through the Acute Medical Model enabled by the Scheme, the strategic theme of **developing people to improve care** will be promoted as the model relies on the introduction of new clinical roles enhancing skills and practice across professional groups including Advanced Clinical Practitioners, Nursing Associates and Clinical Fellows

- The enhanced working environment will help promote the key Trust strategic theme of **developing a home first approach** whereby integrated multi professional and interagency team working will deliver care closer to patients' homes

- The promotion of **interagency partnership and alliance team working** enabling the sharing of expertise and resources for accessible local services (a key Trust strategic theme) is also enabled by the project, which will provide the environment to promote collaborative clinical pathway work in the areas of frailty and mental health

- The project also supports and links in with the key Trust strategic theme of **making the best use of every pound** by providing the environment to help deliver **innovative ways** of delivering clinical services by deploying the Trust and interagency staff resource in the most cost effective way.

The project has also been developed, supported and championed as a key priority supporting the strategy and objectives of the Humber, Coast & Vale Integrated Care System by the Capital and Estates Strategic Board.

3.13 Health Economy Strategies

At a local level, in Scarborough, this OBC is aligned with the North Yorkshire CCG's strategic aims and objectives for the region and is underpinned by our Five-Year Plan and our Estates Strategy.

In terms of the Trust's strategic direction, this OBC has been developed to support and be consistent with the delivery of the following:

- York Teaching Hospitals NHS Foundation Trust (YTHFT) Our Strategy 18 – 23
- YTHFT Clinical Strategy (Nursing & Midwifery Strategy 2017 – 2020)
- YTHFT Estates Strategy v2.0
- Workforce & OD Strategy 2019 - 2024
- YTHFT Sustainable Development Management Plan 17 – 20
- YTHFT Digital Strategy 17 – 22.

3.13.1 YTHFT Our Strategy 2018 - 2023

The York Teaching Hospital NHS Foundation Trust strategy for 2018-2023, outlines the Trust's strategic priorities and objectives that have been developed and informed through listening exercises with senior clinical and non-clinical leaders across all our sites, including a cultural review with a range of staff groups, an operational review, and our staff survey. It has been developed in the context of partnership, including the Humber, Coast and Vale Integrated Care System and has **five** strategic themes outlined below that underpin this OBC.

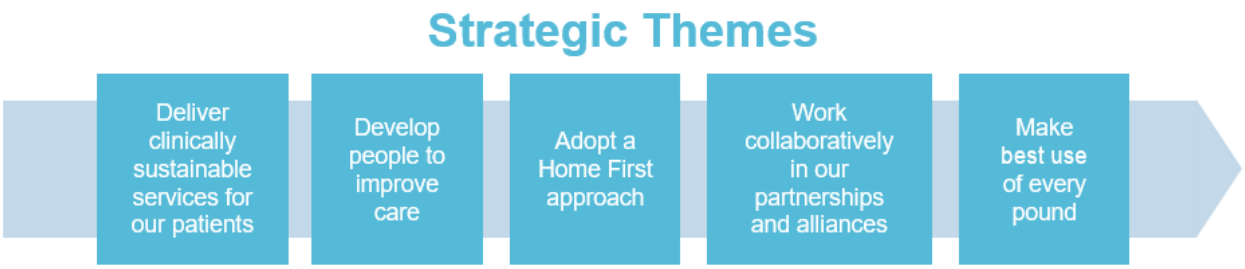

Diagram 7 - Humber, Coast and Vale Integrated Care System Strategic Themes

In support of this project, Theme 4 – **Work collaboratively in our partnerships and alliances**, specifically states that the Trust will *"draw on national funding to support capital schemes that will increase the depth, breadth and quality of the services we provide for patients".*

3.13.2 YTHFT Estates Strategy

The Trust's Estates Strategy is one of a number of key interdependent strategies, representing the dynamic programme of change necessary over the next five years to support delivery of the Trust's vision and its strategic and clinical objectives.

One of the Strategic Frames within the Estates Strategy states that the Trust will *"continually improve its buildings and facilities to meet changing needs".*

To address this Strategic Frame, the Transformation of Emergency & Urgent Care and Site Engineering Infrastructure project is included in the Estates Strategy Development Plans for the next five years.

3.13.3 YTHFT Clinical Strategy (Nursing & Midwifery Strategy 2017 – 2020)

The Nursing & Midwifery Strategy sets out the priorities to achieve high quality, patient focused care, to embrace the opportunities the changing landscape presents and focuses on four key areas:

- Experience and communications
- Workforce
- Safe, quality care
- Partnerships and efficiency.

The Nursing Strategy is based on the national strategy 'Compassion in Practice' (Department of Health, 2012) and sets out our commitment to helping staff reconnect with the behaviours of the 6Cs: Care, Compassion, Competence, Communication, Courage and Commitment.

This Strategy and its aspirational commitments have been used by the clinical team to help shape the clinical input to the project.

3.13.4 YTHFT Workforce and OD Strategy 2019 – 2024

This strategy sets out the Trust's vision to ensure our Workforce is fit for purpose to be *"collaborative leaders in a system that provides great care to our communities".*

The Workforce Strategy outlines the strategic aims and objectives around the following themes that will support the AMM and the Scarborough Hospital Transformation of Emergency and Urgent Care and Site Engineering Infrastructure project:

- Recruitment and Retention

- Health & Wellbeing
- Talent Management
- Leadership
- Culture.

3.13.5 YTHFT Digital Strategy 2017 – 2022

The following themes flow through the Digital Strategy:

- The consolidation and exploitation of existing investment
- Exploiting opportunities and transformation
- Providing enhanced security for systems and information.

These themes support the achievement of the Digital Strategy vision which is *"to be trusted to deliver, safe effective healthcare to our community supported by today's technologies future proofed for tomorrow's needs."*

The Digital Strategy supports the Scarborough Hospital Transformation of Emergency and Urgent Care and Site Engineering Infrastructure project by providing a route map to harness the opportunities for digitisation and implementation and use of new technology in our built estate. It also informs the design of the new facility to build in Digital requirements and future proofed IT infrastructure.

3.13.6 Sustainable Development Management Plan 2017 – 2020

Sustainability is the principle of strategically ensuring the long-term resilience of the health system by establishing a quality and efficient service that is capable of using resources today that does not prejudice our ability to deliver health care tomorrow.

Our Sustainable Development Plan outlines how the Trust will build sustainability and green solutions into its new buildings and this plan will help to inform the design of the new building, how to deal with waste and how we will reduce carbon, moving from OBC to FBC stage in the project.

3.14 Impact on existing service configuration and the wider health economy

This project is a key element of the wider transformation of the local health economy. The facility enables new ways of working both within the confines of Scarborough Hospital and into the broader health network as it promotes collaborative working and provides much needed opportunities for joint ventures. For example, the project will increase the locality's ability to deliver Same Day Emergency Care by providing a single shared vision for that service with multiple contributors including the hospital specialties, social prescribing, primary care and urgent care / out of hours.

In addition, the project provides the physical space for recruitment innovations such as greater use of Portfolio GPs (which is an attractive incentive to grow the local primary care workforce footprint); Advance Clinical Practitioners, Physician Associates and Specialist Nurses, all of whom can work jointly under a single roof delivering acute care with senior oversight and support. The Critical Care floor is consistent with this approach as it provides the ability for clinical staff to work together to deliver both Level 1, 2 and 3 care using skills of the team in a supportive and collaborative nature.

3.15 Support from other bodies

Following Trust Board approval of the Preferred Option, there will be engagement with the North Yorkshire County Council Health and Wellbeing Board. Key members of the Wellbeing Board are also members of the Humber, Coast and Vale Integrated Care System and are supportive of this project.

In addition, the Project Director was invited to present an overview and progress update for the project to the North Yorkshire County Council Scrutiny of Health Committee on 11th September 2020. The Committee was very interested and engaged in the project presentation and the County Councillors asked a number of pertinent and detailed questions about the scheme and its impact in Scarborough and its surrounding area. The Project Director was very keen to seek the engagement of the Committee and the County Councillors with the remainder of the project. The Scrutiny of Health Committee is equally keen to monitor the progress with delivering the project. With this in mind, the Project Director has been invited to attend a further Committee meeting early in 2021 to update the members on progress.

3.16 Conclusion on Strategic Context

The proposed reconfiguration of acute and emergency services is entirely consistent with health and social care strategies at both a national level, in terms of government policy for health and social care and Department of Health and NHSE priorities, and at a local level in terms of the Health & Social Care Partnership and YTHFT strategies.

3.17 Sensitivities and opposition

Since the merger with York Teaching Hospital NHS Foundation Trust in July 2012, Scarborough Hospital has been subject to several local community campaigns when services have been identified for clinical, safety and sustainability reasons to transfer to the York Hospital site. As such, YTHFT, North Yorkshire CCG and East Riding CCG working under the auspices of the Humber, Coast and Vale Integrated Care System, agreed to undertake an independent clinically led review of the configuration of acute services at Scarborough. The review sought to understand the clinical, operational and financial drivers that support a case for change moving from tactical, piecemeal improvements or service developments towards a clinically and financially sustainable model fit for the future.

This Scarborough Acute East Coast Services Review, which concluded Stage 1 with a number of models for consideration, primary among them the commitment to 24/7 emergency care, ensuring specialty support and engagement.

The ensuing Integrated Care System bid focused on provision of a new model and clinical pathway of delivering urgent care at the front door, the AMM. This is only made possible by significant investment in new estate accommodation which also requires the engineering infrastructure to support any development.

This investment proposal is extremely good news for the community Scarborough Hospital serves and sends a clear message that YTHFT are investing in the long-term future and clinical and financial stability of this site. Therefore, we do not expect nor are currently aware of any opposition to the proposed investment and services this will secure.

As the Project Team develops further our Communication Strategy, we will engage widely within our community. However, for obvious reputational risk reasons for the NHS, we cannot proceed with this beyond current stakeholder engagement until the capital allocation has been confirmed.

3.18 Integrated working

Long overdue expansion of the provision of local mental health services has finally been recognised in this locality with near "Core24" services likely to come on-line in the next few years. The project will again enable this expansion of service provision and allow the Trust to provide an enhanced level of care for the increasing mental health cohort of patients that we are seeing.

The joint nature of the facility and closer links with partners delivering 3rd sector activity make the delivery of social prescribing or voluntary sector support significantly easier to deliver, all of which contribute to the main aim of AMM which is rapid first assessment, right place right from the start, admission avoidance and collaborative working.

3.19 Health Care Partnership Service Planning

The Humber, Coast and Vale Integrated Care System is a collaboration of nearly 30 different organisations across a geographical area of more than 1,500 square miles, taking in cities, market towns and remote, rural and coastal communities.

The partners work together to plan health and care services in the area, finding new ways to tackle the challenges that are faced locally.

The HCV ICS are fully supportive of the project as shown in their letter of support from Chris O'Neill, Director of HCV. This letter is included in Appendix 29.

3.20 Patient choice

This strategic investment for the new build and engineering infrastructure ensures the sustainability of clinical services on the East Coast. This provides the community with local, close to home, acute and critical care services together with the necessary specialist services required to support acute and critical care activity. As a consequence, the Trust is able to ensure the NHS Patient Choice Agenda is supported which commits to giving patients greater choice and control over how they receive their healthcare and to empower patients to shape and manage their own health and care.

3.21 Equality and Diversity

An Equality Impact Assessment (EIA) was completed in 2020 (see Appendix 25). It demonstrates that there will be equitable access for everyone, and no group of people will be inadvertently excluded (on the basis of protected characteristics, for example).

The Trust has paid due regard to the Public Sector Equality Duty (PSED) and to the principles of providing an inclusive built environment for everyone by ensuring that our access strategy forms part of the project plan and that a National Register of Access Consultants (NRAC) registered access advisor is available to assist with the project and provide advice and recommendations at preliminary design and detailed design stages of the project.

Recommendations made are in line with the principles of the NHS Constitution, Regulation 15 of the Health & Social Care Act 2008 (Regulated activities Regulations) 2014, Approved Document M (Volume 2) of the Building Regulations and current good practice guidance including Health Building Notes and BS8300;2018 Parts 1 & 2.

Through the Trust Inclusivity and Accessibility Lead, the Trust is also engaging with Third Sector organisations including Health Watch North Yorkshire and Scarborough Disability Action Group to seek the views of disabled people on the design and layout of the proposed new building.

3.22 Changes to Services

3.22.1 Introduction

In 2010, the Government introduced four tests of service reconfiguration. These tests are "*designed to build confidence within the service, with patients and communities".* The organisations involved in developing service change proposals are responsible for working together to show that the evidence in each test is convincing, and thereby to reassure themselves and their communities.

The four tests are for the proposed service changes to demonstrate evidence of:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioner support for the proposals.

We have set out below our approach to assessing the reconfiguration plans against each of the four tests of reconfiguration for clinical assurance

3.22.2 Approach taken to Test 1 - Strong public and patient engagement

Public and Patient involvement (PPI) has been central to the approach taken by the Trust. A summary of the key approaches taken are set out below.

- Scarborough Ryedale CCG (now North Yorkshire CCG) led the *Ambition for Health 5-year Programme* to deliver a joined-up transformation programme for the Scarborough, Whitby and Ryedale community. Public and patient involvement was sought from the outset
- The findings of the Ambition for Health programme led to the Scarborough Acute Review (Scarborough East Coast Review Report) being commissioned. Stakeholder and engagement events were held in October 2018 following publication of the report and a feedback summary report produced on behalf of Scarborough Ryedale CCG
- The Humber Coast and Vale Integrated Care System working with Healthwatch invited further public and patient feedback in response to the published acute review. Healthwatch on behalf of patients published a report on the review for Humber Coast and Vale Integrated Care System.

All documents, reports and summaries are available on the appropriate Trust, CCG and Humber Coast and Vale Integrated Care System websites. All parties continue to encourage patients to provide feedback on current and future service transformation and improvement.

3.22.3 Approach taken to Test 2 - Consistency with current and prospective need for patient choice

In the development of proposals locally, patient choice (for appropriate, high quality services) has been a key factor and is consistent with current and prospective needs and engagement with patients as outlined in Test 1 above.

3.22.4 Approach taken to Test 3 - A clear clinical-evidence base

Clinical leadership has been at the heart of the approach adopted in developing this project, resulting in a strong focus on the evidence base underpinning the Models of Care proposed. Key developments have included:

- The Scarborough Acute East Coast Review was a system wide clinically lead review facilitated by McKinsey
- The proposed Acute Medical Model of service delivery is a model supported by the Royal College of Physicians
- The Acute Medical Model is further described and supported by the Clinical Director of Acute and Emergency Care at Scarborough Hospital through his published article *"The smaller general hospital: delivering joined up cross-specialty working for the benefit of our patients"* Dr Ed Smith.

3.22.5 Approach taken to Test 4 – GP Commissioners support for the proposals

Proposals for service change have been developed with local commissioning organisations and have broad support from partners from across the region. Commissioning organisations have been involved at a number of levels:

- GP's, Commissioners & Acute Clinicians were key stakeholders in the Scarborough Acute East Coast Review
- The STP changed to the Humber, Coast and Vale ICS Integrated Care system have over 30 partners supporting the key work stream for the Scarborough area, which is the development of the Transformation of Urgent and Emergency Care project.

3.22.6 Conclusion on impact of the reconfiguration proposals

The current proposals for the reconfiguration of acute and emergency services have been considered fully in terms of:

- Revised Models of Care
- Activity levels and required bed numbers
- Staffing implications
- Premises implications
- Impact on quality of care
- Impact on patients.

The preferred solution still provides all of the required services, both current and future.

3.23 Overview of Engineering Infrastructure

Within the SOC, Option 3 describes an engineering infrastructure project that is comprised of 12 elements that will tackle key aspects of the site Backlog Maintenance (BLM) burden ensuring that the existing services are fit to support future developments including this proposed capital build.

These schemes were initially derived from a combination of the Site Condition Survey and a focused engineering survey of the site by an M&E consultant firm. They are intended to address the significant, critical, high risk and non-compliant nature of the current engineering infrastructure.

The engineering infrastructure project is intended to provide capacity and resilience to support the Trust's future development aspirations for Scarborough Hospital. With the removal of the Helipad scheme there are now 11 elements described within this OBC, listed below:

1. Low voltage (LV) & network generators
2. High voltage (HV) ring main
3. VIE & Oxygen ring main
4. Ventilation - Air handling units
5. Steam mains/heating strategy
6. Replacement of south block roof
7. Replacement mortuary
8. Water, drainage, gas, utilities
9. Vertical transportation
10. Parking provision and
11. Pneumatic air tube system.

As the project has moved through the RIBA Work Stages 1 and 2 for OBC, opportunities have been taken to consolidate some of the projects into combined work packages where it makes sense to do so from a technical and economic perspective i.e. HV/LV project Nos 1 and 2.

Working through the RIBA Work Stages 1 and 2 with our Integrated Design Team and Cost Consultant we now have a more accurate reflection of the cost of each infrastructure package. It has therefore been necessary to evaluate the order of priority of the infrastructure elements as essential, desirable and optional to ensure an affordability fit within the financial cost envelope proposed.

The most critical infrastructure requirement is to provide sufficient power to the site, this being the HV/LV infrastructure elements. Fundamentally, the cost to provide an HTM compliant, resilient and future proofed solution has more than doubled from the original budget expectations which has meant a re-assessment of the infrastructure elements. The Trust has also been fortunate to receive an amount of BLM 2020/21 central funding (schemes to be completed by end March 2021) which has provided the opportunity to undertake some of the infrastructure elements immediately.

3.24 Main Risks

There are a number of key risks that are being actively managed as outlined in the table below:

Key Risk	Mitigation
Design	
Lack of effective clinical engagement throughout design process	Planning or workshops and meetings to engage stakeholders. Capital team to adapt meetings and workshops to take account of new Covid-19 restrictions.
Sufficient Infrastructure must be delivered to support new build and SDP	Prioritisation of infrastructure schemes by Estates and Operational colleagues.
Scope creep	Ensure RIBA work stages are followed in respect to sign off and gateway reviews.
Build	
Existing "As built drawings" not correct and unforeseen tie in or technical issues	Due to age of current buildings, sufficient surveys to be undertaken to ensure "As built drawings" are correct or understand where there are gaps in information early to address this.
Funding	
Design costs exceed draw down budget (£2.42M Fees)	Strict financial controls in place and monthly monitoring and reporting by the Project Board.
Preferred Option requires augmented funding	Project Board aware of Trust Preferred Option and funding gap to be addressed within the OBC.
Approval of associated revenue business cases	Timely submission of relevant revenue business cases to the Trust and confirmation of commissioning intent from NY CCG.
Operational Risk	
Programme delays	Fortnightly monitoring of programme via the Project Team Meetings and ensure all work to agreed key milestone delivery dates.
Brief not met	Sign off and gateway reviews with stakeholders to ensure the brief is met at each RIBA work stage.
Disruption to existing services must be minimised	Phased planning and engagement with end users to ensure minimal disruption to live hospital working environment.

Table 5 – Key project risks

The current Risk Register for the project is included in Appendix 7.

It should be noted that a remaining generic risk applicable to all projects pre capital allocation is the "consultation risk". For reputational risk reasons for the NHS, the Communication Strategy for public engagement cannot proceed until the capital allocation has been confirmed.

3.25 Constraints

The following constraints on the project have been identified:

- £40M affordability envelope however Preferred Option requests augmented funding to provide a fit out of the critical care floor
- Required engineering infrastructure is affordable
- Blue light access

3.26 Dependencies

The single biggest dependency for the new build facility is that significant and critical engineering infrastructure (mechanical and electrical) investment is required as an enabler of any build.

The Engineering Infrastructure project comprises 11 elements tackling key aspects of the site backlog maintenance (BLM) and ensuring that the existing services are fit to support future developments including this proposed capital build.

4 The Clinical Quality Case

4.1 Introduction

The Clinical Quality Case sets out how the proposed investment will improve the clinical quality of the Trust's services. It describes how the development will improve patient safety and experience by providing a clinically functional environment that facilitates efficient patient flows and optimum clinical outcomes.

This case describes how the OBC is aligned to the Trust's Clinical Strategy to provide high quality services in a financially affordable and sustainable way. It also sets out how the investment will enable the Trust to support the delivery of a sustainable health economy in the future, strengthening the provision of Urgent and Emergency and Critical Care.

The clinical leadership and engagement of clinicians has been fundamental through the life of the project to date and will continue through to the operational commissioning of the new facilities. They have supported the delivery of a design solution which satisfies national best practice guidance and standards and improves the quality of the environment for patients, family and staff; whilst delivering a cost-effective solution. The design solutions are detailed within this section.

4.2 Clinical Strategy and commissioning intensions

As identified in the Strategic Case, the Trust's Clinical Strategy "Caring with Pride" (Nursing & Midwifery Strategy) was first published in October 2017, for the period 2017 to 2020.

The Nursing Strategy focuses on four key areas:

- **Experience and communications**
- **Workforce**
- **Safe, quality care**
- **Partnerships and efficiency.**

The Nursing Strategy is based on the national strategy 'Compassion in Practice' (Department of Health, 2012) and sets out our commitment to helping staff reconnect with the behaviours of the 6Cs: Care, Compassion, Competence, Communication, Courage and Commitment.

The Clinical Strategy is built around ten aspirational commitments:

1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff
2. We will increase the visibility of nursing and midwifery leadership and input in prevention
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health
4. We will be centred on individuals to ensure they experience a high value of care
5. We will work in partnership with individuals, their families, carers and others important to them

6. We will actively respond to what matters most to our staff and colleagues
7. We will lead and drive research to evidence the impact of what we do
8. We will have the right education, training and development to enhance our skills, knowledge and understanding
9. We will have the right staff in the right place, at the right time
10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes.

4.3 Overview of Emergency Department

The main aim of the project is to ensure that as many patients as possible are managed as quickly and safely as possible, preferably without the need to travel to another healthcare establishment.

The facility will be the acute care hub for the entire locality and enable co-working of multiple professions in a co-ordinated manner. The vast majority of patients will be managed without the need for a prolonged hospital admission in order to reduce the risk to those individuals of hospital acquired infection and other nosocomial risks as well as deconditioning in our elderly population.

The current Emergency Department (ED) includes the following services:

- **York Teaching Hospitals NHS Foundation Trust** providing emergency care for same day, intermediate, major and resuscitation undifferentiated patients presenting at the department
- **Vocare Primary Care Services** providing a 24/7 Urgent Treatment Centre (UTC) for all minor injury and illness which includes the locality's GP Out of Hours Service.

The current Acute Medical Unit (AMU) and Surgical Assessment Unit (SAU) are both disconnected from the ED and in dispersed areas of the hospital. Operationally and clinically they run independently from the ED and provide minimal input and connectivity of pathways between these acute areas and the ED. The current way in which we work can be described as:

Traditional
Slow with time wasted between steps
Duplication of tasks
Collaborative working difficult due to poor adjacencies
Care planning and investigations developed as an inpatient and not in the ED – (admit assessing model of care).

The ED is no longer fit for purpose for modern services with the key issue for the department being:

The lack of space for reorganising services
Physical size
Limited number of cubicles and
Lack of dedicated diagnostic services.

Scarborough Hospital is failing many of the ED Key Performance Indicators (KPI's) including the four-hour Emergency Care Standard (ECS). The Trust is unable to achieve these improvements without the proposed investment outlined in this business case.

For the purposes of this project, the re-provision of all emergency and acute care within one floor area provides the ability to implement the new Acute Medical Model (AMM). The AMM will care for all patients from minor to complex needs served by one team of healthcare professionals working collaboratively, operating an assess to admit model of care.

This ethos underpins the cohesive vision of the local health economy in relation to urgent and emergency care which is patient centred and affordable.

4.4 Emergency Department Capacity & Demand

4.4.1 Capacity & Demand

The increasing size and ageing of the local population, as well as increasing demand for urgent healthcare in society, has delivered increasing attendances to Scarborough Emergency Department year on year for many years (variable but up to 5% increase per year).

The current Emergency Department no longer has the capacity to meet the current demand and its design and geographical position prevents any opportunity for expansion and limits implementation of new models of working.

The graph below shows the current and predicted proportion of patients attending the Emergency Department over the age of 65 years.

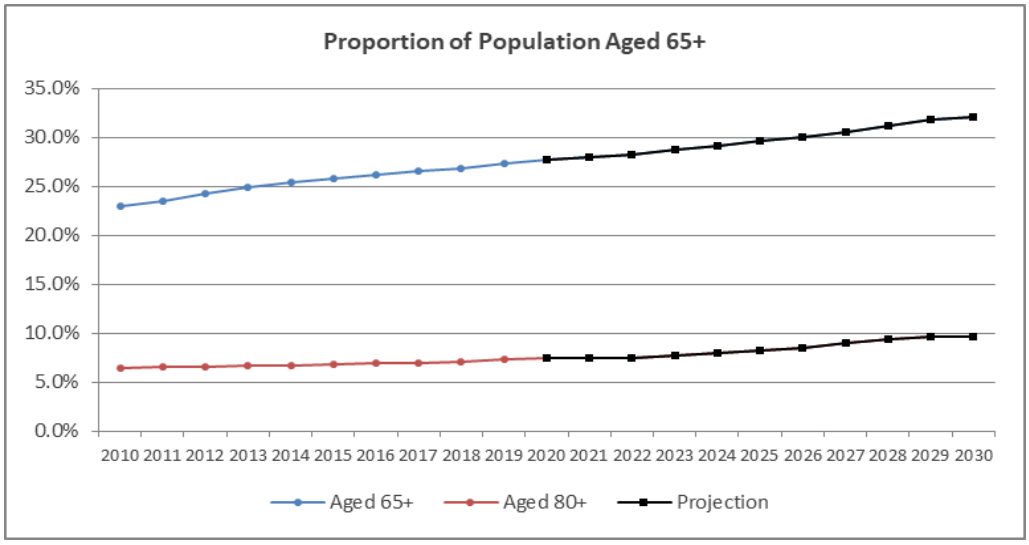

Diagram 8 – Proportion of Patients over 65 attending the ED

The activity/capacity modelling in the investment proposal has been built into the local health economy and Humber, Coast and Vale Integrated Care System capacity planning programmes which reflect system wide workforce plans, organisational service developments and efficiency priorities. This includes the work programmes associated with the HCV Urgent and Elective Care Boards and the Operational Delivery Networks including the areas of Critical Care, Major Trauma and Cardiology.

4.4.2 Utilisation Study

The graph below shows the predicted growth of attendances to the Acute Medical Model Urgent and Emergency Care facility at Scarborough Hospital. The graph also shows the current on-site capacity (rigid and unadaptable) against the new increased flexible patient treatment space sized to meet the changing future demand and service need.

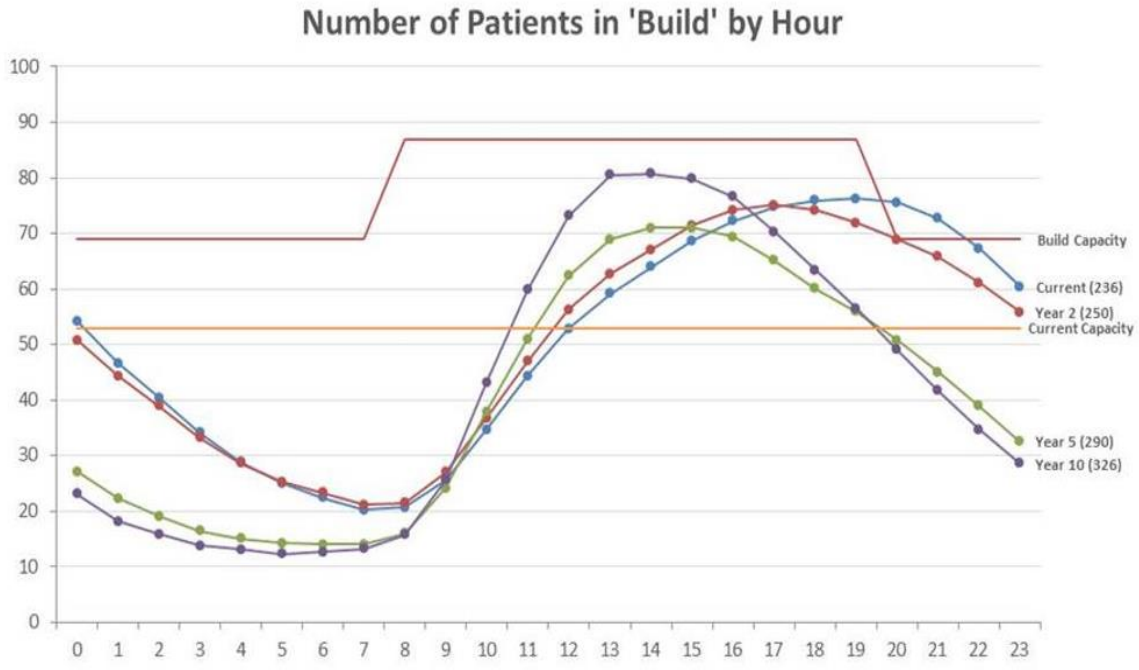

Diagram 9 - Patient Attendance and Site Capacity

The Diagram below shows Same Day Emergency Care (SDEC) activity, with current capacity and build capacity.

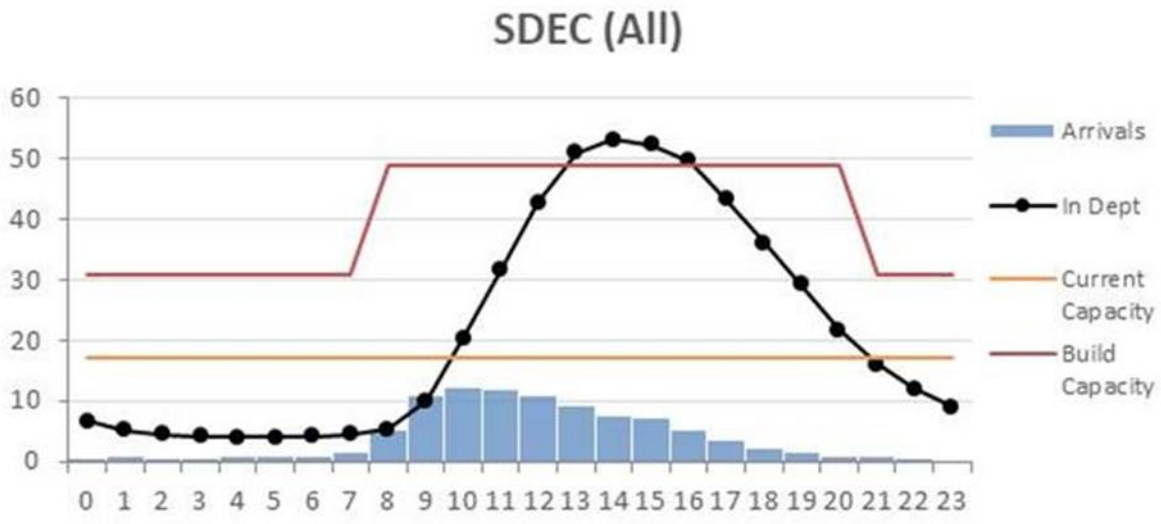

Diagram 10 – SDEC Activity 2030

4.6 AMM Clinical Sustainability

The most important aspect of the project from a sustainability perspective is related to achieving as close as possible to complete integration of clinical services at the front door of the hospital and aligning those services with an outward-facing community focus. The project will embody the future of acute and emergency care and provide an environment to allow mutual support between teams (e.g. Consultant to GP, Allied Health Professional to Nurse Practitioner, Mental Health practitioner to junior doctor etc).

The main outcome measure with respect to the new Urgent and Emergency Care Unit is managing as many patients as possible without the need for hospital admission. Extended hours senior medical cover is more achievable as a result of co-location of specialists and therefore patients will receive the **right care in the right location at the right time.** Where patients do need admission decisions will be made and treatment administered rapidly because of the efficiency produced by ensuring that all the relevant clinicians are working in one physical space.

The project has taken into account the changing landscape of healthcare, through the innovative design of flexible interchangeable space, which will have the ability to adapt as services develop and improve.

The future demand for service has been built into the capacity planning as shown on Diagram 10 above.

The plan below shows the 1:200 layout for the Ground Floor of the new facility.

Diagram 11 – Ground Floor Plan

Throughout the production of the OBC, learning from Covid-19 has been considered. Within the new facility there is ability to successfully divide into appropriate zones to ensure patient safety and effective patient flow. As an example, the plan below shows hot and cold zones in the new AMM.

Diagram 12 – AMM Hot & Cold zones

4.6.1.1 *Innovative changes to service delivery*

The development of The Acute Medical Model Urgent and Emergency Care project has taken into account the many changing demands of acute and emergency care and has been designed throughout with the need to provide flexible working spaces with appropriately adjacent zones to allow the unit to meet the current demand and meet and adjust to the innovative changes to service delivery described below.

TALK BEFORE YOU WALK

Talk before you walk is a new initiative that will significantly alter the way in which patients access urgent and emergency care and will allow our clinicians to stream the patient to the most appropriate health care service, including in many cases providers not physically based in the hospital (e.g. pharmacist, mental health provider, other community service etc.). There is an expectation that implementation of this system in an effective way will reduce or avoid Emergency Department crowding by ensuring that patients arrive where possible over an evenly spread time period. This will in turn reduce delays created by large numbers of patients arriving in ED simultaneously.

STREAMING

A more robust streaming and first assessment model would be achieved through improved accommodation design and service delivery model within the new build. The sole aim to ensure that the patient attends the correct service for their healthcare needs.

URGENT TREATMENT CENTRE

The Urgent Treatment Centre will include provision for Same Day Emergency Care (SDEC) and will incorporate a Home First Unit (HFU) – Emergency Assessment unit within the new build. The measure of success will be a greater proportion of the patients managed through the UTC facility however there are also opportunities to ensure that the UTC and SDEC services work seamlessly together.

The graph below shows the projected SDEC activity in 2030. The capacity created through the SDEC zone will provide sufficient capacity to meet the future demand for the service. The area has been designed with the added ability to provide flexible and expandable space to maintain the capacity required as services develop.

< 24 HOUR WARD AREA

The capital build plans incorporate an area that has a footprint akin to an acute ward area of 12 beds. This has been sized to deliver what is likely to be needed in terms of prolonged stay, without a definitive ward admission. This will be of most benefit in managing the frailty patients who do better with early discharge but who often arrive in the facility later in the evening and need overnight accommodation. Again, it is close to the home of the OT/Physio team and as such patients are well placed to receive an intensive therapy assessment and review with the goal of ensuring their continued support in the community.

One other strong benefit in terms of future proofing and resilience of the proposed build is the ability to use the various areas flexibly and interchangeably, with the view that we would look at the workforce as a whole rather than in compartmentalised or silo working. This would deliver a flexible way of using the space to address the needs of patients during another pandemic and allows much greater attention to infection control than we are currently able to manage. An improved infection prevention and control environment will in addition reduce harm to patients and also length of stay.

4.6.2 Additional Supporting Facilities

4.6.2.1 *Paediatric*

A strategy and model for sustainable paediatric services on the East Coast is currently being developed by the Trust.

Any future service model for paediatrics will require paediatric facilities within the new AMM for emergency care and will adopt the Royal College of Paediatrics & Child Health (RCPCH) Facing the Future – Standards for Children and Young People in Emergency Care Settings. This has been taken into account in the design of the new build which incorporates the following.

- Children's play/waiting area
- Paediatric focused consultation room
- Neonatal and paediatric resuscitation bay
- Paediatric major assessment room.

4.6.2.2 *Mental health*

The unit provides a compliant PLACE mental health assessment/consultation room, with co-located mental health teams based within the new build.

4.6.2.3 *High consequence infectious disease facility*

Following lessons learnt from Covid-19, the opportunity has been taken to design a major consultation/treatment bay which will facilitate the appropriate management of a patient presenting with a High Consequence Infectious Disease. The unit has also been designed with pandemic capability and has the ability to split into two smaller working units to provide "hot and "cold" areas for patient management.

4.6.2.4 *Chemical, Biological, Radiological or Nuclear (CBRN)*

A compliant fit for purpose integrated CBRN facility is provided within the new build.

4.6.2.5 *Pharmacy*

The provision of on-site pharmacy facilities with a consultation room supports the future plan to provide pharmacy consultation support services for patients.

In summary the concept is simple: a multi-professional, multidisciplinary workforce working closely together at all times to manage the acute and emergency patients as close to home and in a non-admitted way wherever possible. Some of the ways that this will be delivered are in development, but others are well established and we can clearly see how the efficiencies of this system will be developed and delivered over the next 2, 5 and 10 years.

4.8 Critical Care

4.8.1 Overview

Currently there are 25 dispersed non-compliant level 1, 2 & 3 beds throughout Scarborough Hospital accommodated within a total floor area of approximately 600m2 comprising:

- 8 x level 2/3 beds located on the Intensive Care Unit (ICU) which includes only 1 side room
- 1 x Post Anaesthetic Care Unit (PACU) bed which acts as a Paediatric Critical Care & ICU overflow
- 10 x level 1 respiratory medicine beds located on Beech Ward
- 6 x level 1 cardiac beds located on the Coronary Care Unit, which includes only 1 side room.

There is a chronic lack of side rooms to support privacy and dignity and infection control measures. Each area has differing degrees of major compliancy Health Building Note (HBN) and Health Technical Memorandum (HTM) issues. There is extremely limited supporting accommodation i.e. offices, storage, relatives' accommodation, staff welfare accommodation, changing facilities and an inefficient staffing model with no flexibility of cross-cover due to the separate location of each department.

The driving focus for the proposed critical care floor is the non-compliant nature of existing Level 1, 2 and 3 areas, lack of single room accommodation and the geographical separation of critical services across the hospital site.

Siting all Level 1, 2 & 3 patients and critical care workforce on one floor directly above the AMM will provide 3,100m2 of compliant accommodation to resolve all the issues identified and provide expedited Anaesthetic and Outreach services into the AMM.

4.8.2 Level 1 patients

The current 20 bed cardiology ward in Scarborough Hospital has six allocated Level 1 high dependent unit beds with an average of five beds consistently occupied with the sixth providing the necessary flexibility to cope with peaks in demand.

A capital scheme on the York site to provide additional Cardiac Catheterisation Labs known as the Vascular Imaging Unit (VIU) is in progress. This additional cardiac capacity in York will not impact on the demand for Cardiology Level 1-unit beds at Scarborough Hospital.

Current pathways linking services for cardiac patients who are acutely unwell and require immediate surgical intervention will remain unchanged and patients will be transferred, as at present, to the Cardiology Unit at Castle Hill Hospital in Hull.

Respiratory Level 1 patients currently occupy ten beds on Beech Ward which is a general medical ward predominantly for respiratory and endocrine/diabetic patients. The ten beds are also utilised for medical patients who are acutely unwell and who risk deterioration to Level 1 care. Pre Covid-19, the ability to cohort the respiratory patients in one area was very challenging due to both the general bed pressures and particularly due to the high demand for side room availability. This resulted in a number of respiratory patients outlying onto other medical wards which introduces

risk into the clinical management of these patients. Since Covid-19, all respiratory patients have been successfully located solely within the ten beds identified on Beech Ward; this has reduced the clinical risk of outlying and has improved the quality of the experience for these patients.

The proposed first floor Level 1, 2 & 3 Critical Care Department of the new build will provide sufficient accommodation; 16 Level 1 bed capacity, to relocate both the six cardiology unit beds and the acute respiratory beds into one central location. The configuration of beds in the new department will provide the necessary flexibility to manage the varying demands for both services whilst maintaining the specialist nursing and medical care they require.

4.8.3 Level 2/3 patients

The current ICU in Scarborough Hospital does not meet the building, infection prevention and environmental requirements of a modern ICU and it cannot be upgraded to meet these standards. An options appraisal was undertaken in October 2016 (see Appendix 14) and concluded that there is no other obvious area of Scarborough Hospital that could be converted to an ICU, recommending that a new build solution is the only viable option.

ICU has had up to 8 occupied beds since 2017 with the monthly 95th percentile to be 6 or 7 patients. Aside from the Covid-19 first wave, this has remained unchanged for the majority of the last 3 years.

A small number of patients have needed to be transferred to other hospital ICU's due to bed capacity issues and these are known as non-clinical transfers. This demonstrates that there is not a big capacity and demand gap for this level of patient.

Currently, we do not have a designated paediatric stabilisation area in the current unit configuration which the new build addresses. This will support specialist care for paediatrics prior to transfer to a specialist tertiary unit.

The main building regulation that needs to be taken into account is HBN 04-02. This is clearly set out in the Guidelines for the Provision of Intensive Care Standards (GPICS). At our last Peer Review in 2015 and GIRFT visit in 2019, we were tasked with creating a plan to explain how we were going to address the lack of compliance with the GPICS. So far, we have been unable to make any improvements towards the recommendations. The proposed new build will enable us to give assurance about this point.

GPICS requires critical care units to have adequate access to side rooms (recommendation of at least 50% of the unit being side rooms). ICU in Scarborough Hospital currently only has one side room which has proved especially challenging in current times due to the additional Covid-19 isolation requirements. In the current plans, every Level 2/3 bed space will be built as a side room. The current unit severely lacks adequate staff change, office and support service accommodation and has no relative accommodation, all of which will be resolved within the proposed new build.

Overall, the requirement for Level 1, 2 & 3 critical care has not fluctuated in demand and as such we are not predicting any growth in future years.

The plan below shows the 1:200 layout for the First Floor of the new facility.

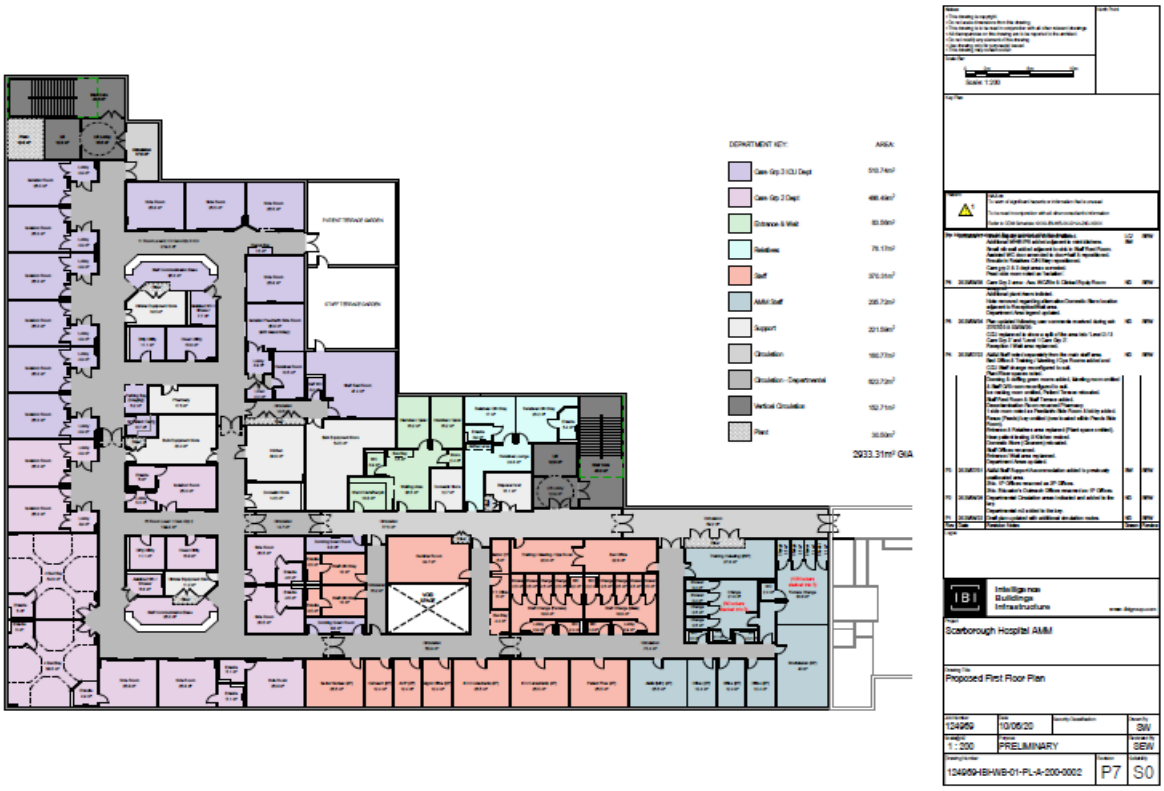

Diagram 13 – First Floor Plan

The new facility provides the following design solutions for 27 integrated critical care beds complaint with HBN 04-02 Level 1, 2 and 3 critical care.

- Highly flexible and adaptable accommodation
- 19 single room accommodation including 10 rooms with positive pressure lobbies (isolation from Covid-19 lessons learnt)
- Ease of nursing to allow flex in staffing models
- Appropriate staff and relative accommodation
- Paediatric stabilisation room with supporting family space. This will enable appropriate and supporting clinical facility for the management of the acutely sick child or young person whilst awaiting Embrace transport for the medical transfer to a specialised children and young person facility for ongoing care.

The integration and colocation of level 1, 2, and 3 critical care patients on the floor directly above the AMM allows for improved clinical management of patients. This new model ensures that the hospital's sickest patients are no longer dispersed around the hospital site but managed from one integrated clinical ward environment. The medical and nursing staff that will clinically manage and care for these patients will provide high quality specialist skills across a range of patient needs to ensure optimum patient outcomes.

4.8.4 Outside terraced areas for staff and patients

The design takes into account the clinical health and wellbeing value of having outside space for patients and staff. The provision of a terrace area that will facilitate the space for a patient bed and maximise the first-floor vista, has been welcomed by stakeholders. Separated staff accommodation

is also included as part of this terrace area and was a hugely important aspect of our lessons learned from Covid-19.

4.8.5 Relative overnight accommodation

Currently the hospital provides relative accommodation in a separate block from the critical care facilities. Relatives are often reluctant to leave their loved ones due to the distance of these facilities to the unit. The provision of flexible overnight relative accommodation adjacent to the unit has been built into the design. Also provided is a small but functional beverage area and flexible relative interview/breaking bad news accommodation.

4.8.6 Staff changing/office/training

The provision of staff changing, and showering facilities has been provided in the new design. A key learning point from lesson learned from Covid-19, was the importance of these facilities to staff. Stakeholder engagement as the design progresses will be paramount.

A near site multi-professional training room has been provided and will aid facilitation of continual learning as the new model of integrated critical care service embeds.

4.8.7 Consultant senior nurse accommodation

A small but adequate number of offices are available for medical and senior nursing staff adjacent to the critical care unit.

4.8.8 Operational command centre

The opportunity to transfer the current operation control centre to a more central position within the hospital has been taken. The centre will be situated within the office accommodation on the critical care floor and above the AMM, which will be the main area of patient flow within the hospital.

4.8.9 Hot/cold

The critical care unit has been designed to ensure that it can be successfully separated into hot and cold zones in line with plans for the floor beneath during a pandemic or infection outbreak situation.

4.9 Design and Build

4.9.1 Introduction

The sections below outline both the individual elements of quality specific to the project and the more generic factors which are applicable collectively.

4.9.2 Healthcare Planner

The Trust has its own Health Planner who is part of the wider capital planning team. The Health Planner provides expertise and oversight to all appropriate Trust projects as required, including the project outlined in this OBC.

4.9.3 Overarching Principles informing the Design Brief

This section outlines the overarching principles which have influenced development of the design.

4.9.3.1 *Clinical models of care and Operational Policies*

Developing the clinical model of care is the first step in the identification of the design brief. The models of care which represent the project have been developed by the clinical stakeholders and are referenced within this OBC.

Underpinning the clinical model of care are Clinical Operational Policies:

- **Acute Medical Model and UEC Operational Policy**. These policies are evolving to reflect what is needed in the new physical environment, however there are already policies in place that govern the principles of managing patients with a "home first" focus and ensuring that patients are supported in non-admitted settings which will improve outcomes
- **Level 1, 2 and 3 critical care services** will be integrated to provide a critical care floor directly above and in support of the new AMM. Operational policies for the management of Level 1, 2 and 3 critical care patients will be reviewed to reflect the changed model of integrated care and patient management.

These detail the future delivery of the service and how they need to function relative to the space they will occupy. The operational policies have been used within the high-level design process to:

- Assist all healthcare professionals involved in the provision of services and external contractors in the design of the facility to understand and interpret the future ways of working in the new environment
- Identify and develop a comprehensive understanding of patient flow in and out of the departments
- Detail the flow of all stakeholders in to and out of the department
- Describe the purpose and function of the accommodation required for all elements of the patient journey
- Describe the purpose and function of the accommodation required
- Identify adjacencies and colocations required for efficient service delivery
- Outline the requirements for business continuity
- Outline any legislative and/or mandatory requirements for the delivery of the service e.g. relevant HBN, HTM recommendations
- Contain the schedule of accommodation required within each respective project.

Front line clinical staff have been engaged in the design process since commencement. There has been a project team in place including senior clinical stakeholders: nursing, medical and allied health professionals from the individual services impacted by the project. The group has also had input around:

- Infection Prevention (IP)
- Pharmacy
- Radiology
- Inclusivity & Accessibility

- Dementia Champion & Adult Learning Disability Lead
- Health and Safety (H&S)
- Mental Health
- Estates & Facilities
- Transport
- Information Management and Technology (IM&T).

This team has developed the Models of Care and been guided by Operational Policies, from which the design layouts have been developed.

4.9.3.2 *Infection Control*

The Infection Prevention Team has been involved in the design from the start of the project and has ensured compliance with HBN 00-09: Infection Control in the Built Environment.

During the build process the team will sign off the built environment risk assessment and monitor as appropriate throughout, giving consideration to aspects such as dust control, routes of access and potential impact on adjacent services.

4.9.3.3 *Quality of care and experience*

The project is designed to incorporate our existing knowledge and experience gained from many years of patient feedback from our population. There are a number of specific examples of where we have ensured that we have referenced best practice with respect to this. These include:

- Ensuring that the initial environment at point of arrival is pleasant, welcoming and airy with clear signage throughout
- Building to modern specification with appropriate space and design
- Incorporating key adaptations for specific groups to acknowledge national guidance with respect to children's services, mental health and dementia patients.

One key principle is to minimise the amount of movement of individual patients and bring the clinician to the patient, rather than the other way around. This should enable patients and service users to navigate the environment more easily and reduce the risk of harm caused by multiple hand-offs between teams.

The integration and colocation of critical care Level 1, 2 and 3 patients will allow a model of centralised medical and nursing expertise to develop and ultimately improve the outcomes for those patients within the hospital with the greatest medical need.

Within AMM, the Mental Health Team will have dedicated PLACE compliant cubicles for assessment and patient management. In addition, there will be a dedicated purpose-built paediatric waiting room, treatment and resuscitation cubicles which will be audio-visually separated.

Critical care patients will be cared for in a compliant flexible space by centralised teams. The ability to step down patients in an efficient and timely manner will prevent patient deconditioning. Patients will have access where appropriate to outside space to improve wellbeing and their general

mental health. The provision of a purpose-built paediatric stabilisation room with supporting parent accommodation will support and enhance the care of the critically ill child prior to transfer to a tertiary centre.

Through imaginative interior design using art, lighting and colours, patient and staff experience will be enhanced. This will be an exciting opportunity to involve stakeholders as we develop the interior designs.

The Trust will follow the University of Stirling Dementia Services Development Design and Audit Tool which will play a part in the detailed design process with particular reference to the use of colour and clear signage. The Trust Inclusivity and Accessibility Lead is an active member and stakeholder within the project delivery team.

4.9.3.4 *Patient Led Assessment of the Care Environment (PLACE)*

PLACE is a patient-led system for the assessment of the quality of the patient environment. The assessments are undertaken each year and the results published to help drive improvements in the hospital environment.

The project will improve PLACE scores in the following ways:

- Decoration will be bright and co-ordinated
- Lighting will be used to enhance the environment
- Furniture will conform to infection prevention requirements i.e. open at the back so as not to collect dirt and made from wipeable material
- Areas will be ventilated to ensure odours do not linger
- Natural light will be maximised
- The provision of adequate storage will promote a tidy environment
- The appropriate use of handrails in toilets and on corridors
- Colour contrasting and signage will support a dementia-friendly environment
- Designs will address privacy and dignity issues
- Equipment will support patient orientation and a calming environment.

4.9.3.5 *Carer and Parent accommodation*

Patient needs and the patient environment have been at the fore front of this development. This has been the consideration for carers who support and accompany our patients at a time of need.

- The Project Team has worked with the Trust's Learning Disability and Dementia Team to ensure that the needs of carers have been taken into consideration. The Project Team will use the University of Stirling Dementia Design Audit Toolkit to ensure the special requirements for patients and their carers are met through design development
- The AMM unit has a contained Bier room, with an adjacent relative room containing a small beverage area

- Within the Main Reception area there is a nappy changing area and separate infant feeding room to comply with Baby Friendly Status
- The critical care floor has the provision for relative overnight accommodation and supportive services. Consideration has also been given to areas which can provide waiting areas for individual family groups
- The Children and Young person's stabilisation area has an adjacent relative area.

4.9.3.6 *Quality of the environment*

Design quality will be achieved through the delivery of the design principles by applying, where possible, guidance, compliance and quality assurance standards.

The Trust is committed to ensuring that the best possible designs are delivered, within the constraints of the footprint and cost envelope, and as such will be undertaking formal reviews of the design to give assurance that this is the case including the use of The Construction Industry Council, Design Quality Indicator as gateway reviews.

4.9.3.7 *Safe Design*

Safe design is imperative to the successful delivery and operation of all patient environments. This covers a number of important aspects including:

- Safety of the patient minimising risk in terms of infection control, movement around the clinical space, and environmental design to minimise slips, trips and falls
- Personal safety to ensure risk of personal attack, loss of property etc. is minimised
- Construction Design Management (CDM) which ensures minimised risk and optimised safety during the construction process
- Safety in the working environment which optimises safety for staff in terms of ergonomics and health and safety.

All these safety aspects will be considered within the design process and undertaken via a joint approach between the Health and Safety Team, Infection Prevention, Security Staff, Clinical Staff and the Design Team. This will reflect patient, staff and goods flows within and between areas.

4.9.3.8 *Access*

Access is important in the development of the design for the project and there will be a site wide review of access:

- **External** - This will include clear signage for all visitors to the site. This is not only important to patients, visitors and staff but also to everyone who will form part of the wider functioning of the estate. Particular attention will be paid to the needs of the 'Blue Light' services (including the Fire Service), with clear access arrangements in place
- **Internal** - Throughout the detailed design process attention will be given to internal way-finding, clinical area access control and flows throughout the site. The flows of goods and facilities management will be separated from patient flows wherever possible.

4.9.3.9 *Security*

The Trust employs a Local Security Management Specialist (LSMS) who is being consulted during the design process. The LSMS role is to deliver a safe and secure NHS environment which allows the delivery of high-quality patient and clinical care. The LSMS has access to specialists including input from the Police Force as required. The LSMS will sign off designs as part of our multi-disciplinary team at each stage. The work of the LSMS is overseen by NHS Protect (formerly known as the Counter Fraud and Security Management Service), whose remit is to help protect and secure the NHS, under Statutory Instrument 2002 No. 3009.

4.9.3.10 *IT systems*

The project will have all relevant Trust clinical IT systems fully integrated within each area of the new build. Opportunities will be optimised to review current systems and processes to maximise technology to provide efficient, seamless transitions of patients through their episode of care. Modern service and user experience design methods will be used to ensure that the new service is fully supported by a meaningful and relevant IT service.

Hub rooms will serve the IT requirement for the project and will meet the new enhanced specification in relation to functionality and resilience.

For patient quality and safety purposes, the in-house developed Electronic Patient Record CPD already integrates with national systems such as SCR (Summary Care Record), PDS (Patient Demographics Service) and regional systems such as Yorkshire and Humber Care Record and EPACCS. In addition, the system integrates with multi agency MDTs, Lab systems, Radiology, and GP systems including Emis and SystmOne.

Due to the fact that we will be using existing software systems, the risk of IT systems impacting on patient safety is mitigated.

Senior clinicians and care group leads are directly involved in prioritisation of development work requests via Care Group meetings and there is oversight via the Executive Committee.

4.10 Scheme Design Development

4.10.1 Design solution

The following areas have been considered in the design of the new building:

- **Privacy and Dignity** will be enhanced through maximising where appropriate use of single room accommodation throughout the AMM and Critical Care floor
- **Key clinical support functions** have been planned to carefully consider optimal logistical movement of goods and services throughout the new build. Design has been developed in conjunction with stores, catering and facilities to ensure support areas are well sited with easy access onto main hospital streets for efficient movement of supporting services

- **Adaptability** - following lessons learnt from the current pandemic, it has been essential to plan and design both the AMM and Critical Care floor to adapt and operate separate flows of patients and staff by segregating infected and non-infected patients. This has been achieved by innovative design and adaptability of zones to provide multi-function accommodation

- **Flexibility of accommodation** is key to providing the operational teams areas that can be flexed to meet demand as it presents, such as design of the first assessment areas to be utilised within SDEC if required or critical care isolation rooms that can also flex to any level of acuity

- **Patient Space Standards** have been achieved or exceeded by following HBN guidance for clinical environments. The design team has worked hard with clinical teams to understand the capacity requirements and flow of patients through each department or zone. Within the AMM this has led to a number of different space solutions i.e. chair centric bays, adaptable trolley bays, bed bays which double up as frailty assessment as required. The Critical Care facility has a variety of rooms including single rooms and 4 bed bays using recognised repeatable rooms standards to ensure space is maximised and efficient.

- **Clinical adjacencies and workflow** are key to the delivery of the AMM and the critical care floor. The scheme design has been crucial to establish effective patient flow. The co-location and integration of currently dispersed services are brought together to maximise clinical productivity and decision making and enhance the patient experience.

4.11 Leadership and Stakeholder Engagement

4.11.1 Clinical Leadership

Clinical leadership is key to the successful delivery of the project objectives.

The Care Group Clinical Director is the key sponsor of the project and has been involved since the inception. He has worked with clinical leads across services in the development and agreement of the models of care and clinical operational policies which support this project.

Clinical leadership from within the operational Care Groups has been critical, and the following have been key to this in both the development of models of care, clinical operational polices and input to and sign off of design solutions that meet the brief and deliver both a clinical and cost effectiveness solution for the provision of patient care:

- Clinical Leads for Emergency and Acute Medicine
- Clinical Leads for Anaesthetics and Intensive Care
- Clinical Lead for Coronary Care
- Clinical Lead for Paediatrics

- Clinical Lead for Surgery
- Mental Health.

4.11.2 Stakeholder Engagement

Stakeholder engagement is a vital part of the project in order to ensure that all needs are met through the delivery of the project. The following engagement has happened to date:

- **Healthwatch** – a Healthwatch North Yorkshire review was carried out in 2018/2019 to understand patient and public views on the challenges facing acute services at Scarborough Hospital. A short survey was created to capture feedback on the report and over 350 people attended stakeholder engagement events as part of the review.
- **Patient Partners** have been identified as part of the Communication Strategy and will be further engaged during the FBC stage.
- **Commissioners** have provided their letter in support of the scheme.
- **Overview and Scrutiny Committee (OSC) –** The Project Director presented an overview and progress update for the project to the North Yorkshire County Council Scrutiny of Health Committee on 11th September 2020. The Committee was very interested and engaged in the project presentation and the County Councillors asked a number of pertinent and detailed questions about the scheme and its impact in Scarborough and the surrounding area. The Project Director was very keen to seek the engagement of the Committee and the County Councillors with the remainder of the project. The Scrutiny of Health Committee is equally keen to monitor the progress with delivering the project. With this in mind, the Project Director has been invited to attend a further Committee meeting early in 2021 to update the members on progress.
- **Internal clinical support services** - Engagement has been undertaken and is on-going across a range of clinical support services impacted by the project to ensure that the implications and impact for them have been considered and taken into account. The services consulted include the below:
  - Radiology
  - Pharmacy
  - Pathology
  - Medical Diagnostics
  - Medical Engineering.
- **Estates and facilities management (FM)** - leads from the Estates and Facilities management team have been fully engaged in the project with regards to the impact of the project from an estates, infrastructure and FM perspective and have been part of the development and sign-off of the design to date.

4.13 Workforce

4.13.1 Overview

Workforce planning is a critical component of any project plan. The approach to workforce development planning has been aligned to the Trust's Workforce and OD Strategy 2019 to 2024.

The Trust will ensure that it uses Organisational Development (OD) input appropriately and has recognised this as a key element of the success criteria. Resources have been identified to support change through the new AMM and Critical Care.

The Trust also understands that the more staff are involved and engaged in the management of change and large-scale projects, the higher the likelihood that these projects will be successful. This means assessing and responding appropriately in terms of communication and engagement with managers and staff and investing the time, energy and resources to utilise proven techniques such as "cultural audits", offering leadership support and team development, but also enacting any bespoke interventions or events that may enhance staff and therefore patient experience.

Ultimately this means creating an environment that takes staff through change in a supportive way, to highlight potential benefits and to influence hearts and minds. Research shows that the more engaged staff are the greater the chance of success and the ability to maximise the benefits of this project and generally developing a culture of 'being in it together'.

4.13.2 Consideration of national drivers

The NHS People Plan (2020) recommends that NHS organisations continue to foster a culture of inclusion and belonging, as well as action, to grow our workforce, train our people, and work together differently to deliver patient care. This aim is reflected in the Trusts People Plan Action Plan and which will support the organisation to work differently, embrace new ways of working in teams and look to technology solutions.

The workforce planning to date for this project is also data driven and takes account of patient activity modelled to enable sufficient staffing at peak times. It takes account of numerous national drivers and best practice guidance such as the nationally recognised recommendations on safe staffing numbers as set out by the Royal College of Emergency Medicine, Royal College of Physicians, the requirements of national junior doctor contract, Royal College of Nursing and fully utilising new roles e.g. ACPs.

The proposal will enable the hospital to attract high quality medical and nursing staff, and this will be key to other local projects such as the East Coast Recruitment Project, which already has a proven track record of success over the previous 2 years in attracting and retaining medical staff to the East Coast.

4.13.3 Training and development in new ways of working

The Trust's response to Covid-19 has shown how quickly and effectively our people can adapt to meet the needs of patients. Staff working and learning together in new multi-professional teams have been critical in meeting the recent challenges. Recent experiences and lessons learned around engaging staff, deployment and redeployment, upskilling staff and use of technology in response to the pandemic has provided a basis from which to develop some new ways of working. Our workforce plans will build on this, developing teams to maximise the range of experience and capabilities of clinical and non-clinical members. Training and development will have renewed emphasis on the importance of flexible skills and building capabilities rather than purely traditional roles. The Trust will continue to work closely with both national partners (e.g. HEE) and local partners (e.g. Coventry University Scarborough)

The educational/teaching requirements needed for all medical roles including consultant shop floor teaching and the ability to support Clinical Educator roles have been considered in the workforce planning to date, including Clinical Fellows to support HYMS and the ability to have portfolio GPs.

4.14 Workforce Plans

At the point of delivery there will be a fully established composite workforce designed to maximise the efficiency and effectiveness of the facilities. This strategy is already well developed and will involve the development of a multidisciplinary workforce working towards the single identified goal of delivering excellent patient care.

This workforce will incorporate a number of roles that exist already, deployed in ways of working that are innovative and collaborative, rather than siloed. These roles will include:

- Consultants, and Associate Specialists in Acute and Emergency Medicine
- Specialty trainees in Acute and Emergency Medicine
- Multi Skilled Critical care Nursing workforce
- Doctors in training of all grades and relevant specialties
- Foundation year doctors
- Advanced Clinical Practitioners and trainees
- General Practitioners
- Physicians Associates
- Nursing staff of all grades
- Emergency Nurse Practitioners
- Emergency Department Technicians
- Extensive support from Allied Health Professionals
- Mental Health workers
- Pharmacists
- Administrative, managerial and support staff to allow the above to operate effectively and efficiently.

The majority of workforce will already be employed in similar operational roles to their future roles and will have developed working relationships in their respective teams e.g. Emergency Department, Emergency Assessment Unit (SDEC/Frailty), Short Stay Ward, Urgent Treatment Centre. The expectation is that the models of care will evolve during the period between now and the opening of the building to ensure that the teams are able to seamlessly fit into the new workforce models. Although there is a revenue implication with this as a result of ongoing increased activity over time there is also an expectation that co-location will deliver efficiencies compared with the current way of working.

The integration of Level 1, 2 and 3 critical care patients into a new purpose-built environment, will encourage the development of a highly skilled multiple specialised nursing workforce. The model is seen as attractive to new and existing staff supporting sustainability for the future workforce.

The revenue impact of the workforce plan is included in the Finance Case.

4.15 Business Continuity

Business continuity falls into two distinctive areas:

- **Planning for known business continuity issues** (e.g. noise, access). These issues will be addressed through a risk management process and mitigated through planning, communication and a costed risk allowance

- **Planning for unforeseen eventuality** in the build period such as severing a main electricity supply cable. These issues form part of the Trust's Business Continuity Plan. The risk will be managed through thorough site surveys, planning and ensuring business continuity with all clinical services at risk of disruption.

Further detail on this will be included in the Full Business Case (FBC).

5 The Economic Case

5.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the OBC documents the wide range of options that have been considered in response to the potential scope identified within the Strategic Case.

The economic appraisal has been undertaken in accordance with the HM Treasury Central Government Guidance on Appraisal and Evaluation (The Green Book) and the Department of Health & Social Care Comprehensive Investment Appraisal (CIA) Model.

The economic appraisal of the options under consideration consists of six analyses:

- Capital Costs
- Recurring annual revenue costs
- Risk
- Benefits
- Net Present Social Value (NPSV) and
- Benefit Cost Ratio (BCR).

The capital costs of implementing each option have been calculated by the Trust's Independent Cost Adviser, Turner & Townsend. The capital costs are used in the calculation of the NPSV and BCR.

The annual recurring revenue costs of each option have been assessed on the basis of current expenditure projected for the full year, and then adjusted for the expected changes that would arise as a result of implementing each option.

The calculation of NPSV is based on the capital costs and annual recurring revenue costs and also takes into account avoided costs. In accordance with national guidance, all costs are adjusted to exclude VAT and capital charges as these represent a transfer of costs within the public sector. The NPSV is illustrative of the relative value for money when comparing options of the same overall expected life.

5.2 Critical Success Factors

The critical success factors (CSFs) shown within the SOC have been revisited in context of the OBC and in response to the SOC approval letter which requested the Trust clarify their intention for the fallow floor.

The revised CSF table is below:

1	**Business Needs - How well the option meets the agreed investment objectives, related business needs and service requirements**
	AMM and Critical Care are designed to meet service needs, regulatory standards and capacity and demand modelling
	AMM and Critical Care designed to optimise adjacency and consolidation of dispersed specialty areas for improved clinical care
	Compliant to current build standards (HBN and HTM) and Local Authority Planning and Building Regulations
	Provide access to improved diagnostics (CT, X/Ray/ Ultrasound, Pathology) and required support services i.e. Mental Health, RATS, Children etc
	Promotes improved patients, visitor and staff experience including emphasis on providing an inclusive environment for all service users
	Improves operational performance against national and local key quality indicators i.e. ECS 4-hour standard etc
	Provides ability to separate AMM and Critical Care into "hot and cold" for future resilience in the current Covid-19 and other potential future pandemic situations
	Meets IPC recommendations to optimise the provision of single occupancy accommodation particularly with reference to lessons learnt from Covid-19
	Enhance service resilience and reduce current BLM burden support capital build and SDP
	Improves the ability to respond to mass casualty, major incident, HCID and pandemic incidents
	Improve working environment for staff
	Improve staff retention and recruitment
2	**Strategic Fit - How well the options provides a holistic fit and synergy with key elements of local, regional and national strategies and programmes**
	Local - Clinical Strategy, Patient Safety Strategy, Our Trust Strategy, Estates Strategy, East Coast Review, Strategic Outline Programme, CQC and GPIX recommendations
	Regional - ICS Strategic Outline Programme - HCaV Clinical Services Strategy, Estates Strategy and Acute Services Review, Major Trauma Unit designation
	National - College of Emergency Medicine, NHS Long Term Plan (Jan 2019), 7 Day Hospital Services - Clinical Standards, GIRFT, Critical Care GPICs

3	**Benefits Optimisation - How well the option optimises the potential return on expenditure and assists in improving overall VFM**
	Economy Direct (Return on expenditure) - reduction in future backlog maintenance costs, improves utilities costs, moves towards model hospital average m2 costs
	Economy Indirect - VFM improves with healthcare partners e.g. improved turnaround of ambulance crews
	Economy Wider - reduce reliance on external funding bids to improve site accommodation. Reduction in transfer costs of patients and visiting families
	Efficiency Direct (Qualitative value) - improve patients, visitor and staff-built environment
	Efficiency Indirect - provide fit for purpose, innovative acute accommodation to assist with recruitment and retention current issues
	Efficiency Wider - possible design award potential
	Effectiveness Direct (Quantitative value) - engineering infrastructure reduces the backlog maintenance burden and provides VFM by supporting the future SDP
	Effectiveness Indirect - provide compliant, fit for purpose accommodation for healthcare partners, i.e. YAS, GP's
	Effectiveness Wider - improve reputational status with built environment accommodation for new acute medical model to improve patient episode & outcomes
4	**Potential achievability - The Organisation's ability to innovate, adapt, introduce, support and manage the required level of change including management of risks, capacity and capability**
	Procurement of Integrated Design Team through robust tender evaluation to provide first class architectural design and innovation together with efficient and cost-effective engineering infrastructure solutions
	Phased implementation plan to minimise disruption to the Trust's operational service delivery during construction phase
	Trust's capability and capacity to deliver the project and manage risks (see risk matrix)
	Timeliness of business case approval
5	**How do we procure the solution including best practice - The ability of the marketplace and potential suppliers to deliver the required services and deliverables**
	Procurement of Cost Consultant to provide an options appraisal considering a variety of construction methods and build contractors
	The markets ability to deliver the solution in line with the project key milestones

6	**Affordability - The Organisation's ability to fund the required levels of expenditure - capital and revenue consequences of investment**
	The solution matches the funding awarded to the Trust from the Wave 4 Capital bid (Dec 2018)
	An option that proposes an augmented funding envelope of an additional £10M to derive additional benefits through delivery of the Critical Care Floor
	The solution enables the wider Healthcare System to fund the revenue consequences associated with the investment through approved Trust business case process
	The solution enables the Trust to meet its key financial targets

Table 6 – Critical Success Factors

5.3 Options Appraisal

5.3.1 Long list

The Long List Options Appraisal report October 2020 prepared by Turner & Townsend, outlines how the SOC long list of options for Scarborough Hospital, Transformation of Emergency & Urgent Care were identified and assessed against key criteria. This report can be found in Appendix 15.

The table below shows the long list of five options within the SOC, which the Project Team used the HMT (2018) guidance options framework to identify.

It should be noted that the fallow floor once fitted out as a critical care facility will allow the Trust to re-provide ward accommodation for services that are currently in the three Nightingale Wards which will then be mothballed and any future use subject to a further business case.

Project	1. Business as Usual (BAU)	2. Do Minimum	3. Do Intermediate	4. Do Intermediate +	5. Do Maximum
1. Project scope – as outlined in the strategic case. Focus on scale of potential change required	1.0 Represents the business as usual and as such does not have capital spend or revenue/monetisable (cash / non-cash releasing) benefits	1.1 Under Acute Medical Model (AMM) patients will be assessed and increasingly, seen/ treated in the same day, improving recovery times. Additional costs incurred from the estates and facilities costs of serving a larger area are partially offset by savings from the closure of the existing facility and changes in ways of working under AMM. The use of the existing ED facility will form part of the wider Estates Strategy, SDP, going forward.	1.2 Includes the same benefits as the model in Option 2, with the additional benefit of clinical expansion space above the Acute Medical Model Floor. This will allow the Trust to re-provide all the current 4 Nightingale 1930's adult ward accommodation into this space in future years.	1.3 Includes the model in option 3; with the addition of further capital spend on elimination of backlog maintenance of £1m.	1.4 Includes the model in option 4; with the addition of a basement storey & roof helipad

Table 7 – Long List of Options

5.3.2 Long List to Short List process

A SWOT analyses was carried out on each of the five Long List options as shown in the Long List Options Appraisal report October 2020 (see Appendix 15). The Long List Options were then assessed against the Investment Objectives (IOs) and Critical Success Factors (CSFs) for the project (also included in the Appraisal report).

The tables below show this assessment.

Option	1. Business as usual	2. Do-Minimum	3. Do Intermediate	4. Do Intermediate +	5. Do Maximum
Investment Objectives (IO's)					
IO1: Reduces cost	Does not meet	Partly meets	Partly meets	Fully meets	Fully meets
IO2: Improves efficiency	Does not meet	Partly meets	Fully meets	Fully meets	Fully meets
IO3: Improves quality	Does not meet	Partly meets	Fully meets	Fully meets	Fully meets
IO4: Re-procurement	Does not meet	Partly meets	Fully meets	Fully meets	Fully meets
IO5: Compliance & conformance	Does not meet	Partly meets	Partly meets	Fully meets	Fully meets
Critical Success Factors (CSFs)					
CSF1: Business needs	Does not meet	Partly needs	Partly meets	Fully meets	Fully meets
CSF2: Strategic Fit	Does not meet	Partly meets	Fully meets	Fully meets	Fully meets
CSF3: Benefits Optimisation	Does not meet	Partly meets	Partly meets	Fully meets	Fully meets
CSF4: Achievability	Partly meets	Fully meets	Fully meets	Fully meets	Fully meets
CSF5: Best Practice solution	Does not meet	Partly meets	Partly meets	Fully meets	Fully meets
CSF6: Affordability	Does not meet	Fully meets	Fully meets	Partly meets	Does not meet
Summary	Carry Forward for comparison only	Carry Forward for comparison only	Preferred Way Forward	Preferred Way Forward	Discounted

Table 8 - Assessment of Options against IOs & CSFs

Option	1. Business as usual	2. Do-Minimum	3. Do Intermediate	4. Do Intermediate+	5. Do Maximum
CSF1: Business needs	Very unlikely to deliver against the business needs	Partially addresses needs	Partially addresses needs	Likely to fully meet business needs	Likely to fully meet business needs
CSF2: Strategic Fit	No Strategic Fit	Partial fit	Strategic Fit	Strategic Fit	Full Strategic Fit
CSF3: Benefits Optimisation	No Benefits will be realised	May partly meet required benefits	May partly meet required benefits	Likely to fully meet required benefits	Likely to fully meet required benefits
CSF4: Achievability	BAU could continue but for how long?	Yes	Yes	Yes	Yes
CSF5: Best Practice solution	Not Best Practice	Partly Best Practice	Partly Best Practice	Best Practice	Best Practice
CSF6: Affordability	Affordable in short term?	Affordable	Affordable	Affordable	Not affordable

Table 9 – Assessment of Options against Critical Success Factors

5.3.3 Short List

Based on the evaluation in the section above, a Short List of four options was approved by the Project Board to be taken forward within the OBC for economic appraisal. The four options below are the revised options for evaluation within the OBC.

5.3.3.1 *Option 1 – Business as Usual*

This option represents the status quo:

- Undersized accommodation & fragmented services
- No engineering infrastructure to support any capital expansion/site development

5.3.3.2 *Option 2 Do minimum (£39,989M)*

This option represents the do minimum:

- Two storey right size accommodation for the:
  - AMM (ground floor)
  - Plant room (first floor)
- Sufficient site wide engineering infrastructure to support the AMM capital build and future Site Development Plan:
  - HV/LV
  - Re-provision of car parking spaces
  - Steam
  - Cold water supply & drainage
  - VIE & oxygen ring main
  - Ventilation – AHU's

- Replacement lifts
- Mortuary

5.3.3.3 *Option 3 Do intermediate (£39,989M)*

This option represents the intermediate solution:

- Three storey right size accommodation for the:
  - AMM (ground floor)
  - Fallow floor to provide future Level 1,2 & 3 critical care (first floor)
  - Plant floor (second floor)
- Sufficient essential only engineering infrastructure to support the capital build and future Site Development Plan:
  - HV/LV
  - Re-provision of car parking spaces
  - Steam
  - Water storage tank

5.3.3.4 *Option 4 Do intermediate + (£49,998M)*

This option represents the intermediate plus solution:

- Three storey right size accommodation for the:
  - AMM (ground floor)
  - Level 1,2 & 3 integrated critical care (first floor)
  - Plant floor (second floor)
- Sufficient essential only engineering infrastructure to support the capital build and future Site Development Plan:
  - HV/LV
  - Re-provision of car parking spaces
  - Steam
  - Water storage tank.

5.4 Economic Appraisal

5.4.1 Introduction

This section provides a detailed overview of the main costs and benefits associated with each of the four short-listed options, along with key assumptions. These have then been reconciled in a Comprehensive Investment Appraisal (CIA) (See Appendix 5) to identify which option provides the greater benefits for the least cost. The CIA model has been used to carry out the Economic Appraisal.

5.4.2 Identifying the benefits

The benefits associated with each option were identified during a workshop held on 23 June 2020 and a further refresh session held on 2 November 2020, with the stakeholders and customers for the scheme.

5.4.3 Description, sources and assumptions

The benefits identified fell into the following **main** categories. In each case, the sources and assumptions underlying their use are explained.

Type	Direct to NHS Organisation(s)	Indirect to NHS Organisation(s)
Cash releasing (CRB)	These are financial benefits – for example, avoided spend, reduced cost etc.	As shown
	The above is accounted for in the financial and economic case appraisals	***The above is NOT accounted for in the financial case appraisals***
Non-cash releasing (NCRB)	These are economic benefits – for example, opportunity cost of staff time etc.	As shown
	All of the above are accounted for in the economic case appraisals	***All of the above are accounted for in the economic case appraisals***
Societal Benefits (SB)	A societal benefit is one which is quantifiable in monetary terms, but the benefit is realised by society outside DHSC / the NHS	As shown
	All of the above are accounted for in the economic case appraisals	***All of the above are accounted for in the economic case appraisals***
Unmonetisabe Benefits (UB)	Values of benefit to society but cannot be monetised. For example: improved environment (age / accessibility)	As shown
	Subject to weighting and scoring – see below	***Subject to weighting and scoring – see below***

Table 10 – Main types of Benefits

The benefits, per annum, included in the CIA are summarised as follows:

	Option 1	*Option 2*	*Option 3*	*Option 4*
	£'000	£'000	£'000	£'000
CRB		£5,540	£5,540	£5,540
NCRB		£188,556	£188,556	£456,823
SB		£20,618	£20,682	£25,606
UB	Not Quantifiable	Not Quantifiable	Not Quantifiable	Not Quantifiable
Grand Total		**£214,714**	**£214,778**	**£487,969**

Table 11 – Benefits per annum in CIA

Cash Releasing Benefit
Improved access to diagnostics (CT, X/ray/US) and improved resilience with 2nd CT

Table 12 - Cash Releasing Benefits

Non-Cash Releasing Benefit
Rapid assessment and decision making leading to shorter waiting times and improved Emergency Care Standard (ECS)
Avoiding unnecessary inpatient admissions
Centralised management of level 1, 2 and 3 critical care patients in improved, complaint, single occupancy accommodation
Avoiding unnecessary inpatient transfers
Improved working environment including dedicated staff welfare facilities to aid recruitment and retention into specialty areas which has previously been extremely difficult at Scarborough Hospital.
Improved infection control outcomes
Carter compliance (clinical/non-clinical % and cost per m²)
Improved recruitment and retention of key medical and nursing posts (reduction in agency spend)
Improved maintenance of plant and equipment through design
Deliver an improved and robust emergency preparedness resilience and response plan
Improved YAS turnaround times and handover
3rd sector opportunities
Investment in sustainable local health services for the population of the East Coast

Table 13 – Non-Cash Releasing Benefits

Societal Benefit
Building Research Environmental Assessment Method (BREEAM)/environmental/ecological/sustainability
Supports education and apprenticeships during design and construction period
Potential boost to local economy during construction period and future
Aids recruitment opportunities in the local area, for non-NHS workers during the construction of the new build.
Increased reputational value and significant investment to healthcare in the locality may attract new workforce into specialty areas which has previously been extremely difficult at Scarborough Hospital.

Table 14 – Societal Benefits

5.4.4 Capital Costs

This capital costs associated with each of the short-listed options have been prepared by the Trust's Independent Cost Adviser, Turner and Townsend in accordance with standard NHS methodologies. The Capital Costs of the Short List Options are shown in the Table below.

Description	Option 1 – Business as Usual	Option 2 – Do Minimum	Option 3 - Do Intermediate	Option 4 – Do Intermediate +
		£'000	**£'000**	**£'000**
Capital Build				
Construction & Infrastructure costs		28,751	29,139	34,484
Fees		2,487	2,594	3,104
Non-Works costs		90	90	90
Equipment costs		1,850	1,750	3,750
Planning contingency		2,691	2,444	2,999
Optimism Bias		2,285	1,924	2,936
Inflation adjustment		1,835	2,048	2,635
Capital Build Total		**£39,989**	**£39,989**	**£49,998**

Table 15 – Short List Options Capital Costs

5.4.6 Revenue Costs

The revenue costs for each Short List Option have been assessed based on current year values with future growth in costs having been applied over the life of the project as follows:

Costs	Growth
Fixed	0%
Semi Fixed	2%
Variable	In line with growth in activity

The net growth applied to all revenue costs is as follows:

Year	2023/24	2024/25	2025/26	2026/27	2027/28
Growth	2.32%	2.17%	2.01%	2.02%	1.85%

Inflation has been excluded from revenue assumptions based on the CIA guidance; however, a relevant GDP deflator has been applied according to the Office for National Statistics (ONS) Long Term Economic Determinants:

	2023-24	2024-25	2025-26	2026 Onwards
GDP Deflator	2.0%	2.3%	2.3%	2.3%

VAT is excluded from all revenue assumptions.

The following table highlights the increase in revenue costs over current BAU levels that will require funding in future years. Costs are presented in annual terms with the first full year impact anticipated in 2024/25, although the project team expects the new facility to open in December 2023.

Both the Long-Term Financial Model and the Comprehensive Investment Appraisal consider a December 2023 start date, but for illustrative purposes a full year effect is included below.

Costs	Option 1	Option 2	Option 3	Option 4
	Business as Usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Revenue Costs				
Additional Support Staff (Radiology / Ultrasound)	£0	£175	£175	£175

Estates & Facilities running costs associated with increased floor area - AMM Unit	£0	£1,810	£2,132	£2,132
Assumed closure and mothballing of old ED area	£0	-£322	-£322	-£322
Increased FM costs on infrastructure services	£0	£221	£221	£221
Background running costs of empty first floor shell	£0	£0	£65	£0
Estates & Facilities running costs associated with fit out of first floor	£0	£0	£0	£1,392
Assumed closure and mothballing of Nightingale Wards	£0	£0	£0	-£501
Overheads	£0	£496	£512	£719
Total Revenue Costs	**£0**	**£2,380**	**£2,783**	**£3,816**

Note: All costs are exclusive of VAT

Table 16 – Revenue Costs

5.4.7 Avoided Costs

Due to the extensive compliancy and patient safety issues within the current ICU, an options appraisal identified the requirement for a new build.

Option 4 – Intermediate + includes £10m to fully fit out the first floor of the proposed new build. Should the new capital build not go ahead, the cost of a new stand-alone purpose-built critical care unit built 2 years following this development in 2026/27, is assessed as £20m. Should Option 3 be the Preferred Option, which includes a fallow floor only, the cost to fit out this floor at a later date for a fully functioning critical care unit is assessed at £14m. Avoided costs are therefore included in the CIA model as follows:

Avoided Capital Cost	Option 1 – Business as Usual	Option 2 – Do Minimum	Option 3 - Do Intermediate	Option 4 – Do Intermediate +
	£'000	**£'000**	**£'000**	**£'000**
Critical Care Unit	£20,000	£20,000	£14,100	£0
Total	**£20,000**	**£20,000**	**£14,100**	**£0**

Table 17 – Avoided Costs

5.4.8 Avoided Backlog Maintenance

An assessment of backlog maintenance has identified the need for £25m critical capital expenditure to ensure the Scarborough Hospital site can remain operational, £16m of which is an imminent requirement. This is an increase on the values included in the SOC (£21m critical capital

expenditure and £13m imminent requirement) due to the progression of the detailed design and the refinement of the actual cost of the infrastructure works.

Lifecycle maintenance is included in the capital cost of the project over the 60-year life to ensure the proposed £49.9m capital build is maintained to condition B status. The inclusion of the lifecycle maintenance will reduce the burden on the current backlog maintenance programme.

This is an avoided cost per option as follows:

Option 2- Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
£'000	£'000	£'000
£24,627	**£18,353**	**£19,103**

Table 18 – Avoided Costs

Option 2 has the highest avoided cost as the scheme allows for additional infrastructure works that are not included in Options 3 and 4. This is due to options 3 and 4 having a greater cost on the capital build element of the project. The schemes not included in options 3 and 4 are:

- 2nd VIE / oxygen ring main
- AHU vent replacements
- Mortuary / body store / viewing area refurb (**Note: the mortuary is classed as a high priority for Scarborough Hospital and as contingency is released from the project the mortuary refurbishment will be added back into the scheme for options 3 and4)**
- Cold water supply & drainage (essential work is included within the costed options)
- Replace two lifts in main entrance (controls and internals)
- South Block Roof replacement.

The above schemes have been assessed as required but not detrimental to the new capital build if they do not go ahead.

Option 4 has a higher avoided BLM cost over option 3 due to the transfer of the Coronary Care Unit to the 1st floor of the new build.

5.4.9 Avoided Revenue Costs

Avoided revenue costs are only applicable to Option 1, Business as Usual, which includes the avoided cost of an additional ward (£2.5m per annum) which will be required if we do not change the patient pathways and reduce the length of stay; new ways of working are planned within the proposed new build Acute Medical Model which will negate this requirement.

5.4.10 Lifecycle Costs

Lifecycle costs have been calculated for the 60-year life of the project as required by section 5.2 of the Comprehensive Investment Appraisal Model user guide.

Lifecycle costs	Option 1	Option 2	Option 3	Option 4
	Business as Usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Capital Build		£8,779	£10,123	£10,829
Lifecycle management		£173	£304	£325
Risk		£289	£506	£541
Overheads		£312	£547	£585
Profit		£655	£1,148	£1,228
Totals		**£10,208**	**£12,628**	**£13,508**

Table 19 – Lifecycle Costs

The lifecycle costs primarily relate to the construction of the capital build and increase proportionally for each option as the capital requirements increase.

Option 2 however has additional lifecycle cost for the following infrastructure schemes that are not currently included in options 3 and 4:

- AHU vent replacements
- Mortuary / body store / viewing area refurbishment.

The lifecycle costs compared to the avoided backlog maintenance costs are more cost effective, as expected due to the ageing / critical condition of the current site as compared with the new capital build.

	Option 1	Option 2	Option 3	Option 4
	Business as usual	Do Minimum	Do Intermediate	Do Intermediate +
	£'000	£'000	£'000	£'000
Lifecycle Costs		£10,207	£12,628	£13,508
Avoided Backlog Maintenance		£24,627	£18,353	£19,103
Net Saving		**£14,420**	**£5,725**	**£5,595**

Table 20 – Lifecycle Costs

5.4.11 Sunk Costs

Sunk costs are costs that have already been incurred and are excluded from the economic appraisal.

In the CIA, the following costs have been excluded, taking into account costs that have been incurred and will be incurred up to the OBC submission date in November 2020.

- Option 2 - £560k
- Option 3 - £561k
- Option 3 - £571k

The above costs represent 94% fees and 6% works costs.

5.4.12 Net Present Cost

The detailed economic appraisals for each option are included in the Comprehensive Investment Assessment (CIA) in Appendix 5 together with detailed descriptions for costs and benefits, and their sources and assumptions.

The net present costs of each option are summarised in the following table:

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate +
Opportunity costs	£0.00	£0.00	£0.00	£0.00
Capital costs	£32,882	£53,359	£54,392	£50,874
Capital costs optimism bias* uplift	£0.00	£2,091	£1,755	£2,658
Capital costs + optimism bias uplift	£32,882	£55,450	£56,147	£53,532
Revenue costs	£1,999,690	£1,977,952	£1,981,821	£1,980,138
Transitional costs	£0.00	£0.00	£0.00	£0.00
Externality costs	£0.00	£0.00	£0.00	£0.00
Net Contribution costs	£0.00	£0.00	£0.00	£0.00
Total costs	**£2,032,572**	**£2,033,402**	**£2,037,968**	**£2,033,670**
Rank	**1**	**2**	**4**	**3**

Table 21 – Net Present Cost and Rankings

*** Optimism Bias is the systematic tendency for appraisers to be over-optimistic about key project parameters, including capital costs. Optimism bias is included within the capital costs estimate to take into account this tendency and as the appraisal develops and the costs and key risks are further defined, the optimism bias can be reduced.**

The above is calculated with reference to each option's construction periods between 2021 and 2024, plus a further period of 60 years for lifecycle maintenance and takes into account the full revenue implications of operating the new build.

From a total net present cost point of view Option 1 (Business as Usual) is ranked first and the Preferred Option ranked 2nd.

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate+
Capital costs + optimism bias uplift	£32,882	£55,450	£56,147	£53,532
Total costs	**£32,882**	**£55,450**	**£56,147**	**£53,532**
Rank	**1**	**3**	**4**	**2**

Table 22 – Total Capital Cost (including optimism bias) and Rankings

From a capital cost point of view, Option 1 (Business as usual) is the cheapest option with a capital cost of £33m including lifecycle, avoided capital cost and optimism bias, however the Preferred Option, option 4 (do intermediate +) is now ranked 2 with a total capital cost of £54m.

Summary (Discounted) - £'000	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate+
Revenue costs	£1,999,690	£1,977,952	£1,981,821	£1,980,138
Total costs	**£1,999,690**	**£1,977,952**	**£1,981,821**	**£1,980,138**
Rank	**4**	**1**	**3**	**2**

Table 23 – Revenue Costs & Rankings

From a revenue point of view, Option 1 is now the least favoured option, with Option 2 (Do Minimum) ranked 1 and the Preferred Option 4 (Do intermediate +) ranked 2.

However, benefits and risks need to be taken into consideration and therefore the economic summary of the CIA combines the capital and revenue costs of the project with the benefits and risks aligned to each option.

5.4.13 Cost Benefit Analysis

The following table summarises the key results of the economic appraisals for each option:

Detailed Economic Summary (Discounted) - £'000				
	Option 1 – Business as usual	**Option 2 – Do Minimum**	**Option 3 – Do Intermediate**	**Option 4 – Do Intermediate +**
Costs				
Incremental cost increase - capital (including optimism bias)	£0	-£22,568	-£23,265	-£20,650
Incremental cost increase - risks	£0	-£2,264	-£2,056	-£2,523
Incremental costs - total	£0	-£24,832	-£25,321	-£23,173
Benefits				
Incremental cost reduction - revenue	£0	£21,738	£17,869	£19,552
Incremental benefit - cash releasing	£0	£5,540	£5,540	£5,540
Incremental benefit - non-cash	£0	£17,759	£17,759	£43,026

releasing				
Incremental benefit - societal	£0	£20,618	£20,682	£25,606
Incremental benefits - total	£0	£65,655	£61,851	£93,724
Value for Money				
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio	£0	2.64	2.44	4.04
Rank	**4**	**2**	**3**	**1**

Table 24 – Detailed Economic Summary

The above table appraises the capital and revenue costs and the monetisable benefits over the project life to assess the benefit-cost ratio.

In line with the Department of Health and Social Care Comprehensive Investment Appraisal (CIA) Model user guide, the absolute value for money (AVFM) threshold for health spending is 4. So, for every £1 spent, £4 is generated in quantified benefits.

The Benefit Cost Ratio demonstrates that **Option 4 is the only option that meets the AVFM threshold with a BCR of 4.04.**

Should funding ultimately be constrained within the original £40m envelope then the Preferred Option, following the investment appraisal, would be Option 2. The appraisal reveals that construction of the fallow floor (for later fit out and completion) scores marginally lower than removing the floor construction completely and making an investment in additional backlog maintenance.

5.4.14 Options Ranking

The results are summarised and shown in the following Table.

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs - total	£0	-£24,832	-£25,321	-£23,173
Incremental benefits – total	£0	£65,655	£61,851	£93,724
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio		2.64	2.44	4.04
Rank	**4**	**3**	**2**	**1**

Table 25 – Summary of Results

The key findings are as follows:

Option 1 – Business as Usual

This option ranks 4th.

Option 2 - Do minimum (£39,989M)

This option ranks 2nd.

It provides £65.6m of incremental benefits over the life of the project, offset by an incremental cost of £24.5m.

Option 3 – Do intermediate (£39,989M)

This option ranks 3rd.

It provides £61.8m of incremental benefits over the 60-year life of the project, offset by an incremental cost of £25.3m

Option 4 – Do intermediate + (£49,998M)

This option ranks 1st.

It provides £93.7m of incremental benefits over the 60-year life of the project, offset by an incremental cost of £23.2m

5.4.15 Options Appraisal Conclusions

Although Option 4 has the greater capital cost which exceeds the current funding allocation, it only has the 2nd highest revenue cost over the life of the project. This combined with the value of the benefits over the 60-year life results in **Option 4 having the greatest Benefit Cost Ratio of 4.04 and is therefore the Preferred Option.**

5.5 Qualitative benefits appraisal

5.5.1 Methodology

A workshop was held on 2 November 2020 to evaluate the qualitative benefits associated with each option.

In addition to the cash releasing and non-cash releasing quantifiable benefits above, the un-monetisable benefits have been assessed from a qualitative perspective to provide a NPSV per benefit score.

The appraisal of the qualitative benefits associated with each option was undertaken by:

- Identifying the benefits criteria relating to each of the investment objectives
- Using a raw scoring methodology, each of the short-listed options were valuated against the unmonetizable benefit on a scale of 0 – 5.

5.5.2 Qualitative benefits criteria & scoring

The benefits criteria were scored as follows for each investment objective:

Main Benefits Criteria	Option 1	Option 2	Option 3	Option 4
Patient at the centre of clinical decision making by providing appropriate clinical accommodation and diagnostic support services to implement the Acute Medical Model	5	1	1	1
Improved environment (age appropriate	5	2	2	1

accommodation i.e. paeds/elderly/accessibility etc)				
Maximise single occupancy accommodation to comply with infection prevention best practice and improve privacy and dignity and lessons learnt from Covid-19	5	2	2	1
Improved environment (age appropriate and accessibility) including dedicated breast-feeding room and baby changing facility	5	1	1	1
Additional and improved bereavement and quiet space accommodation within the Acute Medical Model and Critical Care facility	4	1	1	1
Dedicated relatives' day and night accommodation within the critical care floor	5	0	0	1
Innovative design of a range of clinical spaces to provide the required capacity to care for all acute patient attendances	5	1	1	0
Improved access to multi-disciplinary integrated care teams in AMM and Critical Care	4	1	1	1
Improved working environment and staff welfare facilities	4	1	1	1
Reception area design to promote confidentiality issues on check-in	3	2	2	0
Improved CQC rating - compliance	4	1	1	1
Reduced backlog maintenance programme	4	2	2	1
Delivery of Site Development Plan (Estates Strategy)	5	2	2	1
Compliant level 1, 2 and 3 critical care facilities	5	0	0	1
Supports integrated primary and secondary care pathways	3	1	1	0
Benefits Score	**66**	**18**	**18**	**12**

Table 26 – Qualitative Benefits Criteria and Scoring

5.5.3 Qualitative benefits scoring

Benefits scores were allocated on a range of 0-5, (where 0 = N/A, 1 = Very good and 5 = Very Poor) for each option and agreed through consensus by the workshop participants to confirm that the scores were fair and reasonable.

5.5.4 Analysis of key results

The results of the benefits appraisal are shown in the following table:

	Option 1 – Business as usual	Option 2 – Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
Benefit score	66	18	18	12
NPSV	£0	£40,823	£36,529	£70,551
NPSV per benefit score	0	£2,267.96	£2,029.40	£5,879.24
Rank	**4**	**2**	**3**	**1**

Table 27 – Benefits Appraisal Results

Option 4 has the lowest benefit score and the highest Net Present Social Value and therefore ranks 1st on a qualitative basis, supporting the BCR as Option 4 as the Preferred Option.

5.5.5 Risk

5.5.5.1 *Methodology*

A workshop was held on 23 June 2020 to review and update the SOC risks and counter measures.

The CIA model costed risks were identified during the infrastructure and clinical design workshops. These were approved by the Project Team and submitted to the Project Board for approval.

Following Project Board approval, the risks were then valued within the CIA model for each option by the Cost Advisor.

The CIA risk template was completed by:

- Identifying which CIA risks were applicable at this stage of the project
- Assessing the probability and severity
- RAG rating each total score.

5.5.5.2 *Valuation of Risks*

Each risk identified within Options 1 – 4 were valued with the following methodology:

1) Each risk was assessed as to the probability of the risk as a percentage of:

   a. High Impact

   b. Medium Impact

   c. Low Impact

   d. No Impact

For example:

Example from Option 2	High impact	Medium impact	Low impact	No impact	Sum of probabilities
Design Risk					
Failure to translate design	15%	30%	45%	10%	100%

1) The next step was to assess the value of the risk should it materialise:

For Example:

	Value per annum (£'000) if risk materialises				Expected Value per Annum
Example from Option 2	**High impact**	**Medium impact**	**Low impact**	**No impact**	
Design Risk					
Failure to translate design	£30.45	£20.30	£15.22	£0.00	£17.51

2) Step 3 assessed the period that the risk would be present, and the total number of years that would be impacted by the risk:

For Example:

Risk	Expected Value per Annum £'000	Time period that risk is present		
Example from Option 2		From (year)	To (year)	No. of Years
Design Risk				
Failure to translate design	£17.51	1	2	2

3) This analysis then resulted in the total value of the risk as both a discounted and undiscounted value:

For Example

Risk Description	Discount Factor	Undiscounted Risk Value £'000	Discounted Risk Value £'000
Example from Option 2			
Design Risk			
Failure to translate design	1.90	£35.02	£33.26

A summary of the risk appraisal results is shown below.

Quantitative Risks (Discounted) - £'000				
	Option 1 - Business as Usual	Option 2 – Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
Design	£0	£532,000	£483,000	£593,000
Construction	£0	£405,000	£368,000	£452,000
Performance	£0	£0	£0	£0
Operating	£0	£129,000	£117,000	£144,000
Revenue	£0	£0	£0	£0
Termination	£0	£0	£0	£0
Technology	£0	£0	£0	£0
Control	£0	£0	£0	£0
Residual value	£0	£0	£0	£0
Other	£0	£0	£0	£0
Additional	£0	£1,198,000	£1,088,000	£1,335,000
Total	**£0**	**£2,264**	**£2,056**	**£2,523**
Rank	**1**	**3**	**2**	**4**

Table 28 - Summary of the Risk Appraisal Results

Option 4 was ranked 4th for risks. Option 1 was assessed as having no quantifiable risks and the next comparable data is in Option 3 which was ranked second. If Option 4 is compared with Option

3, the value of risk is £0.5m higher however it should be expected that the value of risks for a £50m capital build would be significantly higher than a capital build of £40m.

5.5.6 The Preferred Option

The results of investment appraisal are as follows:

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs - total	£0	-£24,832	-£25,321	-£23,173
Incremental benefits – total	£0	£65,655	£61,851	£93,724
Risk-adjusted Net Present Social Value (NPSV)	£0	£40,823	£36,529	£70,551
Benefit-cost ratio		2.64	2.44	4.04
Rank	**4**	**2**	**3**	**1**

Table 29 - Summary of Overall Results

5.5.7 Conclusion

The Preferred Option is Option 4 as the resultant combined assessment of costs and benefits outweigh the other options over the life of the project.

The Preferred Option is Option 4 as the value of the benefits outweighs the capital and revenue costs and the value of the risks associated over the 60-year life of the project.

5.5.8 Sensitivity analysis

Sensitivities have been introduced to the Comprehensive Investment Appraisal (CIA) to identify how much of a change would be required to move the Preferred Option to another option.

The methods used were:

c) 'switching values'

d) scenario planning / analysis ('what if ') by altering the values of the 'uncertain' costs and benefits to observe the effect on the overall ranking of options.

The CIA was used to explore a number of sensitives as follows:

1) Increase lifecycle costs by 15%

2) Increase in revenue costs by 10%

3) Increase risks by 10%

4) Decrease Non-Cash Releasing Benefits by 10%

The outputs of the exercise are included are shown below.

5.5.9 Results of switching values

The tables below show the values that change in the economic summary as a result of the sensitivity analysis and the change in BCR and rank of the Preferred Option.

Sensitivity Analysis 1 – Increase in Lifecycle costs by 15%

Lifecycle costs are one of the most difficult elements to cost accurately, hence there is more uncertainty around these costs. This scenario was also chosen as lifecycle costs might favour the new build options over Option 1 (Business as Usual) due to the higher cost of back log maintenance on an ageing site.

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs – total		-£25,275	-£27,083	-£23,738
Incremental benefits – total		£65,655	£61,851	£93,724
Risk-adjusted Net Present Social Value (NPSV)		£40,380	£34,768	£69,986
Benefit-cost ratio		2.60	2.28	3.95
Rank	**4**	**2**	**3**	**1**

Table 30 – Sensitivity Analysis Number One

Sensitivity Analysis 2 – Increase in revenue costs by 10%

This option was chosen as the option to include a fully fit out critical care unit in Option 4 is new to the appraisal at OBC and therefore will need a greater degree of analysis and refinement as we go through to the Full Business Case.

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	**Option 2 - Do minimum**	**Option 3 - Do intermediate**	**Option 4 - Do intermediate +**
Incremental costs – total	£0	-£24,832	-£25,321	-£23,173
Incremental benefits – total	£0.00	£65,655	£61,851	£86,091
Risk-adjusted Net Present Social Value (NPSV)	£0.00	£40,823	£36,529	£62,918
Benefit-cost ratio		2.64	2.44	3.72
Rank	**4**	**2**	**3**	**1**

Table 31 – Sensitivity Analysis Number Two

Sensitivity Analysis 3 – Increase in risks costs by 10%

The option to test the sensitivity of the risks was chosen due to the uncertainty of the value of the risks at the OBC (RIBA Work Stage 1 and 2) concept design. As we move through the developed and technical design stages to RIBA Work Stages 3 and 4, the risks will be further developed and refined providing greater reassurance as to the value of these risks.

Economic Summary (Discounted) - £'000

	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate +
Incremental costs - total	£0.00	-£25,058.06	-£25,526.99	-£23,425.32
Incremental benefits – total	£0.00	£65,655.02	£61,850.53	£93,723.85
Risk-adjusted Net Present Social Value (NPSV)	£0.00	£40,596.96	£36,323.54	£70,298.53
Benefit-cost ratio		2.62	2.42	4.00
Rank	**4**	**2**	**3**	**1**

Table 32 – Sensitivity Analysis Number Three

Sensitivity Analysis 4 – Decrease Non-Cash Releasing Benefits by 10%

As we progress through OBC to FBC and move to a single Preferred Option. The focus will be on the relevant benefits of the Preferred Option and will therefore include further scoping and increased certainty on the value.

Economic Summary (Discounted) - £'000				
	Option 1 - Business as Usual	Option 2 - Do minimum	Option 3 - Do intermediate	Option 4 - Do intermediate +
Incremental costs - total	£0.00	-£24,831.67	-£25,321.36	-£23,173.03
Incremental benefits – total	£0.00	£63,879.10	£60,074.61	£89,421.26
Risk-adjusted Net Present Social Value (NPSV)	£0.00	£39,047.43	£34,753.26	£66,248.23
Benefit-cost ratio		2.57	2.37	3.86
Rank	**4**	**2**	**3**	**1**

Table 33 – Sensitivity Analysis Number Four

5.5.10 Key observations

Sensitivity Analysis 1 – Increase in Lifecycle costs by 15%

Increasing the lifecycle costs by 15% does not result in a change to the rank of the Preferred Option, however it does reduce the BCR to below the recommended value of 4.0 (i.e. for every £1 spent, £4 is generated in quantified benefits).

Option 4 – remains the Preferred Option.

Sensitivity Analysis 2 – Increase in revenue costs by 10%

Increasing the revenue costs on Option 4 by 10%, reduces the BCR to below the recommended value of 4.0, however, Option 4 is still ranked 1st, with a greater benefit than cost over the life of the project.

Option 4 – remains the Preferred Option.

Sensitivity Analysis 3 – Increase in risks costs by 10%

Increasing the risks by 10% reduces the BCR of the Preferred Option to 4.00 rather than 4.04; however, it does not result in a change to the rank of the Preferred Option.

Option 4 – remains the Preferred Option.

Sensitivity Analysis 4 – Decrease Non-Cash Releasing Benefits by 10%

Decreasing Non-Cash Releasing Benefits by 10% does not result in a change to the rank of the Preferred Option, however it does reduce the BCR to below the recommended value of 4.0 (i.e. for every £1 spent, £4 is generated in quantified benefits).

Option 4 – remains the Preferred Option.

5.5.11 Results of scenario planning

The table below summarises the results associated with increasing uncertain costs by 10% - 15% and reducing uncertain benefits by 10%.

Results of scenario planning										
	Comprehensive Investment Appraisal		Sensitivity 1 – Increase Lifecycle costs by 15%		Sensitivity 2 – Increase Revenue Costs by 10%		Sensitivity 3 – Increase risks by 10%		Sensitivity 4 – Decrease Non-Cash Releasing Benefits by 10%	
	BCR	Rank	BCR	Rank	BCR	Rank	BCR	Rank	BCR	Rank
Option 1 – Business as Usual	0	4	0	4	0	4	0	4	0	4
Option 2 – Do Minimum	2.64	2	2.60	2	2.64	2	2.62	2	2.57	2
Option 3 – Do Intermediate	2.44	3	2.28	3	2.44	3	2.42	3	2.37	3
Option 4 – Do Intermediate +	4.04	1	3.95	1	3.72	1	4.00	1	3.86	1

Table 34 - Summary of Results from Scenario Planning

5.5.12 Key observations

In addition to the key scenarios above, further analysis was taken to ascertain, if all of the above scenarios were true, would this materially impact the outcome of the CIA. The effect was to reduce the BCR across all options however this did not cause a switch in the preferred outcome.

Following scenario planning, 'what if' analysis and switching values, the impact on the Benefit Cost Ratio has an effect on reducing the BCR, and for some scenarios reducing this below the Absolute Value For Money threshold for health spending of 4.0.

However, in none of the scenarios outlined above is the Preferred Option anything other than Option 4, as this still gives the greatest benefit over costs of all other shortlisted options. This demonstrates that the Preferred Option is a robust proposal that does not react to moderate and realistic sensitivities.

Given that Option 4 is also the Preferred Option following the qualitative appraisal, it's continued ranking through changing costs and benefits and the sensitivity analysis applied through the CIA model, the ranking of the options overall does not change and Option 4 remains as the Preferred Option.

The Preferred Option is Option 4.

5.6 Comprehensive Investment Appraisal (CIA)

The economic appraisal has been undertaken in accordance with the HM Treasury Central Government Guidance on Appraisal and Evaluation (The Green Book) and the Department of Health & Social Care Comprehensive Investment Appraisal (CIA) Model.

A copy of the Comprehensive Investment Appraisal (CIA) Model can be found in Appendix 5.

5.7 Summary and way forward

5.7.1 Conclusion

The table below summarises the results of the Sensitivity Analysis carried out.

	Option 1 – Business as Usual	Option 2 – Do Minimum	Option 3 – Do Intermediate	Option 4 – Do Intermediate +
Net Present Cost	1	2	4	3
Capital Cost + Optimism bias uplift	1	3	4	2
Revenue Costs	4	1	3	2
Benefit Cost Ratio	4	2	3	1
Qualitative Score	4	2	4	1
Risk	1	3	2	4
Sensitivity Analysis 1	4	2	3	1
Sensitivity Analysis 2	4	2	3	1
Sensitivity Analysis 3	4	2	3	1
Sensitivity Analysis 4	4	2	3	1

Table 35 – Summary of Sensitivity Analysis

Throughout the analysis applied through the CIA Model, Option 4 has ranked 1st in 6 out of 10 scenarios.

The scenarios where Option 4 was not ranked the highest were as follows:

1. **Net Present Cost** – Option 4 was ranked 3rd for net present cost, however the total capital and revenue costs combined are only £1m more than the 1st ranked option in this scenario (Option 1) due to the greater capital cost, but reduced revenue consequences over the life of the project.

2. **Capital Cost** – Option 4 was ranked 3rd for capital cost. The £54m capital cost including capital build, lifecycle and avoided backlog maintenance is greater than the option ranked 1st (Option 1) with a variance in capital cost of £20.1m, however is cheaper than options 2 and 3 by £1.9m and £2.6m respectively).

3. **Revenue Costs** – Option 4 was ranked 2nd for revenue costs. This should be expected as the cost of running an additional floor with a 3,120sqm area will be more expensive in terms of facilities management services, than the 1st ranked option (option 2) that is a single storey build only.

4. **Risks** – Option 4 was ranked 4th for risks, the lowest placing throughout all scenarios, however it should be expected that the value of risks for a £50m capital build would be significantly higher than a capital build of £40m.

The resulting Benefit Cost Ratio after applying all scenarios outlined in this economic appraisal is 4.04 for Option 4. This ranks as the 1st place option and provides an absolute value for money score greater than the threshold of 4 for health spending.

The Trust's Preferred Option is Option 4 however it is accepted that this option breaches the current funding envelope and supplementary funding would be required.

Should funding ultimately be constrained within the original £40m envelope then the Preferred Option, following the investment appraisal, would be Option 2. The appraisal reveals that construction of the fallow floor (for later fit out and completion) scores marginally lower than removing the floor construction completely and making an investment in additional backlog maintenance.

6 The Commercial Case

6.1 Introduction

This section of the OBC outlines the proposed procurement method in relation to the Preferred Option (Option 4).

This case outlines the provision of construction works to provide redesigned acute and emergency and critical care services within a new fit for purpose, compliant, capital build which will support significant operational benefits for the Trust and the wider community.

It also outlines the required site-wide engineering infrastructure to support the new build and Site Development Plan (SDP) for Scarborough Hospital.

6.2 Scope

6.2.1 Acute Medical Model & Critical Care Floor New Build Scope

6.2.1.1 *Overview*

The Acute Medical Model Urgent and Emergency Care build project at Scarborough Hospital will be the acute care hub for the entire locality enabling the co-working of multiple professions in a coordinated manner. The new facility will enable patients to be managed appropriately as quickly and safely as possible without the need to travel to another healthcare facility.

The new facility has been designed and developed for the post Covid-19 world where there is an opportunity to re-set urgent healthcare services and the need to continue to evolve the way in which we provide these locally.

The proposed capital development will provide a three storey fully integrated Acute Medical Model, Level 1, 2 & 3 integrated critical care facility, and plant floor within a single building situated to the west of the main hospital estate. The AMM and the Critical Care Floor will occupy a floor space of 3,100m2 per floor.

The new building will be located on land used for existing parking and as such, a new car park is proposed on the site of the existing helipad to mitigate this loss and provide additional capacity for the hospital.

Due to the fall away of the proposed site towards the existing South Block and Hospital Main Entrance, the ground floor of the proposed build will be directly linked to level 1 of the South Block; the first floor will directly link to level 2 and the plant floor at level 3. The proposed construction site is currently being utilised for staff car parking.

6.2.1.2 *Site Plan*

The Site Plan below shows the position of the proposed build in red and the proposed ambulance route.

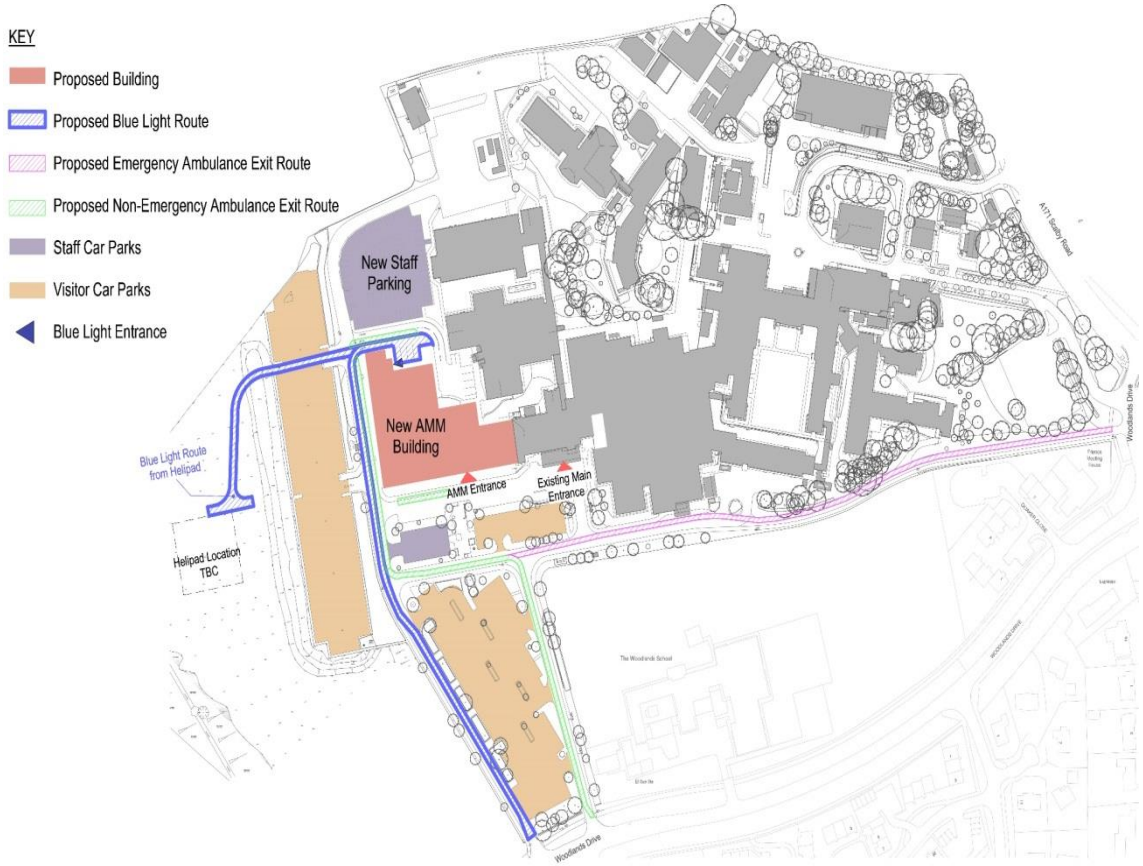

Diagram 14 - Site plan incorporating capital build

6.2.1.3 *Future AMM & Critical Care Floor*

The current plan for the new Level 1, 2 & 3 critical care facilities will provide 19 single rooms with 10 isolation rooms with positive pressure lobbies and 2 x 4 bed bays and supporting accommodation within 3,100m2. The critical care floor will provide sufficient accommodation to relocate the current ICU, Level 1 cardiology and respiratory patients and paediatric stabilisation facility. This configuration of beds will provide the necessary flexibility and resilience to manage the varying demands for all levels of critical care patients maintaining the specialist nursing and medical input they require.

The plan for the new AMM will provide a combination of patient treatment areas flexed to accommodate trolley bays, chair centric bays, bed bays for overnight assessment and supporting accommodation within 3,100m2 providing an approximate capacity of 90 patient treatment spaces.

The design has taken into consideration external access to the new build by providing:

- Compliant sized and sufficient number of ambulance bays adjacent to resus and the lobby and lift access to the critical care floor above for ease of transfer of acutely unwell patients
- Drop-off designated car and ambulance spaces directly in front of the new AMM entrance for ambulatory patients arriving by car or ambulance (YAS "Fit to sit" initiative)
- Re-routing of the blue light ambulance route

- Due to the fall away of the proposed site consideration has been made to provide all necessary access routes for a variety of patients mobility issues including an external covered seating area adjacent to the new AMM entrance to provide a support and rest area
- Dedicated accessible car parking spaces will also be provided with ease of access to the new AMM entrance
- The external cladding of the new build (proposed to be curtain walling) will extend beyond the new build to include the current main entrance to the hospital as shown in the external concept below
- Learning from Covid-19, secure external space for staff and patients has been highlighted as an important factor for wellbeing. Stakeholder engagement with the clinical teams has led to the design of external staff and patient areas on each clinical floor as shown in the external concept below.

Concept design images for the new facility are shown below.

6.2.2 Required services

This new facility will allow the Emergency Department to expand and thereby incorporate same-day assessment and treatment facilities as well as the site's Acute Medical Unit.

The opportunity to address further estate and compliancy concerns on the Scarborough site were reviewed. This resulted in an additional floor of patient accommodation for all patients with a critical care rating Level 1, 2 and 3. This will relocate the current ICU, Level 1 cardiology and respiratory patients and paediatric stabilisation facility.

The required products and services for the new AMM and Critical Care facility are identified in Appendix 28.

6.2.3 Site Infrastructure Scope

The Infrastructure project comprises 11 elements that will tackle key aspects of the site backlog maintenance burden, ensuring that the existing services are fit to support future developments including this proposed capital build. These schemes were initially derived from a combination of the Site Condition Survey and a focused engineering survey of the site by an M&E consultant firm. They are intended to address the significant, critical, high risk and non-compliant nature of the current engineering infrastructure.

The engineering infrastructure project is intended to provide capacity and resilience to support the Trust's future development aspirations for Scarborough Hospital. The 11 elements are:

1. Low voltage (LV) & network generators
2. High voltage (HV) ring main
3. VIE & Oxygen ring main
4. Ventilation - Air Handling Units
5. Steam mains/heating strategy
6. Replacement of south block roof

7. Replacement mortuary
8. Water, drainage, gas, utilities
9. Vertical transportation
10. Parking provision and
11. Pneumatic air tube system.

As we have moved through the RIBA Work Stages 1 and 2 for OBC, opportunities have been taken to consolidate some of the projects into combined work packages where it makes sense to do so from a technical and economic perspective i.e. HV/LV project Nos 1 and 2.

Working through the RIBA Work Stages 1 and 2 with our Integrated Design Team and Cost Consultant we now have a more accurate reflection of the cost of each infrastructure package. It has therefore been necessary to evaluate the order of priority of the infrastructure elements as essential, desirable and optional to ensure an affordability fit within the financial cost envelope proposed.

The most critical infrastructure requirement is to provide sufficient power to the site, this being the HV/LV infrastructure elements. Fundamentally, the cost to provide an HTM compliant, resilient and future proofed solution has more than doubled from our original budget expectations which has meant a re-assessment of the infrastructure elements. We have also been fortunate to receive an amount of BLM 2020/21 central funding (schemes to be completed by end March 2021) which has provided the opportunity to undertake some of the infrastructure elements immediately.

Within our Preferred Option the scope of infrastructure packages to be delivered have been limited to essential within the priority list:

- HV/LV
- Re-provide car parking
- Steam main/heating strategy
- Water
- Mortuary.

6.2.4 Specialist Equipment

A considerable amount of work has already been undertaken with regard to equipment purchase for the multiple schemes within the project to ensure that the equipment cost allocation within the cost plan summary is reasonable and adequate and also to identify any long-lead items i.e. CT Scanner. In particular, our Radiology Department have already agreed tender specifications and choice of equipment and are poised to move forward with this at the appropriate time. Medical Engineering have spoken to clinical teams to understand medical equipment requirements at this stage to inform the equipment costs and Estates and Facilities have produced a list of requirements which have been costed into the plan.

6.3 Procurement Strategy and Implementation Timescales

6.3.1 Background

The proposed capital build and site-wide engineering infrastructure upgrade will be funded through the Wave 4 capital bid as part of a regional acute strategy led by Humber, Coast and Vale Integrated Care System.

The procurement route to be adopted for a project is probably the single most important factor governing the way any development is undertaken, its administration and the total project duration. It also exerts considerable influence over the project team's ability to achieve a successful balance between the objectives of cost, time and quality.

6.3.2 Requirements & drivers

The various procurement strategies available entail fundamental differences in the allocation of risk and responsibilities between the parties and the suitability of the different approaches have been considered in relation to the specific nature of this project.

The key drivers for the project focuses around the requirement for cost certainty at Full Business Case submission (with the cost being substantiated via a competitive tender process), the transfer of risk and achieving a tight programme, whilst also retaining control over design and construction quality.

6.3.3 Procurement Options

A Procurement Options report was prepared by Turner & Townsend Cost Management on 24 June 2020. This report outlined a range of procurement options available to the Trust for the New Build and Infrastructure works projects.

A copy of this report is included in Appendix 10.

6.3.4 Preferred Procurement route

The Turner & Townsend report recommended a **two-stage Design & Build process with Guaranteed Maximum** Price procurement route as the Preferred Option:

- Securing early Contractor involvement that in turn can provide benefits in increased understanding of client objectives, opportunity to undertake enabling works in advance of finalising the main contract and contribution to design process and
- Maximising cost certainty and avoidance of cost increases during construction, i.e. risk reduction.

The following procurement two-stage Design & Build process with Guaranteed Maximum Price options has been considered the most suitable procurement solution:

- JCT Standard Form of Contract – Design & Build (D&B)
- Pagabo - Framework agreement and
- Procure22 (P22) - Framework agreement.

These frameworks have been chosen because they are already EU compliant framework agreements for public sector organisations and are readily utilised within the health sector or because through an OJEU advert, they could be compliant.

The appointed independent cost advisor has undertaken a review of the JCT Standard Form of Contract – the analysis proposes that the ProCure22, (P22) framework is the favourable procurement route for the Trusts UEC Development and Site Engineering Infrastructure project.

The two elements of the new build and engineering infrastructure will be packaged together and released as a programme of work under the ProCure 22 framework. The benefit of combining the two elements is that the management costs that would normally be expended during the pre-construction stage of a project can be combined to also manage the infrastructure projects. By utilising the ProCure 22 framework as the choice of procurement, as evidenced in the procurement options appraisal undertaken, our financial risk is managed by the GMP and gain share allocation incentives are a part of the ProCure 22 contract.

6.3.5 EU compliance

The Trust will be using the ProCure22 framework to ensure the procurement process is fully compliant with the Public Contracts Regulations 2015.

ProCure22 was created by the Department of Health and is administrated by NHS England and NHS Improvement, ensuring full legal compliance and oversight at Government level.

The Trust procurement team have also been fully involved from the start of the process.

6.3.6 Timescales

The key milestones for the Procurement Plan are outlined below.

Procurement Milestone Activity	Date
Scheme registered	14/10/20
High Level Information Pack (HLIP) issued	23/10/20
Open day	04/11/20
PSCP confirm	11/11/20
PSCP expression of interest submission	13/11/20
Short listing	17/11/20
PSCP Interviews	20/11/20
Trust Board approve appointment of PSCP	25/11/20
PSCP appointment	26/11/20

Table 36 – Procurement Milestones

6.3.7 Market Interest

The overall value of the project should generate a good degree of interest from the market and soft intelligence suggests a robust degree of interest from ProCure 22 PSCP's.

6.3.8 Accountancy Treatment

A full overview of the accountancy treatment for the project and the parties involved is included in Appendix 11.

6.4 Commercial feasibility and deliverability

6.4.1 Overview

Through the monthly meetings, updates and reports submitted, the Project Board have a high degree of assurance that this project is viable and deliverable and Trust Board approval of the Outline Business Case in November 2020, before submission for central approvals, will reinforce this view.

6.4.2 Cost Plan

At conclusion of RIBA Work Stage 2, a robust Cost Plan summary has been developed by our external cost consultant in conjunction with the Integrated Design Team and Trust stakeholders and project managers, to ensure cost affordability is realistic and takes account of the programme in terms of inflation, optimism bias and risk contingency. This will be developed further as we move through the RIBA Work Stages of detailed design and through engagement with our PSCP once appointed.

6.4.3 Programme

The programme supporting the Outline Business Case is deemed to be realistic and deliverable and is developed in conjunction with our procured external advisory team. The programme is reviewed fortnightly by our Project Management Team and reported to the Project Board on a monthly basis. The programme has been adjusted in light of our preferred procurement Route that of ProCure 22 and takes account of the time required by the PSCP for the commercial aspects to inform the GMP and contract.

6.4.4 Resources

Sufficient and adequate skilled resource will be made available to successfully manage the procurement, implementation and operational stages of this project.

With the support of the appointed integrated design team, a review of the skills and specialist advisors required for the implementation and delivery of the project have been identified.

To complement the existing internal Project Team; Capital Planning, Finance, Procurement, Estates, Clinical and Operational colleagues, a range of special advisors have been procured to support the implementation and delivery of a successful programme.

6.5 1:200 Drawings

1:200 drawings for the Preferred Option are included in Appendix 3.

6.6 Schedule of Accommodation (SoA)

To enable designs and 1:200 plans to be produced, a Schedule of Accommodation (SoA) for the Preferred Option was developed, through engagement with the clinical and operational stakeholder groups to confirm the required functional content.

The Schedule of Accommodation is included in Appendix 4.

6.8 Design Quality Review

The Design Quality Indicator (DQI) is a process for evaluating and improving the design and construction of new buildings and the refurbishment of existing buildings, focusing on actively involving a wider group of stakeholders in the design of buildings than is usually the case. It involves not only the design team but all those who will use, finance and be affected by the building.

DQI is designed to set and track design quality at all key stages of a building's development and incorporates post-occupancy feedback. It plays a fundamental role in contributing to the improved design, long term functionality and sustainability of building projects.

An online workshop has been held, where the scheme design was described in detail to a selected group of Stakeholders and any questions answered. The selected group of Stakeholders then answered a Survey Monkey questionnaire which asked specific questions around function, design, flexibility and sense of place. The Trust Capital Projects Team and IBI Group then put together a set of questions/statements based on DQI and Government Soft Landings to give a Gateway Review with constructive feedback on what the Stakeholders want from the building, how it works and how it looks.

The Concept Design Review/Stage 2 DQI 'Lite' was then held across two workshops on the 8th and 15th of September 2020. The workshops were facilitated by a DQI Facilitator and the design team presented the Stage 2 Design proposals at this key milestone. Overall, the review was a success, and the team were complimented on a well-considered and coherent approach with some clear direction on where proposals could be improved. An agreed set of outcomes will be addressed during the Stage 3/4 design development.

6.9 Mandatory Government Construction Strategy

This project has been developed in line with the Government Construction Strategy policy paper 2016-2020. This includes:

- Early engagement with the supply chain to develop designs which are buildable, cost effective and which account for site constraints
- Use of BIM level 2
- Government Soft landings
- Benchmarking construction costs to annual publication of cross-government data
- Securing good quality and better value for money driving increased construction productivity
- Whole-life approach to cost and carbon reduction including operation and maintenance.

6.10 Government Consumerism Requirements

Our design solutions will, wherever possible, comply with Department of Health consumerism requirements. These include:

- Achieving high levels of privacy and dignity
- Creating gender specific day spaces

- Good use of natural light
- Use of high-quality materials to reduce life cycle costs
- Provision of single sex wash facilities.

The table below outlines at a high level the delivery of each scheme against the criteria; with further detail being provided in the Clinical Quality Case.

Consumerism Requirement	Preferred Option
Acceptable levels of privacy and dignity at all times	
Gender specific day rooms	**n/a**
High specification fabric and finishes	
Natural light and ventilation	
Zero discomfort from solar gain	
Dedicated storage space to support high standards of housekeeping and user safety	
Dedicated storage for waste awaiting periodic removal	
Inpatient configurations and use of en-suite facilities – partially met. The ground floor AMM <24 hour stay zone does meet the requirement with 2 x 4 bed bays each with en-suite and 4 x single en-suite rooms. The first-floor critical care facility has two distinct zones • Zone 1, Level 1 patients do meet consumerism requirement • Zone 2, Level 2/3 patients do not meet consumerism requirement however is built to HBN guidance for a critical care facility. Level 2/3 patients are generally not fit enough to utilise en-suite facilities and would be stepped down to Level 1 compliant facilities as soon as medically appropriate.	
Single sex washing and toilet facilities	
Safe and accessible storage of belongings including cash	
Immediate patient access to call points for summoning assistance	
Patient control of personal ambient environmental temperatures	
Lighting at bed head conducive to reading and close work	
Patient bedside communication and entertainment systems - due to the nature of services on the ground and first floors, it is not intended to install individual entertainment consoles in all rooms	
Elimination of mixed sex accommodation	

Table 37 – Consumerism Requirements

6.11 Compliance with HBN/HTM

Whenever possible, the project will comply with Building Regulations, European Standards, British Standards and Codes of Practice, guidance on the design and construction of primary care and general medical facilities. Much of this is contained in a series of DH publications and guidance documents primarily written for the NHS, including but not limited to the following:

- Health Building Notes (HBNs)
- Health Technical Memoranda (HTMs).

The NHS Constitution commits the NHS to provide services in a clean and safe environment that is fit for purpose and based on national best practice. The HBN and HTMs provide national best practice for the design and layout of facilities. HTM 00 Policies and Principles of Healthcare Engineering, provides specific guidance on the design, installation, and effective operation of a healthcare facility from an engineering technology perspective and should be read in conjunction with relevant HTM's. For this project, key titles among many that will be relevant include:

- BS 8300 British Code of Practice (Accessible and Inclusive Environments)
- HBN 00-01 General Design Guidance for Health Care Buildings
- HBN 00-03 Clinical and clinical support spaces
- HBN 04-01 Adult inpatient facilities
- HBN 00-09 Infection Control
- HBN 04-02 Critical Care Units
- HBN 00-07 Planning for a Resilient Healthcare Estate
- HTM 01 Decontamination
- HTM 02 Medical Gases
- HTM 03 Heating & ventilation
- HTM 04 Water systems
- HTM 05 Fire safety
- HTM 06 Electrical services
- HTM 07 Environment and sustainability
- HTM 08 Specialist services.

The design development of this scheme has endeavoured to be delivered within these guidance documents.

Some recommendations made by the DH guidance will not be achievable – these will be noted as derogations. The Trust will systematically review and where required, approve each derogation before it is implemented and produce a derogation schedule at the next stage of design.

6.12 BREEAM (Building Research Establishment Environmental Assessment Method)

An initial BREEAM workshop was held on 4 June 2020 to identify a route map towards achieving the required BREEAM rating. The BREEAM assessment process is being undertaken by WYG Engineering and a pre assessment review has been developed for guidance only at this stage but will be further developed at FBC stage.

The Trust's focus will be to achieve **BREEAM Excellent**, which is achievable based on the current design carried out and with the potential to achieve an Outstanding rating.

The BREEAM pre-assessment report can be found at Appendix 20.

6.13 Fire Code

Fire code compliance is ensured through the development of The Fire Strategy for the capital build. An external advisor has been commissioned to develop The Fire Strategy in conjunction with the Trust's internal Fire Officer. The Fire Strategy at OBC stage has been signed off and will be developed further within the FBC.

6.14 Energy & Sustainability

6.14.1 Sustainability Management Plan

The Trust endeavours to implement environmentally sustainable facilities across all of its activities and processes with a strong focus on clinically led service redesign. The Trust has a Sustainability Management Plan 2017 to 2020 and the commitments in it have been a reference point for this project.

The Sustainable Development Group meets quarterly to progress the work set out in the Sustainable Development Management Plan (SDMP) tackling the environmental, social and economic aspects of coordinating the integration of sustainability into all areas of Trust business.

Progress against the SDMP is reviewed regularly to ensure that the Trust continues to stay focused on integrating sustainability principles and practices throughout the organisation, tackling rising carbon emissions against the Climate Change Act 2008 target to reduce carbon emissions by 34 % by 2020 (or 28% from a 2013 baseline) and 80% by 2050, and using the national targets for the Good Corporate Citizenship score (currently at 44% at the end of 2016) as a focus for action planning and the aim of achieving a score of at least 50% in all 9 sections and at least 75% in 4 sections by 2020.

6.14.2 Sustainable Design Guide

The York Teaching Hospital NHS Foundation Trust introduced the use of a Sustainable Design Guide in 2017 as part of the Trust's Board approved commitment to sustainability and the Sustainable Development Management Plan 2017-2020 which highlighted the requirement to achieve BREEAM excellent for all new buildings in excess of a £2million spend and to work towards achieving the requirements of the Climate Change Act 2008 of achieving 80% carbon emissions reduction by 2050 (which has now been amended to zero carbon emissions by 2050).

6.14.3 Sustainable Procurement Plan

The Trust has a Sustainable Procurement Plan prepared specifically for this project (see Appendix 22). This plan helps to support York Teaching Hospital NHS Foundation Trust's commitment to delivering sustainable buildings and to set minimum standards that build on the Trust's Sustainable Building Design Guide, with the aim to motivate the supply chain to provide more sustainable products and services. The plan helps to:

- Satisfy the BREEAM 2018 New Construction Mat 3 Responsible Sourcing of Materials credit to provide a Sustainable Procurement Plan and

- To incorporate the sustainable procurement requirements within the framework of environmental assessment such as HQM, SKA, CEEQUEL, BREEAM (all schemes), WELL Building standards, LEED etc.

6.15 Low and Zero Carbon

A Low and Zero Carbon Feasibility Study has been prepared for this project by specialist advisors Hoare Lea. This study identifies a number of opportunities for the new build facility as outlined below.

6.15.1 Ground Source Heat Pumps

Based on reducing carbon intensity of the grid there will be additional carbon benefits of a building which is serviced by electrically powered building services going forward. As there is substantial open area surrounding the new facility, there is an opportunity to incorporate an electrically driven ground source heat pump (GSHP) system. GSHP are best suited to developments with a balanced heating and cooling load, to avoid long-term heating or cooling of the ground /ground water and associated decreased efficiency of the heat pump. As preliminary calculations suggest heating and cooling loads for the new facility may not be balanced and it is proposed to size a system to meet the smaller of the two loads (i.e. cooling in this scenario) and serve the remaining heating load from a supplementary system.

6.15.2 Photovoltaics

To offset the draw of electricity from the grid and further reduce the CO2 emissions from the proposed development, it is anticipated that on-site renewable energy production could be achieved with the introduction of a photovoltaic array on the building's roof above the plant deck.

Using a primarily electric led strategy means that as the national grid continues to decarbonise, the building should see year on year reduction in emissions.

6.16 Resilience to Threats & Hazards

In planning the design for the project, consideration has been given of the advice in HBN 00-07 (Planning for a Resilient Healthcare Estate).

This will include ensuring resilience to:

- Electrical supplies - using standby generation, Combined Heat and Power (CHP) and uninterruptable power supply facilities where appropriate (HV/LV Scheme)

- Water supplies - using dual storage capacity (cold water supply & drainage scheme)

- Installation of an additional duel fuel boiler linked to the existing low temperature hot water distribution system (steam main replacement scheme).

6.17 Travel Plan

This project takes account of requirements under the Trust's approved 'Green Travel Plan' – see Appendix 21.

The Trust has also commissioned a Travel Statement in support of the development of the site which will include the following information:

- A detailed description of the existing and proposed conditions around the proposed development. This will include a review of the existing highway, public transport, walking and cycling infrastructure
- Due consideration will be given to the Scalby Road / Woodlands Drive and Scalby Road / Stepney Drive junction improvement schemes, which are currently being implemented
- A review of the access arrangement (including the local road network), as well as the internal road layout and parking provisions
- A full review of the highway safety record around the site. It is proposed to use the online crash map database and consider the latest five-year time period. It is proposed that this area will incorporate Woodlands Drive between Scalby Road and Graham School and the A171 Scalby Road between its junctions with Stepney Drive and Lady Edith's Drive
- The development proposals will be described in detail, including a plan of the proposed site layout. The internal layout will be considered with respect to servicing arrangements and emergency vehicle access, with vehicle swept path analysis completed as appropriate
- Parking will be considered with respect to both the relevant standards in the most recent policy documents and the anticipated levels of demand. Where possible car parking data will be obtained from the hospital and utilised in this analysis
- A detailed review of access to the site by non-car modes of transport
- The multi-modal trip generation of the entire hospital site, pre- and post- the proposed development will be established using the TRICS trip rate database. As the proposed development predominantly involves the relocation and refurbishment of existing hospital facilities it is considered that there is negligible net impact on the local highway network and as such no junction modelling is proposed at this stage as part of the TS work and
- National and local transport planning policy will be reviewed in relation to the proposed development
- The new blue light route for emergency vehicles which will need to be relocated in order to access the new build.

The full Highway Technical Note 01 is attached as Appendix 24 and the Scoping Note for Transport Statement as Appendix 23.

6.18 Planning Permission

Separate pre-application enquires for both the proposed Critical Care/AMM building and the Helipad (now a separately funded project) have been submitted to the Council. The feedback from the Local Planning Authority in their letter dated 11 October 2020 (see Appendix 30) advises that in principle the proposal is acceptable, subject to a detailed Planning Application.

There are some outstanding highway concerns that require to be resolved with the Highways Authority, but these are not expected to cause any issues in obtaining Planning Permission.

6.19 Risk Transfer & allocation

The general principle is that risks should be managed by the most appropriate partner in the construction process ensuring that the responsibility is placed on the designated partner with the ability to control and insure against that risk.

An assessment of how the associated risks might be apportioned between the Trust (Public Sector), the professional design team and the construction company (Private Sector) has been carried out for each aspect of the project. Allocation of risk is very clearly defined within the ProCure 22 framework and appropriate transfer of risk to the PSCP has been one of the deciding benefits of selecting this procurement route.

On completion of RIBA Work Stage 2 and in preparation for commencement of RIBA Work Stage 3, the ProCure22 PSCP will be appointed and the Risk Transfer Matrix updated to reflect the joint risk and apportionment between the Trust and the PSCP which will be reflected in the P22 framework NEC 3 contract.

6.20 Proposed Charging Mechanisms

The Trust will make payments in accordance with the valuation periods prescribed in the contracts. Prior to payment our external cost advisor will certify each invoice having ensured that it is valid and reflects the relevant valuation.

6.21 Proposed Contract Timelines

The length of the construction and infrastructure contract will reflect the construction programme and the prescribed defects period as shown in the following table:

Milestone Activity	New build	Infrastructure
Award Construction Contract	26 November 2020	26 November 2020
Commencement of construction	Quarter 3 2021	Quarter 3 2021
Construction complete	January 2024	January 2024
End of Defects Liability period	January 2026	January 2026

Table 38 – Proposed Contract Lengths

The Programme has been subject to review throughout the RIBA Work Stages 1 and 2. The Project Board have assurance that the programme is sufficiently detailed and robust to approve the above milestone activity.

6.22 Proposed Key Contractual Clauses

Standard construction contracts will be used for the project and at RIBA Work Stage 2 and Outline Business Case stage, there are no commercial or legal issues identified.

6.23 Implications for Trust staff

There are no TUPE implications associated with the project. This can only be considered as a positive impact on Trust staff to aid recruitment and retention which has been one of the key drivers for this investment.

Stakeholder engagement to date has been extremely positive in terms of the new environment and facilities that are proposed.

7 The Financial Case

7.1 Introduction

The Financial Case examines the affordability of the Preferred Option and sets out the financial implications for the Trust in terms of capital expenditure and cash flow, and the income and expenditure account and borrowing. The purpose of this section is to set out the forecast financial implications of the Preferred Option as set out in the Economic Case and the proposed procurement method as described in the Commercial Case.

The Trust has used the Long Term Financial Model (LTFM) issued by NHS Improvement to provide a set of fully integrated financial statements (income and expenditure, balance sheet and cash flow) based on the key drivers and assumptions underpinning the Trust's financial projections for the preferred option.

The LTFM covers the period April 2017 – March 2030 as follows:

- April 2017 – March 2020 – Prior Year audited accounts
- April 2020 – March 2021 – Outturn Year
- April 2022 – March 2030 – Forecast.

The transaction date is set at July 2021 as this is the date that the infrastructure works will begin.

The Long Term Financial Model can be found in Appendix 9.

7.2 Historical Financial Performance

Historical Surplus / Deficit April 2017 – March 2020			
	Mar - 18	**Mar - 19**	**Mar - 20**
	£'000	£'000	£'000
Income	489,240	517,602	556,539
Expenditure	(501,680)	(520,435)	(553,307)
Operating Surplus / (Deficit)	**(12,440)**	**(2,833)**	**3,232**
Non-Operating expenses	(7,692)	(7,019)	(5,877)
Surplus / (Deficit)	**(20,132)**	**(9,852)**	**(2,645)**

Table 39 – Trust Financial Performance

The table above illustrates the financial performance of the Trust for the three years preceding the current outturn year (2020/21). It should be noted that the recorded I&E deficits are inclusive of impairments, which is a technical I&E entry and one of the adjustments excluded by NHS England and Improvement (NHSE&I) in determining whether a Trust has met its NHSE&I set control total.

In 2017/18, the Trust delivered a £20.1m I&E deficit. To compare with the control total set by NHSE&I, the I&E deficit once adjusted for impairments, the I&E impact of capital donations and grants, and CQUIN reserve adjustments increased to £24.1m; placing it £27.2m behind the expected control total of an adjusted I&E surplus of £3.1m. As a result of this performance the Trust was the subject of a licence breach investigation by NHSE&I, and subsequently had undertakings placed against it.

In both of the following years (2018/19 and 2019/20) the Trust exceeded the control totals set by NHSE&I by £6.4m in 2018/19, and £0.1m in 2019/20.

In respect of the Trust's undertakings, following significant progress made by the Trust, and dependant on agreeing a system and organisation financial plan for Phase 3 Covid-19 recovery within the North Yorkshire system envelope (which has been achieved) to demonstrate improved system working which was the key outstanding issue, NHSE&I have indicated that the Trust's undertakings are likely to be removed in December 2020.

7.3 Outturn Year (2020/21)

As the Trust entered 2020/21, the nation and the NHS were experiencing the full impact of the Covid-19 pandemic. As part of its response to the pandemic within the NHS, NHSE&I introduced an emergency financial regime to support NHS organisations focus and respond quickly to rapidly growing numbers of patients requiring care for Covid-19 symptoms, and not be unduly hamstrung by financial constraints. The regime was initially to operate from April to July 2020, but later extended to September 2020. It included a retrospective top-up mechanism that ensured NHS organisations were able to deliver an I&E balanced position for each month in the first half year of 2020/21. In addition, to ensure that provider NHS organisations did not experience cash shortages during this crucial period, two monthly payments were received in advance during April 2020 to ensure a healthy cash balance. This resulted in the Trust having a reported cash balance of £62m at the end of September 2020.

For the second half year of 2020/21 the emergency financial regime was revised to follow a more allocation based approached with the expectation that NHS organisations live within their allocation. Allocations were distributed at local system level in relation to baseline services, Covid-19 expenditure, prospective top-up, and growth. Whereas some of the allocations were specific at an organisational level, the allocation of others had to be agreed between system partners. NHSE&I also made an assumption that other 'non-patient care' related income for each NHS organisation would get back to the levels seen in 2019/20 pre-Covid-19, although it was acknowledged by the regulator that for numerous reasons this would prove very challenging for many organisations. There is no-retrospective top-up process for the second half year of 2020/21, with the Trust being expected to live within its allocations plus other 'non-patient care' related generated income. In terms of cash, confirmation is still awaited from NHSE&I whether the extra month payment received in April 2020 will be clawed back in March 2021, although the regulator has indicated that whatever process is put in place it will not unduly jeopardise NHS organisation's cash positions.

The Trust has submitted financial plans for the second half year of 2020/21 to NHSE&I both in its own right and as part of the North Yorkshire and York sub-system of the Humber, Coast & Vale ICS. The plan agreed by the Board at its 4 November 2020 meeting resulted in a £5.5m I&E deficit for the second half of 2020/21, and is attributable to (a) other 'non-patient activities' income being £4.6m less than assumed by NHSE/I in determining allocations to the Trust, and (b) an increased annual leave accrual of £0.9m for staff unable to take their full leave entitlement due to the Covid-19 pandemic. Both these issues are common across many organisations and are acknowledged and understood by NHSE&I as requiring a national solution, which is currently awaited.

The Trust has just prepared its report for October 2020 under the revised financial framework, and is reporting an I&E surplus of £0.5m, with a cash balance of £64m.

In terms of the financial regime and expectations on the Trust for 2021/22 and beyond we await further guidance from NHSE&I, although early informal indications suggest that for 2021/22 a similar allocation base approach may be adopted.

The Trust has used the Long Term Financial Model (LTFM) issued by NHS Improvement to provide a set of fully integrated financial statements (income and expenditure, balance sheet and cash flow) based on the key drivers and assumptions underpinning the Trust's financial projections for the preferred option.

7.4 Elements of the Long Term Financial Model

7.4.1 Capital Costs

At the conclusion of RIBA Work Stage 2, a robust Cost Plan summary has been developed by our external cost consultant in conjunction with the Integrated Design Team and Trust stakeholders and project managers, to ensure cost affordability is realistic and takes account of the programme in terms of inflation, optimism bias and risk contingency.

The full Capital Cost plan can be found in Appendix 6 and the capital costs for the Preferred Option are summarised as follows:

Item	Description	Option 4 Do Intermediate +
100	**Construction**	
101	Construction costs	£ 25,485,558
102	Fees	£ 2,534,350
103	Non-Works costs	£ 60,000
104	Equipment costs	£ 3,750,000
105	Planning contingency	£ 2,548,556
106	Optimism Bias	£ 2,382,428
107	Inflation adjustment	£ 2,314,597
108	**Construction Total**	**£ 39,075,489**
200	**Infrastructure Works**	
201	HV / LV ring main	£ 7,759,706
204	Steam main replacement	£ 313,585
207	Cold water supply and drainage	£ 250,000
211	Re-provide car parking spaces	£ 676,022
212	Fees	£ 569,750
213	Non-Works costs	£ 30,000
215	Planning contingency	£ 449,966
216	Optimism Bias	£ 553,701
217	Inflation adjustment	£ 320,082
218	**Infrastructure Total**	**£ 10,922,813**
	TOTAL	**£ 49,998,302**

Table 40 – Capital Cost Plan Summary

Lifecycle costs have been assessed at £13.6m for Option 4 (Do Intermediate +) and residual backlog maintenance at £5.6m. Both backlog maintenance and lifecycle costs resulting from the capital scheme will be funded through the Trust's own Capital Depreciation Annual Allocation.

7.4.3 Equipment Schedule

A considerable amount of work has already been undertaken with regard to equipment purchase for the multiple schemes within the project to ensure that the equipment cost allocation within the cost plan summary is reasonable and adequate and also to identify any long-lead items e.g. CT scanner. In particular our Radiology Department have already agreed tender specifications and choice of equipment and are poised to move forward with this at the appropriate time. Medical Engineering have spoken to clinical teams to understand medical equipment requirements at this stage to inform the equipment costs and Estates and Facilities have produced a list of requirements which have been costed into the plan.

The equipment costs are included in the capital costs as per the above table, and a full breakdown can be found in the Capital Cost Plan Summary in Appendix 6.

7.4.4 Revenue

The Trust has developed robust methodologies for this project, and has deployed these alongside the LTFM, to review affordability. These methodologies include a number of key assumptions around activity, income and expenditure. These assumptions are discussed below and will be the subject of further review between the OBC and FBC.

7.4.5 Inflation Assumptions

Inflation for the long-term financial planning model has been applied following NHSE/I Long Term Planning implementation assumptions as per Annex B of the following:

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf

The current assumptions run to 2023/24, for the purpose of this Business Case, the inflation rates for 2023/34 are assumed for all future years.

7.4.6 Predicted Activity and Capacity Demand

The following assumptions on activity and capacity demand and growth in costs have been applied to the base line costs for the economic appraisal, however costs are included in the LTFM at baseline 2020/21 prices (net of growth and inflation).

Activity demand on the Urgent and Emergency Care Department has been assumed for the next 10 years as follows:

Year	2020/21	2021/22	2022/23	2023/24	2024/25
Growth in demand	0%	6%	6%	5%	4%
Year	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Growth in demand	3%	3%	2%	2%	2%

Table 41 – Future Growth in Demand on Urgent and Emergency Care

Activity growth in years 2020 - 2023 represents the current planning assumptions agreed with the commissioners in the 5 year plan.

7.4.8 Growth in Costs

Following assessment of the Trusts Service Line Reporting, growth in costs have been applied over the life of the project as follows:

Costs	Growth
Fixed	0%
Semi Fixed	2%
Variable	In line with activity growth above

Table 42 – Growth in costs

The net growth applied to all revenue costs is as follows:

Year	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Growth	2.43%	2.45%	2.32%	2.17%	2.01%	2.02%	1.85%

Table 43 – Net growth applied to revenue costs

7.4.9 Service Developments

The Trust has analysed the capital and revenue costs associated with this project and discussions have taken place with North Yorkshire system partners, and the HCV ICS, and agreement has been sought from the partners to commit to meeting the revenue implications, as evidenced in the letter of support in Appendix 16.

The OBC is aligned to the Trust's Clinical Strategy to provide high quality services in a financially affordable and sustainable way. It also sets out how the investment will enable the Trust to support the delivery of a sustainable health economy in the future, strengthening the provision of Urgent and Emergency and Critical Care.

The clinical leadership and engagement of clinicians has been fundamental through the life of the project to date and will continue through to the operational commissioning of the new facilities. They have supported the delivery of a design solution which satisfies national best practice guidance and standards and improves the quality of the environment for patients, family and staff; whilst delivering a cost-effective solution.

The following table highlights the service developments that will require funding in future years. Costs are on an annual basis and the first full year impact is anticipated in 2024/25, however the current project expects the new facility to open in December 2023.

The table below represents the service developments as a full year impact when the scheme is completed, based on 2020/21 real prices (i.e. net of inflation).

	Additional Revenue implications of preferred option	
	Full year impact 2024/25 at 2020/21 prices.	
	WTE	**£'000**
Additional Support Staff (Radiology / Ultrasound)	3.39	159
Estates and Facilities running costs:		
Associated costs with increased floor area - AMM Unit (Ground Floor)	36.71	1,945
Associated costs with increased floor area – Critical Care Unit (First Floor)	27.37	1,270
Increased Infrastructure Costs	2.81	201
Assumed closure and mothballing of old ED area	-6.81	-294
Assumed closure and mothballing of Nightingale Wards	-10.59	-457
Agency Savings		-670
Depreciation		1,073
Total Operating Expenditure	**52.88**	**3,227**
PDC		1,811
PDC relieve on impaired value		-660
Total Non-Operating Expenditure		**1,151**
Total increase in revenue costs		**4,378**

Table 44 – Additional Revenue Implications

7.4.9.1 *Additional Support Staff*

Additional support staff have been identified for Radiology and Ultrasound due to the provision of a dedicated radiology zone within the AMM providing CT / General X-ray and Ultrasound.

7.4.9.2 *Estates and Facilities costs*

Increased estates and facilities costs shown in the table below have been identified for the increase in floor area as follows:

- **Ground floor AMM unit**, which has an increase in floor area from a current Emergency Department and Cherry Ward combined 1,395sqm to 3,120sqm in the new build.
- **First floor Critical Care Unit**, which has an increase in floor area from 1,459sqm (ICU / Beech / CCU) to 3,120sqm in the new build.

The estates and facilities costs are broken down as follows:

	AMM (Ground Floor)				Critical Care (First Floor)			
	Total	WTE	Pay	Non-Pay	Total		Pay	Non-Pay
			£'000	£'000			£'000	£'000
SQM	**3,120**				**3,120**			
Domestics	836	23.62	753	83	634	17.92	571	63
Maintenance costs	425	7.06	252	173	425	7	252	173
Utilities (excl. Energy Management)	207			207	75			75
Rates	51			51	51			51
Waste	10			10	0			
Medical Engineering	183	1.12	42	141	0			
Porters/FO's	127	3.60	115	13	85	2.40	77	8
Catering	107	1.32	31	76	0			
Total	**1,945**	**36.71**	**1,193**	**752**	**1,270**	**27.37**	**900**	**370**

Table 45 – Estates and Facilities Costs

7.4.9.3 *Increased Infrastructure Costs*

Domestics, maintenance and portering costs have been factored into the revenue implications to take into account the increased demand on these services following the HV / LV ring main and Cold Water Supply infrastructure schemes.

	Infrastructure Costs			
	Total	WTE	Pay	Non-Pay
			£'000	£'000
Domestics	83	2.47	74	9
Maintenance costs	99			99
Porters/FO's	19	0.34	19	
Total	**201**	**2.81**	**93**	**108**

Table 46 – Increased Infrastructure costs

7.4.10 Capital Charges

7.4.10.1 *Public Dividend Capital (PDC)*

The Trust is required to make a payment to the Department of Health based on the value of its assets. This would normally include Assets Under Construction (AUC) on which PDC is payable before the asset is complete. However, in June 2020 the Trust received a letter confirming that we would receive PDC relief on AUC for this scheme, therefore PDC will only apply when the asset is brought into use, and the LTFM reflects this.

The financial model assumes that the programme is financed through input of additional PDC. There will therefore be a corresponding increase in the PDC charge.

The capital value used for the purpose of calculating both PDC and depreciation is the full capital cost for the buildings and infrastructure works in the scheme, impaired by 30%. This impairment is based on revaluations of the Trust's recent new builds, such as the Endoscopy suite at York, which was impaired at 25%, and also takes into consideration that properties in York are generally valued higher than in Scarborough.

The District Valuer will however value the new buildings once they are completed and the actual value attributed to the new buildings will be on the Trust's balance sheet. An estimate of the District Valuer's valuation will be included at FBC stage.

7.4.10.2 *Depreciation*

The Trust is required to make a charge to its I&E account for the use of its assets. Depreciation for the new build is calculated on the asset once it has come into use. The modelling assumes that infrastructure works will be completed and in use by January 2022, and the capital build complete and in use by December 2023.

The cost of new build depreciation is calculated under International Financial Reporting Standards (IFRS) with reference to each identifiable asset being capitalised under a relevant asset class and using the asset life under that class. The depreciation was calculated by taking the impaired asset over a weighted-average asset life.

The sensitivity analysis described below assesses what the impact on the I&E would be, should the impairment of the asset be less than 30%.

7.4.11 Efficiency Savings

7.4.11.1 *Closure and Mothballing of the old estate*

Following the transfer of services to the new build, a number of areas will be closed as part of this Business Case. There are therefore a number of assumed savings from mothballing these areas of the site.

The transfer of Emergency and Urgent Care Services to the ground floor AMM unit will allow the current Emergency Department to close. This has a floor area of 917.4sqm and the associated estates and facilities savings that will be generated because of this closure is £294k per annum.

Level 1, 2 and 3 critical patients will transfer to the purpose built first floor of the new build. Following a number of subsequent moves following this transfer, three Nightingale Wards in the old 1930s block will be closed. The total floor area for these wards is 1,426 sqm and the associated reduction in estates and facilities will generate a saving of £457k per annum.

Any future use of these areas of the site will be subject to the Trusts internal Business Case process.

The breakdown of the savings is as follows:

	Mothball Emergency Department				Mothball Nightingale Wards			
	Total	WTE	Pay	Non-Pay	Total		Pay	Non-Pay
			£'000	£'000			£'000	£'000
SQM	**917.4**				**1,426**			
Domestics	-191	-5.98	-172	-19	-297	-9.30	-268	-29
Maintenance costs	-27	-0.45	-16	-11	-42	-0.71	-25	-17
Utilities (excl. Energy Management)	-15			-15	-23		0	-23
Medical Engineering	-61	-0.37	-14	-47	-95	0.58	-22	-73
Total	**-294**	**-6.81**	**-202**	**-92**	**-457**	**-10.59**	**-315**	**-143**

Table 47 – Breakdown of Savings

7.4.11.2 *Agency Savings*

Following the transfer of services to the new AMM unit, savings of agency premium costs have been assumed following the combining of services in a co-located space. The value of these savings are assessed at £670k at 2020/21 prices.

7.4.12 Quality Assurance of Financial Model

The Trust has used the Long Term Financial Model (LTFM) issued by NHS Improvement (Now NHS England & Improvement) to provide a set of fully integrated financial statements (income and expenditure account, balance sheet and cash flow) based on the key drivers and assumptions underpinning the Trust's financial projections for the Preferred Option.

NHS Improvements LTFM is used to collect, analyse and sensitise provider financial forecasts as part of a risk assessment process.

The model has the capacity to:

- Provide comparison between Business as Usual (BAU) and the Preferred Option to provide counterfactual analysis
- Apply sensitivities to facilitate scenario analysis

The limitations of the model are:

- The model is a strategic planning tool and not a detailed budget setting tool and therefore detailed analysis of the capital and revenue costs has been carried out prior to input into the LTFM
- The model has a maximum forward time period of nine years, and given our outturn year is 2020/21 but the 1st year full impact of the revenue implications is not until 2024/25, the forecast outlook is only for a short time period after the date the expenditure is first incurred.

The LTFM has been quality checked. There are no error flags in the LTFM and 11 amber flags, all of which have been reviewed and narrative provided as to their source and relevance.

The LTFM has been reviewed and signed off by Andrew Bertram, Finance Director, on 12 November 2020.

7.4.13 Funding Options

7.4.13.1 *Revenue Funding*

Discussions have taken place with the Trust's North Yorkshire system partners and the HCV ICS and agreement has been sought from the Trust's North Yorkshire partners to commit to meeting the revenue implications.

This is evidenced in the letter of support confirming the funding of the proposal is included at Appendix 16.

7.4.13.2 *Capital Funding*

The HCV ICS Wave 4 bid for funding outlined in the Strategic Outline Case (SOC) focused on provision of a new model and clinical pathway of delivering urgent care at the front door - the Acute Medical Model (AMM), requiring a capital build solution and investment in mechanical and electrical engineering infrastructure to support the build for the Scarborough site.

The Trust's preferred option requests an augmented funding envelope requiring £49.998m of capital investment. The SOC approval letter confirmed a funding bid of £39.998m subject to approval of the subsequent OBC and FBC. However, the SOC approval letter also went on to request that the OBC "…..should….explore other options to fund the capital cost above allocation of some of the higher value options. The OBC should also explore as part of this the additional costs of developing the first-floor ward space as part of this programme of work and identify the cost / benefit analysis of doing so."

This exact programme work has been undertaken as part of the OBC development and has been costed at a further £10m, taking the total scheme value from the original allocation of £39.989m to £49.998m.

At the time of submission of the OBC, whilst commitment exists from the ICS to deliver the full £49.998m scheme, agreement has not been reached on the final funding solution. The ICS has confirmed that it prioritises this additional investment and fully supports the eradication of substandard Nightingale accommodation in its hospitals (see Appendix 29).

Work on a funding solution will continue as part of the preparation of the Full Business Case submission. The Trust is working with the ICS and with the Regional NHSE/I Team to explore the potential for a three-way funding split including exploring the potential for additional central Public Dividend Capital (should this be available), a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme.

This commitment would include CDEL cover in respect of any contribution from the ICS or the Trust.

The Trust has considered and discounted loan funding as, under the present national capital regime, this option is no longer available. The Trust's Charity would be keen to support the development but this would be on a softer furnishing and patient extra item basis only as the Charity does not have sufficient funding to contribute significantly to the programme of additional capital work.

7.4.14 Summary

Following the appraisal of the impact on I&E / Balance Sheet and Cash flows, and based on the commitment from the Trust's North Yorkshire system partners and the HCV ICS commitment to meet the revenue implications, this scheme is affordable as can be evidenced by the financial statements below.

7.5 Statement of Comprehensive Income/Statement of Financial Position

7.5.1 Statement of Comprehensive Income

York Teaching NHS Hospital NHS Foundation Trust
Income & Expenditure Pre and Post Service Development

	Baseline (Pre Serv Dev) T1												
	Actual	Actual	Actual	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Mar-18	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	Mar-25	Mar-26	Mar-27	Mar-28	Mar-29	Mar-30
Forecast - including inflation													
Income	489,240	517,602	556,539	570,596	580,344	587,918	593,209	598,548	603,935	609,370	614,854	620,388	625,972
Expenditure	(501,680)	(520,435)	(553,307)	(569,795)	(575,144)	(580,469)	(586,289)	(591,756)	(596,969)	(601,980)	(607,287)	(612,393)	(617,796)
Operating Surplus / (Deficit)	**(12,440)**	**(2,833)**	**3,232**	**801**	**5,200**	**7,449**	**6,920**	**6,792**	**6,965**	**7,390**	**7,567**	**7,996**	**8,176**
Non-Operating expenses	(7,692)	(7,019)	(5,877)	(6,245)	(8,202)	(8,472)	(8,390)	(8,281)	(8,164)	(8,079)	(8,019)	(7,968)	(7,935)
Surplus / (Deficit)	**(20,132)**	**(9,852)**	**(2,645)**	**(5,444)**	**(3,002)**	**(1,023)**	**(1,471)**	**(1,489)**	**(1,199)**	**(689)**	**(451)**	**28**	**240**

	Post Serv Dev T1												
	Actual	Actual	Actual	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Mar - 18	Mar - 19	Mar - 20	Mar - 21	Mar - 22	Mar - 23	Mar - 24	Mar - 25	Mar - 26	Mar - 27	Mar - 28	Mar - 29	Mar - 30
Income	489,240	517,602	556,539	570,596	580,618	589,125	595,810	603,696	609,132	614,616	620,150	625,735	631,372
Expenditure	(501,680)	(520,435)	(553,307)	(569,795)	(575,146)	(580,656)	(587,217)	(595,070)	(600,304)	(605,334)	(610,663)	(615,789)	(621,213)
Operating Surplus / (Deficit)	**(12,440)**	**(2,833)**	**3,232**	**801**	**5,473**	**8,469**	**8,593**	**8,625**	**8,828**	**9,282**	**9,487**	**9,946**	**10,159**
Non-Operating expenses	(7,692)	(7,019)	(5,877)	(6,262)	(8,476)	(9,487)	(10,052)	(10,091)	(9,979)	(9,896)	(9,839)	(9,792)	(9,764)
Surplus / (Deficit)	**(20,132)**	**(9,852)**	**(2,645)**	**(5,461)**	**(3,004)**	**(1,018)**	**(1,459)**	**(1,466)**	**(1,150)**	**(614)**	**(351)**	**154**	**394**

	Variance to Baseline												
	Actual	Actual	Actual	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Mar - 18	Mar - 19	Mar - 20	Mar - 21	Mar - 22	Mar - 23	Mar - 24	Mar - 25	Mar - 26	Mar - 27	Mar - 28	Mar - 29	Mar - 30
Income	0	0	0	0	275	1,207	2,601	5,148	5,197	5,246	5,296	5,346	5,400
Expenditure	0	0	0	0	(2)	(187)	(927)	(3,314)	(3,335)	(3,355)	(3,375)	(3,396)	(3,417)
Operating Surplus / (Deficit)	**0**	**0**	**0**	**0**	**273**	**1,020**	**1,674**	**1,833**	**1,863**	**1,891**	**1,920**	**1,950**	**1,983**
Non-Operating expenses	0	0	0	(17)	(274)	(1,015)	(1,662)	(1,811)	(1,815)	(1,817)	(1,820)	(1,824)	(1,829)
Surplus / (Deficit)	**0**	**0**	**0**	**(17)**	**(1)**	**5**	**11**	**23**	**48**	**75**	**100**	**126**	**154**

Table 48 – Income and Expenditure

Pre Service Development the I&E shows a transition from £5.4m deficit in 2020/21 to a surplus of £0.2m in 2029/30, income is assumed to grow by 1.3% in 2022/23 and by 0.9% thereafter, and all operating expenditure with the exception of capital is assumed to grow by the same.

In addition to the change in inflation, an adjustment for £0.9m is included in other expenditure in the year ending March 2022. This adjustment represents a reversal of a non-recurrent holiday accrual in 2020/21 due to the impact on staff and annual leave during the COVID Pandemic.

A further adjustment has been made to income in years ending March 2022 and March 2023. The value of this adjustment is £2.3m in each year and has been made to reflect other non-patient related income back to levels seen in 2019/20 (pre COVID levels), assuming in the year 2021/22 that the Trust will be back to 50% of pre COVID levels and in 2022/23, back to 100% of income levels for non-patient related income.

Post Service Development, the I&E shows a transition from £5.5m deficit to a surplus of £0.4m at the end of 2029/30.

The change in the outturn year of £17k is the result of the PDC impact of the capital expenditure and specifically the initial fees and non-works costs that have been incurred on the scheme to date, as funding for the current outturn year has been agreed by the Trust and it's system partners, income to offset this additional charge has not been included in the LTFM.

From April 2021, there is a further increase in non-operating expenses, once again in relation to PDC as the scheme moves through the OBC approval process and into FBC. Non-operating expenses continue to rise through 2023 – 2024 and peak in the financial year 2024/25 following the completion of the build in December 2023. However, as noted above, the PDC is overstated in the LTFM and in 2024/25 this is an overstatement by £660k.

The infrastructure works within the scheme are due to be completed and operational by December 2021, and therefore depreciation is included in the LTFM from April 2022, the impact in this initial year is £187k, and remains constant in 2023/24. Depreciation then increases to £1m per annum from April 2024 following the completion of the capital build.

All other pay and non-pay expenditure are assumed from December 2023 following the proposed timescale for opening the new build and represents a change in 2023/24 of £740k and £2.2k each year thereafter (plus inflation).

Following the letter of support, it is assumed for the purpose of the LTFM that funding will be increased through the North Yorkshire system to offset the increase in operating and non-operating expenses outline above.

7.5.2 Impact on Cashflow

York Teaching NHS Hospital NHS Foundation Trust
Cashflow Statement

	Cash and Cash Equivalents at end of period												
	Actual	Actual	Actual	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Mar - 18	Mar - 19	Mar - 20	Mar - 21	Mar - 22	Mar - 23	Mar - 24	Mar - 25	Mar - 26	Mar - 27	Mar - 28	Mar - 29	Mar - 30
Baseline	16,806	9,705	11,385	59,618	12,762	12,246	11,628	11,552	11,762	9,592	10,597	12,078	13,766
Post Service Development	16,806	9,705	11,385	59,601	12,708	12,263	11,752	12,607	13,945	12,972	15,198	17,925	20,886
Variance	0	0	0	(17)	(53)	17	124	1,055	2,183	3,380	4,601	5,847	7,120

Table 49 – Cashflow Statement

Although the table above shows an increase in cash balances between April 2022 and March 2030, this is predominantly due to the effect of inflation over the forecast periods, as capital expenditure is assumed in the OBC to be covered by Public Dividend Capital and revenue implications covered by the North Yorkshire system.

7.5.3 Balance Sheet Treatment

York Teaching NHS Hospital NHS Foundation Trust
Balance Sheet

	Total Net Assets Employed												
	Actual	Actual	Actual	Outturn	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Mar - 18	Mar - 19	Mar - 20	Mar - 21	Mar - 22	Mar - 23	Mar - 24	Mar - 25	Mar - 26	Mar - 27	Mar - 28	Mar - 29	Mar - 30
Baseline	237,554	186,094	195,111	237,724	234,722	233,699	232,228	230,739	229,540	228,851	228,400	228,428	228,668
Post Service Development	237,554	186,094	195,111	238,694	249,112	276,017	282,213	280,747	279,596	278,982	278,631	278,785	279,179
Variance	0	0	0	970	14,390	42,319	49,985	50,008	50,056	50,131	50,231	50,357	50,511

Table 50 – Balance Sheet Statement

Although the Trust has assumed that that value of the capital build will be impaired by 30%, due to the limitations of the model, the asset is included at the full value of £50m, and therefore the model illustrates that the Trust's net assets will increase by this value, as expected following the successful completion of the project.

As can be seen in the table above, the profile of the increase in property, plant, and equipment, begins in 2020/21, considering the fees and non-works costs incurred to date. The year ending March 2022 sees a further increase in assets of £14k which represents the infrastructure works and further fees and non-work costs. With the greatest impact on the balance sheet in the year ending March 2023 when the majority of the new build will be close to completion.

7.6 Technical checks

7.6.1 Capital/Revenue split

The split of costs between revenue and capital is accounted for in line with the current capitalisation policy, within the Government Accounting Manual (GAM).

7.6.2 Ownership of the assets

The Trust established a subsidiary company in 2018. York Teaching Hospital Facilities Management LLP (YTHFM) was incorporated on 7th March 2018 and became operational on the 1st October 2018.

YTHFM:

- Provides estate, facilities and procurement services under a Master Service Agreement (MSA); this will include the design, construction and management of new infrastructure as well as the management of existing infrastructure
- Is paid a monthly unitary payment in regards to services provided; the payment schedule is agreed in the MSA and only varies due to the impact of indexation or the variation of the contract services
- Has at minimum; a right of access to all Trust infrastructure for which it provides management services.

The MSA has been designed to resemble a PFI contract in that it includes:

- The construct or maintenance of infrastructure used in the delivery of publics services, namely hospitals used in the delivery of healthcare

- A contractor relationship between the grantor (Trust) and the operator (Subsidiary), the contract specifies the services the operator will provide and how it is remunerated. The contract term is 25 years of which it is currently in year two
- Supply of services by the operator, include construction or upgrade of infrastructure, as well as its operation and maintenance
- Payment of the operator being tied to the availability of the infrastructure, in many cases the operator will not be paid during the initial construction or upgrade of the infrastructure
- Return of infrastructure to the Grantor at the end of the contract, i.e. legal title to the property lies with the Grantor at the end of the contract.

As such the MSA satisfies the common features of a service concession and hence it is maintained that the principal accounting policy that governs the transitions under the contract is IFRIC 12 (IFRIC12.3).

Infrastructure constructed is not recognised as Property, Plant and Machinery (PPM) of the Subsidiary as the MSA conveys the benefits of the infrastructure to the Trust and therefore the asset sits on the Trust's balance sheet. The Trust will also provide a non-exclusive license over the infrastructure to the operator for the duration of the MSA granting YTHFM access to the infrastructure for the purpose of its operation and maintenance.

The accounting treatment for YTHFM is as follows:

- On agreement of the MSA, the Subsidiary will commence the construction or upgrade of specified infrastructure
- The costs incurred by construction works will be taken to the balance sheet as Work In Progress (WIP) within stock; on completion of agreed milestones those costs will be released to the profit and loss account (P&L) as costs of sale
- On release to the Trust, YTHFM will also accrue revenue in regards to the construction services (IAS 11); the fair value of this consideration will be considered to be costs of construction plus margin. The generally accepted margin for internal PFI construction is considered to be 0.5% given the low risk attached
- The accrued revenue will generate a financial debtor; this Financial Debtor (FD) will be repaid over the duration of the MSA
- It will also attract interest over this period. Both FD repayments and financial interest will be received via a monthly unitary invoice which the Subsidiary will raise against the Trust. When this invoice is raised, part of the revenue will be allocated to the repayment of the FD rather than to the P&L, this reflects the fact that the revenue was previously accrued in order to generate the FD. A further amount will be recognised as financial interest and the remainder as revenue for maintenance services.

The accounting treatment for the Trust is as follows:

- The Trust will recognise a PPM in regards to the Subsidiary's capital expenditure, a balancing financial liability will be created which matches the financial debtor in the subsidiary and eliminates on consolidation

- Any capital profit element included on the capital spend by the Subsidiary, is not included in the value of the PPM capitalised. This is recognised as a cost of sale, simplifying later consolidation

- The monthly unitary invoices paid by the Trust will be split and recognised as a repayment of the financial liability (Balance Sheet), a financial interest expense (P&L – interest payable) and a cost of services (P&L – cost of sales).

The Group's Annual Accounts were audited by Grant Thornton for the year ending March 2019 and they reported:

> '*Our audit work identified a large number of accounting and disclosure issues around reporting this material and complex transaction. Post audit amendments there are no unadjusted misstatements or unreported disclosure requirements in relation to this significant risk.'*

We obtained sufficient audit evidence and various expert assurances to conclude that post audit adjustments:

- The Trust's accounting policy for accounting and disclosure of newly created component complies with the DHSC Group Accounting Manual 2018/19, and other relevant financial reporting standards and has been properly applied and

- Accounting and disclosures of around newly created component are not materially misstated.

7.6.3 Procurement costs

The internal project management team are permanent staff within the Capital Projects Team and as such have allocated annual establishment budget which is re-charged to their projects at year-end through the internal corporate management accounting process. This project has required the procurement of external project management engagement through Turner and Townsend Project Management Ltd for which the cost is borne from the professional fees line within the Capital Cost Summary.

7.6.4 VAT treatment

As referred to above, the construction of the new build and infrastructure works will be contracted out to the Trust's subsidiary, YTHFM. Under the MSA, YTHFM will undertake all construction and therefore VAT is recoverable. YTHFM is registered at Companies House and claims VAT in line with Companies House Act. As YHTFM is a limited liability partnership, the treatment of stamp duty, and payment of corporation or any other taxes are not applicable.

7.7 Contingencies

7.7.1 Contingency Plans

7.7.1.1 *Capital Funding*

Capital funding of £40m has been secured through HCV ICS Wave 4 bid. At the time of submission of the OBC, whilst commitment exists from the ICS to deliver the full £49.998m project, agreement has not been reached on the final funding solution. The ICS has confirmed that it prioritises this additional investment and fully supports the eradication of substandard Nightingale accommodation in its hospitals.

Work on a funding solution will continue as part of the preparation of the Full Business Case submission. The Trust is working with the ICS and with the Regional NHSE/I Team to explore the potential for a three-way funding split including exploring the potential for additional central Public Dividend Capital (should this be available), a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme.

Further clarity on this position is expected for the FBC, at which time the requirement for additional contingency plans will be considered.

7.7.1.2 *Revenue Funding*

As detailed above discussions have taken place with the Trust's North Yorkshire system partners and the HCV ICS and agreement has been sought from the Trust's North Yorkshire partners to commit to meeting the revenue implications.

As the revenue is developed through FBC, should any increase in operating expenses arise, this will be discussed through a collaborative approach with our system partners.

7.7.1.3 *Risk Register*

The Project Team has undertaken a risk assessment to identify the major areas of risk and a fully costed Risk Register can be found in Appendix 7.

7.7.1.4 *Capital Contingencies*

Contingencies are included within the Capital Cost Plan in the form of optimism bias and planning contingency. There are also contingences within the equipment costs.

7.7.2 Sensitivity Analysis

A Sensitivity Analysis has been applied to the LTFM to understand what impact a change in several events would impact on the current financial projections.

The following scenarios were explored:

1) Increase in operating expenses (excluding Depreciation) by 10%

2) Increase in the valuation of the asset by 5%, as a result of the impairment of 30% assumed being less than anticipated

3) Increase in the total capital cost of 10%

4) Combination of all of the above.

The results were as follows:

York TeachingHospital NHS Foundation Trust
Single Oversight Framework (SOF) Pre and Post Development - Including Sensitivities

	Actual Mar - 18	Actual Mar - 19	Actual Mar - 20	Outturn Mar - 21	Forecast Mar - 22	Forecast Mar - 23	Forecast Mar - 24	Forecast Mar - 25	Forecast Mar - 26	Forecast Mar - 27	Forecast Mar - 28	Forecast Mar - 29	Forecast Mar - 30
Overall risk rating after overrides													
Baseline	3	2	3	3	2	2	2	2	2	2	2	2	2
Post Service Developments	3	2	3	3	2	2	2	2	2	2	2	2	2
Sensitivity 1 - Increase operating expenses by 10%	3	2	3	3	2	2	2	2	2	2	2	2	2
Sensitivity 2 - Reduce capital impairment by 5%	Not available due to limitations of LTFM												
Sensitivity 3 - Increase capital costs by 10%	Not available due to limitations of LTFM												
Capital Service Cover													
Baseline	(0.25)	2.25	1.12	0.28	1.44	1.57	1.65	1.67	1.85	1.96	2.00	2.06	2.11
Capital service cover rating	4	2	4	4	3	3	3	3	2	2	2	2	2
Post Service Developments	(0.25)	2.25	1.12	0.28	1.36	1.48	1.52	1.61	1.76	1.86	1.90	1.95	2.00
Capital service cover rating	4	2	4	4	3	3	3	3	2	2	2	2	2
Sensitivity 1 - Increase operating expenses by 10%	(0.25)	2.25	1.12	0.28	1.36	1.48	1.51	1.59	1.74	1.84	1.88	1.93	1.98
Capital service cover rating	4	2	4	4	3	3	3	3	3	2	2	2	2
Sensitivity 2 - Reduce capital impairment by 5%	Not available due to limitations of LTFM												
Capital service cover rating													
Sensitivity 3 - Increase capital costs by 10%	Not available due to limitations of LTFM												
Capital service cover rating													
Liquidity													
Baseline	(6.43)	(7.88)	(24.74)	(4.86)	(5.97)	(5.29)	(5.19)	(4.64)	(4.25)	(3.80)	(3.17)	(2.26)	(1.14)
Liquidity rating	2	3	4	2	2	2	2	2	2	2	2	2	2
Post Service Developments	(6.43)	(7.88)	(24.74)	(4.87)	(6.55)	(6.31)	(6.60)	(5.86)	(5.25)	(4.58)	(3.70)	(2.52)	(1.09)
Liquidity rating	2	3	4	2	2	2	2	2	2	2	2	2	2
Sensitivity 1 - Increase operating expenses by 10%	(6.43)	(7.88)	(24.74)	(4.87)	(6.55)	(6.31)	(6.66)	(6.09)	(5.66)	(5.15)	(4.42)	(3.39)	(2.11)
Liquidity rating	2	3	4	2	2	2	2	2	2	2	2	2	2
Sensitivity 2 - Reduce capital impairment by 5%	Not available due to limitations of LTFM												
Liquidity rating													
Sensitivity 3 - Increase capital costs by 10%	Not available due to limitations of LTFM												
Liquidity rating													
I&E Margin													
Baseline	-4.61%	0.65%	0.07%	-0.88%	-0.44%	-0.10%	-0.18%	-0.19%	-0.14%	-0.06%	-0.03%	0.05%	0.08%
I&E Margin Metric	4	2	2	3	3	3	3	3	3	3	3	3	3
Post Service Developments	-4.93%	0.77%	0.04%	-0.88%	-0.60%	-0.25%	-0.32%	-0.32%	-0.27%	-0.18%	-0.13%	-0.05%	-0.02%
I&E Margin Metric	4	2	2	3	3	3	3	3	3	3	3	3	3
Sensitivity 1 - Increase operating expenses by 10%	-4.93%	0.77%	0.04%	-0.88%	-0.60%	-0.25%	-0.34%	-0.37%	-0.31%	-0.22%	-0.18%	-0.09%	-0.05%
I&E Margin Metric	4	2	2	3	3	3	3	3	3	3	3	3	3
Sensitivity 2 - Reduce capital impairment by 5%	Not available due to limitations of LTFM												
I&E Margin Metric													
Sensitivity 3 - Increase capital costs by 10%	Not available due to limitations of LTFM												
I&E Margin Metric													

Table 51 – Sensitivity Analysis

Sensitivity 1

Should operating expenses increase by 10% between December 2023 and March 2030, the impact on the I&E is an increased deficit / reduced surplus by an average of £267k per annum.

The biggest impact of increasing non-operating expenses by 10% is the impact on the Trust's liquidity rating, reducing this from -1.09 in 2029/30 to -2.11, however the rating is still 2 overall.

The I&E margin reduces from -0.02% to -0.06% but again does not change the overall rating of 3.

It is assumed for the purpose of this sensitivity that the additional cost will be an overspend that will need to be mitigated within the Trust; however it is more likely that there will be a collaborative approach with our system partners, and a way forward agreed.

Sensitivity 2

Sensitivity 2 assumes that the impairment of assets will be 25% rather than 30%. Although in the LTFM PDC is calculated on the full value of the asset, the change increase in valuation would increase the depreciation charge.

The LTFM does not pick up the changes to the I&E following the application of the sensitivity, which will need to be addressed for the FBC, however, the output would be a minor change to the value of capital charges (Depreciation) and a reduction to the post development surplus of £1.12m in 2029/30.

Sensitivity 3

Sensitivity 3 assumes an increase in capital costs by 10%, as with Sensitivity 2, the LTFM does not pick up the changes to the I&E following the application of the sensitivity, however the effect of this change would be an increase in capital charges and reduction in I&E surplus, plus a reduction on the Trust's cash reserves by £5m.

7.7.3 Optimism Bias

The Optimism Bias has been based on a percentage calculation which is derived from a list of risk factors and mitigation in accordance with the HMT Green Book. The % included within the cost plan reflects the current risk factors and mitigation which have been assessed to reflect the current status of the project and will be reviewed as the project progresses.

7.7.4 Land Transactions

There are no land transactions associated with this project.

8 The Management Case

8.1 Introduction

8.1.1 Overview

The management case details the project management and governance arrangements that the Trust has put in place to support the delivery of this project. It sets out the following arrangements:

- Project Plan
- Project Management
- Project Reporting & Monitoring
- Benefits Management
- Change Management
- Business Continuity
- Risk Management
- Contingency Plans.

8.1.2 Premises Assurance Model (PAM)

The Trust was an early implementer of PAM. It is the chosen method of demonstrating compliance against NHS standards. Compliance against PAM categories are audited monthly and provide a significant part of the contract monitoring between the Trust and the LLP. Policies, procedures, training records, action plans and many other components are held within the system.

The policy for capital development projects is held within the PAM completed by the Trust, along with the details of the backlog maintenance requirements and how these are risk rated. This gives the details required by the Board to make strategic site development investment decisions.

8.2 Project Plan

The Project Programme is intended to deliver the project by January 2024. The milestones for the programme are set out below:

Milestone Activity	Date
Submit OBC draft to Project Board meeting	09/11/2020 - complete
Submit OBC to Trust Board	25/11/2020 - complete
Submit OBC to Humber, Coast & Vale ICS Board	01/12/2020 - complete
Set up fortnightly Infrastructure user groups	Commenced 17/03/20
Set up fortnightly AMM clinical user groups	Commenced 26/03/20
Set up fortnightly Project Team meetings	Commenced 01/04/20
Site investigation surveys undertaken	01/04/20 – complete
Set up fortnightly finance meetings for OBC and revenue business case completion	Commenced 15/06/20 – complete
Appointment of special advisors	Complete to end of OBC

Milestone Activity	Date
Complete high-level infrastructure packages for cost advisor costing for OBC	31/08/2020 - complete
DQI workshop	08/09/2020 - complete
Pre-Planning Application	15/10/2020 - complete
Tender and Appointment of PSCP	Completion by 01/12/2020
Submit FBC to Project Board	01/07/2021
Submit FBC to Trust Board	01/07/2021
Submit FBC to HCV	01/08/2021
Construction Milestones for procurement of equipment/training etc – to be developed following appointment of the PSCP	Commence Jan 2022 - 2 Years
Benefits realisation	January 2024 onwards

Table 52 – Delivery Milestones

The full Project Programme can be found in Appendix 19.

8.2.1 Contract Management Plan

The Contract Management Plan, which will outline the method in which the contracts will be administered and executed will be developed and agreed at FBC stage.

Each construction component will have a cost advisor and contract administrator appointed.

8.2.2 OGC Gateway Risk Potential Assessment (RPA) and Health Check Review

All significant public sector projects are required to complete the Office of Government Commerce (OGC) process of detailed peer review and assessment at key stages or gateways.

The requirement to register a project for formal review is based upon an initial Risk Potential Assessment (RPA). Completion of an RPA results in a project being classified as Low Risk, Medium Risk or High Risk. Completion of the RPA has identified a High-Risk category predominantly related to the funding gap for the Preferred Option.

Guidance states that the RPA form should be completed as early in the life of a change initiative as possible, for example, when policy is being formulated and be revisited as the project evolves through the Business Case process.

The RPA, which is included in Appendix 27, has been populated for OBC stage and on present information available.

The Trust appreciates that Gateway, Health Check and Peer Reviews provide valuable external perspective on the project including risks, stakeholder involvement, management and governance arrangements, costs and affordability. The RPA has been submitted in November as part of the suite of documents within the appendices.

8.2.3 Post Project Evaluation

The capital team have a well-developed and documented guide to follow for all projects in excess of £1m capex and will use this for the project.

This is undertaken in the form of a workshop with multi-disciplinary stakeholders facilitated by an independent facilitator appointed in accordance with the Post Project Review (PPR) procedure. The workshop will allow a thorough review of all the project specific outcomes and analyse project success against the original objectives. The evaluation is a team effort, where each member of the team is able to put forward their point of view, identifies good practice; advises on lessons learnt and makes suggestions to benefit future projects. It is recognised that a successful aspect of the project for one party, may have been perceived as detrimental by another.

The workshop will:

- Allow data collection
- Review the project baseline against the proposal/ brief
- Review the actual outcome against the baseline
- Review the project approach/processes, including project organisation, governance & controls
- Review contributor's performance including external suppliers
- Analyse success against the objectives
- Allow documentation of the review and learning for future projects.

Each of these will be considered through the various stages of the project from inception to completion of the construction contract and rectification of snagging.

A Pre-Workshop Survey will be conducted as part of the PPR workshop preparation. The questionnaire will be issued as a separate document prior to the workshop. The PPR guide details topics for evaluation with section headings including, start-up and design, procurement and construction, handover, operations and user perspective and follows a comprehensive set list of questions for each section. Further to this the PPR will include pre and post occupancy valuation with patients and staff members.

Following the completion of the workshop the Facilitator and Project Manager will produce a report summarising the output and conclusions of the review.

An appropriate budget will be assigned for Post Project Evaluation from the overall project budget as the capex cost summary is refined during FBC stage.

8.3 Project Management

8.3.1 Project Management Budget

The internal project management team are permanent staff within the Capital Projects Team and as such have allocated annual establishment budget which is re-charged to their projects at year end through the internal corporate management accounting process. This project has required the procurement of external project management engagement through Turner and Townsend Project Management Ltd for which the cost is borne from the professional fees line within the capital cost summary.

8.3.3 Project Management Structure

The Project Management Structure is included within the Governance Structure chart in Section 9.3.5.4.

The Project Lead will manage the Integrated Design Team; Cost Advisors; Specialist External Advisors and Internal Advisors. The Project Lead will chair the Project Team Meeting Group which will be the forum to manage the design and implementation of the project.

The Project Lead will report to the Project Board, the Clinical Steering Group and the Infrastructure Steering Group.

8.3.4 Project Management Methodology

The methodologies and approach for this project rely on our internal Capital Projects Team management processes which follow the principles of PRINCE 2 and follow the construction industry standard best practice.

Project direction and management will be determined by the Project Director.

8.3.5 Governance

8.3.5.1 *Transformation of Emergency and Urgent Care and Site Engineering Infrastructure (HCV Wave 4) Project Board*

This Project Board is a sub-group of the Capital Programme Executive Group (CPEG).

Issues will be escalated or referred for decisions as appropriate from the Project Board via the appropriate Trust governance / approvals hierarchy to the Executive Directors and thereafter, if necessary, to the Trust Board.

The Project Board will receive information from the Clinical Steering Group (Acute Medical Model & Critical Care) and Infrastructure Steering Group.

The Project Board is responsible for monitoring the development and delivery of the Trust's Transformation of Urgent and Emergency Care Project on behalf of the Trust Board. The Project Board will provide assurance to the CPEG on the development and delivery of the project.

8.3.5.2 *Infrastructure Steering Project Group*

The Infrastructure Steering Project Group is responsible for day-to-day development of the respective elements of the Trust's Scarborough Hospital Transformation of Urgent and Emergency Care and Site Engineering Infrastructure project.

This group is a sub-group of the Scarborough Hospital Transformation of Urgent and Emergency Care and Site Engineering Infrastructure Project Board.

The Infrastructure Steering Project Group will provide assurance to the Project Board regarding the development and delivery of the Estate Infrastructure element of the Project.

8.3.5.3 *Clinical Steering Group (Acute Medical Model & Critical Care)*

The Clinical Steering (Acute Medical Model & Critical Care) Project Group is a sub-group of the Scarborough Hospital Transformation of Urgent and Emergency Care and Site Engineering Infrastructure Project Board.

Issues will be escalated or referred for decisions as appropriate from the Clinical Steering (AMM & Critical Care) Project Group to the Scarborough Hospital Transformation of Urgent and Emergency Care and Site Engineering Infrastructure Project Board.

The Clinical Steering Project Group is responsible for day-to-day development of the AMM & Critical Care element of the project.

The Clinical Steering Project Group will provide assurance to the Project Board regarding the development and delivery of the AMM & Critical Care element of the Scarborough Hospital Transformation of Urgent and Emergency Care and Site Engineering Infrastructure project.

8.3.5.4 *Governance Structure*

The Organisation Chart below outlines the Governance Structure for this project as well as including External and Internal Advisors.

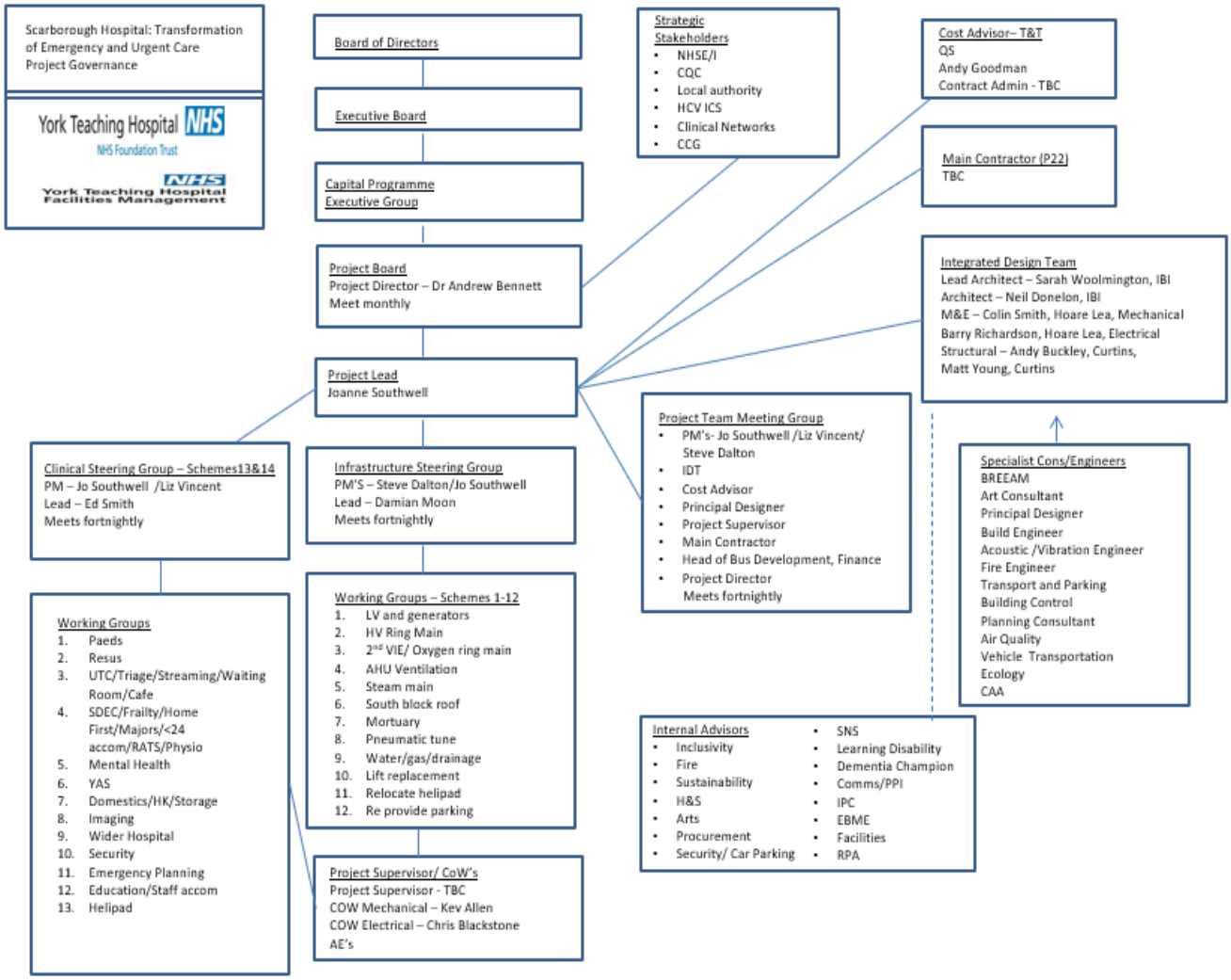

Diagram 15 – Project Governance Structure

8.3.6 The Project Team

8.3.6.1 *Team composition*

Key members of the Project Team are shown in the table below:

Role	Name	Responsibilities	Full Time Equivalent
Head of Capital Projects	Dr Andrew Bennett	Project Director	0.2WTE
Strategic Capital Planning Manager	Joanne Southwell	Project Lead	0.8 WTE
Senior Capital Project Manager	Liz Vincent	Support for Project Lead	0.6 WTE
Infrastructure Project Manager	Steve Dalton T&T	Project Lead for Infrastructure	0.6 WTE
Head of Business Development	Sarah Barrow	Financial Management support for Business Case development	0.6WTE
Project Administration	Hannah Bailey	Administrative Support to Project	1.0 WTE

Table 53 – Project Team

Senior management and clinical time have been assessed and factored into resource requirements for this project.

The Trust has allocated senior operational support in the form of the Deputy Chief Operating Officer to ensure that appropriate operational time and engagement for the project is established and maintained. The Project Lead briefs the Deputy Chief Operating Officer on a fortnightly basis who in turn reports directly to the Chief Operating Officer to report on progress.

The Care Group's senior management team have allocated time within their workload for the prioritisation of the project support and delivery.

Due to the outbreak of Covid-19 at the beginning of the preparation of this OBC, clinical time has been allocated from the Consultant's Special Programmed Activity (SPA) element of their job plan and this has been sufficient to progress the project thus far and will be reviewed as the project develops.

Reporting lines and communication lines are shown in the Governance chart in section 9.3.5.4.

8.3.6.2 *Use of Specialist Advisers*

Special advisers have been used in a timely and cost-effective manner in accordance with HM Treasury Guidance. The use of special advisers is outlined in the tables below:

Specialist Area	Adviser
Cost Advisor	Andy Goodman, Turner & Townsend
Architect	Sarah Woolmington/Neil Donelon, IBI Group
Procurement & Legal	Ian Willis YTHFT Head of Procurement
Business Assurance	YTHFT Head of Business Development – Sarah Barrow
Mechanical Consultant	Colin Smith, Hoare Lea

Specialist Area	Adviser
Electrical Consultant	Barry Richardson, Hoare Lea
Principal Designer	Robert Clarke, Aegis Services Ltd
Principal Contractor	To be Confirmed
Radiation Specialist Advisor	Stephen Rimmer, Leeds Medical Royal Infirmary Medical Physics
Asbestos Specialist Advisor	Troy Gallagher, Atmosphere Environmental
Interior Design Architect	To be Confirmed
Traffic Management & Parking	Shazid Khan, Curtins Consulting Ltd
Local Council Planning Officer	Karen Lawton, Scarborough Borough Council
Highways & Byways Planning Officer	Helen Watson, Scarborough Borough Council

Table 54 – Specialist Advisors

8.3.6.3 *Managing Contractor bids*

All aspects of the Contractor procurement will be considered carefully and involve the Trust procurement team from outset. The appointment of the Contractor will be made in accordance with the Public Contract Regulations 2015 using the NHS England / Improvement construction framework, ProCure22, or its successor P2020.

The Trust has measures in place to ensure that the staff involved in preparing and assessing the bids will be trained in their duties and declarations of interest will be captured from the outset.

Oversight from the Framework owner will also give independent oversight in managing all aspects of the bid process and appointment against nationally agreed terms.

8.4 Project Reporting & Monitoring

The Trust's Chief Executive is the Senior Responsible Owner (SRO). The Managing Director of YTHFM is the Project Sponsor and the Head of Capital Projects, the Project Director.

Throughout the development of the proposals regular monthly, briefings and communications have been scrutinised and reported to CPEG and ultimately the Trust Board.

Membership of the Project Board and Steering Groups/sub-groups are shown in the Governance Chart in section 9.3.5.4. Terms of Reference are in place for each of these groups.

The following reports will be prepared:

Report	Prepared by	Sent to	When
Project Report Summary	Project Lead	Project Board	Monthly
Project Board Report	Project Director	Project Board & Capital Programme Executive Group (CPEG)	Monthly
RIBA Work Stage 2 report	Integrated Design Team	Project Board	End of OBC

Table 55 – Project Reporting

8.4.2 Post-Occupancy Evaluation

Post-Occupancy Evaluation (POE) is the process of obtaining feedback on a building's performance once in use. POE is valuable, particularly in healthcare environments, where poor building performance will impact on running costs, occupant well-being and business efficiency.

Post-Occupancy Evaluation will:

- Highlight any immediate teething problems that can be addressed and solved
- Identify any gaps in communication and understanding that impact on the building operation
- Provide lessons that can be used to improve design and procurement on future projects
- Act as a benchmarking aid to compare across projects and over time.

The Trust will confirm in the Full Business Case the means by which it will procure POE for this project.

8.4.3 Lessons Learned

In addition to the POE outlined above, a Lessons Learned Workshop will be held on the completion of the FBC and on completion of all building and infrastructure works on site.

The Workshops will be facilitated by the Project Lead and will involve the Design Team, Specialist Advisors (internally and externally), Contractors and any other key stakeholders. The outputs of these workshops will be shared with all attendees and used by Estates in future projects at Scarborough Hospital and the wider YTHFT.

8.5 Benefits Strategy

The delivery of benefits will be managed through the Project Board.

At FBC stage, this will be developed into a detailed plan for each benefit covering the following:

- A description of the benefit
- The baseline and target measure of the benefit
- A summary of how the benefit will be achieved
- Details of the timescale over which the benefit will be achieved
- Identification of the lead responsible for delivering benefits.

Responsibility for monitoring and achieving benefits delivery will be assigned to the relevant Care Group or YTHFM Department as appropriate.

A Benefits Workshop was held on 23 June 2020 with the multi-disciplinary stakeholder group. The workshop was held to review the tables documented in the SOC to establish fit for the revised options presented in this OBC.

This approach generated some design points which were agreed as not strictly benefits and would be carried forward as part of the later design review workshop.

The focus for the workshop was to conclude the following key tables for inclusion in the OBC:

- Business scope and key service requirements
- Confirm and prioritise the infrastructure scheme
- Investment objectives
- Critical success factors
- Risks and counter measures
- Main benefits criteria
- Constraints
- Investment objectives & benefits criteria including direct, indirect and wider benefits.

A further Benefits Workshop was held on 2 November 2020 and the Benefits refreshed for inclusion in the Economic Case.

The benefits at FBC stage will be more precisely refined once the Preferred Option has been supported and approved.

8.6 Change Management

8.6.1 Overview

Change management associated with the project will be managed through the Project Board, under the chairmanship of the Project Director.

Day to day change management issues will be discussed at a project level and any resultant contract and/or cost changes will need to be approved by the Project Board.

8.6.2 Users support

Users of the new facility have been involved in and are fully supportive of the project and will be included in the planning and implementation of the project.

The stakeholder engagement process and outputs have been outlined in section 4.10.6 of this OBC.

8.6.3 Organisational/Cultural Impact

The organisational and cultural impact of the Preferred Option has been considered and built into the Trust's local Care Group and overall Human Resource and Estates Strategies. It is also a key part of the evolving Trust-wide Clinical Strategy and the work programme of the multi-agency Scarborough Acute East Coast Services Review which is concerned with the development of sustainable and integrated clinical services for the local catchment population.

There have been pilot studies undertaken recently of the operation and application of the Acute Medical Model and Frailty Model which have reviewed and considered the organisational and cultural impact of these clinical service transformation programmes. The 'pilot' for AMM has, in effect, been the way the Trust has been working in Scarborough for some 2-3 years. Our onsite 24/7 Urgent Treatment Centre and co-located 24/7 Same Day Emergency Care (SDEC) service have proved to be successful proofs of concept, delivering what is, in effect, the AMM Interim Operating Capability; Full Operating Capability will be achieved when services move into the new facility. Operationalising AMM including the Critical Care initiative involves re-providing workforce from current disparate services into the new combined facility thereby combining knowledge, skills and experience under a single roof.

The new building will be managed and operated by the Scarborough Acute, Emergency Medicine and Elderly Care and Theatres, Anaesthetics and Critical Care, Care Groups on a day to day basis. The cross Organisation and inter-agency project management structure will be maintained initially to ensure the service model and workforce plans are delivered and sustained.

8.7 Risk Management

8.7.1 Introduction

The Project Team has undertaken a risk assessment to identify the major areas of risk and highlighted the controls currently in place, or to be put in place, to mitigate the risks.

The Project Board monitors the risks that may affect the delivery of the project. Project risks are managed through the Risk Register (Appendix 7). This is a dynamic document and as such will be amended as the project progresses. The project clinical and infrastructure steering groups will monitor the risk and actions and will collectively review alterations to ensure a consistent approach. The risk register is also reviewed periodically at the Project Board, with the highest rated risks escalated to the Capital Programme Executive Group and Trust Board as appropriate.

8.7.2 Risk Management approach

The Trust's approach to risk management, in accordance with its Board Assurance Framework, the Capital Investment Manual and HM Treasury Green Book, is designed to ensure that the risks and issues are identified, assessed and mitigation plans developed in a risk management plan. All risks have a responsible owner identified.

The risk management approach for the project is in accordance with PRINCE2 principles. At completion of the SOC, the Project Team were maintaining two risk registers: one for the capital build and one for the infrastructure schemes. However, during OBC the Project Team agreed to combine the two risk registers into one combined risk register which complies with the CIA template to allow for ease of valuing the risks and completion of the CIA template.

The Project Team has undertaken an initial identification and assessment of the risks to the project and has then reviewed each risk to provide a consensus scoring and RAG rating as per the Risk Register in Appendix 7. This details who is responsible for the management of risks and the required counter measures, as required. The risk register is a standing agenda item on the Project Team fortnightly meeting and is reviewed and updated as part of this meeting.

8.9 Contingency Plans

This OBC seeks approval for investment in central funding to provide a capital build and engineering infrastructure which without this funding the Trust is unable to address:

- The extensive clinical and operational challenge in providing sustainable, responsive emergency care in a department which is **too small, overcrowded, non-compliant, inflexible and no longer fit for purpose**
- The **non-compliance of critical care environments** and support a model of integration of all critical level 1, 2 and 3 patients
- The **critical fragility of the existing engineering site infrastructure** which is non-compliant and at maximum capacity with major operational critical services working on non-essential power together with the burden of outstanding backlog maintenance.

The reality of the current situation of running an Emergency Care service in a sub-optimal facility is that our patients incur unacceptable waiting times. Ambulances are unable to off-load patients in a timely manner and dedicated practitioners are, despite their best efforts, unable to deliver the standard of care that our health population deserve.

The facility that this investment will deliver is crucial to reducing the clinical risk and patient safety issues within acute and emergency care. It also supports our future transformation programme of acute services and improved patient flow that together will deliver improved patient outcomes and experience.

Receipt of this capital investment is the only way that we can address the urgent patient safety issues some of which were highlighted in the Care Quality Commission (CQC) Scarborough Hospital Quality Report of 24 March 2020, which rated the department as inadequate and served a section 31 notice and 29A notice. Facility and patient flow issues have temporarily been addressed but the long-term solution remains with implementation of this project.

The options appraisal to consider how best to rectify the inadequacy and non-compliancy of our existing critical care facilities concluded that the only viable option requires a new build accommodation solution. The Trust's Preferred Option to rectify these clinical and estate safety issues are to bring together all our acutely unwell patients in one integrated critical care facility in support of the AMM in new compliant fit for purpose accommodation.

In relation to the engineering infrastructure, our Site Condition Survey describes the catastrophic, critical, high risk and non-compliant nature of the current engineering infrastructure. Without this investment, the current infrastructure is unable to support this proposed capital build and service transformation or any future capital expansion.

9 Recommendation

York Teaching Hospital NHS Foundation Trust and YTHFM are committed to a vision for the redevelopment of clinical services provided on the Scarborough Hospital site.

Delivery of the proposed new build will enable the single most transformative clinical delivery model to sustain clinical services for the future. In addition, the engineering infrastructure will allow the Trust to set strategic direction and plan with ambition in the confidence that the site can support development in the future from this critically important level of investment.

The proposal is fully endorsed by North Yorkshire CCG and Humber Coast and Vale Integrated Care System and supported by the clinical and operational teams within the Trust and external stakeholders involved in designing and developing the proposals.

We recommend that:

- This Outline Business Case is submitted to the Trust Board in November 2020 for approval
- The Trust Board acknowledge that the funding envelope for Option 2 is already established within the original £40m bid proposal but is not the optimal option
- **Option 4, at a cost of £49.998m** is carried forward as the **Preferred Option** by closing the £10m funding gap through continued working with the ICS and with the Regional NHSE/I team to explore the potential for a three-way funding split including the potential for additional central capital, a prioritised commitment from future years' ICS capital allocations and a contribution from the Trust's own internal capital programme. If this option proves ultimately unaffordable then Option 2, at a cost of £39.989M, would be the Trust's second Preferred Option
- That the Full Business Case (FBC) is developed without delay utilising the early drawn-down fees received whilst awaiting central approval of the OBC.

10 Appendices

The Appendices to this OBC are available in zip files from The Trust, by contacting:

Hannah Bailey

Project Administrator

Hannah.Bailey@ythfm.nhs.uk

1. List of Stakeholders
2. Architect's RIBA Work Stage 2 OBC Report
3. Architect's 1:200 Drawings
4. Schedule of Accommodation
5. Comprehensive Investment Assessment
6. Capital Cost Plan Reports
7. Costed Risk Register
8. Lifecycle Costs
9. Long Term Financial Model – Sarah Barrow
10. Comparison of Procurement Routes
11. Accountancy Treatment
12. McKinsey Acute East Coast Services Review Phase One Report
13. Our Strategy 2018 – 2023
14. Options Appraisal for current ICU Oct 2016
15. OBC Long List Options to Short List Options analysis
16. Letter of support from North Yorkshire CCG (to follow)
17. New Model of Service Delivery - article written by Dr Ed Smith
18. Care Quality Commission Report March 2020
19. Project Programme
20. BREEAM Pre Assessment Report
21. Green Travel Plan
22. Sustainable Procurement Plan
23. Scoping Note for Transport Statement
24. Highway Note 01
25. Equality Impact Assessment
26. NHSE Business Case Checklist
27. Risk Potential Assessment
28. Required Services
29. Letter of support from Chris O'Neill (to follow)
30. Pre-Application Letter – Scarborough Council.

Outline Business Case – List of Appendices

1. List of Stakeholders
2. Architect's RIBA Work Stage 2 OBC Report
3. Architect's 1:200 Drawings
4. Schedule of Accommodation
5. Comprehensive Investment Assessment (CIA) Model
6. Capital Cost Plan Report
7. Costed Risk Register
8. Elemental Lifecycle Cost Model
9. Long-Term Financial Model (LTFM)
10. Comparison of Procurement Routes
11. Accountancy Treatment
12. Scarborough Acute East Coast Services Review Phase One Report
13. Our Strategy 2018 – 2023
14. Options Appraisal for current ICU Oct 2016
15. OBC Long List Options to Short List Options analysis (slide deck)
16. Letter of support from North Yorkshire CCG
17. New Model of Service Delivery - article written by Dr Ed Smith for the Royal College of Physicians describing the new model of service delivery, which will be applied to this project
18. Care Quality Commission Report March 2020
19. Project Programme
20. BREEAM Pre Assessment Report
21. Green Travel Plan
22. Sustainable Procurement Plan
23. Scoping Note for Transport Statement
24. Highway Note 01
25. Equality Impact Assessment
26. Business Case Checklist
27. Risk Potential Assessment (RPA)
28. Required Services
29. Letter of support from HCV ICS
30. Pre-Application Letter –Scarborough Council Local Planning Authority

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Board of Directors – 25 November 2020
Quality Committee Minutes – 20 October 2020

Attendance: Lorraine Boyd (LB) (Chair), Heather McNair (HM), Jenny McAleese (JM), Stephen Holmberg (SH), Wendy Scott (WS), James Taylor (JT), Lynette Smith (LS), Lynda Provins (LP), Liam Wilson (LW), David Watson (DW), Matt Morgan (MM), Rhiannon Heraty (RH) (minutes)

Apologies for Absence: Caroline Johnson (CJ)

1. Welcome

LB welcomed everyone and declared the meeting as quorate.

2. Declaration of Interests

There were no declarations of interests declared.

3. Minutes of the meeting held on 22 September 2020

LS noted two small changes on P9 – the minutes should read 'LS said our workforce would be a risk if the wave exceeded those expectations' rather than 'as the wave' and '[i]t is not anticipated' was added to '[t]here will not be another national stand-down'. These have now been updated and the rest of the minutes were agreed as a true and accurate record.

4. Matters arising from the minutes and any outstanding actions

There were no matters arising from the minutes.

Action 4 – JT confirmed the Clinical Effectiveness Group will be picking up on these going forward. JT said we are collating various information streams that come into the Trust, which was started before the pandemic and has now restarted.

Action 36 – HM said these should not be combined but that CQC is on the agenda and TF will bring inpatient survey update to Committee in November.

Action 42 – HM confirmed the ward establishment review would not go to Executive Committee in time for November deadline so this was moved to December.

Action 44 – JT said DR has discussed this with primary care colleagues. JM flagged psychological harm as a concern she has raised before and said we need assurance as

there is more evidence around the negative impact that Covid is having on people without access to their normal treatment. JM said if DR is not able to offer clarity, we may need to look at other options for assurance. JT gave some assurance that communications are being increased with GP's and patients around our waiting list position. JT said there is a clinical summit planned for early November where this can also be discussed.

Action 45 – HM noted this and action 47 relate to the same action. TF will bring an update to November meeting.

5. Escalated Items

There were no items escalated from the Board or other Committees.

Focus on Risk

6. To receive the following updates on risks and related issues including any COVID-19 updates:

Performance Update

LS noted the new report format and welcomed feedback. She highlighted key issues and risks from the report.

LS noted the Emergency Care Standard (ECS) challenges around the need to swab and isolate patients until they receive their test results, which can take up to 12 hours. Some rapid assessments are being prioritised including ICU and maternity, and LS confirmed this is being worked on. LS added that we are in the midst of a capital scheme to create more isolation capacity on both sites to help with flow over the winter period as part of our winter plan implementation.

Routine care performance has improved and LS said we were tracking the national position in August (53%) at 51% whilst recognising significant backlogs. Routine diagnostic performance levels are also improving (53%) and some modalities are over 80% as services resume.

Cancer services have improved including 14 day fast-track, and we are currently tracking above the national position. Endoscopy remains the biggest concern within cancer pathways and we are now starting to see patients delayed for treatment going through these due to stand down of diagnostic procedures through the pandemic. LS said this warrants further conversation and confirmed that JT is also picking this up within the clinical harm reviews.

With regards to the Trust plan to restore services, there has been positive feedback both nationally and regionally that we are delivering more than anticipated in September despite challenging targets. Compared to our percentage of activity last year we have achieved the target for Outpatients and are also seeing improvement in some day cases through September. Ordinary elective levels have decreased against the restoration plan due to it being highly dependent on take up of extra contractual activity. Staff do not want to pick up extra shifts and we are currently looking at staff incentives. Another issue is that the Trust experienced reduced ability to fill short notice patient cancellations due to the requirement to self-isolate before surgery. Work is being done on whether it would be

reasonable in consultations to develop a holding list where patients would have to self-isolate whilst understanding that they may not get their surgery, and LS said a local lockdown may make this a more desirable option.
With regards to delivery of capacity, diagnostics achieved overall the same amount of activity as last September but this was predicated on colonoscopy doing more, but doesn't show the level of activity needed to get through backlogs. LS said it was testament to the staff that we have been able to deliver similar capacity to last year. LS noted that October will be more challenging as we are currently behind target on ordinary electives and Outpatients.

LS said we are currently in our winter planning phase and undergoing detailed scenario work, and we have been asked to submit a model to test our bed base. It is anticipated that if we reach 20% of our bed base this is when our elective programme is likely to be stood down and we are currently at 5% despite operational pressures including track and trace. WS said she had met with Liz Hill earlier today to explore how to increase activity in elective care and acknowledged the challenges with staffing and theatre capacity.

JM asked for a Covid update and noted the difficulty in returning to business as usual whilst managing Covid pressures. JM asked about the Nightingale facility use for West Yorkshire pressures and the impact this could have on staffing and activity levels. LS said in terms of Covid bed base pressures we are currently in Surge 1.2 with two wards open on the York site but these are within our management boundaries and we should not be seeing routine standing down of ordinary electives due to bed base pressure.

The greater impact is on workforce due to track and trace and consequently the primary reason for clinic cancellations and stand-down of elective services is due to staff having to isolate. LS confirmed that HM and JT have been working on IPC controls to reduce the risk of this. HM said she had been asked to revisit nurse staffing for the Nightingale facility and contact all who initially applied as they have to be ready within five days of stepping up and will need refresher training. It will be the equivalent of 25 WTE staff and a combination of anaesthetists, ODP's, nurses and HCA's.

JM asked about the national contract for the Independent Sector and LS confirmed that this ends in December 2020 rather than 2021. LS said there is an opportunity for more companies to join the supply chain such as providers for Ophthalmology and Endoscopy services but this is more likely to be an outsourcing arrangement. There is also the risk that the private sectors will have their own backlog and JM agreed that patients have been waiting for private treatment as well.

WS acknowledged a report that the Trust Head of Information has done and said the 7 day average for daily admissions for positive and suspected patients is 6 patients – this was 4.6 the week before and 3.3 the week before that. 7 day average Covid-19 bed occupancy is currently 35.1% - it was 30.5% the week before and 23.1% the week before that so it is increasing but only slightly compared to the first wave. There were 10 deaths in October. WS noted that NLAG have 45 positive patients compared to our 32 and are now seeing an increasing number of patients.

SH said that performance issues were discussed at Clinical Risk & Oversight Committee this morning and said there are two areas for assurance around waiting lists that are the biggest worry. Our ECS is currently bending under not yet normal attendance levels and that we have done a lot of work on this but may not be in a better position when attendance levels match demand. SH asked if people are sitting on the diagnostic waiting list as we can offer assurance once patients are on a pathway but these are pre-pathway

patients and need to be closely watched for risk stratification ahead of diagnosis. WS agreed and said this is an acute challenge in ED, and that we are working with the Emergency Care Intensive Support Team (ECIST) who are supporting improvements. There has been a struggle to adopt best practice in some areas and ECIST have suggested focusing ED on changeable areas to improve. SH asked for assurance around benchmarked lengths of stay and LS said this is difficult to provide as a lot of routine information has been stood down so this would need an audit. Our average length of stay is significantly lower than it was last year but they would need to look at specifics and find comparable data. JT said that pre-pandemic, work was done with elderly groups of patients and length of stay was reduced due to better flow and more regular ward rounds, which has been maintained. LB asked if there was any progress on Talk Before You Walk and whether this would impact the through-put. LS said this is being implemented from December and is modelled on an assumption of 25% reduction of type 3 attendances. This should help with type 3 but is not likely to have much impact on the fundamentals of type 1 attendances.

JM noted the difficulty that Covid numbers seem relatively low and that people are possibly dying with Covid rather than from it, whilst some people have undiagnosed conditions that could lead to death if not treated. WS agreed and noted that of the 32 positive patients, some are incidental findings rather than being admitted with Covid symptoms. It is important to get the balance right between Covid and business as usual. JM asked how they can help. LS said the prioritisation of cancer and fast-track is important due to risk of becoming non-curative as well as Cardiology, Cardio-Respiratory, Endoscopy and Ophthalmology. JT said the issue we have is the extra layers of protection needed for both staff and patients to treat patients safely and although the Covid numbers are lower than expected, it is still very present in our community and causing anxiety so mitigation and precautions are necessary but do slow processes down.

The Committee:

- **received and discussed the Chief Operating Officer's Performance Update Report**
- **noted the progress in the delivery of Phase 3 Elective Services Restoration and the Winter Plan**
- **were assured that the Trust is well sighted on the waiting list position, prioritising fast track, cancer and urgent cases with clinical risk and clinical harm reviews informing decision making.**
- **noted the continued challenge to performance and were assured that the Trust continues to work with system partners and Independent Sector to consider collaborative solutions to the risks and secure additional capacity and by the other outlined mitigating actions being undertaken**
- **recognised the risk to the delivery of the plans presented by the emergence of a second wave of COVID-19 and associated issues and that appropriate mitigating actions are being identified**

Action: WS/LS to look at average lengths of stay benchmarking data and bring back to Committee

Patient Safety Updates including:

i) Nurse Staffing (CN2)

HM confirmed this is a mandated report and said there is no significant harm with regards to staffing levels but the bank agency bill is significant. HM said there have been challenges re staffing wards and track and trace has had a big impact - 15 staff in CCU at Scarborough were at home last week, which was devastating for the ward and continuity of services for patients. This combined with parents whose children have been sent home from school has been difficult.

There is a pipeline of newly qualified overseas nurses – 55 in York and 13 in Scarborough – and our vacancy rates are 5.2% and 15.7% respectively. Scarborough has a bigger issue but it is better than it previously has been.

There are some retention issues that are being addressed via collaboration with the University of York around two lecturer practitioner posts, which is a positive initiative that is jointly funded. Another Covid impact is around HCA recruitment – we have always struggled to recruit HCA's at York but not Scarborough. The role went to advert last month and there were 105 applications for York, which is unheard of and is likely due to the issues with the tourism and hospitality industry, and there are consequently no HCA vacancies remaining.

SH asked what the situation is with recruiting over establishment and whether we are allowed to do this. HM said she had never been in the position to do this but it would be her preference to do so as there is always a flux of leavers, maternity leave and staff moving around departments. With regards to nurse staffing, once we have our international nurses next year and Coventry University graduates join in the summer, it is hoped there will be very little need for any more international nurses re our ongoing requirements so from next summer we will look to recruit local graduates from York and Coventry universities

JM said this was encouraging to hear and asked about the retention and reception of new international nurses. HM said there is work being done around this and that there is no evidence of a lack of retention for international recruits. There is evidence that they move around within the hospital but the number of lost staff is in single digits. HM said Care Group 3 (Surgery) has in the past had the highest level of staff turnover re newly qualified nurses that leave within 24 months and we are looking into why this is happening as surgery is normally very good at retaining staff. SH said this is unusual and asked if exit interviews are giving any insight. HM said the exit interview process is not robust enough so there is not a lot of evidence to explain why this is happening but they are now tracking any staff that have given their notice to gain more insight.

The Committee:

- **received and discussed the Nurse Staffing Report**
- **were assured that delivery of safe nursing remains dynamic and o escalation of associated risk or harm has been necessary during the past month**
- **noted the limitations of full rate data as a result of bed base variations during the course of the month**
- **noted the continued challenge presented by the staffing implications from the ongoing pandemic, including the call to prepare to support the staffing of the Harrogate Nightingale Hospital**

Action: LP to refer exit interview procedure to Resources Committee for assurance

ii) Infection control risks (CN7, CN8)

HM gave an overview of the report that described how we have gone about the QIA processes and the mitigations that have been put in place re social distancing. HM said the biggest issue is showing evidence of compliance and said this has been audited across all sites as well as exploring what other mitigation is being done and how risks are being flagged for patient social distancing. HM said we are mindful of the CQC report for William Hart hospital that raised concerns around PPE and social distancing and assurance work is being carried out for our sites.

HM said there is a risk around crowding in ED, which will get worse in winter. HM gave the Committee assurance that this is not being taken lightly and noted that it is an iterative piece of work that needs reviewing on a daily basis as York moving to Tier 2 has meant that visiting has been cancelled.

JM asked for clarity on what was required as this report was marked for approval. HM confirmed it was for approval of the approach being undertaken around IPC and social distancing. HM apologised for any lack of clarity and said this approach allows us to look back at why things went wrong, what the intended approach was and to learn from mistakes. LB confirmed endorsement of the risk management process that has been developed.

SH said that C.Diff risk does not seem to be going away despite changes in practice and improvements. SH said we do not get a breakdown of where the infections are and noted that this might be useful to track in a more granular way to focus on local isolated problems. JT said that a related issue is antimicrobial stewardship, and said we are looking at this as well as looking at doing audits on the work being done. HM noted that we are seeing half the number of C.Diff cases compared to last year, and added this could be due to the heightened IPC precautions or the specific work around C.Diff. HM noted that there have also been less patients in the hospital this year.

The Committee:

- **received and discussed the Social Distancing QIA Summary paper and were verbally updated on other IPC issues**
- **endorsed the outlined social distancing risk process that has been developed**
- **noted the range of mitigating actions being taken to minimise the risk**
- **noted the challenges to fully maintaining social distancing in all areas associated with rising activity levels as a result of restart of services and increasing non elective activity**
- **noted a continued gap in assurance relating to Clostridium difficult infection control**

Action: HM to bring IPC audit results to next Committee meeting

Action: HM to bring C.Diff paper with more detail and historical plotting of previous infections to next Committee meeting

Action: JT to bring update on antimicrobial stewardship re IPC control risks to next Committee meeting

iii) Potential patient harms and issues contributing to this risk (COO23, MD5 patient harms associated with Covid-related service delivery risks)

LB noted papers B3 and B4. JT said he has spoken to the Care Group Directors and consultants about patient harms and confirmed that the cancer harm review report will be available next month. This will show that we are reporting an increased number of cancer harm reviews that occur when the pathway exceeds 104 days. We are seeing an increase in numbers, particularly in colorectal and upper GI pathways. JT has started to receive some isolated anecdotal data but needs to collect more to identify themes and trends.

LB asked DR about action 44 and DR said he didn't know how this could be measured. LS said the clinical harm process for cancer is purely physical but that the Living Well and Beyond Team were looking at how to capture patient psychological impact. LB said the biggest source of anxiety is the not knowing and HM said this is not just related to cancer. JT said we know that patients are suffering from psychological harm and the official definition is 28 continuous days of mental health issues or psychological harm before this is labelled as moderate harm, which is very difficult to measure. It is becoming increasingly prevalent in both patients and staff. LB said we need further clarity but that the rest may be outside our capacity.

The Committee:

- **received and discussed a verbal update from the October Clinical Risk and Oversight Committee meeting and minutes from the September meeting**

Action: LS to raise how to capture psychological harm at Cancer Delivery Group for discussion

Action: JT to bring cancer harm review report and any further data around patient harm to next Committee meeting

iv) Items escalated by Care Groups via Executive Quality Group including new and emerging quality or performance risks for information or discussion

There were no additional items for discussion that are not already included in the agenda.

The Committee:

- **received the minutes from the September Executive Quality Committee**

v) Consider other potential new or emerging risks (IBR)

SH asked for an update on complaints. HM said she would bring the quarterly complaints report to the next Committee meeting. HM said the average response time for Care Group 1 complaints is 33 days compared to the 30 day target but that there are some outstanding complaints exceeding 100 days due to demands for face to face meetings. These have been offered as well as virtual meetings but complainants do not

want to come into the hospital during the pandemic. SR asked if there was a better way to see this on the IBR and HM said she would look at this and speak to Nicky Slater about more granular detail.

LB asked if the Same Day Emergency Access statistics in the ED conversion rate count as SDEC or as a different number. LS said they are still classed as admissions in data recording but admitted into SDEC. The average length of stay and long waits in ED (8 hours or more) have dropped significantly from last year and we need to check that these patients are going to SDEC. There is still work to do around data processes for SDEC and there is a Data Working Group looking at the SDEC dashboard that monitors usage. More information can be provided on SDEC than is listed in the IBR and LB said this would be useful to understand as this is one of our key mitigations.

The Committee:

- **received and discussed the Integrated Business Report**

Action: HM to bring quarterly complaints report to next Committee meeting and look at more granular presentation of complaints data on IBR

vi) Quarterly Board Assurance Framework Review

LP said this work follows on from a risk session held with Mike Gill (MG) at the Board, where MG suggested a number of amendments including providing greater definition to the risk by adding cause and effect. LP confirmed she has made a start but needs to work through all risks with the idea that some risks are being reassigned to just one lead. LP referred to Appendix 2 re trend analysis, which MG demonstrated in the session, and said she has spoken to Simon Morritt about putting a session on for LP and CJ to speak to MG about risk in general.

WS noted there were some months missing in Appendix 2 and LP said this was meant to be quarterly but was brought to Board more often and so the months reflect when any changes to scores were made. SH said the left hand column is not dynamic and that the mitigations do not appear to have affected the risk, therefore not projecting the ideal situation.

There was a discussion about how each risk should be assigned and handled. DW asked if those assigned risks should be invited to the relevant Committee or Board to discuss the risk and any associated actions taken. SH and MM supported DW and SH said a conversation with the relevant Executive would be a good way to evidence action on the BAF. LP suggested that this conversation could follow each paper as an update or via a reflection session at the end of the meeting to review the Committee BAF risks. MM said he had not seen evidence of Committees or Board being kept up to date on risks. DW suggested an hour within Board to go through each risk with the Executive responsible to provide an update for the Board to then decide which Committee the Executive reports to in future. DW asked that the minutes reflect the concerns that the Committee has around the level of risk the Trust is currently running with and that further assurance is needed from individual risk holders around how these are being managed.

The Committee:

- **received and discussed the BAF Quarterly Report**

- **were supportive of the improvement work underway on the BAF and CRR, noting that this is a work in progress, requiring further discussion with Executive Teams and CEO**
- **were concerned by the level of risk the Trust appears to be carrying**

Action: LP to discuss BAF Review with Simon Morritt and Sue Symington and provide an update at next Committee meeting

vii) Quarterly Corporate Risk Register Review

This was discussed in the Quarterly Board Assurance Framework Review.

The Committee:

- **received and discussed the CRR Quarterly Review**
- **noted the limitations of the presentation format of the CRR**
- **acknowledged the importance of the ongoing review of the content and presentation of the CRR**

7. Focus on Quality Assurance (BAF 1)

- ### Quality Report

LP said there are some sections that are yet to be finalised but that this needs to go to Board for approval so that it can go to stakeholders in November and be published in December. JM asked if HM could identify someone in the Chief Nurse team to look at reformatting the report for next year. SH noted that it is almost out of date and LP said this would normally be finalised in May to go out with the annual report but we took the option to defer which had been made available nationally due to the pandemic.

The Committee:

- **received and Quality Report, noting the gaps yet to be completed**
- **recommended Board to approve the Report prior to it being forwarded to stakeholders for comment**

- ### Health & Safety Report

HM confirmed that this is a regulatory report and no further discussion was required.

The Committee:

- **received the Health and Safety Report for information and assurance as a regulatory requirement**

- ### CQC Audit Report

HM confirmed that this is a regulatory report and no further discussion was required. HM said that she, WS and JT have spoken about ED performance and this remains an area

for concern as both sites were deemed inadequate, and further investigations would show limited progress.

SH noted the new format as greatly improved although it is still not quite clear on the risk section.

The Committee:

- **received the CQC Update Report for information and assurance as a regulatory requirement**

- **Governance/Structure Update**

LW gave an overview of the report and confirmed the structures for Care Groups will be finalised in November. HM said this was long overdue in terms of a line of sight between wards and Board and mapping progress. JM said she would like MG to be involved in this to review structure and gave her full support as Audit Chair.

SH said he was not clear on Executive Committee position. LP confirmed that Executive Committee is the senior decision-making Committee of the Trust. LS said there is still work to do around the Care Group post-implementation review to ensure appropriate escalation upwards from Care Groups Boards for performance, operations and finance. The current structure describes the many working groups and ensures the feed upwards from Care Groups, and it is due to be completed at the end of November.

LB confirmed endorsement of travel and progress to date with an aim for either the Committee or Board to approve in its entirety once finalised.

The Committee:

- **received and discussed the Proposed Corporate Clinical Governance Structure**
- **noted the progress to date and endorsed the direction of travel**
- **look forward to further update on the development of the complimentary Care Group clinical governance processes and the Ward to Board lines of sight.**

- **Any other assurance from Medical Director (MD Report), including sepsis assurance update (MD4, MD5, MD6a&b)**

JT gave an overview of the report and confirmed the usability of the Datix system is being looked into following feedback and how we can improve reporting. With regards to outlier status for orthopaedic work, this is still being disputed within the Trust and colleagues believe there is a data quality issue, which is being worked through. JT said we are under-reporting our position in terms of seven day services. JT said Surgery and Paediatrics have assured him that they are seeing 100% of patients daily but this is not what is being recorded. There has been feedback regarding the usability of the CPD system, which is being looked at. Weekend compliance remains the biggest issue and will remain a challenge when delivering a seven day service. This is being monitored regularly and discussed every Monday with the Care Group Directors.

SH said we have to find a way around reporting issues and asked that where there is no compliance with standards and concerns around senior review, is this because there is not

the capacity in the system for people to do the work or are people simply not job planning. JT said generally the biggest concern around post-take reviews and senior reviews is Scarborough. He said there is a medical staffing issue as well as insufficient staff, job planning issues and behavioural issues but that there is also a need for quality improvement work. SH said it would be helpful for key issues to be identified so that the Committee knows where the issues lie and what it should be principally dealing with.

JT said if we can create an improvement culture in Scarborough, it makes it a more attractive place to recruit and retain staff. One of the issues for Scarborough is the level of support that can be offered from York colleagues and one of the barriers to this is the feeling from York staff that Scarborough staff are not supporting themselves. MM said it sounded like York and Scarborough are two organisations rather than one single unified Trust delivering a service. MM asked how we are tackling this attitude. JT said he is speaking with colleagues and asking for improvement work in Scarborough as well as a conversation to improve working relationships between sites. JT added that he had four physicians ready to go to Scarborough before the pandemic started and said the current plan is for a conversation between Care Group 1 and 2 around what support will look like in the future. JT added that he thought that improvement work is required in Scarborough and that the Committee needs to support it. HM queried whether the Care Group structure hasn't helped in that all other Care Groups are cross-site except 1 and 2 and whether the case for mutual aid would be different if this was not the case. JT said there is definitely a feeling in Scarborough that they are under-represented and the reorganisation and combination of the Care Groups should be considered although he was hesitant to completely endorse it at this stage. WS noted that Simon Morritt gave the commitment at Executive Committee that the structure would not change so this conversation may need to happen elsewhere.

The Committee:

- **received and discussed the Medical Director Report**
- **noted the gaps in assurance relating to incident reporting and support the work underway to understand and address the factors impacting on reporting**
- **noted, with concern, the continued gap in assurance relating to seven day services and post take review and the contribution of limited assurance on the underpinning data, as a result of inconsistent recording and capture and variable improvement culture across the organisation.**
- **gained assurance from the actions outlined to address overdue baseline assessments, audits and outlier reports**
- **noted gaps in assurance relating to Risk Registers and supported the plan outlined to make rapid improvements**
- **noted gaps in assurance in relation to Duty of Candour and welcomed the development of the new Duty of Candour policy and accompanying programme of training in mitigation**
- **noted the gaps in assurance regarding supporting clinical documentation (policies, procedures and guidelines) and look forward to receiving the proposed improvement plan in November 2020**

- **Continuity of Carer in midwifery services**

LB confirmed this report as statutory and was to be received by the Committee for information only. MM said it does not provide an update on implementation and is an almost identical report each month, and asked if there could be an action plan provided for next month.

The Committee:

- **received the Community of Carer in Midwifery Report for information**

Action: HM to provide Continuity of Carer action plan at next Committee meeting

- **Action Plan to reduce post-partum haemorrhage update**

SH asked HM what she thought the main issue has been as this has been going on for a while. HM said Dr Kathleen Merrick has been working with the regional team around what other Trusts are doing and the only thing apart from better risk assessment and earlier intervention is the site where the Syntonetrine injection is being given – this was traditionally given in the leg but some places have started giving it in the arm for faster absorption. This will be re-audited in Q4 but it remains unclear why we are currently an outlier.

The Committee:

- **received and discussed the Action Plan to Reduce PPH Update**

Action: HM to bring audit report and results on why we are an outlier for post-partum haemorrhage to Committee

- **Q2 Guardian of Safer Working Report**

LB noted that the Committee were asked to receive this report and discuss as a regulatory requirement. JT said a risk of this is the pandemic and redeployment of junior doctor but added that we are following guidance. The Committee noted its congratulations to the winners and finalists of the Junior Doctor Awards.

MM said it was good to see that our exception reporting trends are much lower this year.

The Committee:

- **received and discussed the Guardian of Safer Working Report as a regulatory requirement**

Focus on Governance and Policies

8. Consideration of items to be escalated to the Board or other Committees

The Committee agreed the following items to be escalated to the Board:

For Approval:

- The Committee recommended approval of the Quality Report by Board once finalised

For information:

- Information on progress of phase 3 implementation
- Safe nurse staffing
- Social distancing QIA discussions
- Statutory reports that have been received for information
- JM asked to escalate the harms associated with patients remaining on waiting lists

9. Any other business

There was no further business to discuss.

10. Time and Date of next meeting

The next meeting will be held on 17 November 2020 by teleconference. Dial-in details will follow.

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
25/9/19	1.	Progress report on 14 hour consultant review	JT	Nov 20
27/11/19	4.	JT to consolidate information streams from multiple external sources into, & within the Trust.	JT	Jan 21 (Q4)
21.07.20	34	KH to provide cancer update, including staging data, to November Committee meeting	KH	Nov 20
21.07.20	36	CJ and TF to combine inpatient survey findings with current CQC position to bring to next Committee	CJ TF	Completed
21.07.20	37	LP/CJ to provide update on Committee structure at next Committee meeting	LP/CJ	Completed
18.08.20	42	HM to bring the ward establishment review back in November 2020	HM	Dec 20

18.08.20	43	JT/CJ to provide update/feedback from Risk & Oversight Committee	JT CJ	Ongoing
18.08.20	44	DR to raise importance of GP input and handling of psychological harm at next Clinical Risk & Oversight Committee	DR	Oct 20
18.08.20	45	TF to discuss Estates & Facilities involvement around Inpatient Survey at next LLP Management Group meeting and provide update to Committee	TF	Nov 20
18.08.20	46	HM to provide Quality Committee with update on maternity action plan to reduce post-partum bleeds in October	HM	Oct 20
22.09.20	47	TF to circulate update on Estates & Facilities involvement in Inpatient Survey	TF	Completed
22.09.20	48	TF to circulate written brief around visiting guidelines to Committee	TF	Completed
22.09.20	49	JT to bring sepsis report to Committee in c.4-6 months - date to be confirmed once data received	JT	TBC
22.09.20	50	HM to circulate latest IPC report	HM	Completed
22.09.20	51	CJ to bring CQC audit report and development update to October meeting	CJ	Completed
22.09.20	52	HM to bring accreditation process report which relates to the Perfect Ward	HM	Feb 21
22.09.20	53	HM to bring nutrition report priorities to December meeting for discussion	HM	Dec 20
22.09.20	54	CJ to provide monthly update on patient reporting and reviews	CJ	Ongoing
20.10.20	55	WS/LS to look at average lengths of stay benchmarking data and bring back to Committee	WS LS	Nov 20
20.10.20	56	LP to refer exit interview procedure to Resources Committee for assurance	LP	Nov 20

20.10.20	57	HM to bring IPC audit results to next Committee meeting	HM	Nov 20
20.10.20	58	HM to bring C.Diff paper with more detail and historical plotting of previous infections to next Committee meeting	HM	Nov 20
20.10.20	59	JT to bring update on antimicrobial stewardship re IPC control risks	JT	Jan 21
20.10.20	60	LS to raise how to capture psychological harm at Cancer Delivery Group for discussion	LS	Nov 20
20.10.20	61	JT to bring cancer harm review report and any further data around patient harm to next Committee meeting	JT	Nov 20
20.10.20	62	HM to bring quarterly complaints report to next Committee meeting and look at more granular presentation of complaints data on IBR	HM	Nov 20
20.10.20	63	LP to discuss BAF Review with Simon Morritt and Sue Symington and provide BAF update at next Committee meeting	LP	Nov 20
20.10.20	64	HM to provide Continuity of Carer action plan at next Committee meeting	HM	Nov 20
20.10.20	65	HM to bring audit report and results on why we are an outlier for post-partum haemorrhage to Committee	HM	Jan 21

Board of Directors – 25 November 2020
Resources Committee Minutes – 20 October 2020

Attendance: Lynne Mellor (LM) (Chair), Jim Dillon (JD), David Watson (DW), Andrew Bertram (AB), Polly McMeekin (PM), Delroy Beverley (DB), Andrew Bennett (ABe), John Dickinson (JDi), Malcolm Veigus (MV), Liz Johnson-Betts (LJB), Kevin Beatson (KB), Adrian Shakeshaft (AS), Lynda Provins (LP), Richard Kafergy (RK), Penny Gilyard (PG), Joanne Best (minute taker)

Apologies: Dylan Roberts (DR),

The following staff were stood down from attending due to the Covid 19 situation: Graham Lamb, Steven Kitching

1. Welcome

LM welcomed everyone to the meeting, declaring the meeting quorate.

2. Declaration of Interests

There were no changes to the declarations and no one declared any conflicts of interest arising from the agenda.

3. Minutes of the meeting held on 22 September 2020

The minutes of the meeting held on 22 September 2020 were approved as a correct record.

4. Matters arising from the minutes and any outstanding actions

LM reviewed the action log with the Committee:

Item 1 – Highlight new limited assurance audits in your committee reports – LM noted this was ongoing on a monthly basis.

Item 2 – Provide update on GIRFT – AB confirmed that Richard Khafagy would provide an update on GIRFT during today's meeting.

Item 3 – Papers to be submitted in line with Committee deadlines and item 4 – Minutes from Committees reporting into Resources Committee to highlight items for escalation or be FIO – LM stated both will be ongoing on a monthly basis and therefore

will discuss them with LP outside the meeting to consider if monthly reports should continue or if they should be included in the Resources Committee Terms of Reference.

Action: LP / LM

Item 5 – LLP Report on Lessons Learnt during the Covid period – DB confirmed Andrew Bennett will update the Committee during today's meeting.

Item 6 - To produce a plan for how we engage the Board in what is involved in digital transformation – AS confirmed the plan is on schedule to be shared with the Committee at the November meeting.

Action: DR

Item 7 – Artificial Intelligence Report to come through - KB confirmed Donald Richardson will join today's meeting and share a presentation with the Committee.

Item 8 – Sustainability Team Management to move from Trust to Estates Management – DB confirmed a verbal update will be given to the Committee during today's meeting.

Item 9 - Update on manual workarounds to use before CAFM system is in place Update on handsets to support CAFM system – DB confirmed an update would be given to the Committee today.

Item 10 – Provide update COVID spend bench mark - AB confirmed the Benchmark report is on today's agenda.

Item 11 – Provide an update on the people plan – to include colour coding and a clearer timeline – LM stated this item was ongoing as had been discussed at last month's meeting.

Item 12 – Circulate a list of apprenticeships the Trust deliver via email – LM confirmed this had been completed and should be removed from the Log.

Item 13 - To review if the use of tablets on the ward can be used to support communication with patients families linking in with the LLP and the perfect ward programme – AS confirmed the action log should record December as the completion date.

Item 14 – Present an update on video consultation – LM confirmed this is due in December.

Item 15 – To submit a report on the CDIO initial recommendations – LM confirmed this is a monthly update.

5. Executive Reports

YTHFMLLP

CAFM (Computer Aided Facilities Management) - DB addressed the Committee stating for some time there had been an intention to invest in a computer system which will allow them to map and track the compliance of KPI measures across LLP activities. DB

confirmed an order has now been placed for the CAFM system and asked JDi to deliver an update to the Committee.

JDi informed the Committee the aim is to upgrade the current Backtraq system to Micad. The Backtraq system uses windows mobile devises which are now obsolete with a number of these units now failing. Additional / replacement devises cost approximately £1,000 a handset indicating a cost implication of approximately £40k to support the system as it is now.

JDi gave the Committee an overview of the capabilities of the Micad system noting the contract allows access to all modules and upgrades within the Micad suite. This system will enable the collection of data from when a job is reported to completion it will provide evidence in relation to performance, also having the capability to support electronic purchasing and provide audit information along with meaningful benchmark data.

The new system will allow live monitoring and include data tagging of all rooms within the organisation. Micad have also agreed to implement improvements to their system to support the LLP's requirements.

The proposal is to implement the Micad system for one year at a cost of £25k, the system uses mobile phone technology therefore there will be an additional cost to purchase phones. An app would be down loaded which would allow the data to be transferred to a new system in the future if required.

PG told the committee that a key element of this work is to provide assurance for key areas which the LLP are currently not able to report on, noting that the Micad system is an interim measure as detailed within the report and will allow a full procurement exercise to take place. Working in partnership with the Trusts IT colleagues it will provide sufficient time to conduct the exercise appropriately along with the creation of a detailed implementation plan to support the requirements of both the Trust and the LLP.

JD noted the system sounds good but stressed concern the system will be implemented for only 12 months taking into account the costs and the amount of work that will be involved with training etc. asking why this system had been chosen?

JDi – confirmed Micad is used by 170 Trusts throughout the UK therefore seen as a market leader, it is considerably cheaper than other systems which have been investigated who are on the procurement framework with costs in the region of £200,000 to implement a system along with £60k licensing fees a year in relation to £17k licensing fees for the Micad system.

DB confirmed the likelihood is that the Micad system will be the preferred route and takes confidence from a large number of Trusts already using the system, noting the 12 months exercise is a component of the procurement process and will allow the LLP to explore fully which elements of the system work well and which don't.

JD noted he was reassured by these responses.

LM - The report noted other systems had been explored fully and knowing the Micad system is a market leader as it is used by 170 other Trusts why does the Trust need to have a full procurement exercise which will take 12 months? and could costs be saved by agreeing a deal with them now rather than in 12 months?

DB confirmed the 12 month trial is a component of the procurement process which must be adhered to.

AB also stated the Trust is subject to public sector procurement legislation and the 12 month trial is part of that process.

LM asked if the cost of purchasing the Micad system as noted in the report could be checked and amended if necessary. Page 34 indicates a requirement of £64k to purchase Micad and page 37 indicates £63,543.

PG confirmed this was the required cost to implement the changes.

LM noted the Committees assurance for this report confirming the report will now be directed to the Executive Committee for approval.

Compliance Report – LJB stated of the 120 KPI's reported for September 64 are green, showing an improvement on August which recorded 57 green, the additional 7 moved from amber to green, leaving 10 in amber for September with 7 KPI's remaining in red.

Sickness absence remains an area of concern and although sickness absences numbers had reduced 4 of the 7 KPI's recorded remain red. The KPI for very high risk cleaning audit has shown a further deterioration from August to September with a drop of 0.5% but remained in amber. It was noted Bridlington had remained in green but it had dropped by 0.39%, York had improved by 0.54% and remained in amber, Scarborough moved from amber to green for September but unfortunately Selby also dropped by 0.85%. This remains an area of concern and additional work is being undertaken. The contract management meeting was held on 7th October and these issues where discussed in detail with service leads and service area managers, assurance was given that these issues are being addressed.

The Internal Compliance meeting was held at the end of last week both the East Coast and West Zone reported an increase in positive scores for the audits for very high risk areas demonstrating changes implemented from late September into October are having a positive impact.

Catering Hygiene audits for Selby and Malton have previously been highlighted as areas of concern but following audits of both sites during September they have both moved from amber to green. It was noted areas of work which are preventing other sites moving from amber to green are covered under the backlog maintenance plan, it has been confirmed these works will be completed by the end of this financial year.

LJB stated the Committee had asked for additional assurance during the September meeting with regard to KPI's which the LLP are still not able to measure, noting their concern about the impact on service delivery and what this might mean for patient care. This was not addressed in the main Compliance report therefore LJB referred the Committee to the previously submitted addendum for the Compliance Report.

From last week an additional nine KPI's had started to be monitored, these will be included in the December report. This reduces the number of KPI's the LLP are not able to report on by approximately 1/3.

Looking at any risk to patients / patient care, service leads had given assurance they are managing the KPIs performance to ensure there is no impact on patient care noting this

may result in other areas which would not impact on patients / patient care not being addressed.

LJB confirmed in relation to the other KPI's not being recorded if necessary a work around solution could be used but this would mean a retrograde step which may involve dockets. This would be a labour intensive solution and could not be completed within the current budget. The preference would be to wait for the CAFM system to be introduced noting the 23KPI's not measured could be addressed first.

MV stated that single issue meetings have commenced with the entire team to look at why the domestics are returning red KPI's with the responses filtered into two areas, transactional in terms of cleaning and transformational. Exploring both, he stated the transactional issues would appear easily remedied if good quality software was available. This has been tested by reintroducing old tablets in to the system and resulted in good quality data being made available which in turn was shared with the domestic on the ward. This is a daily process with which domestics appear to be more invested in as they are able to view their performance based on the digital output delivered by these tablets. This appears to have had an impact on individuals acknowledging how their performance impacts on the overall service. Also exploring what makes a good quality domestic assistant with the possibility of developing career grades for domestics as it would appear that people are using this role as an entry level into the NHS with the intention of moving into healthcare, which is having a big impact on retention numbers. The hope is if career grades are developed and individual progress to supervisory roles some of the cultural issues will be addressed and improved.

LM thanked MV for his brief update and asked if once the finding with regards to the transactional and transformation changes have been completed could he report back to the Committee.

Action: MV

JD acknowledged career grades for domestic staff is a positive move and a good way of motivating people along with giving flexibility to the ongoing needs of the organisation.

LM – was assured improvements are being made although noted her concern around the critical areas such as food waste and cleaning which had been highlighted at previous meetings.

LM referred to page 26 of the LLP Compliance report noting the reference to the Trust tasking a Matron with supporting reducing food waste, she stated this is a sizable task and enquired if this is just one Matron? If so, is this adequate or is further support required? LM requested the Committee be updated at a further meeting.

Action: LJB / DB

Lessons Learnt – DB noted when he commenced in post the Trust was in the midst of a global pandemic and lessons learnt report from an LLP perspective had been requested.
ABe told the Committee section 2 of the paper gives a brief insight of additional requirements and response of the LLP to support the Trusts preparation as the first wave of the Covid Pandemic reached the UK and North Yorkshire and the additional activities requested by the Trust and how the LLP addressed them. Section 3 covers the resources, health and safety challenges and communication challenges faced by the service, and highlights some of the main lessons learned by service leads from their Covid experiences. Suggesting the two main areas of the report for the Committee to focus on

should be the resources section which highlights the pace which staff had to be recruited and trained to meet the increased demands of activity for cleaning of the two main sites and the communication section. The LLP had good communications with the Trusts Silver and Gold Command supporting the provision of funds to support any additional requests. But acknowledging there were occasions when communication was not so good. Section 4 looks at space utilisation moving forwards and flexible space which could be more easily segregated should a second wave of the Pandemic occur.

For some time the Trust has focused on reducing the estate footprint to support efficiency, highlighting the Pandemic had created a need to increase the footprint as additional space was required to support operational requirements and social distancing. The LLP noted their involvement in supporting projects to gain off site accommodation. ABe asked to what extent the LLP should be challenging the return of these services to the Trusts site

JD thanked ABe for the very comprehensive report.

LM noted the report had assured her and thanked everyone within the LLP for their efforts supporting the Trust during the Covid pandemic. LM suggested an executive summary report could be developed highlighting some of the achievements during this time. Highlighting the report refers to LLP as a 'silent service' and it would be good to emphasize the efforts made by everyone including porters, security guards etc to support the Trust highlighting their achievements and it would be good to ensure that a clear action plan is developed from the lessons learnt.

Action: ABe/DB

LM referred to ABe's question as to the extent to which the LLP should challenge the return of services to the Trusts sites since the pandemic.

AB responded confirming the LLP had been included in the Operations team discussion in relation to the return of services to site, highlighting the space discussion included the Community Stadium but noting there had been further delays with its completion.

Sustainability – DB stated a workshop will take place during November to map all sustainability functions and determine if they sit within the LLP or the Trust. A report highlighting these findings will be given to the Committee either December / January.

Action: DB

Finance

GIRFT – AB explained GIRFT is getting it right first time and derives from an initiative by a surgeon from the royal national orthopaedic hospital who when undertaking a review of the orthopedic department realised there was a vast variation in clinical practices within the department and challenged these variations. It was picked up nationally by the DOH and NHSE/I and a national GIRFT team has been formed. The GIRFT principles are being rolled out across an expanding number of specialties.

RK introduced himself to the Committee stating he is a urologist with the Trust and has been working on GIRFT for approximately 12 months; he confirmed the GIRFT reviews have been ongoing for nearly 4 years. National work streams which were originally specialty based but have now spread to other specialties including medicine and clinical support services confirming GIRFT is a developing programme. Submitted data is collated

and discussed at a ‘deep dive’ meeting where agreed strategies are developed with a series of review meetings to follow.

RK discussed the direction of travel of the GIRFT programme noting the expectation it will focus on specific diseases which are in the public domain. The Trust collates data using a dashboard which RK shared and explained to the Committee, he discussed how the data is analysed and how new standards are derived along with objectives to support the department achieve the new standards.

RK discussed the 5 recurring themes which have come out of the review. Variation, measuring activity, material resources, recruitment and staffing resource and clinical harm review. He continued to give an overview of each of these, explaining to the Committee variation is acceptable with justification and when variation is not acceptable. Stating the clinical harm review is an ongoing project with the expectation NHSI/E will be involved looking for instant patterns and changes to resource which could explain these changes.

Donald Richardson joined the meeting.

AB thanked RK for his comprehensive, concise presentation acknowledging how GIRFT links with the Quality and Safety agenda.

LM confirmed the presentation had given the Committee a good insight to the overall process and was assured the Trust is constantly looking at how it can make improvements.

JD stated he was assured the Trust is working to learn from their own and others best practice and asked if when looking at others best practice how they will be reviewed. He also stressed it would be refreshing if GIRFT could be applied to non-clinical areas.

RK responded to JD stating that GIRFT work is confidential, therefore does not share which hospital the best practice has derived from, stating he would feed this comment back to GIRFT team. He confirmed procurement is included in the GIRFT plan, but suggests it may have been delayed due to the Covid situation and would expect once it commences it will permeate across the whole organisation.

AB confirmed Procurement will be involved with GIRFT imminently, noting the Trust does have access to data from the model hospital project which is closely aligned to GIRFT. This offers costs in relation to peers and although not as structured or nationally supported as the GIRFT programme it has supported the Trust to action a reduction in the number of Internal Audit days.

AB confirmed this is the last month of the retrospective top up process noting as expected for September the Trust achieved an I&E balance. The trueing up value for September was £3.7m which exceeds the average request of £1.5m by £2.3m, noting the increase for month 6 is consistent with the Trust’s peers.

AB noted there are three reasons for this increase, firstly the retrospective pay award for doctors which was nationally administered, back dated to April and paid in September and equated to just over £800,000, second reason related to aborted capital schemes giving an example of changes which had been made to a children’s ward at Scarborough Hospital which will now not be going ahead as planned and the third reason being that activity has increased as part of the Trust’s recovery programme.

AB confirmed from October the Trust will move to the new financial regime as outlined to the Board last month and the I&E plan for the second half of the year will be submitted on 27 October once it has been finalised and will be shared at the next Board meeting in November.

Covid Cost Benchmarking – AB, following a request at a previous meeting Audit Yorkshire had been appointed to review Covid expenditure and delivered an anonymized report which provides an overview of the types of expenditure claimed for by a number of providers.

Referring to the table on page 65 of the Resources Committee pack which gives an insight into what Trusts had been claiming for and calculates Covid spend as a % of operating expenditure. The expectation of NHSE/I was that Covid costs would be around 4 – 6% of operational expenditure for an Acute Trust which did not have any additional costs such as supporting a Nightingale Unit or contributing to additional PPE requirements. Therefore this report should provide assurance that the Trust's spend is as expected noting all requested costs submitted under the trueing up programme have been met.

LM was assured by the Audit Yorkshire Report and asked AB if given that NHSE/I advised NHS organisations could seek reimbursement of any genuine and reasonable costs incurred due to the COVID-19 pandemic and noting the lack of consistency between all of the anonymised organisations the audit looked at could this report be of benefit to others or is it specific to Yorkshire and could the benefits of the audit be marketed and shared with other areas?

AB responded noting Audit Yorkshire had been able to access the data of other organisations within the Yorkshire patch, as finance managers had agreed to share their data for the report. AB suggest in hindsight this could have been marketed but as the current regime of retrospective top up ceases at the end of September he is not sure the report would be of benefit moving forward. AB confirmed as at 1st October through to March a Covid allocation of £12m will be issued with the assumption of a Covid spend of approximately £2m a month with no further resource available but confirmed he would discuss the possibilities of sharing the report with Helen Kemp- Taylor.

Action: AB

LM stated this could be a retrospective opportunity noting page 57 the report states a significant difference 'of the four mental health organisations with two reclaiming costs for additional out of area capacity. However, there is a significant difference in value reclaimed (£377k and £16k)' and perhaps a small fee for the work that Audit Yorkshire have carried out could support the amount that they could reclaim. AB confirmed he would discuss the matter further.

Action: AB

<u>Workforce</u>

PM stated she would deliver a brief update of the headlines as noted in the IBR.

Retention - There are some very positive headlines in relation to the Trust Stability index which is the retention rate noting an improvement in the retention rate of 1.1% giving a retention level of 89.8%, using model hospital as a benchmark the Trust has now moved from low to medium to medium to high.

Appraisal – PM noted appraisals had been discussed at last month's meeting stating a decision had been made to extend the appraisal window to the end of November for non-medical staff. Last month reported an appraisal rate of 36.3% as of this morning 81.2% of appraisals have been completed. PM confirmed this is an excellent position. The LLP is also in a good position reporting 85.3% of appraisals completed, confirming they are recorded separately to the Trusts records.

Staff Absence – This remains a concern specifically the impact of the test and trace implications, noting the previous week up to 50 staff had been recorded as absent each day due to test and trace, this is staff that had been in contact with a person who had tested positive for Covid. This will be monitored closely, the test and trace team has been expanded as they cover both patients and staff.

Vacancy rate – Nurse staff vacancy rate for the Trust is at 6.5%. The Trust reported 28% unfilled rate which is higher than normal but this is due to the demand on the nurse bank to fill staff absentees which maybe due to test and trace.

PM confirmed the 7 day swabbing service is processing all Covid tests within 24 hours to support staff returning to work as quickly as possible if their test is negative. Noting approximately 30 staff / house hold members of staff a day are being swabbed, of these only one or two are returning a positive result.

A winter incentive payment of 10% for October and November and 20% uplift from December to March has been brought forward to encourage staff to work on the nurse bank specifically within the acute inpatient areas as the community has not experienced absentee rates at the same level.

International Nurse Recruitment - This has recommenced following a brief pause over the summer months due to Covid. Two cohorts will arrive before the end of the year which will prove challenging as they need to complete OSCE training to allow registration, accommodation to house the training is under discussion as the Community Stadium is not ready.

Flu – The campaign has commenced PM told the Committee there are 143 peer vaccinators, noting this is approximately 100 more than last year and reported 18% of front line staff have now been vaccinated. The number will fluctuate as staff leaver and new starters have to be included in the numbers. This will be closely tracked as the target is that 90% of frontline staff need to be vaccinated.

JD stated completed appraisals are at an outstanding level and congratulated everyone involved in achieving this acknowledging the amount of work that had taken place to accomplish these levels especially recognising the LLP noting recently many of the LLP front line staff has said they had not had an appraisal for a long time.

LM also stated it is a tremendous achievement to see the absenteeism numbers improve also acknowledging the positive move in staff retention numbers.

Workforce Disability and Workforce Race Equality Action plan – PM stated for the first time this is a combined action plan. Both reports have previously been submitted to the Resources Committee and there is a requirement to publish the action plan on the Trust Website before the end of October. This ten point action plan has been developed with the support of the recently formed race equality network with both having very similar objectives. The following amendments have been made since the papers were published,

recommendation 10 relates to improving representation in leadership roles, PM highlighted the development of the Non-executive Director development programme along with plans to seek agreement from the Council of Governors to open the catchment area should a new Non-executive Director need to be recruited going forward to support greater diversity within the Board.

PM confirmed this paper had been submitted to the Committee for information.

JD referred to staff engagement and workshops noting this will be very challenging due to the current Covid pandemic situation.

PM acknowledged this, noting the time staff are spending on webex's is being managed but by using webex it saves travel to venues for workshops, noting generally with the use of webex staff are engaging well in these kind of events.

LM noted her assurance in the action plan as a way of addressing race equality.

Digital

Artificial Intelligence Report – Risk of Death in Hospitals, Mortality and Sepsis – DR presented a power point presentation to the Committee stating work with Bradford University and the Health Science Research Department for a number of years looking at death in hospitals together with mortality and sepsis. At York Hospital there are approximately 1300 non elective admissions every month, of these approximately 90 of these patients will die. The aim is ensure the end of life for these patients is a peaceful and comfortable as possible. To support this data which is routinely collected as part of usual clinical care is collated and used to try to predict death. DR explained briefly the data that is used to calculate a patient's risk of dying, suggesting for further information the following website could be accessed – http://carssresearch.org/

The Trusts IT team has devised an algorithm to include both patient with or without a Covid positive test and have designed this into the patients' health record. DR demonstrated how this data is recorded on the health record screen. He also discussed ongoing collaborations including links with the Humber Coast and Vale Radiology Group. He stressed the main message is the Trust holds a large amount of patient data which could be used for clinical good used either for research operationally, research clinically noting even if outcomes are not able to be changed this data could support better preparation of the inevitable outcome.

LM thanked DR for the presentation stating this was an outstanding piece of work working with the vast amount of data that the Trust holds to further improve patient care and asking if there is any further support required by the Trust.

DR noted it is fantastic to use the Trust's data in this way in order to improve outcomes but it requires a foundation of appropriate investment in digital technologies and a platform with which all the clinician work, noting that strategically the aim is to move to a paperless record which will enable data to be captured in a digital way. For this there is a need to ensure that hardware is up to date and refreshed regularly and users need to be engaged. Therefore the Trust needs to find other partners with which they are able to engage with to use the data already collected and there is a need to invest in digital infrastructure.

LM asked LP if this achievement could be included as an agenda item for the Board with a view to obtaining additional support for AI.

Action: LP

Update on modernising the Trust's approach to Digital – As confirmed a workshop had taken place to review operational risk, with an additional workshop planned. The BAF was updated prior to submission to this month's agenda.

Upgrade of CPD Oracle Forms environment – AS confirmed the upgrade for CPD forms environment will be deployed during November giving additional transparency across care groups to allow prioratisation of work load.

Digital Aspirant Programme – Following discussions with Humber Coast and Vale ICS the Trust has been put forward to become a Digital Aspirant, which will give the opportunity to access additional external funds to raise the digital maturity as a Trust whilst progressing the integration agenda with partners. The Trust is working with the ICS to complete the application.

N365 project – AS confirmed he had not been able to source any in house project management for this project therefore an external appointment will need to be made.

LM addressed the Committee asking if there was any internal resource available to support the implementation of N365 noting it is a critical project. AB confirmed this was being discussed by himself and DR.

AS confirmed Kathy Stanley had been appointed as a project manager and would be supporting the embedding of DIS.

Window 10 - This is due for completion in December 2020. Additional out of hours work is underway to support completion, but as there is no additional resource available in house, so agency staff will need to be appointed to ensure the completion target is met.

VPN & Remote working – AS confirmed that an additional 163 laptops have been received with another 250 on order to support the increasing demands for home working.

Mobile Tasking Application – KB confirmed the trial has been live since late July in Scarborough and is successfully being used to support the hospital at night. The aim is to roll the system out across the wider Trust and beyond hospital at night to 24/7 working to support the efficiency of medical staff.

Digital BAF – AS confirmed this had been updated prior to the meeting.

6. Board Assurance Framework Quarterly Report

LP told the Committee the BAF had been reformatted following a recent Board risk session with Mike Gill. Changes will continue over the next couple of months and include all 12 strategic risks. The changes will provide clarity around Executive Leads, risk description and action monitoring. LP gave an overview of what the BAF report will look like moving forward, highlighting the cause and effect, actions, time lines and appropriate leads will be noted on the report for each risk.

LP stated that a trend analysis has also been provided which will allow identification of relevant trends such as when Covid hit along with highlighting actions which are not addressing the gaps.

DW noted he had previously been a Risk Officer and considered the BAF to be an impressive document, noting the risks highlighted are all above the target risk level. He stated he would like to have a better understanding of the BAF and enquired what actions are happening to reduce the risks down to target levels.

LP stated that she will meet with DW outside of the Resources Committee to discuss the BAF.

Action: LP

LP confirmed the actions to reduce the risks will become clearer as we move forward and the actions are highlighted for each risk.

AB confirmed the risk table is being worked through and reviewed thoroughly noting the trend analysis table reflects the latest data noting the finance situation showing amber which is due to the current trueing up system that has been in operation for the previous 6 months.

LM thanked LP for the effort that has been put into updating the BAF agreeing the trend analysis table is a positive addition to the report.

LM confirmed she had not addressed updates to the BAF at the end of each section as she was aware of the BAF review.

PM confirmed BAF8 – Leadership still requires updating and will be for the November meeting.

Action: PM

7. Consideration of items to be escalated to the Board or other Committees

LLP

- Compliance issues, Cleanliness, Food waste
- CAFM – for submission to Executive Board
- Lessons Learnt – requires hero's of LLP to be highlighted

Finance

- Month 6 position, Doctors pay awards, A & E, Activities – sub contracted such as elective endoscopy
- I and E plan for the second half of the financial year

Workforce

- Retention Rate
- Appraisal rates
- Staff absence
- Apprenticeships

Digital

- AI demonstration to the Board
- N365

8. Any Other Business

No other business was discussed.

9. Time and Date of next meeting

The next meeting will be held on 17 November 2020 at 9am via webex. Dial in details are within your diary invite.

ACTION LOG

Item No	Meeting Date	Action	Owner	Due Date	Complete
1.	29.05.19	Highlight new limited assurance audits in their report to the Committee.	Execs	Monthly	Completed – Executives Responsible
2.	30.01.20 25.10.19 20.10.20	Provide update on GIRFT	AB	Mar 20	~~Oct 20 Agenda~~ Completed
3.	21.01.20	Papers to be submitted in line with Committee deadline to enable effective dissemination of the agenda	All	Monthly	Completed – Executive responsible
4.	21.01.20	Minutes from committees reporting into resources committee to highlight items for escalation or be FIO	All	Monthly	LM/LP to discuss – include in RC's TofR
5.	22.09.20 19.05.20 20.10.20	LLP Report on lessons learnt during the Covid period. To highlight achievements during pandemic period.	DB ABe		Completed
6.	22.09.20 19.05.20	To produce a plan for how we engage the Board in what is involved in digital transformation ~~Board discussion on digital Transformation leadership support~~	DR ~~AB~~	May/ Jun 20	Nov 20 Agenda
7.	21.07.20	Artificial Intelligence Report to come through.	KB	Sept 20	completed
8.	22.09.20 18.08.20	Sustainability Team Management to move from Trust to Estates Management. Further update required.	DB	~~Sept 20~~ Dec / Jan 21	
9.	22.09.20 18.08.20	Update on manual workarounds to use before CAFM system is in place Update on handsets to support CAFM system	AS/Abe/DB	Sept 20	completed
10.	22.09.20 18.08.20 20.10.20	~~Provide update COVID spend bench mark~~ Discuss possible use of bench mark	AB	Nov 20	

		project data			
11.	22.09.20	Provide an update on the people plan – to include colour coding and a clearer timeline	PM	Jan 21	
12.	22.09.20	Circulate a list of apprenticeships the Trust deliver via email	PM	Sept 20	Completed
13.	22.09.20	To review if the use of tablets on the ward can be used to support communication with patients families linking in with the LLP and the perfect ward programme	AS	Dec 20	
14.	22.09.20	Present an update on video consultation	DR	Dec 20	
15.	22.09.20	To submit a report on the CDIO initial recommendations	DR	Monthly	
16.	20.10.20	To update on domestics transactional / transformational changes	MV	Dec 20	
17.	20.10.20	To provide update on food waste / Matron support	LJB / DB	Dec 20	
18.	20.10.20	BAF – LP to discuss with DW	LP / DW	Dec 20	

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York Teaching Hospital
NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Quality Committee	Date: 17 November 2020	Chair: Stephen Holmberg

Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	For Recommendation or Assurance to the receiving body
6 – Covid update	Further assurance required around decision making and priorities for treating patients and that all decisions are captured	Board	Further assurance requested
6.	The Committee felt it was positive that the Trust had been reducing the backlog created by the first Covid wave, but noted that this is now being affected by the second wave.	Board	Assurance
6i – Nurse Staffing	CQC has asked the Trust to stop reporting the Scarborough staffing figures and the vacancy rate is coming down.	Board	Assurance
6iv	Concerns were raised about medical staff compliance with statutory and mandatory training	Board	Escalation
6vi – Board Assurance Framework	The Board are asked to consider whether strategic risk 10 – partnership working is still considered a risk in light of the work with the ICS and other partners	Board	Recommendation to remove

York Teaching Hospital
NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Resources Committee	Date:17 November 2020	Chair: David Watson

Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	For Recommendation or Assurance to the receiving body
	Committee offered its condolences to the family of Linda Foster, the LLP staff member who died, most likely from COVID-related causes, this weekend. Polly McMeekin working to ascertain cause of death and connection, if any, with Scarborough Hospital COVID outbreak	Board	Information
Workforce	Exit interview compliance currently at 6.4%. There are plans to improve this.	Executive	For Action
Workforce	Staff absences due to sickness running at 600 per day, 48% COVID-related. Whilst Centre continue to encourage York/Scarborough to maintain services, it may be necessary to start to think about stepping down certain procedures	Board	Information
Workforce	Annual appraisal rates for current year now at 85%. Great outcome for Workforce team	Board	Information
BAF	Underlying risks on corporate risk register need to be properly reflect on BAF. There is concern about a "disconnect"	Executive	For Action
Workforce	Planning underway for COVID vaccination programme of all Trust staff and students, C.10.5k personnel based on Pfizer vaccine. Logistics will be complex	Board	Information
DIS	Dylan Roberts reported that the biggest concern within IT/Digital is capacity within the team, not least where there is a single point of expertise for key systems. Additional resources most likely required and Andrew Bertram to benchmark our IT spend against the model hospital data	Board Executive	Information For Action

DIS	No DIS report in IBR. Need to develop KPIs	Executive	For Action
DIS	Excellent report from Data Protection Officer highlighting a broad range of data governance and other IT risks. Are these risks properly reflected in Corporate Risk Register and thence the BAF	Board Executive	Information For Action
Finance	Overall I&E performance better than plan, we will be paid for 13 months in financial year, not 12. Centre will develop claw-back mechanism for surplus cash	Board	Information
Finance	Material increase in Capital Expenditure to be completed before year end	Board	Information
Finance	Emergency budgets implemented for each care area. Currently overall performance broadly in-line with plan	Board	Information

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York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Goal	Strategic Risks	Exec Lead	Quality of Resources	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	**CN**	**Quality**	**25**	**25 ↔**	**6**
Patient Care	2. Failure to maintain and transform services to ensure sustainability	**COO**	**Quality**	**20**	**20 ↔**	**6**
Patient Care	3. Failure to meet national standards	**COO**	**Quality**	**25**	**20 ↔**	**1**
Patient Care	4. Failure to maintain and develop the Trust's estate	**FD**	**Resources**	**25**	**16 ↔**	**9**
Digital & Information	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	**CDIO**	**Resources**	**20**	**16 ↔**	**12↑**
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	**W& OD**	**Resources**	**25**	**20 ↔**	**9**
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	**W& OD**	**Resources**	**20**	**16 ↔**	**6**
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	**W& OD**	**Resources**	**16**	**12 ↔**	**1**
Finance	9. Failure to achieve the Trust's financial plan	**FD**	**Resources**	**25**	**9 ↔**	**6**
Finance	10. Failure to develop and maintain engagement with partners	**COO**	**Quality**	**16**	**9 ↔**	**4**
Finance	11. Failure to develop a trust wide environmental sustainability agenda	**CN**	**Quality**	**20**	**12 ↔**	**1**
Finance	12. Failure to achieve the System's financial plan	**FD**	**Resources**	**25**	**9 ↔**	**6**

Revised BAF approved in Aug 18 – current version 0.28 (Nov 20)

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (1) Failure to maintain and improve patient safety and quality of care **CRR Ref**: MD 2a&b, 3, 4, 5, 6a&b, 7, 8, 10, 11 – CN 2, 7, 8, 17, 22, 24, 25, 26 – COO 2, 3, 6, 7, 8, 17, 18, 19, 20, 23 – HR 1a&b, 4, 9, 15, 18 – CE 5a&b, 9 – DE1, 2 **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Medical Director, Chief Nurse, Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure including o Assigned Director Portfolios, Structures & Teams o Daily Incident reviews o Weekly Quality and Safety meeting attended by all care groupsWard to board nursing structures & teams o Patient Experience Steering Group o Safeguarding Children & Adults Teams & Internal & External Structures o Health & Safety Systems & Groups o Infection Prevention & Control meeting structures - Strategies, Policies & Procedures o Nursing and Midwifery Strategy, Patient Experience Strategy, Sign up to Safety Campaign pledges and Patient Safety Strategy. o Risk Management Framework o Performance Management Framework - Systems &Monitoring o Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities	- External inspections including CQC Reports - Internal Audit Programme - CQC and Choices website feedback - SHMI - New Clinical Environment Risk Group implemented to oversee backlog maintenance spend risk managementNational Survey Action Plans, Friends & Family Test - Premises Assurance Model, PLACE/TAPE Reports - Patient Experience Work Plan & Quarterly Reports - Quarterly Pressure Ulcer & Falls Reports - Mortality Reports – Learning from Deaths - IPC Quarterly Report & Annual Report - Patient Safety, Quality, Workforce, Finance and Performance Report to Board/Committees - Annual Complaints Report to Board - Quality Report - Patient Safety Walk Rounds - NICE, NSF and Clinical Audits/Effectiveness Reports - Safeguarding Children & Adult Reports to Board	- Implementation of 7 day working systems and controls - Jnr Drs Contract (National) - 2003 Consultants Contract does not facilitate 7 day working(National) - - Risk registers are not fully aligned - Governance structures have some gaps affecting the effectiveness of ward to Board communication – these will be addressed by the new structure - Quality of SI investigations identified as variable and learning not sufficiently embedded - Staffing Vacancies PEM consultant Scarborough, medical staffing at Scarborough and nursing C Diff rates at Scarborough due to estate issues - Limited capital to address estates issues that impact on quality and safety - Under performance against key national targets and standards - Surge plan if social distancing ineffective - Critical care capacity – establishment of Nightingale Y&H facility – transfer of care - Access & maintenance of adequate oxygen supply - Access to appropriate supply & distribution of PPE

Revised BAF approved in Aug 18 – current version 0.28 (Nov 20)

○ CQUINs & contract monitoring ○ Recording of escalation systems NEWS etc ○ Medicines Management/EPMA implementation ○ National Surveys ○ NICE, NSF and Clinical Audit ○ Capital Programme ○ Maternity CNST ○ Performance reporting and accountability/ performance reviews/ performance dashboards - Statutory and mandatory training – trained professional staff - A number of local adaptations in relation to 7 day working - Lead medical examiner role introduced - Covid 19 command structure - Daily bronze, silver and gold meetings - Action Log and Loggists in place - COVID 19 specific SOPS, IPC BAF and risk assessed measures for management of beds and waiting lists - Weekly gold strategic meeting chaired by CEO - HCV & North Yorks & York command structure in place - Processes, pathways and SOPs in place	- Maternity Reports - Staffing Reports - Learning Hub Data - Health & Safety Reporting - 7 day audit – 7 day task & finish group & plan - Integrated Board Report - COO led monthly operational performance meetings with each Care Group - CEO led efficiency meetings with each Care Group - QIA of each efficiency scheme signed off by MD and Chief Nurse. - Medical Examiner appointed - Local ownership of MCA/DoLS – matrons audit carried out – Nothing raised by CQC - Performance recovery plans - Performance framework (OPAMs) - Daily and weekly Covid 19 actions logs - Review at weekly gold CEO led group - Covid 19 dashboard - Submission of required Covid 19 returns for assurance - MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place & no significant concern raised. -	- Increased risk of secondary deaths due to services not being accessed and impact of long waits for elective surgery - Possible increased risk to children & adults in community due to social distancing - Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence Actions (Identify plans to address gaps) - Full review of governance structures – paper to Oct 21 Quality Committee - Quality improvement project underway to redesign the incident management processes (including serious incidents and learning) - Staffing – East Coast Review looking at sustainability – CQC weekly monitoring continues (review Oct 20) - Full review of risk registers to ensure risks appropriately rated and managed - Infection Control - NHSE/I Lead Review & Report – HPV Business Case approved & machines on site (completed) - Care Group improvement programmes & performance recovery plans developed by each Care Group (reviewed & updated monthly) - CQC Unannounced visit & Well Led responses and action plans (monthly monitoring at Board & Quality Committee) - Safeguarding Team aware of risk to vulnerable adults & children – access to team for advice & support established during this period (review Oct 20)

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (2) Failure to maintain and transform services to ensure sustainability **CRR Ref**: MD 8, 10 – CE 3, 5a&b, 8, 9 – COO 2, 3, 6, 7, 8, 13, 17, 18, 19, 20, 24 – DE1, 2 **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
Governance Structure of the Trust to monitor the effectiveness and sustainability of service include: - Trust Committee & Governance Structure o Executive Directors Portfolios – Chief Operating Officer is the Trust Transformation Lead o Executive Committee – decision making forum comprising Care Group Clinical and Executive Directors o Operational Performance and Assurance Meeting (OPAM) – escalation of key services issues that affect sustainability and service e/g/ performance, quality, workforce, finance and identification of improvement/ transformation opportunities) o Care Group Boards (x6) - responsibility for the effective delivery of sustainable services o Business case management system for significant service change o Performance Management Framework o Clinical Strategy development (Trust and Care Group) - The Trust works in partnership to identify and deliver service transformation and sustainability;	A range of regular reports are provided across the tiers of the organisational governance to provide assurance. These include: - Integrated Board Report - Executive Committee Forward Plan and reports, e.g. Scarborough Services Review, Winter Resilience, Business Cases and Care Group Escalations - OPAM papers and action logs - Care Group Board Papers and action logs - Dashboards on performance across KPI and clinical services. Reports are shared with system partners as required. Minutes and action logs from partnership meetings are shared across the Operational leadership to ensure Trust actions are implemented. Humber Coast and Vale and Regulatory action	- Workforce recruitment, in particular at the East Coast to sustain services - Capacity across Hospital Estate and wider partnerships to deliver transformational pathways (financial constraints, capital constraints) - Shortfall of capacity to meeting the growing demands of the population e.g. waiting list delays, increased demand in Emergency Care - Trust wide clinical strategy (in development) Actions (Identify plans to address gaps) - Scarborough Services Review and appointment of Programme Director to drive change and delivery - Establishment of East Coast Leadership Team - Refresh of the Performance Management Framework and supporting information and analysis across Care Groups and the Trust. - Clinical Risk and Oversight Committee established to oversee clinical risk stratification in delayed patients and to prioritise limited capacity during the COVID pandemic - Engagement in system partnerships to explore options for capital monies to support estate reconfiguration, equipment opportunities and collaborative pathways - HCV People's Plan and associated work streams

including: ○ Humber Coast and Vale Integrated Care System, including Clinical Leads Network and Acute Care Collaborative. ○ Operational Delivery Networks (e.g. Stroke/ Critical Care) ○ North Yorkshire and York System Leaders Executive ○ Joint Planned Care Board ○ Humber Coast and Vale Cancer Alliance and Trust Cancer Strategic Board ○ Health and Care Resilience Board ○ Scarborough Services Review ○ Facilitated External review, e.g. ECIST, Elective IST, GIRFT and Model Hospital ○ Health and Well-Being Boards ○ Local Resilience Forums ○ Contract Management Arrangements Through the Performance Management Framework and Digital & Information Service, a wide range of data is available and scrutinised to plan and deliver services; identify operational challenges and inform service change	plans, including: - Operational Plans - COVID operational plans, Phase2, Phase 3 - Scenario testing of surge plans - CQC action plans - Winter planning and Resilience plans The Trust has operational meetings in place to monitor and respond to operational requirements including: - Daily Operational Meetings (up to x4 a day under site pressures) - Weekly review of patient lists for Cancer and routine Care - Weekly performance meetings across Care Groups; and escalation - Weekly Recovery and Performance Meetings with senior operational managers	- Programme Director appointed to drive and develop a comprehensive Clinical Strategy for the Trust.

Strategic Goal: To deliver safe and high quality patient care as part of an integrated system **Principal Risk**: (3) Failure to meet national standards **CRR Ref**: COO 2, 3, 6, 7, 8, 13, 17, 18, 19, 20, 24 – CE 8 – MD 6a&b, 7, 8, 10 **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Chief Operating Officer, Chief Nurse, Medical Director	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
To meet national access standards the Trust has the following controls in place: - Trust Board - Quality Committee - Corporate Performance Team - Performance Management Framework – including Business Managers across the Care Group Structure and processes for escalation and resolution through Operational Performance Assurance Meetings and Executive Board. - Commissioner and provider forums: - performance meetings - Planned and Unplanned Care meetings to manage capacity and demand across the system - Trust Operational Planning – Annual cycle supported by weekly and monthly monitoring - Demand and Capacity training - Winter Resilience Planning - Emergency Planning Functions - Strategies, Policies & Procedures o Trust Strategy, Clinical Strategy and Care Group Strategies o Policies & Procedures/Standard Operating Procedures o Performance Recovery Initiatives o Winter Planning/System Resilience/Winter Plan o Trust Operational Plan	The Trust receives assurance through - Reports to Executive Board, Quality Committee and Trust Board on key access indicators through the Integrated Board Report - Live, daily and weekly management information through corporate dashboards - Externally commissioned reports, e.g. EY - CQC action plans - Performance Recovery Plans - Winter Resilience Plan - Emergency Planning - including scenario testing. - E & Y Reports - External Benchmarking of systems and pathways - Internal Audit Programme - Performance Reports - Operational Performance Recovery Plan - Winter Plan/System Resilience Plan - SAFER Local Delivery Plan - Planned Care Transformation Plan - Validation - Operational Plan - Learning Hub Data	- Sustainable delivery of access targets at the East Coast - Continued challenges around achieving the ECS on a sustainable basis - 7-day services (14 hour post take and daily senior review) below 90% trajectory - Delivery of long wait routine care as a result of the national pandemic - Recruitment - Robust process required to identify harm - Actions (Identify plans to address gaps) - East Coast Review Phase 2 (31.07.19) – presentation to Board (Nov 19) completed Programme Director appointed for Scarborough Services Review - East Coast Leadership Team to be appointed - ECS daily monitoring - Phase 3 recovery plan for elective care, supported by weekly monitoring - Surge scenarios mapped for COVID 2nd wave impact - HCV HCP capital bid for SGH – business case approved & machines on site – Trust working to national timetable for submissions (review quarterly) - Recruitment - linked to strategic staffing risk (6) actions - Single integrated improvement plans being developed with regular monitoring via PAMs (from 1.8.19

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- Training & Development Elements of assurance framework deferred ie: work plans, engagement with Internal Audit and 'routine' operational planning In line with national guidance, usual reporting arrangements have been suspended. Current reports as per national requirements but minimal.		onwards) – Y & S refreshed post Covid (review quarterly) - Ambulance handover action plan developed – improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Board sub committee

Principal Risk: (4) Failure to maintain and develop the Trust's estate Causes - due to lack of resources including capital and staffing, volume of work required Effects – worsening of backlog maintenance issues, substandard estate, regulatory intervention **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structures o SLAs between Trust and LLP – contract management structure o LLP Committees/Governance Structure - Strategies, Policies & Procedures o Capital Programme o Estates Strategy o PLACE/TAPE Programme o Compliance Report Schedule o HCV Estates Strategy	- Compliance with P21+ and DH approved process for specific capital schemes - Condition Surveys - HCV HCP Capital Group Reports & Minutes - Internal Audit Programme - NHS Premises Assurance Model - Board/Committee Reports incl: Compliance, Capital, Sustainable Development, Health Safety & Fire - Full site backlog maintenance survey - Prioritised backlog maintenance register - Enhanced transparency of capital programme management via Executive Committee & Board.	1. Lack of capital to maintain/develop Trust estate – Pursuing discussions with ICS over access to supplementary PDC **(Quarterly Review) –** Commissioned RIBA 0, 1 and 2 reviews of key development issues in order to support business case development **(Quarterly Review) –** Seeking to place the Trust in the best possible position to bid for nationally released PDC funding **(Quarterly Review) -** Targeted and proactive use of Trust depreciation funding to remedy critical infrastructure issues **(Quarterly Review)** 2. Work associated with realigning wards for Covid has meant some minor works have been deferred (although some work has taken place) 3. Some key projects aligned to the CQC plan have been put on hold ie childrens area in York ED - CQC Plan areas ie: childrens area in York ED will be delivered from emergency Covid 19 **(Mar 21)** 4. Capacity of the LLP to support the Covid 19 expanding work programme – Procurement of temporary capacity **(Jan 21)** 5. LLP ability to monitor full set of KPIs and provide assurance – procuring LLP KPI automated monitoring system (CAFM)**(Apr 21)** 6. Cultural acceptance of poor quality environment – Cultural work underway in LLP **(July 21)**

Principal Risk: (5) Risk of a failure to develop, maintain, replace and secure information and technology systems in a timely manner. Causes - increased demand , increased complexity, limited capacity (technical, workforce and financial funds) and capability (technical, workforce) Effects - data breaches, regulatory fines, loss of reputation, inefficient ways of working **Lead Committee:** Board Quarterly (last forma review – Jul 20) **Director Lead:** CDIO	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 4 Score: 12

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)

- CDIO appointment August 2020
- Statutory, contractual and quality reporting
- Care Group support being provided
- Dashboards and reports being produced
- Collaborative working with partners
- Inpatient clinical coding function being delivered
- Business continuity and disaster recovery plans being reviewed
- Information Asset Owners and System Owners being identified and appointed
- Reporting structure into Exec Committee, Resources and Board
- To continue to support
  - On-call Service
  - Internal monitoring/alerting systems
  - Third Party Monitoring
  - Ongoing User Awareness Programme
	- External & Internal Audit Reports
	- External review and Health Check
	- Information Governance Exec Group Reports
	- Board NHSI Declaration – Data Security & Protection Requirements
	- Learning Hub Data
	- DSP Toolkit Compliance
	- Information Asset Owner Register
	- Cyber Security Assessment & Action Plan
	- SUS Data Quality
	- Incident Management reporting and learning
	- CDIO immediate observations and recommendations – September 2020 to committees and board.
	- Coding audits
		Lack of capacity and capabilities in the team - Develop the case for staffing increase across critical roles **(Jan 2021**), Develop proposals for shared services and partnering across the region/ICS **(Apr 2021)**
		
		Lack of operational funds - Develop the case for staffing increase across critical roles (Jan 2021), Develop the case for external funds through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of capital funds - Develop the case to secure funding for essential services program capital scheme (Feb 2021), Develop the case for external funding sources through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of prioritisation or strategic alignment of work coming into DIS - Deliver new Project and Portfolio Management approach to bring rigour to project delivery, set priorities and manage the pipeline of work into DIS **(May 2021)**
		
		Lack of CCIO, Digital Nurses and AHPs available capacity to work with DIS on delivery - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** - Develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way**. (Apr 2021)**

	-	Lack of Digital Leads or “Business Partners” embedded into care groups - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)** Lack of effective and standard change methodology or approach – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)**

Principal Risk: (6) Risk of failure to ensure the Trust has the required number of staff with the right skills in the right location Causes – inability to recruit the levels of nursing/medical staff required especially on the East Coast, limited applicants available in some specialties, national policy on training numbers Effects – Compromised service delivery, limited capacity to open surge/esc areas, regulatory scrutiny **Lead Committee:** Board Quarterly (last forma review – Jul 20) **Director Lead:** Dir. of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Workforce & OD Strategy & workforce redesign - People Plan - HCV HCP Workforce Strategy - Bank Management and Governance - Appraisal processes – Job Plans - Apprenticeship & Volunteering Programmes - Overseas Recruitment - Statutory and Mandatory Training - East Coast Medical Recruitment Programme - SLAM course - CleverTogether staff engagement forums and outcomes Covid19 specifically - Skills questionnaire to enable safe deployment of staff Homeworking enabled where possible 7-day swabbing service for staff and household members NHS Covid 19 App Health and Wellbeing measures to support resilience Race Equality Network	- Staff Survey/Staff FFT - National standards & visits - Trust Committee/Governance Structure - - ROA reporting to HEE - Internal audit programme - Programmes designed and evaluated by HEI and NHS Elect - SSW/FTSUG Monitoring Reports - Board & Committee reports - Data from E-rostering Data/CHPPD, Learning Hub, Exit Questionnaires - NHSI maintaining workforce safeguards - QIA for new nurse roles Covid 19 update Real time sickness data being captured through central 'hub' Staff requiring isolation to be signed off via OH and placed on medical suspension	- Work/life balance expectations of the future workforce - Brexit/ Immigration Policy - Objective Structural Clinical Exam (OSCE) - Age Profile - National changes to standards, applications & implementation of new policies. - Effective utilisation of E Rostering Tool - Implementation of electronic job planning - HEE Policy – jr dr allocations - Medical rostering system (not yet procured. BC **approved Sept 20**) Actions (Identify plans to address gaps) - Clever Together actions **(Mar 21)** - Health & Wellbeing Initiatives being implemented **(Sept 20)** - Revised Agile Working Policy - Workforce Plan **(Oct 21)** - Apprenticeship Steering Group Outputs **(Jul 21)** - e-Job Planning **(Oct 21)** - Continue to develop Bank **(Dec 21)** - HCV HCP Workforce Action Plan **(Oct 21)** - East Coast medical recruitment project **(on-going)** - International Nurse recruitment **(Mar 21)**

Principal Risk: (7) Risk of failure to ensure a healthy engaged and resilient workforce Causes – high levels of Covid related absence, constant pressure in the system ie: Covid, winter, flu Effects – Compromised service delivery, organisation culture, regulatory scrutiny, lowering of morale and wellbeing, limited capacity, vacancy rate across nursing/medical, increased staff attrition **Lead Committee:** Board Quarterly(last formal review – Jul 20) **Director Lead:** Director of Workforce & OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Occupational Health Service/EAP - Junior Doctor Forum & LNC/JNCC - Workforce & OD Strategy - Star Awards/Celebration of Achievement & Benefits programme - Recruitment and Retention Processes - Workforce redesign - Appraisal processes – Job Plans - Schwartz Rounds & RAFT - Emergency planning - Statutory and Mandatory Training - FTSU/SWG & Fairness Champions Covid 19 update: Psychological support increased – drop in sessions (now virtual) for staff working in cohorted areas. Tailored Schwartz rounds Headspace app being pursued Clear daily communication updating staff Staff testing for Covid 19 – Test & Trace Helpline and support sessions staffed by Clinical Psychologists RAFT/TiPi Apps to support mental wellbeing (Headspace, unmind and Sleepio). 7-day swabbing service for staff and household members Resilience Training	- Staff Friends and Family Test - Sickness absence/turnover analysis - Board & Committee reports - Trust Committee/Governance Structure - Data - E-rostering Data/Flexible working, health & Wellbeing, Learning Hub, Health Assured & FTSU/SWG monitoring - Staff Survey - RAFT evaluation Covid 19 update: Real-time sickness data collated via central 'hub'. Support for Managers for virtual working	Work/life balance expectations of the future workforce Shift patterns and impact on Health & Wellbeing Actions to address the gap: Clever Together actions **(Mar 21)** Values and Behaviours implementation **(Sept 21)** Implementation of Agile Working policy **(Mar 21)** Continued Implementation of RAFT **(Nov21)** Implementation of Health & Well-being Strategy **(Dec 21)** Workforce Plan implementation **(Oct 20)** Safe Working Group Feedback initiatives **(continuous)** Line Manager Competency Training **(continuous)** Clever Together Programme **(Mar 21)** Impact of Lateral Flow Testing Programme/Test and Trace – Covid vaccine – (**Review Jan 21)**

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Principal Risk: (8) Failure to ensure there is engaged leadership and strong, effective succession planning Causes – FT Catchment area; new (and unfamiliar) application of talent management framework and workforce planning. Effects – Lack of appropriate strategy; poor culture; increased staff attrition; compromised quality of patient experience. **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Director of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 3 Severity= 4 Score: 12	Likelihood = 2 Severity= 3 Score: 6	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure - Workforce & OD Strategy - Gender Pay Analysis - WRES/WDES - HCV HCP workforce plan - Appraisal / Revalidation Processes - Board Development - Talent Management Framework - Progression and evaluation of internal leadership courses Covid Guidance for Managers for remote working	- Succession Planning Papers - Directors Portfolios - Team Structures - Learning Hub Data - Board/Committee HR Reports - Internal Leadership/Managerial Programmes - Revalidation data - WDES/ WRES action plan - NED development programme	Board Development Programme needs revising due to Covid - Board development **(Quarterly Review)** Shadow Board - this will recommence following Covid **(Quarterly Review)** Up to date Succession Plan - Succession Plan being developed **(Sept 21)** BAME representation at Board and in senior management – Constitution Review Group to discuss changes to Trust Constituencies **(Dec 20) -** NED Development – (ICS) Programme starts **(Jan 21)** Previous values & behaviours not aligned/embedded – Embedding values and behaviours **(Sept 21)**

Principal Risk: (9) Failure to achieve the Trust's financial plan Causes – pressure from agency spend, system finance pressures, Effects – regulatory scrutiny **Lead Committee:** Board Quarterly (last formal review – Jul 20) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working (stakeholders, LA's, Trusts (Harrogate, Hull, Leeds) (HCV Contractual MOU) - Shared Risk Contract - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) - North Yorkshire & York Leadership System - Primary Care Networks through CCGs COVID-19 Exceptional Measures: - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of efficiency requirements.	- External and Internal Audit Programmes - NHSE/I Reporting - External Audit - Value for money review - NHSE/I Use of Resources Review - Monthly Accounts & Reports - Operational Plan - Business Cases and benefits monitoring - Committee Papers - Capital Programme Reports and monitoring - Medium Term Financial Planning - East Coast Review	1. Continued recruitment difficulties placing financial pressure from agency and locum replacement staff resulting in pressure against the Trust's agency cap. 2. Additional staffing requirement from covid segregated areas and duplication of functions. **To address gaps 1 and 2:** - Multiple Recruitment initiatives listed on strategic risk 6 – MD, CN & DoWF scrutiny & challenge of agency rates, structured review of long term commitments each week **(ongoing review quarterly).** - Premium implemented for bank staff 3. Failure to deliver system wide QIPP with financial pressure on the system partners and the Trust through the shared risk contract (temporarily suspended) 4. System affordability issues in relation to delivery of constitutional standards **To address gaps 3 and 4:** - Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards. Due Dec 20. Work underway with ICS on understanding current financial positions and resource requirements going forwards. Restoration and Recovery Plan submission **(22 Oct 20)**

Strategic Goal: To ensure financial stability **Principal Risk**: (10) Failure to develop and maintain engagement with partners **CRR Ref**: CE3 – DOF 4, 11 – COO 2, 3, 6, 7, 8 **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Chief Operating Officer	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 2 Score: 4

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
The Trust is engaged in a wide range of partnerships to work collaboratively to deliver care for our patients, change patient pathways and manage demand on hospital and community services. The Trust works through the Humber Coast and Vale Integrated Care System and associated governance structures. Support Corporate Operations this includes (not exhaustive): • HCV Clinical Leads • HCV Executive Group • North Yorkshire and York Systems Leaders Executive • Urgent Care Network • North Yorkshire and York Health and Care Resilience Board (Urgent Care) • HCV Planned Care Board • North Yorkshire and York Joint Planned Care Board • HCV Acute Care Collaborative • HCV Cancer Alliance and associated sub-structures	The Trust receives assurance through Appropriate level attendance at partnership meetings to act on behalf of the Trust - Minutes and action logs of the partnership meetings - CQC System Reports - NHSE/I action plans - Contractual reports to Resources Committee and Board - Integrated Board Report.	- Place Based Strategic Plans - System governance arrangements that describe approach to delivery of the system transformation programme - Programme structure for the Acute Care Collaborative Actions (Identify plans to address gaps) - Phase 3 recovery plans developed at place and Humber Coast and Vale level - North Yorkshire and York Finance and Performance Meeting established to lead on planning and delivery - Provider analytical networks established to support and inform the Acute Care Collaborative - Programme approach to be agreed for the Acute Care Collaborative

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In addition through the national pandemic response the Trust is actively engaged in the North East and Yorkshire Regional Cell and associated sub-structures, including Local Resilience Forums. Through Business as Usual arrangements, the Trust has regular communication and meeting arrangements with commissioners and regulators to negotiate and manage contractual issues to reduce the risk of financial penalties. This includes: - Contract management arrangements - Monthly performance meetings with commissioners - CQUIN quarterly reviews NHSE/I Quarterly reviews and deep dive assurance meetings through HCV.		

Strategic Goal: To ensure financial stability **Principal Risk**: (11) Failure to develop a trust wide environmental sustainability agenda **CRR Ref**: DOF 1, 3, 4, 8, 9, 11 – HR 1a&b, 4, 15, 18 – DE1, 2 **Lead Committee:** Board (last formal review – Jul 20) **Director Lead:** Chief Nurse	Assurance Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure - Trust Sustainable Development Management Group o Board Commitment - Travel and Transport Group - Head of Sustainability - Processes & Systems o Good Corporate Citizen/ Sustainability Development Assessment Tool o Sustainable Development Unit Template (measures Carbon footprint) - Sustainability Champions - Consultancy Contract Phase 1 and 2 - 12 month sustainable awareness development programme - Partnership Working	- Sustainable Development Management Plan/Green paper under development to comply with Standard Contract 2020/21 - Sustainable Development (SD) Reports/Papers - Transport Group Reports/papers - Compliance with NICE - Sustainability Annual Report - Trust Annual Report Sustainability Section - Carbon Savings figures - Savings Cost Benefit Analysis - Travel Plan - Benchmarking using SD Assessment Tool - Travel Survey - York Hospital selected as one of 12 in UK for Modern Energy Partners Programme to provide free sub-metering and pathway programme for buildings with aim of achieving 50% carbon reduction by 2032 - Feasibility for electric vehicle charging at York Hospital	- Engagement of staff including Senior Management trust wide - Raised awareness when procuring plus Covid 19 impact on waste - Energy Reduction Working Group – est Oct 19 (work stopped in Mar 20 due to Covid 19 (SD Grp not held in May 20) - National Clinical Waste Provision Issue - Travel Survey Analysis – completed – Travel Plan being updated - Long Term Climate Change Act target changed to 0 carbon by 2050 - NHS operational planning guidance 2020 requires all new builds to be net zero carbon standard - NHS Long Term Plan targets 2019 and NHS Standard Contract 2020-21- new risks highlighted – the contract requires a plan by Mar 21 - Capital budgets not yet allocated **Actions** (Identify plans to address gaps) - Restart Energy Reduction Working Group and SD Group (July 2020) - Green Plan to with projects to achieve Climate Change Act Targets – reviewed annually – Aug 20 - Business cases then to be developed (March 2021) - Sustainable Development Assessment Tool Action Plan (reviewed annually) (last score Mar 20 62% - to improve by Mar 21 - Clinical Waste – NHSI to monitor contract – nationally agreed to Mar 21 - awaiting further developments National Waste Strategy to be published in Summer of 2020 (delayed due to COVID 19 New frameworks expected, Improve recycling of waste for domestic black back and catering waste- new tenders delayed due to Covid 19 work - new

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		contracts Oct 2020) - Travel Survey actions to be included in the Travel Plan (Jun 20) - Review of SD/Green plan including risks being conducted against Long Term Plan targets and NHS Standard Contract 2020-21 – risks to be reviewed at SD Grp (Jul 20)Comprehensive Business cases needed for electric vehicle charging infrastructure, reducing estate carbon emissions; reducing waste, water, vehicle use and procurement carbon impacts; & achieving Climate Change Act Targets 50% by 2032 from 2017 and net zero by 2050 (Mar 21)

Principal Risk: (12) Failure to achieve the system's financial plan Causes – financial pressures on organisations within the system, lack of capital/revenue, unforeseen expenditure requirements such as equipment failure Effects – ICS and regulatory scrutiny, loss of reputation **Lead Committee:** Board Quarterly (last formal review – Jul 20) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working - Shared Risk Contract - HCV & Partnership working ie: Contractual MOU - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) COVID-19 Exceptional Measures - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards. - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of QIPP and efficiency requirements	- NHSE/I Reporting - Quarterly System Finance Meetings - Internal & External Audit - Monthly Accounts & Reports - Operational Plan - Medium Term Financial Planning - East Coast Review	1.Failure to deliver system wide QIPP with financial pressure on system partners and the Trust through the shared risk contract (temporarily suspended) 2.System affordability issues in relation to delivery of constitutional standards. 3.Pressure on non-York FT CCG contract expenditure. 4.Operational pressures for the Trust **To address gaps 1 to 4** - Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards **(Due Dec 20)** - Work underway with ICS on understanding current financial positions and resource requirements for Oct to Mar. Restoration and Recovery Plan submission (**22 Oct 20)** - Full engagement with the ICS to develop and agree longer term recovery plans **(expect to submit April 21)**

Board Assurance Framework

BAF definition adopted by the Governance, Assurance & Risk Network (GARNet): 'the key source of information that links the strategic objectives to risk and assurance'.

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the Trust. The evidence to back up this Statement is supported by the Board Assurance Framework.

The Trust's Board Assurance Framework is based upon the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board of Directors to resolve issues or concerns and to improve control mechanisms.

The risk scoring matrix (appendix 1) is part of the Trust's Risk Management Framework and will be used to score risks.
Risk Appetite (appendix 2) is part of the Trust's Risk Management Framework

Strategic Goals	**The planned objectives which an organisation strives to achieve**
Principal Risks	**The key risks the organisation perceives to achieving its strategic goals**
Key Controls	**The controls or systems in place to assist in addressing the risk**
Assurances on Controls	**Sources of information (usually documented) which service to assure the Board that the controls are having an impact, are effective and comprehensive**
Gaps in Controls	**Where we are failing to put control/systems in place**
Gaps in Assurance	**Where we are failing to gain evidence that our control systems, on which we place reliance are effective**
Risk Appetite	**The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives – appendix 2: Trust Risk Appetite.**

Temporary governance arrangements in relation to the Covid 19 pandemic which follow national guidance

- The Trust has introduced a bronze, silver and gold command structure to co-ordinate efforts for the pandemic – all decisions are logged
- Bronze, silver and gold meetings are held every day with a weekly gold group which has replaced the Executive Committee during this period – Executive Committee planned to restart in June
- The Board and sub-committees are following the 'reducing the burden' national guidance and meetings have been limited to a one hour meeting which discusses Covid issues and then there is a section for papers which are for information.
- Any documents still requiring approval of the Committees/Board are covered under any matters of urgency – due to large number of items for approval in March, this was done by email (all emails retained) a paper detailing the approvals was taken to the April Board.
- The Board is introducing a bi-monthly workshop which is longer in order to discuss Covid issues in more detail – this is initially planned until September 2020
- Board and Committee Action Logs dates continue to be scrutinised to ensure that elements are covered or reviewed periodically
- Audit Committee in May streamlined to focus on year-end only – the July time out meeting will now be a normal agenda incorporating the time out elements
- The Council of Governors has been stood down, but communications are still being sent from the Chair and FT Secretary – in May 2020 a plan was agreed to look at how technology could be used to get the governors around a virtual table.
- Covid capital and revenue spend processes have been put in place

Appendix 1: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity - Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood - Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest l risk score that must be referred to on the risk register**.

Appendix 2 - Risk Appetite Statement (Risk Management Framework - Appendix 4)

1. Quality & Safety - Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk adverse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

2. Patient Centred Care - This Trust has made a commitment to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services. The trust is risk adverse (Low) to enabling care without validating and verifying what outcomes are possible and desirable with all stakeholders.

3. Partnerships - This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

4. Financial Stability - The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose. The Trust is averse (Low risk appetite) to committing non evidence based expenditure without its agreed control limits.

5. Recovery - As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk adverse (Low) to recovery that does not provide high levels of compliance with service user outcome measures.

6. Improvement and Innovation - Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

7. Leadership & Talent - The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

8. Operational Delivery of Services -The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the activity for which it has been commissioned. The Trust has an adverse (Low) appetite for failing to deliver the requirements outlined and agreed in commissioner contracts.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 November 2020
Question to the Board

Question received on 8 November 2020

You may be aware that a planning application has recently been submitted to Scarborough Borough Council in order to construct halls of residence in the town centre to accommodate NHS key workers and Coventry University students. The proposal appears to create a very large residence with accommodation for 50 NHS key workers and 150 students. It has been well documented that student halls of residences have been areas of high infection and spreading of Covid-19.

Whilst the provision of much needed accommodation for NHS key workers is to be welcomed, this cannot be allowed to put lives at risk by exposing those NHS key workers to a higher risk of exposure to the Coronavirus. We all hope for a vaccine, but the success of this strategy is as yet unproven, particularly if the virus continues to mutate.

Whilst social distancing and other measures can be adopted to mitigate exposure, there is still a high risk that accommodating the NHS key workers and university students in the same halls does increase the risk of infection and asymptotic transmission. The consequence of NHS key workers inadvertently bringing the infection into our hospital could be disaster and undermine the work being carried out to protect society at large.

Has this Trust considered the risks associated with the transmission of Covid-19 between university students and NHS key workers, with the further risk of infection being brought into our hospital?

Can satisfactory safeguards be implemented to prevent transmission of the Coronavirus to the NHS key workers who would be living with the university students?

Does the risk posed to transmission of the virus undermine the proposal to accommodate the NHS key workers and students in the same halls of residence?

Please acknowledge receipt of this e-mail and confirm that the question will be raised at the Board meeting.

Simon Morritt, Chief Executive's Response

I write in response to your question to the Board of Directors regarding a planning application to build halls of residence in Scarborough town centre to accommodate students and NHS key workers.

The project is a town regeneration project principally between Scarborough Borough Council, Wrenbridge (a developer) and Coventry University.

The Trust's interest in the project is to provide residential accommodation for medical students, nursing staff and/or medical staff who are working at Scarborough Hospital. The proposals for the project currently offer the Trust an entire separate floor of the proposed development, with the remainder of the block for Coventry University students.

We are supportive of the project as it provides a fantastic opportunity to access high quality accommodation in the centre of Scarborough that we can offer to junior doctors and nurses as part of our recruitment and retention strategy, and for Hull York Medical School students to support the expansion in their numbers.

Whilst the COVID-19 pandemic has had an enormous impact, I do not think that it should cause us to rethink our support for this development. Our broader challenges in relation to recruitment and retention of staff still remain, and we need to be planning for the future, beyond COVID-19, as to how we will address these challenges. I understand that, should it gain approval to proceed, the project would not be completed until the summer of 2022. By this time I am optimistic that we will be past any peak, and will potentially have a vaccine that is widely available. Even if this is not the case, we will by necessity have further adapted how we work and live to coexist with the virus, as we cannot allow it to impede indefinitely.

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York Teaching Hospital
NHS Foundation Trust

Board of Directors – 25 November 2020
Implementing Continuity of Carer in midwifery services

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☒
For discussion	☒	A regulatory requirement	☐
For assurance	☒		

Purpose of the Report

To provide information regarding progress and action plan to maintain 35% until March 2021 and deliver 51% of continuity of midwifery carer to York Teaching Hospitals NHS Foundation Trust by March 2022

Executive Summary – Key Points

There is strong evidence along with many national drivers to support the use of Continuity of Carer in maternity services as an operating service model and choice for women.

To implement this recommendation, with relation to achieving the 2019/2020 target of 35% of women being cared for within a continuity of carer model, at York Hospitals we have:

- Piloted 3 schemes at Scarborough and York sites
- Successfully bid for transformation funds 2019/20 to implement wholescale change at Scarborough site
- Launched the wholescale change at Scarborough site
- Launched an on-call case-loading team at York site.

Recommendation

For the Board to note progress in implementation of Continuity of carer, no action is required.

Author: Gillian Locking, Midwife Manager

Director Sponsor: Heather McNair, Chief Nurse

Date: 06/11/2020

1. Introduction and Background

Maternity Services in England have remained in the spotlight since the publication of Better Births in April 2016, the report of the National Maternity Review. The national Maternity Transformation Programme is the vehicle used to facilitate the implementation of the Better Births recommendations.

Continuity of carer means there is consistency of the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour, and the postnatal period. This includes a named midwife taking responsibility for coordinating a woman's care, and for ensuring all the needs of the woman and her baby are met, at the right time and in the right place, throughout the antenatal, intrapartum and postnatal periods. Consequently the woman will develop an ongoing relationship of trust with her midwife, who cares for her over time.

Based on available evidence, case-loading 700 women will provide the following positive outcomes:

- 16% less likely to lose their baby
- 15% fewer epidurals, providing an annual cost benefit of £21,250.
- 24% fewer preterm birth, providing a cost benefit of £12,505.87 for each Level 2 cot day plus ongoing costs of caring for a preterm infant.
- 16% fewer episiotomies, which would equate to 22 women every year not having an episiotomy
- 10% less likely to have an instrumental birth, which would equate to 10 fewer women having an instrumental birth every year.

2. Detail of Report and Assurance

Month	Number of births attended by woman's continuity team midwife	Births attended by woman's continuity team midwife as a percentage off all Scarborough births.	Births attended by Continuity Team midwife as percentage of all Trust births	Births attended by non-continuity midwife as percentage of Trust births
January	33	31%	9%	91%
February	28	26%	8.5%	91.5%
March	32	27%	8.7%	91.3%
April	21	21%	6.4%	93.6%
May	28	24.8%	7.7%	92.3%
June	36	26%	11%	89%
July	60	39%	16.5%	83.5%
August	58	38%	17%	83%
September	62	41%	16.5%	83.5%
October	73	45.5%	19%	81%

CoC booking percentage for October = 42%

It should be noted that the percentage of received CoC has increased month on month. Due to Covid-19 we have not progressed further plans launch the Jorvik or High Risk teams on the York site, which are likely to require additional investment. time work continues to strengthen the existing teams and focus on the received CoC of the teams in place as this is where we will see the evidenced benefits for women.

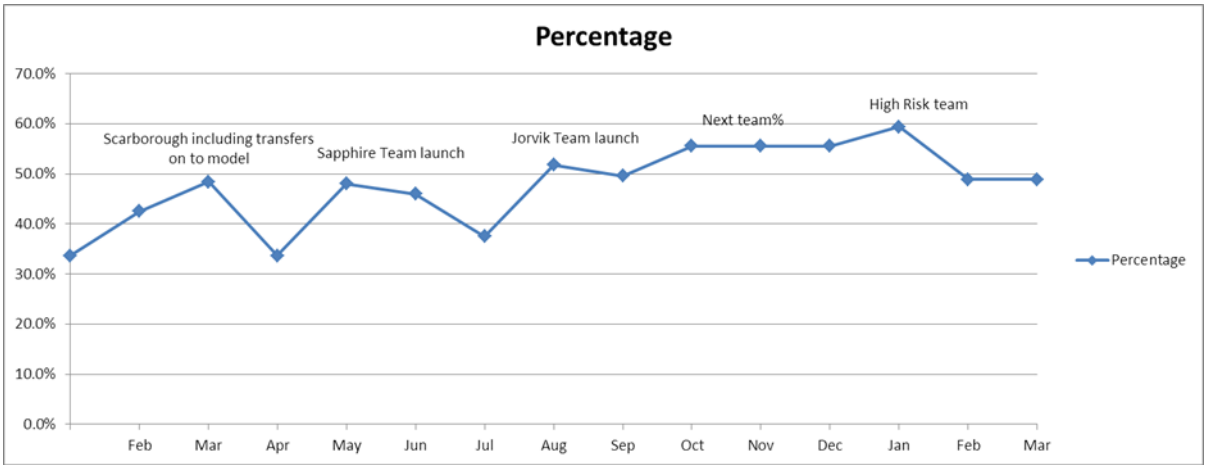
Planned Trajectories - January 2020.

Scarborough site – Whole scale change to Continuity on 06/01/2020. Following consultation with midwives and taking into account feedback, this model was launched as 5 teams of midwives working geographically within an integrated model. Over time, this model alone has shown a 25% received Continuity of carer.

York site – The Sapphire team commenced early March 2020 providing full on call continuity of carer to their caseloads. Due to covid and staffing issues, it was decided that as the team had not yet started working the on call system yet that they would remain community midwives until staffing levels allowed the return to the on call model. The team recommenced in June 2020.

The charts below show how we planned to evolve the model throughout 2020/2021.

	sgh bookings	ydh bookings	total bookings (A)	sgh transfers	ydh transf	Total Tran	A+B	B+C	Percentage	
Feb	160	0	160			0	160	475	33.7%	
Mar	160	0	160	100	0	100	260	611	42.6%	
Apr	160	0	160	136	0	136	296	611	48.4%	
May	160	0	160		0	0	160	475	33.7%	
Jun	160	18	178		50	50	228	475	48.0%	Sapphire Team
Jul	160	18	178		50	50	228	496	46.0%	
Aug	160	18	178			0	178	475	37.5%	
Sep	160	36	196		50	50	246	475	51.8%	Jorvik
Oct	160	36	196		50	50	246	496	49.6%	
Nov	160	54	214		50	50	264	475	55.6%	High Risk
Dec	160	54	214		50	50	264	475	55.6%	
Jan	160	54	214		50	50	264	475	55.6%	Next team
Feb	160	72	232		50	50	282	475	59.4%	
Mar	160	72	232			0	232	475	48.8%	
Apr	160	72	232			0	232	475	48.8%	



Re-evaluated trajectories - September 2020 & current position

Trust wide current position – 4 teams integrated, 2 on call teams.

On evaluation, on call teams provide 85-90% received continuity of carer and evidence a much better work life balance and job satisfaction. Feedback from service users shows this to be the most popular model.

As the outcomes for women rely on building trusting relationships with their team of midwives, it would be too early to evidence outcomes. We plan to review this in the New Year.

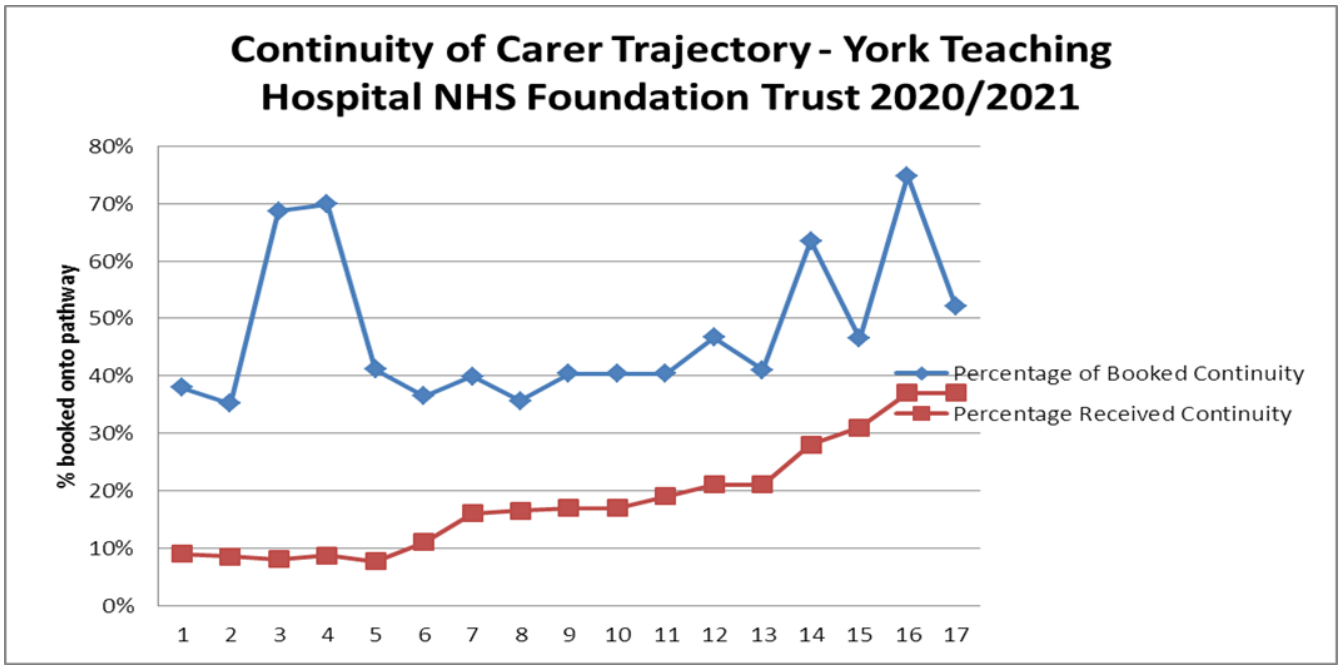
The charts below show how we plan to proceed with the continuity model throughout 2020 and early 2021. A business case will be submitted to support the evolvement of the model throughout 2021.

We have already achieved 35% booked onto a continuity pathway by 2021 as set out in national targets. The original target of 51% been moved to March 2022.

In Light of Covid 19 pandemic with evidence of increased risk to women in BAME categories, focus on meeting the target of 75% of BAME women booked onto a pathway will be increased with a view to expedite plans.

We have had much interest from other trusts regionally and nationally with our wholescale approach on Scarborough site.

2020	SGH bookings onto CoC pathway	York bookings onto CoC pathway	Total bookings onto a continuity pathway(A)	SGH transfers onto pathway <29w	York transfers onto pathway <29w	Total transfers (B)	A + B	Total Trust wide bookings (C)	B + C	Percentage of women booked onto pathway	Comments	
January	185		185			0	185	488	488	37.91%		
February	154	3	157			0	157	446	446	35.20%		Sapphire team launched - not on call
March	166	29	195	100	36	136	331	482	618	68.67%		Sapphire team on hold due to Covid-19
April	188	27	215	136		136	351	502	638	69.92%		
May	139	18	157			0	157	382	382	41.10%		
June	128	17	145			0	145	398	398	36.43%		Sapphire team relaunch
July	168	19	187			0	187	469	469	39.87%		Jasmine Team launch
August	137	14	151			0	151	424	424	35.61%		
Septembe	121	18	139			0	139	366	366	37.98%		
October	168	8	176			0	176	421	421	41.81%		
Novembe	160	18	178			0	178	441	441	40.36%		Lavender Team Launch 09/11/2020
Decembe	160	21	181		25	25	206	441	466	46.71%		0.8WTE to aSapphire team with caseload
2021												
January	160	21	181			0	181	441	441	41.04%		
February	160	45	205		100	100	305	441	541	69.16%		2nd on call team - York site (Jorvik)
March	160	45	205			0	205	441	441	46.49%		
April	160	70	205		100	100	330	441	541	74.83%		3rd on call team - York Site
May	160	70	230			0	230	441	441	52.15%		



3. Next Steps

Malton team is re-launching as an on call team, Lavender on 09/11/2020. The increase in received continuity can be seen in the above chart.

Await Birthrate plus review before building a business case to facilitate plans for 2021.

We will continue to report our monthly progress to the board.

4. Recommendation

For the Board to note progress in implementation of Continuity of carer, no action is required.

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York Teaching Hospital NHS Foundation Trust

Board of Directors – 25 November 2020
Bi- annual Midwifery Workforce Review - Update for Maternity Incentive Scheme standard 4

Trust Strategic Goals:

☒ **To deliver safe and high quality patient care as part of an integrated system**
☒ **To support an engaged, healthy and resilient workforce**
☒ **To ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

This report is intended to update the Board on the Bi-annual review of Midwifery workforce in relation to Maternity Incentive Scheme standard 4.

Executive Summary – Key Points

While staffing ratios continue to meet national standards it is accepted that the current desktop review tool and acuity and dependency spreadsheets are now dated. Accuracy of assessment will be improved following a full birthrate plus review; this is the only workforce review tool available for maternity services. The process of undertaking this has now commenced and will take 2 months. Following this a report will be prepared for board based on the recommendations. Implementation of a new web based acuity and dependency tool for maternity areas has also been commenced and this will provide additional accurate information.

Recommendation

The Board is respectfully requested to formally minute the receipt of a bi-annual workforce review document in order to comply with requirements of the maternity incentive scheme.

Author: Freya Oliver, Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: 30 October 2020

1. Introduction and Background

Workforce provides a critical part of the Maternity safety standards and as such regular reviews and the development of subsequent actions plans where standards are not met is required.

2. Midwifery Workforce review

The Midwifery workforce has been reviewed against the nationally recognised maternity workforce tool Birthrate Plus in a table top exercise in July 2020.

Midwifery staff ratios are currently 1 midwife per 27 births which is above the national recommendations of 1 midwife per 29.5 births for hospital and midwifery led units. York site now meet national recommendations whilst Scarborough site are higher than recommended levels due to the minimum level of staff required to provide a safe service.

Trust midwife ratio per births	York site	Scarborough site
1 midwife : 27 births	1: 28	1: 22

Whilst the continued reduction in births by 2.4% in 2020 has improved the overall midwife to birth ratio, high acuity of women at York requiring a higher level of care continues, which is in line with national and regional trends

One to one care in labour is shown to have a positive impact on the woman's experience and level of intervention required, as well as need for pain relief and outcomes. Compliance percentages have increased following some data quality work and changes are being made to the maternity information system to address. Mitigation remains in place for escalation if 1:1 care falls below 100%. Monitoring of compliance is possible via Signal.

Supernumerary status of the Labour Ward co-coordinator is 100% of the planned Rota, achieving above 90% on both sites with escalation being implemented where any compromise occurs.

Mitigating action:

- Labour Ward on- call midwife in place to provide support in periods of high activity and acuity.
- Maternity escalation plan in place to manage activity and acuity. Labour Ward staffing guidance plans for the Labour Ward co-coordinator to remain supernumerary.
- NICE red flag staffing incidents recorded and discussed at weekly risk meeting (summarised in risk management section)

Plan:

- Continue to closely monitor staffing rates and 1:1 care achievement.
- Working group to plan and assess resource and service change required to maintain Continuity of Carer for 35% women by March 2021 and achieve for 51% women by March 2022. This includes work to specifically look at including 75% of

BAME women on continuity pathways by March 2022. This should have a further positive impact on one to one care in Labour and the supernumerary status of the Labour Ward coordinator.
- Undertake full birthrate plus review
- Implement web based acuity and dependency tool
- Review of maternity escalation guidance

The age profile of midwives in 2020 is similar to 2019 (table below), however it is noted over the last two years the percentage in the under 40 bracket has risen, particularly in Band 7 roles. Recruitment of midwives has not been problematic on either site.

Midwives age range (years)	**Total midwives %** (actual numbers) 2019	**2020**	**Band 7 %** (actual numbers) 2019	**2020**
40 or less	49.4 % (115)	**54.6% (130)**	36.4% (12)	**47.3% (18)**
41 to 50	16.7% (39)	**19.7% (47)**	21.2 % (7)	**31.5% (12)**
51 to 55	21.5% (50	**12.6% (30)**	30.3% (10)	**10.5% (4)**
56 and above	12.4 % (29)	**13% (31)**	12.1 % (4)	**10.5% (4)**

Aspirational midwifery roles considered with a view to develop are:

- Consultant midwife/Advanced Midwifery Practitioner (recommended Safer childbirth 2007)
- Public health midwife and substance misuse midwife to improve outcomes (NICE and NHS Long Term Plan to improve public health, reduce smoking in pregnancy and levels of obesity)

Roles progressed in 2020 are:

- Saving Babies Lives lead Midwife .2 WTE
- Increase in Bereavement Midwife Hours by .3WTE
- Fetal monitoring lead Midwife .4 WTE

Future Plans:

- Full workforce review to look at requirements to look at all aspects of midwifery staffing and to include future Continuity of Carer (CoC) requirements
- Increase Maternity Support Workers roles on postnatal ward and in community to support the midwife role, promote healthy lifestyles, increase breastfeeding, reduce readmission of babies to children's services and enhance the patient experience.
- Consolidate and maintain the Continuity of carer to 35% in March 2021 , additionally begin to measure achieved CoC pathways.
- Develop further plans to include 75% BAME women on CoC pathways by March 2022
- Develop and deliver service change to achieve 51% offer of CoC pathway by March 2022 (NHS Long Term Plan January 2019). There is a risk to the Directorate of not achieving this and therefore this is on the directorate risk register and discussed at the Exec PMM. National Maternity transformation funding to support this is hoped to be received via the HCV LMS.

- Business case to be developed as required to support staffing increase to support CoC
- Further funding required for an additional .4WTE fetal monitoring lead as the requirement is now .4 WTE for each consultant unit

3. Next Steps

Complete full Birthrate plus workforce review and develop detailed recommendations from this. Implement full the upgraded web based acuity and dependency tool.

4. Detailed Recommendation

The Board is respectfully requested to formally minute the receipt of a bi-annual workforce review document in order to comply with requirements of the maternity incentive scheme.

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NHS

York Teaching Hospital

NHS Foundation Trust

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nominations Booklet
October 2020

StarAward

A monthly award which recognises the achievements of staff and volunteers

The MSK Physio Admin Team | **Community Based** | **Nominated by A colleague**

A number of our Physio Admin Team have created a lovely garden for all the staff to use at Archways. They have populated it with colourful flowers and plants. It has been really peaceful and relaxing to sit out there at lunchtime. It has helped deal with stress and anxiety which Covid-19 has produced. Andy Bertram Deputy Chief Executive saw this at first hand together with Karen Cowley from Care Group 6.

Jackie Lingard Administration Assistant | **Community Based** | **Nominated by Sian Norman A colleague**

Myself and colleague had gone to assess a patient who was struggling with chair transfers. It was identified that their chair required chair raisers installing but on attempting to remove the existing feet, it became apparent that we required a larger screw driver. The patient was sitting in a low chair which they could not be safely left in and myself and colleague were in full PPE as per Trust Standard Operating Procedure. It was 30 degrees and our hearts sank. We rang the office to see if any Generic Support Workers were passing the area and could bring us a larger screwdriver. Jackie took my call and said she would deal with it. Unbeknown to us, all other available staff were already out on visits so Jackie took it upon herself to bring us the required tool. She had cycled to work so to get to us she had to cycle in the intense heat but did so with good humour. Her prompt response meant staff on the visit did not have to doff PPE to return to base or leave the patient unattended on an unsuitable chair. The chair was successfully raised and the patient and spouse were delighted with the service provided. Thank you Jackie - a fine example of Trust values being upheld.

Thomas Daniel Physiotherapist | **Community Based** | **Nominated by A colleague**

Tom is a band 5 physio that gained a static post at Selby. When the coronavirus arrived at our hospitals he was redeployed to ICU and respiratory wards at York. He is a lovely caring young man that never complains and I know he will have put 100% effort into looking after the care of COVID patients. It's people like Tom that never receive the recognition they deserve. He is an outstanding young man. Well done Tom

StarAward

A monthly award which recognises the achievements of staff and volunteers

York Community Midwives Sapphire Team **Community Based** **Nominated by Lily Camillo A patient**

I would like to nominate the Sapphire Team for a Star Award because they made the last trimester of my pregnancy, birth and postnatal experience second to none and one I will never forget. Being pregnant and giving birth during the pandemic had been such a strange and surreal experience, from not having your partner with you for important appointments and scans, to the worry of what your experience is going to be like in hospital when you have to attend and give birth was something that kept playing on my mind and worried me, everything was up in the air and my community based midwife changed so frequently, it felt that regardless of how wonderful and kind each individual I met was, I never had any continuity, until Rowan Jackson (who I'd seen Three times on and off) asked if I would like to continue seeing her and be looked after by the Sapphire Team to which I agreed! I cannot thank this wonderful team enough for the care and support they provided me throughout my last trimester, labour and postnatally. The team gave me such amazing support and I can't tell you how much having that continuity and knowing the team you are likely to encounter means and has had such a positive impact on my experience and I cannot praise or thank the team enough for that. I had a few difficulties during the beginning of my pregnancy and also suffered with a pregnancy related pelvic condition which really took its toll on me and having that consistent support and not having to try to start and build a new relationship with from scratch and explain everything again and again was a big relief and meant I felt really comfortable too. I would also like to express how special my named midwife Rowan Jackson and student midwife Megan Hodgson, (Meg went above and beyond to be there during my birth and to attend all my postnatal appointments & was so so fantastic) and Liz Brazil (who delivered my daughter with Meg) all made my experience. I would also like to thank Jess Sellers for arranging and coming into the hospital to see me for appointment last minute when she was on call. I get asked how was it having a baby during lockdown etc and I feel so lucky to say how positive my experience was and that's all thanks to the Sapphire Team. I hope that this team continues to be the future of community based midwifery and just how important it is for mums to have that consistency and support to have a small team of familiar faces follow your pregnancy journey to birth. It was also amazing that Bev Waterhouse (who delivered my first born and is a manager/team leader of the Sapphire team) made the effort to pop in and see me on the postnatal ward which made my experience even more lovely! Thank you all so much! A Star Award is the least you deserve for what Fab service and care you provide to others and deserve this recognition!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Hannah Garnett **Community Setting** **Nominated by**
Therapy Assistant **Clara Brady**

I am nominating Hannah for a star award after her heroic actions with a palliative care patient that she went to visit and could not get access. On looking through the windows she was able to spot the patient on the floor. Hannah then ran around the neighbours to see if she could get a spare key. On gaining access to the property, Hannah called an ambulance and waited with the patient for 40 minutes holding patient's hand and making him as comfortable as possible following his head injury as she had built a good rapport with him through therapy input. Hannah kept speaking to the patient to ensure that he stayed awake as she could clearly see he was coming to the end of his life. Hannah stayed while the paramedics got the patient into bed and made him comfortable. Sadly the patient passed away 10 minutes after he had gotten into bed. Hannah is an exceptional individual who goes above and beyond for her patients to make sure they are cared for as well as possible.

Selby and York **Community Based** **Nominated by**
Community Therapy Team **Fiona Skelton and Cath Speechley**
Colleagues

We would like to acknowledge and recognise how immensely proud we are and appreciative of the Selby and York Community Therapy Team's flexibility ,resilience ,professionalism and commitment throughout this COVID experience. Everyone has had their up's and down's along their own journeys but every step of the way you have supported one another and us to continue to deliver an effective Community Service. Also learning new skills, stretching your boundaries all in a stressful uncertain time, supporting our CRT colleagues. Not one Patient was missed all were contacted ,supported and treated effectively. We are incredibly grateful and proud of you all. Every one of you is appreciated. Thank you.

Ann Learmonth **Community Based** **Nominated by**
Nursery Nurse **Claire Wensley**
A colleague

Ann stepped in, at short notice, to support a family in their home following a very difficult antenatal diagnosis. They had received medical news with far reaching consequences for the whole family. Ann used her skills as a nursery nurse to help the family. She was able to help with explaining the situation to their other children and give strategies of how to deal with the ongoing challenges that the family are dealing with. The whole family has found her support to be invaluable. She continues with her visits as the family continue along this journey. Ann works as part of the Children's Community Nursing team and due to workload increases during the pandemic has been doing a lot of this work without the usual support mechanisms in place. We would like to thank her for all the care and support that she has provided.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Karen Cooper
Midwife

Community Based

Nominated by
Danielle Hoyle
A patient

Our baby boy, Oscar, was born in December 2019. Our first night at home was very challenging as we struggled significantly to establish breastfeeding. We were visited at home by Karen the next day and the support that she provided was outstanding. She turned a very traumatic time for us into one filled with hope and optimism. I felt compelled to provide feedback as Karen made such an enormous difference to our parenting journey, breast feeding experiences and overall emotional wellbeing. The support she provided that day has had a long lasting impact. Oscar was exclusively breastfeed until we recently began introducing foods at six months. This is an achievement that I am very proud of and it would not have been possible without the help we received from Karen. Karen's approach was very caring and empathic. She gave us clear information and then empowered us to make informed choices that felt right for us. We felt valued and supported, and Karen's in-depth knowledge meant she was able to support us with a range of problems that we were experiencing. Karen's guidance was so amazing that I actually look back on that day very fondly, even though Oscar had lost a significant amount of weight and our first night at home had been so challenging. I ended the day filled with hope for the future, which we have now realised, in our view, Karen is an asset to the midwifery profession and we feel so lucky that we received her support as part of our parenting journey.

Kirsty Skinner
Midwife

Community Based

Nominated by
Jayne Pilcher
A relative

Kirsty is a very professional, caring and very lovely midwife. She gave so much information, care and support at a very stressful and difficult time. She spent probably more time than she had at my daughters appointment to make sure she had all the support she needed. I can't thank her enough. My daughter now has more information and definitely the knowledge she needed at a time when she felt very low, she feels much more confident and comfortable after her visit with Kirsty. Thank you Kirsty you made a real difference not just for my daughter but to the whole family.

The Selby Hospital Day Surgery Team 03/09/2020

Community Based

Nominated by
Jill Shepherd
A patient

This was the best hospital experience I have ever had. Completely professional, relaxed, friendly, thoughtful, quick, cheerful - any other words that can relate to a surgical intervention! Superb service all round.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Haldane Day Unit **Scarborough Hospital** **Nominated by**
Sarah Crossland
A colleague

The Theatre team in Scarborough have been amazing and have enabled the opening of a day unit on Haldane ward which has meant that over 100 patients have had their operation since 1st July. This has involved the teams' being trained to be able to run an admissions unit and being adaptable to the change in role. The patient feedback for this unit is extremely positive and I am very proud of what the team have achieved and feel this should be acknowledged.

Sue Dawson **Scarborough Hospital** **Nominated by**
Resuscitation Officer / **Zoe Morrigan**
Clinical Skills Facilitator **A colleague**

I completed my Basic Life Support (BLS) training with Sue earlier this week, I am a student midwife coming to the end of my training and Sue made me feel very welcome and safe. Sue has so much knowledge, I learnt so much during my training and I feel very comfortable in BLS, if and when the emergency arises I feel confident in managing it. Thank you Sue.

Tasmin wade **Scarborough Hospital** **Nominated by**
Speech and Language **Louise Brown**
Therapist **A colleague**

Tasmin has worked tirelessly over the past few months and demonstrated some fantastic leadership skills. She has adopted a leadership role when the team leader and other senior in the department went on maternity leave at the same time. Tasmin stepped up to the challenge despite the team consisting of only her and 2 newly qualified therapists. She worked hard to ensure patient care was met, whilst developing training programmes for the two junior staff members to get them trained up and ensuring their wellbeing was a priority. Tasmin never complains and is truly dedicated to the patients and staff. She always goes the extra mile and will offer training out of hours and is always putting others first. I would like her to know her hard work, positive attitude and dedication has not gone unnoticed.

Jennie Kettlewell **Scarborough Hospital** **Nominated by**
Biomedical Scientist **Carl Burkinshaw**
A colleague

Jennie has stepped in to support not only the Biochemistry Department but also the Point of Care Department on many occasions over the last five months. She has covered staff shortages due to maternity and sickness in both departments stepping in at the last minute, doing multiple extra shifts sometimes reorganising her personal life at the last minute. At short notice she also carried out the required verification for the Covid-19 antibody testing on the Scarborough site in preparation for its rollout Throughout all of this she has maintained a positive and happy infectious persona. I feel it is only right that she is recognised for her selfless commitment to work and the team.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Gail Dawes
Therapy Assistant

Scarborough Hospital

Nominated by
Andy Rossol
A colleague

I work in A&E and had a very specific spinal brace request for a person with a fractured spine. A&E were unable to procure it. I called Gail's team to ask for a physiotherapist to discuss this with, but Gail advised me one was not available on the day in question. Without hesitation she asked if she could help. Not only did she find me the correct brace, she personally came down to A&E with it and used her experience with them to help me measure, fit and counsel the patient. Without Gail this patient would not have got her fractured spine treated as well as she did. Thank you.

Sheeba George
Staff Nurse

Scarborough Hospital

Nominated by
Raja
A relative

Sheeba is a mum of two who excelled in all areas, never taking a day off during the COVID-19 pandemic times. She worked hard and helped many patients in their recovery. We all need to proud of her and what she does for the community.

The Medical Records Team

Scarborough Hospital

Nominated by
Julia Haddington
A colleague

My team at Scarborough have worked well together as a team during COVID-19 ensuring that all case notes have been delivered to wards and departments in a timely manner and also due to the reduction of clinics have all worked together to tidy up the department and streamline processes where possible to improve the functionality of the department during the lockdown. We also had a patient climb onto the fire escape and try and jump off the top and the team dealt with this professionally and calmly until security and nursing staff arrived and the patient was brought back to safety. I am proud of the way my team have worked during the pandemic and continued to support all the clinical staff without question during COVID-19.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Joanne Armstrong
Senior Patient Experience and PALs Manager

Scarborough Hospital

Nominated by
Justin Harle
A colleague

During the pandemic Jo offered to help the Bereavement service at Scarborough Hospital. The substantive member of staff then went on sick leave and Jo ran the service for 6 weeks almost single handed. During this time a totally new process was introduced and Jo had to implement this, ensuring that doctors and ward staff were aware of the new way of working. Jo spoke to families with the compassion that she brings to her day job and had to explain why they couldn't visit their loved ones in the chapel of rest due to the pandemic which was very distressing for all. She liaised with the consultant's to ensure the medical certificates stating the cause of death (MCCDs) were completed in a timely way and she kept families, funeral directors and the mortuary technician informed at all times. She worked with the registry office daily and showed the consultants how to complete the MCCDs and crematorium forms. She referred cases for consultants to the Coroner and helped with the induction of the new medical examiner. When the substantive member of staff returned to work Jo also trained her on the new system. Jo went above and beyond, demonstrating the very best of the NHS. Consultant commendation: It has been an absolute pleasure working with you Jo. You have been an absolute Godsend and the hospital would have fallen apart without you in x's absence! The way you have talked to the bereaved families (and staff having a bad day!) has been outstanding. A true NHS hero.

Vanessa Sunmer
Ward Clerk

Scarborough Hospital

Nominated by
A colleague

At the beginning of the COVID-19 influx Vanessa was one of the first Ward Clerks to volunteer and the first to start on a COVID Ward. Vanessa was put right on the front line which required her to wear full PPE3 on Lilac ward. She worked extended hours as well as most weekends for a number of weeks. She took this all in her stride and was humble when praised for her dedication by follow colleagues.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Matt Marks | **Scarborough Hospital** | **Nominated by**
Charge Nurse | **Amy Mann**
A relative

Matt has been absolutely incredible, Matt has been the calming energy we have needed whilst going through a rollercoaster of emotions this weekend being told to expect the worse. He has kept us up to date with any changes, he has been the kindness and love my family have needed whilst having to make tough decisions and has been there when meetings have been called to be the hand that supports everyone. Matt is a credit to Scarborough ICU, all the staff have, but Matt is a shining star who has helped us to remain calm and collected when emotions ran high.

Amy Anfield | **Scarborough Hospital** | **Nominated by**
Senior Phlebotomist | **Janine Mallinson**
A colleague

Amy has been instrumental in the set up and delivering of the government supported SIRENS clinical research study. It was looking very unlikely that Scarborough Hospital could offer the study here due to lack of space and clinic capability and capacity. Amy volunteered to swab and take bloods from all 144 staff members fortnightly for the next year - a huge commitment! By all means this is no small feat. She then devised a one way system, made visual signs and then sacrificed her office for us for use of the computer and privacy to make appointments and ask occupational health questions. During all of this, Amy was still saying "what more can I do". Nothing is too much trouble and has certainly gone above and beyond her role.

The Malton Hospital | **Community Setting** | **Nominated by**
Facilities | **Jane Guildford**
A colleague

I would like to nominate the facilities team in Malton and those that helped them from elsewhere as we have set up a new Ophthalmic department on the old Ryedale Ward. They have moved equipment, cleared rooms filled with equipment, put up shelves, made stairs safe, cleaned, all through this pandemic that was already a demanding situation for them. All of the outpatient staff appreciated their can do attitude and without this we would not have the smart, clean efficient department that we have.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Karen Hoop **Senior Occupational Therapist**	**Community Based**	**Nominated by** **Natalie Ross** **A colleague**

Karen demonstrates an unwavering commitment to her role as an Occupational Therapist. In April this year Karen caught Coronavirus she was admitted to hospital with breathing difficulties, although she has now made a full recovery she went through a period of being really unwell, Karen returned to work to our community therapy team working throughout the pandemic. Karen has an exceptional level of expertise. In fact I would actually describe her as being a 'talent' within our team. Karen on a day to day basis solves problems and resolves complex situations to allow patients to stay at home, which in the current situation is more important than ever. For example a patient who requires hoisting, Karen can sensitively explain this to the patients family and will train both informal and professional carers in how best to use required equipment. She will regularly stay beyond her working hours in order to do this as promptly as possible .Karen in her ability to assess and treat patient's at home plays a vital contribution in reducing hospital admissions. Our working lives and the lives of the patients she cares for are so much better for having Karen as part of our team. She represents everything that is best about the NHS.

The Community Therapy Team	**Community Based**	**Nominated by** **A colleague**

I would like to nominate the CTT Team in recognition of how they have consistently gone above and beyond in order to provide the best possible care for their patients during what for everyone has been a challenging year. They work efficiently, with compassion and dedication. As a team they look out for each other too and led by Cath The Community Therapy Team Manager consistently check in with each, both by virtual contact and telephone in order to provide support to each other and facilitate team working when difficult to do so. At the height of the pandemic staff changed their working days, rearranged childcare and worked weekends in order to provide support to The Community Response Team. Helping to facilitate hospital discharges, keep safe patients safe in the community and enable timely discharges from York Hospital. Cath Team Lead, Rebecca Macfarland Admin and all of the Generic Therapy Assistants, Occupational Therapists and Physios deserve a nomination in recognition of how hard they have worked to keep patient's 'home first' in often difficult and challenging circumstances.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Chris Williams
Anatomical Pathology Technician

Scarborough Hospital

Nominated by
Laura Sullivan
A relative

When my dad passed away Chris in the mortuary was unbelievably helpful I live in South Wales and wanted to see my dad as soon as possible Chris kept me up to date on everything going on and made the experience of seeing my dad so easy he was supportive and professional I really can't thank him enough and feel that he should be recognised for everything he does. It is an impossible situation for anyone saying goodbye to a loved one so from the bottom of my heart thank you Chris.

Gabriela Kissova
Healthcare Assistant

Scarborough Hospital

Nominated by
Selwyn Davies
A patient

This individual has a kind, generous and a reassuring manor. She has a lovely sense of humour that would definitely cheer anybody up and bring a smile to anyone's face she certainly made me feel very comfortable.

Claire Hopkins
Domestic

Scarborough Hospital

Nominated by
Eleanor Fawthrope
A colleague

Claire is currently our relief domestic on the children's ward. We have recently had a mock CQC inspection and it was noted that the ward was spotless and the cleanliness was outstanding. She has a great relationship with the children and families, is an absolute asset to our team and we all agree she needs to be recognised for all her hard work.

Amy Dailey and Melissa Jenkinson
Sisters

Scarborough Hospital

Nominated by
Ed Smith
A colleague

On 31st July 2020 a seven year old child came into the department in cardiac arrest and, tragically, passed away. Although the entire team managing this catastrophic event were brilliant, Amy and Melissa were absolutely magnificent in going the extra mile to support the family at that devastating time. They put in a huge amount of their own time over the next few days to support the family in the way which has been demonstrated to be best practice after the Manchester bombing of 2017 and coordinated the rest of the team around managing the situation and supporting the family as well as was possible. They also did an enormous amount to support the team as well and worked seamlessly with the portering services and mortuary team. I almost can't find words to describe how much of a credit they are to the organisation and their profession. They embody the values of the Trust and serve as an example to us all. Thank you Amy and Melissa.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Irene Spurr
Healthcare Assistant

Scarborough Hospital

Nominated by
Angela Alexander
A patient

Irene appeared dedicated to her nursing work, providing care in an efficient and professional way. In addition, she showed great empathy and had a very pleasant, warm manner towards every patient on the ward, irrespective of a patient's age and level of distress and/or confusion. Treating each patient with due dignity and respect.

Sarah Tibbett
Discharge Liaison Officer

Scarborough Hospital

Nominated by
Donna Tindall
A colleague

Sarah went over and above to keep myself and my family informed of the care my mum was receiving whilst in Scarborough Hospital, from going into A&E to the ward. Sarah even went to see my mum to reassure her everything would be ok as she was very worried about her stay and spoke to the staff looking after my mum about the past issues she had when is hospital in 2011.

Pauline Rabet,
Occupational Therapist
Holly Richardson,
Physiotherapist
David Tose, Occupational Therapist

Scarborough Hospital

Nominated by
Angela Alexander
A patient

On 27 August 2020, following my recovery from surgery for a broken ankle, Pauline and Holly came to assess me on Maple Ward with a view to my discharge from hospital. I found them to be very helpful, extremely pleasant and enthusiastic. They were not only very knowledgeable but also very professional and thorough. A week later, I had a problem with DVT which required an overnight stay on Graham Ward, where I was reassessed on 2 September 2020 by David. He too was very knowledgeable, professional, thorough and very pleasant. He was particularly helpful in asking additional questions, such as what was I finding most difficult to manage at home on my own. Having discussed the problems in detail he came up with a solution, an excellent caddy for walking frames, which is proving invaluable and making life much easier for me. We also discussed the difficulty I was having in accessing my study, the door to which is over the far side of my bedroom and meant I was having to carry my own walking frame across my king-size bed, as the space at the bottom of the bed was too narrow for a walking frame. He therefore provided me with an additional walking frame for use in my study. Again this is making life much easier for me. All in all, I was impressed with the knowledge, enthusiasm and thoroughness of the Occupational Health Team, the pleasant manner in which they conducted their assessments and the speed with which they got everything into place for me.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Cancer Information and Support Services Team | **Trust Wide** | **Nominated by Jackie Frazer A colleague**

During the pandemic both centres had to close their doors. This meant that delivering information and support particularly during such an uncertain time became very challenging. The team suffered additional set-backs with sickness meaning the service had to flex and change to meet the needs of the cancer patient population and use the resources available in more creative ways. The team built on relationships with other departments such as community palliative care, psycho-oncology and tumour site specific teams to support patients virtually and to sign post to local services that similarly either started up new or adapted existing services. Michelle Kirkman & Gemma Kellerman in particular was and continue to be the constant in delivering vital reassurance, care and compassion through the ever changing environment.

Emma Deans International Nurse Project Manager | **Trust Wide** | **Nominated by Liz Alinaitwe A colleague**

I am an International Nurse, and this October I will be turning one year at Scarborough Hospital. Looking back, I believe that Emma has been a star that shines in the dark. About 2 weeks before I left home, I received a message from Emma welcoming me to York Teaching Hospital, and she said she would help me in everything I needed. That message made me believe that I had made the best choice coming to this trust, I felt accepted. The day I left home, she was in touch with me through-out the day, she wanted to know if I was at the airport, she went to sleep when I told her that I was going to board. I left people at home happy because, they thought that where I was coming, there was someone who would help me. On 7th October, she picked me from the airport and took me to my accommodation, and she assured me that she would help me until I did not need her help any more. Well, the moment she left, I got fear, anxiety and panic of being in a completely new place. I had worked hard to come and work in England, but having no one to talk to, joke with nearly ruined my career. I was getting depressed and it was affecting my work. Emma realised how lonely I was, she constantly checked on me, joked with me and she went an extra mile to write a letter that introduced me to Archbishop Sentamu because I had told her that he is the only Ugandan I knew who lives in England. The Archbishop and wife immediately arranged to meet me and introduced me to other people. That was the beginning of me getting my smile back. I became happier and more productive. Well, it's not only just me, but Emma has been a friend who all international nurses run too. She has been our strength when we are weak, she has been our voice, and she has helped us without judging us. She is a star and she definitely has a heart of Gold!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Holly Roffe **York Hospital** **Nominated by**
Deputy Sister **A colleague**

Not only has Holly been newly promoted to a complex and difficult role she also volunteered to fit test the York Theatre teams for PPE during the difficult and unsettling first wave of the Covid-19 pandemic, she always goes out of her way to be helpful and continues to work in other hospitals providing specialist care, Always approachable, she is a benefit the Trust.

Jon Pinder **York Hospital** **Nominated by**
Theatre Practitioner **A colleague**

Jon is a highly dedicated ODP who always goes above and beyond to support his colleagues in high stress complex surgery and emergency cardiac arrest situations. Despite long shifts in PPE3 he is always cheerful and approachable and is a role model for newly qualified staff. When not at work he is a keen fundraiser for the Yorkshire Air Ambulance and other charities, always doing what he can to be helpful and setting an example for others with his high level of patient care.

Tracey Butterfield **York Hospital** **Nominated by**
Maternity Support Worker **Natalie Heilds**
A patient

I would like to nominate Tracey Butterfield to receive a star award for being an angel to myself and many other mum's to be. Tracey has looked after and given help and support to a lot of people who weren't sure about having a baby, the pain, being scared. She would say the kindest words and make you feel great about yourself and give you the confidence to go through till the end. Tracey is such an inspiration to myself and many more. I want to go into training to become a midwife because of her! Thank you.

Adrian Hanna **York Hospital** **Nominated by**
Junior Doctor **Juliette Kennedy**
A patient

Dr Hanna saw me during an obviously busy A&E shift on a Sunday night. I had a minor injury yet only waited an hour. He was very kind and caring and explained everything very well. He was keen to ensure I was kept informed and had pain relief. I was very impressed with the care he gave me and my relatively minor problem. I was also touched by the general calm, obvious highly competent efficiency and kindness going on around me - in the 2 hours I was able to observe - while in the department. I am also a doctor and appreciate the challenge the ED has with COVID at present and I am very impressed at how adaptations have been made while still keeping patients at the centre - very well done!

StarAward

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York Diabetes Pregnancy Team **York Hospital** **Nominated by Paul Jennings A colleague**

Pregnancy greatly increases women's risk of infection. This is even greater in patients with pre-existing diabetes or those who develop diabetes during pregnancy. Around the world many such women have died or had still-births due to COVID-19. At this time it became essential to reduce the need for these very vulnerable women to attend hospital except when essential. Good control of blood glucose levels in the mothers is paramount if the baby is to survive pregnancy and delivery. The OPD team of specialist Mid-wives, Diabetes specialist nurses, Dieticians and Medical staff rapidly and completely changed their working practices. Utilising only the essential appointments when women had to attend for ultra-sound baby scans all essential screening investigations were performed and women were provided with methods to treat and monitor their blood glucose with devices that could be analysed remotely. The women were then supported throughout their pregnancy via telephone consultations facilitating insulin starts, diet and treatment modifications and delivery plans. From clinic sizes of 25-30 numbers attending for face to face consultations fell to 7-10 per week all linked to scans. The women have greatly appreciated the service, both they and the clinical staff's risk of infection has been greatly reduced and the pregnancy outcomes for the women have not been adversely affected. This has taken a lot of work by all the team with a special mention to Diabetes Staff Nurse Nicola Lloyd-Jones and Diabetes specialist Mid-wife Alex Dexter who have been contacting the women throughout the pregnancies in the evening and at week-end if required.

The Materials Management Unpacking Team **York Hospital** **Nominated by Julie Dixon A colleague**

The team have come in during the entire length of time that we have had to cope with the COVID pandemic. They have unpacked the stock on the wards, trying to keep the areas as tidy as possible, ensuring that we had the stock needed for patient care. They have also assisted with taking stock out to the wards when stores was inundated with PPE stock. They have tried to keep the areas as tidy as possible even during lots of ward moves and staff shortages due to people working from home. One member of staff even contracted COVID and was very poorly just managing to avoid been hospitalised. Once he was able he came back as soon as possible and has continued to work extremely hard. Without their support the materials management team would not have been able to do their role and enable some staff to work from home to enable the social distancing rules.

Lucinda Pannett Occupational Health Nurse **York Hospital** **Nominated by A colleague**

Lucinda ,as far as I am concerned, went above and beyond what would be required of her, She was an absolute rock when I was at a low point, she helped arrange various appointments for me and we kept in regular contact during my absence and helped when it came to the point of redeployment (with a great deal of encouragement). In my eyes what a star.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Linda Gude | **York Hospital** | **Nominated by**
Staff Nurse | **Marie Lawrence**
A colleague

I have worked with Linda for a few years now, she was a health care assistant before becoming a nurse she has only been qualified a year, she puts her all into her job, caring kind and goes beyond her role, over the last couple of months with COVID I was redeployed with her to HDU, it was hard and emotional, but Linda was a rock for me, keeping me sane, through such hard times, I think she is well deserving of this nomination.

Claire Kershaw | **York Hospital** | **Nominated by**
Speciality Registrar | **Sally Irwin**
Gerry McGonigal | **A colleague**
Consultant
Sandeep Kesavan
Consultant

Claire, Gerry and Sandeep stood in during COVID-19 pandemic to take over completion of death certification for the trust. They provided consistent completion for all deaths during COVID-19, reducing delays for families during what was already a very difficult time for all. It also helped support clinical teams on the COVID-19 wards as well as staff in the bereavement suite.

Harry Corker | **York Hospital** | **Nominated by**
Junior Doctor

I just want to thank Harry for his hard work attending to my ear infection. After two weeks suffering it is such a relief to feel so much better.

Daniel Turnock | **York Hospital** | **Nominated by**
Consultant Clinical | **Joanna Andrew**
Scientist | **A colleague**

Last year a group was set up to enable the laboratory service to work with the CCG's in York & Scarborough in order to develop a demand management strategy. Having a demand management strategy, standardising requests and using evidence based guidelines will ensure patients are not put at undue risk by avoiding unnecessary test procedures and will free up clinical time which can be used for those tests which are evidence based and appropriate. It is an opportunity to improve patient care and experience by reducing the number of patients undergoing testing that is unnecessary and ensuring, where patients should be having tests, this is happening in a timely manner. Without the support, enthusiasm and clinical expertise of Dr Dan Turnock the group would not have been as successful as it has been and we would not have achieved as much as we have done already.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Geraldine Downing
Peritoneal Dialysis Specialist Nurse

York Hospital

Nominated by
Jenny Hind and Grace Oliver
Colleagues

Recently on ward 33 we were short of nurses due to staff sickness, we were under extra pressure that day as we needed a staff nurse for a patient escort to Leeds for a procedure. The peritoneal dialysis nurses are based on ward, with their own busy case load and that day Geraldine heard our call for help. We are so grateful for Geraldine Selfless actions, who rearranged her busy day to allow time to escort our patient to Leeds. This was above and beyond Geraldine's responsibility, helped to prevent a delay in patient treatment and massively reduced the stress on myself and Grace staffing the ward. We are so thankful for Geraldine's support, she is a true star.

The Midwifery Night Shift Team 15 & 16 August 2020

York Hospital

Nominated by
James Rotchell
A relative

Abbie, Frankie and team supported my wife and I throughout her labour, leading to our beautiful daughter Edie being born at 0335 on 16AUG20. I know that not everyone has a positive birthing experience, so I am truly grateful to the whole team, but in particular Abbie who did such an amazing job to make Marie and I comfortable and informed throughout. We never felt in the dark and were so confident that everything was in control, allowing us both to relax. I have no doubt that the behaviour and expertise of the team made Edie's delivery much smoother and quicker than it may have otherwise been. The aftercare by the midwifery and surgical team along with the incredible healthcare assistants on the labour ward were second to none! Thank you so much - you've made me the happiest and proudest Daddy and Husband!

Karen Harrison
Staff Nurse

York Hospital

Nominated by
Maddie Pallier
A patient

In this time of COVID-19 emergency Karen has been so helpful and supportive. She has gone the extra mile in ensuring I could continue with my monthly treatments at home, and ensuring that I had a supply of equipment and prescription medicine followed with a monthly phone call. Karen's care has given me the confidence to undertake the treatment myself. The whole department she works within have always treated me with the utmost care and respect. I would like to say thank you.

Ian Taylor
Endoscopy Technician

York Hospital

Nominated by
Joanne Ellis-Collins
A patient

Ian was very, very caring, holding my hand and just being there helping me with the gas and air, during, what was, a very uncomfortable procedure to say the least. Without that reassurance I am sure that I would have run a mile and ceased the procedure.

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The Plaster Room Technicians | **York Hospital** | **Nominated by Gemma Phillips A relative**

My 9 year old daughter, Ocean broke her leg, she has global development delay and intellectual disability disorder. On arrival Ocean was very nervous and scared but we were greeted by 3 lovely, happy ladies (Laura McIntyre, is AMAZING) who clearly love their jobs. They went above and beyond for Ocean!! Who very quickly become happy and relaxed, they asked what she had done which got Ocean talking about the Greatest Showman (Ocean loves this film) they started playing the sound track and singing along with Ocean while they were putting her pot on, they asked Ocean what colour pot she would like she asked for purple and they then passed her a tub of glitters to pick some magic glitter to put on as well, not only did they put glitter on they hand cut pink love hearts to put on it as well! They went well above and beyond and I can't thank them enough, my daughter speaks about them every day, we have a lot of people stop us in the street to say how incredible the pot is and they have never seen one like it, which makes my daughter so happy and has lifted her confidence loads, I really hope they get the appreciation they deserve!!

Denise McNaughton Administrator | **York Hospital** | **Nominated by Kelly Cauley**

Denise has been extremely dedicated to the department during the pandemic. She has cancelled annual leave to ensure that the service continues to run. Denise is covering for staff who have been off work for months and continues to also do her job. Denise displays the Trust values on a day to day basis, she works long hours and still has time to support her staff. I feel lucky to work alongside such a dedicated member of staff.

The Eye Clinic Team | **York Hospital** | **Nominated by Christine Tattersfield A relative**

The eye department at York Hospital, have stayed open throughout the pandemic, seeing patients who needed treatment alongside emergencies. Working within the COVID guidelines and wearing full PPE, to make sure all patients requiring treatment received it. They are the only outpatients clinic that stayed open through-out , and are now nearly back to normal capacity.

Emily Coulby-Ackroyd Staff Nurse | **York Hospital** | **Nominated by Ali Coulby-Ackroyd A relative**

Emily works really hard, she works long hours and always has a smile on her face, I think she is an absolute star and deserves some recognition for everything she does and continues to do to help families with their premature babies. She raises money for underpaid services and is an asset to the team.

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Kate Iley and the team in Audiology | **York Hospital** | **Nominated by Anne-Marie Becker A colleague**

Kate and the audiology team have worked really hard over the previous months to adapt to the new guidelines providing virtual clinics for patients and have manged to increase their postal service significantly . This has meant that patients needing hearing aid repairs could continue to access these without the need to visit a clinic or book an appointment. The postal service has always been available but patients have tended to prefer a face to face appointment the service as a whole has managed to change quickly and adapt to new virtual clinics with a significant increase for the postal service going from 2% to 22 % of patients using that part of the service. A great use of resources.

Patrick Boyes Ward Clerk | **York Hospital** | **Nominated by A colleague**

Patrick is an incredibly empathetic and conscientious member of the team on Day Unit / Extended Stay Area. He is always considerate of how his team is feeling and consistently supports the nursing staff to get through challenging shifts. For newly qualified nurses, starting a new career it is daunting, and you often don't get told when you are doing a good job. Patrick always offers words of encouragement to staff, and hearing his kind words as a new nurse got me and my fellow newly qualified nurses through a lot of tough shifts. No matter how busy he is Patrick will always find time to help with his characteristic calm and good humour, which puts patients and relatives at ease.

The Team on Ward 34 | **York Hospital** | **Nominated by A colleague**

There are so many outstanding members of the ward 34 team that I feel a team nomination is most appropriate. The ward 34 team has shown incredible teamwork through the difficult last 6 months, moving wards 3 times and staffing Covid-19 HDU. Throughout everything the team has shown warmth to new staff who have been redeployed to them and many have stepped up to act as fantastic mentor figures. No matter how difficult a shift is staff always pull together and work as a tightly knit team to ensure patients are well cared for. The ward prides itself on its high standards of teaching and management of patients on None Invasive Ventilation (NIV), which became an absolutely invaluable attribute during the last few months. Senior nurses on ward 34 were able to put together a NIV outreach service from scratch to meet the demands of the coronavirus pandemic, as well as training up staff across the hospital.

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Leila Fahel
Consultant

York Hospital

Nominated by
Kathryn Chaganis
A patient

I had to have a caesarean birth during lockdown. Dr Fahel looked after me prior to this and I really felt in safe hands despite the current climate, having various serious health issues and this being my first child. She always took the time to explain things thoroughly to me and always rang back when she said she would -on occasion this being out of her duty hours. She even went out of her way when organising the caesarean to ensure I was as shielded as possible (due to my health) eg I arrived just after staff change over time and only had the same day/night staff caring for me. After the birth she even visited me and my son to ensure we were well, which was so lovely- especially as he was born during lockdown so no outside visitors were allowed! She has no idea what a difference she made to me during difficult and unpredictable times. I can't thank her enough!

The Heart Failure Specialist Nursing Team

York Hospital

Nominated by
Donna Jack
A colleague

The heart failure team are a small team with an ever growing caseload caring for patients with differing degrees of heart failure. During COVID-19 they completely redesigned their service and moved it offsite to try and avoid patients from coming to the hospital but maintained a service where patients were still seen, a comprehensive assessment completed and treatment given. This potentially avoided a hospital admission, something that we were trying to avoid in the high risk patients. While operating this new service they continued to review patients in the hospital and even took on partial redeployment to support different areas in the hospital. There are 3 members of the team usually based in the hospital - 2 specialist nurses and our admin co-ordinator. The team have worked closely with their community colleagues working together to provide a streamline service and with the cardiology consultants to ensure patients who are needing quick and effective treatment plan have access to this while ensuring the risk to patients is low. They have worked so hard and have been quickly reactive to any need that arises. We have had patients come forward with great feedback for the service and a family that have been fundraising as they would like to help raise funds for the team. I am very proud and in awe of all their hard work and passion to deliver high quality care in the challenging circumstances that we are in. Well done to all the team!

Mr Bandy and Team

York Hospital

Nominated by
Charles Brown
A patient

Throughout my flexible sigmoidoscopy procedure, I was made to feel at ease, and confident that I was in the safe hands of a very capable, caring and professional team, led by Mr Bandy. They are truly a credit to their profession and I thank them.

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The Gynaecology Assessment Unit (GAU) | **York Hospital** | **Nominated by Emma Firth A patient**

I have spent a lot of time in and out of GAU recently due to complications after a miscarriage and the whole team has been amazing. From the Sonographers to the nurses and Doctors, I have had outstanding care. They have been kind, caring compassionate, they have been there for me when I needed to cry and made me laugh through all the examinations I have had to keep my spirits up. Everything has been explained clearly and thoroughly and they have done everything possible to make sure I have been comfortable and pain free. They have been on the end of the phone for me whenever needed for the past 5 weeks and although my complications are still currently on going they are doing everything they can to try and get me sorted quickly. Amazing people and I could not have asked for a better team to look after me. They even recognise me now when I walk into the unit and have a friendly chat!! I'd like to give a special mention to Gail Crow such a lovely lady who has made me feel so at ease as well as all of the above.

Libby Ridsdale Healthcare Assistant | **York Hospital** | **Nominated by Trudy Fletcher A colleague**

I would like to nominate Libby for a star award as she went above and beyond her call of duty. We had discharged a patient from our ward and one medicine had been missed. Libby offered to drop the medicine off to the patient on her way home from work. Upon calling at the patients house Libby found that the patient was quite worried about being alone at home after a long stay in hospital. She sat with the patient for an hour and made them a cup of tea and gave reassurance. I am so proud of Libby she is an asset to our ward. Her care for our patients is brilliant and shows that we never stop caring even when the patient has been discharged.

Ward 31 | **York Hospital** | **Nominated by Richard Carew A relative**

The team on Ward 31 are amazing. As well as their obvious medical competence, there is a baseline kindness in the way that they look after their patients (my wife in this case) which is stunning. Individuals within the team regularly go the extra mile to look after the patient's family as well as the patient themselves. Ian Fowler describes the Ward as 'family'- and that has certainly been our experience. Thank you.

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Lizzie Verity **York Hospital** **Nominated by**
Midwife **Helen Cawthorne**
A patient

In December 2018, I was 34 weeks pregnant and went into maternity triage with reduced movements. The midwife Lizzie Verity noticed the babies heart rate was abnormally fast and her quick thinking meant I was rushed for an emergency C-section and our baby was born. Unfortunately, our baby Barney died at 32 hours old after being diagnosed with a heart condition. If it wasn't for her quick thinking Barney would have been stillborn and we wouldn't have been able to spend the time we did with him. When I became pregnant again, it was an extremely anxious time. I had PTSD which was triggered by returning to Maternity triage but at each visit Lizzie spent time speaking to my husband and I about Barney making the experience easier for us both. However, COVID-19 meant that my husband wasn't able to come to maternity triage in the later stages of pregnancy. Lizzie spoke to my husband on the phone and spent longer periods of time reassuring me in triage and helped to arrange an extra scan with my Consultant after some worrying movements. I never thought I'd give birth to a living baby but Lizzie gave me the strength to believe I could. On the day of my C-section, unfortunately my bereavement midwife wasn't able to attend due to sickness. Lizzie was at work and offered to deliver our baby she helped us feel calm and relaxed. The birth was an amazing experience and Lizzie made James feel involved in the whole process. Baby Otis was born healthy in lockdown, May 2020. Lizzie went above and beyond by coming to see me on the postnatal ward which provided me with emotional support as my husband wasn't able to visit due to COVID. Lizzie also made an attempt to visit Barney in the cemetery but it was closed due to the lockdown.

David Moate **York Hospital** **Nominated by**
Medical Equipment **Louise Magson**
Engineer **A colleague**

I would like to nominate David for a star award. I am a theatre sister in the general surgery team at York hospital and on many occasions I have reported equipment to medical engineering. David always comes to the department promptly to assess equipment and he quickly finds a solution. He is friendly, helpful and nothing is too much trouble. He is able to explain things in a simple way to people who may not fully understand engineering terminology. David simply makes my job a lot easier! I personally believe that you shouldn't have to do something extraordinary to win a star award. The people who live the trust values and do their job exceptionally well and consistently deserve to be celebrated too.

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Samantha Mitchell-Robinson
Healthcare Assistant

York Hospital

Nominated by
A colleague

Sam has worked within the Head and Neck speciality for many years and has a wealth of knowledge and experience. She is always willing to step up and try new ways of working and has offered many inspirational ideas. She is highly respected by her work colleagues and wider MDT team. She has recently returned to the head and neck OPD from redeployment and has adapted well to new ways of working. With fresh eyes she has shared new ideas and most impressively stepped up to help out our Admin team by running the front desk when they were short staffed by booking patients in once they had had there temperatures checked by another member of staff. Sam even went one step further and managed to do patients COVID assessments and temperatures at the same time by simply moving the computer so she was able to do two peoples jobs at the same time. This then meant that only one member of the nursing team was required instead of having to use bank staff to help with the shortfall. Sounds simple, but it is often the little things which matter most.

Michelle Hughes
Healthcare Assistant

York Hospital

Nominated by
A colleague

Michelle has gone above and beyond and has shown care and compassion to one of our patients who required a lot of support whilst undergoing a diagnostic procedure. Due to COVID-19 a registered nurse would have assisted the Dr and supported the patient whilst wearing full PPE, but Michelle put herself forward rather than making the patient wait, who was already highly anxious, which was made worse by seeing the Dr in full PPE. The patient was also not aloud their family member to be present in the room. Michelle calmed the patient down and reassured them throughout the procedure. She was very professional and had a soothing voice which enabled the patient to relax and made the procedure less difficult to perform. The patient was able to leave feeling reassured after their consultation and diagnosis and avoided having to have a general anaesthetic. I understand that this was the first time Michelle has ever worn full PPE 3 which must have been daunting for her.

Neil Norman
Operating Department Practitioner

York Hospital

Nominated by
Lesley Phillips
A colleague

I would like to nominate my college Neil for going above the call of duty and helping transfer an acutely sick patient by ambulance from Scarborough Hospital when Scarborough were short staffed. Neil went to Scarborough from York in a taxi at short notice to help alleviate the staffing issues and safely transferred a patient to ICU. Neil embodies the trust ethos and is a credit to the Hospital.

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Alison Bull **York Hospital** **Nominated by**
Medicines Management **Sharon Jardine**
Assistant **A colleague**

Alison has been a great team player and contributed a lot of extra efforts in the adjustments to the department following the COVID-19 outbreak. Alison has made herself available to help in all areas of the pharmacy department including pharmacy stores and carrying out a lot of ward stock checks and top up as well as moving stock efficiently during ward moves so the ward have all the medication ready to use for the patients. Alison has contributed to a new and quicker way to order stock medications for our sub pharmacy team in Beta room which has been very successful and saves so much time to carry out other duties. She has also helped by stepping in to cover staff illnesses and carrying out patient counselling, taking on extra slots in facilitating patients discharges. Alison is very knowledgeable and professional in her job and is always there to offer help whether by contributing extra tasks that need done or by offering a friendly ear. Alison is a greatly valued member of the pharmacy team that deserves recognition and I personally think she deserves a star award.

The Laboratory Medicine **York Hospital** **Nominated by**
Office Ladies **Alison Jones**
A colleague

When one of our small team of five Clinical Biochemists took a year off work to have a baby, we knew we would struggle to continue to provide our services to the standard we wanted to. We reviewed some of the tasks regularly undertaken by the clinical team to see if other members of the department could take on some of our tasks. We noted that most of the abnormal results telephoned to requestors were actually passed onto receptionists or secretaries, and therefore didn't require clinically trained staff to make such phone calls. We approached the busy admin team in the York Blood Sciences office, who receive most of the telephone enquiries coming into the department, to see if they could help. We used some of the maternity backfill money available to fund some extra band 2 hours. Then we set up a system for directing abnormal results from primary care and out-patient clinics to the admin team for verbal communication, after review by the Clinical Biochemists. The team took up the challenge with enthusiasm and good will. Their flexibility, adaptability and willingness to get on with the job has exceeded the original expectations of the project. The admin team in Scarborough lab also now support the system, and the teams across both sites work together to ensure daily cover. It is estimated that now, over a year after the project was piloted, they have freed up in excess of 1PA (4 hours) of clinical staff time every week (probably closer to 2PAs). Not all of the admin team have been directly involved in the project, but all support the wider team by covering the other duties in the offices. Therefore the whole team are deserving of a Star Award for their invaluable support and good humour.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

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Nominations for November 2020

Sian Norman **Community Based** **Nominated by**
Occupational Therapist **Fiona Skelton**
A colleague

I have just received some lovely feedback from an OT student about her educator Sian Norman and felt it warranted recognition. "For my first placement at Selby Community Therapy Team, I was met with mixed emotions, however, having Sian as my supervisor vastly helped allay my concerns" "Despite being on annual leave at the time of my arrival to the placement, Sian had informed me of the plans ahead. She had also put me in contact with the members of staff I was going to meet and how I would work in the interim; once more my anxiety was allayed due to her care and concern" "Working alongside her in the Community Therapy Team (CTT), the Community Response Team (CRT) and the Inpatient Patient Unit (IPU) presented me with more opportunities to learn despite of the Covid-19 working conditions. As the office was working under social distancing measures and guidelines, Sian kept me fully informed at all times, by ensuring that we planned the week in advance and worked flexibly when any changes occurred. Sian also ensured that she allowed me to work autonomously across the above teams, which in turn provided me with opportunities for inter-professional working. I was presented with the opportunity to work with physiotherapists, general support workers, and general therapy assistants other occupational therapists, nurses, doctors and consultants. Working inter-professionally allowed me to gain further experience; such skills included how to deal with non-compliant patients which in turn made it easier to interact with other professionals during handover team meetings. I feel that the placement was very well organised especially considering the current Covid-19 climate. I felt that I was communicated with at all times and updated with any changes in advance by Sian and any member of the team that I was due to work with. Sian was very familiar with the assessment process of my placement; she assessed me fairly and gave me constructive feedback throughout the placement. Therefore, I would strongly recommend this placement to other students who may be concerned with working within a community setting during the Covid-19 pandemic. My only recommendation is that they remain flexible and understanding of the changes in the working environment during the Covid-19 pandemic to ensure they glean the most from the placement" "Overall, I have found my experience whilst working alongside Sian to be outstanding. I was also greatly impressed by her ability to maintain an attitude of continuous learning, regardless of her twenty eight years of professional experience" "I strongly believe that the occupational therapy profession needs individuals with her vast experience, knowledge but above all her approachable personality. "

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Heather Mather **Community Based** **Nominated by**
Physiotherapist **Peter Williams**
A relative

I write to express my appreciation of a member of your Community Physiotherapy Team.

My wife was diagnosed with an incurable cancer earlier in the year that progressively disrupted her ability to walk. The McMillan nurses at YDH contacted your group and Heather Mather made contact with us.

Heather visited on a number of occasions and advised and organised walking aids to help my wife Julie. On each occasion her help was invaluable and improved my wife's quality of life. Heather was always friendly, cheerful and totally professional

On the last occasion I contacted Heather, she organised a portable commode and arranged for it to arrive the same day. I believe she also contacted the Hospice at Home team and informed them about my wife's deterioration. The following day, I was contacted by a member of their team who decided to visit us that day. This intervention was so timely because my wife's condition worsened very dramatically later that day. Because the Hospice at Home team were involved, they immediately organised a care programme that was set up within a day. The care provided eased the last two days of my wife's life and I would just like you to know what an important part Heather played throughout the care of my wife and especially in her last days.

It is refreshing to see members of the NHS working so well across disciplines and teams to look after patients. Thank you all so much.

Deborah Barrett **Community Based** **Nominated by**
Nurse Admin Team Leader **Karen Wiley**
A colleague

I would like to nominate Deborah, Due to long-term absences within her team, she has stepped in and on many occasions worked her non-working days to cover the service, all this whilst still undertaking her own role in the community. Often working in different locations to support the nursing teams which is vital and has a great impact when the support is not there for the clinical teams, the successful rate of recruitment into the wider team. I would like to show my appreciation by this nomination.

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Kerry Pentland **Community Based** **Nominated by**
Community Nurse **Jane Venable**
A colleague

Kerry visited a patient on the District Nurse caseload to check her blood glucose levels and administer the patient's insulin. Kerry checked the previous blood glucose readings and realised the patient needed reviewing by the Diabetic Specialist Nurse because the patient's readings were low. Kerry contacted the Diabetic Specialist Nurse and the patient's insulin dose was changed. Kerry organised an email to be sent to the patients GP to alter the patient's prescription. The next day Kerry visited the patient again. The new insulin was not in the house so Kerry went to the GP's surgery to collect the prescription form. Kerry then tried to obtain the new insulin from several chemists who did not have it. She then contacted a chemist who stated they did have the required insulin but unfortunately after travelling there and waiting, the insulin was not available. Kerry left the prescription at the chemist and contacted the patient's son to collect it later. Kerry then went back to visit the patient to check she was ok and contacted the Diabetic Specialist again; Kerry was advised to omit the insulin because the patient's blood glucose level was within range and start the new regime the following day. Kerry's commitment and tenacity ensured the patient did receive the care she needed.

Wendy Verity **Community Based** **Nominated by**
Community Nurse **Jane Venable**

Wendy visited a patient to check her blood glucose level and administer her insulin. The patient's blood sugar reading was low and the patient said she hadn't had any food but she was expecting her son to bring her evening meal. Wendy gave her some biscuits and fruit but was unable to contact the patient's son to find out when he would be bringing the patient's meal. Wendy did not give the patient her insulin but agreed to come back later and check the patient's blood sugars and give her insulin. Wendy returned at 18.00 and rechecked the patient's blood sugars; the patient still had not eaten so Wendy went to the shop to buy her some food to eat. It is important for patient's with diabetes to have regular meals and without Wendy's intervention this patient would not have eaten for 24 hours, she demonstrated compassion and kindness for the patient and went beyond the usual role of a community staff nurse to benefit the patient in her care.

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Laura Newsham **Community Based** **Nominated by**
Retinal Screener **A colleague**

Laura was completing courtesy calls to patients before their eye screening appointment. On one call the patient's wife answered in a very distressed state and was concerned for the health of her husband who may not be breathing. Laura calmly explained to the patient's wife that she would organise some help for her. And tried to get more information form the patient's wife. She called out to other staff available to call for an ambulance due to concerns for the patient. Whilst staying on the phone with the patients wife to offer reassurance, in a caring and professional way. Laura really went the extra mile to send help to this patient on the information given whilst all the time ensuring the patients wife was comforted and understood that help was being arranged for her. Laura showed clear compassion and empathy whilst delivering high quality patient centred care even in this unusual circumstance.

Adam Shaw **Community Based** **Nominated by**
Diabetic Eye Screener and Grader **Shelly Widdowson**
A colleague

Adam has worked for the North Yorkshire Diabetic Eye Screening Programme since December 2017. In that time he has always shown willingness to learn and go the extra mile to be helpful and do the best that he can for both patients and staff. Most recently Adam has really stepped up again to help the programme and staff with a problem that arose as a result of the COVID19 outbreak. The programme has adopted new ways of working to manage the recovery of the service, which meant that the staff rota was more complicated than usual. This was due to more cross-site clinic cover; staff needing to work adjusted hours; staff needing to self-isolate at short notice and clinics running longer than usual to meet the demands of the backlog of patients who need screening. The rota is changing regularly and staff were concerned that they might miss changes which could result in them going to wrong venues or not being sure which days they were working. Adam was asked to look at 'Google Drive' and see if this would be a workable solution for us to share a live rota on this platform and make the rota accessible to staff at any time day using their mobile phones or tablets and home or work laptops. Adam took time and effort and worked out of hours to make sure that he was familiar with the online solution. He talked through the issues and then went away and resolved them. A few iterations later and accompanied by guides for staff, the rota is live! Adam acted quickly on some early adjustments after receiving feedback from colleagues, and this has resulted in a great piece of work which will be of help to all staff and the service. Well done Adam!

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Leanne Roebuck
Community Midwife

Community Based

Nominated by
Daniella Purce
A patient

Leanne was my community midwife on both my pregnancies. After suffering with PND and PTSD following an emergency C-Section, she made sure I was put at ease with my second pregnancy, always on the other end of the phone if I needed her. She is kind, caring and very professional, she absolutely went the extra mile when looking after me and listened to all my concerns. My second child was born via elective C-Section and the aftercare I received from her was wonderful, not discharging me until I felt ready. Leanne made a huge difference to my pregnancy 2nd time round and I will be forever grateful for the excellent care I received from her.

Julie Stephenson
Generic Therapy Assistant

Community Based

Nominated by
Deborah Sawyer
A colleague

Julie .....my good friend and colleague supported me during my 4 month shielding period . This was a very difficult time, she phoned me at least once every day sometimes several times a day as she knew how difficult I was finding this time. She also fought to try and get more support for me. She will never know how much she helped me but I want everyone to know what an amazing hard working caring person she is.

Stephanie Pearse
Generic Support Worker

Community Based

Nominated by
Joel Crosland
A colleague

We had a patient on our caseload who we have been supporting for a while, and aside from some social contact at his local pub, he has no family or other support networks in place. It was recently his birthday and Steph had gone out of her way to buy him a birthday card and get some of the staff members in that day to sign this card. The patient was very proud to show off his birthday card to his friends in the pub. Steph always has patient's best interests at heart and I feel this example shows how much she cares.

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Kath Buck
Healthcare Assistant

Malton Hospital

Nominated by
Gemma Ashworth
A colleague

Every Thursday Morning Kath enters the department with a jovial welcoming "morning". I work in a different department to Kath, however our clinical rooms are in the same area and her happy nature and care towards the patients is very infectious and admirable. She has worked through the harder times in the year with COVID and yet has remained upbeat and positive throughout the process. Kath is very approachable and is always willing to help, even if the patients are not Dermatology related. She ensures both staff and patients are okay and her willingness to help on a daily basis and offer support to her colleagues is immeasurable. It is really enjoyable to work alongside a member of staff who has a positive outlook on life and puts patients at ease whilst maintaining a professional attitude.

Mr Lyon
Consultant
Kath Buck
Healthcare Assistant

Malton Hospital

Nominated by
Margaret Laycock
A patient

My appointment was just a great experience from beginning to end. Dr Lyon is a great professional, and promotes confidence throughout, he also has a great sense of humour and he and Kath are a great team. They work so well together and bounce off each other. They made me feel right at home and so very comfortable with them. The whole atmosphere was so relaxed and yet so professional. I just can't begin to explain what a difference such an atmosphere makes from the patient's point of view. I had every confidence in the whole team. The most pleasant experience I have ever had in any hospital. The procedure was carried out with the minimum of fuss and I was in and out in minutes. Thank you so much.

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Tanya Barber **Scarborough Hospital** **Nominated by**
Domestic **Jan Stephens**
A relative

The iPad on Oak Ward was not working when our mother was a inpatient last week. Mum has Alzheimer's Dementia and it was really important that she was able to use Zoom as visiting was (understandably) not permitted. Tanya moved heaven and earth to facilitate Mum seeing us all on a Zoom meeting and it made such a difference to Mum's week long stay in Scarborough hospital and to the whole family including Dad, a 91 year old, who was missing his wife so very much. So a huge thank you to Tanya from all the Stephens family for her support, care and professionalism that enabled such a wonderful experience for Mum.

Paul Thompson **Scarborough Hospital** **Nominated by**
IT Engineer **Jackie Forsdyke**
A colleague

The Temporary Staffing Team, like many other teams, has had to adapt to a new way of working during the pandemic. With the majority of the team working from home, technology plays a really important part of enabling us to do our jobs, particularly when providing such a busy operational service. Our phone system is vitally important, it enables us to communicate effectively as a team but also to be able to keep in touch with our bank workforce and wards /departments to ensure the service runs smoothly and staffing issues are addressed in the moment. Paul's support in managing our phone system has been simply invaluable; there has never been a time when it was too much trouble and it provides great reassurance when you know Paul is looking into something for you. He is always a happy individual, smiling and joking with us and takes the time to know us by name, while being very patient and more than willing to support. Paul has always gone above and beyond over the years, not just during COVID. We know he will be under increasing demand at this time, yet he always approaches us and the issues we are having with the same cheerful demeanour and professional service, even when we must test his patience! His support has enabled us to keep running the service smoothly in such different circumstances and makes all of our lives that much easier, something we are genuinely grateful for – he deserves a medal never mind a Star Award!

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Paul McGuire
Team Leader

Scarborough Hospital

Nominated by
Jess Glanvill
A Colleague

I recently started my job in January this year and was quickly moved to the Emergency Department to help with the COVID pandemic. I found this very hard and a big change to what we do on the ward and Paul has been so welcoming, supportive and gone out of his way to help me. He is the rock and glue that holds ED together. He's outstanding at his job, always remains calm, and continues to provide excellent care to staff whilst looking after patients and doing all the office bits and off duty. He's very approachable, team player and an asset to the ED department.

Richard Hutchinson
Healthcare Assistant

Scarborough Hospital

Nominated by
Sarah Moss
A colleague

There was a very confused patient on the ward who became agitated very easily. Richard took the time to sit with him to really get to know him. Because of Richard's kind and friendly attitude the patient became very comfortable around Richard and was much calmer in his presence. Richard even went to the trouble of offering to switch his shifts around last minute to look after the patient overnight as this is when he was the most confused. Richard displayed excellent communication skills and is a wonderful example of how to put our trust values into practice. He is a very hardworking member of our team and a great example for others to follow.

The Emergency Department

Scarborough Hospital

Nominated by
Margaret Laycock
A patient

On the three occasions when I have presented myself at A&E I have been impressed with the quality of care I received, from the girls on Reception, through to the assessment areas. At all times I was treated with the greatest quality of care. This was across the whole of the department. I could not single out any one particular member of staff as they were all equally brilliant and treated me with the utmost respect and care at all times.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Mr Houghton and The Team on CCU | **Scarborough Hospital** | **Nominated by Margaret Laycock A patient**

I was admitted onto CCU for tests and can honestly say that the care which I received while on this ward was second to none. I was treated with a complete air of competence, professionalism, kindness, courtesy and respect. The whole atmosphere gave complete confidence and reassurance in their ability. From the domestic staff, whom carried out their tasks with a friendly word, to the nursing staff, I had a really good experience. The nursing staff create a atmosphere of complete calm and extremely efficient manner. Nothing was too much trouble. The hospital food was also worthy of praise, as the staff have to provide meals for varying appetites and personal preference, which isn't easy. I found the menus provided a really good variety of choice and the food was always hot on delivery.

Mr. Houghton is a complete professional. His whole bedside manner is one which should be given by all medical professionals. He is patient, very caring and listens to what one has to say. He radiates confidence in his diagnosis and whatever treatment he decides is one which gives a complete assurance that all will be well. He is the perfect mentor for his students and they can do no better than follow in his footsteps. By doing so they will learn an abundance of knowledge for their future careers.

Beth Carsey Assistant Rota Coordinator | **Scarborough Hospital** | **Nominated by Nicky Kidd A colleague**

Beth is a member of the Rota Team and works extremely hard to ensure Medical cover is sufficient in Scarborough Hospital. This week in particular has been really challenging due to staff sickness and annual leave. Beth has single handily covered the Scarborough service all week and has done so with a positive attitude. The stability of the rotas this week has been testament to Beth's hard work and ability to stay calm under pressure. Beth puts patient safety at the forefront of her mind when at work and this is evidenced in her amazing achievements this week. Well done and thank you Beth!!

Jo McManus Staff Nurse | **Scarborough Hospital** | **Nominated by Kelly-Ann Firman A patient**

I have autism and horrendous anxiety Jo did her absolute upmost to keep me calm with respect and compassion at a time I was finding it almost impossible to do so during my procedure.

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A monthly award which recognises the achievements of staff and volunteers

Darren Ford | **Scarborough Hospital** | **Nominated by**
Superintendent Radiographer | | **Becky Headlam**
| | **A colleague**

Darren always tries to do his best for all patients in his care as well as helping other staff members. Without failure he always goes one step further in trying to help individuals as much as possible; by this it is always noticed how much care he gives to the department as a whole. Nobody ever leaves the radiology department without an answer when he is around; in particular if he does not know the answer then he will do his very best to try and gain an answer for you.

Paul Thompson | **Scarborough Hospital** | **Nominated by**
Network Engineer | | **Sheena Mason**
| | **A colleague**

Paul is always quick to respond, extremely helpful and always has carries a smile. Who can ask for more?

Louise Brown | **Scarborough Hospital** | **Nominated by**
Allied Health Professionals Therapies Senior Manager | | **Abigail Wainwright and Charlotte Boynton**
| | **Colleagues**

As the AHP senior manager in care group 2 Louise has worked tirelessly to support her teams during the recent challenging times. Louise has regularly been working well beyond her contracted hours to support both her AHP teams and the wider hospital site. Louise is a dedicated driven and supportive leader, who leads by example and strives to improve at all opportunities. Louise has inspired many members of the team to improve and progress, and is always available for help and advice. During the Covid pandemic she was always willing to complete tasks outside of her job role to improve patient and staff experiences.

StarAward

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Ruth Popham
Discharge Liaison Officer

Scarborough Hospital

Nominated by
Jacob Gentile and Sana Aniqu
Colleague

Jacob Said:
Ruth works non-stop, the ward wouldn't work without her. She goes above and beyond her call of duty, and always stays late (should be compensated more than a star award but it's a start) to get patient to where they need to be. The best DLO I have ever seen. Ruth the bearer of truth.

Aniqu said:
Ruth is a fantastic person to have on our team. Always friendly, kind, willing to answer all of our questions and of course an excellent DLO to have when you regularly have dozens of discharges to get through. Ruthlessly efficient yet never rushed or hasty.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Woman's Health Admin Team | **Trust Wide** | **Nominated by Jemma Brett A colleague**

I would like to nominate the York admin team in particular Denise McNaughton, Gaynor Church, Katrina Mansfiled, Hannah Taylor & Melaney Young Service Manager for Scarborough. They have worked tirelessly through the pandemic, supporting and leading on the colposcopy admin from Scarborough. They all did an amazing job covering for absent colleagues over in Scarborough, setting up aligned systems and services in a short period of time and through extremely challenging circumstances. Their hard work and determination has allowed the colposcopy service to continue to function during Covid-19 with the patients receiving nothing but a streamlined service where nothing was too much to ask.

Secretaries to the Breast Surgeons | **Trust Wide** | **Nominated by Andrea Ward A colleague**

The breast surgeon secretaries at York and Scarborough work amazingly hard to co-ordinate the patient's journey alongside the rest of the team. They are always super busy and I think are not recognised enough for the importance of their role in supporting excellent patient care. In particular they make my life much easier by always being willing to help and by being cheerful and enthusiastic in making sure everything is done correctly and patients receive the information they need.

The Chaplaincy Team | **Trust Wide** | **Nominated by Lydia Larcum A colleague**

The Chaplaincy Team work right across all hospital sites providing support and comfort to both staff and patients. During the pandemic they have faced some incredibly difficult situations and their dedication to their work has been, quite simply, amazing. The have continued to provide face to face support to patients and relatives, including patients in Covid areas. When family have not been able to visit patients they have often provided a link and comfort to the family knowing that their relative has had a visit from them. They have found ways to try to help families feel close by providing tea lights and little hearts that the family can have with them. They have provided exceptional support to bereaved families. They have undertaken funerals for couples who have lost babies at a time when funeral arrangements have been affected by Covid restrictions. This has made such a massive difference to many families. They have been central to the Health and Wellbeing work undertaken to support staff, particularly championing the two weeks of reflection. They have adapted their work by embracing technology, so the comfort they provide can still be accessed by many. During incredibly testing times they have never waivered in the support they provide.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Kanak Patel
Consultant

York Hospital and Community

Nominated by
Rosalind Southee
A colleague

Kanak has strived relentlessly to set up and develop a minor ops unit at Selby hospital for the treatment of head and neck skin cancer under LA. He has encouraged and taught outpatient nurses from York and Selby to run a gold standard service. Kanak has created a dedicated, hardworking, skilful, respectful, enthusiastic patient focussed team. Every aspect of patient care has been covered from patient safety to patient's actual enjoyment of their treatment. There is feedback to prove it!. One patient commented that the team should teach others how to provide such a high quality service. The environment Kanak has created is insurmountable. I feel his efforts deserve to be recognised.

Scott Caul
Physiotherapist

York Hospital

Nominated by
The Medical / Surgical Physiotherapy Team

On behalf of the medical and surgical therapy team we would like to nominate Scott for the amazing work he does on a regular basis. Scott is a physiotherapist who works predominantly down on ICU, helping patients regain their functional ability following a period of being acutely unwell. Patients that are transferred to the ward regularly praise not only the physical but also emotional support that Scott provides in ICU. Not only does he go above and beyond for patients in critical care, he also supports new physiotherapists training in an area that can be daunting for many and is an approachable and friendly face that colleagues may come to for support. Scott recently completed a solo tandem ride from Land's End to John O' Groates over 10 days and raised almost four thousand pounds for new equipment on ICU and York Mind charity. This is only an example of the selflessness and caring nature of a man who gives his all to patients and colleagues. He is not only an asset to the Surgical physiotherapy team but to York Hospital and his profession.

The Ophthalmology Admin Team

York Hospital

Nominated by
A colleague

During the covid-19 pandemic the Ophthalmology team have been incredible. Everyone in the team really stepped up and took on work that was above and beyond their pay banding, ensuring patients were seen if needed and ensuring others did not make unnecessary trips into the hospital when their appointments were cancelled. The team worked tirelessly throughout the pandemic and continue to do so. Everyone supported each other during the most challenging of times and I feel they really deserve to be recognised for coming through this with a smile still on their faces.

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Alistair McCleary
Consultant

York Hospital

Nominated by
The Cystic Fibroses Team
Colleagues

Mr McCleary provides expert vascular access including urgent midlines to start intravenous antibiotics for people with cystic fibrosis who attend the York Hull Adult CF Centre. The majority of intravenous antibiotic treatment in people with CF is given without a hospital admission and for acute exacerbations where deterioration is unpredictable and can be rapid without prompt intervention. This outpatient service is better for a group of people who need frequent courses of antibiotics throughout their life and who want this treatment to interfere with their lives as little as possible. During the COVID response people with CF have been part of the shielding population and it has so been even more important to avoid admissions & acute site attendances where possible. Mr McCleary has always gone above and beyond to provide a responsive vascular access service at short notice, often arriving early, staying late or dashing between surgical lists to provide expert ultrasound guided midlines to a group of people with challenging venous access and in an environment that is comfortable for the patient. As part of the COVID response the CF centre has moved outpatient services to Clifton park hospital. Mr McCleary recognised our need to provide treatment including starting intravenous antibiotics at the Clifton park site. He has been amazingly flexible in coming over to the Clifton park site to site lines at short notice and despite the additional challenges attending different sites has. We're aware as a team that the pressures on him over the COVID response will have been increased and yet he never makes it feel a problem to be available and always emphasises that all that matters is that the patients get the treatment they need. We'd like him to know how appreciated this is and we feel that he deserves recognition of the patient focused care he provides.

Tracy Murray
Clerical Officer

York Hospital

Nominated by
Darren Shipley
A relative

We had dropped my father in law (Paul W Hutchinson) off for his 3pm x-ray on Thursday 17th Sep, "call us when you want picking up" we said and waved him on his way, once 4pm had been and gone we thought maybe the appointment overran, tried his mobile and home and no answer. Gave it a little more time and then I called the 726328 number at 16:39, Tracy picked up and confirmed the x-ray had been done and Paul had left the department, I explained the situation and Tracy said she would go and see if she could find him, Tracy true to her word called back and had found him sat in reception with his phone battery flat and no clue of our home or mobile numbers, we got to the hospital and picked him up after his long wait, Paul totally unfazed, "had a coffee and blueberry muffin and just thought you'd turn up!" I have no doubt that Tracy is already busy enough so our heartfelt thanks goes to her for calming us down regardless of how chilled Paul already was!

StarAward

A monthly award which recognises the achievements of staff and volunteers

Alex Evans | **York Hospital** | **Nominated by**
Advanced Clinical | | **Sarah Baker**
Specialist Renal Dietitian | | **A colleague**

Alex has worked incredibly hard over the last few months to transform our outpatient clinics in order to meet the needs of patients and deliver the best possible service within our current resource. This has meant refining our referral criteria, exploring new ways of working to include virtual clinics, virtual group consultations, and ensuring that dietetic input is visible to other healthcare professionals through the use of electronic documentation on CPD. Alex has shown excellent leadership skills throughout this transition and has supported staff in navigating all of the changes. Thank you Alex!

Claire Oxby and Team | **York Hospital** | **Nominated by**
| | **Alicia Vaughan**
| | **A patient**

I wanted to give thanks to the women who performed my emergency C section on 12th May 2020 (1pm). The procedure and lead up was well managed, well communicated and overall a pleasant experience given the circumstances. I have also had several health professionals (midwife, HV and phsyio) remark on the neatness of the incision! I want to thank the team for their excellent work delivering my baby safely, and leaving me with a “beautiful scar”.

Anna Miszka | **York Hospital** | **Nominated by**
Domestic | | **Jean Scaum & Vanessa Brind**
| | **Colleagues**

This lady is the weekend domestic on ward 16 she is such a hard worker and nothing is too much trouble she always happy to help staff and patients. Anna takes such a pride in her work you can always tell when she been on the ward as she does a fantastic job and is a credit to our team

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Team on Ward 32 **York Hospital** **Nominated by**
Brian Jackson
A patient

This is my first experience of being a patient in any hospital. I have found the nursing team on ward 32 to be so kind and helpful whilst I have been a patient. They work tremendously hard and everyone has been brilliant and so polite to me as a patient. I expressed my gratification to the Matron when she came onto the ward. I congratulated her on a wonderful team that she has on this ward and I would like this team to receive a Star reward for all their hard work in this very challenging time. I would like to share my admiration and no words can express my thanks. for their commitment and care to all the patients.

The Emergency Department Team **York Hospital** **Nominated by**
Tracey Gray
A colleague

I was redeployed to York ED due to COVID from my job in none clinical practise. I was apprehensive to come back to a busy department after nearly 5 years away from being a clinical nurse. All of the staff have been amazing, teaching me, guiding me and supporting me through one of the biggest challenges of our careers to date. I enjoyed my time so much that I have joined the nurse back and pick up ED shifts around my normal job. I thoroughly enjoyed my Redeployment so much and I'd like to thank all the York ED staff for their kindness and support during every shift , you are all amazing , thank you xx

Maggie Higginbotham **York Hospital** **Nominated by**
Renal Specialist Nurse **John Wetherell**
A relative

My wife was in CCU having difficulties, she asked me to contact someone in Renal (a department she had absolute trust in) to see if someone could help. Maggie, who neither of us had met, answered the call. She contacted/arranged with CCU for me to visit and help sort things out with my wife. Then rang me in the evening to see how things had gone (her GP takes at least a week!) A STAR, a patient not under her departments care but she provided, help, reassurance and a degree of comfort, in knowing somebody cared. The young male Sister in CCU is also commended following Maggie's involvement.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Nicholas Salisbury **York Hospital** **Nominated by**
Service Desk Manager **Maya Liversidge**
A colleague

Nick offered to help the Fundraising Team film a recent virtual event after work one evening in Scarborough. He finished work in York and travelled to Scarborough in his own time and spent 3 hours filming with his own drone and setting up the event. He went above and beyond for the team and didn't have to. He was so helpful and we could not have done the filming without him. He has allowed us to offer another way of supporting the charity to our donors and this is taking us forward as a charity. he will also have spent time pulling the filming together to ensure we have the right content to put the film together.

Verity Sedgwick **York Hospital** **Nominated by**
Ward Clerk **Karen Wiley**
A colleague

I would like to nominate Verity for her flexibility, changing her days of work to a Saturday and Sunday allowing full Ward Clerking Service due to a vacancy. We have now recruited into the position and Verity has gone back to working Monday to Friday and I would like to take this opportunity to that her for being so flexible.

Jo Bradley-Smith and **York Hospital** **Nominated by**
Laura McIntyre **Emily Wood**
Plaster Technicians **A relative**

I just wanted to say a huge thank you to Jo and Laura in the plaster room. My 5 year old daughter is now on her third leg cast following a nasty break. They have been so incredibly wonderful, making her (and me!) feel very at ease and bringing joy and laughter to our visit. They work tirelessly to make sure that each patient has a 5 star service. I would love for them to be recognised for their wonderful work. Many thanks Lorna's mum Emily.

Paul Greendale and **York Hospital** **Nominated by**
Matthew Bradshaw **Karen Wiley**
Painters **A colleague**

Both Paul and Mathew have been decorating Clementhorpe Health Centre. Their professional manner is outstanding, nothing is too much trouble, seen and not heard. When undertaking their task in communal areas very respectful and considerate. always neat and tidy and the end result speaks for itself. You tend to work better when your work place looks and feels good. Always adhering to our core trust values. I would like to say on behalf of the Staff at Clementhorpe A BIG Thank you

Adam Longden **York Hospital** **Nominated by**
Healthcare Assistant **Kathleen Embleton and family**
A relative

My grandma would like to send a heartfelt thank you to the staff on Ward 32, and in particular HCA Adam Longden. The way in which he cared for Grandma was absolutely outstanding, and we will be forever grateful. No matter if it was 7am in the morning or 7pm at

night, Adam was always full of energy and compassion. Nothing was too much trouble for him and he made Grandma feel so well looked after. Anyone that knows my grandma will know that she has such high standards when it comes to the delivery of person centred care, with her having a career within the care industry. Adam somehow managed to surpass those expectations. From the family... Adam... THANK YOU so so much for absolutely everything you have done, you have no idea how reassuring it was to know that you were there to look after Grandma when we were unable to

Jennifer Lake **York Hospital** **Nominated by**
Staff Nurse **Bex Brooks**
A colleague

Jen was recently coordinating during a particularly busy and stressful shift. She took on the challenge and managed exceptionally well; she remained calm and prioritised her patient care appropriately, as well as supervising junior / bank staff and supporting them.

Bethany Pasquill **York Hospital** **Nominated by**
Administrator **Annette Farrington**
A colleague

Due to vacancies in the admin function of Care Group 1 Bethany found herself with a vastly increased workload which she took in her stride and rose to the challenge to provide the best service possible in that situation. Since new admin colleagues have been recruited, Beth has and is in the process of passing on her knowledge of the role to them and ensuring they have as much information as possible to enable them to settle in quickly and learn what is required of them and the team. Beth is always happy to reprioritise her workload to enable her to help her colleagues which is very much appreciated by them, me and the management team we support. I am immensely proud of Bethany and grateful to her for her hard work and flexibility in helping new colleagues whilst maintaining the level of service required.

StarAward

A monthly award which recognises the achievements of staff and volunteers

James Bennett and The Team on Ward 29 | **York Hospital** | **Nominated by Daniel Palmer A colleague**

I would Like to Nominate James Bennett and the team on ward 29 for their unmatched resilience, I truly believe there isn't a more resilience team in this organisation. As Simon stated in the week ahead update the number of inpatients who are testing positive for Covid-19 has continued to rise over the last week and he was pleased to report that both hospital sites continue to cope well. This is in no small part down to the team on ward 29 who despite staffing short falls continue to do an amazing job. The back ground to ward 29 is that it is a 29 bedded elective orthopaedic ward and normally sees peaks and troughs in its demand. Every winter ward 29 changes its function to an elderly care ward. When this happens it is met with anxiety and concern from some but never the less James and his ward 29 team switch their mentality to that of elderly care nurses. When that switch for 6 months happens some would think it would come with risk to patients having a ward of surgical nurses looking after elderly patients but every year they prove people wrong, the ward is ran for 6 months with no fall, no pressure ulcers no complaints and no PALS. Once those 6 months are up they switch back to orthopaedics concentrating on enhanced recovery. This year was no different a switch to elderly in December 2019, a switch back to Orthopaedics in February, then one day at the end of February we transferred out all orthopaedic patients to Bridlington and ward 29 became the COVID ward. This was scary stuff, all around the hospital people were making the move to work from home to keep their colleagues safe and ensure other vital services continued like payroll, HR etc. But here we were again asking these elective orthopaedic nurses to change function again to a COVID ward. Then the patients started to arrive and once again they stood up to the challenge and still to this day those orthopaedic nurses are still running the COVID ward. On a final note when the trust stepped down all the other COVID wards, Jame's ward remained, not only did James manage ward 29 he was also asked to manage ward 25 with the same group of staff with no extra resource. After writing this I am going to check if this is resilience or just that fact James can't say no. But either way James and ward 29 are an asset to this organisation and the most resilient team we have.

Maria Bower Healthcare Assistant | **York Hospital** | **Nominated by Jessica Ulrich A patient**

I had a visit in hospital this week of a very upsetting and personal nature. On arriving on the ward Mia was so supportive, compassionate and fully engaged in her role. She helped me get through the toughest day of my life. Things weren't going well with the theatres and I was waiting 17 hours to go into surgery but she kept checking on me, supported me when I was emotional, made me smile when I didn't think it was possible and I felt she genuinely cares for her patients. She deserves recognising for her exceptional positive attitude, especially when she's full of energy and smiles to make you feel better at half seven in the morning. I'm a big believer that people who go above and beyond in their role should be recognised and she is definitely one of those individuals so hope that you can thank her from me and recognise her incredibly supportive care.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Adrian Hanna
Specialist Registrar

York Hospital

Nominated by
Jane Azopardi
A patient

I am a cancer patient and as a side effect of my chemo-therapy tablets I had begun to experience psychotic delusions and dangerous physical sensations. After stopping treatment for 2 days I was still experiencing frightening side-effects and didn't feel safe at home so on the advice of the emergency oncology unit (ward 31) I was told to come into hospital, however, they had no beds so they told me to go to A&E saying they would contact them explaining my situation and letting them know I was coming in. I went in with my sister on Sat evening (10/10/20) in quite a confused & fragile mental state, feeling very vulnerable and frightened at what was happening to me. Unfortunately on arrival we were told that ward 31 hadn't contacted A&E and no-one had any information about my reason for being there. We explained why I was there and asked the A&E staff at the counter to contact ward 31 for the details which they said they would do but they can't have done because from that moment on I was treated as a psychiatric patient. We waited in a treatment room expecting someone to arrive with the info from ward 31 but instead a nurse came in to fill out a psychiatric assessment form. From then on I had several interactions with staff and even phoned ward 31 from the treatment room asking for their help but they said I "wasn't their patient" and I should ask A&E to contact the on-call oncology doctor which, I asked them to do but they didn't. In the meantime I was in a fragile state and quite weepy as I continued to be regarded as a psychiatric patient instead of a cancer patient with no seeming communication between A&E and ward 31. Then after 2 hours of trying to convince people I was a cancer patient not a psychiatric one, in rode my knight in shining armour Dr Adrian Hanna! He entered the room expecting to meet a patient with psychiatric problems but as I began to explain everything his willingness to listen meant he was able to piece it all together and finally someone understood what was going on. His calm, kind and considerate manner made me feel secure when I was really vulnerable and because of his willingness to listen he could see and understand what was happening. He then examined me and went and made the necessary enquiries and ultimately I was discharged back home again. Dr Hanna's "bedside manner" was exemplary, his willingness to listen meant someone finally was able to understand my situation and then his clear explanation of what he would do and how he would proceed helped me considerably at a time of confusion and insecurity. He should be commended for his excellent communication skills, kind approach and simply a willingness to listen. Both my sister and I were hugely impressed by his care, he is a credit to A&E which felt like quite a hostile place at that point because no-one was listening to me.

StarAward

A monthly award which recognises the achievements of staff and volunteers

Tina Hodgson and the Pre-Assessment Team | **York Hospital** | **Nominated by Jill Wilford A colleague**

I am nominating this team for their real 'Can do' attitude. They currently manage the patient pre-theatre Covid swabbing service from less than ideal working environment. They go out to the patients in all weathers and carried on working even when their gazebo then the poly tunnels blew down in a storm. They acquired and donned waterproof onesies and wellies and carried on regardless. They are even have a giggling despite knowing they are going to be working in heavy rain. They have continued this work throughout Covid and I must say every day I visit the ward and they are always smiling and just getting on with it. The patients tell me that they feel safe and well looked after and always know what the plan for them is. From their Amazing Sister Tina Hodgson and Deputy Sister Ruth Horsfield there is great compassionate leadership and this is reflected on the entire teams attitude and the patients journey. I am super proud of each and every one of them.

Eve Rowntree Waiting List Clerical Officer | **York Hospital** | **Nominated by Heidi Ridgewell A relative**

I called the Contact Centre on the morning of Tuesday 13 October 2020. My adult son had received an appointment, but due to his health conditions he was unsure about attending. I explained to Eve that I also as well as caring for him, cared for my elderly parents, so we were very cautious and were trying to avoid going anywhere. She straight away offered to email his Consultants secretary and explain things and rang me back shortly afterwards to say that they had made his appointment a virtual one via the telephone. This helped not only my son, the patient, but also my parents. She was absolutely lovely and we appreciate her help so much in making our life easier during these difficult times.

The Sleep Services Team | **York Hospital** | **Nominated by Barbara Hull A patient**

I use a Cpap machine which has improved my quality of life tremendously. It suddenly developed a loud fault that prevented me from sleeping meaning I could not use it any more. I left a message with the Sleep Clinic. They quickly returned my call and I was able to collect a replacement Cpap the same day (14th Oct) They even arranged for me to collect the new machine and return the old one in the carpark so that I did not even have to enter the building. I am impressed by the standard of service and the pleasant manner in which my problem was dealt with. Bravo!

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Michelle Kirkman
Cancer Care Centre Administrator

York Hospital

Nominated by
Lucy Doughty and Sarah Cowling
Colleagues

We are York based Upper Gi Cancer Nurse Specialists and are responsible for all patients diagnosed in York with upper Gi cancers. At present the team is short staffed and without a pathway co-ordinator and Michelle has provided the nurses and their patients with invaluable support by providing those that require additional input and support with regular support calls enabling the patients to feel well supported when the nurses are sadly unable to provide the level of telephone support that they would like to due to an increased service demand with a rise in patient referrals. We would like Michelle to know how much we and the patients value her support, she is a star!

The Library Service Team

York Hospital

Nominated by
Jane Martin
A colleague

The whole team are professional, cheerful, approachable, patient and helpful in fulfilling their library duties. However, above and beyond this, is their work to support staff and provide a means of lifting spirits and using creative initiatives to promote and uphold staffs' health and wellbeing. For example a recipe competition, good reads, a book club monthly, MacMillan coffee morning and quiz. We look forward to their Christmas endeavours. Their work goes unnoticed often, so I feel privileged to put them forward for a Star award.

Leah Moorhouse
Assistant Recruitment Manager

York Hospital

Nominated by
Helen Hey
A colleague

Leah has supported my work with diligence and speed for the last six months. She has taken on new work supporting the process for opt in student nurses; bring back staff and delivered information on reporting in what are challenging and complex times. The process for opt in students and bring back students coordinated by central NHS teams was particularly confusing and ever-changing and whilst many people undertook additional work to support this Leah in particular has managed and understood all the processes and kept the Trust on track. The Trust has particularly been complimented by NHSE/I and Health Education England on its process and commitment to supporting the opt in student nurses during COVID-19 When I have asked for supplementary information this is collated and emailed through speedily and it is always accurate. Leah is really positive and always willing to respond to additional requests. A great colleague to have at the end of the phone!

StarAward

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The Haematology, Oncology and Nuffield Teams

York Hospital

Nominated by
Kim Hinton
A colleague

The haematology and oncology team along with our colleagues at the Nuffield oversaw a successful move of services from the York site to the Nuffield site to maintain services to this vulnerable group of patients during the COVID response. Patients continued to be able to access treatments successfully during this period and all of the teams worked together to provide a positive patient experience and safe environment. The teams also went above and beyond coming in on weekends to ensure the move to and back from the Nuffield happened with no disruption to patients. I want to particular highlight and thank Laura Milburn, Lizzie Walker, Matron Sally Pank and Hospital Manager Andrew Blackburn for all of their hard work and support to make this happen. There were many other teams and staff involved including all of the Nuffield staff, haematology and oncology teams, pharmacy, IT, estates, etc who made it possible and this was a true collaboration and example of the Trust values. The Matron at the Nuffield wrote to our Chief Nurse saying: On behalf of the SMT, Andrew Chris, Richard and myself, I just wanted to say how fabulous it has been working with you all and how well everyone has integrated and gelled. I can still remember that first visit with excitement and a modicum of trepidation; and then the weekend move when we didn't think that you would fit everything in, let alone start the service on the very next day. But as testament to your true professionalism and our dogged determination to squeeze you in, you did and it worked and I think the patients have had a satisfying journey?! The work that you do is so very humbling and you do it with such good grace and humour. You have been a tremendous asset to Nuffield and we are proud to have had you here as part of our team. We shall be so sorry to see you go and hope that our paths cross again. Our doors are always open if you need a chat or a rant or a cuppa, please feel free to pop in. We wish you and your patients a successful transition back into York Hospital and continue with the amazing work that you do.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

StarAward

A monthly award which recognises the achievements of staff and volunteers

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