SPECIAL MEETING OF THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MEETING, 6TH FEBRUARY, 2007

Present – Councillors Morgan (Chair), Greenhalgh (Vice–Chair), Burrows, Connell, Mrs. Fairclough, Hornby, Lord, Mrs Rothwell, Spencer, J. Walsh (deputy for Councillor Hollick) and A. Wilkinson.

Councillor Clare	-	Executive Member for Adults' Social Care and Health
Councillor Morris	-	Chair, Bolton Hospital Trust

Also in attendance:-

Ms. A. Gannon	-	Director of Health and Social Care Integration
Mr. D. Fillingham	-	Chief Executive, Royal Bolton Hospital
Mr. D. Grogan	-	Assistant Director, Legal and Democratic Services
Ms. H. Dobrowolska	-	Assistant Chief Executive, Bolton PCT
Mr T. Evans	-	Chief Executive, Bolton PCT
Mr. M. Maguire	-	Bolton PCT
Ms. J. Was	-	Strategic Health Authority
Ms. P. Senior	-	Chair, Bolton PCT
Mr. R. Landon	-	Head of Democratic Services
Mr. N. Aspey	-	Senior Democratic Services Officer
Miss. K. Treadwell	-	Democratic Services Officer

Representatives from the Local PPI Forums and Trade Unions.

Apologies for absence were received from Councillors L. Byrne, Hollick, R. Ronson and J. Silvester.

Councillor Morgan in the Chair.

38. PROPOSALS FOR THE INTRODUCTION OF INTEGRATED CLINICAL ASSESSMENT AND TREATMENT SERVICES – TO CONSIDER THE POLICY CONTEXT AND IMPLICATIONS FOR BOLTON

Mr. M. Maguire, Bolton PCT, gave a presentation which gave Bolton's PCT's response to the proposals for Integrated Clinical Assessment and Treatment Services (ICATS). In addition, Royal Bolton Hospital also gave a presentation which outlined its views on ICATS.

Mr. M. Maguire informed members that Outpatient waiting lists stood at approximately six months in Bolton and that diagnostic tests could take anything up to twenty weeks to be performed. It was stated that if ICATS were introduced the waiting time for outpatient services would be compressed to eighteen weeks. Waiting times were classed as from the G.P referral till the date of the procedure.

Mr. M. Maguire stated that another issue regarding the current referral system was that, due to long waiting times some patients did not have their procedure done due to ill health.

Mr Maguire then went on to highlight what ICATS could provide for Bolton:-

- clinical triage;
- clinical assessment;
- first line diagnostics;
- treatment planning;
- pre-op Assessment;
- second line diagnostics;
- minor treatment;
- follow up case care and time limited; and

- therapy (physiotherapy etc)

Mr. Maguire stated that ICATS built on the work of Greater Manchester PCTs in developing tier two services and was in line with national policy. It was predicted that 85% of patients treated under the ICATS would have a two week wait.

The presentation highlighted that although ICATS built on the tier two service, ICATS would be able to treat a greater volume of patients. Examples were given of how ICATS would work in specific cases.

The presentation advised that Bolton PCT had had an ICATS type service running in three areas for over a year. This had meant that hundreds of patients had had surgery in less than eighteen weeks, this was two weeks ahead of the national target.

Mr. Maguire outlined the key principles of ICATS:-

- contracts with the Independent Sector;
- five year agreement;
- choice and plurality;
- additional capacity;
- expand new ways of working; and
- technological solutions.

In addition, Mr Maguire highlighted the main objectives for the Service:-

- achievement of the eighteen week target;
- greater choice for patients; and
- promising innovation.

The presentation stated that the target commencement date was set for March, 2008.

Mr Maguire advised that Acute Hospitals could compete with other hospitals regarding ICATS services. However, these hospitals should both be attempting to attain the same performance standards. There

would be no exclusive contracts from G.Ps to a provider as it would be patients who would have the choice.

Mr Maguire stated that Bolton PCT estimated the financial implications for the Royal Bolton Hospital would be a maximum of £1.6 million. This potential loss could be offset by the following:-

- women and children's reconfiguration;
- ability to develop services to the ICATS specification; and
- additional surgical activity.

Mr. Maguire concluded his presentation by stating that there had been a series of events held across Greater Manchester to discuss the implications of ICATS to which the Royal Bolton Hospital had been invited.

Mr D. Fillingham, Royal Bolton Hospital, gave a presentation, in light of the PCT's presentation, which outlined the hospital's response to the ICATS proposals.

The presentation highlighted that the Independent Sector (IS) were being asked to take over the Outpatient assessment and associated diagnostics of 90% of GP referrals in five major surgical specialities – ENT, Urology, Gynaecology, General Surgery and Orthopaedics.

In addition, the presentation went on to make the following points about ICATS:

- Location and staffing arrangements for the IS ICATs were not yet known. However, one of the sites would be Bolton;
- patient pathways had not yet been designed and it was not clear, for example, whether patients would require a further Outpatient appointment as well as an ICATS attendance;
- It was unclear whether patients seen in ICATS would then be referred to an NHS hospital for further treatment or to the IS; and
- In Lancashire and Cumbria there was a similar development known as CATS (Capture, Assessment and Treatment Services). Following representation by Trade Unions and MPs there was to be a period of public consultation.

Mr Fillingham went on to outline the affects that ICATS could have if it was implemented in Bolton:-

- Bolton already had locally delivered ICATS in Orthopaedics managed by the PCT and the implications in this speciality might not be too great;

- However, the PCT projections for the other specialities were for reductions of up to 90% in GP referrals with a consequent reduction in follow up appointments, for example, the overall reduction in outpatient activity for Urology from 2006/07 to 2009/10 would be -62%;

- there would be reductions in associated diagnostics – particularly radiology, pathology and audiology;

- this would amount to £3.7 million of income and could potentially affect up to 130 jobs by 2008/09; and

- the IS ICATS providers aimed to be up and running by the end of 2007.

The presentation did state that Bolton PCT were committed to working collaboratively with the hospital to find pragmatic solutions to the risks which ICATS might pose. However, the Hospital had still identified potential risks which caused concern. These included:-

- loss of income from outpatients and diagnostics;

- loss of consequent elective activity if subsequent referrals went elsewhere;

- de-skilling of staff (such as gynaecologists no longer able to perform colposcopies) and loss of training opportunities;

- added steps for the patient, lack of co-ordinated care and breakdown of relationship between GPs and consultants; and

- strategic impact of weakened gynaecology and ENT services at a time when the hospital was to be asked to act as a “super centre” for women’s and children’s services.

However, the potential benefits of ICATS if effectively managed would lead to 'one stop shop' services with quicker access, fewer visits for patients and a reduction in unnecessary hospitalisation. In addition, competition and choice could encourage innovation to improve quality and drive down costs.

Mr Fillingham advised that the Hospital's proposals regarding ICATS were as follows:-

- a period of public engagement and discussion;

- the ability to compete on a level playing field with the IS should the hospital decide to do so;

- the ability to enter into joint ventures with the IS: this might protect both income for the Hospital Trust and employment for some Hospital staff;

- a mechanism to protect staff adversely affected by ICATS; and

- greater clinical engagement in the design of ICATS related pathways.

Mr Fillingham concluded the presentation by stating that the greatest risk and uncertainty was in relation to the IS ICATS proposals. Over the next three years the Hospital would gain over £10 million in new income, but would also loose more income than that amount through ICATS and reductions in emergency admissions. A redesign strategy was needed to change the balance of what the Hospital did in order to retrain and redeploy staff as the mix of services offered altered.

During the ensuing discussion the following points were raised by members:-

- that the Hospital would now be able to compete with the IS providers in providing ICATS was welcomed;

- the attempts by Bolton PCT to achieve the national waiting time target of 18 weeks from GP referral to first treatment was acknowledged;

- concern regarding the inadequate engagement of professionals and partner agencies in the development of the proposals;

- that the proposed changes constituted a ‘significant variation’ in the way the service was both commissioned and delivered and should therefore have been submitted to the Committee as a formal consultation;

- that the lack of consultation with the local PPI Forum was worrying as they should be central to the development of this policy and its implementation;

- concern regarding the consultation with GPs and their knowledge of how the new system would work;

- the impact of the loss of income from outpatients and diagnostics;

- whether the hospital had a ‘level playing field’ to compete with the Private Sector Providers; and

- concern regarding the potential de-skilling of staff and loss of training opportunities.

Resolved – (i) That the presentations be noted and recommended:-

(ii) That further engagement takes place with relevant professionals and partner agencies with regard to ICATS services.

(ii) that bodies such as the PPI Forum and Trade Unions be fully consulted with regard to the ICATS proposals, as now detailed.

(The meeting started at 9.30am and finished at 11.30am)