Clinical Assessment Service (CAS)

Project Initiation Document

Submitted by	*Paula Simms*
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Project Sponsor (if known)	*Christine O'Connor*
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D0.2	03/07/06	PS	2nd Draft

Distribution

Name	Role	Action
Christine O'Connor	Project Sponsor	
Denise Boardman Paula Simms	Project Manager Project Lead	
TBA	Project Steering Committee	
TBA	Project Portfolio Committee	

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1 Project Objective

One of the key strategies across Beds and Herts StHA in delivering the challenging financial targets and bringing the health economy into financial balance is to manage demand within primary care.
The objective of the Clinical Assessment Service (CAS) will be to:

- deliver an administrative and clinical assessment function which will manage referrals from primary care, provide a triage service and forward referrals onto the most appropriate service.
- provide real time management information about the flow of referrals. Thus providing accurate information regarding true demand and true referral rates within a given population.

2 Project Description

2.1.1 To create a new referral route from all GPs in the Dacorum and Watford & Three Rivers PCT area, into a central point to be logged (Referral Management Database (RMD)) in support of the projects already being developed in the following specialties:

- Musculoskeletal (MSK)
- Minor Surgery (MS)
- Minor Oral Surgery (MOS)
- Diagnostics APMS
- ENT
- Dermatology
- Diabetes
- Other Specialties TBC

2.1.2 This covers the following business areas:

a) Administration – Data entry/collection, patient advice and liaison, the booking of appointments using Choose & Book and reporting using real time data.

b) Clinical Triage – paper triage, patient assessments, telephone discussions with patients and treatment where appropriate.

3 Project Background

A CAS is a specialist service aimed at providing a greater level of assessment then would normally be expected of primary care. It is designed to ensure that patients are directed efficiently and effectively into the most appropriate care pathway.

CAS can be provided by any clinician with the appropriate clinical qualification and may include:

- GP with a Specialist Interest (GPwSI)
- Other Health Care Professionals
- Multi-Disciplinary Teams (including other health care practitioners)
- Consultants (or other secondary care clinicians)

Although benefits of a CAS may include financial savings, an administrative referral or demand management service is not considered to be a CAS.

4 Scope

4.1 In Scope

- Setup of CAS to capture and process onward referrals
- Reporting and monitoring of impacts for 3 months post implementation
- Referral numbers collected from MSK triage on a weekly basis
- Dacorum & Watford & Three Rivers PCT's, GP's and top 10 specialities

4.2 Out of Scope

- Savings in specialities such as MSK, Minor Surgery, Dermatology, etc.
- Systems development and selection to manage process

5 Constraints and Assumptions

5.1 Constraints

- Some GP's may choose to not use CAS due to being signed up to Choose & Book.

5.2 Assumptions

- All referrals will go through CAS, only top 10 to be assessed
- Adequate clinical engagement
- Minimum 3 Full Time Equivalents
- Housed at PCT offices
- Electronic system to support CAS workflow management, reporting, etc. (full Payments by Results (PbR) functionality)
- CAS to support Choose and book facility (use system)
- Ensuring GP's send the referrals through the Referral Management process and CAS and not direct to the trust
- Key Performance Indicators (KPI) project will support reporting requirements

6 Proposed Solution

6.1 Basic Principles of a CAS

A CAS should be set up to benefit a patient's journey. Below are some basic guidelines and principles (as set out in the Choose and Book 'Implementing Clinical Assessment Services' version 8. May 2006) to adhere to when setting up and running a CAS:

- CAS should be set up for high referring/demand specialties in order to gain the greatest benefit, and have to be speciality/sub-speciality specific.
- CAS should add clinical value to the patient's journey. This benefit may accrue to patients in speciality/sub-speciality as a whole.

- CAS should not add additional time to the patient's journey, which should be completed in line with current targets.
- Patient's who are referred to a CAS should be assessed within the appropriate timescales, without adding delay to the patient's journey.

6.2 Overview of CAS Model

A CAS can operate as either a Directly Bookable or Indirectly Bookable CAS depending on whether the hospitals PAS systems have been integrated with Choose & Book. A CAS may take on one or more of the following forms:

- **See Style CAS** – The patient is physically seen and assessed by a clinical specialist at an allotted time. The patient is then referred to another service or advice sent back to the patient's GP to assist with management.
- **Review of Referral** – The CAS clinician simply adds expertise to the assessment of the referral information provided by the GP and the patient is then referred on or advice returned to the GP.
- **See and Treat CAS** – This differs from the See Style CAS in that a patient, upon assessment, may be treated by the clinicians or team that provide the assessment.
- **Telephone CAS** – A telephone CAS operates by taking referral information and then using a telephone conversation with the patient to gain additional information for the assessment. Patient then referred on or advice returned to the GP.
- **A mix of the above.**

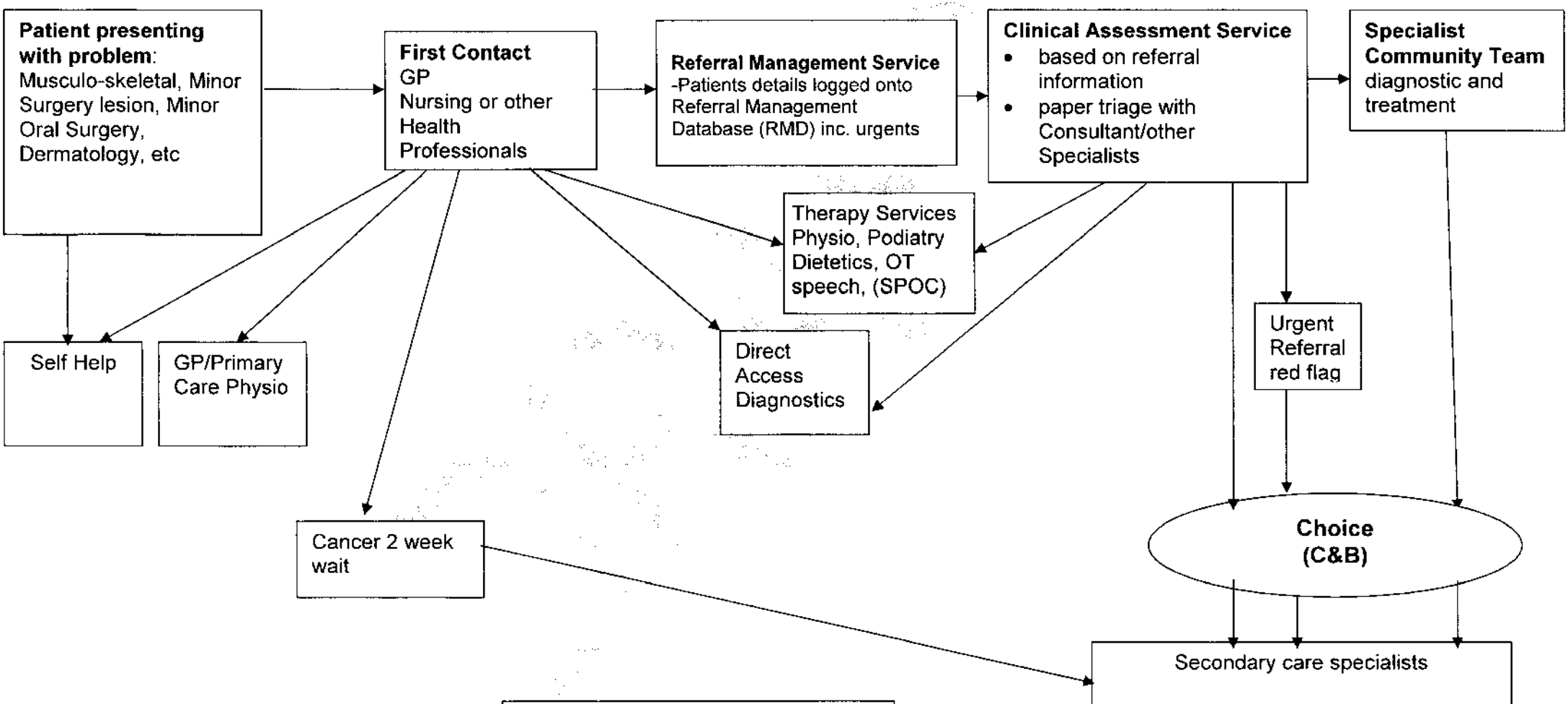
6.3 Drivers for implementing CAS

To ensure that patients get to the right place first time:

- Managing high demand services or specialties
- Providing greater control over GP referrals
- Providing additional local data and information on referral patterns, demography and health needs
- Providing information in assisting finance and capacity problems

6.4 Draft CAS Elective Care Pathway

6.4 DRAFT (4) - Clinical Assessment Service for Elective Pathway



Referral routes
- From Primary Care
- Referral Management Service
- From Clinical Assessment Service

Glossary

MSK – Musculoskeletal
RMD – Referral Management Database
SPOC – Single Point of Contact
OT – Occupational Therapy

7 Completion Criteria

The project will be deemed complete when:

The referrals for the agreed specialties are being received from ALL the GP practices within Dacorum and Watford & 3 Rivers PCTs, logged onto the Referral Management Database, clinically triaged and/ or assessed and treated in a timely fashion.

From the role out of the final specialty (proposed date 31/03/07) 3 months of reporting and monitoring that all GP's are sending all the appropriate referrals through the CAS. Once this is agreed the CAS project will be deemed complete and become operational.

8 Known Risks

Risk & Cause	Impact (H/M/L)	Probability (H/M/L)	Preventative or contingent action
Clinical engagement to utilise the CAS	H	M	The following meetings have been arranged to discuss the project and processes: **6th June 2006** – meet with practice managers **20th June 2006** – CAS & Choose & Book workshop with GP's and CAS leads **28th June 2006** – Rhetoric to Reality Day W3R GP's **5th July 2006** – first meeting with GP nominated leads for Dacorum and Watford & Three Rovers PCTs **11th July 2006** – Hot Topic Day Dacorum GPs
There is possible fragmentation in West Herts quadrant due to different PCT alliances proposing and utilising different models.	H	H	To be raised Project Steering Office meeting for Director level discussion and agreement.

9 Impacts

Stakeholders

- GP's
- Patients
- Secondary Care

- Practice Based Commissioning
- Primary Care Leads
- PCT Commissioners
- Referral Systems and Processes

9.1 Other Projects or Programmes

- Musculoskeletal (101_MSKT)
- Minor Oral Surgery (102_MOS)
- Practice agreement for the set quota of referrals (103_PASQ)
- Dermatology (111_DERM)
- Diagnostics (112_DIAG)
- Pain Service at WHHT (506_PAIN)
- Diabetes (110_DPBC)
- ENT (301_CEPPT)

10 Alternative Solutions Considered

10.1 Alt. Solution 1

For the Practice Based Commissioning clusters to provide the CAS service with administrative support from the PCT to assist in the delivery and to maintain the service around offering choice and reporting.

10.2 Alt. Solution 2

For all referrals to be sent through the CAS – the specialties listed (under CAS) would be triaged and assessed as previously suggested. For all other specialties the patient would be offered choice and referral sent to hospital of choice/patient booked direct using the Choose & Book mechanism by the administration team, thus relieving the offer of Choice from the GP's (some funding for this option would come from the DES moneys).

10.3 Do nothing

- To do nothing would mean continued inequitable referral patterns for patients with similar symptoms and possibly under utilisation of more appropriate methods of treatment in primary care settings.
- Patients who might be suitable for treatment in a community setting waiting unnecessarily on secondary care waiting lists.
- Demand Management will fail to reach a required level of standard.
- Inequitable services offered across the quadrant (St Albans & Harpenden PCTs are currently out to tender for 13 specialties for an ICATS)
- Significant financial implications for patients (who could be offered an alternative) being inappropriately seen within a secondary care setting rather than primary care. PBR ensures that for many treatments there is

an incentive to the hospitals to treat patients and this may create a perverse incentive for secondary care providers.

- Financial targets in FRP will not be met through this reduction in referrals.

11 Proposed Project Organisation

Role	Name	Department
Project Sponsor	Christine O'Connor	Catchon
Project Manager	Denise Boardman	Commissioning Team
Project Team Members	Paula Simms	Commissioning Team
Others (as necessary)	PBC Group Practice Managers Patient Consultants GPwSI Extended Scope Practitioners (ESPs) GPs Finance HHIS	

12 Resource Required

Name/Role	Responsibilities	Planned Start Date	Planned End Date	% Availability
Paula Simms	Project Lead	03/07/06	ongoing	100
HHIS	Data Analysing	June 2006	June 2006	10
Angie Biela	Minor Oral Surgery	June 2006	August 2006	10
Janice Omar	Diagnostics APMS	June 2006	August 2006	20
Monica Hough	Dermatology & Pain Management	ASAP	Dec 2006	20
Shahnaz Kausar & Therese Fletcher	Financial	June 2006	June 2007	30
Finance	Financial	June 2006	June 2007	30
HR	Recruitment	June 2006		10
PPI	Patient Involvement	June 2006		5
Nominated GP Leads	Sheila Borkett-Jones Avi Gupta Jerry Bulger Trevor Fernandes Nicholas Foreman	June 2006		10

13 Key Milestones

Task ID	Description	Start Date	End Date	Duration (working days)	Resource	Dependency
1	**Confirmation of PbC commissioner involvement.**	**21/06/2006**	**30/06/2006**			
1.1	PbC engagement W3R	21/06/2006	28/06/2006	5	LP/SB-J	
1.2	PbC engagement Dacorum	21/06/2006	30/06/2006	7	JP	
2	**Decision on sequence of rollout per speciality**	**16/06/2006**	**30/06/2006**			
2.1	Obtain data from HHIS regarding total no. of referrals by specialty during 05/06	16/06/2006	21/06/2006	3	HHIS	
2.2	Establish National Referral Ratio targets by specialty.	20/06/2006	22/06/2006	2	SHA	
2.3	Agree Specialties for presentation to Clinical reference Group	21/06/2006	22/06/2006	1	DB	
2.4	Set up clinical reference group to agree specialties and clinical knowledge required	21/06/2006	30/06/2006	6	SB-J/AG/JB	
3	**Service model agreed with practice based commissioners**	**30/06/2006**	**14/07/2006**			
3.1	Project Lead to meet with Clinical Reference Group to establish service model and pathway, numbers of staff clinical/admin	21/06/2006	30/06/2006	7	SB-J/AG/JB	2.4
3.2	Prepare service model and obtain Project Sponsor sign off. Project Sponsor to advise if Service Model to be agreed by PEC/Board.	30/06/2006	07/07/2006	5	CO'C	3.1
3.3	Service Model signed off by PbC	07/07/2006	14/07/2006	5	PbC	2.4/3.1
4	**Establish implementation group/CAS steering group**	**30/06/2006**	**14/07/2006**			
4.1	Meet with 'Head of Public Involvement' to establish a Patient Rep.	20/06/2006	27/06/2006	5	Heather Aylward	
4.2	Clinical Reference Group to advise on other members of steering group	21/06/2006	30/06/2006	7	SB/J/AG/JB	3.1
4.3	Organise first steering group meeting	30/06/2006	14/07/2006	10	TBC	2.4/3.1

5	**Implementation/Project Lead contracted/employed. Other staff recruitment**	**19/06/2006**	**30/06/2006**			
5.1	Interview Project Lead suitable applicants	30/06/2006	30/06/2006	0	TS/DB/HR	
5.2	Project Lead appointed and commenced	30/06/2006	03/07/2006	1		
5.3	Project Lead to draft job descriptions for PCA's	03/07/2006	05/07/2006	2	HR	
5.4	Interview PCA's and appoint	05/07/2006	28/07/2006	17	HR/TS/DB	
6	**Counting of all referral data for 1 week from PBC practices at practice level.**	**07/07/2006**	**14/07/2006**			
6.1	Discussion with PbC leads on how to move forward with the data collection.	28/06/2006	07/07/2006	7	SB/J/AG/JB/ PbC Groups	1.1/1.2
6.2	Prepare system for data collection	21/06/2006	07/07/2006	12	Project Lead/CfH	
6.3	Start receiving data	07/07/2006	28/07/2006	15	Project Lead/CfH	1.1/1.2
7	**Counting of all referral data for 1 week from remaining practices at practice level.**	**14/07/2006**	**28/07/2006**			
7.1	Discussion with PbC leads on how to move forward with the data collection.	28/06/2006	14/07/2006	10	SB/J/AG/JB/ PbC Groups	1.1/1.2/6.1/6.3
7.2	Start receiving data	14/07/2006	28/07/2006	20	Project Lead/CfH	1.1/1.2/6.1/6.3
8	**Information processes and systems in place.**		**30/09/2006**			
8.1	Choose & Book training - Project Lead/PCA's	14/06/2006	28/06/2006	10	CfH	
8.2	CAS & Choose & Book Training all practices	28/06/2006	31/07/2006	23	CfH	8.1
8.2	Establish databases suitable for CAS	30/06/2006	01/09/2006	44	CfH/HHIS	
8.3	Set up database and run dummy system	01/09/2006	05/09/2006	3	Project Lead	8.3
8.4	Clinical pathways in place per specialty	14/07/2006	01/01/2007	120	Clinical Ref Group/Consultants/GPwSI /ESP	3.2
8.5	GP's/Practice Managers/CAS clinicians/ Receiving Trusts updated with procedures and processes	21/06/2006	31/03/2007	200	PS/Pbc/SB-J/AG/JB	8.1/8.2/8.4

9	**All 10 specialities included.**	**01/06/2006**	**31/03/2007**			
9.1	MSK & Minor Surgery	01/07/2006	28/07/2006	20	Project Lead/DB/MH/ CfH	
9.2	2 specialties TBC	01/07/2006	30/09/2006	65	TBC	2.3/3.3/5.1/5.48.4
9.3	2 specialties TBC	01/07/2006	24/11/2005	105	TBC	2.3/3.3/5.1/5.48.4
9.4	2 specialties TBC	01/07/2006	28/01/2007	150	TBC	2.3/3.3/5.1/5.48.4
9.5	2 specialties TBC	01/07/2006	31/03/2007	195	TBC	2.3/3.3/5.1/5.48.4
10	**Reporting gateway**	**31/07/2006**	**07/04/2006**			
10.1	Weekly reporting and monitoring of service	31/07/2006	07/04/2006	210		All of the above
11	**Project Close**		**07/06/2007**			
11.1	3 months reporting from date of last specialty to be rolled out.	31/03/2007	07/06/2007	60		9.5

14 First Estimate Cost Benefit Analysis

Costs

Type of Cost	Estimated Costs in (£)
Staff Costs	£90 000 p.a. = 3 admin staff – other staffing levels TBC
Investments (e.g. Capital Equipment)	
Operational Costs (e.g. Consultancy)	

Cost Benefit Summary (for details please see calculation sheet)

Total Costs	TBC
Quantifiable Benefit	Reduction in referral numbers into secondary care.
ROI	
Payback period (years)	Less than 1 year
Qualitative Benefits	• Patients will be offered choice. • Getting the right patient to the right place at the right time. • A person at the end of the phone to discuss the process with. • Data capture, demand management, financial management. • Avoidance of PBR tariff payments and the development of primary care services. Note: During the project, the team will attempt to further quantify these benefits and look for increased payback potential.

Identify any on-going costs:

15 Approved and budget released

Project Sponsor:	**Date:**
Project Manager:	**Date:**
Project Portfolio Committee:	**Date:**
Programme Steering Committee:	**Date:**
Others (if necessary):	**Date:**

Programme Management Approver and Budget Allocation	*Enter Approval Status here*
Budget (€)	
Cost Centre	
Control Priority	

PID approved

..... (Project Sponsor) - Date

..... (Project Portfolio Committee) - Date

GP Referrals and Activity to CAS by Specialty across All Providers, for FY 2005/06

Appointment Specialty		GP Referrals		OP 1st Attendances		IP Spells (EI & DC)		OP to IP Ratio		
		DACORUM	W3R PCT	DACORUM	W3R PCT	DACORUM	W3R PCT	DACORUM	W3R PCT	
502	GYNAECOLOGY	1921	2658	2735	3943	1030	1474	0.38	0.37	
130	OPHTHALMOLOGY	2464	3007	2188	3825	1195	1339	0.55	0.35	
100	GENERAL SURGERY	2489	3591	2826	3824	1747	2372	0.62	0.62	
*330	DERMATOLOGY	2175	2313	2463	2947	132	28	0.05	0.01	
*110	TRAUMA & ORTHOPAEDICS	2050	2482	2430	2814	1934	1933	0.80	0.69	
*120	ENT	1749	2254	2210	2419	652	656	0.30	0.27	
*410	RHEUMATOLOGY	495	1159	1205	1978	21	73	0.02	0.04	
*320	CARDIOLOGY	1074	881	1394	1522	632	931	0.45	0.61	Heart Failure Pathway
101	UROLOGY	570	1038	829	1214	1440	1641	1.74	1.35	
301	GASTROENTEROLOGY	618	1014	720	1019	1659	1317	2.30	1.29	
160	PLASTIC SURGERY	292	676	363	887	468	1015	1.29	1.14	
340	THORACIC MEDICINE	444	626	398	596	250	294	0.63	0.49	
*140	ORAL SURGERY	810	1258	156	293	290	376	1.86	1.28	
191	PAIN MANAGEMENT	68	84	81	103	20	46	0.25	0.45	
Grand Total		17219	23041	19998	27384	11470	13495	0.53	0.48	

Key Code
Data in order of 1OPA W3R descending
Specialty already covered in a project *

Please note 90% of referrals are W3R into WHHT and 65% Dacorum into WHHT but WHHT fail to record 1/3 of referrals!!! Therefore the referral numbers will be

	Diabetes
	Heamotology
	Mental Health