Clinical Impact and Mitigations of Capital Delay

Author: Ian Scudamore & John Jameson Sponsor: Andrew Furlong **Trust Board paper F**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	x
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	x
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board	June ESB 2019 August 2019 October 2019	Clinical discussion and support of proposals
Trust Board Committee		
Trust Board	July 2019	Escalation of clinical risks with action plan to identify mitigations

Executive Summary

Context

The Trust Board have been routinely updated on the delays to accessing National capital in order to progress with our reconfiguration programme. The 2019 Spending Round announced on the 4th September 2019 confirmed that there was no new capital in this financial year, but that there was a plan to release significant capital in 2020.

The ongoing delay has an impact on the sustainability of our clinical services. The more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in a small number of our clinical services.

This paper builds on the work presented to the Trust Board in July which articulated the clinical risk in relation to the delay in accessing capital in order to progress with the reconfiguration programme. It identifies the risk mitigations and costs associated with those mitigations. Mitigations have been discussed at the September and October Executive Strategy Boards; and will be fed into a prioritisation process for service changes requiring additional revenue in October.

The services identified as carrying clinical risk are:

- ICU Expansion at LRI
- Renal medicine move to follow renal transplant to the GH
- Urology & Interventional Radiology
- Neonatal services
- Maternity services

Questions

1. What progress has been made in identifying the mitigations to the risk?

Conclusion

1. The clinical risks for maternity, neonates and ICU expansion are identified on the trust risk register (Section 6 main paper). The risk relating to renal medicine is not currently on the trust risk register and will be included in the next iteration. Urology and interventional radiology are currently project risks and sit on the ICU and associated services risk register; good progress on risk mitigation has been made since this was last escalated to the Trust Board in July.

ICU Expansion at LRI

2. As identified previously, the mitigation for the inadequate space and poor facilities at the LRI is that this project will be the first priority when capital is announced.

   In August 2018, the Executive Strategy Board supported the approach that in the event that external capital is not forthcoming, then this will be progressed through internal capital (CRL). However at circa £31m, this will be very challenging to achieve given the many and competing calls on our very limited internal capital; but this is being built into the 5 year capital plan over a number of years from 2021/22.

   Since this risk cannot be mitigated until capital is available, this will need to be an accepted risk for the trust.

Renal In-patient Beds

3. It is known and recognised that the interim ICU project necessarily splits the transplant service from the inpatient renal service for a short period.

   Recognising that this is not clinically sustainable in the longer term, the Trust has agreed to move the inpatient renal service from the LGH to the GH approximately 6 months after the transplant service moves funded from our internal capital (CRL). This has been identified as a pre-commitment in our 2021/22 capital programme.

Urology & Interventional Radiology

4. Since the paper was presented to the Trust Board in the July, further work has been undertaken with the services to review the models of care and standard operating procedures for urology and interventional radiology at the LGH once the level 3 ICU and associated services move off the LGH to the LRI and GH. Initial work is identifying that risks will be mitigated with revised models of care; but this work still needs to be completed. Any additional workforce will be considered as part of the Star Chamber process within the ICU and Associated Services Programme which is due to take place in February 2020.

Neonatal & Maternity Services

5. On the basis of the summary above, the two services that need firm mitigations instigating are neonates and maternity.

Neonatal services at LGH

6. Neonatal services are currently split across two sites. This split site working breaches the British Association of Perinatal Medicine (BAPM) standards for consultant staffing, and has been raised as a concern by the Care Quality Commission (CQC) and the NHS England Quality & Safety Review. We are aware that we are one of a very few centres nationally who have a split site neonatal service.

   The Maternity Unit at the LGH supports 4,000 births per year. The neonatal unit at the LGH is essential to ensure new-borns have access to any specialist care they need. This is not always predictable. It is therefore not be possible to resolve split site working until the maternity services are moved off the LGH to create a single maternity hospital and neonatal unit at the LRI.

   Interim Mitigations have been identified as follows:

   - Establish a resident consultant tier on LRI site in order to provide 24/7 cover to LRI with a second on consultant from home (BAPM requirement) by appointing to new consultant posts. The second on consultant will cover LRI as a backup, the LGH and the transport service. Two posts will be appointed this year and it is proposed that an additional three posts will be staggered over the subsequent 2 years.
   - Appoint Physicians Assistants to support the junior tier rota by providing increased day time cover to the LRI site.

Maternity Services

7. A number of external reviews of the maternity service have also identified the need for co-location owing to fragility in staffing structures.

   The following interim steps have been identified to mitigate the risks of sustaining Maternity services on two sites:

- Separate the elective obstetric pathway at LGH to provide another Consultant on site and take pressure off the emergency pathway and decongest the delivery suite.
- In order to develop a robust elective pathway, capital is required to improve the current LGH maternity theatre and to upgrade the adjacent procedure room to create a second facility (theatre) suitable for the elective pathway.
- Increase the out of hours support for emergency theatre activity at the LGH.
- Increase senior consultant obstetrician presence and decision making for the Maternity Assessment Units and Ward cover on both the LRI and LGH sites.
- Develop a Day Care antenatal assessment service on both sites working alongside MAU and Fetal and Maternal Medicine; largely midwifery provided but supported by increased Consultant commitment to MAU and the Wards.
- Enhance the triage service in Antenatal Assessment (MAU and Day Care) and Ultrasound

Timing, Resource Implications and Proposed Funding

8. In light of recognition that these mitigations will require revenue and capital to implement and will involve recruitment processes, a phased approach has been proposed by the Maternity & Neonatal services and supported by the Trust's Financial Recovery Board as below:

Date	Mitigation
Dec 2019	• Appoint two neonatal consultant posts • Appoint Physicians Assistants in Neonates • Upgrade the LGH procedure room
April 2020/21	• Start the elective pathway and appoint LGH MAU Consultant * • Commence out of hours theatre team at LGH* • Start triage and day care services* • Appoint one neonatologist* (* appointment process will need to commnece in January 2020 to ensure pathways can be implemented April 2020)
October 20/21	• Appoint one neonatologist
April 2021/22	• Appoint one consultant neonatologist • Provide 4.5 PA's consultant obstetrician cover to LRI MAU

Based on this phased implementation, the total revenue cost impact of both maternity and neonatal services, assuming that the theatres have been upgraded is as below:

Preferred Option	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£134,600	£1,585,300	£1,791,103	£1,744,226	£1,744,226

In addition, capital is required to upgrade the maternity theatres as identified in section 24 of the main report.

The proposed mitigations have been discussed and agreed at the Financial Recovery Board and the September and October Executive Strategy Boards. Some aspects have already been funded, for example two neonatal posts this year; and subject to the Trust Board confirming support for the recommended phased approach to these, the remainder will be prioritised in the process to agree service changes requiring additional revenue & capital in 2020/21 in October.

Input Sought

We would welcome the Trust Board input to:

1. **Confirm support** for the following mitigations outlined in the paper:

    a. **ICU at LRI:** accept that this risk cannot be mitigated until capital is available

    b. **Renal move to GH following transplant move within ICU programme:** accept that this risk will be mitigated approximately 6 months after the transplant service moves to GH by allocated capital in the 2021/22 CRL

    c. **Urology & Interventional Radiology:** note initial work is identifying that risks will be mitigated with revised models of care; but this work needs to be completed and any additional workforce will be considered as part of the Star Chamber process within the ICU and Associated Services Programme

2. **Note** the mitigating actions identified to minimise risks within maternity and neonatal services

3. **Note & confirm support** for the phased approach to implementing these mitigations

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Not applicable]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Not applicable]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
  EIA carried out as part of the pre-consultation business case (PCBC) to cover the whole programme.
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
  No patient activity at this stage required.
- How did the outcome of the EIA influence your Patient and Public Involvement?
  Whilst EIA for PCBC re-iterated need for patient involvement throughout the programme, this paper purely focuses on clinical risk resulting from lack of funding.
- If an EIA was not carried out, what was the rationale for this decision?
  As above

Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**x**	Principle risk 7
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**x**	See section 6 of main report
New Risk identified in paper: What ***type*** and ***description***?		
None		

4. Scheduled date for the **next paper** on this topic: [TBC]
5. Executive Summaries should not exceed **5 sides** [My paper does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TO: **Trust Board**

FROM: **John Jameson, Deputy Medical Director;**
Ian Scudamore, W&C Clinical Director;
Nicky Topham, Reconfiguration Programme Director

DATE: **3rd October 2019**

SUBJECT: **Mitigating the Clinical Impact of the delay in accessing capital funding to progress the Reconfiguration Programme**

Background

1. The Trust Board have been regularly updated on the ongoing delay to accessing national capital in order to progress with our reconfiguration programme. The 2019 Spending Round announced on the 4th September 2019 confirmed that there was no new capital in this financial year, but that there was a plan to release significant capital in 2020.

2. The delay has an impact on the sustainability of our clinical services. The more time that elapses between our current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in a small number of our clinical services.

3. A paper was presented to the July Public Trust Board outlining the services impacted. It articulated that appropriate steps would be progressed to mitigate the risk, on the basis that even if the overall capital bid is supported soon, the solutions will still take a number of years to deliver. The pace of implementation of the various mitigating solutions will necessarily be impacted by financial and workforce resourcing considerations and this will be reflected in the continuing risk assessment process.

4. The proposed mitigations have been discussed and agreed at the Financial Recovery Board and the September and October Executive Strategy Boards. Some aspects have already been funded, for example two neonatal posts this year; and subject to the Trust Board confirming support for the recommended phased approach to these, the remainder will be prioritised in the process to agree service changes requiring additional revenue & capital in 2020/21 in October.

Clinical services impacted:

5. The services identified as carrying clinical risk are:
    - Neonatal services at LGH.
    - Maternity services
    - ICU Expansion at LRI
    - Renal move to follow transplant to the GH
    - Urology & Interventional Radiology

6. The clinical risks for maternity, neonates and ICU expansion are identified on the trust risk register as shown below. The risk relating to renal is not currently on the trust risk register and will be included in the next iteration. Urology and interventional radiology are currently project risks and sit on the ICU and associated services risk register; good progress on risk mitigation has been made since this was last escalated to the Trust Board in July.

Area of risk	Trust Risk Reference	Current risk score	Mitigated risk score	Actions / timescales	Comments
ICU at LRI	**3113** If the infrastructure in our ITU's is not updated and expanded to meet current standards and demand for all patients requiring level 2 or 3 care, then it may result in detrimental impact on safety & effectiveness of patient care delivered benchmarked against other centres (ICNARC), leading to potential for patient harm.	12	8	Impact of reconfiguration on priorities, site and size. Reviewed 26/03/19 delay due to final finance release from Parliament. Enabling works commenced for some areas of phase one. Plans for site and size continue to be worked up with task and finish groups and project Champions. These are in their early stages. LRI has been prioritised for funding possibly 2020/21. Review - September 2019	Owing to the quantum of capital required, this cannot be managed within CRL until at least 2021/22. This will need to be an accepted risk since there is no alternative
Neonates	**3084** If split site Consultant cover of the Neonatal Units at the LRI and LGH is not addressed, then it may result in widespread delays with patient treatment leading to potential harm and withdrawal of the neonatal service from the LGH site impacting significantly the Maternity Service.	20	5	A business case to incrementally recruit to a 6 person resident consultant rota has been produced. There is current resident consultant cover 1/3 of the time at LRI. There is 24 hour registrar cover at LGH with 2.5 gaps in tier 2 rota from August 2017. Obstetrician and midwives on delivery suite trained in neonatal resuscitation Criteria developed for in-utero transfer of babies considered at high risk of neonatal complications for delivery at LRI Activation of escalation SOP for Neonatal Staffing (appended) when necessary, ultimately leading to transfer of new obstetric admissions to the LRI site until adequate staffing restored. Community midwives to advise women with pre term labour (less than 32 weeks gestation) to attend the LRI	2 posts confirmed for 2019/20; further posts needed as part of this risk escalation as below.
Maternity	**3023** If the split site Maternity configuration strategy is not enacted, then it may result in a detrimental impact on safety & effectiveness of Maternity services at the LGH site leading to potential harm	20	6	Consultant Obstetrician presence until 20.00 Delay of elective LSCS if emergency LSCS are required Use of second theatre if emergency LSCS required while El LSCS in progress Post-natal pathway of care for elective LSCS cases for staff to follow Delivery Suite Consultant & SpR can be contacted for any emergencies Consultants undertaking additional sessions to cover rota gaps (unpaid) and visit wards prior to clinics etc. Locum Consultants are employed to provide cover if no other alternative Senior Specialist Trainee's only allocated to cover out of hours Formation of working party to implement recommended changes in working practices	Risk will be partially mitigated as identified below.
	3484 If there is no 24/7 scrub nurse cover	12	2	Midwives are trained in scrub practice and are allocated to scrub in an emergency out of	Risk will be mitigated as

	for obstetric theatres at the LGH and midwives have leave the ward and MAU to be used in the role, then it may result in delays to women who are in delivery suite for observation, enhanced care or induction of labour, leading to potential for harm.			hours. The rota on the LGH site is the same number of midwives out of hours as during the day. 24 hr ODP cover Datix reporting, out of hours on call manager, escalation to matron In the case of a second theatre needing to be opened there is an SOP in place provided by theatre which could provide staff from emergency Main Theatre covering if they are not operating. Escalation policy in place	identified below.
Renal split from transplant	Not currently on the trust risk register but is being actioned for inclusion in the risk register and will be presented to the CMG Board in October.			This would be a high risk if there was not a plan to move the renal service within 6 months of the transplant service moving. The mitigation is including this in the 2021/22 capital plan.	This is currently highlighted in the 2021/22 capital plan as a pre-commitment of £1.5m.

ICU expansion at LRI

7. As identified previously, the mitigation for the inadequate space and poor facilities at the LRI is that this project will be the first priority when capital is announced.

8. In August 2018, the Executive Strategy Board supported the approach that in the event that external capital is not forthcoming, then this will be progressed through internal capital (CRL). However at circa £31m, this will be very challenging to achieve given the many and competing calls on our very limited internal capital; but is being built into the 5 year capital plan over a number of years from 2021/22. (It cannot be expedited earlier owing to other pre-commitments e.g. the move of the East Midland Congenital Heart Centre from the GH to the LRI.)

9. In order to ensure we are ready to progress with the project as soon as capital is available, a feasibility study is currently being undertaken to confirm how the current ICU will be expanded and the design solution.

10. Since this risk cannot be mitigated until capital is available, this will need to be an accepted risk for the trust.

Renal In-patient Beds

11. It is known and recognised that the interim ICU project necessarily splits the transplant service from the inpatient renal service for a short period. Equally it is known that this is not clinically sustainable in the longer term, where it would create issues around quality of care, staffing, training and the requirement to meet NHS England service specification and national peer review recommendations.

12. Recognising this, the trust has agreed to move the inpatient renal service from the LGH to the GH approximately 6 months after the transplant service moves; funded from our internal capital (CRL). This has been identified as a pre-commitment in our 2021/22 capital programme. This will be added to the trust risk register to identify the risk in the event that CRL is not available and the service is unable to move within 6 months.

Urology & Interventional Radiology

13. This risk was escalated to the Trust Board in the July. Since then further work has been undertaken with the services to review the models of care and standard operating procedures for urology and interventional radiology at the LGH once the level 3 ICU and associated services move off the LGH to the LRI and GH. Initial work is identifying that risks will be mitigated with revised models of care; but this work needs to be completed. Any additional workforce will be considered as part of the Star Chamber process within the ICU and Associated Services Programme which is due to take place in February 2020.

Neonatal & Maternity Services

14. On the basis of the summary above, the two services that need firm mitigations instigating are neonates and maternity.

Neonatal services at LGH.

15. Neo-natal services are currently split across two sites. This split site working breaches the British Association of Perinatal Medicine (BAPM) standards for consultant staffing, and has been raised as a concern by the Care Quality Commission (CQC) and the NHS England Quality & Safety Review. We are aware that we are one of a very few centres nationally who have a split site neonatal service.

16. The Maternity Unit at the LGH supports 4,000 births per year. The neo-natal unit at the LGH is essential to ensure new-borns have access to any specialist care they need. This is not always predictable. It will therefore not be possible to resolve this split site working until the maternity services are moved off the LGH to create a single maternity hospital and neonatal unit at the LRI.

Interim Mitigations for the neonatal service have been assessed and agreed as follows:

17. Establish a resident consultant tier on LRI site in order to provide 24/7 cover to LRI with a second on consultant from home (BAPM requirement). The second on consultant will cover LRI as a backup, LGH and the transport service. It must be noted that this is still not ideal; the full tier of resident consultants only provides night cover to the LRI with a second on call consultant; and there will be times (e.g. weekends and 5pm to 10pm) that cross site cover is needed. Therefore these mitigations still do not allow the service to meet the service specification for consultant staffing and neonatal medicine. The only viable medium to long term option is a single site service. Appointing to more consultant posts would compromise consultants maintaining their ITU skill set.

18. Appoint physicians assistants to support the junior tier rota by providing increased day time cover to the LRI site.

19. Additional staffing requirements have been identified as follows:

Consultants:

- On 8th March, the Revenue Investment Committee supported two new consultant posts in 2019/20; one post has been appointed and will be filled in September 2019; the other is currently being advertised.

- Three additional posts are needed and it is proposed to stagger these over the next 2 years.
    - o one in April 2020/21
    - o one in October 2020/21
    - o one in April 2021/22

Physicians Assistants (PA):

- Appoint two Physicians Assistants in October to provide increased day time cover to the LRI site. These will need to be pump primed in order to complete on the job training, after which they will positively form part of the rota and be funded from existing budgets. The Physicians Assistants will support the service with our Advanced Neonatal Nurse Practitioners.

Maternity services

20. A number of external reviews on the maternity service have also identified the need for co-location owing to fragility in staffing structures. For example:

- **Rotas and Services.** Duplication in services generates inefficiencies; the current need for all clinicians to work across sites creates inefficiencies (cover at the LGH is variable and between 1 to 4 consultants can be based on the LGH site during day).

- **Medical Staffing.** There is a staffing deficit across the sites caused by split site working; medical staffing is lesser in number at the LGH with the staff cohort focussed at the LRI in order to maintain separate emergency and planned deliveries.

- **Midwifery Staffing**. The Birth Rate Plus report recommends that the midwifery establishment is enhanced overall, with additional establishment required at LGH to support the emergency theatre process out of hours.

- **Better Births.** The emphasis on care for vulnerable women requires extra midwifery capacity in specialist midwifery, mental health and safeguarding. In addition to this, the number of women on the Continuity of Carer pathway needs to increase to 35% by March 2020, requiring increased Midwife to Birth ratios. (This pathway ensures that women have consistency with a small team of midwives who care for them throughout the antenatal, intrapartum and postnatal periods of care.)

Interim requirements to mitigate risk of sustaining Maternity services on two sites:

21. A number of service developments have been proposed to mitigate the risks associated with sustaining Maternity services on two sites until formal co-location can be pursued. Staffing commitments recommended recognise the need to be consistent with the staffing model and complement required in a co-located service. The proposals are as follows:

Maternity Priority 1

22. Separating the elective obstetric pathway at LGH to provide another Consultant on site and take pressure off the emergency pathway and decongest delivery suite is the top priority. This requires increased staffing in Obstetrics, anaesthesia and theatre as well as capital to create a second obstetric theatre and provide a safe theatre environment.

23. In order to develop a robust elective pathway, capital is required to improve the LGH maternity theatre (which has the biggest maintenance requirement of all the UHL theatre stock); and to upgrade the adjacent procedure room to create a second maternity theatre. Whilst it would be possible to appoint an additional consultant without the theatre capacity to add extra support to the LGH; this is a less effective use of extra senior clinical resource without dedicated capacity for them to operate on the elective pathway.

24. The upgrade to provide two theatres in Delivery Suite at LGH should be completed as soon as possible. The initial indication on costs is that the full upgrading the theatres at the LGH will cost circa £1.375m (incl. VAT). In the event that emergency capital is not forthcoming to undertake the whole project at once, a number of key interim improvements have been identified which will still support the development of this pathway at a lesser cost. These improvements have been discussed with Infection Prevention and are confirmed as a safe option whilst longer term improvements are awaited.

25. The other mitigation needed as soon as possible is to upgrade the out of hours support for emergency theatre activity at the LGH. This will improve midwifery capacity out of hours by avoiding the need to take midwives to theatre as scrub nurses.

Maternity Priority 2 – the following can be done individually; however the models are linked and as such are more efficient and more effective if done together

26. Increase the senior presence and decision making for the Maternity Assessment Units and Ward on both the LRI and LGH sites. This is largely a staffing solution but will benefit from change in care pathways (e.g. joint telephone triage - see section 28 below). It is of note that a CQC unannounced inspection in May 2019 expressed concern at Consultant availability for the MAU and the Wards.

27. Develop a Day Care antenatal assessment service on both sites working alongside MAU and Fetal and Maternal Medicine; largely midwifery provided but supported by increased Consultant commitment to MAU and the Wards (as noted above). This will facilitate outpatient care of patients instead of admission and provide dedicated elective capacity to decongest MAU allowing the MAUs to focus on their non-elective patient care.

28. Triage in Antenatal Assessment (MAU and Day Care) and Ultrasound will be enhanced. As an interim measure, we propose to develop a centralised process to assess calls and referrals to provide advice and where appropriate allocate the patient to the right service on either the LRI or LGH, taking into account activity, capacity and clinical need (e.g. preterm emergency assessment at LRI). This will help prevent congestion in the Wards and in MAU, reduce delays in assessment and ensure patients present appropriately to the right site.

Timing, Resource Implications and Proposed Funding

29. In recognition that these mitigations will require revenue and capital to implement and will involve recruitment processes, a phased approach has been proposed by the Maternity & Neonatal services and supported by the Trust's Financial Recovery Board as below:

Date	Mitigation
Dec 2019	• Two neonatal consultant posts already appointed to • Appoint the physicians assistants to Neonates • Upgrade the LGH procedure room
April 2020/21	• Start the elective pathway and LGH MAU Consultant * • Start out of hours theatre team at LGH* • Start triage and day care services* • Appoint one neonatologist* (* appointment process will need to commnece in January 2020 to ensure pathways can be implemented April 2020)
October 20/21	• Appoint one neonatologist
April 2021/22	• Appoint one consultant neonatologist • Provide 4.5 consultant obsterician PAs toLRI MAU

30. Assuming this timed implementation, the total revenue cost impact of both maternity and neonatal services, assuming that the theatres have been upgraded is as below:

Preferred Option	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£134,600	£1,585,300	£1,791,103	£1,744,226	£1,744,226

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31. In addition, capital is required to upgrade the maternity theatres as identified in section 24.

Conclusion

32. This paper has been developed with robust clinical input; with a view that by implementing these actions, the clinical risk, at least in the short to medium term, will be mitigated.

33. The proposed mitigations have been discussed and agreed at the Financial Recovery Board and the September and October Executive Strategy Boards. Some aspects have already been funded, for example two neonatal posts this year; and subject to the Trust Board confirming support for the recommended phased approach to these, the remainder will be prioritised in the process to agree service changes requiring additional revenue & capital in 2020/21 in October.

Recommendation

Trust Board is requested to:

1. **Confirm support** for the following mitigations outlined in the paper:

    a. **ICU at LRI:** accept that this risk cannot be mitigated until capital is available

    b. **Renal move to GH following transplant move within ICU programme:** accept that this risk will be mitigated approximately 6 months after the transplant service moves to GH by allocated capital in the 2021/22 CRL

    c. **Urology & Interventional Radiology:** note initial work is identifying that risks will be mitigated with revised models of care; but this work needs to be completed and any additional workforce will be considered as part of the Star Chamber process within the ICU and Associated Services Programme

2. **Note** the mitigating actions identified to minimise risks within maternity and neonatal services

3. **Note & confirm support** for the phased approach to implementing these mitigations