Meeting of the Governing Body
Summary sheet
Date of meeting: 04/07/2017
For: Public session (Part 1)
For: Information

<table>
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<tr>
<th>Agenda item and title:</th>
<th>Proposed Contract Variation for Minor Injury Units (MIU)</th>
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<tbody>
<tr>
<td>Author(s):</td>
<td>Sarah Foster, Deputy Director Finance</td>
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<td>Karen Kay, Director of Integrated Care (in hospital care)</td>
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<td>Presented by:</td>
<td>Helen Childs, Chief Operating Officer</td>
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<td>Lead Director/GP from CCG:</td>
<td>Karen Kay, Urgent and Emergency Care Executive Lead for Cornwall and the Isles of Scilly</td>
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<td>Dr. Rob White, GB Clinical Portfolio Lead - In Hospital Care</td>
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<td>Clinical Lead:</td>
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Executive summary:

RCHT (provider of emergency department at Truro and the MIU at West Cornwall) and CFT (provider of MIUs) have jointly requested that the CCG agrees to a contract variation which transfers the MIU service provision from CFT to RCHT at a proxy value of £6.3m.

The stated aim of the providers’ request is a technical adjustment to enable national reporting against the A&E 4hr standard to include activity carried out in CFT MIUs in addition to activity in West Cornwall Hospital and Treliske, which are already reported together. This will enable the system performance across all sites to be recognised in national monitoring.

This combined reporting is forecast to result in an improvement in reported performance equivalent to about half the difference between reported ED performance and 100%, i.e. if at 70% it approximately increases performance to 85%, if current reported performance is 86% it would increase to 93%. It is therefore expected to significantly strengthen the ability to meet the submitted STF trajectory for performance against the A&E 4hr standard and therefore achievement of the associated financial incentive.

RCHT have assumed achievement of the STF trajectory and the associated income in their financial plan for 2017/18. Failure to achieve this will create up to a £2.5m budget pressure, RCHT have a planned surplus of £1.4m for 2017/18.

The providers indicate that RCHT will sub-contract MIU service provision back to CFT and both parties intend the management arrangements to remain unchanged from those in place now.

This change in isolation is not intended to have any impact (positive or negative) on quality,
safety or ACTUAL performance although there are substantial programmes of work already in place and being developed to address each of these issues. This proposal will not create an unusual situation as it brings reporting arrangements into line with many other health economies e.g. North Devon, and is purely intended to increase income into the Cornwall Health Economy.

All organisations in the system will continue to prioritise actions to improve performance, safety and quality through existing and new mechanisms that are separate and distinct from this transaction e.g. A&E Delivery Board.

Notwithstanding the purely technical intention, the process of transferring the MIU services from one provider to another gives rise to a number of issues that the CCG must assure itself of prior to agreeing the contract variation and the extent to which these are addressed is set out in the main body of the report.

More specifically the report brings together the responses to questions posed by NHS Kernow to RCHT & CFT and provides assurance about the due diligence regarding procurement regulations undertaken with advice from the CCG’s legal Provider.

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**Recommendations and specific action the Governing Body needs to take at the meeting?**

Finance Committee agreed Option 2 with a condition to be included in the variation order that monitors any change to activity in MIUs and mitigates any risk of transfer of activity from MIUs to the emergency department which would increase the overall cost to the system.

On 6th June 2017 the Governing Body received this report and endorsed the decision of the Finance Committee. The decision was made in part 2 private session of the meeting due to Purdah.

The report is now being made available in public session and the Governing Body are asked to note and record the above decision in part 1, in the interests of transparency.

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**Evidence in support of arguments:**

- Responses from RCHT & CFT
- Legal Advice from Browne Jacobson

**Who has been involved/contributed:**

- Governing Body members have all had the opportunity to influence the information requested of providers for assurance.
- RCHT – Proposed Provider of MIUs
- CFT – Current Provider of MIUs
- Browne Jacobson CCG’s Legal Provider
- NHSI and NHSE views have been sought

**Cross reference to strategic objectives:**

As above

**Engagement and involvement:**

- As above

**Communications issues:**

This decision will be communicated as one that enables the system to be monitored on the same basis nationally as many other systems, ie including MIU performance, and will increase the likelihood of securing STF income into the Cornwall economy for investment into care. The
decision and the rationale will be communicated publicly, including the publication of this report, and pro-actively to stakeholders to minimise any risk that this might be perceived as an attempt to misrepresent improved performance.

### Financial implications:

No anticipated financial impact for the CCG.
To support RCHT achievement of STF income assumed in financial plan. The financial value used for the variation order is notional and should not therefore be relied upon in subsequent plans for service changes signalled in the STP – Shaping Our Future.

### Review arrangements:

This variation order will remain in effect only for as long as CFT are the provider of the Adult Community Services contract (including MIUs).

### Risk management:

### National policy/legislation:

NHS England Technical Guidance to Standard Contracts  
Public Contract Regulations 2015  

### Public Health Implications:

N/A

### Equality and Diversity:

N/A

### Other external assessment:

For use with private and confidential agenda items only

### FOI consideration – Exemption*

Qualified /absolute*

### Section 22 - Information intended for future publication

Section 22 - Qualified

If exemption is qualified then public interest test required. Check to see if the public interest in the information being released outweighs the exemption being used and record your consideration here to justify inclusion on the private and confidential agenda. Note the Information Commissioner states that there is a general public interest in transparency. For advice, contact [KCCG.FOI@nhs.net](mailto:KCCG.FOI@nhs.net)
1.0 Purpose
The Governing Body is asked to endorse the decision of the Finance Committee i.e. to agree to the request from providers for a contract variation which transfers the MIU service provision from CFT (provider of MIU services) to RCHT (provider of the emergency department at Treliske and MIU at West Cornwall Hospital).

2.0 Background information

2.1 Performance reporting against A&E 4 hour standard
A&E departments are categorised by type and are required to be reported separately on Unify according to type.
Below is a link to the latest guidance which sets out the rules governing how performance against the A&E 4 hour standard is reported.

In summary “A type 1 A&E department is a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients. A type 2 A&E department is a consultant-led single-specialty A&E service (e.g. ophthalmology, dentistry) with designated accommodation for the reception of patients. A type 3 A&E department may be doctor led or nurse led. It may be co-located with a major A&E department or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats minor injuries and illnesses (e.g. sprains) and can be routinely accessed without appointment.”

The guidance hyperlinked above describes this in more detail on page 7

Below is also an extract from the FAQ section of the above guidance:
“FAQ 6.8 We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?
Such attendances can be recorded by the trust in the following circumstances
a) The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust’s involvement is limited to clinical governance.
b) The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.”

2.2 Current reporting for Cornwall patient activity
The above guidance means that activity and performance reported against the 4 hour standard for Cornwall currently includes and excludes as follows:
Treliske Emergency Department and West Cornwall MIU is combined and reported against the 4 hour standard for RCHT. Activity in MIUs managed by CFT is excluded.
Derriford Emergency Department is reported against the 4 hour standard for PHNT. Activity in MIUs in the Derriford footprint i.e. in Plymouth, West Devon and South Hams is excluded.

2.3 Sustainability and Transformation Funding – rules and the link to performance against the A&E 4 hour standard.

Set out below are relevant extracts from the guidance. The aim of including them here is to answer the questions asked by Governing Body members about how the STF can and should be used and the extent to which this can be commissioner influenced.

“The planning guidance confirms that a £1.8 billion Sustainability and Transformation Fund (STF) will be allocated to trusts in both 2017/18 and 2018/19, based on an allocation determined by NHS Improvement. This additional income for trusts is non-recurrent and should not be counted on beyond 2018/19. As in 2016/17 the fund will concentrate on sustainability rather than transformation, aiming not to fund service enhancements but to sustain services.”


‘In 2017/18 and 2018/19 the Sustainability and Transformation Fund will build on the progress achieved in 2016/17, supporting the levels of financial and operational recovery required to sustain the delivery of NHS services. It will continue to accelerate the financial recovery trajectory of trusts that are in deficit, and consolidate the maintenance of (or progress towards) NHS Constitution service standards.’

‘Funding must deliver at least a pound-for-pound improvement in the aggregate trust position, to stabilise the financial position of the trust sector. It will not, for example, be used for reconfiguration, transactions, new care models or private finance initiative buyouts, unless at least pound-for-pound benefits to the bottom line can be realised in-year by the trust receiving the funding.’

‘The main benefits of the Sustainability and Transformation Fund to trusts are:

- improvement in income and expenditure (I&E) margin
- increase in cash balances
- improved metric scores under the Single Oversight Framework ‘use of resources’ assessment
- suspension of fines to ensure the double jeopardy commitment is met
- settling the planning numbers earlier and for a longer duration thereby enabling more energy to be devoted to redesigning and delivering better, more efficient care.’

‘Commissioners will not ask for the fund to be spent on delivering increased volumes of activity. The full impact needs to flow to trusts’ bottom-line positions and it cannot result in any extra costs to trusts. The Sustainability and Transformation Fund is a ring-fenced pass-through payment and cannot be used by commissioners to offset the cost of extra volumes of care required or any other elements of usual contractual arrangements’.

2.4. Sign-off of Sustainability and Transformation Fund allocations

NHS Improvement has calculated the provisional allocations of Sustainability and Transformation Fund to trusts for both years.

Commissioners will not sign off the STF
Monitoring delivery of control totals

A trust’s achievement of its year-to-date control total in each quarter of the two-year period acts as a binary on/off switch to secure its indicative allocation of Sustainability and Transformation Fund for that quarter. Calculations will compare a trust’s actual financial performance to its financial control total. Having achieved (or exceeded) the control total, the organisation becomes eligible for funding. If a trust fails on its financial performance target it will not be eligible for any STF funding in that quarter even if it meets all other eligibility criteria.

Achievement of the financial control total for the quarter is weighted at a minimum of 70% of the trust’s indicative allocation. This may in practice be as much as 100% depending on which performance standards the trust is also being monitored against for STF calculation purposes (see the next section 3.3 for more details).

Delivery of access standards (or agreed performance improvement trajectories)

Access to up to 30% of a trust’s STF allocation depends on it maintaining delivery of core access standards through 2017/18 and 2018/19.

The intention is that no tolerances will be allowed for failure to meet access standards (or improvement trajectories) in any quarter of 2017/18 or 2018/19.

Section 3.5 [of the guidance] sets out how payment will be calculated and paid

3.0 Decisions to be taken and evidence to support.

The table below sets out a summary of the considerations in order to reach an informed position on the providers’ request.

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<tr>
<th>Decision</th>
<th>Evidence</th>
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<tr>
<td><strong>PERFORMANCE</strong></td>
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<td>Does adding the MIU activity to the RCHT reporting achieve / improve the A&amp;E national performance threshold of 95%?</td>
<td>The proposed change alone will not achieve the national performance threshold of 95% if actual performance remains the same. Based on 16/17 activity the overall effect with the MIU data included would be 91.6%.</td>
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<tr>
<td>Does adding the MIU activity to the RCHT reporting achieve the A&amp;E Sustainability and Transformation Fund (STF) A&amp;E trajectory?</td>
<td>RCHT have submitted an A&amp;E trajectory for the STF; 81.1% Q1, 82.9% Jul-Aug, 90% Sep-Feb, and 95% March. There is a high probability of delivery against the trajectory until July, at which point the trajectory becomes more challenging based on historical performance levels. However, it is important to note that as the STF income is calculated on cumulative achievement, it would be likely that the margin of achievement in Q1 and Q2 would also mean that the Q3 and Q4 targets were achieved on a cumulative basis. So integrating the performance would effectively guarantee STF delivery in Q1 and Q2 (which would otherwise be at risk), and provide every opportunity that Q3 and Q4 were also achieved by virtue of having built up a positive cumulative position.</td>
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If (as per later answer) resubmission is not permitted, the more the start point is delayed, the less cumulative gain
against the trajectory will be made in Q1 and Q2 and the more threatened the Q3 and particularly the Q4 position become.

### Other considerations impacting performance

In addition RCHT have been awarded a £1m capital investment to implement Primary Care Streaming. The bid states that this will enable the Trust to deliver 92.5% ED 4 hour performance in 17/18 and 95% from April 2018. This is without the MIU change. Therefore, successful implementation of the bid would deliver the required level of performance to achieve the STF trajectory, without the MIU activity included. However, including the MIU activity would provide mitigation if there is slippage in the implementation of Primary Care Streaming.

### FINANCE

**Does adding the MIU activity to the RCHT reporting secure the additional STF money?**

If the change was made from the 1st April 2017 it would be likely that the margin of achievement in Quarter 1 & 2 would indicate that the Quarter 3 & 4 targets have the potential to achieve on a cumulative basis. Integrating the performance could influence the STF delivery in Quarter 1 & 2. This would provide greater opportunity for Quarter 3 & 4 to achieve by virtue of secured a positive cumulative position.

**Note:** STF income is calculated on cumulative achievement.

**What are the financial benefits and risks to the individual organisations (RCHT, CFT, and CCG) if the STF money is or is not awarded to RCHT?**

RCHT’s risk assessed financial position assumes full delivery and achievement of STF funding as required to meet its control total and deliver its target £1.4m surplus in 17/18.

STF income contributes to the overall financial sustainability of RCHT. Indirectly RCHT has made a number of investments in critical service areas, for instance extending the timings of cover in ED and has made significant staffing investments which have enabled it to maintain clinical safety in the context of the severe pressures encountered over the last year.

No direct financial benefit to NHS Kernow or CFT Cornwall Health System financial control total – if STF funding is not achieved the total risk increases by £2.5m

### SERVICE IMPACT

**What is the impact on patients?**

There would be no change as a result of this decision. Patients will still attend the same buildings, be treated by the same staff members, with the same level of service.

**What is the impact on the clinical service?**

There is no planned clinical service change from making this decision.
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<tr>
<th><strong>Is the Variation permissible through the contract terms of RCHT &amp; CFTs 2017-18 contracts and or EU Procurement regulations?</strong></th>
<th>Based on the analysis by the CCG’s legal advisers it appears that entering into the variation will constitute the direct award of a contract, which does not appear to be justified under Regulation 5 and therefore the Finance Committee carried out an assessment of risk (set out below) and agreed that the risk appeared to be minimal.</th>
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<tr>
<td><strong>What is the risk if the CCG were to go ahead and make the contract variation order?</strong></td>
<td>The term of the variation is only for as long as CFT hold the contract for Adult Community Services. If this Variation Order is not agreed then the services would remain with CFT as part of their existing contract and would not become available to the rest of the market. It is therefore felt unlikely that there would be challenge from other providers as they would understand the nuances of this proposed variation. This would seem to indicate a LOW risk.</td>
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<td><strong>MIUs are defined in the community services contract as ‘commissioner requested services’ – what are the implications of transferring these.</strong></td>
<td>If the CCG wishes to maintain the same level of business continuity protection, the services would be varied into the RCHT contract as ‘essential services’. In theory this carries the same importance, but the legal standing of contracts with NHS Trusts does not have the same ‘weight’ as with FT’s and the independent sector, so in theory becomes a risk, albeit low in probability. The responsibility for delivery of the service and its performance then rests entirely with RCHT.</td>
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<tr>
<td><strong>PERCEPTION AND REPUTATION</strong></td>
<td><strong>HOSC generally concern themselves with ensuring that the impact of proposed service changes is properly considered and that decisions are taken in accordance with due process and with appropriate consultation. In this instance there is no service change proposed and therefore no basis for challenge. There may be a risk of perception that figures are being manipulated. This risk will be mitigated by pro-active and transparent communication about the reason for change, including this report, and commitment to locally still report information separately for emergency departments and MIUs as it is now.</strong></td>
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<tr>
<td><strong>Will the regulators support this</strong></td>
<td>Both NHSE and NHSI have indicated their support for this early in the discussions.</td>
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| **Is the performance and quality status of the respective providers a factor** | RCHT - inspected in May 2016.  
- West Cornwall Hospital, including MIU, is rated ‘good’. |
Treliske – ‘requires improvement’
New inspection carried out early 2017 – report awaited.
CFT - Current CQC rating of MIUs is 'good' but was inspected in 2015 whilst PCH, the previous provider was in control and so is not an indication of CFT, the current provider.
CFT rating for mental health services is 'good'.
CQC due to inspect MIUs during the course of 2017.
Conclusion: insufficient conclusive information alongside the fact that the variation order itself will not have any positive or negative impact on service delivery model or quality and safety.

4.0 Evaluation Decision Points

Including the MIU activity in the overall performance calculation of the A&E department would provide mitigation against slippage of any improvement plan due to be implemented in year.

The performance uplift would just be statistical and there would be no real change or improvement to the service offered to the public as a result of this change. That will be pursued through other existing programmes of work.

It would provide a high degree of probability that RCHT will secure a proportion of the STF money, contributing to the system wide financial position.

The financial benefits are undisputable however, the current regulatory framework does not permit this change and legal advice is clear, it would contravene procurement regulations, although the risk is considered to be low. Challenge against a direct award to RCHT is unlikely to come from other Providers.

There is no compelling evidence one way or another in relation to the CQC view of quality and safety and this proposal is not intended to impact on actual quality and performance.

5.0 Options available to NHS Kernow

There are a number of options available for consideration in light of the legal advice. The impact of each has been assessed below to support a conclusion.

Option 1 - NHS Kernow makes no change.

Option 2 –agree variation order as requested by providers.

Option 3 - don’t agree VO. Ask regulators to allow aggregated reporting without the need for variation order.

As a system, the advice by the regulators (NHSE & NHSI) and set out in the national guidance, is that MIU activity can only be included in the A&E performance reporting if the same organisation “owns” the activity.
There appear to be other systems throughout the country that are reporting the activity together, where the same provider does not “own” the activity. The recently created ACS and ACO are working and reporting performance as one system, yet remain separate organisations until the legal framework is developed to support the new ways of working. The suggestion is the system challenge the regulatory view and makes contact with other systems to explore and understand how they have achieved it, with regulatory support and without breaching procurement and contractual regulation.

**Option 4 – don’t agree VO. Serve notice on both RCHT and CFT and re-procure fully integrated urgent care system as a block contract.**

In the spirit of Shaping our Future and the move towards an Accountable Care System NHS Kernow could serve notice on the entire Urgent Care system (MIU’s, Acute GP service and A&E). This would need the full support and agreement from RCHT and CFT to work to 6 month notice. A fully integrated Urgent Care solution could then be procured as a fixed block contract. CFT and RCHT would then have the opportunity to submit a joint bid, along with any other potential bidders in line with procurement legislation, allowing for not only an improved system/ performance on paper but potentially making a real difference to the service provided and more quickly than planned.

**Conclusion:**

**Option 1:** No risk but also no positive impact and risk to system financial position remains.  
**Option 2:** Some risk around procurement but thought to be low. Has the potential to increase likelyhood of £2m+ income into system. **Recommended.**  
**Option 3:** No procurement risk; time consuming to negotiate and low probability of success unless national framework changes. Unlikely to be in place in time to secure STF for 17/18  
**Option 4:** This option does present an opportunity to bring forward our ambitions for greater integration of care that are set out in Shaping Our Future. However, the bottom up co-production of the desired model of care and associated consultation has not yet been completed and so we do not yet have a clear idea about what that should look like nor will it secure the STF money this year. As such this option is considered to be premature and therefore not viable.