NHS
Wirral Clinical Commissioning Group

Jordan Lane
Corporate Officer
Direct Line: 0151 643 5334
Email: foirequests.nhswirralccg@nhs.net

Date: 02.03.2015

NHS Wirral Clinical Commissioning Group
Old Market House
Hamilton Street
Birkenhead
Wirral
CH41 5AL
Tel: 0151 651 0011

Re: Freedom of Information Request

Thank you for your request for information made under the Freedom of Information Act 2000 which was received into this office on 10.02.2015.

You Asked for:

1. **Can you tell me what are the key research evidence and other sources which were and are being used in the production of the CCG's Vision 2018 strategy?**

   NHS planning has in the past been successful in supporting the delivery of annual incremental improvement. However due to the unprecedented challenges facing the NHS and Social Care, a longer term view of the planning of services to reflect the transformational change required is necessary.

   NHS Wirral Clinical Commissioning Group's strategy and plans have developed taking into account this level of challenge, together with a number of strands of work including:

   Legacy Strategies

- The NHS Wirral Clinical Commissioning Group 2013-2016 Strategic Plan

   Currently available guidance and evidence base

- The NHS Constitution
- Joint Strategic Needs Assessment (available at http://info.wirral.nhs.uk)
- 2015/16 Planning Guidance: The Forward View Into Action:
- Planning For 2015/16
- CCG Assurance Framework
- A 'Call to Action' letters and guidance
- Better Care Fund guidance
- Commissioning for Value information
- Regional Directors of Finance Planning Assumptions
- Performance Reports
- Engagement Insights working directly with the Vision 2018 Engagement with People Group
- 10 ideas for 21st Century Healthcare. Innovation Unit 2014.
- Health Foundation June 2011 – Evidence in Brief: Getting Out of Hospital

- Royal College of Nursing March 2013. Moving care to the community an international perspective
- Kings Fund Feb 2014 Service Transformation-Lessons Mental Health
- All together now : making integration happen. London : NHS Confederation, 2014
- Commissioning and contracting for integrated care. London : The King's Fund, 2014
- Providing integrated care for older people with complex needs : lessons from seven international case studies. London : The King's Fund, 2014
- Leading local partnerships : how CCGs are driving integration for their patients and local populations. London : NHS Clinical Commissioners, 2014
- Commissioning primary care : transforming healthcare in the community. Briefing ; February 2014 London : NHS Clinical Commissioners, 2014
- Lessons from experience : making integrated care happen at scale and pace. London : The King's Fund, 2013
- Evidence review : integrated health and social care. Skills for Care discussion paper ; October 2013 Leeds : Skills for Care, 2013

2. In addition to that general question above there are three sets of specific questions:

a. What evidence about clinical and cost effectiveness was used to produce the strategy?

i. For example, Vision 2018 refers to an emphasis on, "More hospital services in the community, with consultant led teams". Yet the evidence nationally and locally runs counter to this move. 'Community' clinics are not more cost effective; they are more expensive (http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0005/81266/BP-08-1210-035.pdf). It becomes more complicated when patients need to be referred on; who takes care of hospital in-patients who (e.g.) develop a complication if the service is moved away from the hospital?

There has been national and international research into the effectiveness of moving services from hospital to community settings, see further references below. The evidence shows that it is beneficial to deliver aspects of their care in a community setting for certain groups of the population e.g. disease-specific services or pathways. For example the majority of case studies that focused on specific services showed that patient experience is improved, health outcomes are similar and there were reduced costs[1]. The evidence states the importance not to just move the same service from hospital into the community but to redesign the pathway for the patient/service user so the services are designed to meet the needs of the patients and they receive appropriate treatment at the right time in the most appropriate setting[1].

There are numerous options for the delivery of community based services, models are developed that include the skills of specialist nurses, social workers, GPs, consultants, GPs with Special Interests (GPSIs) and other professionals to ensure the model is suitable for the needs of the patients. The evidence base shows that an integrated approach to the new models is the most effective way to coordinate care for patients and reduce organisations duplicating work[2].

Therefore, to identify which services are suitable to be available in the community the Programme Managers of the different Vision 2018 workstreams are reviewing the evidence base and developing the models with staff, patients, service users and carers prior to implementing any changes. Any changes would need to adhere to NICE guidance and meet

clinical safety standards, this will include having access to appropriate clinical and medical skills and equipment to meet the needs of patients if a complication arises.

ii. How does professional development work when there is no education and training infrastructure on-site?

As experience has already shown, the shared responsibilities between individual employees and their employing organisations for ensuring the CPD of medical / professional personnel are unaffected by any changes to the location within which they are based: as now, these continue to revolve around regular supervision and ensuring that identified training needs are met – including those relating to registered staff.

If by 'infrastructure' you are thinking simply of the proximity of a specific physical training centre, it is acknowledged that community based staff may have to travel slightly further to any events held in that than their hospital based colleagues. However, increasingly staff development activities take place without the need to be physically in a training centre and, in any case, as all Vision 2018 partner organisations have their own training facilities, the range of options available to particular teams or groups of staff may actually increase.

Both NHS and social care services have a history of giving priority to ensuring that the professional development needs of their staff are met. That underlying commitment does not change in any shift from hospital to community based services: the details of how that continues to be met locally will always form part of management's consultation with all directly affected staff (and their recognised representatives or professional bodies) as specific changes are worked through.

b. How do you counter the allegation that the term 'consultant-led' is a euphemism? In the Virgin Southport dermatology clinic, for example, this means the consultant coming and running a clinic one day every two months - unlike hospital clinics where the consultant is always available.

If a service is Consultant led this means that the consultant retains overall clinical responsibility, the consultant is not necessarily physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care. The number of times that the Consultant will visit the patient will depend on the patient pathway requirements i.e. based on NICE guidance for that condition and the patient's individual needs.

c. How do you respond to this evidence from David Eedy, president of the British Association of Dermatologists, referring to the transfer of work from a large teaching hospital to 'the community' in the form of Circle Health? "From a tertiary referral centre staffed by consultants widely recognised as national authorities on eczema, psoriasis, paediatrics, occupational, surgical and vulval and mucosal dermatology to a functional department dependent on non-CCT consultants in a few years is a national travesty brought about by the perverse incentives of commissioning in a 'new NHS'".

The CCG has no current plans to transfer dermatology work from secondary care providers to community providers. The CCG has however facilitated collaborative stakeholder meetings between Wirral's secondary care and community providers to develop pathways to ensure right place, right time, right clinician. These pathways are near to completion and will be implemented as part of our Vision 2018 aims to deliver effective coordinated care.

References

1. Health Foundation June 2011 – Evidence in Brief: Getting Out of Hospital

2. Royal College of Nursing March 2013. Moving care to the community an international perspective

3. Kings Fund Feb 2014 Service Transformation-Lessons Mental Health

I hope this sufficiently answers your FOI enquiry however if you require any further information please do not hesitate to contact a member of the FOI team (contact details at the top of this letter).

Yours sincerely

Paul Edwards
Director of Corporate Affairs
NHS Wirral Clinical Commissioning Group

Re- Use of Information