DRAFT FOR CONTRIBUTER AND EXECUTIVE TEAM REVIEW - NOT FOR CIRCULATION

Clinical Assessment and Treatment Services in Hertfordshire

A Review and Policy Recommendations

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with

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There are no short cuts to any place worth going

Beverly Sills

A place where…..

GP clinical leaders and consultants work together with a multidisciplinary team, to provide specialist care for a defined locality within an allocated budget, and are accountable to ensure value for money, from not only their specialist service but also from primary care and the specialist services which they are responsible for commissioning.

And where care pathways (with empowered patients at the centre), agreed between clinicians, commissioners and patient representatives underpin local service delivery

Steven Laitner

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Clinical Assessment and Treatment Services in Hertfordshire – A Review and Policy Recommendations

1 Purpose

This paper sets out the findings of a review of clinical assessment and treatment services in Hertfordshire, commissioned by the two newly formed Hertfordshire PCTs and carried out in November and December 2006.

This paper also sets out clear recommendations for strategic direction in CATS implementation, for the PCT executive team to consider in January 2007.

2 Executive Summary

2.1 Background

Clinical Assessment Services have been introduced across the country to enable more care to be delivered closer to home and to better manage demand for secondary care services through the triaging of referrals and directing referrals either back to GPs or onto more cost effective alternatives than acute hospital secondary care.

Clinical Assessment Services (CAS) and Clinical Assessment and Treatment Services (CATS) have been introduced across Hertfordshire under the management of the former PCTs and thus slightly different service models, implementation strategies and stages of development exist.

2.2 Conclusions

2.2.1 CATS as a service model (for demand management, financial recovery and delivery of *Care Closer to Home*)

2.2.1.1 CAS/ CATS have the potential to manage demand (and thereby reduce cost) for secondary care services through effective referral triage and the signposting or provision of more cost effective specialist service alternatives to secondary care assessment and treatment

2.2.1.2 The main ways in which demand can be managed within CATS are:

- Preventing referrals for low priority conditions/ treatments
- Managing the threshold for referrals from primary care and helping push care to primary care and self care where appropriate

- Providing cost effective specialist assessment and specialist support to primary care without referral
- ‘Skilling up’ general practice and ensuring value for money from primary care. This will include the identification of training needs and the provision of education and training interventions
- Managing the thresholds for diagnostic tests and providing/ commissioning more cost-effective diagnostic tests where available
- Managing the thresholds for outpatient, day case and inpatient elective treatment and providing more cost-effective alternatives
- Redesigning the care pathway for conditions within that speciality, starting with common conditions and high volume procedures
- Providing more cost effective, holistic, multidisciplinary care in a primary care setting and under primary care leadership

2.2.1.3 In order to deliver CATS need to be ale to provide the following (either themselves or through commissioning other primary care services):

- Specialist clinical triage according to agreed clinical policies and thresholds
- Specialist advice and guidance to primary care
- Specialist clinical assessment
- Specialist diagnostic tests and procedures
- Specialist outpatient and day-case treatment
- Informed consent and direct listing for high-volume day-case and inpatient treatment

2.2.1.4 CAS/ CATS also have the potential to improve the patient experience through delivering multidisciplinary specialist care close to the patients home

2.2.1.5 CAS/ CATS have the potential to break down the barriers between primary and secondary care clinicians and between health disciplines through joint working within a locality

2.2.1.6 However where CATS replicate existing practices and pathways under a different name or organisation, without transforming the care provided and the settings where it is provided, then no improvements or savings will be realised

2.2.1.7 CAS/ CATS risk *increasing* referrals by lowering the threshold for referrals and evidence of this have been highlighted in this report

2.2.1.8 It is therefore imperative that CATS actively manage the threshold for GP referral and support the delivery of primary care services (GMS and enhanced GMS)

2.2.1.9 CATS must be devolved an indicative or real budget in order o align clinical and financial responsibility

2.2.1.10 Clinical Care Pathway development, based upon national templates, for common presenting conditions/ common reasons for referral/ specialist advice/ support and for high volume procedures, is essential to underpin CATS delivery within a health care community.

2.2.1.11 Whilst there is potential for overall cost savings from CATS where they receive sufficient GP referrals and where there is little or no increase in overall referrals, the greatest potential for costs savings is in the provision of more cost-effective day-case treatments within the CATS

2.2.1.12 There is strong evidence of increased consultant to consultant referrals for the East and North Herts PCTs which is likely to offset any saving from CAS.

2.2.1.13 There is a lack of robust data and financial analysis prior to this review to assess cost effectiveness of CATS on an ongoing basis

2.2.1.14 There is a risk of *overestimating* savings by assuming all CATS activity is a substitute for more costly 2' care activity

2.2.1.15 A risk also exists of *underestimating* savings by not assessing the more cost effective delivery of or the reduction of day case treatments

2.2.1.16 Financial predictions of CATS models are challenging and requires dedicated support from data analysts and accountants

2.2.2 CATS implementation process to date

2.2.2.1 The CATS implementation process has been for many stakeholders been too rapid and without sufficient local clinical engagement of GPs, consultants and patients

2.2.2.2 There is now a strong will to engage in this process from Practice Based Commissioning leads and many innovative GPs

2.2.2.3 CATS need to receive ALL GP referrals, as well as Consultant to Consultant referrals in order to capture information on the total "specialist and elective" health care need/ demand of the population it serves, as well as having an opportunity to mange that demand more cost-effectively

2.2.2.4 It is therefore essential for Choose and Book and CATS to be aligned

2.2.2.5 There are strong vested interests, power base defences and perverse incentives in the health care system which can create barriers to change, even when in the public and patients best interests. These need to be recognised and actively managed

2.2.2.6 There has recently been perceived a loss of impetus and loss of PCT direction in CATS and this risks losing the enthusiasm of converted GPs and consultants. One local GP group have now classed CATS as an endangered species!

2.3 Recommendations

2.3.1 CATS must be accepted as the PCT strategic mechanism to deliver demand management for elective care, whilst accepting that significant changes to the current models need to be made

2.3.2 Mechanisms need to be found (perhaps through Practice Based Commissioning) to align the clinical responsibility for a specialist CATS with the financial responsibility for commissioning services for that speciality. This could be enabled in the same way as Hertfordshire Partnership Trust (HPT) has been devolved the commissioning budget for inpatient care outside of HPT services.

2.3.3 Primary care clinical champions for CATS should be established in each PBC locality to drive forward development (in the context of a PCT strategy) and with the support of the PBC locality group and the PCT. Ideally these clinical champions would be members of the PBC locality management or executive group

2.3.4 Similarly a member of the PCT PEC should be identified as the clinical champion for CATS and clinical champion for service redesign between secondary and primary care

2.3.5 GPs with a special interest in service development of the key CATS specialities need to be identified in each locality by the clinical champions. These GPs do not necessarily need to have an expertise or an interest in providing clinical services but must be passionate about service redesign for that speciality and able to work with the local PBC group, consultants from within or outside of the locality and the PCT.

2.3.6 The development of CATS needs to focus initially on the key high volume specialities for transformation service redesign (including secondary to primary care shift), namely:

- Musculoskeletal Services (MSK) – incorporating Orthopaedics, Rheumatology and possibly physiotherapy)
- Dermatology and Plastic Surgery
- Gynaecology
- Ophthalmology

- ENT
- Urology
- Gastroenterology
- Cardiology
- Oral Surgery
- General Surgery

There is also a recognised potential for a significant shift in paediatric outpatient services to the community. The transfer of community paediatrics to the PCT provider function provides a unique potential for the development of paediatric CATS and discussion should commence without delay.

2.3.7 A Hertfordshire CATS Hub needs to be established to receive referrals for these specialities, to capture *real time* referral data (on a minimum data set), to deliver immediately to the clinical triage individual or multidisciplinary team within the relevant locality (possibly by secure email), to track the progress of the referral and provide a point of contact for the patient. This Hub could in time develop to provide patient centred outcome data for surgical interventions to feedback to commissioners

2.3.8 Each referral needs to be mapped onto database (? READ code) of speciality and “presenting complaint” or conditions and against any existing Map of Medicine/ 18 week patient pathways

2.3.9 The Hertfordshire CATS Hub requires dedicated administrative, management, information and financial resources for the day-to-day tracking of activity and cost. Dedicated overall clinical leadership support is also required, possibly from a PEC member.

2.3.10 CATS need to quickly take on the responsibility for managing the threshold for referral from primary care (thereby ensuring value for money from GMS), providing routine feedback from referrals, providing challenge to primary care peers and operating within a finite resource. Primary care clinical leaders within CATS (together with their specialist colleagues) need to advise their PBC and PCT colleagues on commissioning for that speciality within a limited budget

2.3.11 CATS must be accountable to develop the skills of the primary care clinicians its serves, including clinical assessment skills, the *appropriate* use of direct access investigations and the provision of a range of treatments

2.3.12 It is important not to replicate the risk for supplier induced demand, as seen in secondary care, through the introduction of payment by results (actually payment by activity) for CATS. In order to achieve this the necessary counterbalance for supplier induced demand through commissioning incentives needs to be provided

2.3.13 CATS need to receive ALL referrals from primary care for that speciality, even where they need to be immediately transferred to secondary care in order that referrals and demand can be continuously assessed and managed. In order to effect this the CATS would be the only option under choose and book for that speciality

2.3.14 CATS need to receive ALL consultant – consultant referrals

2.3.15 Choice and "Choose and Book" need to be delivered by the Hertfordshire CATS Hub and by the locality CATS teams

2.3.16 Multidisciplinary teams need to be established within CATS comprising at least a GP clinical leader (may or may not be GPwSI), specialist (likely to be a consultant) and specialist nurses and/ or therapists and dedicated administrative and management support

2.3.17 Clinical pathways must be locally agreed for commonly referred "presenting symptoms" or conditions, especially when leading to high volume procedures (based upon nationally agreed care pathways such as 18 Weeks and Map of Medicine)

2.3.18 Care plans for GPs and patients to follow need to be developed, where appropriate, to replace outpatient follow-up

2.3.19 The public and patients need to be actively engaged in radical service redesign within each locality

2.3.20 There needs to an open competitive process for the identification and appointment of individual specialists to work with the GP clinical leader in the CATS

2.3.21 Local primary care communities need to be able to select consultants who the wish to work with after an open and fair selection process

2.3.22 Whilst we need to be aware of unintended consequences on the acute trust, this should not be a reason to prevent progress in service redesign

2.3.23 Primary care and CATS need to have the opportunity to use available local health care facilities, whilst paying appropriately for those facilities

2.4 Background

There are various types of clinical assessment services and each has different functions; most of the possible functions are listed below:

- Centralised administration of referrals from general practices

- Administrative “triage” of referrals against required referral information and NHS treatment exclusions
- Data collection of GP referrals
- Choice, Choose and Book
- Clinical referral triage, often by a GP with special interest (GPwSI), a nurse specialist, therapist or medical specialist (e.g. consultant)
- Routing of referral to appropriate secondary care service or back to GP with advice
- Provision of specialist clinical assessment in primary care, often by a GP with special interest (GPwSI), a nurse specialist, therapist or medical specialist (e.g. consultant)
- Provision of specialist treatment in primary care, often by a GP with special interest (GPwSI), a nurse specialist, therapist or medical specialist (e.g. consultant)

There are a number of names and acronyms for these services which describe the functional elements which they contain. These include:

- Referral Information Centre (RIC)
- Referral Management Service (RMS)
- Clinical Assessment Service (CAS)
- Clinical Assessment and Treatment Service (CATS)
- Inter-professional Clinical Assessment and Treatment Service (ICATS)

Clinical Assessment Services have been introduced across the country to enable more care to be delivered closer to home and to better manage demand for secondary care services. Early work in developing these services appears to have originated in the North West, particularly across Greater Manchester SHA and in Bradford PCTs.

Greater Manchester developed a strategy about 4 years’ ago to establish “tier 2” primary care services. These were described as services which would sit between primary and secondary care and provide services which had traditionally been delivered in a secondary care setting. Early successes were reported from Stockport PCT which had managed to reduce orthopaedics out patient demand by approximately 40% through a referral management centre alongside alternative provision of extended primary care services including GPwSIs and extended scope physiotherapists. The SHA continued to roll out the programme and was held up as an example of best in the HSJ on 20 April 2006 with the following quote:

> *“The SHA introduced “Tier 2” services as an alternative to referring patients to hospital and said 59,802 people had been treated through this route.” “Basically our whole programme of local reform has been linked to helping us achieve financial balance. So the Tier 2 scheme – demand management for elective services – has helped to ease pressure on hospital-based services which in turn has helped financial stability.”*

Bradford West PCT had developed a large number of GPwSIs operating within a primary care centre and had also successfully reduced out patient demand in various specialties.

Locally, within East and North Hertfordshire a number of Clinical Assessment Services have been introduced where local acute hospitals have failed to cope with GP referrals to certain specialities and the CAS has provided specialist clinical triage and referral onto alternative primary and secondary care services.

In West Hertfordshire a number of bids are being invited to develop primary care led CATS which deliver specialist clinical triage of referrals, clinical assessment, outpatient treatments and day case treatments within primary care.

Across Hertfordshire, the ability of CAS/ CATS to deliver both cost-effective primary care services and the commissioning of appropriate secondary care services is seen as fundamental to the delivery of financial recovery by many but not all stakeholders.

3 Introduction

Different models of CAS/ CATS, at various stages of development, exist across Hertfordshire.

Stakeholders such as GPs, consultants and patient groups have been anxious about the establishment of new pathways for clinical referrals and some concerns remain regarding these services.

There has been limited sharing, across the previous eight PCTs of Hertfordshire, of best practice regarding these new primary care services.

Since the establishment of the two PCTs in Hertfordshire and a single management team it has become clear that an urgent piece of work is required with the following aim:

4 Aim

To review the current arrangements for Clinical Assessment Services/ Clinical Assessment and Treatment Services in Hertfordshire and to propose a strategy for the consistent delivery of best practice services across Hertfordshire.

5 Objectives

5.1 Describe existing CAS/CATS provision across Hertfordshire and locality plans for development

5.2 Assess stakeholder views

5.3 Assess the impact of CAS/CATS on outpatient activity and overall costs

5.4 Review national best practice in CAS/CATS and compare with local practice

5.5 Put forward proposals for the roll out of practice services across the county

6 Methods

6.1 Describe existing CAS/ CATS provision across Hertfordshire and locality plans for development

CAS/ CATS locality leads and/ or managers were identified within each locality and asked to provide information on existing and planned CAS/ CATS according to the following template:

Issue	CATS 1	CATS 2	CATS 3		
Geographical configuration					
Geographical scope					
Functions					
Specialties covered					
Management leadership					
Management structure					
Clinical leadership					
Clinical structure					
Pathway for referrals					
Administrative triage					
Clinical triage services					

Clinical assessment services					
Clinical treatment services					
Clinical care pathways					
Delivery of Choice/Choose & Book					
IT system					
Administrative policies					
Waiting times across the pathway					
Procurement process, contestability					
Clinical governance					
Development plans					
Training and professional development					

The leads identified were as follows:

St Albans and Harpenden and Hertsmere – Suzanne Novak and Katrina Power
Watford and Three Rivers and Dacorum – Monica Hough and Paula Simms
East and North Hertfordshire – Yvonne Goddard and Annabel Bennett

6.2 Assess stakeholder views

6.2.1 Interviewees

PBC Leads	Area	Result
Roger Sage	St Albans	No reply
Nicholas Small	**Hertsmere**	**Interviewed**
Peter Shilliday	**Welwyn & Hatfield**	**Interviewed**
Gerry Bulger	**Dacorum**	**Interviewed**
Kamal Nagpal	SE Herts - South	Declined telephone interview
Peter Keller	SE Herts – North East	Not available on dates

		offered
Mark Andrews	**SE Herts – West and central – job share**	**Interviewed**
Nick Condon	SE Herts – west and central – job share	No Reply
Jeremy Cox	**North Herts, Clinical lead for localities PBC**	**Interviewed**
Sheila Borkett-Jones 07767 351052		**Interviewed**
PEC Chairs		
Michael Edwards	Hertsmere	Not available on dates offered
Tony Kostick	PBC lead Stevenage also	No reply
Consultants		
Graham Ramsay	**Medical Director East & North Herts**	**Interviewed**
Jane McCue	Medical Director East and North Herts	Not available on dates offered
LMC		
Jonathan Freedman	**GP in St Albans, LMC Chairman and LMC advisor to Starcom**	**Interviewed**
Peter Graves	**Chief Executive**	**Interviewed**
Patient Forum		
Malcolm Rainbow	**Vice Chair of West Herts PCT PPI Forum**	**Interviewed**
Beryl Jeffreys	Chair of East & North Herts Trust PPI Forum	Not available on dates offered
New PCT		
Leslie Watts	**Transition Director**	**Interviewed**
Gareth Jones	**Strategic Commissioning**	**Interviewed**
Melanie Walker	**East & North Herts**	**Interviewed**
CATS developers, managers and clinical leads		
Yvonne Goddard	**East & North Herts**	**Interviewed**
Suzanne Novak	**West Herts**	**Interviewed**
Mark Bevis	**West Herts**	**Discussion**
Mike Edwards	**West Herts**	**Discussion**

6.2.2 Interview Structure

The interviews were semi-structured telephone interviews, where opinion and experience was captured and followed the schedule outlined in Appendix A

6.3 Quantify CATS activity and assess the impact of CAS/CATS on outpatient activity and overall costs

6.3.1 Adrian Lambourne, Head of Health Information, was brought onto the project group to map the current impact of CAS/ CATS on outpatient activity.

6.3.2 Stuart Lines, Public Health Specialist Trainee was asked map the CAS/ CATS activity by locality

6.3.3 Jeremy Maynard has been asked to assess the impact on overall costs to the commissioner

6.4 Review national best practice in CAS/ CATS and compare with local practice

6.4.1 Linda Mercy, Specialist Registrar in Public Health was asked to review the literature and source reviews which have been carried out elsewhere in the country

6.5 Put forward proposals for the roll out of best practice services across the county

Dr Steven Laitner, Public Health Consultant and GP, will collate the material in the report and formulate conclusions and proposals, which he will put forward to the PCT Executive Team on 23 January.

7 Results

7.1 Describe existing CAS/ CATS provision across Hertfordshire and locality plans for development

7.1.1 West Hertfordshire PCTs

7.1.1.1 St Albans and Harpenden Locality

Issue	MSK CATS
Geographical configuration	MSK CATS based at St Albans City Hospital with clinics at the Lodge Surgery
Geographical scope	Covers population of St Albans & Harpenden
Functions	Provides paper triage, assessment via phone or face to face, some treatments and referral on as necessary
Specialties covered	Orthopaedics Rheumatology Physiotherapy
Management leadership	Interim contracts held by Dr Mark Bevis GP and Mr Ram, Orthopaedic Consultant with physiotherapy provided by PCT.

	Permanent contract planned to be held by STARDOC
Management structure	Dr Bevis, Mr Ram and Marjorie Chown provide overall leadership and manage their own service provision. STARDOC will become the overall management lead for the contract with sub contracting arrangements to the other parties either by STARDOC or the PCT
Clinical leadership	Dr Mark Bevis GPwSI in Rheumatology is the Clinical Leader for the service and is accountable for its overall performance, clinically and financially
Clinical structure	GP Clinical Leader, Orthopaedic Consultant and Extended Scope Physiotherapist work as a MDT leading the clinical provision. The ESP is professionally accountable to Marjorie Chown
Pathway for referrals	GPs can ring, email, fax or post referrals to the service via STARDOC. GPs have the choice of referring to the CATS but will receive an incentive payment if they switch at least 80% of their MSK referrals to the CATS. GPs can also write on their referral if they and the patient have agreed that the patient needs to be seen by a particular consultant The MDT do a paper triage and either bring patients in for a face to face assessment or they refer patients on to secondary care or to one of their own services or to another appropriate service or they refer back to the GP with a management plan.
Administrative triage	There is no administrative triage, all referrals are seen by a member of the MDT.
Clinical triage services	Triage on paper is carried out by the MDT: Consultant, GPwSI and ESP
Clinical assessment services	Face to face assessment is carried out by whichever service was considered best to do so at paper triage stage: Physiotherapy, Orthopaedic Consultant or GPwSI in Rheumatology
Clinical treatment services	Treatment services offered: Extended scope physiotherapy Joint injections Carpal tunnel – splints and injections Education and advice re self management, exercises, medication etc
Clinical care pathways	For example Knee Pain Pathway
Delivery of Choice/Choose & Book	Patients needing secondary care are referred on via Choose & Book which will shortly undertaken by STARDOC on behalf of CATS for patients of all the practices – this is done by the practices giving formal permission for STARDOC to act as part of their practice so that STARDOC can raise the UBRN
IT system	The CATS team are using the Community IT system – System 1 for all data collection, activity monitoring and reporting. Referrals can be sent electronically using NHS Net

<table>
<tr>
<td>Administrative policies</td>
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These are in place for Paper screening and referral to MSK CATS
e.g.
<u>Policy for Paper Screening.</u>

All referrals are to be paper screened daily by a Specialist Therapist with any queries to be taken to a weekly meeting involving a Consultant, GPwSI and therapist.
After paper screening, the referral will be forwarded to the appropriate department/service or for face to face triage.

<u>Physiotherapy</u>
Clear diagnosis but not responding to GP advice/meds or acute injury

<u>Pain Management Team</u>
Chronic pain, no further intervention/surgery indicated and poor response to therapy in past

<u>Foot Health Service</u>
Foot/ankle pain with evidence of altered biomechanics/poor foot posture

<u>Orthopaedics via Choose and Book</u>
Red flags, obvious deformity or surgical candidate

Pain Clinic via Choose and Book
Pain is the primary problem, surgery not indicated and may require a multi-disciplinary approach

Policy for Referrals To Musculoskeletal Assessment Clinic:
All referrals should be on the approved referral form or in letter format, legible and include the following information, where possible and as appropriate, so that the referral may be processed most efficiently:

Name, address and date of birth
Daytime contact number
NHS number
Reason for referral including

Duration of symptoms
Mechanism of onset
Presence of neurology
Any red/yellow flags
Work status
Any functional impairment
Investigations undertaken with results
Treatment to date

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	▪ Previous episodes, treatment and outcome including reports from other health providers ▪ General health and medication
Waiting times across the pathway	ESP: 1-2 weeks GPwSI: 6-8 weeks Ortho Consultant (Within MSK CATS): 6-8 weeks
Procurement process, contestability	The interim contract was placed following local advertisement across West Herts. The permanent contract was advertised in the HSJ and across West Herts and led to a process of competition where bidders were judged by a multi disciplinary assessment panel against agreed criteria for a service specification which had been consulted on locally.
Clinical governance	Dr Mark Bevis is responsible for the overall clinical governance of the service. Strong ethos of mutual learning and accountability within the team. GPwSI supervised by Consultant Rheumatologist.
Activity and Savings	Increase quality and quantity of feedback to referring GP's with the aim of improving the appropriateness and quality of subsequent referrals into the service. Increase the number of Rheumatology referrals into the service (currently seem under-represented) Consolidate existing care pathways e.g Carpal Tunnel Syndrome and develop and agree new ones e.g. Knee Pain, Back Pain. Improve access to and turnaround times for Imaging, including work up for onward referral patients.
Training and professional development	This is funded as part of the contract Aspects of this have been neglected and will need to be addressed more fully once permanent contract in place.
Patient feed back on the service to date	Patient questionnaires to be developed and monitoring and analysing complaints. To date there have been 3 formal complaints which when investigated the issues were with the acute trust – the time the hospital providing onward care took to action the referral from CATS.
Means of ensuring the service substitutes for secondary care rather than being additional and creating more demand	Referral protocols have been devised by the team e.g.: Management of hip Management of knee Management of low back pain Management of shoulder pain Protocol for trigger finger The GPwSI is auditing referrals and advising/reminding practices of conservative treatments they should be carrying out first and ensuring that treatments such as pain injections etc are carried out within primary care and maximising use of the GMS

	contract. The care pathway into secondary care is being worked through to avoid duplication of outpatients and diagnostic tests. GP referral data is being analysed and taken back via Practice Based Commissioning Groups to test appropriateness. Follow up protocols are being developed
Plans to develop this specific CATS further	Further work on the patient pathway into secondary care will be done to advise acute contracting what to commission e.g. no outpatient appointment in secondary care, fast track on to operating lists and redirect follow up back to primary care. Identify procedures that could be carried out in primary care Identify and develop links from MIU and A&E into CATS for areas such as sports injuries etc Develop cost effective timely diagnostics either with local NHS providers or independent contractors
Plans to develop further CATS	Plan to roll out the CATS approach across about a dozen specialties. Dermatology implementation planned for Jan/Feb 07 (expect 15-20% saving against national tariff) Gynae planned for Feb/March 07 (negotiations re savings still ongoing) ENT to be re-advertised in the new year (savings to be assessed) Urology – expected start date April 07 (savings being assessed and for all those below) Respiratory – expected start date April 07 Cardiology – expected start date April 07 Minor Oral Surgery – expected start date April 07 Geriatrics – to be assessed before Xmas Gastroenterology - to be assessed before Xmas Ophthalmology - to be assessed before Xmas Neurology – to be assessed late January Diabetes – currently being discussed with PBC LMG and Turnaround Director

7.1.1.2 Hertsmere

Issue	**MSK CATS**
Geographical configuration	MSK CATS based at Potters Bar Community Hospital, BUPA Bushey and a Borehamwood practice – start date October 2006
Geographical scope	Covers population of Hertsmere
Functions	Provides paper triage, assessment via phone or face to face, some treatments and referral on as necessary

Specialties covered	Orthopaedics Rheumatology Physiotherapy
Management leadership	Contract held by Herts Health Ltd, a private company set up by Hertsmere GPs.
Management structure	Dr Mike Edwards GP is the overall GP Clinical Leader with another local GP. Subcontracting arrangements are in place between Herts Health and Orthopaedic Chambers (consultants from Barnet & Chase Farm) and Physiotherapy Chambers (also from B&CF)
Clinical leadership	Dr Mike Edwards provides overall clinical leadership and is accountable for the performance of the service.
Clinical structure	GP Clinical Leader, Orthopaedic Consultant and Extended Scope Physiotherapist work as a MDT leading the clinical provision. Mr Dan Rousseau is the lead consultant.
Pathway for referrals	GPs can ring, email, fax or post referrals to the service via the administration service of the CATS. GPs have the choice of referring to the CATS but will receive an incentive payment if they switch at least 80% of their MSK referrals to the CATS. GPs can also write on their referral if they and the patient have agreed that the patient needs to be seen by a particular consultant The MDT do a paper triage and either bring patients in for a face to face assessment or they refer patients on to secondary care or to one of their own services or to another appropriate service or they refer back to the GP with a management plan.
Administrative triage	There is no administrative triage, all referrals are seen by a member of the MDT.
Clinical triage services	Triage on paper is carried out by the MDT: Consultant, GP and Physiotherapist
Clinical assessment services	Face to face assessment is carried out by whichever service was considered best to do so at paper triage stage: Physiotherapy or Orthopaedic Consultant
Clinical treatment services	Treatment services offered: Extended scope physiotherapy Joint injections Education and advice re: self-management, exercises, medication etc
Clinical care pathways	These are in the process of being developed
Delivery of Choice/Choose & Book	Patients needing secondary care are referred on via Choose & Book which will shortly undertaken by administrators at PBCH on behalf of CATS for patients of all the practices – this is done by the practices giving

	formal permission for the admin team to act as part of their practice so that they can raise the UBRN
IT system	The CATS team will be using their own bespoke IT system for all data collection, activity monitoring and reporting. Referrals can be sent electronically using NHS Net.
Administrative policies	Being developed
Waiting times across the pathway	10days-2 weeks
Procurement process, contestability	The contract was advertised in the HSJ and across West Herts and led to a process of competition where bidders were judged by a multi disciplinary assessment panel against agreed criteria for a service specification which had been consulted on locally.
Clinical governance	Dr Mike Edwards is responsible for the overall clinical governance of the service. Mutual learning between all clinicians in this team is an essential part of the bid and up skilling of primary care. An audit programme to identify training needs within referring practices e.g. injections. The leads will visit practices twice a year to provide service feedback. Audit data will be used to develop care pathways.
Activity and Savings	Increase quality and quantity of feedback to referring GP's with the aim of improving the appropriateness and quality of subsequent referrals into the service. Develop and agree care pathways e.g. Knee Pain, Back Pain, Hip. Improve access to and turnaround times for Imaging, including work up for onward referral patients. Maximise us of GMS contract.
Training and professional development	This is funded as part of the contract Training plan to be developed. An audit programme to identify training needs within referring practices e.g. injections. The leads will visit practices twice a year to provide service feedback. The GP leads will engage with orthopaedic chambers to develop their clinical output, which will require further training . The team will develop rheumatological skills to increase the capacity of the CATS
Patient feed back on the service to date	Patient questionnaires are being developed. To date there have been no formal complaints.
Means of ensuring the service	Strong clinical leadership by a GP who will hold the delegated budget for the specialty and therefore will overspend if the service is additional rather than

substitutes for secondary care rather than being additional and creating more demand	substituting. GP Clinical Leader accountable to the PBC LMG for performance against budget.
Plans to develop this specific CATS further	Development of care pathways e.g. hips, knees & backs; develop CATS rheumatological services; develop one stop service e.g. injection clinics, shoulder clinics and development of a direct access protocol for MRI/arthroscopy from primary care as part of demand management; development of fast track surgery e.g. carpal tunnel surgery.
Plans to develop further CATS	Plan to roll out the CATS approach across about a dozen specialties. Dermatology implementation planned for Jan/Feb 07 (expect 15-20% saving against national tariff) Gynae planned for Feb/March 07 (negotiations re savings still ongoing) ENT to be re-advertised in the new year (savings to be assessed) Urology – expected start date April 07 (savings being assessed and for all those below) Respiratory – expected start date April 07 Cardiology – expected start date April 07 Minor Oral Surgery – expected start date April 07 Geriatrics – to be assessed before Xmas Gastroenterology - to be assessed before Xmas Ophthalmology - to be assessed before Xmas Neurology – to be assessed late January Diabetes – currently being discussed with PBC LMG and Turnaround Director

7.1.1.3 Dacorum

Issue	MSK CATS	Minor Surgery CATS
Geographical configuration	MSK CATS based at Hemel Hempstead General Hospital Physiotherapy Dept. Start Date – 08/03/2006	Minor Surgery provided by 2 GP practices in Dacorum and 2 GP practices in Watford & 3 Rivers. Start Date – 01/02/2006
Geographical scope	Service covers the population of Dacorum	Service covers Dacorum and W3R patients.

	and, if required W3R patients.	
Functions	Provides paper triage, assessment via phone or face to face and treatments where appropriate. Referral onto secondary care as necessary.	Provides assessment and treatment as appropriate.
Specialties covered	Orthopaedics Rheumatology Physiotherapy	Minor Surgery
Management leadership	Contract held by PCT Provider Services (Physiotherapy)	Local Enhanced Service contract held with 4 GP Practices.
Management structure	Marjorie Chown provides overall leadership and manages the service. Subcontracting arrangements in place between provider services and West Herts Hospital Trust in place to provide Consultants for triaging.	Lead Clinician from each practice: • Dr Ojo-Aromokudu – Gossoms End Surgery Berko • Dr Kerry – Bennetts End Surgery, HH • Dr Nick Brown – Pathfinder Practice.,Watford • Dr Soon Lim – Attenborough Surgery Watford
Clinical leadership	Marjorie Chown – Head of Physiotherapy is accountable for its overall performance, clinically and financially	Dr Nick Brown. PCT hold the budget.
Clinical structure	Consultant Orthopaedic Surgeon and Rheumatologist, Associate Specialist in MSK Medicine, Extended Scope Practitioners, Podiatrist and Physiotherapist.	GPwSI
Pathway for referrals	GPs fax or post referrals to MSK at HHGH (Choose & Book referrals arrive via ‘Choice Team’ and are faxed to MSK HHGH). All direct referral routes to hospitals are blocked, therefore all Orthopaedic	GPs post or fax referral to Choice Team at Royalty House. Patient offered Choice of provider. Referral faxed to chosen provider. Chosen provider triages

	and Rheumatology referrals are sent through this service. Referrals logged onto System1 and triaged by appropriate clinical specialist. Patients are sign-posted to the most appropriate service. Those requiring secondary care are sent to Choice Team based at Royalty House.	referral to establish referral is suitable for this service.
Administrative triage	There is currently no administrative triage, all referrals are seen by a member of the MDT.	Choice Team upon receipt of referral check that specific criteria have been met i.e. age/site/low priority.
Clinical triage services	Paper triage is undertaken by Consultant and ESPs.	Provider GP checks that procedure suitable for the Minor Surgery service.
Clinical assessment services	Face to face assessment is carried by ESP and/or Associate Specialist in MSK Medicine.	N/A
Clinical treatment services	Treatment services offered: Extended Scope Physiotherapy Joint injections Podiatry	Provider GPwSI
Clinical care pathways	See attached – Musculoskeletal pathway for Dacorum and W3R	See attached – LES Minor Surgery Process
Delivery of Choice/ Choose & Book	Following triage the Choice Team at Royalty House receive all manual referrals requiring secondary care1st outpatient appointment. Choosing your hospital brochure and letter sent to patient offering a choice of 4-5 providers. Patient telephones the team with choice of provider. Referral sent via post to hospital of patient's choice.	See attached – LES Minor Surgery Process

	C&B referrals are faxed to MSK for triage. Triaged outcomes received back within 48 hours. Patients requiring secondary care are telephoned and choice of provider discussed. Appointment booked. Patients requiring ESP, Podiatry etc are offered appointment via physiotherapy department. Choice Team update patients record in C&B and complete UBRN.	
IT system	MSK service using System 1. Choice Team using Excel spread sheets for manual referrals and Choose & Book for electronic referrals.	GPs using own IT systems to record data. Choice Team using Excel spread sheets.
Administrative policies	The MSK Service has operational policies within the service. See attached. Choice Team admin policy -log manual referrals and send 'choice offer letter' to patient within 24 hours of receipt. Patient's who do not respond within 10 working days second letter. If patient has not responded within a further 10 working days discharge letter sent to patient and copy to GP. Choose & Book referrals patient is telephoned twice if no response a letter is sent inviting the patient to call Choice Team to book appointment. If in 10 working days no response second letter	Choice Team admin policy log manual referrals and send 'choice offer letter' to patient within 24 hours of receipt. Patient's who do not respond within 10 working days second letter. If patient has not responded within a further 10 working days discharge letter sent to patient and copy to GP.

	sent as above.	
Waiting times across the pathway	Triage Waiting times – C&B refs 48hrs. Manual 7-14 days ESP – 8 weeks Ass Sp – 20 weeks Podiatry – 4 weeks Physiotherapy – Urgent 21 days Routine 8 months	Procedure carried out 1-4 weeks from receipt of referral.
Procurement process, contestability	Service spec developed and local NHS and Independent provider invited to express interest. Robust bidding process took place. Bids assessed by Multi-disciplinary panel of: Consultants, PbC GPs, PPI rep, Director of Commissioning, Director Public Health	Service spec developed as a LES. Local GP practices invited to express interest. Robust Bidding process took place. Bids assessed by Multi-disciplinary panel of: Consultants, PbC GPs, PPI rep, Director of Commissioning, Director Public Health. Prior to awarding contracts practice premises were inspected for compliance re DDA, infection control etc.
Clinical governance	Dr Sheila Borkett-Jones	Dr Nick Brown
Activity and Savings	No. of referrals received and triage across **both PCTs** for 7 months = 4114. No. of referrals triaged to Community service= 1705 No. of referral triaged to secondary care = 2409 Potential saving for 7 months = £173451 (NB this saving is across the 2 PCTs)	Reduction in activity at WHHT = 55% savings = £84793 Cost of providing LES service = £9000 Therefore overall savings=£75793
Training and professional development	As part of contract	As part of contract
Patient feed back on the service to date	Part of the contract is to carry out patient's satisfaction survey. This will be carried out in Jan 07.	Part of the contract is to carry out patient's satisfaction survey. This will be carried out in Jan 07.
Means of ensuring the service	Monthly auditing and monitoring carried out by PCT to ensure meeting	Monthly auditing and monitoring carried out by PCT to ensure meeting FRP.

substitutes for secondary care rather than being additional and creating more demand	FRP. Regular review meetings with service provider.	
Plans to develop this specific CATS further	Carpal Tunnel Pathway being developed. Recruitment of another Ass Sp to improve waiting times.	When dermatology CAS rolled out links will be formed with Minor Surgery and some dermatology minor procedures will be performed by the GPs holding the LES.

Plans to develop further CATS

Dermatology – Currently in discussions with WHHT to provide a community dermatology service for both Watford and Dacorum patients.

It is envisaged that if the service goes ahead manual referrals would be received in the community by the dermatologists who would triage and set up appointments for patients to be seen in the community. The referrals for patients requiring secondary care appointments would be sent to the CAS administrative team for them to offer the patient a choice of provider. The process would be the same as the manual process for the MSK service.

It is not expected at this stage that the 2 week cancer waits would go through the triage process.

Proposed Activity

	No of referrals to be triaged	Expected number to be seen in community	Number to be offered Choice
Dacorum	2500	1500	1000
Watford	2900	1740	1160

This project is currently on hold as advised by the Assistant Director of Finance, Acute Service and Contracting, Project Lead awaiting further advise.

Minor Oral Surgery – to commence April 07
The aim is to set up a pilot for 2007. The original assumptions were incorrect. East and North Herts are currently doing a similar exercise and the aim is to learn from this.

Diabetes in the Community

Diabetes Secondary to Primary	Phase One Dec 2006	Phased approach agreed. Consultant & GPwSI input so Follow Ups currently in the system can be discharged/reviewed through One

Care Shift	Phase Two April 2007	Stop Shop
	Jan 2007	Test Bed for Diabetes shift Parallel One Stop Shop initiative with Pharmaceutical sponsorship
	Oct 2006	Suitable premises have been identified in the community. Benefits realisation paper has been approved by PSC
	Oct 2006	Wat.Com and CGC PBC Executive is on board.
	Nov 2006	Management Paper to Dac.Com

Forecast of Savings to be Achieved

- 20% reduction from PBR (in-year) £56,971
- 4 months rental/services paid for Coach House £25,000
- £50K Capital Funding from Glaxo Smith Kline (could offset this against revenue?)

Gynaecology

Gynaecology is not a speciality on FRP, the work up for this project began October 2006. We are engaged with a Watford & Three Rivers GPwSI and the West Herts Hospital Trust Gynaecology Consultants have agreed to work with us on this project.

Initial thoughts are to run a paper triaging service for 3 months to collate data. A review after 3 months will then give a clear picture if the Gynaecology CAS will be cost effective.

Haematology (WATCOM Commissioning intentions, further discussions needed)
All referral letters including cancer 2 week wait referrals to be triaged by a consultant haematologist for referral back to GP with advice or seen in haematology clinic. Reduction of referrals to secondary care by 20% (?)

PCT wide community based, nurse led INR testing & anticoagulation clinic

Gastroenterology (WATCOM Commissioning intentions, further discussions needed)

Specialist Triage of all referral letters, with redirection to GPs with advice, referral to Community gastroenterology clinic or secondary care, and adherence to the Local Dyspepsia guidelines for referral to direct access “community” endoscopy service in the Watford area.

7.1.1.4 Watford and Three Rivers

Issue	MSK CATS	Minor Surgery CATS
Geographical configuration	MSK CATS based at Watford General Hospital Physiotherapy Dept. Start Date – 08/03/2006	Minor Surgery provided by 2 GP practices in Dacorum and 2 GP practices in Watford & 3 Rivers. Start Date – 01/02/2006
Geographical scope	Both services listed above cover the population of W3R and, if required Dacorum patients.	Service covers W3R and Dacorum patients.
Functions	Provides paper triage, assessment via phone or face to face and treatments where appropriate. Referral onto secondary care as necessary.	Provides assessment and treatment as appropriate.
Specialties covered	Orthopaedics Rheumatology Physiotherapy	Minor Surgery
Management leadership	Contract held by PCT Provider Services (Physiotherapy)	Local Enhanced Service contract held with 4 GP Practices.
Management structure	Marjorie Chown provides overall leadership and manages the service. Subcontracting arrangements in place between provider services and West Herts Hospital Trust in place to provide Consultants for triaging.	Lead Clinician from each practice: • Dr Nick Brown – Pathfinder Practice Watford • Dr Soon Lim – Attenborough Surgery Watford • Dr Ojo-Aromokudu – Gossoms End Surgery Berko • Dr Kerry – Bennetts End Surgery HH
Clinical leadership	Marjorie Chown – Head of Physiotherapy is accountable for its overall performance, clinically and financially	Dr Nick Brown. PCT hold the budget.
Clinical structure	Consultant Orthopaedic Surgeon and	GPwSI

	Rheumatologist, Associate Specialist in MSK Medicine, Extended Scope Practitioners, Podiatrist and Physiotherapist	
Pathway for referrals	GPs fax or post referrals to MSK at HHGH (Choose & Book referrals arrive via 'Choice Team' and are faxed to MSK HHGH). All direct referral routes to hospitals are blocked, therefore all Orthopaedic and Rheumatology referrals are sent through this service. Referrals logged onto System1 and triaged by appropriate clinical specialist. Patients are sign-posted to the most appropriate service. Those requiring secondary care are sent to Choice Team based at Royalty House.	GPs post or fax referral to Choice Team at Royalty House. Patient offered Choice of provider. Referral faxed to chosen provider. Chosen provider triages referral to establish referral is suitable for this service.
Administrative triage	There is currently no administrative triage, all referrals are seen by a member of the MDT.	Choice Team upon receipt of referral check that specific criteria have been met i.e. age/site/low priority.
Clinical triage services	Paper triage is undertaken by Consultant and ESPs.	Provider GP checks that procedure suitable for the Minor Surgery service.
Clinical assessment services	Face to face assessment is carried by ESP and/or Associate Specialist in MSK Medicine	N/A
Clinical treatment services	Treatment services offered: Extended Scope Physiotherapy Joint injections Podiatry	Provider GPwSI
Clinical care pathways	See attached – Musculoskeletal pathway for Dacorum and W3R	See attached – LES Minor Surgery Process

Delivery of Choice/Choose & Book	Following triage the Choice Team at Royalty House receive all manual referrals requiring secondary care1st outpatient appointment. Choosing your hospital brochure and letter sent to patient offering a choice of 4-5 providers. Patient telephones the team with choice of provider. Referral sent via post to hospital of patient's choice. C&B referrals are faxed to MSK for triage. Triaged o utcomes received back within 48 hours. Patients requiring secondary care are telephoned and choice of provider discussed. Appointment booked. Patients requiring ESP, Podiatry etc are offered appointment via physiotherapy department. Choice Team update patients record in C&B and complete UBRN.	See attached – LES Minor Surgery Process
IT system	MSK service using System 1. Choice Team using Excel spread sheets for manual referrals and Choose & Book for electronic referrals.	GPs using own IT systems to record data. Choice Team using Excel spread sheets.
Administrative policies	The MSK Service has operational policies within the service. See attached. Choice Team admin policy -log manual referrals and	Choice Team admin policy -log manual referrals and send 'choice offer letter' to patient within 24 hours of receipt. Patient's who do not

	send 'choice offer letter' to patient within 24 hours of receipt. Patient's who do not respond within 10 working days second letter. If patient has not responded within a further 10 working days discharge letter sent to patient and copy to GP. Choose & Book referrals patient is telephoned twice if no response a letter is sent inviting the patient to call Choice Team to book appointment. If in 10 working days no response second letter sent as above.	respond within 10 working days second letter. If patient has not responded within a further 10 working days discharge letter sent to patient and copy to GP.
Waiting times across the pathway	Triage Waiting times – C&B refs 48hrs. Manual 7-14 days ESP – 8 weeks Ass Sp – 20 weeks Podiatry – 4 weeks Physiotherapy – Urgent 21 days Routine 8 months	Procedure carried out 1-4 weeks from receipt of referral.
Procurement process, contestability	Service spec developed and local NHS and Independent provider invited to express interest. Robust bidding process took place. Bids assessed by Multi-disciplinary panel of: Consultants, PbC GPs, PPI rep, Director of Commissioning, Director Public Health	Service spec developed as a LES. Local GP practices invited to express interest. Robust Bidding process took place. Bids assessed by Multi-disciplinary panel of: Consultants, PbC GPs, PPI rep, Director of Commissioning, Director Public Health. Prior to awarding contracts practice premises were inspected for compliance re DDA, infection control etc.
Clinical governance	Dr Sheila Borkett-Jones	Dr Nick Brown

Activity and Savings	No. of referrals received and triage across **both PCTs** for 7 months = 4114. No. of referrals triaged to Community service= 1705 No. of referral triaged to secondary care = 2409 Potential saving for 7 months = £173451.	Reduction in activity at WHHT = 34% savings = £97382 Cost of providing LES service = £12240 Therefore overall savings=£85142
Training and professional development	As part of contract	As part of contract
Patient feed back on the service to date	Part of the contract is to carry out patient's satisfaction survey. This will be carried out in Jan 07.	Part of the contract is to carry out patient's satisfaction survey. This will be carried out in Jan 07.
Means of ensuring the service substitutes for secondary care rather than being additional and creating more demand	Monthly auditing and monitoring carried out by PCT to ensure meeting FRP. Regular review meetings with service provider	Monthly auditing and monitoring carried out by PCT to ensure meeting FRP.
Plans to develop these specific CATS further	Carpal Tunnel Pathway being developed. Recruitment of another Ass Sp to improve waiting times.	When dermatology CAS rolled out links will be formed with Minor Surgery and some dermatology minor procedures will be performed by the GPs holding the LES.

Plans to develop further CATS

Dermatology – Currently in discussions with WHHT to provide a community dermatology service for both Watford and Dacorum patients.

It is envisaged that if the service goes ahead manual referrals would be received in the community by the dermatologists who would triage and set up appointments for patients to be seen in the community. The referrals for patients requiring secondary care appointments would be sent to the CAS administrative team for them to offer the patient a choice of provider. The process would be the same as the manual process for the MSK service.

It is not expected at this stage that the 2 week cancer waits would go through the triage process.

Proposed Activity

	No of referrals to be triaged	Expected number to be seen in community	Number to be offered Choice
Dacorum	2500	1500	1000
Watford	2900	1740	1160

This project is currently on hold as advised by the Assistant Director of Finance, Acute Service and Contracting, Project Lead awaiting further advise.

<u>Minor Oral Surgery</u> – to commence April 07
The aim is to set up a pilot for 2007. The original assumptions were incorrect. East and North Herts are currently doing a similar exercise and the aim is to learn from this.

<u>Diabetes in the Community</u>

Diabetes Secondary to Primary Care Shift	Phase One Dec 2006 Phase Two April 2007	Phased approach agreed. Consultant & GPwSI input so Follow Ups currently in the system can be discharged/reviewed through One Stop Shop
	Jan 2007	Test Bed for Diabetes shift Parallel One Stop Shop initiative with Pharmaceutical sponsorship
	Oct 2006	Suitable premises have been identified in the community. Benefits realisation paper has been approved by PSC
	Oct 2006	Wat.Com and CGC PBC Executive is on board.
	Nov 2006	Management Paper to Dac.Com

Forecast of Savings to be Achieved

- 20% reduction from PBR (in-year) £56,971
- 4 months rental/services paid for Coach House £25,000
- £50K Capital Funding from Glaxo Smith Kline (could offset this against revenue?)

<u>Gynaecology</u>
Gynaecology is not a speciality on FRP, the work up for this project began October 2006. We are engaged with a Watford & Three Rivers GPwSI and the West Herts Hospital Trust Gynaecology Consultants have agreed to work with us on this project.

Initial thoughts are to run a paper triaging service for 3 months to collate data. A review after 3 months will then give a clear picture if the Gynaecology CAS will be cost effective.

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PCT wide community based, nurse led INR testing & anticoagulation clinic

Gastroenterology (WATCOM Commissioning intentions, further discussions needed)
Specialist Triage of all referral letters, with redirection to GPs with advice, referral to Community gastroenterology clinic or secondary care, and adherence to the Local Dyspepsia guidelines for referral to direct access “community” endoscopy service in the Watford area.

7.1.2 East and North Hertfordshire PCTs

Issue	MSK	Gastro	OMFS	Skin Health (Dermatology/ Plastics)	Ophthalmology
Geographical configuration	CAS based at Charter House Parkway Welwyn Garden City Primary Care services based in Welwyn Garden City, Cheshunt and Hertford.	CAS based at Charter House Parkway Welwyn Garden City Primary Care services based in Saffron Walden and Welwyn.	CAS based at Charter House Parkway Welwyn Garden City Primary Care services based in Stevenage & Watton at Stone.	CAS based at Charter House Parkway Welwyn Garden City Primary Care services based in Welwyn, Welwyn Garden City, Hatfield, Stevenage, Cheshunt, Broxbourne, Ware and Bishops Stortford. .	CAS based at Charter House Parkway Welwyn Garden City Primary Care service based in Potters Bar. Plan to set one up in Stevenage/Hitch in area
Geographical scope	Covers population of East and North Herts PCT (formerly South East Herts, Welwyn Hatfield, North Herts and Stevenage and RBBS)				
Functions	Provides paper	Provides paper	Provides paper	Provides paper	Provides paper

	triage assessment, streaming to primary care diagnostics and treatments, streaming to secondary care providers including independent. Small amount of face to face triage	triage assessment, streaming to primary care diagnostics and treatments, streaming to secondary care providers including independent.	triage assessment, streaming to primary care diagnostics and treatments, streaming to secondary care providers including independent.	triage assessment, streaming to primary care diagnostics and treatments, streaming to secondary care providers including independent. Small amount of face to face triage	triage assessment, streaming to primary care diagnostics and treatments, streaming to secondary care providers including independent.
Specialties covered	Orthopaedics Physiotherapy	Gastroenterolog y GI Endoscopy	OMFS	Dermatology Minor Ops and Plastic Surgery)	Ophthalmology
Management leadership	CAS Service Manager Yvonne Goddard clinical background medical Matron and ward manager acute services recently appointed.	CAS Service Manager Yvonne Goddard clinical background medical Matron and ward manager acute services recently appointed.	CAS Service Manager Yvonne Goddard clinical background medical Matron and ward manager acute services recently appointed.	CAS Service Manager Yvonne Goddard clinical background medical Matron and ward manager acute services recently appointed.	CAS Service Manager Yvonne Goddard clinical background medical Matron and ward manager acute services recently appointed.

	Primary Care service providers manage their individual department/serv ices - Caroline Oakes –physiotherapy	Primary Care service providers manage their individual department/serv ices - Dr Roger Aubrey Bridge Cottage Welwyn, Dr Patrick Ward Booth-Saffron Walden	Primary Care service providers manage their individual department/serv ices - Dr M. Somaia and Dr R Chauhan	Primary Care service providers manage their individual department/serv ices Finola Bifield-Skins and Plastics	Primary Care service providers manage their individual department/serv icesMr Adrian Parnaby-Price-Herts Eye Hospital
Management structure	Yvonne Goddard CAS Service Manger Annabel Bennett Lead Clinicians for triage - Caroline Oakes Orthopaedics	Lead Clinician for triage - Patrick Ward-Booth until 2/1/07 Peter McIntyre from 2/1/07	Up to Oct. 06 Director of Commisioning held overall clinical and managerial accountability for the service.	Lead Clinician for triage - Finola Bifield and Phil Lancaster	Lead Clinician for triage - Adrian Parnaby-Price

Clinical leadership	Up to Oct. 06 Director of Commissioning held overall clinical and managerial accountability for the service. Yvonne Goddard commenced October 16th supporting and strengthening supervisory arrangements line management responsibilities lie with the Localities Director in the new structure.				
Clinical structure	Lead Clinicians for triage - Caroline Oakes Orthopaedics	Lead Clinicians for triage Patrick Ward-Booth Gastro until 2/1/07 Peter McIntyre	Lead Clinicians for triage - Martin Dyer, Herts Dental Advisor	Lead Clinicians for triage - Finola Bifield, specialist nurse dermatology and Phil Lancaster GPWSI -Chivers Mcrae Independent service providers Finula Bifield,	Lead Clinicians for triage - Adrian Parnaby-Price

<table>
<tr><td>Pathway for referrals</td><td colspan="5">GP uses CAS courier system internal post, royal mail or fax sending in written referrals. There could also be a future possibility of CAS doing all Choose and Book therefore enabling GP to send electronic referrals if they wish. CAS uses TPP system one so GP surgeries with this system can already send referrals electronically if they wish. GPs should use CAS for all CAS specialties. There is no current incentive to do so. A future incentive may be the reduction of costs to practices in PBC by reducing outpatient activity where not required and redirecting referrals to less expensive community based services.</td></tr>
<tr><td>Administrative triage</td><td colspan="5">There is no administrative triage however the admin staff log all stages of the referral. The admin staff have no clinical input in the process.</td></tr>
<tr><td>Clinical triage services</td><td colspan="5">All referrals are seen by clinicians with extensive training in the relevant specialty with the exception of URGENT referrals as these are faxed directly to the nearest Trust.

All on paper carried at at Charter House, orthopaedics carried out at QE11 and Lister</td></tr>
<tr><td>Clinical assessment services</td><td colspan="5">Face to face assessment is carried out by whichever service was considered best to do so at paper triage stage for Primary or secondary care providers.</td></tr>
<tr><td>Clinical treatment services</td><td>Treatment Orthopaedics Physiotherapy</td><td>Primary Care Gastroenterolog y Saffron Walden Gastroscopy, flexible sigmoidoscopy Bridge Cottage flexible sigmoidoscopy both primary</td><td>OMFS local dental providers Stevenage Dental Surgery, Watton at Stone dental surgery Tooth extraction simple, surgical removal of impacted wisdom teeth,</td><td>Chell Surgery for MOPS skin Cappio independent providers</td><td>PCT Opthalmology Minor ops oculoplastic surgery minor to intermediate Medical retina, cornea General ophthalmology Diabetic eye care</td></tr>
</table>

		care	wisdom teeth, tooth nec, extraction of multiple teeth, retained root removal		Herts Eye Service
Clinical care pathways	Completed pathways for process purposes (would not call these clinical pathways as such) for all specialties referred through CAS. Reviewed Aug. 06.Gastro Orthopaedics, Ophthalmology OMFS Skin Health Pathways include triage brief and provider exclusions				
Delivery of Choice/Choose & Book	Patients needing secondary care are referred on via postal referral but we would like to have Proxy rights for CAB – this would be done by the practices giving formal permission for the admin team to act as part of their practice so that they can raise the UBRN				
IT system	TPP(System 1)				
Administrative policies	Admin process pathways in place reviewed regularly.. Reviewing Operational Policy which will include time measured processes				
Waiting times across the pathway	1-28 days depending on specialty, routine or urgent				

<table>
<tr><td>Procurement process, contestability</td><td colspan="5">Orthopaedic triage integrated and developed with existing PCT Services
Expressions of interest invited for MOPS evaluated and established
Expressions of interest invited for Gastro and Ophthalmology services evaluated and established
Establishment of Primary Dental Services followed National Guidance on processes</td></tr>
<tr><td>Clinical governance</td><td colspan="5">Yvonne Goddard responsible for overall Clinical Governance arrangements.
The mechanism for incident reporting is as per risk management policy guidelines supported by the Clinical Governance Team.</td></tr>
<tr><td>Activity and Savings</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Training and professional development</td><td colspan="5">All triage leads currently employed within their specialist areas where they have ongoing training and development provided.</td></tr>
<tr><td>Patient feed back on the service to date</td><td colspan="5">Have drawn up a patient survey to be sent out end of January 2007 Stakeholder survey to be sent out end on January 2007</td></tr>
<tr><td>Means of ensuring the service substitutes for secondary care rather than being additional and creating more demand</td><td colspan="5">Direct to diagnostics with Gastro reduces unnecessary OPA pre test Triage driven by clinical experts consultant decision making rather than junior doctor decision making in outpatients.
CAS gathering data to identify need over a wide area reduces too many clinics with poor demand.</td></tr>
</table>

<table>
<tr><td>Plans to develop CATS (specific developments of current specialities)</td><td></td><td>Potential expansion of Bridge Cottage to help scope demand once bowel screening is live</td><td>Additional dental clinic planned</td><td>Current work on expanding Skin Health model</td><td>Ophthalmology planned to include cataracts</td></tr>
<tr><td>Plans to develop current CATS in general</td><td colspan="5">We could take CAS forward in several ways:
continue reducing demand management by triage of referrals in overperforming specialties thus setting up primary care to reduce either out patient attendance or diagnostics.
managing admission avoidance pathways incorporating Matron usage and secondary care in-reaching in A&E and nursing /residential home discharges thus reducing bed days for treatment.
Development of Choose and Book for all referrals not just our current five specialties
make triage more robust and use as an educational tool giving constructive feedback and advice from the triage clinicians. Improve work ups and develop more direct to test routes.
Produce detailed Directory of Herts services so become a central point for referral info.
work with GPs to improve confidence in the system and thus increase referral buy in.</td></tr>
</table>

Plans to develop further CATS specialities	Gynae planned for roll out March 07 . Ophthalmology Cataracts in primary care roll out March 07. Plan to roll out CAS approach across any specialties where significant savings can be achieved specialties identified Cardiology Urology Gynae ENT Neurology Endocrinology Respiratory Previous work on the ENT pathway could be rolled out March 07 savings to be assessed.

7.2 Assess stakeholder views

7.2.1 CATS and demand management

There is a consensus that we need to manage demand for elective care and that the various elements of CATS provide an opportunity to do so.

There are a range of opinions as to whether all elements or certain elements of CATS offer the greatest opportunity to manage demand (Triage of “inappropriate” referrals (e.g. low priority or where management should be carried out in primary care) – i.e. managing the threshold for GP referral, managing the threshold for 2’ care treatment or proving more cost-effective alternatives to secondary care assessment and outpatient/ day-case treatments.

The majority of stakeholders felt that the clinical triage element alone was not sufficient to manage demand effectively and that most of the other elements detailed above are also required.

Need to prove the case for the ability to provide more cost-effective care than current services.

The majority of Practice Based Commissioning Stakeholders felt that it is vital to break down the current barriers between primary care and specialist care.

Some felt that there is a risk of CATS increasing total GP referrals due to a reduction in the threshold for GP referrals and that this risk needs to be actively managed.

Primary care settings such as Diagnostic and Treatment Centres (DTCs) would increase the scope for 2’ to 1’ care shift.

It was also felt that CATS have the ability to improve patient experience through the prevention of duplication and encouraging local services and one-stop services. However it is vital that the services have the right clinical competence.

Designing pathways to meet the patients needs whilst avoiding unnecessary visits to hospital.

CATS could and needs to skill up GPs to deliver more care in primary care.

For some services there is a concern that the CATS is too close to the local acute trust and it is difficult to see a distinction.

Demand needs to continue to be managed at a practice level, for example through practice referral meetings, and CATS must enhance not reduce these initiatives.

CATS allow innovation and new ways of working

Needs to engage patients in the redesign of services to get imaginative solutions otherwise could get same 2' care service delivered in 1' care.

Clinical care pathways needed to be integral to the delivery of CATS.

Best service is a combination of GPs and consultants working together.

There has previously been insufficient dialog between primary and secondary care regarding the design of services

There were many stakeholders who felt that CATS need to receive ALL GP referrals.

7.2.2 CATS development across Herts

A lack of clinical engagement, a rush to deliver too many services too quickly and the re-organisation of PCTs with the associated uncertainty of management support and *administrative paralysis*, as well as some of the actions of acute trusts have led to problems according to many stakeholders.

The new PCT with a senior management team across Hertfordshire is seen as opportunity to reduce inconsistencies.

Needs funding from the PCT and someone to say "DO IT".

Need to have strong financial analysis.

A concern in East and North Herts relating to the delay of some referrals by the CAS some time ago has left a legacy of distrust, however this concern seems to be lessening especially amongst PBC leads.

The lack of PCT investment in DTCs is considered a barrier to progress.

There is a perceived resistance from secondary care consultants regarding the setting up of CATS. It is considered that this is due to many reasons including; a concern about a reduced quality service, loss of secondary care skills, current employment model for most consultants.

The CATS needs to be an NHS body in order to provide NHS pensions for staff working within the service.

The lack of robust clinical activity data is seen as a barrier to progress.

There is also concern about lack of capacity in primary care to allow GPs to carry out additional work in CATS.

Local clinical engagement is the key! Need clinical champions from both primary and secondary care (with PCT facilitation). This is needed for care pathway development by GPs as specialists as well as CATS development.

Where there are local relationships between primary and secondary care, local service development is seen as the best model.

Care pathways can be improved through the CATS implementation process.

Information is crucial to understand what is happening to the referrals.

A competent manager and slick administrative processes are required.

PBC engagement is vital.

Good regular communication with local stakeholders is important and a number to ring whenever there are concerns.

Clinicians from both primary and secondary care can make the CATS process work or can jeopardise the process.

There will always be teething problems with new services.

Problems with manual referral process, need electronic referral process and electronic referral tracking system.

Needs up front funding and PCT leadership.

7.2.3 Commissioning CATS

Needs to have proper governance around the commissioning process.

There were mixed views as to whether a formal tendering process or a less rigid process is appropriate, but all agreed that a clear service specification and business case thinking is required. There were concerns about the length of time formal tendering process and the need to preserve local clinical relationships.

It is important to be aware of any conflicts of interest.

A broad consensus that should be a PBC led process.

PBC to provide ideas, energy, clinical steer and local delivery, PCT role to facilitate.

However it was acknowledges that the PCT would need to undertake the commercial contracting and financial evaluation.

GPs need to form provider organisations providing services for a locality.

A competitive process prevents complacency from local providers and stimulates the market.

7.2.4 Links with secondary care

Stakeholder acknowledge that the development of CATS is a threat to current power bases.

Some felt that it was not feasible to develop partnerships as there was a conflict of interest with the acute trusts seeking to increase demand (including for low priority treatments).

The driver needs to be primary care and PBC and they need to choose which consultants they wish to work with (may not be from local trust).

The acute trusts need to reduce their overheads as commissioners move contracts for procedures or whole departments away from them. Some saw no evidence of the acute trust downsizing.

All recognised that it is important to communicate the PBC and PCT commissioning plans to the acute trust and to recognise potential impact on acute trust.

However *it is their job to manage the impact, resize and re-focus.*

They need to engage in a very difference way, need to move on

Need to be a hard nosed element to discussions and to add challenge to local status quo.

Most felt it was not reasonable for acute trusts to prevent consultants working independently for local CATS.

7.2.5 What sort of CATS model

Need to agree care pathway and referral criteria between primary care and specialist care. There needs to be a clear clinical model within the local CATS.

The care pathway should include preventative services and the CATS should have responsibility for these services too.

Most agreed that the CATS model should provide referral clinical triage, specialist assessment and treatment (otherwise will just be seen as rationing) and should contain a multidisciplinary team including a consultant. Administrative support within the CATS is fundamental

The risk is if there is no clinical challenge between peers.

Primary care clinical leadership is felt to be key and more important than GPwSI provision of services (this is now also the Royal College of General Practitioners view (SL - Personal correspondence).

The consultant's role should include care pathway development, referral triage, clinical governance, clinical support to others in MDT, quality assurance, audit and to work as a consultant i.e. consulting, advising, without necessarily taking over the patient's care.

The CATS service must provide education and training to local GPs.

CATS need to be able to reduce hospital follow-ups.

The CATS need to provide Choose and Book.

CATS need a population view and engage with public health expertise for care pathway development.

There were mixed views as to whether CATS should commission as well as provide although there was a consensus that CATS should have close links to commissioning so that commissioning can benefit from the specialist knowledge of CATS.

Need to have robust clinical challenge from well-informed patients.

Need to have excellent links with diagnostic services within the locality.

Need to ensure a local service, with local GP ownership, otherwise can be seen as an amorphous service with a depersonalised referral process, which can disempower the referrer.

Any referral templates need to be flexible enough to take account of the various reasons why GPs refer.

Need to be sure that the CATS model is more cost-effective than the traditional model and does not drive up costs through increasing GP referral rates and the higher hourly rate of GPwSI.

The CATS can be a hub of local clinical expertise based around community health facility and a vehicle to deliver local clinical leadership.

CATS need to link into PBC in order to drive forward demand management with a responsibility for service costs.

7.2.6 Stakeholder roles

7.2.7 Any other comments

Although there will be flaws, need to say go for it and learn as we go along

7.3 Quantify CATS activity and assess the impact of CAS/CATS on outpatient activity and overall costs

7.3.1 West Hertfordshire PCTs

7.3.1.1 St Albans and Harpenden

7.3.1.1.1 CATS Activity

CATS activity in St Albans & Harpenden 2005-06 and 2006-07

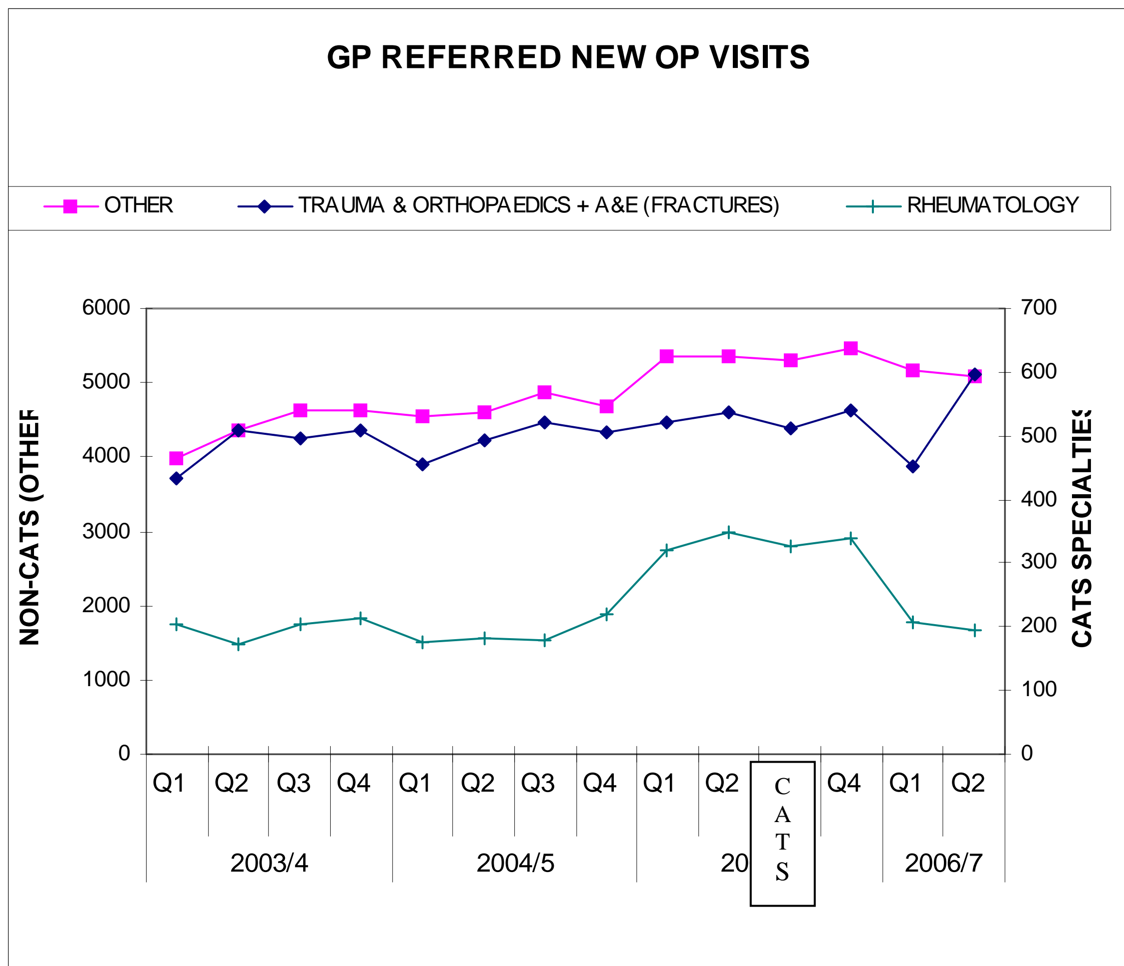
			2005-06					2006-07			
			Q1	Q2	Q3	Q4	Total 05-06	Q1	Q2	Q3	Total 06-07 To Date
St Albans & Harpenden	MSK CATS Start Qt 1 2006/7	Referrals received by CATS	0	0	0	0		753	863		**1616**
		Referrals returned to primary care (%)						19%	14%		**16%**
		Referrals triaged to secondary care (%)						34%	46%		**40%**
		Referrals retained by CATS (%)						47%	39%		**44%**

7.3.1.1.2 Outpatient Activity

GP referred new outpatient attendances 2003 to 2007, by CATS specialties and all others

Financial Year as Text	Financial Quarter	OTHER	TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)	RHEUMATOLOGY
2003/4	Q1	3976	433	205
	Q2	4351	508	174
	Q3	4618	495	203
	Q4	4632	510	214
2004/5	Q1	4560	454	176
	Q2	4593	492	183
	Q3	4862	521	180
	Q4	4686	506	219
2005/6	Q1	5348	520	320
	Q2	5366	536	348
	Q3	5295	511	325
	Q4	5460	541	338
2006/7	Q1 (CATS Start)	5175	453	206
	Q2	5078	597	194

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others



Although there was an initial drop in trauma and orthopaedics outpatient attendances in quarter 1 2006/7 there was an increase the following quarter. This was also the case in Hertsmere (for West Herts Hospital Trust activity in the main), which did not have an established CATS at this time. It is likely therefore that the increase is not due to CATS but the CATS has failed to prevent the increase, partly due to the fact that only 67% of GP referrals were directed through CATS and only 44% were retained by the CATS.

This increase in outpatient attendances at West Herts needs to be looked at in greater detail to ascertain the reasons.

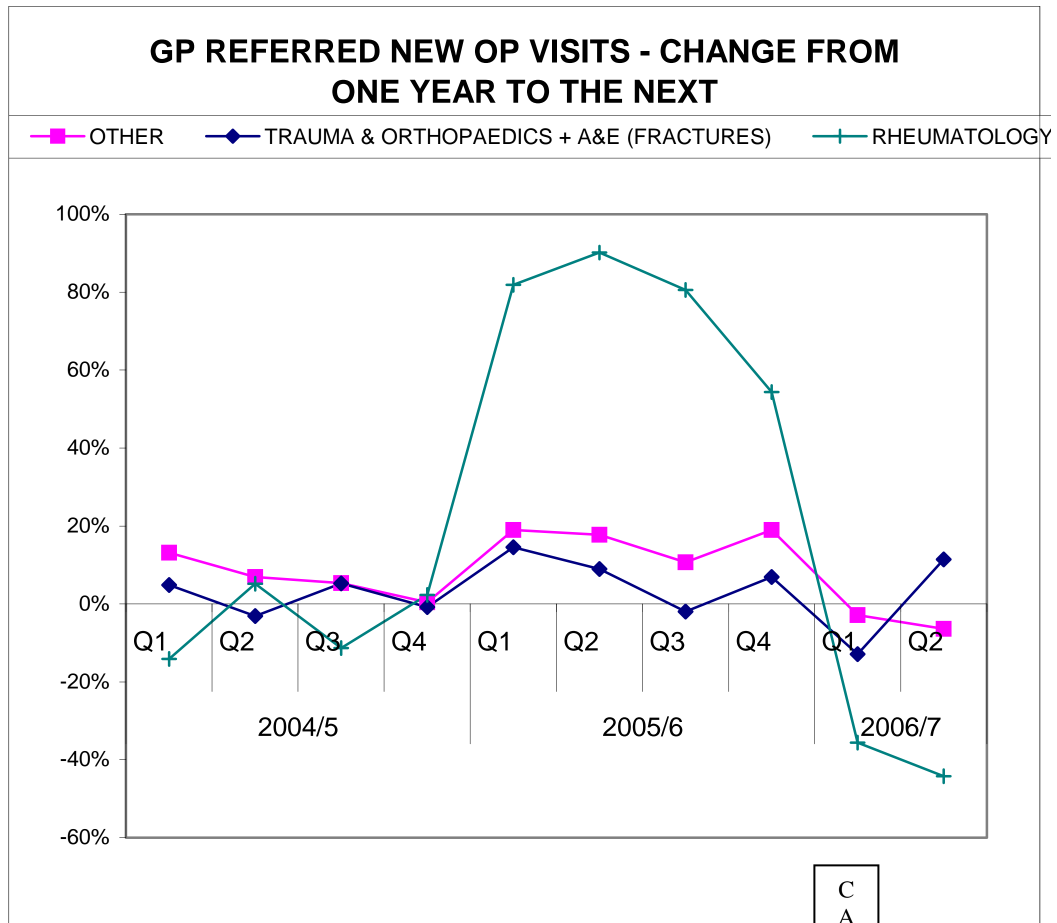
There was a significant drop in Rheumatology outpatient attendances but only back to 2004/5 levels.

DRAFT FOR CONTRIBUTER AND EXECUTIVE TEAM REVIEW - NOT FOR CIRCULATION

Percentage change by quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	OTHER	TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)	RHEUMATOLOGY
2004/5	Q1	13%	5%	-14%
	Q2	7%	-3%	5%
	Q3	5%	5%	-11%
	Q4	0%	-1%	2%
2005/6	Q1	19%	15%	82%
	Q2	18%	9%	90%
	Q3	11%	-2%	81%
	Q4	19%	7%	54%
2006/7	Q1 (CATS start)	-3%	-13%	-36%
	Q2	-6%	11%	-44%

Percentage change by quarter 2004/05 to 2006/07



The reasons for the increase in Rheumatology activity in 2 /6 needs to be ascertained, as well the increase in Orthopaedics in quart 2006/7.

7.3.1.2 Hertsmere

7.3.1.2.1 CATS Activity

CATS commenced October 2006 (Quarter 3 2006/07).

CATS activity in Hertsmere 2005-06 and 2006-07

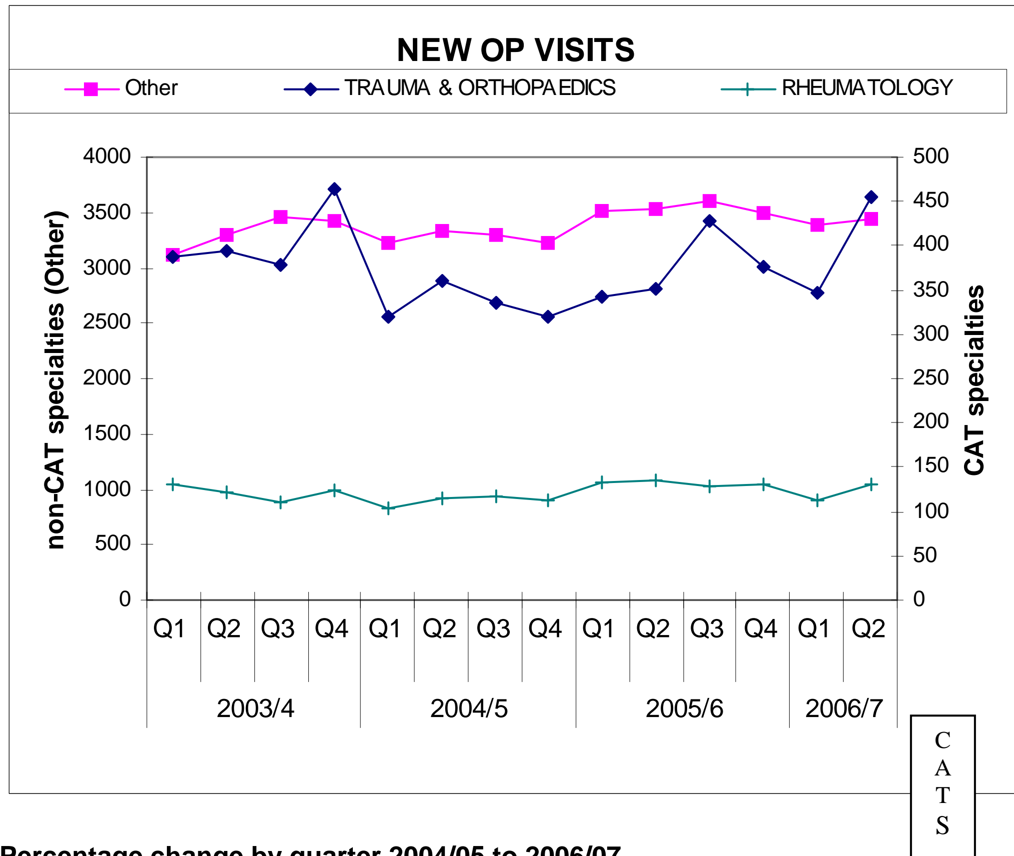
			2005-06					**2006-07**			
			Q1	**Q2**	**Q3**	**Q4**	**Total 05-06**	**Q1**	**Q2**	**Q3**	**Total 06-07 To Date**
Hertsmere	**MSK CATS** *6 weeks activity 9/10/06 to 20/11/06*	**Referrals received by CATS**	0	0	0	0		0	0	154	**154**
		Referrals returned to primary care (%)								0%	
		Referrals triaged to secondary care (%)								37%	**37%**
		Referrals retained by CATS (%)								63%	**63%**

7.3.1.2.2 Outpatient Activity

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	**Financial Quarter**	**OTHER**	**TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)**	**RHEUMATOLOGY**
2003/4	Q1	3155	390	130
	Q2	3346	398	122
	Q3	3523	386	111
	Q4	3504	468	124
2004/5	Q1	3325	329	103
	Q2	3442	366	115
	Q3	3382	338	116
	Q4	3344	323	112
2005/6	Q1	3644	345	132
	Q2	3683	354	136
	Q3	3756	432	129
	Q4	3669	377	130
2006/7	Q1	3541	351	112
	Q2	3451	458	131
	Q3 (CATS start)	NA	NA	NA

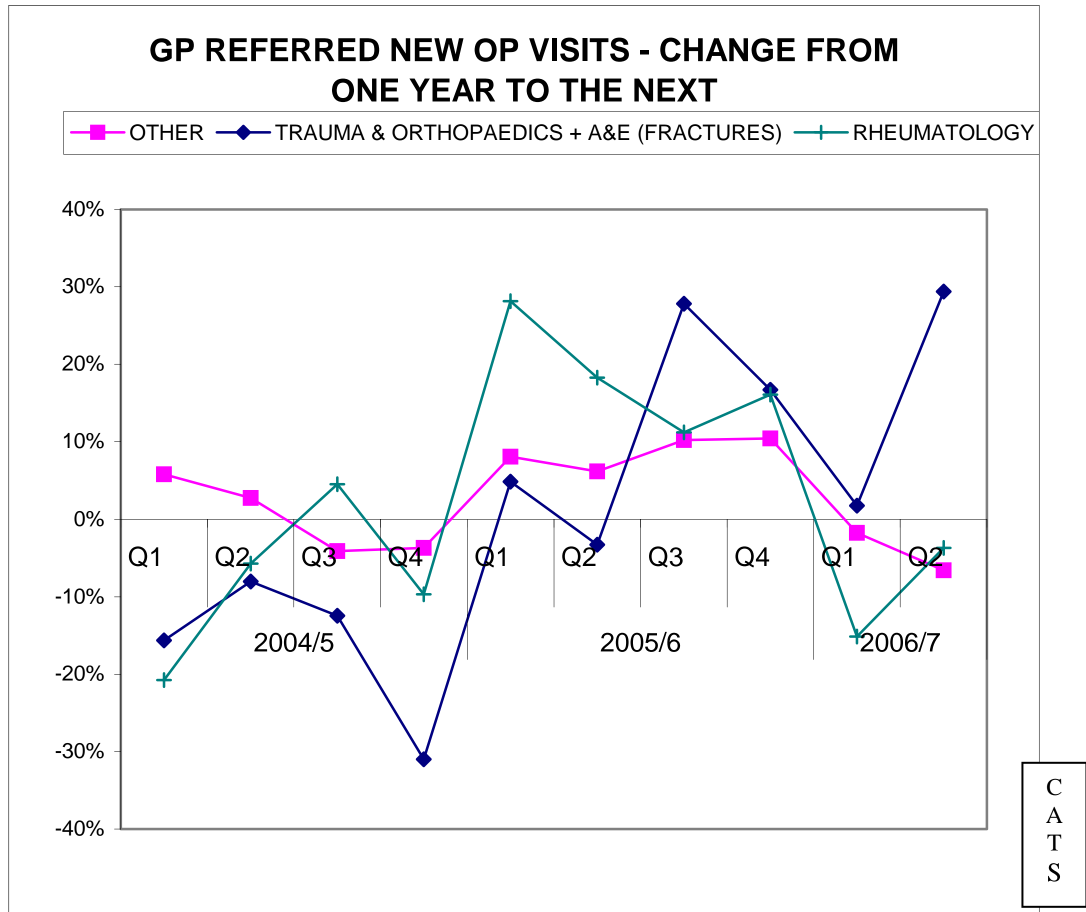
GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others



Percentage change by quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	OTHER	TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)	RHEUMATOLOGY
2004/5	Q1	6%	-16%	-21%
	Q2	3%	-8%	-6%
	Q3	-4%	-12%	5%
	Q4	-4%	-31%	-10%
2005/6	Q1	8%	5%	28%
	Q2	6%	-3%	18%
	Q3	10%	28%	11%
	Q4	10%	17%	16%
2006/7	Q1	-2%	2%	-15%
	Q2	-7%	29%	-4%

Percentage change by quarter 2004/05 to 2006/07



Note – there has been an 84% increase in Trauma and Orthopaedic attendances at WHHT (from GP referral) between quarter 2 2005/6 and quarter 2 2006/7 in which accounts for this large increase. As mentioned above this required further investigation.

7.3.1.3 Dacorum and Watford and Three Rivers

7.3.1.3.1 CATS Activity

MSK CATS commenced March 2006 (Quarter 4 2005/06).

Minor surgery CATS commenced February 2006 (Quarter 4 2005/06).
CATS activity in Watford and Three Rivers and Dacorum 2005-06 and 2006- 07

			2005-06					2006-07			
			Q1	Q2	Q3	Q4	Total 05-06	Q1	Q2	Q3	Total 06-07 To Date
Dacorum and Watford &	**MSK CATS**	**Referrals received by CATS**	0	0	0	148	**148**	1360	1994	1431	**4785**

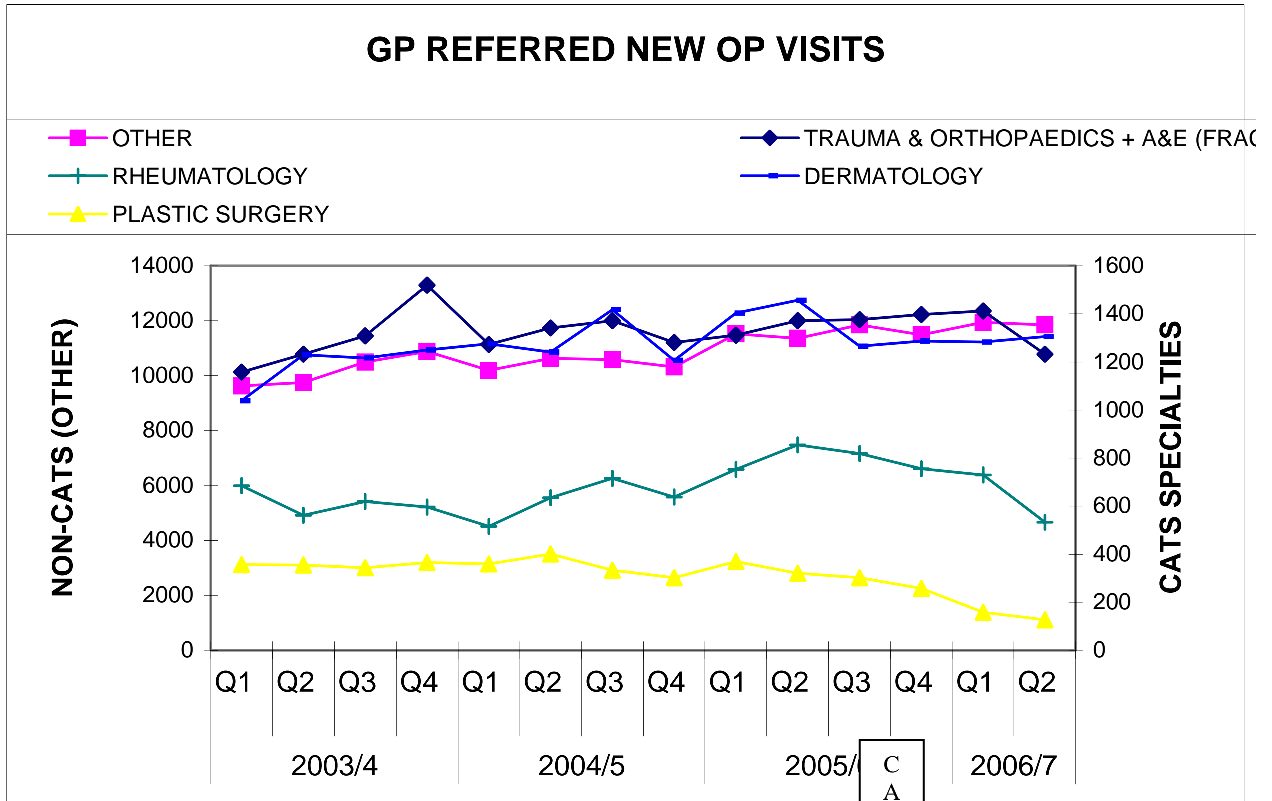
Three Rivers		**Referrals returned to primary care (%)**	0%	0%	0%	0%	**0%**	0%	0%	0%	**0%**
		Referrals triaged to secondary care (%)	0%	0%	0%	20%	**20%**	50%	65%	64%	**60%**
		Referrals retained by CATS (%)	0%	0%	0%	80%	**80%**	50%	35%	36%	**40%**
Dacorum and Watford & Three Rivers	**Minor Surgery**	**Referrals received to Minor Surgery**	0	0	0	25	**25**	49	92	53	**194**
		Referral returned to Primary Care (%)	0	0	0	7	**28%**	9	32	4	**23%**
Dacorum and Watford & Three Rivers	**Minor Surgery**	**Referrals triaged to secondary care (%)**	0	0	0	0	**0**	6	2	2	**5%**
		Referrals retained by Minor Surgery provider (%)	0	0	0	18	**72%**	34	58	47	**72%**

7.3.1.3.2 Outpatient Activity

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	Financial Quarter	OTHER	TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)	RHEUMATOLOGY	DERMATOLOGY	PLASTIC SURGERY
2003/4	Q1	9631	1157	685	1038	356
	Q2	9752	1232	562	1229	355
	Q3	10494	1309	619	1216	343
	Q4	10882	1520	596	1249	365
2004/5	Q1	10188	1272	516	1276	359
	Q2	10634	1342	635	1241	401
	Q3	10584	1371	715	1417	333
	Q4	10312	1281	637	1206	301
2005/6	Q1	11528	1311	753	1403	369
	Q2	11367	1371	854	1456	321
	Q3	11847	1376	818	1265	302
	Q4	11488	1398	756	1287	257
2006/7	Q1 (CATS start)	11936	1412	729	1283	158
	Q2	11845	1232	533	1306	126

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others



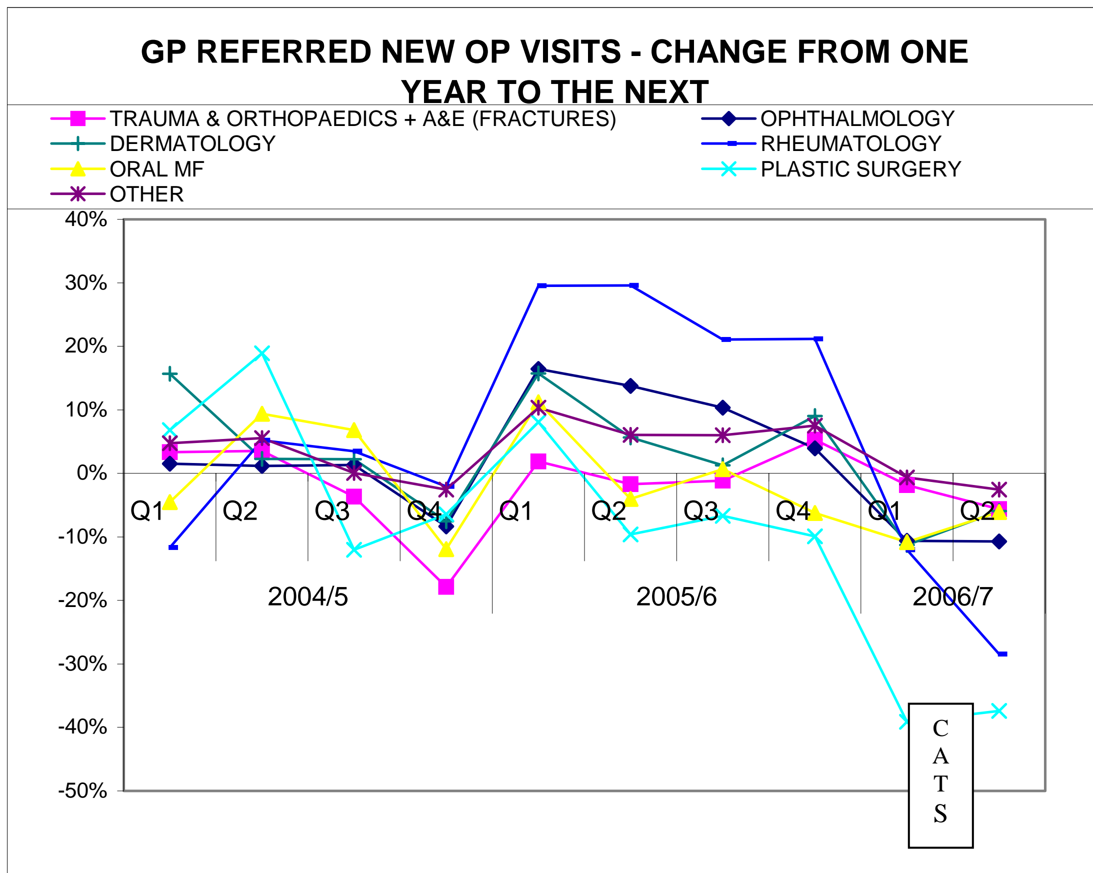
There appears to be a significant drop in most CATS related outpatient activity after the introduction of CATS, whilst non-CATS speciality activity has remained fairly stable. This is not the case for dermatology outpatients and plastics outpatients is following a trend which commenced before the introduction of CATS. This is because the Minor Surgery CATS in Watford, Three Rivers and Dacorum is as substitute for day-case minor surgery procedures rather than outpatient attendance – see cost analysis appendices.

Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	TRAUMA & ORTHOPAEDICS + A&E (FRACTURES)	OPHTHALMOLOGY	DERMATOLOGY	RHEUMATOLOGY	ORAL MF	PLASTIC SURGERY	OTHER
2004/5	Q1	3%	2%	16%	-12%	-5%	7%	5%
	Q2	4%	1%	2%	5%	9%	19%	6%
	Q3	-4%	1%	2%	3%	7%	-12%	0%
	Q4	-18%	-8%	-8%	-2%	-12%	-6%	-3%
2005/6	Q1	2%	16%	16%	30%	11%	8%	10%
	Q2	-2%	14%	6%	30%	-4%	-10%	6%
	Q3	-1%	10%	1%	21%	1%	-7%	6%
	Q4	5%	4%	9%	21%	-6%	-10%	8%
2006/7	Q1 (CATS start)	-2%	-11%	-11%	-12%	-11%	-39%	-1%

	Q2		-6%	-11%	-6%	-28%	-6%	-37%	-3%

Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07



This graph shows a dramatic reduction in outpatient attendances in most of the CATS specialities compared with the non-CATS specialities.

7.3.1.4 West Hertfordshire PCTs

7.3.1.4.1 Outpatient Activity

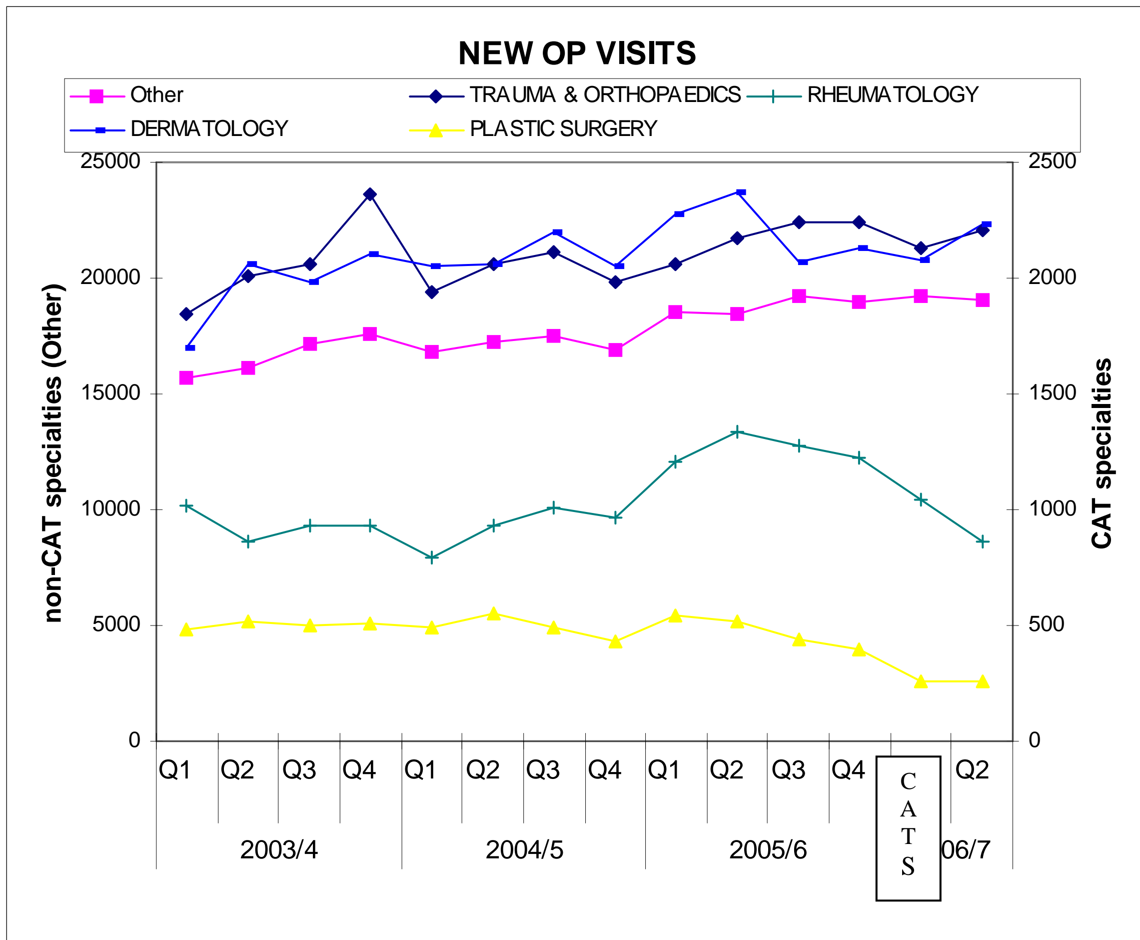
7.3.1.4.1.1 GP New Attendance

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	Financial Quarter	Other	TRAUMA & ORTHOPAEDICS	RHEUMATOLOGY	DERMATOLOGY	PLASTIC SURGERY
2003/4	Q1	15705	1848	1020	1701	480
	Q2	16153	2012	858	2061	514
	Q3	17183	2060	933	1983	502
	Q4	17554	2364	934	2100	509

2004/5	Q1	16775	1943	795	2054	489
	Q2	17271	2061	933	2063	548
	Q3	17458	2116	1011	2197	492
	Q4	16889	1984	968	2050	432
2005/6	Q1	18572	2064	1205	2274	541
	Q2	18469	2170	1338	2374	516
	Q3	19219	2242	1272	2071	440
	Q4	18965	2245	1224	2127	394
2006/7	Q1	19267	2130	1047	2075	260
	Q2	19031	2210	858	2232	257

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others

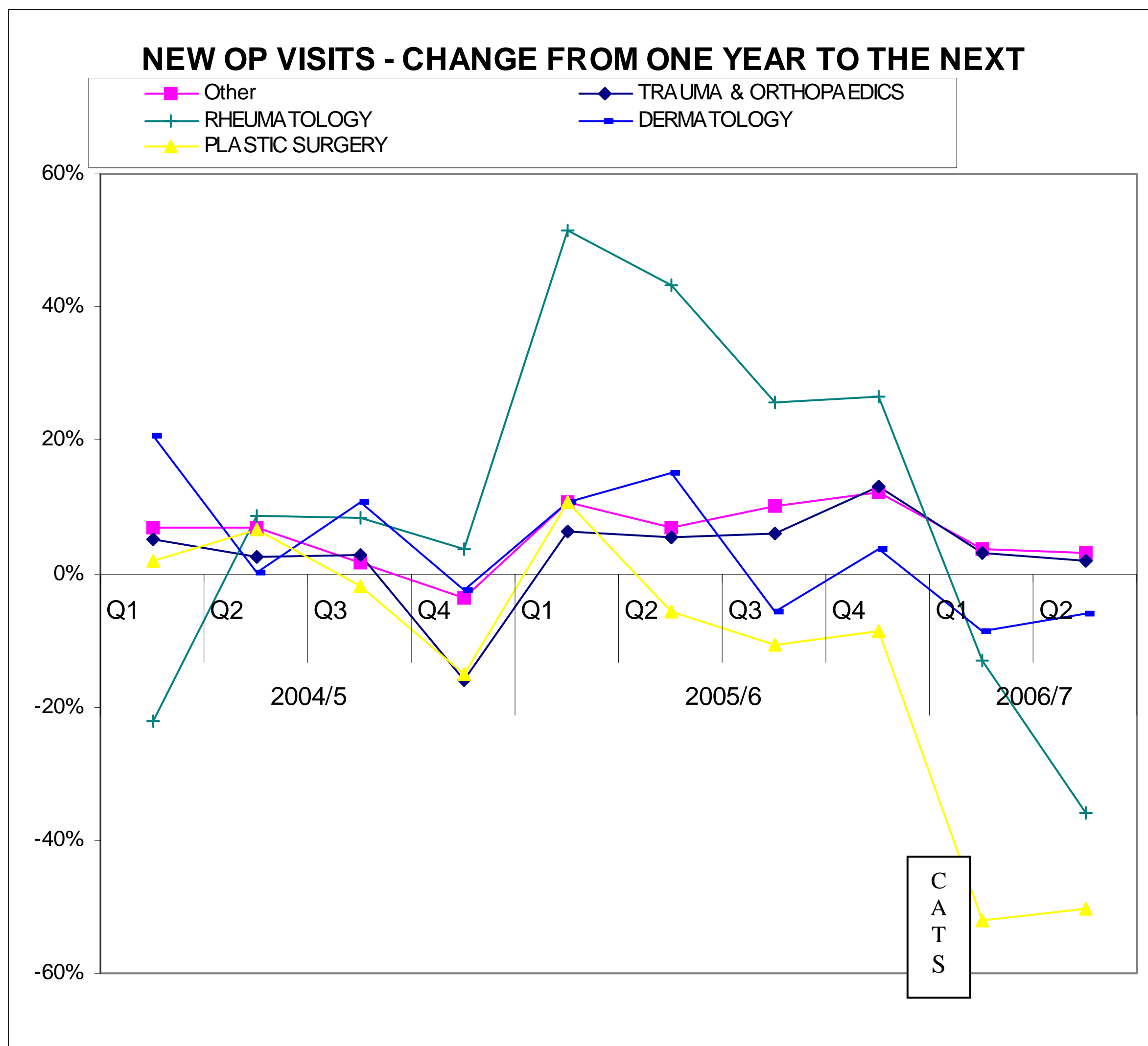


Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	Other	TRAUMA & ORTHOPAEDICS	RHEUMATOLOGY	DERMATOLOGY	PLASTIC SURGERY
2004/5	Q1	7%	5%	-22%	21%	2%
	Q2	7%	2%	9%	0%	7%
	Q3	2%	3%	8%	11%	-2%
	Q4	-4%	-16%	4%	-2%	-15%
2005/6	Q1	11%	6%	52%	11%	11%

	Q2	7%	5%	43%	15%	-6%
	Q3	10%	6%	26%	-6%	-11%
	Q4	12%	13%	26%	4%	-9%
2006/7	Q1	4%	3%	-13%	-9%	-52%
	Q2	3%	2%	-36%	-6%	-50%

Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07



The reductions in plastics and rheumatology outpatient attendances are significant, although in Rheumatology this may be actually due to increases in 2005/6 compared with 2004/5. In plastics the reduction in outpatients is probably not due to CATS as there is a similar drop in St Albans PCT commissioned activity where there is no CATS.

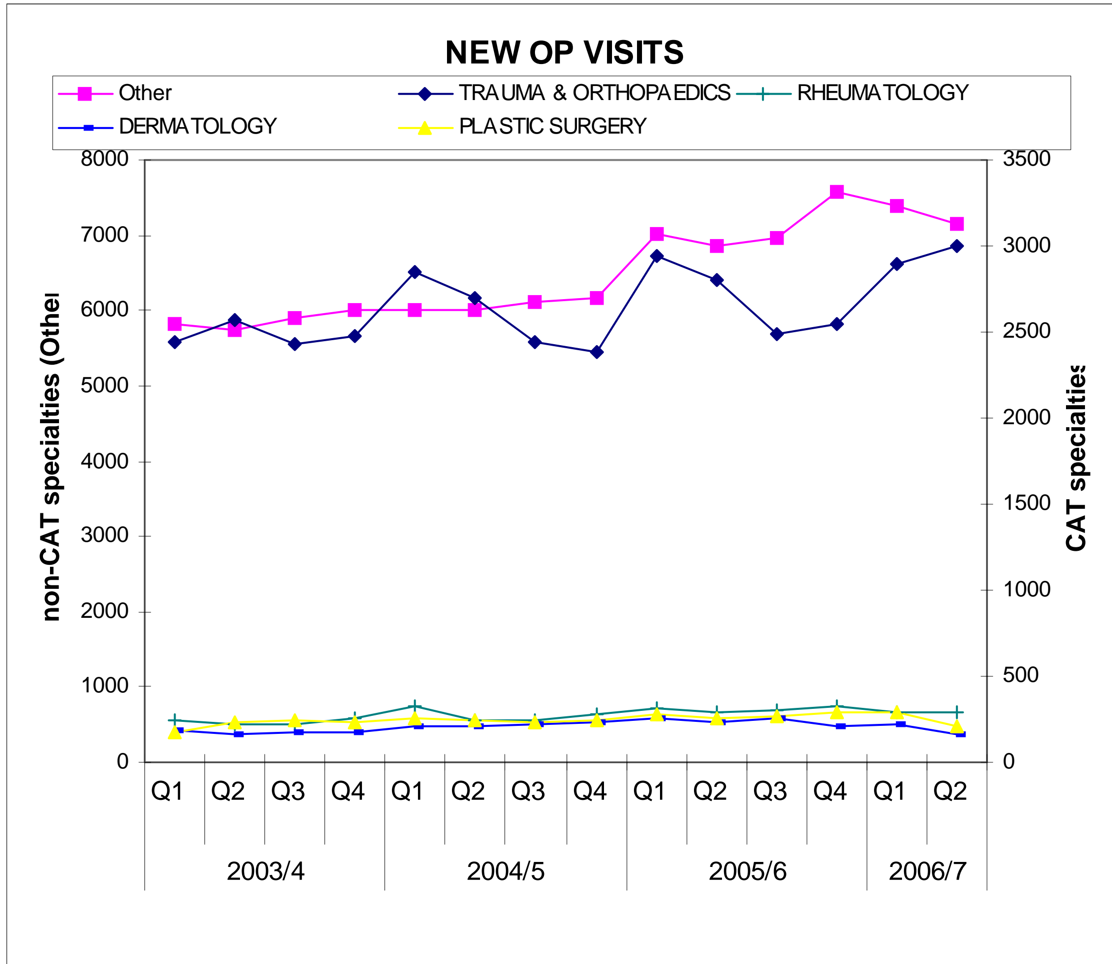
The lack of progress across these specialities is due to the lack of CATS development in all these specialities across West Herts during this period and the fact that not all GP referrals are directed to each of the CATS which are established.

7.3.1.4.1.2 Outpatient attendance from "other" referral (Consultant to Consultant)

"Other" referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	Financial Quarter	Other	TRAUMA & ORTHOPAEDICS	RHEUMATOLOGY	DERMATOLOGY	PLASTIC SURGERY
2003/4	Q1	5810	2440	241	185	175
	Q2	5740	2568	217	168	234
	Q3	5890	2427	217	179	240
	Q4	5999	2481	261	179	238
2004/5	Q1	6004	2848	323	211	251
	Q2	6008	2694	244	214	244
	Q3	6123	2438	239	222	235
	Q4	6158	2383	282	227	239
2005/6	Q1	7021	2939	311	253	284
	Q2	6856	2805	289	230	258
	Q3	6974	2491	299	255	267
	Q4	7587	2550	322	209	293
2006/7	Q1	7377	2897	295	219	290
	Q2	7145	3005	296	165	211

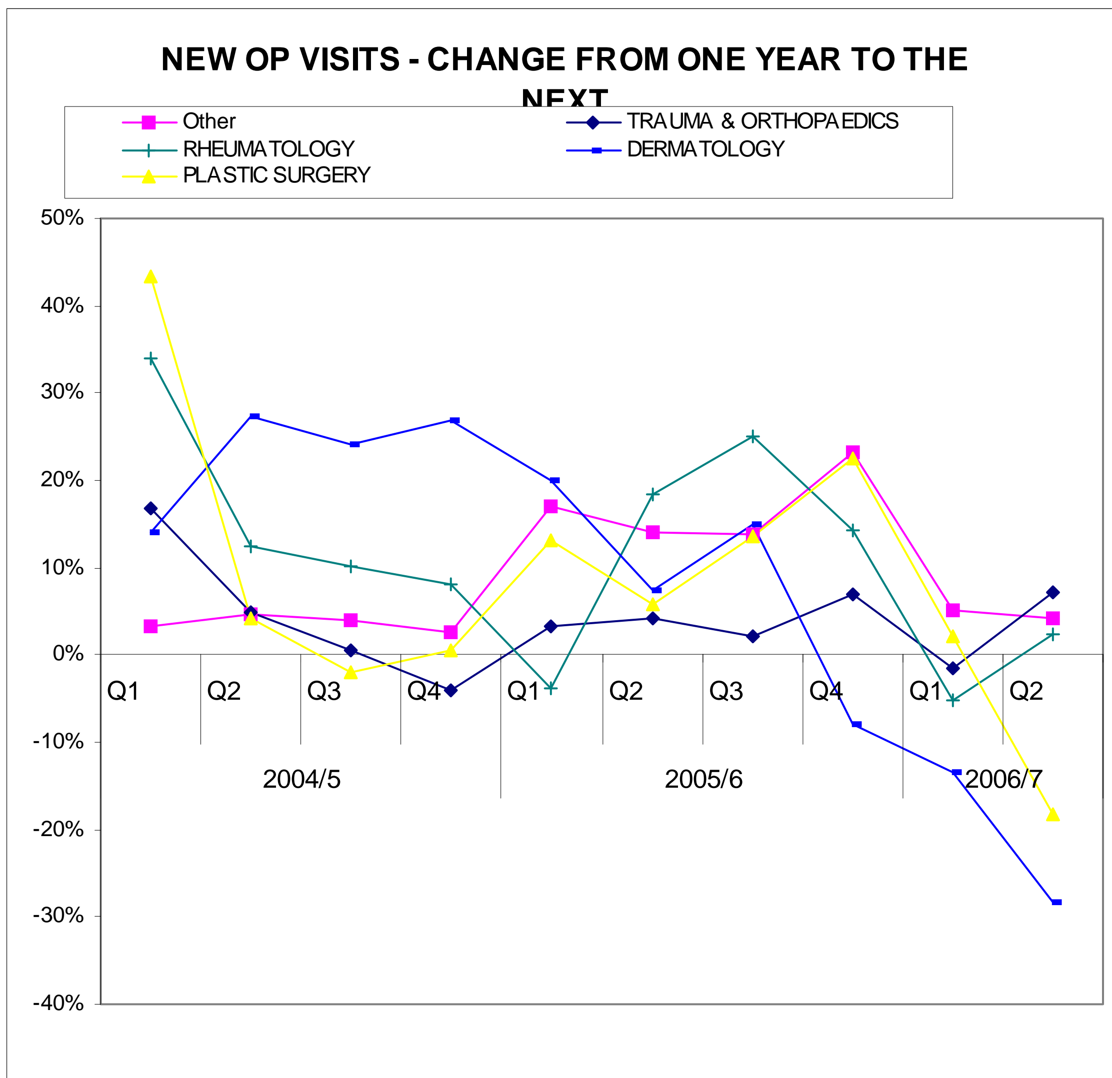
"Other" referred new outpatient visits 2003 to 2007 by CATS specialties and all others



Percentage change in outpatient attendance from "other" referral by each quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	Other	TRAUMA & ORTHOPAEDICS	RHEUMATOLOGY	DERMATOLOGY	PLASTIC SURGERY
2004/5	Q1	3%	17%	34%	14%	43%
	Q2	5%	5%	12%	27%	4%
	Q3	4%	0%	10%	24%	-2%
	Q4	3%	-4%	8%	27%	0%
2005/6	Q1	17%	3%	-4%	20%	13%
	Q2	14%	4%	18%	7%	6%
	Q3	14%	2%	25%	15%	14%
	Q4	23%	7%	14%	-8%	23%
2006/7	Q1	5%	-1%	-5%	-13%	2%
	Q2	4%	7%	2%	-28%	-18%

Percentage change in outpatient attendance from "other" referral by each quarter 2004/05 to 2006/07



In West Herts the previous rise in consultant to consultant referrals seems to have stabilised however this has not been the case recently for Trauma and Orthopaedics.

7.3.1.4.2 Overall activity and Costs

Please see appendices B and C for a detailed analysis of activity and costs.

The percentage of GP referrals into CATS varies from 5% to 67%.

For minor surgery CATS in Watford, Three Rivers and Dacorum there is a 15% reduction in overall referrals, perhaps due to an increased awareness/ implementation of the Priorities Forum policy of minor surgery for cosmetic skin lesions.

However for MSK CATS across West Herts there appear to be a 23%-40% increase in GP referrals, perhaps due to an increase in GP referrals for self-limiting musculoskeletal conditions which previously would not have been referred to hospital outpatients.

There is a reduction in secondary care activity for all CATS specialities.

All CATS show a reduction in cost, compared with the same activity going through hospital outpatients, of between £29, 482 and £219,582.

However the total cost for the commissioner (CATS and hospital outpatients combined), taking account of the increase in GP referrals (and assuming *all* due to the introduction of CATS) is *greater* for MSK CATS in Watford Three Rivers and Dacorum by £85,000.

The total cost for the commissioner for minor surgery demonstrates a saving of £330,304 for Watford Three Rivers and Dacorum due to the more cost effective minor surgery being carried out by the CATS.

The total cost for the commissioner for MSK CATS demonstrates a saving of £10,394 for St Albans and Harpenden due to the reduction in outpatient attendances, whilst taking account of the additional costs of providing the CATS service, as well as the additional costs of the increased GP referrals.

7.3.2 East and North Hertfordshire PCTs

7.3.2.1 CATS Activity

CATS commenced January 2005 (Quarter 4 2004/05) except Gastroenterology which commenced August 2005 (Quarter 2 2005/06) although received some referrals from Quarter 1 2005/06.

CAS activity in East and North Herts 2005-06 and 2006-07

		2005-06					**2006-07**			
		Q1	**Q2**	**Q3**	**Q4**	**Total 05-06**	**Q1**	**Q2**	**Q3**	**Total 06-07 To Date**
MSK	**Referrals received by CATS**	731	487	964	1029	**3211**	1317	1078		**2395**
	Referrals returned to primary care (%)					**3%**				**4%**
	Referrals triaged to secondary care (%)					**70%**				**63%**

	Referrals retained by CATS (%)					**27%**				**33%**
OPHTHALMOLOGY	**Referrals received by CATS**	360	636	735	1844	**3575**	2558	1376		**3934**
	Referrals returned to primary care (%)					**3%**				**2%**
	Referrals triaged to secondary care (%)					**65%**				**64%**
	Referrals retained by CATS (%)					**32%**				**34%**
SKIN HEALTH	**Referrals received by CATS**	178	192	211	310	**891**	357	228		**585**
	Referrals returned to primary care (%)					**6%**				**10%**
	Referrals triaged to secondary care (%)					**43%**				**49%**
	Referrals retained by CATS (%)					**51%**				**41%**
OMFS	**Referrals received by CATS**	2	19	558	686	**1265**	1127	811		**1938**
	Referrals returned to primary care (%)					**0%**				**0%**
	Referrals triaged to secondary care (%)					**43%**				**26%**
	Referrals retained by CATS (%)					**57%**				**74%**
GASTROENTEROLOGY	**Referrals received by CATS**	157	38	418	932	**1545**	894	427		**1321**
	Referrals returned to primary care (%)					**0%**				**0%**

	Referrals triaged to secondary care (%)					**58%**				**36%**
	Referrals retained by CATS (%)					**42%**				**64%**

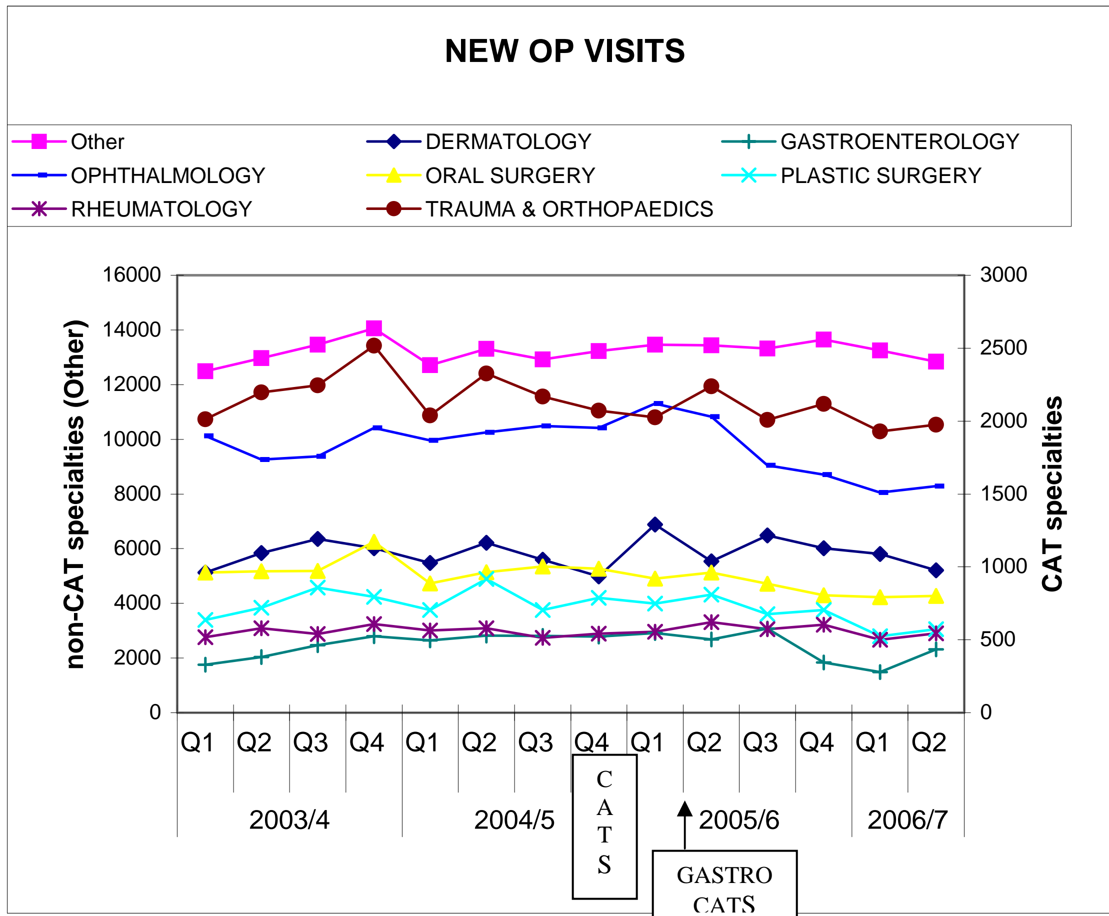
7.3.2.2 Outpatient Activity

7.3.2.2.1 GP Referral

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	Financial Quarter	Other	DERMAT-OLOGY	GASTRO-ENTEROLOGY	OPHTHALM-OLOGY	ORAL SURGERY	PLASTIC SURGERY	RHEUMAT-OLOGY	TRAUMA & ORTHO-PAEDICS
2003/4	Q1	12490	962	330	1899	961	637	519	2012
	Q2	12964	1096	382	1735	969	719	579	2197
	Q3	13461	1191	463	1757	973	859	540	2245
	Q4	14053	1128	525	1954	1172	795	607	2517
2004/5	Q1	12712	1027	496	1868	886	704	564	2039
	Q2	13304	1166	529	1922	964	918	579	2326
	Q3	12922	1048	526	1967	1003	705	513	2169
	Q4 (CATS Start)	13231	935	522	1953	987	788	541	2072
2005/6	Q1	13455	1291	547	2119	919	748	555	2026
	Q2 (Gastro CATS Start)	13440	1037	503	2029	961	809	621	2238
	Q3	13317	1215	578	1697	884	677	573	2009
	Q4	13642	1128	345	1633	806	705	604	2117
2006/7	Q1	13255	1089	278	1510	793	525	501	1928
	Q2	12837	976	435	1553	801	572	544	1976

GP referred new outpatient visits 2003 to 2007 by CATS specialties and all others



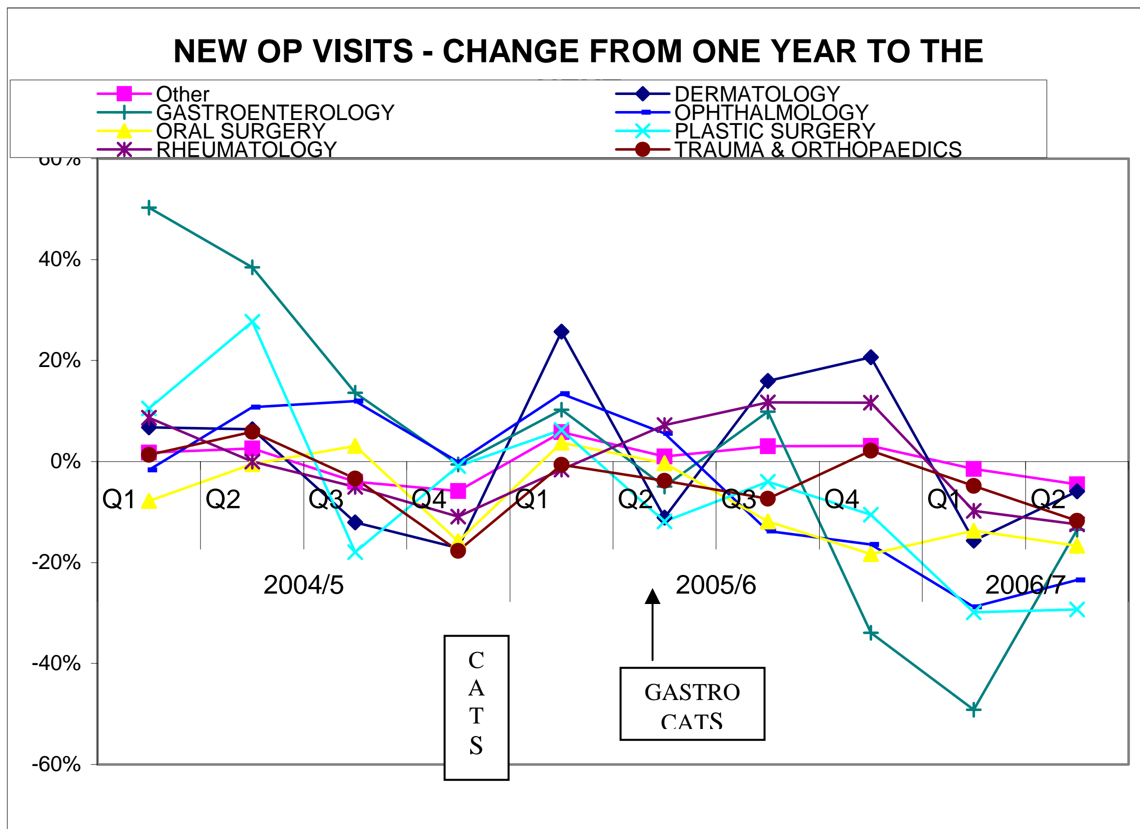
There appear to be reductions in outpatient attendances in Ophthalmology, Dermatology, Oral Surgery, and Gastroenterology in relation to the establishment of CAS, although in gastroenterology the activity *may* be increasing again.

Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	Other	DERMAT-OLOGY	GASTRO-ENTEROLOGY	OPHTHALM-OLOGY	ORAL SURGERY	PLASTIC SURGERY	RHEUMAT-OLOGY	TRAUMA & ORTHO-PAEDICS
2004/5	Q1	2%	7%	50%	-2%	-8%	11%	9%	1%
	Q2	3%	6%	38%	11%	-1%	28%	0%	6%
	Q3	-4%	-12%	14%	12%	3%	-18%	-5%	-3%
	Q4 (CATS Start)	-6%	-17%	-1%	0%	-16%	-1%	-11%	-18%
2005/6	Q1	6%	26%	10%	13%	4%	6%	-2%	-1%
	Q2 (Gastro CATS Start)	1%	-11%	-5%	6%	0%	-12%	7%	-4%

	Q3	3%	16%	10%	-14%	-12%	-4%	12%	-7%
	Q4	3%	21%	-34%	-16%	-18%	-11%	12%	2%
2006/7	Q1	-1%	-16%	-49%	-29%	-14%	-30%	-10%	-5%
	Q2	-4%	-6%	-14%	-23%	-17%	-29%	-12%	-12%

Percentage change in outpatient attendance by each quarter 2004/05 to 2006/07



Reductions in CATS speciality outpatient activity appear to be greater than for non-CATS specialities, although this difference will naturally be lessening as we begin compare across years which both have CATS established.

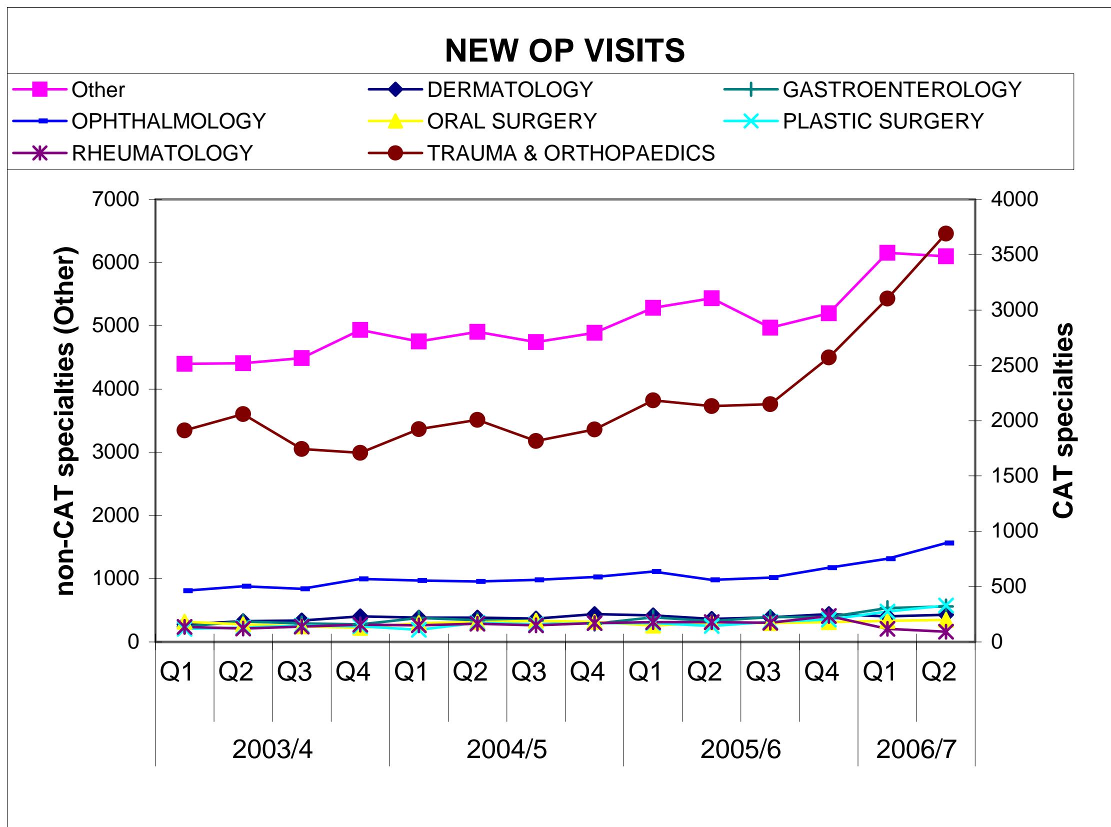
7.3.2.2.2 Non GP Referral Outpatient Attendance (mainly consultant to consultant)

“Other” referred new outpatient visits 2003 to 2007 by CATS specialties and all others

Financial Year as Text	Financial Quarter	Other	DERMAT-OLOGY	GASTRO-ENTEROLOGY	OPHTHALM-OLOGY	ORAL SURGERY	PLASTIC SURGERY	RHEUMAT-OLOGY	TRAUMA & ORTHOPAEDICS
2003/4	Q1	4397	158	138	462	181	119	137	1913
	Q2	4411	188	186	503	159	130	122	2059
	Q3	4487	195	168	481	143	147	140	1745
	Q4	4937	230	160	570	127	141	156	1710
2004/5	Q1	4751	221	216	555	171	111	149	1924
	Q2	4906	220	196	546	180	174	164	2006
	Q3	4743	212	193	562	191	160	151	1815

	Q4	4891	253	166	587	183	171	170	1921
2005/6	Q1	5282	239	223	637	148	170	178	2183
	Q2	5438	209	188	562	176	144	180	2133
	Q3	4969	222	226	580	171	183	174	2149
	Q4	5196	253	226	672	180	202	235	2572
2006/7	Q1	6157	231	308	751	190	276	119	3102
	Q2	6098	245	322	895	199	331	92	3690

“Other” referred new outpatient visits 2003 to 2007 by CATS specialties and all others



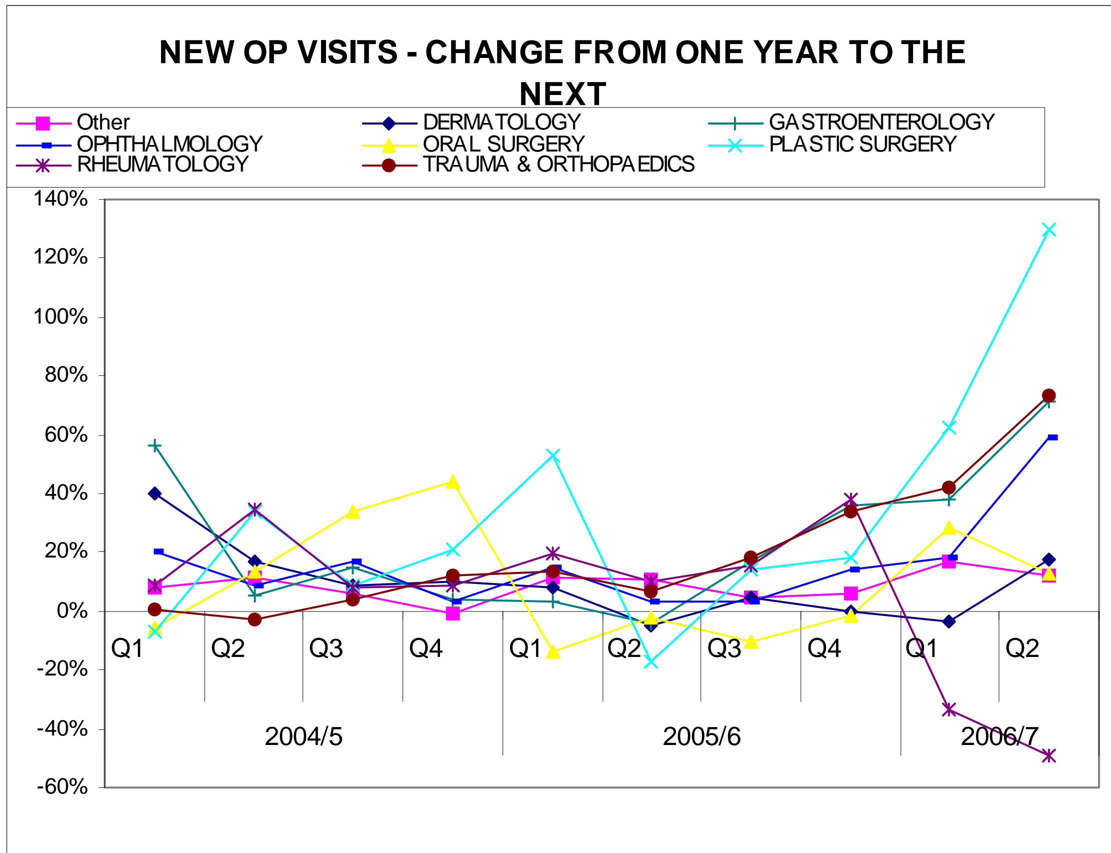
There is a phenomenal rise in consultant to consultant referrals, especially for Trauma and Orthopaedics, Ophthalmology and all non-CATS specialities which required further investigation and discussions with the acute providers as a matter of urgency.

Percentage change in outpatient attendance from “other” referral by each quarter 2004/05 to 2006/07

Financial Year as Text	Financial Quarter	Other	DERMAT_ OLOGY	GASTRO_ ENTEROLOGY	OPHTHALM- OLOGY	ORAL SURGERY	PLASTIC SURGERY	RHEUMAT- OLOGY	TRAUMA & ORTHO_ PAEDICS
2004/5	Q1	8%	40%	57%	20%	-6%	-7%	9%	1%
	Q2	11%	17%	5%	9%	13%	34%	34%	-3%
	Q3	6%	9%	15%	17%	34%	9%	8%	4%
	Q4	-1%	10%	4%	3%	44%	21%	9%	12%
2005/6	Q1	11%	8%	3%	15%	-13%	53%	19%	13%
	Q2	11%	-5%	-4%	3%	-2%	-17%	10%	6%
	Q3	5%	5%	17%	3%	-10%	14%	15%	18%

	Q4	6%	0%	36%	14%	-2%	18%	38%	34%
2006/7	Q1	17%	-3%	38%	18%	28%	62%	-33%	42%
	Q2	12%	17%	71%	59%	13%	130%	-49%	73%

Percentage change in outpatient attendance from "other" referral by each quarter 2004/05 to 2006/07



The dramatic increase in *consultant to consultant* referrals is particularly the case in quarters 1 and 2 - 2006/7 and for all specialities except rheumatology.

7.3.2.3 Overall activity and costs

Please see Appendix B for a detailed analysis of activity and costs.

The percentage of GP referrals into CATS varies from 26% to 54%.

There appears to be an 8%-23% increase in overall GP referrals in the CATS specialities between 2004/5 and 2005/6.

There is a relatively small reduction in secondary care activity for all CATS specialities of between 0.5% and 7%.

All CATS show a reduction in cost, compared with the same activity going through hospital outpatients, of between £16,998 and £210,734.

However the total cost for the commissioner (CATS and hospital outpatients combined), taking account of the increase in GP referrals (and assuming *all* the increase is due to the introduction of CATS) is *greater* for all CAS services £996 and £197,366.

7.4 Review national best practice in CAS/ CATS and compare with local practice

Review of National Examples of Referral Management Services

7.4.1 Introduction

In *Our health, our care, our say*[1] the Department of Health gave a clear policy drive to develop primary, community and preventative services and shift care from acute hospitals to local community settings. The prioritisation of Care close to home has also been emphasised in the new *NHS in England: the operating framework for 2007/08*[2]. Around England and Wales a variety of services have already been developed in primary care in order to manage the referral of patients on to secondary care. These services range from simple administrative triage to services providing clinical assessment and treatment (CATS).

The aim of this review was to find national examples of services that offered clinical assessment and treatment (CATS) and describe their structure and any outcomes that had been reported.

The different models of CATS that have developed nationally make comparisons and evaluation rather challenging. The designs may vary between specialties and often reflect how the service developed as a response to local need – although all essentially providing some form of ‘intermediate’ care.

The literature that was searched to produce this review included peer reviewed work (Medline), Department of Health publications and other reports that were identified from the grey literature, including local reports and other academic reviews.

7.4.2 Service Design

A number of different models were identified from the literature and the structure of the services was found to vary in terms of staffing, consultant input, and also in terms of location and number of sites. Table 1 and 2 give brief descriptions of orthopaedic and dermatology services (taken from the

Case Studies, Care Closer to Home project (Sept06)[3]. They show that some services might be led by a practitioner with a special interest, such as a podiatrist or physiotherapist, and others by a secondary care consultant.

Table 1 Orthopaedic models

Location	Brief description of structure
Kingston and Richmond Community, Musculoskeletal Triage Team	GP direct access service, allows GPs and other clinicians from the local trust to refer directly to the triage team. Clinics are run by extended scope physiotherapists who are able to order investigations (inc MRI) and provide joint injections. ESP clinics are run in three sites alongside a consultant or a GPwSI
Orthopaedic Clinical Assessment and Treatment Service Bolton Primary Care Trust	The service is consultant led – it has two PCT permanently employed Orthopaedic Consultant surgeons within a multidisciplinary team consisting of GPwSI, a Consultant Physiotherapist and extended scope practitioner physiotherapists. Sited in a ‘Primary Care Resource Centre’ in Bolton town centre.
Middlesborough Specialist Musculoskeletal Service	Extended scope podiatrist as the clinical lead. In addition the team has three GPwSI, two extended scope physiotherapists, one extended scope podiatrist and one GPwSI in acupuncture. Based in a community facility at a different site from secondary care. Diagnostic facilities inc radiography onsite.

Table 2 Dermatology Models

Location	Brief description of structure
Middlesborough Primary Care Skin Services (MPCSS)	GPwSI providing three clinics a week and GPwSI in minor surgery providing four clinics a week Full and part-time nurses and a health care assistant. A third GPwSI is being trained. Consultant in plastic surgery attends the clinic once

	a month. Base in community centre in Middlesborough town centre.
Dermatology Service, Hull PCT and East Riding of Yorkshire PCT	The move of services into the community was driven by the geography of the area – with many patients having great distances to travel. Service is provided at a number of health centres across the area – with GPwSIs at each site supported by the Consultant Dermatologist who advises on more complex cases.

7.4.3 Referral

The referral processes described were broadly of two types –

- GPs were able to refer to a single point with cases then triaged to the appropriate service.
- GPs had the choice of referring to the CAT service or could bypass it and refer patients directly to secondary care.

7.4.4 Training Arrangements and Clinical Governance

The training and accreditation of practitioners within CATS is not currently standardised. The DH has produced guidance for the appointment of practitioners with special interests, but no training courses are currently recognised. Some GPs are able to train through special salaried GP posts, for example at the City and Hackney PCT[4], while others may have gained necessary skills in a particular speciality before training as a GP.

A report from the NHS Service Delivery and Organisation R&D Programme (2006)[5] summarised some findings around training, accreditation and clinical governance of GPs with special interests (GPwSI).

- The shortage of qualified GPs meant that the PCTs could not be 'too stringent' about the competencies or accreditation process of the doctors they recruited.

- There was a lack of consensus on whether hospital consultants or established GPwSIs should take responsibility for 'signing off' newly recruited GPwSIs.

- Robust clinical governance arrangements were seen as an important way to ensure quality and safety in the absence of routinely collected outcome data – but there was continuing uncertainty over whether the PCT of NHS trust was responsible for clinical governance.

- While most GPSIs undertook some kind of continuing professional development, the content varied. Most GPSIs attended multidisciplinary hospital clinical departmental meetings either infrequently or not at all. The exception was those GPs employed by the hospital trust, who attended courses laid on for hospital practitioners.

- There was no uniform procedure for GPSIs to engage in routine clinical audit, for complaints or for obtaining consent for treatment involving surgical procedures. Requesting patients' hospital notes in advance was possible only at the hospital-based clinic.

Another review (Manchester University 2005[6]) found that these services often lack systems to collect data on outcomes and long term follow-up.

The variations around local arrangements with training and accreditation processes have led to the suggestion in Greater Manchester that the Deanery (in relevant specialties), Primary Care and Acute Trusts should be coming together to integrate the existing training arrangements for GPs. It is felt they should prescribe more definitive training modules for GPwSIs and allocate the appropriate level of expertise to run these training sessions.

7.4.5 Outcomes

7.4.6 Clinical Outcomes

While there is anecdotal evidence that the outcomes for patients are comparable little published work was identified comparing CAS/Ts with usual outpatient routes of care. The best evidence is from a randomised controlled trial that looked at dermatology services for selected conditions provided by a GPSI compared to the usual dermatology department[7]. The study found no difference in clinical outcomes between the groups.

7.4.7 Patient Experience

Table 3 outlines some findings from evaluations of patient experiences. Patients appear to be satisfied with care provided by CATS services and with the reduced waiting times that have resulted, although accessibility is not always improved.

Table 3 Examples of findings from patient experience evaluations

Dermatology GPSI Bristol[8]	Clinics more accessible than hospital outpatient clinics – largely related to access to parking and did not apply to urban residents who lived nearer the hospital. Patients seen more quickly Slightly more satisfied with the service

Oldham PCT Tier 2 reports (2004/5)[9]	Patients reported access and transport problems Pleased at being seen quickly Efficient and friendly Treatment instituted more quickly

The NHS SDO review of GPSI projects (2006)[5] summarised their findings on patient experience with the following key messages -

- Patients deemed suitable for referral to a GPSI clinic were equally satisfied with the clinical care provided in either type of clinic.

- Patients referred to a GPSI were broadly satisfied with the service provided – though some had initial concerns about the quality of care and the possibility of longer waiting times for patients who eventually required a consultant appointment.

- Patients expressed a slight preference for the accessibility, convenience and shorter waiting times of locally-based GP clinics. However, these factors were seen as less important to patients than the thoroughness of the consultation and the expertise of the doctor.

7.4.8 Referrals and Waiting times

A measure of success of the services was often taken as a reduction of referrals into secondary care and a reduction in waiting times and table 4 summarises several examples that showed these improvements. Another measure used was the proportion of surgical cases referred on to secondary care that subsequently required surgery. For example in Southampton only 18% of cases were referred on to secondary care and 75% of those needed surgery.

Other evaluations looked at the total number of referrals in the system – to see whether the service was generating an increase – and while some areas reported large increases, others did not see this (table 5).

Table 4 Examples of impact on waiting times and secondary care outpatient activity

Location	**Outcomes**
Kingston and Richmond Community, Musculo-skeletal Triage Team[3]	Reduction of GP referrals to Trauma and Orthopaedics outpatients of 25% 85% of referrals to the team seen within 8 weeks

Middlesborough Specialist Musculoskeletal Services[3]	Reduced waiting time 5% decrease in number of patients seen by orthopaedics
Middlesborough Primary Care Skin services[3]	Secondary care dermatology waiting lists decreased from 149 to 83 days Plastic surgery waiting list decreased from 260 to 41 days
Multi-professional triage team (MPTT) for orthopaedics, Southampton[10] (GPwSIs, physios, podiatrists and radiographers – 8 sites)	Waiting time for orthopaedic appointment reduced from 18months to 6 weeks for routine and 2 weeks for urgent. Only 18% of patients seen by the MPTT were referred on to the consultant and 75% of those went on to surgery
Oldham Tier 2 projects[9]	Reduced number of 13+ week waiters
Physiotherapy and GP musculoskeletal interface service – Somerset Coast Primary Care Trust[11]	Waiting time is 4-6 weeks 20% of patients seen were referred for a surgical opinion – 75-80% of these were listed for surgery
Musculoskeletal Service – University of North Staffordshrie NHS Trust[11]	Reduced waiting times to meet 13 week target Orthopaedic surgical conversion rate increased from 18% to 60%

Table 5 Evaluations looking at total number of referrals

NW Wales 'Targeted early access to Musculoskeletal services' (TEAMS)[12]	Over 18 months the number of referrals more than doubled. Despite this, waiting times for musculoskeletal services fell; this was noticeable for rheumatology and pain management. Surgery conversion rates did not change.
Sanderson(2002) – evaluation of GPwSI in Ear Nose and Throat[13]	Found that some of the increase in referrals found in the evaluation were of patients who would not have otherwise been referred to secondary care by their GP.
Rosen (2005)[14] 3 x dermatology services 1 x musculoskeletal service	This study reported mixed results concerning referral volumes with increases in some areas and decreases in others. 30% of referring GPs saw GPSI as an addition to hospital outpatient – 'it allows me to refer patients whom 'I would not normally refer to hospital'

Bradford PCT addressed the problem of increased total referrals by introducing a quality measure to track referral rates to dermatology – with an increase of more than 2% causing the practice to fail to reach the mark[15].

7.4.9 Non-attendance rate

Two reviews found lower DNA rates in GPSI settings. (Sanderson 2002, Rosen 2005)

7.4.10 Costs and Savings Reported

It is difficult to compare the costs of CATS compared to usual outpatient care. Where costs and savings have been reported they often do not cover all the relevant areas such as –

- Training
- Follow-up
- Administration costs
- Cost of facilities used
- Investigations ordered
- Treatments
- Staff cover – locums etc – what it will take to make the service sustainable

Variations in costs are likely to be influenced by the service model adopted, equipment costs, clinic locations, number of sites and patient throughput. Costs of staff employed are also an important factor - GPwSI are likely to be paid more than the non-consultant grade doctors doing similar work in hospitals.

It is worth noting that the service examples in tables 6 and 7 were developed before the rolling out of Practice Based Commissioning.

Table 6 Examples of costs and savings reported by individual services

Location	Costs and Savings Reported
Middlesborough Skin services[3]	05/06 there were 1458 patient contacts and the cost of delivering the service was £232k *The team is in the process of doing a full evaluation against the Payment by Results – 'early indications are that the savings could be as much as 25%'*
Bristol Dermatology GPSI service[8] (Economic evaluation of a general practitioner with special interests led dermatology service in primary	Costs to the NHS for patients attending the GPSI were £208 compare with £118 for hospital outpatient care. – but authors felt additional cost needs to weighed against

care. Coast, J. et al BMJ 2005;331;1444-1449	improved access and broadly similar outcomes.
Somerset Coast PCT musculoskeletal service[11]	*'The approximate cost saving of using this service is £700 per patient'* This takes into account the lower conversion rate to surgery than the local orthopaedic department and the savings made by using the Independent Sector Treatment Centre (ISTC)

Table 7 Findings of reviews looking at costs

Rosen (2005) [14]looking at four sites	Cost per patient to the NHS varied from £35.27 to £93.69 The paper does not compare to hospital costs – but the findings do illustrate that the costs are context dependent – equipment required at some of the sites and some sites ran more sessions - economies of scale
Sanderson (2002)[13] GPwSI in ENT	GPSI costs per consultation were £30-£40 compared with the hospital HRG costs of £60 to £80 per outpatient. However, hospital costs include capital and overheads which were not included in the GPSI costs. GPSI costs also excluded hospital supervision, training and the costs of managing the scheme.
Oldham Tier 2 Projects (2005 report)[9]	All Tier 2 schemes had higher tariffs when compared with the Acute Trust in the area. General factors contributing to this – Overhead costs are high for Tier 2 due to the limited scale of the operation Tier 2 is more of a one stop service More of a quality service – shorter waiting times
Oldham Rheumotology Tier 2	*The cost for Rheumatology is nearly 4.8 times higher than local acute trust.* *Factors contributing include high new to follow-up ratio, higher infrastructure costs as offered at three sites, three posts (osteoporosis nurse, psychology and*

	physiotherapist) add value in terms of quality.
Oldham Tier 2 Ophthalmology	*Tariff is 2.8 times higher – contributing factors include – Significant capital investment at the start, new to follow-up ratio is low*

7.4.11 Conclusions from the literature review

- There is a clear policy direction to develop primary, community and preventative services, in line with what the public want.
- There are many examples of redesigned services. Benefits for patients are typically cited as:
    - Reduced waiting times
    - Better access
    - More Choice
    - Improved experience

- Services set up to manage demand for outpatient appointments may not reduce demand overall as they may encourage GPs to refer patients who would not have been referred to outpatients
- Some redesigned services claim to make cost savings, although generally the financial evaluation available is limited. For others, the cost is higher due to overhead costs associated with service decentralisation.
- There is some variation in the training and clinical governance arrangements in place within CATS
- The literature implies that CATS require a robust IT and information management infrastructure.

7.5 Put forward proposals for the roll out of best practice services across the county

See recommendations (section 2.3, page 8)

8 References

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9 Appendices

10 Appendix A - Interview Structure

10.1.1.1 PCT Commissioners

10.1.1.1.1 CATS as a service model

- Ability to manage demand for elective care and contribute to financial recovery – if not alternative models for demand management?
- Ability to improve patient care/ experience

10.1.1.1.2 Progress in CATS development across Herts

- Barriers to progress
- Facilitators of progress
- What is working well
- What is working not so well

10.1.1.1.3 Commissioning process

- Tendering or placing of contracts - (Pros and cons of each?)
- PCT or PBC led process?

10.1.1.1.4 Links with secondary care

- Partnership or competitive approach?
- Managing impact on acute trusts
- Views on acute trusts controlling consultants to limit competition

10.1.1.1.5 CATS model

- Triage only or triage and assess or triage assess and treat
- GPwSI/ Specialist/ Specialist nurse or therapist or MDT
- Role of consultant if there
- Is clinical leadership, particularly GP leadership, important for a CAS/CATS?
- Choose & Book – best done through a CATS or individual practices?
- Providing only or providing and commissioning of 2’ care too diagnostics and tx through PBC?

10.1.1.1.6 Any other comments

10.1.1.2 Practice based commissioners

10.1.1.2.1 CATS as a service model

- Ability to manage demand for elective care and contribute to financial recovery – if not alternative models for demand management?
- Ability to improve patient care/ experience

10.1.1.2.2 Progress in CATS in your patch

- Barriers to progress
- Facilitators of progress
- What is working well
- What is working not so well

10.1.1.2.3 Commissioning process

- Tendering or placing of contracts - (Pros and cons of each?)
- PCT or PBC led process?
- How best to secure GP ownership of CATS and their referrals?

10.1.1.2.4 Links with secondary care

- Partnership or competitive approach?
- Managing impact on acute trusts
- Views on acute trusts controlling consultants to limit competition

10.1.1.2.5 CATS model

- Triage only or triage and assess or triage assess and treat
- GPwSI/ Specialist/ Specialist nurse or therapist or MDT
- Role of consultant if there
- Is clinical leadership, particularly GP leadership, important for a CAS/CATS?
- Choose & Book – best done through a CATS or individual practices?
- Providing only or providing and commissioning of 2’ care too diagnostics and tx through PBC?

10.1.1.2.6 Sites

10.1.1.2.7 Employment type

10.1.1.2.8 Any other comments

10.1.1.3 GP representatives (LMC)

10.1.1.3.1 Is it reasonable to manage demand and if so, how best (practice level or collectively?)

10.1.1.3.2 CATS appropriate model?

10.1.1.3.3 What models from elsewhere excite the LMC?

10.1.1.3.4 What role would the LMC have in ensuring we get CAS/CATS right in terms of future development?

10.1.1.4 Patient representatives

10.1.1.4.1 What is your understanding of a CATS?

10.1.1.4.2 What do you feel are the potential benefits?

10.1.1.4.3 What do you feel are the potential risks?

10.1.1.4.4 What are your views of the process so far (and refer to patient involvement)?

- What has worked well?
- What has not worked well?

10.1.1.4.5 How can we ensure patients views are integrated in service planning and monitoring?

10.1.1.4.6 What are your recommendations for the future?

10.1.1.5 Acute trust/ consultant representatives

10.1.1.5.1 CATS as a model to manage demand for elective care

- Is it appropriate for PCTs, PBCs and GPs to manage demand for elective care?
- If so is CATS an appropriate model to do so?
- If not which models are appropriate?

10.1.1.5.2 What model of CATS would you recommend?

- Triage/ assessment/ treatment
- GPwSI, specialist, specialist nurses and therapists or MDT
- Specialist or GP or specialist nurse/ therapist led
- Model of specialist working within
- Proving only or providing and commissioning
- Can GP leadership work? (pros and cons)

10.1.1.5.3 Model of development

- Placing or tendering of contracts
- PCT or PBC led
- Who has led the development of bids – managers or clinicians? What worked best?

10.1.1.5.4 What have been the problems with implementation?

10.1.1.5.5 Which approaches have worked well from your perspective and why?

10.1.1.6 Providers of CATS

10.1.1.6.1 What do you see as the greatest strengths of CATS (in terms of managing demand)?

10.1.1.6.2 What are the risks?

10.1.1.6.3 What services should a CATS provide (triage assess, tx)?

10.1.1.6.4 Who should work in them?

10.1.1.6.5 Employment model

10.1.1.6.6 Commissioning model

10.1.1.6.7 What is working well?

10.1.1.6.8 What is not working well?

10.1.1.6.9 What are the barriers?

10.1.1.6.10 What are the facilitators?

10.1.1.6.11 Recommendations for development

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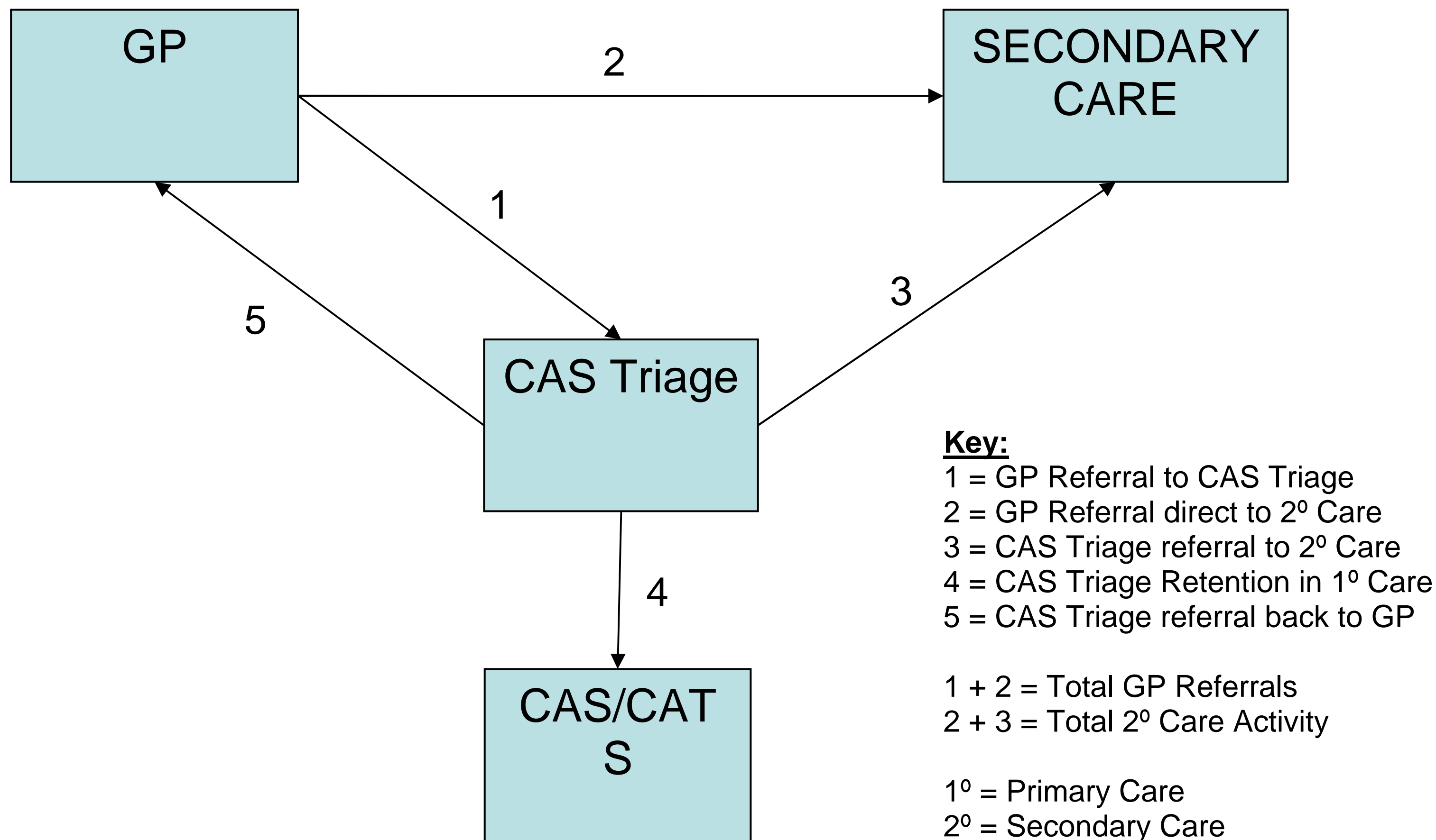
9.2 Appendix 2 East & North Hertfordshire PCT

CATS Review Activity Costing Analysis, East and North Hertfordshire PCTs

OUTPATIENTS

	Total Outpatient Activity	GP Referral to CAS	% GP Referral to CAS	% Retained in CATS	% Returned to GP	% Referred to Secondary Care	GP Referral to Secondary Care	CAS Referral to Secondary Care	Total Secondary Care Activity	Total Retained by CATS	Total Returned to GP	Total GP Referrals	GP Referral % movement on year	Secondary Care % movement on Year
Flowchart		*1*					*2*	*3*	*2 + 3*	*4*	*5*	*1 + 2*		
Opthalmology														
2004/05	7710			0%	0%	0%	7710	0	7710	0	0	7710		
2005/06	7478	3575	48%	32%	3%	65%	5154	2324	7478	1144	107	8729	13.22%	(3.01%)
MSK														
2004/05	10803			0%	0%	0%	10803	0	10803	0	0	10803		
2005/06	10743	3211	30%	27%	3%	70%	8495	2248	10743	867	96	11706	8.36%	(0.56%)
OMFS														
2004/05	3840			0%	0%	0%	3840	0	3840	0	0	3840		
2005/06	3570	1265	35%	57%	0%	43%	3026	544	3570	721	0	4291	11.74%	(7.03%)
Gastroenterology														
2004/05	2073			0%	0%	0%	2073	0	2073	0	0	2073		
2005/06	1973	1388	70%	42%	0%	58%	1168	805	1973	583	0	2556	23.30%	(4.82%)
Skin Health														
2004/05	3115			0%	0%	0%	3115	0	3115	0	0	3115		
2005/06	2939	891	30%	51%	6%	43%	2555	384	2939	454	53	3446	10.63%	(5.65%)

CAS/CATS Review – Referral Flowchart



Key:
1 = GP Referral to CAS Triage
2 = GP Referral direct to 2° Care
3 = CAS Triage referral to 2° Care
4 = CAS Triage Retention in 1° Care
5 = CAS Triage referral back to GP

1 + 2 = Total GP Referrals
2 + 3 = Total 2° Care Activity

1° = Primary Care
2° = Secondary Care

CAS estimated cost with current staffing - East & North Hertfordshire PCT

	Establish-ment WTE	In Post WTE	Cost £	Opthalmology	OMFS	Gastro-enterology	Skin / Plastics	Orthopaedics
Opthalmology PCA	2.4	3	60,000	60,000				
OMFS PCA	1.2	0.8	16,000		16,000			
Gastroenterology PCA	0.87	1	20,000			20,000		
Skin/Plastics PCA	0.36	0.3	6,400				6,400	
Orthopaedics PCA	1.68	0.86	17,290					17,290
CAS Dep Manager	1	0.86	26,000	5,200	5,200	5,200	5,200	5,200
CAS Service Manager	1	1	44,000	8,800	8,800	8,800	8,800	8,800
Temp Staff		2	40,000	0	10,000	10,000	10,000	10,000
Total			**£229,690**	**£74,000**	**£40,000**	**£44,000**	**£30,400**	**£41,290**
Triage								
Opthalmology			£5,000	5,000				
Gastroenterology			£4,800			4,800		
Dental			£4,500		4,500			
CATS								
Opthalmology			£167,198	167,198				
OMFS			£126,896		126,896			
Gastroenterology			£106,883			106,883		
Skin / Plastics			£68,100				68,100	
Orthopaedics			£69,360					69,360
TOTAL			**£782,427**	**£246,198**	**£171,396**	**£155,683**	**£98,500**	**£110,650**

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Secondary Care Savings - East & North Hertfordshire PCT

Secondary Care Savings

	Follow-Up ratio	Retained by CATS	Returned to GP	Total Redirected from Secondary Care	Tariff	Ophthalmology	OMFS	Gastro-enterology	Skin / Plastics	Orthopaedics
Ophthalmology		1144	107	1251	100	125,100				
	2.3			2877	48	138,096				
OMFS		721	0	721	530		382,130			
Gastroenterology		583	0	583	348			202,884		
Skins/Plastics		454	53	507	554				280,878	
Orthopaedics		867	96	963	160					154,080
	1.9			1830	74					135,420
TOTAL SAVINGS						£263,196	£382,130	£202,884	£280,878	£289,500
NET SAVINGS / (COSTS)						£16,998	£210,734	£47,201	£182,378	£178,850

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CATS Review Activity Costing Analysis - East & North Hertfordshire PCT

OUTPATIENTS

CAS estimated CATS costs

Ophthalmology

		Tariff	£
Activity Retained in CATS	1144	£90	£102,960
Follow-up ratio (1 follow-up included free)	1.3		
Follow-up activity	1487	£43	£64,238
			£167,198

OMFS

		Tariff	£
Activity Retained in CATS	721		
Fixed Price		£176	
Cost			**£126,896**

Gastroenterology

		Tariff	£	
Activity Retained in CATS	583			
Flexi Sig		£150		
OGD		£250		
Cost			**£106,883**	Assumed Activity 2/3 1/3

Skin / Plastics

		Tariff	£
Activity Retained in CATS	454		
One appointment		£150	
Cost			**£68,100**

Orthopaedics

		Tariff	£
Activity Retained in CATS	867		
One-off cost		£80	
Cost			**£69,360**

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CATS Review Activity Costing Analysis - East & North Hertfordshire PCT

OUTPATIENTS

Estimated Capacity Calculation

		Opthalmology	OMFS	Gastroenterology	Skin / Plastics	Orthopaedics
GP Referrals to CAS		3575	1265	1388	891	3211
Retained in CA(T)S		1144	721	583	454	867
Returned to GP		107	0	0	53	96
Total Referred & Retained CAS Capacity		**4826**	**1986**	**1971**	**1398**	**4174**
WTE Days	(Note 1)	545	272	197	82	381
Estimated Capacity per WTE Day		**8.86**	**7.30**	**10.01**	**17.05**	**10.96**

Notes

1. WTE Days calculation :	Establishment WTE	2.4	1.2	0.9	0.4	1.7
	x Net Working Days	227	227	227	227	227
		545	272	197	82	381

Net Working Days	
Working Days	260
Annual Leave	-25
Bank Holidays	-8
	227

2. Estimated Capacity per WTE Day assumes an equal allocation of time for Triaging, Referral and CATS Retention treatment

CATS Review Activity Costing Analysis - East & North Hertfordshire PCT

Ophthalmology

TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	7710				
Follow-Up ratio	2.3				
Referrals to 2º Care	7710	100	771,000		
Follow-Ups	17733	48	851,184		
Total Cost 2004/05			**1,622,184**		
2005/06					
Total Referrals	8729				
Follow-Up ratio	2.3				
Referrals to 2º Care	7478	100	747,800		
Follow-Ups	17199	48	825,552		
2º Cost			**1,573,352**	(48,832)	(3.01%)
CAS			74,000	74,000	
CATS			172,198	172,198	
Total Cost 2005/06			**1,819,550**	**197,366**	
(Savings) / Net Increased Costs			**197,366**		
2005/06 Increased Cost without CAS/CATS			214,364		
2005/06 Increased Cost with CAS/CATS			197,366		
(Savings) / Net Increased Costs			**(16,998)**		

Without CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	7710				
Follow-Up ratio	2.3				
Referrals to 2º Care	7710	100	771,000		
Follow-Ups	17733	48	851,184		
Total Cost 2004/05			**1,622,184**		
2005/06					
Total Referrals	8729				
Follow-Up ratio	2.3				
Referrals to 2º Care	8729	100	872,900		
Follow-Ups	20076	48	963,648		
2º Cost			**1,836,548**	214,364	13.21%
Total Cost 2005/06			**1,836,548**	**214,364**	
(Savings) / Net Increased Costs			**214,364**		

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CATS Review Activity Costing Analysis - East & North Hertfordshire PCT

OMFS — TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	3840				
Follow-Up ratio	0				
Referrals to 2º Care	3840	530	2,035,200		
Follow-Ups	0	0	0		
Total Cost 2004/05			2,035,200		
2005/06					
Total Referrals	4291				
Follow-Up ratio	0				
Referrals to 2º Care	3570	530	1,892,100		
Follow-Ups	0	0	0		
2º Cost			**1,892,100**	(143,100)	(7.03%)
CAS			40,000	40,000	
CATS			131,396	131,396	
Total Cost 2005/06			**2,063,496**	**28,296**	
(Savings) / Net Increased Costs			**28,296**		
2005/06 Increased Cost without CAS/CATS			239,030		
2005/06 Increased Cost with CAS/CATS			28,296		
(Savings) / Net Increased Costs			**(210,734)**		

Without CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	3840				
Follow-Up ratio	0				
Referrals to 2º Care	3840	530	2,035,200		
Follow-Ups	0	0	0		
Total Cost 2004/05			2,035,200		
2005/06					
Total Referrals	4291				
Follow-Up ratio	0				
Referrals to 2º Care	4291	530	2,274,230		
Follow-Ups	0	0	0		
2º Cost			**2,274,230**	239,030	11.74%
Total Cost 2005/06			**2,274,230**	**239,030**	
(Savings) / Net Increased Costs			**239,030**		

CATS Review Activity Costing Analysis - East & North Hertfordshire PCT

Gastro-enterology — TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2004/05

	Activity	Tariff	£	Var	Var %
Total Referrals	2073				
Follow-Up ratio	0				
Referrals to 2º Care	2073	348	721,404		
Follow-Ups	0	0	0		
Total Cost 2004/05			**721,404**		
2005/06					
Total Referrals	2556				
Follow-Up ratio	0				
Referrals to 2º Care	1973	348	686,604		
Follow-Ups	0	0	0		
2º Cost			**686,604**	(34,800)	(4.82%)
CAS			44,000	44,000	
CATS			111,683	111,683	
Total Cost 2005/06			**842,287**	**120,883**	
(Savings) / Net Increased Costs			**120,883**		
2005/06 Increased Cost with CAS/CATS			120,883		
(Savings) / Net Increased Costs			**(47,201)**		

Without CAS/CATS

2004/05

	Activity	Tariff	£	Var	Var %
Total Referrals	2073				
Follow-Up ratio	0				
Referrals to 2º Care	2073	348	721,404		
Follow-Ups	0	0	0		
Total Cost 2004/05			**721,404**		
2005/06					
Total Referrals	2556				
Follow-Up ratio	0				
Referrals to 2º Care	2556	348	889,488		
Follow-Ups	0	0	0		
2º Cost			**889,488**	168,084	23.30%
Total Cost 2005/06			**889,488**	**168,084**	
(Savings) / Net Increased Costs			**168,084**		

CATS Review Activity Costing Analysis – East & North Hertfordshire PCT

Skin / Plastics

TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	3115				
Follow-Up ratio	0				
Referrals to 2º Care	3115	554	1,725,710		
Follow-Ups	0	0	0		
Total Cost 2004/05			**1,725,710**		
2005/06					
Total Referrals	3446				
Follow-Up ratio	0				
Referrals to 2º Care	2939	554	1,628,206		
Follow-Ups	0	0	0		
2º Cost			**1,628,206**	(97,504)	(5.65%)
CAS			30,400	30,400	
CATS			68,100	68,100	
Total Cost 2005/06			**1,726,706**	**996**	
(Savings) / Net Increased Costs			**996**		
2005/06 Increased Cost without CAS/CATS			183,374		
2005/06 Increased Cost with CAS/CATS			996		
(Savings) / Net Increased Costs			**(182,378)**		

Without CAS/CATS

2004/05	Activity	Tariff	£	Var	Var %
Total Referrals	3115				
Follow-Up ratio	0				
Referrals to 2º Care	3115	554	1,725,710		
Follow-Ups	0	0	0		
Total Cost 2004/05			**1,725,710**		
2005/06					
Total Referrals	3446				
Follow-Up ratio	0				
Referrals to 2º Care	3446	554	1,909,084		
Follow-Ups	0	0	0		
2º Cost			**1,909,084**	183,374	10.63%
Total Cost 2005/06			**1,909,084**	**183,374**	
(Savings) / Net Increased Costs			**183,374**		

CATS Review Activity Costing Analysis – East & North Hertfordshire PCT

Orthopaedics — TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2004/05

	Activity	Tariff	£	Var	Var %
Total Referrals	10803				
Follow-Up ratio	1.9				
Referrals to 2º Care	10803	160	1,728,480		
Follow-Ups	20526	74	1,518,924		
Total Cost 2004/05			**3,247,404**		

2005/06

	Activity	Tariff	£	Var	Var %
Total Referrals	11706				
Follow-Up ratio	1.9				
Referrals to 2º Care	10743	160	1,718,880		
Follow-Ups	20412	74	1,510,488		
2º Cost			**3,229,368**	(18,036)	(0.56%)
CAS			41,290	41,290	
CATS			69,360	69,360	
Total Cost 2005/06			**3,340,018**	**92,614**	

(Savings) / Net Increased Costs	**92,614**
2005/06 Increased Cost without CAS/CATS	271,464
2005/06 Increased Cost with CAS/CATS	92,614
(Savings) / Net Increased Costs	**(178,850)**

Without CAS/CATS

2004/05

	Activity	Tariff	£	Var	Var %
Total Referrals	10803				
Follow-Up ratio	1.9				
Referrals to 2º Care	10803	160	1,728,480		
Follow-Ups	20526	74	1,518,924		
Total Cost 2004/05			**3,247,404**		

2005/06

	Activity	Tariff	£	Var	Var %
Total Referrals	11706				
Follow-Up ratio	1.9				
Referrals to 2º Care	11706	160	1,872,960		
Follow-Ups	22242	74	1,645,908		
2º Cost			**3,518,868**	271,464	8.36%
Total Cost 2005/06			**3,518,868**	**271,464**	

(Savings) / Net Increased Costs	**271,464**

9.3 Appendix 3 West Hertfordshire PCT

CATS Review Activity Costing Analysis - West Hertfordshire PCT

6 Months: Apr - Sep 2006

OUTPATIENTS

	Total Outpatient Activity	GP Referral to CAS	% GP Referral to CAS	% Retained in CATS	% Returned to GP	% Referred to Secondary Care	GP Referral to Secondary Care	CAS Referral to Secondary Care	Total Secondary Care Activity	Total Retained by CATS	Total Returned to GP	Total GP Referrals	GP Referral % movement on year	Secondary Care % movement on Year
Flowchart		*1*					*2*	*3*	*2 + 3*	*4*	*5*	*1 + 2*		
MSK (W3R & Dac)														
2005/06-Qtrs 1 & 2	4289			0%	0%	0%	4289	0	4289	0	0	4289		
2006/07-Qtrs 1 & 2	3906	3354	63%	41%	0%	59%	1972	1934	3906	1382	0	5288	23.29%	(8.93%)
MSK (St Albans)														
2005/06-Qtrs 1 & 2	1724			0%	0%	0%	1724	0	1724	0	0	1724		
2006/07-Qtrs 1 & 2	1450	1616	67%	44%	16%	40%	804	646	1450	711	259	2420	40.37%	(15.89%)

DAY CASE

	Day Case Activity (WHHT)	GP Referral to CAS	% GP Referral to CAS	% Retained in CATS	% Returned to GP	% Referred to Secondary Care	GP Referral to Secondary Care	CAS Referral to Secondary Care	Total Secondary Care Activity	Total Retained by CATS	Total Returned to GP	Total GP Referrals	GP Referral % movement on year	Secondary Care % movement on Year
Flowchart		*1*					*2*	*3*	*2 + 3*	*4*	*5*	*1 + 2*		
Minor Skin Procs. (W3R & Dac)														
2005/06-Qtrs 1 & 2	773			0%	0%	0%	773	0	773	0	0	773		

CAS estimated cost with current staffing – West Hertfordshire PCT

OUTPATIENTS

PERIOD: APRIL to SEPTEMBER 2006

CAS estimated cost with current staffing

	Establish-ment WTE	In Post WTE	Cost £	MSK (W3R & Dac)	Minor Skin Procs. (W3R & Dac)	MSK (St Albans)
Team Lead	1	1	29,000	13,050	1,450	
PCA's	2	2	41,000	18,450	2,050	
Total			**£70,000**	**£31,500**	**£3,500**	
CATS						
MSK (W3R & Dac)			£165,500	165,500		
Minor Skin Procs. (W3R & Dac)			£12,880		12,880	
MSK (St Albans)			£72,000			72,000
TOTAL			**£320,380**	**£197,000**	**£16,380**	**£72,000**

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Secondary Care Savings – West Hertfordshire PCT

Follow-Up ratio	Retained by CATS	Returned to GP	Total Redirected from Secondary Care	Tariff	MSK (W3R & Dac)	Minor Skin Procs. (W3R & Dac)	MSK (St Albans)
MSK (W3R & Dac)	1382	0	1382	160	221,120		
1.9			2626	74	194,324		
Minor Skin Procs. (W3R & Dac)	92	41	133	579		77,007	
MSK (St Albans)	711	259	970	160			155,200
1.9			1843	74			136,382
TOTAL SAVINGS					**£415,444**	**£77,007**	**£291,582**

NET SAVINGS / (COSTS)	**£218,444**	**£60,627**	**£219,582**

DRAFT FOR CONTRIBUTER AND EXECUTIVE TEAM REVIEW - NOT FOR CIRCULATION

CATS Review Activity Costing Analysis – West Hertfordshire PCT

OUTPATIENTS

CAS estimated CATS costs			**6 months**	
MSK (W3R & Dac)				
			£	
Activity Retained in CATS	1382			
Annual Costs			£331,000	
Cost - 6 months		£120	**£165,500**	
Minor Skin Procs. (W3R & Dac)				
		Tariff	£	
Activity Retained in CATS	92			
Fixed Price		£140		Average
Cost			**£12,880**	
MSK (St Albans)				
			£	
Activity Retained in CATS	711			
Cost per Month - 6 mths			£12,000	
Cost		£101	**£72,000**	

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CATS Review Activity Costing Analysis - West Hertfordshire PCT

6 Months: April to September 2006

MSK (W3R & Dac) — TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	4289				
Follow-Up ratio	1.9				
Referrals to 2º Care	4289	160	686,240		
Follow-Ups	8149	74	603,026		
Total Cost 2005/06			**1,289,266**		
2006/07					
Total Referrals	5288				
Follow-Up ratio	1.9				
Referrals to 2º Care	3906	160	624,960		
Follow-Ups	7421	74	549,154		
2º Cost			**1,174,114**	(115,152)	(8.93%)
CAS			31,500	31,500	
CATS			165,500	165,500	
Total Cost 2006/07			**1,371,114**	**81,848**	
(Savings) / Net Increased Costs			**81,848**		

	£
2006/07 Increased Cost without CAS/CATS	300,292
2006/07 Increased Cost with CAS/CATS	81,848
(Savings) / Net Increased Costs	**(218,444)**

Without CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	4289				
Follow-Up ratio	1.9				
Referrals to 2º Care	4289	160	686,240		
Follow-Ups	8149	74	603,026		
Total Cost 2005/06			**1,289,266**		
2006/07					
Total Referrals	5288				
Follow-Up ratio	1.9				
Referrals to 2º Care	5288	160	846,080		
Follow-Ups	10047	74	743,478		
2º Cost			**1,589,558**	300,292	23.29%
Total Cost 2006/07			**1,589,558**	**300,292**	
(Savings) / Net Increased Costs			**300,292**		

CATS Review Activity Costing Analysis – West Hertfordshire PCT

Minor Skin Procs. (W3R & Dac)

6 Months: April to September 2006
TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	773				
Follow-Up ratio	0				
Referrals to 2º Care	773	579	447,567		
Follow-Ups	0	0	0		
Total Cost 2005/06			**447,567**		

2006/07	Activity	Tariff	£	Var	Var %
Total Referrals	587				
Follow-Up ratio	0				
Referrals to 2º Care	454	579	262,866		
Follow-Ups	0	0	0		
2º Cost			**262,866**	(184,701)	(41.27%)
CAS			3,500	3,500	
CATS			12,880	12,880	
Total Cost 2006/07			**279,246**	**(168,321)**	
(Savings) / Net Increased Costs			**(168,321)**		

2006/07 Increased Cost without CAS/CATS	(107,694)
2006/07 Increased Cost with CAS/CATS	(168,321)
(Savings) / Net Increased Costs	**(60,627)**

Without CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	773				
Follow-Up ratio	0				
Referrals to 2º Care	773	579	447,567		
Follow-Ups	0	0	0		
Total Cost 2005/06			**447,567**		

2006/07	Activity	Tariff	£	Var	Var %
Total Referrals	587				
Follow-Up ratio	0				
Referrals to 2º Care	587	579	339,873		
Follow-Ups	0	0	0		
2º Cost			**339,873**	(107,694)	(24.06%)
Total Cost 2006/07			**339,873**	**(107,694)**	
(Savings) / Net Increased Costs			**(107,694)**		

DRAFT FOR CONTRIBUTER AND EXECUTIVE TEAM REVIEW -
NOT FOR CIRCULATION

CATS Review Activity Costing Analysis – West Hertfordshire PCT

MSK (St Albans)

6 Months: April to September 2006
TOTAL COMMISSIONING COSTS COMPARISON

With CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	1724				
Follow-Up ratio	1.9				
Referrals to 2º Care	1724	160	275,840		
Follow-Ups	3276	74	242,424		
Total Cost 2005/06			**518,264**		
2006/07					
Total Referrals	2420				
Follow-Up ratio	1.9				
Referrals to 2º Care	1450	160	232,000		
Follow-Ups	2755	74	203,870		
2º Cost			**435,870**	(82,394)	(15.90%)
CAS			0	0	
CATS			72,000	72,000	
Total Cost 2006/07			**507,870**	**(10,394)**	
(Savings) / Net Increased Costs			**(10,394)**		
2006/07 Increased Cost without CAS/CATS			209,188		
2006/07 Increased Cost with CAS/CATS			(10,394)		
(Savings) / Net Increased Costs			**(219,582)**		

Without CAS/CATS

2005/06	Activity	Tariff	£	Var	Var %
Total Referrals	1724				
Follow-Up ratio	1.9				
Referrals to 2º Care	1724	160	275,840		
Follow-Ups	3276	74	242,424		
Total Cost 2005/06			**518,264**		
2006/07					
Total Referrals	2420				
Follow-Up ratio	1.9				
Referrals to 2º Care	2420	160	387,200		
Follow-Ups	4598	74	340,252		
2º Cost			**727,452**	209,188	40.36%
Total Cost 2006/07			**727,452**	**209,188**	
(Savings) / Net Increased Costs			**209,188**		