NHS England

Revisions to Clinical Reference Groups in Specialised Commissioning:

Engagement period outcome report

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Description	This document sets out the outcome of the engagement period on proposed changes to how Clinical Reference Groups within specialised commissioning will operate and to their membership. It also sets out the final revised CRG structure that NHS England will now implement following stakeholder feedback.
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Revisions to Clinical Reference Groups in Specialised Commissioning: Engagement period outcome report

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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1 Acknowledgments

1. NHS England would like to thank all of the chairs and members of the Clinical Reference Groups for their continued support and help over the past few years. We would also like to thank those CRG chairs and members, individuals, patient groups and organisations that supported the engagement by contributing to the webinars and providing feedback on the revised proposals.

2 Introduction

2. NHS England is responsible for commissioning £15.6 billion of specialised services to meet a wide range of health and care needs. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders.

3. Clinical advice and leadership is vital to the success of improving the commissioning of specialised services across the NHS.

4. Clinical Reference Groups (CRGs) are an integral part of this and bring together groups of clinicians, commissioners, public health experts, patients and carers. They use their specific knowledge and expertise to advise NHS England on the best ways that specialised services should be provided.

5. CRGs lead on the development of clinical commissioning policies, service specifications and quality dashboards. They also provide advice on innovation, conduct horizon scanning, advise on service reviews, identify areas of unexplained clinical variation and guide work to reduce variation and deliver value.

6. CRGs, through their Patient and Public Voice (PPV) members, also help ensure that any changes to the commissioning of specialised services are co-produced with and involve patients and the public.

7. All the CRGs, with the exception of the cross cutting medicines management CRG, are grouped around and report into, one of six National Programme of Care (NPoC). Further details on the current arrangements for CRGs and the NPoCs they are aligned to, can be found on the NHS England website.

8. CRG membership currently consists of a chair who is a senior clinician in the relevant specialty, up to 14 specialty members from 'Senate' areas, four PPV members and four members from affiliated organisation (such as Colleges and Societies).

9. CRG chairs and members do not currently receive additional NHS England honoraria or payments for their work, but are supported by their employers to participate in CRGs.

10. NHS England has listened to feedback from CRG members and wider stakeholders on how the current system is working through workshops for chairs and PPV members held over the past 18 months. We also listened to feedback from CRG members and wider stakeholders through the Investing in Specialised Services public consultation in 2015.

11. The purpose of revising the specialised commissioning CRG structure was to respond to this feedback and also to ensure that this clinical advisory mechanism aligns with the priorities of NHS England as set out within the NHS Mandate, the strategic way forward within the Five Year Forward View, the need to ensure best value for patients and appropriate clinical advances and innovations.

3 The proposed revisions

12. In January 2016, NHS England's agreed to engage on proposals to streamline CRGs and enhance the support they get so as to expand their impact.

13. The following **guiding principles** have underpinned the proposals:

    a) Delivering clinically led commissioning that is consistent with NHS England principles and priorities. A competency framework and development programme for CRGs will be created with engagement of the PPV Assurance Group to ensure CRGs, under NPoC leadership, are focused on NHS England priorities and work within the NHS England operating model.

    b) CRGs Chairs to be a formal NHS England appointment – with remuneration at one Programmed Activity (PA) per week (four hours) – to bring recognition and accountability. In clinical areas that do not have a National Clinical Director or associate director, CRG chairs may take a specialty 'National Clinical Lead' role where NHS England requires this.

    c) Maintaining the CRG working model. There is a consensus that improving the current model rather than developing a new one is more likely to deliver constructive outputs in the timescales required.

    d) Providing comprehensive coverage of the specialised commissioning portfolio. In the proposal to reduce the number of CRGs from 67 to 44, those CRGs not providing specific support to areas that are a responsibility

of specialised service commissioning are removed, and those that currently cover related commissioned clinical services are combined.

e) Simplifying the operation of the CRGs. The previously agreed proposal (prior to consultation) reduces and refreshes the CRG membership, for a more streamlined, fully-engaged group. Clinical members will be reduced from 14 'Senate' area members to four regional clinical members. A new recruitment process will be run for all CRG Chairs. There will be a reduction in PPV members from four to two per CRG. Affiliated members will be maintained at up to four per CRG.

4 The engagement process

14. A 30-day engagement period took place with CRG members and wider stakeholders to test the proposals. An engagement guide was produced which set out the proposed revisions in detail and asked a number of questions.

15. To support the engagement process, NHS England hosted six webinars (one per NPoC) which were well attended. In total, NHS England received 437 responses through the consultation hub. We received a further 64 responses through email and post.

16. The key findings and themes that emerged from the engagement period are set out in Appendix 1 of this report alongside NHS England's response.

5 Changes to the general proposals that apply to all CRGs

17. Following the feedback received during the engagement period the following revisions to the proposals have been agreed by NHS England's Specialised Commissioning Oversight Group:

a) **NO CHANGE**: Additional resources have been identified for CRGs to support the work of the groups. Budgets will be allocated for increased administration support, holding meetings, planning engagement events and forming working groups.

b) **NO CHANGE**: The CRG Chairs will become a formal NHS England appointment with remuneration at one Programmed Activity (four hours a week). A recruitment process will be launched refreshing the chair for each CRG. All current CRG Chairs will have the option of applying in competition with new applicants for a three year appointment. All chairs will be accountable to the National Programme of Care Clinical Lead.

c) **NO CHANGE**: Patient and Public Voice members of CRGs will be eligible for involvement payments in recognition of their contribution to the work of their CRG where they are not supported by an organisation. This brings the

position for CRGs in line with other strategic PPV roles across specialised commissioning and will initially be subject to a maximum of four days a year per PPV member. Travel and subsistence expenses for PPV members will continue to be paid in line with existing NHS England policy.

d) **CHANGED**: To ensure work dovetails with the revised operating model for specialised commissioning, NHS England will simplify the operation of CRGs. The clinical membership will be reduced from 14 'senate' clinical members to **eight** (increased from four) regional clinical members **(two per region)** and PPV membership will change from four to **three** (increased from two) individuals. The affiliated membership, including organisations such as Colleges and Societies, will remain at up to four members.

e) **NO CHANGE**: All current clinical and PPV members have the option of applying in competition with new applicants for a three year appointment. The regional clinical members and affiliated members will continue to be supported by their organisations and will not be remunerated.

f) **NO CHANGE**: NHS England will continue to make use of sub groups and working groups to supplement the expertise of CRG members where further specialised expertise is required (for example when developing a clinical policy for a rare condition).

g) **ADDITIONAL CHANGE**: During member recruitment the following will be taken into consideration:

I. The two regional representatives will come from different senate areas within each region

II. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise (see CRG-specific requirements below)

III. One of the regional members is defined as an data, information and pricing lead, who will take up a place on the relevant Health and Social Care Information Centre (HSCIC) Reference Group and NHS Improvement

IV. One of the regional members is defined as a research lead, who will take up a role in the developing partnership work with National Institute for Health Research (NIHR) and other potential research opportunities from the CRGs work.

V. One of the regional members is defined as a commissioning for value lead, who will join the commissioning for value work stream.

VI. One of the regional members is defined as a National Institute for health and Care Excellence (NICE) liaison lead providing advice to NICE.

VII. During recruitment we will ensure that at least one of the three PPV members is from an organisation (preferably an umbrella organisation or one that represents the widest possible range of patient groups covered by the CRG). The other two members could either be individual or organisational members. As organisational members do not qualify for an involvement payment, this will not increase costs above current budget. NHS England's PPV Assurance Group will be asked to assure the recruitment process for PPV members.

h) ADDITIONAL CHANGE: A CRG Guide will be developed and published combining the current CRG clinical and stakeholder guides into a single document. This will also set out clearly the role and function of subgroups. The Guide will be available for newly appointed CRG members in May/June.

i) **ADDITIONAL CHANGE**: The following accountability arrangements will be put into place:

I. The clinical accountability for the chairs of the CRGs is to the NPoC Clinical Co-Chair who in turn are accountable to the Clinical Director for Specialised Services in NHS England. The regional clinical members are accountable to the Regional Clinical Directors for Specialised Commissioning.

II. The CRG as a whole reports to the NPoC whose chair is a Regional Director of Specialised Commissioning, or one of two National Directors.

III. Each CRG will be supported by an NHS England specialised commissioning staff member who will be identified to become the 'lead commissioner' for that CRG (the term 'accountable commissioner' will no longer be used). This gives every CRG a dedicated and accessible contact point in NHS England. The lead commissioners will be accountable to the NPoC senior manager for their CRG related work.

IV. Each CRG will be supported by a Public Health England lead drawn from the embedded network in specialised commissioning.

6 Changes to the proposals for individual CRGs within each NPoC

18. The following changes will apply to arrangements for specific CRGs following the engagement period. For ease of reference and comparison, appendix 2 sets out the list of current CRGs, proposed CRGs and revised (final) list of CRGs:

INTERNAL MEDICINE

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Specialised Respiratory	Join Specialised Respiratory, Cystic Fibrosis, and Pulmonary Hypertension to a single CRG.	Minimum 2 members with Cystic Fibrosis expertise. Minimum 2 members with Pulmonary Hypertension expertise. Specialist Nursing & Physiotherapy in membership	Pulmonary Hypertension requested to move into respiratory. Strong representation that Cystic Fibrosis CRG should remain.	Reinstate Cystic Fibrosis CRG
Hepatobiliary and Pancreas	Unchanged	None		N/A
Specialised Endocrinology	Unchanged	Minimum 1 member with specialised diabetes expertise. Specialist Nursing in membership		N/A
Specialised Vascular	Unchanged	Minimum 2 members with interventional radiology expertise.		Could be amalgamated with Cardiac Services. Resulting CRG would have a very broad scope.

Cardiothoracic Services	Join Cardiac Surgery, Cardiology, Cardiac Transplantation	4 members with Cardiology expertise, 1 from each region. 4 members with Cardiac Surgery, expertise, 1 from each region. Minimum 1 transplant surgeon.	General support for amalgamation. Representation from main clinical areas needed on the CRG.	N/A
Renal Services	Join Dialysis and Renal Transplantation	4 members with Renal Medicine expertise, 1 from each region. 4 members with Renal Transplant surgery expertise, 1 from each region. Specialist Nurse and Transplant Coordinator in membership	General support for the joining into a single CRG.	N/A
Specialised Colorectal Services	Unchanged	None		N/A
Specialised Dermatology	Continue as separate CRG	None	Had proposed joint CRG with Rheumatology. Strong views in consultation that the two areas did not sit well together.	N/A

Specialised Rheumatology	Continue as separate CRG	None	Had proposed joint CRG with Rheumatology. Strong views in consultation that the two areas did not sit well together.	N/A

Closed CRGs:

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Severe & Complex Obesity	To close. Paediatric element to transfer to Paediatric Surgery	Ensure member with expertise in paediatric obesity surgery included in paediatric surgery CRG		N/A
Interventional Radiology	To close	Ensure members with interventional radiology expertise in key CRGs	Strong representation that a specific CRG is needed.	Continue by creating a joint imaging CRG
Specialised Imaging	To close	Ensure Cancer Diagnostics CRG has a mix of expertise	Strong representation that a specific CRG is needed	Continue by creating a joint imaging CRG

CANCER

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Radiotherapy	Unchanged	At least one lead Radiographer, at least one lead Physicist. Expertise in new technology.	Raised the issue that stereotactic radiosurgery could be included in the portfolio	N/A
Chemotherapy	Unchanged	None		N/A

Cancer Surgery	New CRG Structure to support cancer strategy	Minimum 1 member with expertise in each of the following areas: Thoracic cancer, Upper GI cancer, Urological cancer, Gynaecological cancer, Sarcoma, Central Nervous System cancer and Head and Neck Cancer.	Importance in ensuring expertise across the surgical areas. Bring Gynaecological Cancer into the cancer programme. Clear arrangements for forming working groups.	Maintain separate CRGs
Cancer Diagnostics	New CRG Structure to support cancer strategy	Minimum 2 members from separate regions for PET-CT. Minimum 2 members from separate regions with expertise in cross sectional imaging. Minimum 2 members from separate regions with expertise in Ultrasound.	Strong representation to keep separate PET-CT CRG.	Maintain a PET-CT CRG.

Children and Young People Cancer	Join Teenage and Young People Cancer with Paediatric Cancer	4 members with Paediatric Cancer expertise, 1 from each region. 4 members with Young Adult Cancer expertise, 1 from each region.	Concern that smaller clinical membership arrangements would have failed to cover both service areas.	Maintain Separate CRGs

Closed CRGs:

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Thoracic Surgery	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG		Maintain CRG
Upper GI Surgery	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG		Maintain CRG
Sarcoma	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG	Strong representation for maintaining separate CRG	Maintain CRG
CNS Tumours	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG		Maintain CRG
Specialised Urology	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG		Maintain CRG
Complex Head & Neck	Join Cancer Surgery CRG	Ensure member in cancer surgery CRG		Maintain CRG

MENTAL HEALTH

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Specialised Mental Health	Join Eating Disorders, Deaf Mental Health and Tier 4 Personality Disorder (PD) into a single CRG	Minimum 2 members with Eating Disorders expertise. Minimum 2 members with Deaf Mental Health expertise. Minimum 2 members with Tier 4 PD expertise.	Original CRGs for Deaf and Tier 4 PD were due to close but wanted to continue to be linked in to CRG structures.	Maintain Separate Eating Disorders CRG. Close Deaf Mental Health, Tier 4 PD.
Adult Secure	Joins Adult Secure and Low Secure	Mix of levels of service provision	To keep separate CRG	Maintain separate CRG
CAMHS	Joins CAMHS Tier 4 with CAMHS secure	4 members with CAMHS expertise, 1 from each region. 4 members with CAMHS Secure expertise, 1 from each region.	Representation to keep separate CAMHS secure CRG	Maintain separate CRG
Perinatal Mental Health	Unchanged	At least one midwife and one health visitor in membership		N/A
Gender Identity Services	Unchanged	None	Representation to move out of the Mental Health Programme of care.	N/A

TRAUMA

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Rehabilitation and Disability	Join Complex Rehabilitation and Complex Disability Equipment	Minimum 1 member with prosthetics expertise. Minimum 1 member with expertise in augmentative and alternative communication aids. Minimum 1 member with expertise in environmental controls. 4 members with Complex Rehabilitation expertise, 1 from each region.		Maintain separate CRGs
Major Trauma	Join Major Trauma with Burns	4 members with expertise in Major Trauma, 1 from each region. 4 members with expertise in Burns, 1 from each region.	Representation to maintain separate CRGs	Maintain separate CRGs

Spinal Services	Join Complex Spine and Spinal Cord Injury Rehabilitation	4 members with Spinal Cord Injury expertise, 1 from each region. 4 members with Complex Spine Surgery expertise, 1 from each region (2 orthopaedics, 2 neurosurgery).	Representation to not include spinal cord injury within complex rehabilitation	Maintain separate CRGs
Neurosciences	Join Adult Neurosurgery with Neurology	4 members with Neurosurgery expertise, 1 from each region. 4 members with Neurology expertise, 1 from each region.	Representation to keep separate Adult Neurosurgery CRG	Maintain separate CRGs
Adult Critical Care	Unchanged	None	Initially proposed to close as not directly commissioned. Review in 1 year.	N/A
Specialised ENT and Ophthalmology	Join Specialised Ear Surgery and Ophthalmology	4 members with Specialised Ear Surgery expertise, 1 from each region. 4 members with Specialised Ophthalmology expertise, 1 from each region.	Initially proposed to continue as separate CRGs but synergy exists between services.	Maintain separate CRGs
Specialised Pain	Unchanged	None		N/A

Closed CRGs:

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Specialised Orthopaedics	There is the current Get it right first time project (GIRFT) project with a major focus on orthopaedics. Role of CRG to be considered alongside the project. Reconsider place for CRG in 2017/18	N/A		Maintain CRG
Hyperbaric Oxygen Therapy	Manage through specific working groups	N/A		Maintain CRG

WOMEN AND CHILDREN

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Medical Genetics	Unchanged	None		N/A
Specialised Surgery in Childhood	Unchanged	Minimum 2 members with Cleft Lip and Palate expertise from different regions. Minimum 1 member with expertise in Complex Obesity Surgery.		N/A
Paediatric Medicine	Unchanged	None		N/A
Paediatric Neurosciences	Unchanged	None		N/A

Congenital Heart Services	Unchanged	None		N/A
Metabolic Disorders	Unchanged	None		N/A
Paediatric Intensive Care	Unchanged	At least one lead nurse and on lead allied health professional		N/A
Neonatal Intensive Care	Unchanged	At least one lead nurse and on lead allied health professional		N/A
Women's Services	Complex Obstetrics and Complex Gynaecology join	Minimum 2 members with expertise in Complex Obstetrics from different regions. Minimum 2 members with Complex Gynaecology expertise from different regions. Minimum 2 members with Foetal Medicine expertise from different regions.	Request to move Gynaecological Cancer to Cancer Surgery CRG agreed. Original plan to move complex obstetrics to Collaborative Commissioning delayed.	N/A

BLOOD AND INFECTION

CRG	Recommended CRG structure	Member Constraints	Consultation Issues	Not recommended
Blood and Marrow Transplantation	Unchanged	None		N/A
Blood Disorders	Unchanged	None		N/A
HIV	Unchanged	None		N/A

Infectious Diseases	Unchanged	None		N/A
Haemoglobin-opathies	Unchanged	None		N/A
Immunology and Allergy	Unchanged	4 members with Immunology expertise, 1 from each region. 4 members with Allergy expertise, 1 from each region.		N/A

OTHER

Medicines Management	Unchanged	None		N/A

7. Next steps

Recruitment for chairs and members of the revised CRGs will commence in April 2016 with a view to the new CRGs coming into effect by June 2016. To keep up to date on progress with the implementation of the revised CRG structures and to sign up as a stakeholder, please register on the NHS England website if you are not already registered.

Appendix 1 - Summary of feedback and NHS England's response

We asked	You said	We did
Do you have any comments on the proposed revisions set out in section 2 of the engagement guide around the resourcing of CRGs, the remuneration of members or the number of members in each CRG?	Strong agreement with the additional resources to support the work of the CRGs. Recognition of the need for additional resources is welcomed and appreciated.	This proposal is well supported and will be taken forward. We will make the additional resources available to support the work of the CRGs. Further details of this support and how it can be accessed will be made available once the new CRG structures are in place.
	68% of respondents agreed with CRG Chairs becoming a formal NHS England appointment with remuneration at one Programmed Activity (four hours a week) There were some comments that funding might lead to a lack of independence and a suggestion that funding should go to the employing organisation of the Chair.	We will proceed with remuneration at 1PA for 2016 for the Chair role. Increasing payments beyond 1 PA is not currently affordable, although resources may need to be identified for the clinical leadership of specific pieces of work, such as service reviews. The Chair's organisation will receive the payment to cover the time allocation to the role and other costs,

	Two thirds (66%) of respondents were supportive of payments to Patient and Public Voice (PPV) members of CRGs in recognition of their contribution to the work of their CRG where they are not supported by an organisation. Some concerns were expressed about independence of PPV members and why organisations should bear the financial burden where they supported members	The majority of respondents supported this proposal, which will be implemented. PPV members not supported by an organisation will be eligible for payment for their CRG work (limited to four days a year initially). The payment arrangements for PPV members that are representing an organisation are set in an existing NHS England policy which is out of scope of this engagement process. We will pass these comments on to the team who are responsible for this policy so they can be considered when it is due for review.

	There was disagreement with the proposal to reduce clinical membership (from 14 'senate' clinical members to four regional clinical members) and PPV membership (from four to two individuals).	We will revise the proposals to increase clinical membership from four to eight – two from each region. During member recruitment the following will be taken into consideration: • The two regional representatives will come from different senate areas within each region • CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise (see CRG-specific requirements below) • One of the regional members is defined as an Information and Pricing lead, who will take up a place on the relevant HSCIC Reference Group • One of the regional members is defined as a Research lead, who will take up a role in the developing partnership work with National Institute for Health Research (NIHR) and other potential research opportunities from the CRGs work. • One of the regional members is defined as a Commissioning for Value lead, who will join the Commissioning for Value work stream. • One of the regional members is defined as a NICE liaison lead. • PPV membership to increase from two to three. During

	There were a variety of responses to the proposal for all current clinical and PPV members having the option of applying in competition with new applicants for a three year appointment. 43% of respondents neither agreed or disagreed, while a further 43% disagreed. The prime concern was the freeing up and remuneration of clinicians to allow them to attend meetings.	We propose no change to the initial recommendation. The remuneration of all clinical members of all the CRGs is not affordable for NHS England. The consultant contract allows for some time to be spent in support of the wider NHS and clinical excellence award scheme recognises high quality work over and above contracted work.
	There were a variety of responses to the proposed use of sub groups and working groups to supplement the expertise of CRG members where further specialised expertise is required. Half of respondents neither agreed or disagreed, with a further 33% expressing agreement. Some welcomed the use of subgroups. Some were concerned about how members would be recruited and whether there was a clear process and remit.	Targeted subgroups have been a key recent development with policy, specification, and service review groups established. We accept that there is a need to effectively communicate the role, duration and purpose of sub groups to ensure stakeholders understand how they will work. We will be producing a revised **CRG Guide** combining the current clinical and stakeholder guide into a single document. This will set out the role and function of subgroups and how NHS England will support them. .
Do you have any comments on the proposed revisions set out in sections 3 – 8 of the engagement guide relating to the numbers and remit of the CRGs within each National Programme of Care	A number of general views expressed concern that the reduction in the number of CRGs, along with their broader remits, would negatively impact the range of expertise they could draw on and the outputs of the CRGs.	Responses to proposed changes to individual CRGs are considered in the table below. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise.

	There was concern that the reduction in members of a CRG would lessen the medical representation, regional coverage and public voice of the CRGs. It might reduce the expertise and range of views within an CRG. It would increase the individual and group workload.	As stated above, we will change the proposals so that there are eight clinical members for each CRG, with two from each region. We will increase PPV representation from two to three and clarify how subgroups can be used to bring in further specialist expertise where required.
	Some general views were expressed on the proposed remits of the reduced number of CRGs where some had been merged. There were suggestions that medical areas vary considerably within a CRG and it was inappropriate to group them together. Similarly that complex conditions requiring multidisciplinary treatment would be challenging to discuss, or that more specialised areas would be dealt with less frequently.	Responses to proposed changes to individual CRGs are considered in the table below. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise. Subgroups can be used to bring in further specialist expertise where required.
	There were some positive comments recognising that the proposals could create a more focused approach, concentrate expertise and reduce overlaps. And approval for the administrative support, appointment setup of CRG chairs and remuneration for PPV members.	No action needed.
	Clarification was sought about the exact nature, use and representation of subgroups	See above: We recognise there is a need to effectively communicate the role, duration and purpose of subgroups which we will do through the revised CRG Guide.

Are there any other changes or revisions that NHS England should consider to the role, function or membership of CRGs?	On the reduced membership of CRGs, there were a series of suggestions: There is a need to maintain a more diverse mixture of clinicians, patients, commissioners and representatives of professional bodies. There were worries about keeping the breadth of expertise involved in treatment, including professions such as nurses, radiographers, physicists and pharmacists. There was a suggestion that there should be wider representation, from industry, professional bodies, research and care organisations, stakeholders and the wider clinical community. There should be a minimum number of people who are patients with long-term or rare conditions and a minimum number of carers of such patients. PPV members should receive a full briefing when appointed. There should also be clear and regular mechanisms for patients, the public and others to feed into CRG deliberations as a matter of course. It was suggested that different CRGs may need different compositions to reflect the therapeutic area.	We have revised the proposals to increase the number of clinical members which will allow for a more diverse mixture of expertise. We will be clear in the recruitment materials for clinical members that these roles are not restricted to medical professionals. We will promote the advertisements through other professional membership bodies and networks to encourage a diverse mixture of applicants from different professions. We do not believe it is appropriate to have industry representatives sitting on CRGs as this could be a conflict of interest. However we remain committed to engaging with industry in other ways and involving them at appropriate points in the development of clinical policies and specifications. Induction and training will be organised for all new CRG members alongside the production of a CRG Guide. Wider stakeholders will have an opportunity to feed into the development of clinical policies and services specifications through stakeholder testing and public consultation as currently happens. We will be refreshing the registration process for CRGs. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise.

	There was concern expressed that the reduction in size of CRGs means that decisions run the risk of being made in an evidence vacuum, guided by the personal preferences of the few clinicians involved. A related comment pointed out that research had not been mentioned in the document, and that CRGs have an important role to play to further the research into rare diseases. There was a request for greater clarity on how the CRG recommendations fit with National Institute for Health and Care Excellence recommendations.	As stated above, we will change the proposals so that there are eight clinical members for each CRG, with two from each region. We will increase PPV representation from two to three and clarify how subgroups can be used to bring in further specialist expertise where required. We have also introduced a requirement that one of the regional members will be defined as a research lead, who will take up a role in the developing partnership work with National Institute for Health Research (NIHR) and other potential research opportunities from the CRGs work. We are committed to working closely with NICE across a range of areas and will identify a lead to formally liaise with NICE within each CRG.
	Concerns were expressed that in the merging of some CRGs it would be important to ensure that the voices of smaller disease groups do not become lost.	As stated above, we will change the proposals so that there are eight clinical members for each CRG, with two from each region. We will increase PPV representation from two to three and clarify how subgroups can be used to bring in further specialist expertise where required. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise and representation from the broadest possible range of conditions within each CRG.

	There should be far greater focus on transparency and communication. Plans should be developed and implemented to ensure the work of the CRGs and their sub groups is clear and transparent, that people external to NHS England can access details of how they are governed, when they meet and what they discuss, and that their decisions are made public.	NHS England is committed to improving transparency and communication with stakeholders (including working towards the routine publication of minutes) and we will set out in the revised CRG Guide our expectations of CRGs in this regard.
	NHS England needs to clarify its plans for establishing CRG subgroups.	We recognise there is a need to effectively communicate the role, duration and purpose of subgroups which we will do through the revised CRG Guide.

	Terms of reference and roles need to be clarified further particularly in relation to engagement with regional commissioning teams.	We will produce revised terms of reference for CRGs alongside the CRG Guide. Lines of accountability will be as follows - • The clinical accountability for the Chairs of the CRGs is to the NPoC Clinical Co-Chair who in turn are accountable to the Clinical Director. The regional clinical members are accountable to the Regional Clinical Director. • The CRG as a whole reports to the NPoC whose Chair is a Regional Director of Specialised Commissioning, or one of two National Directors. • Each CRG will be supported by an NHS England specialised commissioning staff member who will be identified to become the 'lead commissioner' for that CRG (the term 'accountable commissioner will no longer be used'). This gives every CRG a dedicated and accessible contact point in NHS England. The lead commissioners will be accountable to the NPoC senior manager for their CRG related work.

	Membership and attendance at the CRGs should be paid for all members, not just chairs, however there should be time limits on the length of membership. The reimbursement should be paid to the clinician's employing trust as the lack of remuneration for clinical members is posing increasing problems as NHS Trusts struggle financially.	See above: We propose no change to the initial recommendation. The remuneration of all clinical members of all the CRGs is not affordable for NHS England. The consultant contract allows for some time to be spent in support of the wider NHS and clinical excellence award scheme recognises high quality work over and above contracted work. Payment goes to the organisation to cover the time for the role.
	CRGs have received limited financial and administrative support. This needs to be improved	See above: The proposal to make additional resources available to support the work of the CRGs is well supported and will be taken forward.
	CRGs need better access to financial expertise in assessing proposed QIPPS and CQUINs	We will set out in the CRG Guide how this support can be accessed. As stated above, one of the regional members is defined as an Information and Pricing lead, who will take up a place on the relevant HSCIC Reference Group In addition, one of the regional members is defined as a Commissioning for Value lead, who will join the Commissioning for Value work stream.
	Stakeholder engagement processes should include opportunities to consult at key stages of the evidence gathering and decision making pathway with adequate time for responses.	This is outside the scope of this work however the clinical policy development process includes periods of engagement with stakeholders and public consultation.

	The current interface for stakeholder registration should be reviewed as it was thought to not be accessible to patients and members of the public who are not involved in NHS commissioning.	We agree and as we said in the engagement guide, we will be reviewing the way we interact with stakeholders and update our stakeholder lists. We are also looking to develop a more interactive and intuitive stakeholder registration process which should be complete by the summer 2016.
	The length of time between the consultation process and the proposed changes occurring was raised as it was felt that it allowed little time for NHS England to respond to concerns raised by the consultation process and implied that little will change from what was proposed in the consultations document.	These timescales have been revised to allow a greater period of time for transition to the new arrangements and recruitment of chairs and members. As can be seen from this report, NHS England has listened to feedback and made some key revisions to the proposals following the engagement period.
	Many CRGs are in the process of resourcing projects they have undertaken for 2016/17 which will require careful and engaged member representation. CRG chairs are likely to suddenly find those allocated members and the expertise they bring might no longer be there and the projects may be put at risk.	NHS England, through its National Programmes of Care will ensure that CRGs are supported during the transition period to the new arrangements.

Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed revisions that we have described	The majority of responses expressed concern with the placement of certain conditions in an overall CRG or an inappropriate group. A high number of responses showed concern that if proposed changes to merge CRGs are implemented, that existing inequalities will persist or get worse. The examples given most were sarcoma, which is experiencing inequalities because of its rarity, and cystic fibrosis, because of its complexity and difficulty of representing the patient population sufficiently.	We believe the changes we have made as a result of the responses to the engagement guide will address these concerns – for example increasing clinical and PPV membership to ensure a broader range of expertise on each CRG. We will clarify how subgroups will be set up and used to ensure expertise in specific areas is retained where this is needed. We believe that the additional resources and support we are allocating to support CRGs, the greater accountability that the payment of CRG chairs and PPV members brings and the use of subgroups where specialist expertise is required, will enhance access to care and help reduce inequalities.
	The geographical locations of a reduced number of CRG members may be a concern. The reduced number of members will have a negative impact in representing patients with different local needs and challenges – for example, patients with different ages and from different ethnic backgrounds that tend to be geographically based. Rare conditions, which in some cases, may tend to occur in certain regional areas were also mentioned.	See above: We will change the proposals so that there are eight clinical members for each CRG, with two from each region. We will increase PPV representation from two to three.

	Merging CRGs covering diseases that affect certain ages was a concern in how they would retain sufficient expertise. Examples given included the CRGs for congenital heart disease, cystic fibrosis and teenage and young adult cancer services.	We have mitigated any concerns by increasing the membership of CRGs and ensuring appropriate representation on CRGs from the major disease areas that each CRG covers.
Do you have any comments on the proposed revisions set out in sections 3 – 8 of the engagement guide relating to the numbers and remit of the CRGs within each National Programme of Care	Rheumatology and Dermatology should be distinct CRGs and not joined as a single group. Alternatively, Rheumatology could be combined with Immunology	We will change the proposal. Rheumatology and Dermatology will continue as separate CRGs and not be merged.
	There should be a distinct CRG for Cystic Fibrosis	We will go ahead with joining the specialised respiratory, cystic fibrosis and pulmonary hypertension CRGs into a single CRG as initially planned. However, a minimum of two clinical members must have cystic fibrosis expertise and two further clinical members must have expertise in pulmonary hypertension.
	The Pulmonary Hypertension CRG should be part of the Respiratory CRG	See above
	There was support for joining renal dialysis and renal transplantation, providing there is equal representation	We will go ahead with this proposal and will ensure the CRG includes four clinical members with renal medicine experience (one from each region) and four members with renal transplant experience (one from each region).
	General concern as to the large remit of the Cancer NPoC, particularly where complex cancers need multidisciplinary treatment	The revised structure has been introduced to support the cancer strategy.

	The Cancer Diagnostics CRG was welcomed, but there were concerns as to the influence of PET/CT as a subgroup	The revised structure has been introduced to support the cancer strategy. We will ensure at least two members of the CRG have expertise in PET-CT.
	Confirmation was sought as to whether stereotactic radiosurgery will be included within the Radiotherapy CRG	Any further work on Stereotactic Radiosurgery commissioning will be led by a working group with members from the appropriate clinical area. It does not have a place in a single CRG.
	Sarcoma should have a distinct CRG and not be included under the larger Cancer Surgery CRG	We will continue with our proposals however we will ensure that at least one of the eight clinical members of the new CRG has expertise in sarcoma.
	Move gynaecological cancer to the Cancer NPoC	Gynaecological cancer will move to the cancer surgery CRG and at least one clinical member will have expertise in this area.
	Move skin surgery and ovarian cancer to the Cancer Surgery CRG	These clinical areas will now come under the new cancer surgery CRG.
	Specialist Personality Disorder must be included within a CRG eg eating disorders	At least two of the clinical members of the specialised mental health CRG must have Tier 4 Personality Disorder Expertise.
	Create a separate NPoC for Gender Identity, which could also include the Child and Adolescent services	As there was no consensus on which other NPoC could best host this CRG, it will remain as part of the Mental Health NPoC. To take it out of the NPoC structure as a stand-alone CRG could make it more difficult for this CRG to access the resources and support provided within the NPoC structures.
	The CAMHS secure and CAMHS tier 4 CRGs should remain separate	We will continue with our proposals to join these CRGs but ensure equal representation on the CRG from both areas.

	There were concerns about the proposal to abandon the mental health and deafness CRG, and the number of mental health CRGs more generally	We will ensure a minimum of two clinical members of the specialised mental health CRG have expertise in deaf mental health.
	There should be a distinct CRGs for spine and Neurosurgery Also: The CRG for Spinal Cord Injury, which has representation from all of England's eight SCI Centres along with other key stakeholders, is undertaking a service review of the SCI Centres. It was felt that both this CRG and the review process should be protected during this period, and that the leadership of the CRG be maintained to ensure the effectiveness of the review.	We have changed the proposals to create a new spinal services CRG which will include four members with spinal cord injury expertise and four with complex spine surgery expertise.
	Burn care should be distinct from the Major Trauma CRG	We will continue with our proposals to join major trauma with burns however we will ensure the new CRG has four clinical members with burns expertise (one from each region) and four with major trauma expertise (one from each region).
	Pleased that Medical Genetics remains a standalone CRG	No action needed
	Concern as to whether cleft lip and palate specialist services will be appropriately or adequately represented within the Paediatric Surgery CRG	A minimum of two clinical members of the paediatric surgery CRG from different regions must have expertise in cleft lip and palate services
	Concern about the removal of the Multi-System Disorders CRG	There are no plans to reintroduce this.

	A request to clarify the remit of the Infectious Diseases CRG	The remit remains unchanged

Appendix 2 - List of current, proposed and revised CRGs

The table shows the current list of CRGs; the proposed list of CRGs as set out in the engagement guide and the final list of CRGs having taken into account stakeholder feedback. The CRGs are grouped by National Programme of Care (NPoC).

Current list of CRGs	Proposed list of CRGs	Final list of CRGs
Internal Medicine NPoC		
Cystic Fibrosis	Hepatobiliary and Pancreas	Hepatobiliary and Pancreas
Hepatobiliary and Pancreas	Specialised Endocrinology	Specialised Endocrinology
Specialised Endocrinology	Vascular Disease	Vascular Disease
Vascular Disease	Renal Services	Renal Services
Severe and Complex Obesity	Specialised Colorectal Services	Specialised Colorectal Services
Renal Dialysis	Cardiothoracic Services	Cardiothoracic Services
Renal Transplant	Dermatology and Rheumatology	Specialised Dermatology
Specialised Colorectal Services	Specialised Respiratory	Specialised Rheumatology
Complex Invasive Cardiology		Specialised Respiratory
Cardiac Surgery		
Pulmonary Hypertension		
Specialised Dermatology		
Specialised Rheumatology		
Specialised Respiratory		
Interventional Radiology		
Specialised Imaging		
Cancer NPoC		
Radiotherapy	Radiotherapy	Radiotherapy
PET-CT	Cancer Diagnostics	Cancer Diagnostics
Thoracic Surgery	Cancer Surgery	Cancer Surgery
Oesophageal Surgery	Chemotherapy	Chemotherapy
Sarcoma	Children and Young People Cancer Services	Children and Young People Cancer Services
CNS Tumours		
Specialised Urology		
Chemotherapy		
Complex Head & Neck		

Current list of CRGs	Proposed list of CRGs	Final list of CRGs
Teenage and Young People Cancer		
Mental Health NPoC Specialised Services for Eating Disorders High and Medium Secure Mental Health Low Secure Mental Health Specialised Mental Health Services for the Deaf Gender Identity Services Perinatal Mental Health Tier 4 Child & Adolescent Mental Health Services (CAMHS) Tier 4 Severe Personality Disorder Services (adults) Mental Health Specialised Forensic Pathway Group Child & Adolescent Mental Health Service (CAMHS) Secure	Eating Disorders Adult Secure Services Gender Identity Services Perinatal Mental Health Children and Adolescent Mental Health Services (CAMHS)	Adult Secure Services Gender Identity Services Perinatal Mental Health Children and Adolescent Mental Health Services (CAMHS) Specialised Mental Health

Current list of CRGs	Proposed list of CRGs	Final list of CRGs
Trauma NPoC Complex Disability Equipment Specialist rehabilitation for patients with highly complex needs Adult Neurosurgery Neurosciences Burn Care Cleft Lip & Palate Specialised Pain Specialised Ear Surgery Specialised Orthopaedic Services Hyperbaric Oxygen Therapy Specialised Ophthalmology Services Spinal Cord Injury Complex Spinal Surgery Major Trauma Adult Critical Care	Rehabilitation and Disability Neurosurgery and Spine Neurosciences Specialised Pain Specialised Ear Surgery Specialised Orthopaedics Specialised Ophthalmology Major Trauma Adult Critical Care	Rehabilitation and Disability Neurosciences Specialised Pain Specialised ENT and Ophthalmology Spinal Services Major Trauma Adult Critical Care

Current list of CRGs	Proposed list of CRGs	Final list of CRGs
Women and Children		
Medical Genetics	Medical Genetics	Medical Genetics
Paediatric Surgery	Paediatric Surgery	Specialised Surgery in Childhood
Paediatric Medicine	Paediatric Medicine	Paediatric Medicine
Paediatric Cancer Services	Paediatric Cardiac Services	Congenital Heart Services
Congenital Heart Services	Metabolic Disorders	Metabolic Disorders
Metabolic Disorders	Paediatric Intensive Care	Paediatric Intensive Care
Paediatric Intensive Care	Neonatal Critical Care	Neonatal Intensive Care
Neonatal Critical Care	Paediatric Neurosciences	Paediatric Neurosciences
Paediatric Neurosciences	Complex Gynaecological Services	Women's Services
Complex Gynaecological Services		
Specialised Maternity Services		
Fetal Medicine		
Multi-System Disorder		
Blood and Infection		
Blood and Marrow Transplantation	Blood and Marrow Transplantation	Blood and Marrow Transplantation
Haemophilia and Other Bleeding Disorders	Haemophilia and other Bleeding Disorders	Blood Disorders
HIV	HIV	HIV
Infectious Diseases	Infectious Diseases	Infectious Diseases
Haemoglobinopathies	Haemoglobinopathies	Haemoglobinopathies
Specialised Immunology and Allergy Services	Specialised Immunology and Allergy	Immunology and Allergy