integrated working

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Dear

Initial Outline Commissioning Intentions 2014/15

This letter sets out the initial outline commissioning intentions of the West Suffolk Clinical Commissioning Group (WSCCG) for 2014/15. It signals the start of the contracting process and is designed to:

- Outline the CCGs strategic direction;
- Give advance warning of changes, opportunities and threats to providers.

The next two years will be financially challenging for WSCCG and it is likely that substantial efficiencies (in the region of 2 – 3% per year) will need to be made particularly in 2015/16. 2014/15 will therefore be a year where radical pathway redesigns are considered and difficult decisions are made about services which could result in decommissioning in some areas.

1. Strategic Initiatives

WSCCG aims to deliver the highest quality health service in the west of Suffolk through integrated working with patients and stakeholders.

We have worked hard to engage with our local patients and stakeholders through patient revolution events and this feedback has fully influenced our work plan.

In addition we have worked closely in developing these commissioning intentions in conjunction with our key statutory partners such as Suffolk County Council. We also work as part of a broader system, County wide, regionally and nationally and our priorities also therefore reflect this.

These commissioning intentions will need to reflect existing and emerging national and regional guidance and policy.

WSCCG has developed six clinical priorities as set out below which will help deliver our ambition;

- Develop clinical leadership;
- Demonstrate excellence in patient experience and patient engagement;
- Improve the health and care of older people;
- Improve access to mental health services;
- Improve health and wellbeing through partnership working;
- Deliver financial sustainability through quality improvement.

It should be noted that there are existing projects and programmes of work that WSCCG will continue to implement and develop with providers. This document does not include ongoing review of existing contracts for services which are a recurring requirement. The focus of this document is to signal either a new or extension of existing developments that will be a priority in 2014/15.

i. Public and Patient Involvement

Public and patient involvement has been an exceptionally important part of our commissioning intentions process this year. We want to improve how we operate so that patients and the public genuinely have a say in how we plan our work programme.
So far we have:

- A vibrant Community Engagement Group, which is a sub-committee of the CCG;
- Held two specific commissioning intentions workshops for integrated care and planned care – the two largest areas which need massive service redesign.
- Held an event attracting 200 members of the community to share their views on services;
- Encouraged 300 members of the community to sign up to a Health Forum, where we share information and ask for views on general services.

In the future we will:

- Make sure all service areas have patient and public representation to meaningfully affect commissioning intentions in the future;
- Grow our Health Forum membership and share our progress;
- Ensure our Community Engagement Group guides us to further improve our patient engagement in all areas.

ii. Patient Safety and Quality

WSCCG fully embraces the recommendations of the 'Francis Report' from its development of a direct email address to enable communication from GPs on commissioned services to the development work undertaken on the structure of visits by the Clinical Commissioning Group to services, in reviewing quality and patient safety.

We note here our intention to implement the recommendations of the over-arching report by the National Advisory Group on the Safety of Patients in England, A Promise to Learn – a Commitment to Act, Improving the Safety of Patients in England. This approach supports that patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts.

iii. Healthy Ambitions

In partnership with Public Health and Suffolk County Council (SCC) the prevention programme aims to improve the health and well-being of the population of the west of Suffolk and to reduce health inequalities. Through agreeing performance indicators or incentive schemes the programme will:

- Improve access to Alcohol and Substance Misuse treatment services;
- Improve access to psychological therapy for those within alcohol and substance misuse treatment services increasing their changes of achieving recovery and improving their quality of life;
- Ensure all patients flow through the weight management pathway appropriately and only have bariatric surgery when everything else has failed.

More specifically the programme has the following intentions:

- Previous needs assessment (ARCS, 2008) and current alcohol health needs assessment (2013) identify A&E as an under-utilised source of referrals to drug and alcohol treatment services (including frequent attenders). The introduction of routine alcohol and substance misuse screening, signposting and referral to appropriate services could move individuals with alcohol and substance misuse needs into planned treatment, rather than reactive acute care;
- Improve lower level mental health support to substance and/or alcohol misusers via the Wellbeing service. To aid individuals chances of recovery;
- Reduced ‘did not attend’ rates for individuals referred from the Marginalised Vulnerable Adults Service to CRI (Substance Misuse Treatment Service) or the Suffolk Alcohol Treatment Service (Norfolk and Suffolk Foundation Trust) could decrease demand on A&E services;
- A review of the obesity pathway and weight management treatment services could improve the quality of interventions for those requiring bariatric care and reduce costs. In particular there is a need to establish Tier 3 support in county rather than use Addenbrookes and ensure that all patients should first be offered Tier 2 support before escalation.

iv. Integrated Care

Overarching aims of the Workstream

The Integrated Care Workstream aims to improve patients’ experience of urgent care, reduce the number of emergency admissions, length of stay in hospital and the number of people who are placed into long term care by:

- Bringing all elements of the health and care system together to manage more people away from crises, urgent care support and into planned care interventions including self-management;
- Ensuring that the provision of emergency and urgent care has fully integrated 24/7 services and a simple way for patients to access them.

The Workstream will be focussing on three particular areas of development over the next two years which include:

- Improving the delivery of emergency and urgent care through whole system redesign;
- Further development of primary and secondary prevention of ill health through interventions such as assistive technology and community development programmes that can safely support people at home;
- Enhancing the current provider landscape through joint working with SCC commissioning colleagues to formally recognise the role of family carers, voluntary and independent organisations as partners of care.

As the first key priority initiative, the CCG will work with the urgent care system and, in partnership with Suffolk County Council, develop a new model of Emergency and Urgent Care provision in the west of Suffolk informed by the key principles arising out of the National Review 2013/14. This will include the review of service specifications for primary care out of hours services, Urgent access number '111' and Community Services (in line with contract end dates).The new model will aim to go live in 2015 and will give consideration to:

- Integrated "whole system" care coordination 24/7;
- Single point of access;
- Access to range of responses including specialist urgent care support outside an acute hospital 24/7;
- Shared information across care pathway;
- The use of assistive technology.

As the second key priority initiative, the CCG will work with Ipswich and East CCG to implement the stroke specification for hyper acute stroke care locally. The CCG will procure the early supported discharge element of the stroke pathway in 2014.

As the third key priority initiative, the CCG will build on the work programme of 2013/14 around supporting frail people at home with a focus on the development of community networks which will include:

- Further development of the virtual wards with access to Comprehensive geriatric assessment;
- Market development that includes a broader range of services to support primary and secondary prevention of ill health that could be delivered in partnership with local communities;
- Implementation of the self-management strategy;
- Implementation of the family carer's strategy.

The fourth key priority initiative is for the CCG to improve patient experience and health outcomes by:

- Reducing the length of stay of frail elderly within an acute and community hospital;
- Providing alternatives to long term home care placements by:
    - Further development of the pull based discharge pathway across the system;
    - Exploring the joint commissioning of episodes/packages of care as a forerunner to Payment by Results (PbR) in Community contracting;
    - Develop alternatives with the third sector (voluntary and charitable) for longer term rehabilitation/reablement.

v. End of Life (EoL)

Overarching aims of the Workstream

This Workstream aims to:

- Support more people dying in their preferred place;
- Ensure EoL care is open and accessible to all within the West Suffolk CCG Locality;
- Ensure the patient experiences the best possible death in the preferred place or usual place of residence;
- Support the development of a well-educated workforce via an agreed EoL care education and training programme in order to deliver services closer to home;
- Ensure provision of an integrated, 24/7 crisis response service.

The following work programmes from 2013/2014 need to be further developed in order to fully embed into everyday clinical practice:

- End of life education across acute/hospice/community care – 95% coverage of training within care homes and primary care by March 2015;
- Electronic Palliative Care Co-ordination System;
- Advanced Care Planning (ACP) initiative including Yellow Folders – 95% of patients identified at end of life to have an ACP agreed;
- User involvement.

vi. Planned Care

Overarching aims of the Workstream:

- That services are local, where possible, and clinically appropriate with integration between healthcare providers and timely communication;
- For shared decision making to be throughout the pathways and patients with long term conditions to feel supported;

- That all patients receive the right care in the right place at the right time.

There are a number of areas which the CCG wish to focus on next year which are outlined below.

West Suffolk Pain Model

- Fully implement and monitor the impact of the newly developed Pain Pathway (Tier(s)1-3).

Ophthalmology Service

- Sustain and develop further services for the commissioned model for referral refinement and extended service providers. Develop a community service for the stable Glaucoma and wet Age-related Macular Degeneration (AMD). Review further opportunities to develop services in the community.

Clinical Management Service (CMS)

- CMS is currently operating at West Suffolk Hospital in a number of specialities to provide GPs with electronic advice and guidance on managing patients where clinically appropriate, thereby reducing the need for some patients to visit hospital.
- The CCG plans to extend CMS across all specialties (where appropriate) at West Suffolk Hospital.
- Develop further providers to offer CMS to GPs.
- Embed CMS to be the first choice for GPs on routine referrals.
- Link CMS with other advice and guidance options with other providers such as Cambridge University Hospitals Trust (CUHT).

Trauma & Orthopaedics (T&O)

- Develop community carpal tunnel opportunities with further providers.
- Review opportunities to deliver joint injections in the community.
- Review the virtual fracture clinic pilot with consideration to mainstream and extend to other T&O areas.

Diabetes Services

- Review and refresh the diabetic strategy for services in the west of Suffolk for patients with diabetes.
- Work with providers to commission diabetic services in the community as demonstrated from the outcomes of the pilot and review undertaken in 2013/14.
- Develop an urgent integrated diabetic foot service.

Cardiology

- Review community services for cardiology, especially for heart failure patients.
- Following the review develop community options for an integrated cardiology service.

Respiratory

- Review rehabilitation services in the community to ensure patients are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
- Develop services to ensure people with Chronic Obstructive Pulmonary Disease (COPD) are supported to manage their condition.

Dermatology

- Explore the possible development of a community dermatology service.

Female Continence Service

- Develop and implement a community based female continence service.

"One Stop Shops"/ Multidisciplinary Clinics

- Work with providers to develop clinically appropriate 'one stop shop' approaches to treat patients in order to reduce unnecessary clinic appointments and diagnostic procedures.

Development of telemedicine and non-face to face approaches to managing patients (e.g. telephone advice)

- Work with providers to explore opportunities to embrace technology and build on CQUIN digital by default approaches to ensure better use of skill mix and local pricing to deliver outpatient alternatives.

GP Practice Referral Support

- Develop a support package for GPs on the pathways and appropriate services to secondary care.
- To support GPs in reviewing their referrals in relation to their peers and any subsequent outcomes e.g. education events.

vii. Planned Care (High Cost Drugs)

Overarching aims of the Workstream

- Ensure that there is a consistent, evidenced-based, cost-effective commissioning programme for the implementation of all tariff excluded high cost drugs;

- Work collaboratively with acute trusts to create savings for the local health economy as a whole;
- Support the local trusts in repatriating activity.

Ensure that only drugs are funded for which consistent evidence exists:

- Work directly with providers to ensure a series of robust terms relating to high cost drugs are incorporated into the contracts;
- Ensure that NICE Technological Appraisals (TAs) are implemented within 90 days;
- Provide horizon scanning to forecast the likely impact of new NICE TAs before their implementation.

Ensure value for money:

- Maintain systems for the facilitation of appropriate payment and checking of all high cost drugs invoicing;
- Work with providers to ensure that patient confidential data issues have minimum impact on our ability to ensure public money is only spent on the most cost-effective treatments.

Improve patient experience and quality:

- Work with providers to review the use of high cost drugs with a view to repatriating care where possible;
- Work with the local providers to increase the basket of drugs available via homecare;
- Take a holistic view to patient care and the heath economy as a whole to look at moving Acute delivered High Cost Drugs into homecare.

viii. Medicines Management

Overarching aims of the Workstream

- To encourage safe, appropriate, evidence based and cost effective prescribing;
- To promote adherence to the same prescribing recommendations across primary and secondary care;
- To promote adherence to the Traffic Light System, as developed by the Suffolk CCGs' Drug and Therapeutics Committee and Clinical Priorities Group;
- To align actual prescribing spends with practice prescribing budgets.

Prescribing Recommendations

Implementation of the following:

- Metrics developed by the WSCCG Medicines Management Team;

- Metrics developed by NHS PrescQIPP, including DROP List (drugs of low priority);
- WSCCG ScriptSwitch recommendations;
- Dietetic reviews.

Traffic Light System

- Adherence to the classifications posted on the WSCCG Traffic Light System;
- Development, ratification and use of Shared Care Agreements for all drugs that have been classified as amber, i.e. drugs that are recommended for initiation by a secondary care specialist then transferred to GP prescribing under the terms of a Shared Care Agreement;
- Development, ratification and use of checklists, where appropriate, to demonstrate compliance with NICE TAs before the prescribing of green drugs (hospital initiated, GP prescribed) is transferred from secondary care specialists to GPs.

Medicines Optimisation

- Implementation of medication reviews in accordance with guidelines detailed in the NHS PrescQIPP document: Optimising Safe and Appropriate Medicines Use;
- Collaboration with WSCCG sessional pharmacists to optimise drug treatments for patients who are on complex regimes, e.g. those who are prescribed more than ten items. This should include patients in care homes.

ix. Mental Health

Overarching aims of the Workstream

- Mental health provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their mental health condition.
- No mental health service user should need to be returned to their GP for onward referral for another mental health service.
- Commission mental health and learning disability services which are integrated with the wider health and social system and which support the recognition that people's mental health should be seen as part of their overall physical and mental wellbeing. This will apply to all people regardless of their age including those marginalised from society.

Norfolk and Suffolk Foundation Trust (N&SFT) Service Delivery

The CCG will work with Ipswich and East Suffolk CCG in order to recognise our common local mental health provider, whilst reflecting any local differences in service priorities to further embed the new service model with an emphasis on:

- Embedding Mental Health PbR to ensure consistency in care packages so that they meet local needs whilst eliminating financial risk to commissioners and providers.

- Reviewing the effectiveness of new service pathways and 2013/14 CQUINS to make sure there is a robust crisis response and they meet the needs of people with personality disorders and dual diagnosis.

N&SFT and West Suffolk Hospital Psychiatric Liaison Service

- Work in partnership with N&SFT and West Suffolk NHS Foundation Trust to extend the 2013/14 Psychiatric Liaison Service CQUIN scheme into 2014/15, to include an evaluation of future commissioning arrangements identifying potential areas to further extend the service, possibly children and young people aged under 18, outpatients and long term conditions and medically unexplained symptoms.

Child and Adolescent Mental Health Services (CAMHS) (see also CYP programme)

- Embed and reinforce the new commissioning model and specification for the emotional wellbeing of children and their families through a joint commissioning approach between health and social care for; a comprehensive service across tiers 1 – 4 drawing together the wider network including education, social care and third sector; ensure a broader focus on early intervention and prevention, particularly developing conduct disorders and enhancing Tier 2 Primary Mental Health Workers (PMHW's).

Dementia

- WSCCG has set a target that by the end of 2015, 66% of those people with dementia will have received a diagnosis evidenced by the numbers on primary care QoF registers.
- To deliver this target, the CCG will commission additional diagnostic capacity and ensure sufficient post-diagnosis support through joint commissioning (with SCC) of community based services from statutory and third sector providers.
- Integrate the Dementia Intensive Support (DIST) service (funded via re-enablement monies) into the N&SFT Complexity in Later Life pathway. This service must then in turn fully integrate with the Suffolk Community Healthcare Community Intervention Service in order to reduce the number of unplanned admissions into acute hospital.
- Agree with all providers a methodology for systematically tracking dementia patients across services.

Joint working with Partners such as Suffolk County Council (SCC)

- Mental Health Pooled Fund: Review the current joint commissioning arrangements with SCC and reach agreement on future plans to commission rehabilitation services that effectively move patients on from inpatient services and repatriate back to the local area.
- CCG will work with SCC to review post-diagnosis dementia support through joint commissioning of community based services from statutory and third sector providers (*see dementia section*).

- CCG will work in partnership with SCC to modernise and re-commission our Learning Disabilities services across all ages to promote progression and independence.

x. Children and Young People and Maternity

Overarching aims of the Workstream

- Promotion of early intervention and prevention approaches.
- Improved multi-agency/professional working based around the child and family.
- A better experience for patients/service users, their families and carers.
- Strong effective partnership working.
- Improve outcomes for vulnerable groups such as Looked After Children (LAC).
- Focus on self- care / building resilience.

Management of Long Term Conditions

- Diabetes: Embedding the 'Year of Care' PbR tariff for <19s considering the level of avoidable emergency activity for diabetic patients.
- Asthma: Roll out the regional pathway for management of asthma.
- Epilepsy & Asthma Community Nurses: Implement and review a pilot for a community based nursing model.
- Looking at other areas to develop community nurse led care e.g. Dermatology.

Development of the Paediatric Urgent Care Pathway

- Review and mainstream the Paediatrician led GP Telephone Advice Line pilot at West Suffolk Hospital (WSH) (13/14 CQUIN).
- Development of a short stay tariff at WSH/ Urgent Paediatric OP clinics.
- Production of education and guidance materials with WSH for Primary Care/ Patients (e.g. Eczema / Feverish Child).
- Consultant Management Service (CMS): Written Consultant advice to GP's for paediatric conditions.
- Respond to the findings of the Suffolk Maternity Needs Assessment due to report in January 2014, focusing particularly on women's mental health.

Joint working with Partners such as Suffolk County Council

- Implementation of the recommendations of the Suffolk Children and Adolescent Mental Health Services (CAMHS) Strategy.
- Respond and implement the statutory requirements of the Children & Families Bill 2014.
- Respond and deliver the actions, with partners, as set out in the Looked After Children review completed in 2013.
- Review/refresh the current Learning Disability Service so that it meets the needs of our population.

- Continue to support the Suffolk Family Focus programme.
- Jointly work together to review and develop Children's Speech & Language Services (SALT).

Children's Emotional Health & Wellbeing

- Implement and review an under 18 years Eating Disorders Service in West Suffolk with Norfolk & Suffolk Foundation Trust.
- Commission and implement an age inclusive diagnostic service for Autism (focusing on a current service gap 11-18 years).
- Further develop our CAMHS service focusing on behaviour and conduct disorder (also see Joint working with SCC).

Longer Term Strategic Aspiration (beyond 2014/15)

- To move to a Single Referral Point of Access (SRPOA) for all Children's Services Providers, be they health or local authority provided, whereby referrals pass through one true conduit. The SRPOA may consist of a multi professional team to review and signpost to the most appropriate intervention first time.

xi. Cancer

Overarching aims of the Workstream

- For Cancer Care provision to be open and accessible to all within the West Suffolk Locality;
- To support cancer survivors and improving cancer survivorship;
- To improve early diagnosis and embed cancer as a long term condition;
- To provide up to date, quality and personalised cancer information – linking with the Shared Decision Making process (SDM).
- Provision of cancer care closer to home

Building on 2013/14 Commissioning Intentions

The following work programmes from 2013/2014 need to be further developed in order to fully embed into everyday clinical practice:

- Acute Oncology Service – to support the delivery of 10% reduction in emergency cancer admissions through implementation of the AOS operational framework;
- Endoscopy – extending access to endoscopy to support the national screening programme;
- Early Access to Diagnostics;
- GP Education;
- The HOPE programme – 95% of patients at the end of their treatment are offered a place on the HOPE programme;
- User involvement.

Further Areas for Development 2014/2016

- Expansion of the existing Acute Oncology Service (AOS) – 7/7;
- Consideration of the introduction of Complementary Therapies for cancer patients;
- Supporting the whole national survivorship agenda:
  - End of treatment summaries and care plans;
  - Information;
  - Access to education and Psychological support – HOPE;
  - Holistic Needs Assessment;
- Support for Carers;
- Improvement in early diagnosis;
- Evaluation of Community Cancer Nurse Pilot.

xii. Primary Care

The West Suffolk CCG GP practices will be commissioned to provide funded, targeted interventions in two ways. The Quality Point element of the Quality Outcome Framework requires the participating GPs to review six pathways, three in planned and three in unplanned care. Once their comments have been considered, and a final pathway decided upon, the West Suffolk CCG GPs that are participating will need to follow the pathway for all eligible patients until 31 March 2014.

The pathways chosen in 2013/14 focus on:

Planned

- Shoulder Pain: patients accessing physiotherapy before a secondary care referral.
- Lipid modification therapy.
- Irritable Bowel Syndrome (IBS) patient pathway.

Unplanned

- Antipsychotic Prescribing in Primary Care.
- Identification of a dementia co-ordinator for each GP Practice.
- Focus on preventing unnecessary admissions to hospital.

The new pathways for 2014/15 will be suggested by Primary Care in September 2013 GP Practice locality meetings based on the 2012/13 data supplied to them as part of the Quality Point process. These pathways will then be further developed during the remainder of 2013/14.

The second set of targeted incentives are in place until 31 March 2014 and were previously called Local Enhanced Schemes (LES). These incentive schemes are currently under review and subject to the outcome will either be terminated or developed further in 2014/15.

2. Quality, Innovation Productivity and Prevention (QIPP)

QIPP remains one of West Suffolk CCG's key priorities for 2014/15. There is a continuing need for new ideas that will help to sustain the financial health of the Suffolk health economy whilst maintaining or improving quality. Providers with ideas relating to changes in commissioning that will help fulfil this agenda are invited to share their ideas with West Suffolk CCG.

3. Market Reviews

West Suffolk will be undertaking the following procurements in 2014/15:

Service	Likely tender start	Service implementation date
Ophthalmology triage	Underway	April 2014
High cost drugs: management support	Winter 2013/2014	April 2014
Out of hours, 111 and potentially urgent care integration areas	April 2014	April 2015
Musculoskeletal physiotherapy	Spring 2014	Early 2015
Stroke early supported discharge	Early 2014	Late 2014
Community services	October 2014	October 2015

In addition there may be further market reviews in the following areas:

- Pain services.
- Learning disability services.
- Dermatology services.
- Community respiratory services.
- Myalgic Encephalomyelitis and Chronic Fatigue Syndrome

4. Activity Levels

The CCG will:

- Rationalise service tariffs where current mix of pricing mechanisms, i.e. block and cost & volume (includes diabetic nursing, community dietetics);
- Review day case procedures expected to be done as OP procedures and specify commissioning levels for these – not limited to, but including, drug injections (subcutaneous, intramuscular, joints) to be outpatient procedures and not day case (only IV infusions funded as day case, where necessary);

- Require compliance with national guidance over recording of day cases versus outpatient procedures;
- Require compliance with 2014/15 payment by results guidance and national data definitions;
- Review the pricing of non-consultant led OP and diagnostic tests;
- Develop pathways for outpatient services to achieve maximum efficiency and quality of care, e.g. one-stop clinics, multidisciplinary clinic, parallel clinics and triage to most appropriate clinics;
- Review maternity pathways to ensure compliance with PbR rules and no duplication of payments;
- Identify potential services eligible for Best Practice tariffs and agree plans/timetable for introduction (must have adequate supporting information).

Review of tariffs for emergency care which may require local tariffs to be developed and agreed.

In relation to pathology services:

- Subject to Office of Fair Trading ruling WSCCG will commission most of its pathology services from Transforming Pathology Partnerships a joint venture of local acute trusts;
- Any residual pathology that needs to be commissioned from local providers will be commissioned at 2013/14 tariff plus or minus standard NHS inflation net of efficiency;
- WSCCG expects providers to continue to provide the same range of services as available in 2013/14.

5. Performance Data / Information

For all contracts WSCCG intend the following:

- Continued on-going compliance with the reporting requirements of UNIFY 2 and SUS, which includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre Guidance and All Information Standards Notices (ISNs), where applicable to the service being provided.

- Where the provider is part of a multi provider pathway then the provider will be expected to proactively participate in the development of integrated information flows that are consistent, complete and timely and compliant with all mandatory data items.

- Any accountable provider who sub contracts out to other providers should provide evidence and assurance to WSCCG that their contracts and schedules with the sub contracted provider are consistent with their contract with WSCCG, so that all providers can be held accountable on the same basis.

- Proactive participation in the provision of daily information to support the system wide urgent care dashboard.

- Providers are required to submit any patient confidential data to the DSCRO (Data Service for Commissioners Regional Offices).

For any new Community Contract WSCCG intend the following:

- Completion, as a minimum, of the community Information dataset and on-going development to ensure that the provider is able to submit the Community Information dataset to SUS and as an interim measure will be able to submit it locally to WSCCG through the DSCRO.

For any new Community Contract WSCCG intend the following:

- Where statutory reporting is required to UNIFY2, Choose & Book, Omnibus, Open Exeter and other statutory reporting for a then the Provider should ensure that they are N3 compliant.

- Compliance with ISN 0149- where completion of NHS Numbers is a mandatory requirement.

6. Workforce

WSCCG will work to ensure that providers have an appropriate, capable and sustainable workforce. The commissioning of local services will need a workforce fit for purpose, as we change the shape of services and where necessary move them closer to patients' homes. Our local workforce will need to be highly flexible to respond to changes in how we deliver healthcare. As services across health and social care become more aligned and are delivered in more flexible ways in the community, providers and commissioners must work towards easing the transfer of staff between different employers and ensure they can minimise cost and maximise efficiencies where the workforce overlaps. WSCCG will commission services that are appropriately skilled and competent in providing high quality and safe services for patients.

I am sure you will agree that 2014/15 and beyond presents significant challenges to us given the recent changes in NHS structures, the financial environment and the imperative to maintain and improve the quality of services during a period of rapid and fundamental change. WSCCG looks forward to working with you in facing these challenges.

Yours sincerely

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Dr Christopher Browning
Chairman