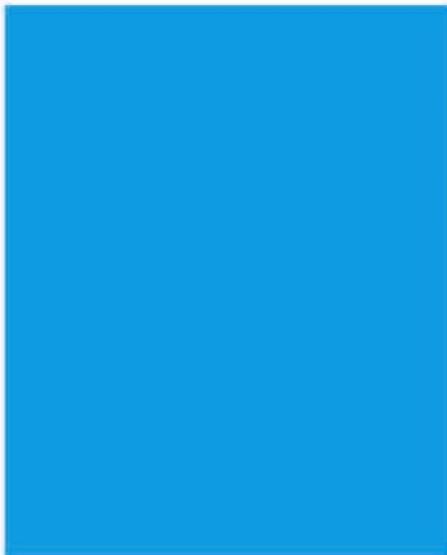


**Clinical
Reference
Groups for
Specialised
Services**

**A Guide for
Clinicians**



Clinical Reference Groups: A Guide for Clinicians

*Clinical advice to the NHS Commissioning Board
for the strategic planning of Specialised Services*

First published: January 2013

There will be a separate guide **Clinical Reference Groups: A Guide for Stakeholders** published by the Patients and Information Directorate, NHS Commissioning Board

Prepared by Medical Directorate, NHS Commissioning Board

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Introduction

Thank you for your interest in becoming a Chair or Clinical Member of one of the Clinical Reference Groups (CRGs) for Specialised Services.

This Guide is aimed at providing you with some background about the CRGs, and in giving you an introduction to the work programme for the groups for the coming year.

This is an exciting time to become involved with the CRGs, as we move towards the end of transition and the formal establishment of the NHS Commissioning Board (NHS CB).

CRGs were initially conceived as assurance groups but were redefined as the key delivery mechanism for the development of specialised services contract products for 2013/14 and beyond. They were tasked with the overall responsibility of ensuring that service specifications and clinical commissioning policies were delivered on time and to a high quality standard.

The development of CRGs was ambitious – bringing together hundreds of clinicians, commissioners, Public Health experts, patients and carers with the sole purpose of improving the commissioning of specialised services.

During their first year of intense activity, the work of the CRGs attracted a great deal of attention. The most remarkable aspect, however, was the fact that all involved gave freely of their time in order to reach a consensus on the products. This dedication and enthusiasm for the job in hand resulted in the NHS CB being able to publish more than 130 service specifications and more than 40 clinical commissioning policies on its website as part of a public consultation.

There will be no time for resting on laurels however, as the next phase of the CRGs' work moves from development of core products, to implementation. CRGs will continue to be the main source of clinical advice to specialised commissioning as the NHS CB moves forward in its direct commissioning role, and there will be greater emphasis on partnership working across the National Programmes of Care and Strategic Portfolios, as described further on in this document.

I hope this document answers some of the questions you might have about the role of Chair of a CRG. If you require any further information, please do not hesitate to contact me directly.

James Palmer

Clinical Director Specialised Services
Medical Directorate, NHS Commissioning Board

Strategic Advice for Specialised Services

1. The strategic planning of specialised services for the NHS Commissioning Board will be informed by bringing specialised expertise and advice together with the views of patients and carers in the form of service-specific Clinical Reference Groups (CRGs). This approach will be coordinated through five National Programmes of Care; and maintain a focus on mental health and rare conditions alongside the bulk of specialised services through three Portfolios.
2. These three 'layers' will allow all parts of the new commissioning landscape (from national to local) to be integrated in the determined aim to deliver equitable access for all to specialised services that are striving to demonstrate improved quality of care.



3. The model of Programmes of Care and CRGs was successfully tested during the transition year. This Guide describes the planned structure moving forward for implementation in 2013. The design follows the principles of the operating model for specialised commissioning, with the single 'do-once' function at a national level, strategic interpretation at a regional level, and a provider/commissioning interface at the Area Team level.

4. The reach of clinical advice for specialised commissioning will span all parts of the NHS CB from a discrete national coordinating team within the Medical Directorate, across the regions, and into the Area Teams. The clinical line of sight will be from the National Clinical Director for Specialised Services - Regional Medical Director - Area Team Medical Director - Provider Medical Director.

National Clinical Director Specialised Services	Holds clinical and commissioning knowledge across specialised services to advise the NHS CB
	Secures service specific advice from Clinical Reference Groups that cover all specialised services
	Leads 3 portfolios: Acute; Highly Specialised; Mental Health and through them 5 National Programmes of Care. These will form the 'do-once' national components of commissioning and strategic planning.
	Manages a small national Clinical Effectiveness Team to procure high quality information that will support the development of commissioning policy
Regional Medical Director	Leads service change that spans more than one Area Team and provides advice on the risks and benefits of change
	Secures service specific advice from the National Clinical Director
	Integrates with the 5 National Programmes of Care working with regional programme managers for each programme to shape the national 'do-once' components of commissioning and strategic planning
Area Team (Specialised Services) Medical Director	Establishes strong lines of communication to the providers of the local area and the Clinical Senates
	With a Public Health Consultant holds the detailed knowledge of the local population and their needs and access to services
	By exception develops time limited derogation from the national service specifications where local services require
	Secures local service specific advice from the Area Team service members on the national CRGs

5. Public Health Consultants will be embedded within each of the specialised commissioning Area Teams to work closely with the Area Team Medical Director on building the understanding of the needs of the local populations for specialised services, their access to services, and integration across pathways of care. A

component of their role will be to support the development of national ‘do-once’ components coordinated through the Programmes of Care. Nationally, the Highly Specialised Portfolio will secure clinical advice from a Public Health lead and the Clinical Effectiveness Team will have dedicated clinical leadership to define and secure the highest quality commissioning information.

6. Clinical advice related to drugs used in specialised services will be coordinated nationally by a specialised commissioning pharmacist in the Clinical Effectiveness Team collaborating with a pharmacist within each of the specialised commissioning Area Teams.
7. The work of the Clinical Reference Groups will be closely aligned to the NHS Outcomes Framework. This framework was first published in December 2010 with an ambition that included acting as a catalyst for driving quality improvement and outcome measurements throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities. The framework is structured around five domains each of which have a lead, domains 1-3 in the medical directorate and 4-5 in the nursing directorate.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

8. The Domain Directors of the Medical and Nursing Directorates will secure their work stream objectives in specialised services through the National Programmes of Care. All work within the programmes will be defined in terms of one of the five domains. Patient safety and experience in specialised services will integrate with the work of the Nursing Director at the Area and Regional teams.
9. The combination of national service specific advice; a programme management structure that links all parts of the NHS CB from national to local; medical director leadership from provider through to NHS CB; and an innovative model of democratic decision making, will support the delivery of a true focus on equitable access to specialised services for all and deliver the greatest value for money for the NHS with national consistency. The focus on outcomes based commissioning is key for future services.

Clinical Reference Group Membership

10. A devolved clinical leadership model forms the basis of clinical advice in supporting the direct commissioning function of the NHS CB, preparing national service strategy and in developing service specifications and policies. The model will proactively provide specialist clinical advice. Clinical Reference Groups (CRGs) covering all prescribed specialised services will draw membership from each of the geographies covered by the 12 Senate areas.
11. Specialised Services CRGs have been established to cover the full range of specialised services defined within the Specialised Services National Definition Set (SSNDS) portfolio. Initially conceived as assurance groups, the programmes of work for specialised services were restructured around the CRGs to redefine them as the key delivery mechanism for the development and assurance of specialised services contract products. The groups will be leaders in developing the products required for the effective commissioning of the specialised services.
12. Each CRG has an identified core set of commissioning 'products' to develop each year. The group will work closely together to gain consensus of agreement in the development and completion of those products.

13. Clinical Reference Groups. Internal Medicine Programme:

Cystic Fibrosis (CFS)	Cardiac Surgery (CSY)
Hepatobiliary and Pancreas (HPB)	Pulmonary Hypertension (PHN)
Specialised Endocrinology (EDO)	Specialised Dermatology (DMT)
Vascular Disease (VAS)	Specialised Rheumatology (RHU)
Morbid Obesity Surgery (MOS)	Specialised Respiratory (RSP)
Renal Dialysis (RDI)	Interventional Radiology (IRY)
Renal Transplant (RTR)	Specialised Imaging (SIG)
Specialised Colorectal Services (SCS)	Specialised Diabetes (SDM)
Complex Invasive Cardiology (CIC)	Heart & Lung Transplantation (HLT)

14. Clinical Reference Groups. Cancer & Blood Programme:

Radiotherapy (RTY)	Specialised Immunology & Allergy (IMM)
PET-CT (PET)	Thoracic Surgery (TSY)
Specialised Cancer (SCR)	Upper GI Surgery (UGI)
Blood & Marrow Transplantation (BMT)	Sarcoma (SCA)
Haemophilia & bleeding disorders (HPA)	CNS Tumours (CNS)
HIV (HIV)	Specialised Urology (URO)
Infectious Diseases (INF)	Chemotherapy (CTY)
Haemoglobinopathies (HAS)	Complex Head & Neck (HAN)

15. Clinical Reference Groups. Mental Health Programme:

Specialised Services for Eating Disorders (EDS)	Tier 4 Child & Adolescent Mental Health Services (CAM)
High and Medium Secure Mental Health (HMS)	CaMHS Secure Services (CSM)
Low Secure Mental Health (LSM)	Tier 4 Severe Personality Disorder Services (adults) (SPD)
Specialised Mental Health Services for the Deaf (MSD)	Mental Health Specialised (MHS)
Gender Identity Services (GIS)	Forensic Pathway Group (group of CRG Chairs)
Perinatal Mental Health (PMH)	

16. Clinical Reference Groups. Trauma Programme:

Complex Disability Equipment (CDE)	Specialised Ear Surgery (SES)
Brain Injury & Complex Rehabilitation (BIR)	Specialised Orthopaedic Services (SOS)
Adult Neurosurgery (NSY)	Hyperbaric Oxygen Therapy (HBO)
Neurosciences (NSC)	Specialised Ophthalmology Services (OPS)
Stereotactic Radiosurgery (SRS)	Spinal Cord Injury (SCI)
Burn Care (BCS)	Complex Spinal Surgery (CSS)
Cleft Lip & Palate (CLP)	Major Trauma (MTS)
Specialised Pain (SPS)	Adult Critical Care (ACC)

17. Clinical Reference Groups. Women & Children Programme:

Medical Genetics (MGS)	Neonatal Critical Care (NIC)
Paediatric Surgery (PSS)	Paediatric Neurosciences (PNS)
Paediatric Medicine (PMS)	Complex Gynaecological Services (CGS)
Paediatric Cancer Services (PCS)	Specialised Maternity Services (SMS)
Congenital Heart Services (PCA)	Fetal Medicine (FMS)
Metabolic disorders (IMD)	Multi-System Disorders (MSD)
Paediatric Intensive Care (PIC)	

18. 'New for 2013' CRGs include the following:

Interventional Radiology. To pick up the themes of interventional radiology that cross a number of the CRGs. These services are not commissioned directly by the NHS CB but form a major part of a number of services.

Specialised Imaging. To provide leadership at a national level for this rapidly changing field which impacts on many of the specialised services. These services are not commissioned directly by the NHS CB but form a major part of a number of services.

Specialised Diabetes. To pick up the previously nationally commissioned services related to diabetes and to develop any specialised or highly specialised components of diabetic care.

Heart and Lung Transplantation. To pick up the previously nationally commissioned services to develop in partnership with NHS Blood & Transplant the specialised and highly specialised services. Adult services only.

Upper Gastrointestinal (GI) Surgery. To pick up the national leadership of Upper GI Cancer Surgery. This group will have a key role in the future commissioning of specialised cancer services.

Chemotherapy. All chemotherapy drugs come under the direct commissioning of the NHS CB from April 2013. This group will have a key lead role in the future commissioning policies for chemotherapy.

Sarcoma. To include both bone and soft tissue sarcoma services. This group will have a key role in the future commissioning of specialised cancer services.

Central Nervous System (CNS) Tumours. To cover all professional disciplines related to CNS Tumours. This group will have a key role in the future commissioning of specialised cancer services.

Specialised Urology. To include Penile and Testicular cancer. This group will have a key role in the future commissioning of specialised cancer services.

Adult Critical Care. To focus on the common themes of specification across the CRGs. These services are not commissioned directly by the NHS CB but form a major part of a number of services.

We will establish a clinical reference group - '**Multi-system Disorders**' - that will include a number of highly specialised services.

19. A number of cancer services will be commissioned directly by the NHS CB. A revised Specialised Cancer CRG whose membership is formed from the Chairs of the site-specific CRG where there is a major cancer service, to ensure common themes across these groups: Upper GI Surgery; Hepatobiliary and Pancreas; Specialised Colorectal Services; Specialised Dermatology; Thoracic Surgery; Radiotherapy; Chemotherapy; Sarcoma; CNS Tumours; PET-CT; Specialised Imaging; Specialised Urology; Blood & Marrow Transplantation; Complex Spinal Surgery; Complex Gynaecological Services; Paediatric Cancer Services. These groups will work both to deliver the NICE site-specific cancer guidance through the commissioning products of specification and service policy.

Chairs of Clinical Reference Groups

20. The clinical Chair role will continue in the format tested during transition. All current Chairs have been asked if they wish to continue in their role to a maximum of three years from appointment. The Chair roles for new CRGs and replacements will be selected using a competitive process. Adverts will be published in January 2013.

21. Role Description:

- A clinical leader in the field of the identified clinical service from a broad range of professional backgrounds. Experienced as a clinical director, network director, medical director, or professional body leader.
- A voluntary role supported by the host NHS organisation within the professional activity component of the individual's clinical role.
- Provides clinical leadership to the CRG in the development and completion of all specialised services contract products and projects.
- Leads on defining the scope of the specialised service.
- Fully supports the contribution of patient and carer voice to the work of the CRG. Experienced in engaging effectively with patient and public representatives or groups
- Works with other NHS CB staff to communicate and engage with stakeholders about the work of the CRG
- Leads on the development of Quality Measures, Quality Dashboards and Quality Standards.
- Supports the on-going refinement of the methodology for collecting and counting information and activity being developed by the specialised commissioning transition team.
- Leads the identification of potential QIPP schemes for development.
- Participates in bi-annual national CRG summits.
- Leads virtual meetings of the group using teleconferencing and web-conferencing technology supported by national administration. The Chair will agree with the group if any face-to-face meetings are required to conduct effective business, taking into account the needs of all members including patient and carer representatives.
- Reports progress through one of 5 Programmes of Care Boards.
- A key role in innovation through leading the team in horizon scanning, identifying and shortlisting potential innovations within the relevant service area (the innovation portfolio).

National Clinical Director Co-Chairs of Clinical Reference Groups

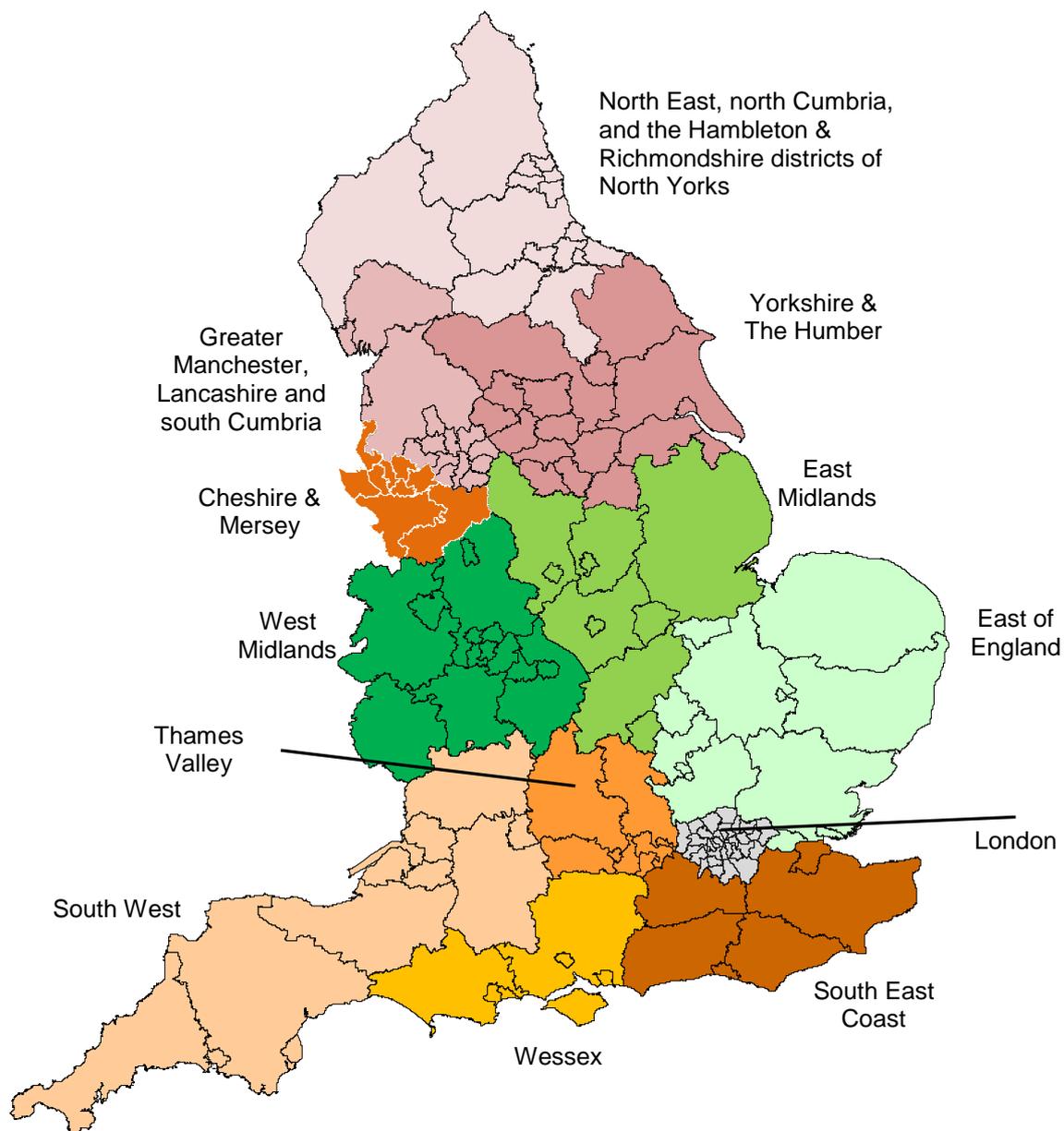
22. The National Clinical Directors will co-chair the CRGs which overlap with their role remit. They will then play a pivotal role in the formation of service strategy that crosses the parts of the health system outside of specialised tertiary care. They may therefore be co-chairing more than one group.

- Children, Young People and transition to adulthood
- Maternity and women's health

- Diagnostics, including imaging
- Urgent care
- Rural and remote care and services
- Dementia
- Integration and frail elderly
- Enhanced recovery and acute surgery
- Rehabilitation and recovering in the community
- Emergency preparedness and critical care
- End of life care
- Major trauma
- Mental health
- Chronic disability and neurological conditions (learning disability)
- Cardiac
- Stroke
- Cancer
- Musculoskeletal
- Spinal
- GI and liver
- Respiratory
- Obesity and diabetes
- Pathology services
- Renal

Regional Clinical Representation

23. For 2013 the regional representation will be modified to be consistent with the new model of direct commissioning through the Area Teams of the NHS CB. A single clinical representative to each CRG from each of the 12 Senate Regions will form the membership.



24. For the London region there will be 3 area representatives due to the different structure of commissioning and the concentration of a number of specialised and highly specialised services in London.
25. All clinical representatives who volunteered for the CRGs in transition will have the opportunity to continue as an Area Team representative. There will be a national process of recruitment via an online application form for new CRGs or for replacement roles, aiming for completion by the end of January 2013. The selection panel will include the CRG Chair and Regional and Area Team Medical Directors.
26. The Area Teams will then have a cohort of service specific leads to support the Area Team Medical Director in their specialised commissioning responsibilities.

27. Each Senate will be able to draw on the service specific expertise for each of the specialised service CRG areas.

28. Role Description:

- Clinical leaders from a broad range of professions related to the clinical field.
- Experienced clinical leaders such as clinical director, network director, or service lead.
- Expert understanding of the clinical field and of any reports, standards, guidance and statutory responsibilities related to that field.
- Represent the clinical body across the sector and in doing so establish strong communication links across all providers. This is the broad range of the clinical body including all professions involved in service delivery.
- Actively participate in the development and completion of specialised services contracts products.
- Work with the team in horizon scanning, identifying and shortlisting potential innovations within the relevant service area.
- Local intelligence as to the impact, clinical and provider interdependences as well as opportunities the products and strategy will have at an area level. They will provide a rich source of information to highlight convergence issues, risks and benchmarking to inform the development of products.
- Role in 'sense check' or 'road test' of concepts and products.

Patient and Public Engagement (PPE) Representatives

29. The position of patients and carers on the CRG is invaluable to the clinical representatives to maintain a patient focus and perspective as commissioning plans and products are developed.

30. To enable patient and carers to fully contribute to the work of the CRG, the Chair needs to be available to PPE reps outside the meetings for additional briefings or discussions, and to be conscious of the need to avoid jargon and acronyms.

31. The future role of the PPE representatives will be defined in the companion paper Clinical Reference Groups: A Guide for Stakeholders.

32. Those representatives, who are already members of CRGs, and wish to continue in their role, will remain in post until a new recruitment process has been developed.

33. Further guidance and support will be available for CRG chairs in working effectively with the PPE representatives, drawing on programme learning to date.

Professional Organisations

34. Professional organisation membership places on the CRGs will be available to professional organisations that play a key part in the coordination and assurance of

training and professional leadership of clinical staff in the service (e.g. Colleges and Associations). There will be no limit on the number that can be affiliated per CRG, but the aim is for no more than 4 organisations (where more than four form a methodology of agreeing who sits as members on the group). The CRG Chair will determine whether the organisation fits the membership requirements and the organisation will propose the individual to represent their organisation.

Commissioning Representation

35. Each National Programme of Care (NPoC) will have two National Directors and 4 Regional Programme Managers. For mental health there are two National Directors and 10 service specialists in each of the specialised commissioning Area Teams. One of the staff members from this structure will have national accountability for two or three CRGs. The allocation will be determined when all are in post. This member will be termed the **Accountable Commissioner**.
36. Other commissioners who worked with CRGs in the transition year may be employed in different parts of the commissioning system in future. In order to aid continuity, their new line managers will be asked to release them to remain part of the CRG at least for the next financial year. This member will be termed the **Collaborating Commissioner**.
37. For some CRGs there may be overlap with other commissioning organisations or national network structures, in which case it might be in the interests of the CRG to include them also as a collaborating commissioner. This can be agreed by the National Programme of Care Director.

Summary

38. The CRG membership is made up of between 15 and 25 individuals. It will be expected that all members maintain an active interest. The Chair will reserve the right to ask members to step down if they are not actively engaged in the functions of the group or persistently fail to meet group determined ground rules.
39. The members are:
 - Clinical Chair. Selected through advertisement in BMJ and NHS Jobs
 - 14 Area Team members. One for each Senate area, 2 additional members from London. Online register of interest on the NHS CB website, selection by Regional and Area Team Medical Directors
 - Patient or carer experience members. Selection methodology to be defined in the paper Clinical Reference Groups: A Guide for Stakeholders
 - Up to 4 professional organisations invited by the Chair but ensuring all professional organisations have equitable access
 - The Accountable Commissioner and one or more Collaborating Commissioners

Stakeholder Engagement

40. The participation of stakeholders in the development of future strategy for specialised services, including rare diseases, is designed to enable the CRGs to deliver significant outputs whilst maintaining efficiency and pace. The revised strategy has been built on the desire to deliver far greater inclusivity; to secure a process for seldom-heard groups (both patients and staff); to enable stakeholders to become more confident and able to convey the issues that affect them, and to focus on the live issues that stakeholders believe are affecting the quality of service delivery. In doing so, there will be greater opportunity for stakeholder engagement in the development of the strategy and commissioning products; promoting openness and transparency in the decision making processes across the portfolio.
41. The stakeholder strategy aims to enable patient support organisations to lead elements of work that will integrate with the work of the CRGs. Many such organisations have the resources to offer a great deal to the strategic development of the commissioning of specialised services.

Stakeholder Identification

42. All stakeholders will be asked to self-register their engagement with each of the service specific CRGs, or with a Programme of Care, or with a Portfolio. This will allow collaborative groups to identify their interaction with a wider part of the structure and with service specific support groups. Stakeholders can register with more than one CRG, Programme, or Portfolio. An on-line registration form will be used, building on the successful use of this technology, in the transition year.

Stakeholder Engagement Plan

43. Each CRG will develop an annual stakeholder engagement plan that is bespoke for the activity that that CRG is planning to undertake during the year. This will be developed with the participant stakeholders and published at the start of each financial year.
44. The financial resources for each engagement plan and the impact on NHS expenditure will be assessed. It is important that the national commissioning team ensures that such plans are financially efficient and maximise the use of modern and varied methods of communication to broaden the level and reach of engagement activities. CRGs will work through regional clinical leads and programme of care leads in utilising the local engagement process wherever possible and appropriate to do so.
45. Further details on the formation of the stakeholder engagement plan will be developed in Clinical Reference Groups: A Guide for Stakeholders.

Programme of Care Boards

46. The CRGs will be organised into five Programmes of Care (functional clustered services) as proposed in the emerging national operating model for specialised commissioning.
47. A single clinical Chair for each Programme of Care is selected from the Chairs of the constituent service specific CRGs. The CRG Chairs select the Programme of Care Chair by election. The position is held for 3 years. Re-election can be for a further 3-year term.
48. The Programmes of Care are:
- **Mental Health – Secure, specialised and highly specialised mental health**
 - **Women & Children** - Women and children's health, congenital and inherited diseases
 - **Cancer & Blood** - Infection, cancer, immunity, and haematology
 - **Trauma** - Traumatic injury, orthopaedics, head and neck, and rehabilitation;
 - **Internal Medicine** - Digestion, renal, hepatobiliary, and circulatory systems.
49. The Programmes of Care work across the national and regional structures of the NHS CB.

Programme Management

50. The five programmes are led managerially by a National Programme of Care Director and by a Highly Specialised Programme Director. They will form a programme management team to include four Regional Programme Managers for each of the acute programmes and one Regional Programme Manager for Highly Specialised Services.
51. For mental health the service specialists in each of the 10 Area Teams will form the National Programme Board
52. There will be a monthly Programme Board for each of the five programmes. These boards are advisory, working through the Portfolio Board to the NHS CB. They are accountable to the Portfolio Board for the work programme they are managing.

Portfolio Management

53. The three portfolios will maintain oversight of the programmes of care and will ensure their strategic focus is aligned to the five outcome domains.
54. There will be monthly Portfolio Board meetings to maintain this oversight. The Clinical Assurance Group and Finance Assurance Group responsibilities will be replaced by this Board.

Pathfinder Working Groups

55. Many of the specialised services work across a pathway of care that extends into many parts of the health system. The NHS CB directly commissions two main elements - primary care and tertiary specialised care. The new commissioning landscape has the opportunity to deliver meaningful change across the end-to-end patient pathway. The integration of patients, primary care, secondary care, tertiary care, with Clinical Commissioning Groups (CCGs) and the NHS CB direct commissioning function, creates an opportunity to deliver innovative solutions which can be diffused and adopted using the available commissioning levers.

Formation of a Pathfinder Group

56. The CRG Chair will seek approval from the Clinical Director that there is an ambition to deliver whole pathway change in a well-defined element of the service. Pathfinder Groups may cross more than one CRG.

57. The Programme Director will seek sponsorship of the Pathfinder Group from one of the five Domain Directors in the Medical and Nursing Directorates and/or a National Clinical Director.

58. A minimum of two CCGs will need to be found who will be prepared to join the Pathfinder Group. It is preferable that the CCGs involved have different population issues related to access to the specialised service in question, such as one urban and one rural CCG. The CCG would need to put in resources to the group work such as a management and clinical lead, providing focus group events, process mapping skills etc.

59. The Portfolio Board will receive a full proposal for a time-limited group to be formed, agree the outputs and approve establishment.

Outputs

60. For the directly commissioned elements of the pathway the outputs should include a revision to the service specification or formation of a new clinical access policy. Clear 'flags' at the start and end of the specialised pathway can then be linked with clarity of the future funding models. Commissioning guidance can be developed for the CCG commissioned elements of the pathway.

Specialised Commissioning Clinical Reference Group Summit

61. A six monthly Summit of the Chairs, Co-Chairs and National Commissioning Team. This will be an opportunity for group members to meet and network and for the National Team to work with CRGs to help set the brief and direction of the work. They will be hosted by one of the top 20 specialised service providers in turn, ensuring rotation around the geographical regions.
62. The first Summit, hosted by North Bristol NHS Trust, had a focus on the introduction of the work programme and the development of service scopes for those services new to specialised commissioning.
63. Imperial College Healthcare NHS Trust in London hosted the second Summit in September 2012. Here, the Chief Executive, Medical Director, and Chief Operating Officer of the NHS CB outlined the future role and function of specialised commissioning.
64. The next Summit is planned for April 2013. CRGs will receive details about the next event in due course.

Communications and Media

65. Communications may be received from external organisations regarding CRG activities. All communications should be directed to the office of the Clinical Director Specialised Services to provide the response on behalf of the NHS CB.
66. The CRG work programme will require support in terms of communications input. Externally, the CRGs need to communicate their work to stakeholders and to the wider public, when appropriate via the media. Internally, it is vital that information flows between individual CRGs, and across the different directorates of the NHS CB, are developed in such a way that they are robust, timely and consistent, and are established in partnership with the CRGs themselves to ensure that they are fit for purpose. This inclusive approach to communications planning will ensure greater ownership of communications amongst the CRGs themselves, and will deliver more positive outcomes in terms of stakeholder engagement and media coverage.
67. Future communications support to CRGs will be the responsibility of the NHS CB. This will include not only internal and external communications, but will also include the production of all public-facing documentation relating to CRGs and associated sign-off and branding processes. Final details relating to NHS CB communications structures are still under discussion. In the meantime, communications support to CRGs will continue to be carried out via the specialised commissioning communications and engagement network, in conjunction with colleagues in the emerging NHS CB structures.

Scoping of Service Lines

68. A national Clinical Advisory Group (CAG), providing formal clinical advice to ministers, will test the scope of specialised services against the four factors in the Health and Social Care Bill. These are the factors that the Secretary of State would consider when deciding whether or not a service should be 'prescribed' and therefore commissioned by the NHS Commissioning Board:

- The number of individuals who require the provision of the service or facility;
- The cost of providing the service or facility;
- The number of persons able to provide the service or facility; and
- The financial implications for CCGs if they were required to arrange for the provision of the service or facility.

69. The CRGs have a lead role in defining and reviewing the scope of each service and how best the specialised elements can be defined and quantified.

70. Previous discussions about prescribed specialised services have recommended that some services might be better commissioned by CCGs rather than by the NHS CB and should be subject to 'early review'. These services are:

- Adult specialist cardiology services
- Adult specialist eating disorder services
- Adult specialist pulmonary hypertension services
- Bone anchored hearing aid services (all ages)
- Neuropsychiatry services (all ages)
- Specialist morbid obesity services (all ages)
- Specialist neonatal care services
- Specialist rehabilitation services for patients with highly complex needs (all ages)
- Specialist services for severe personality disorder in adults

CRGs will have a key role to play in defining the scopes for these services so that they can be considered by the CAG.

71. The CAG also agreed that there were some services that had previously been described as 'specialised' (but which had not been commissioned as such) and which should not be prescribed. In the case of *Specialised services for Asperger syndrome and autism spectrum disorder (all ages)*, the CAG was unable to identify an adult service that met the four factors and recommended that CCG commissioning was a better option, especially in light of the national focus on localism set out in the national strategy. This recommendation would also be subject to 'early review'.

72. CRGs may also need to input to the CAG about services that are currently commissioned by CCGs but which might be more appropriately commissioned by the NHS CB, and about possible new treatments that were not part of existing services and which might be commissioned by the NHS CB.
73. In the event of these changes to the commissioner of services being agreed, the Manual will need to be updated and CRGs will be asked to review the wording to ensure that it is an accurate reflection of that change.

Commissioning Policy Development

74. A commissioning policy is an important document that describes the healthcare treatment that the NHS proposes routinely to commission for a defined patient group with particular illness within a defined financial year.
75. Before transition to the direct commissioning of specialised services there were variations in commissioning policies. A process of convergence was the key requirement of the transition of specialised services commissioning into the NHS CB. Nationally robust and consistent commissioning policies, enabling equitable access into specialised services, no matter where the service user lives or accesses specialised healthcare, is the aim.
76. The work of the CRGs in terms of policy development on an annual basis will need to be prioritised. Such work may need to draw on activities such as health technology appraisals, robust and meaningful consultation, and legal advice.
77. Members of the CRG should take into account the following when considering existing, and developing new, policy:
- Healthcare needs of the population in question – examination of the evidence concerning the disease and the various available treatments; consideration of the clinical and cost effectiveness of the various treatment options, and where the intervention sits within the treatment pathway.
 - Relative priority to be allocated as part of the commissioning framework considering:
 - legal requirements
 - the outcome of consultations
 - national NHS policy/directives e.g. NICE Technology Appraisal
 - ethical decision making
 - clinical effectiveness and cost effectiveness
 - investment decisions
78. Commissioning policy development is a core element of the work of a Public Health Consultant within specialised commissioning. Public Health Consultants from the Specialised Commissioning Area Teams will support this work of the CRGs. Formulation of policy is an iterative process requiring engagement of commissioners, clinicians, patients and other key stakeholders such as legal officers. The Public Health lead will be required to work closely with the Chair and group members, engaging at required points in time and keeping them updated about progress. The Public Health Lead will need to engage with other professional existing bodies and the Specialised Services Public Health Network as required to develop the policy.

79. The policy will be developed using a national template for consistent formatting and to ensure all required elements are included.

80. Work programme:

- Annual stock take of existing policies for that specialised service area
- Utilisation of a framework to prioritise the policies for development – those that pose the greatest risk clinically, financially, or politically
- Development of a project plan for each policy with an agreed timeline for development

81. The National Clinical Effectiveness Team will establish a rolling programme of policy development including:

- Horizon scanning for future NICE guidance that will impact on the specialised service portfolio
- Identifying new NICE Interventional Procedure Guidance that may require clinical commissioning policies
- Collating and evaluating individual funding requests (IFRs) that may require clinical commissioning policies. This will include establishing and managing a national IFR database.
- Liaising with the national CRGs to generate a list of interventions that may require a health technology appraisal and/or a clinical commissioning policy
- Commissioning and evaluating health technology appraisals on behalf of the CRGs
- Reviewing existing clinical commissioning policies to ensure they are fit for purpose and up to date
- Establishing national databases to assess outcomes of specific interventions to inform existing and future clinical commissioning policies

Service Specifications

82. The need to achieve a set of nationally consistent service specifications was identified as a key requirement for the commissioning of specialised services prior to transfer of commissioning responsibility to the NHS CB. Prior to transition, there were very few nationally consistent specifications in place, and for a significant proportion of the portfolio of specialised services, no pre-existing service specifications were in place. The work of the CRGs to deliver a complete set of 130 service specifications (describing the full range of services included in the list of prescribed services – excluding those Highly Specialised Services previously commissioned by the National Specialised Commissioning Team) during the transition year, ready for the 2013/14 financial year, by necessity had to be rapid and involved a significant piece of work by all 60 of the CRGs to describe in a consistent way what the NHS CB will commission for the population of England.
83. The development of service specifications follows a national template for common formatting in order to ensure that all required elements are included. These templates are provided by the Department of Health and are consistent with the contract schedules used by other NHS commissioners. Specific guidance, written by the Specialised Services Transition Team, on completing these templates supports the development of service specifications including topics such as how to write aims and objectives for services; how to describe the patient pathway; and how to define eligibility and referral criteria.
84. The 130 new national service specifications developed by the CRGs for 2013/14, plus the existing 70 national service specifications for Highly Specialised services previously commissioned by the National Specialised Commissioning Team, forms a solid platform for future work on refinement and development. Key foci for CRGs in relation to this work stream for 2014/15 specifications (needed by Autumn 2013) will need to be developing robust quality standards for each of the services and the identification of outcomes linking to the domains of the NHS Outcomes Framework.
85. In the Service Specification workshop at the Specialised Commissioning Clinical Reference Group Summit in September 2012, CRGs were asked, having largely completed the work, to consistently describe what specialised services look like now, to start thinking about the longer term and what individual specialised services should look like in three to five years' time. This more strategic vision will help inform the NHS CB and support the longer term development of service specifications. In addition, by identifying the direction of travel for a service, it will be possible to then identify the incremental changes that will support the delivery of that strategic vision that can, year on year, be reflected in service specifications to facilitate service improvement.
86. Further guidance to support the development of 2014/15 service specifications and a toolkit to aid the development of service strategic visions by CRGs will be issued to support this work stream in due course.

Quality Dashboards

87. As part of the work programme for specialised services, a transitional work stream for quality improvement was established to assist those making decisions about future oversight and governance of quality improvement under the NHS CB from April 2013.
88. One of the key recommendations included that commissioners should specify the quality standards to be achieved for individual services by developing quality dashboards incorporating measures of clinical outcome, patient experience and service effectiveness and efficiency. The providers would complete the quality dashboards and performance against them. These would then be available to commissioners and the public, together with a commentary on any variation and evidence of actions taken where improvements are required.
89. Quality standards form a key component of the national template service specification, and where prioritised and summarised into a dashboard, also provide a helpful and credible lever for improvement at service delivery level. Dashboards should reflect NHS Outcome Framework measures and NICE Quality Standards where these are available. The dashboard is a strong tool to facilitate discussion between commissioners, the provider organisation, and the clinical team to focus on interventions that make a measurable change to care quality.
90. A programme of work has since been underway to develop national quality dashboards. In 2012/13 pilot dashboards are being evaluated. Their future place in the quality assurance of specialised services will be assessed following this pilot phase.

CQUINs

What are CQUINs?

91. The Commissioning for Quality and Innovation (CQUIN) framework was established as part of the 2009/10 NHS Operating Framework as an incentive scheme which forms part of the contract between a commissioner and a provider. CQUIN schemes link successful delivery of specific outcomes and actions with the release of an additional payment to the provider.
92. A CQUIN scheme is made up of a number of separate indicators (“CQUINs”) which address a range of clinical areas and issues. The purpose of a CQUIN scheme is to drive quality improvements across a range of areas. An individual CQUIN needs to focus on one or more of four domains: clinical effectiveness, safety, patient experience and innovation. A CQUIN scheme must cover all four domains.
93. CQUIN schemes are subject to monitoring and assessment of progress. Providers need to submit evidence that the CQUIN requirements have been met in order for CQUIN monies to be released by commissioners.

Overall approach to constructing CQUIN schemes

94. Each provider has a single contract covering all the specialised services commissioned. A specialised services CQUIN scheme forms part of this contract. CQUIN schemes apply to all commissioned providers, including NHS and Independent Sector providers that deliver specialised services. Each year a menu of CQUIN options addressing a range of specialised services is refreshed and commissioners choose from this menu when negotiating the annual contracts.
95. CRGs are key to the CQUIN development process. For 13/14 a number of CRGs were asked to become involved in developing CQUINs, with more CRGs being brought into the process for 14/15. This means that the CQUIN menu will be further strengthened and expanded to cover a wider range of clinical areas.
96. CRGs that are involved in CQUIN development are provided with guidance and support to assist them with the process. All CQUINs are subject to a scrutiny process before they are approved for use to ensure that all CQUINs are robust, challenging and achievable.

What makes a good CQUIN?

97. Developing a CQUIN offers an important opportunity to bring about significant quality improvements and deliver better care and outcomes for patients. A successful CQUIN is one that is accepted by providers and delivers a tangible improvement in quality. **In order to do this a CQUIN needs to comply with the following requirements:**

- **Specific** - A CQUIN must be clearly defined including the overall purpose and the goal(s) that need to be accomplished. This includes providing justification for selecting the area for improvement and benefits of accomplishing the goal(s). This will often include explicit links to QIPP objectives.
- **Measurable** - It is essential that progress with a CQUIN can be monitored in a fair and transparent way. Part of each CQUIN is a set of concrete criteria for measuring progress. Attached to this may be a payment framework to allow commissioners to determine release of associated monies. CQUIN schemes undergo a quarterly monitoring process by commissioners for which providers are required to provide monitoring information. For each CQUIN there must be clearly defined targets or requirements that need to be met each quarter. These can be quantitative measures (e.g. % achieved or number of patients), or qualitative products (e.g. an update report or action plan), or often a mixture of both. Setting the monitoring requirements is part of the CQUIN development process
- **Attainable** - CQUIN goals need to be realistic and attainable – success should not be out of reach nor should CQUINs support “standard” performance. CQUINs need to be challenging and stretching. However, it must also be possible for a provider to achieve the CQUIN. The achievement of a given CQUIN must be within in the control of an individual provider and not dependant on the actions or inactions of a third party
- **Relevant** - Only a small number of CQUINs can be included in any one CQUIN scheme and it is essential that CQUINs are developed in areas that really matter from a quality improvement perspective. The lead role that CRGs will play in CQUIN development will ensure that CQUINs are clinically relevant and have clinical support. Relevant goals (when met) drive the provider forward. A goal that supports or is in alignment with other goals (including QIPP) would be considered a relevant goal
- **Time-bound** - CQUIN schemes are operational only for the financial year of the relevant contract. The timelines and requirements of a given CQUIN must fit within a 12 month period. In a limited number of instances a CQUIN may be rolled into a second or subsequent year.

Quality, Innovation, Productivity and Prevention (QIPP)

98. The Operating Framework for the NHS 2012/13 emphasised the importance of improving services and patient experience whilst maintaining a grip on performance during a period of transition into the new NHS structure. Meeting the quality, productivity and efficiency challenge will continue to be a challenge. Ensuring all elements are met and sustained will require longer term measures to be taken through clinical service redesign as well as utilisation of quicker methods through use of contractual levers for 2013/14. Changes in service delivery and patient pathways will require an investment of time and clinically-based evidence of the need to change but will result in quality and efficiency improvement in the longer term. Specialised healthcare must remain patient- centred at all times, focusing on pathway integration, improvement of outcomes and experience.
99. The move to nationally consistent commissioning of specialised services presents significant opportunities. The CRGs have a role in the development of productivity and efficiency through a programme of identification and development of clinically approved schemes.
100. A Productivity and Efficiency Handbook will present a number of schemes that can be used in the direct commissioning of specialised services in 2013/14 and which form the beginning of a rolling programme of clinically-approved schemes.
101. The CRGs will be fully briefed on current schemes relating to their specific service area through the handbook. CRGs will continue to develop these further through 2013/14 and onwards by building upon and widening existing schemes; the generation of new ideas, and participation in confirm and challenge clinical panels to shape the schemes into robust costed plans. This should encourage greater innovation and ensure that variation in the provision of prescribed services is reduced.

Innovation

102. Innovation is a central component of the NHS and is key to driving up the quality of care and outcomes for patients.
103. Following the publication of the Government's *Plan for Growth* report in March 2011, the Department of Health (DH) carried out a consultation exercise on how to drive up quality in the NHS through innovation, publishing its response: *Innovation Health and Wealth, accelerating adoption and diffusion in the NHS* in December 2011.
104. Innovation Health and Wealth (IHW) outlined the NHS commitment to innovation, both in terms of its support for research and the rapid adoption and diffusion of the most transformative and innovative ideas, products, services and clinical practices.
105. IHW identified that specialised services commissioners, in conjunction with clinicians and others, were in a position to identify innovations with the potential to transform the quality of care and outcomes for patients, and to rapidly test, trial and evaluate their value to the NHS.
106. In order to accelerate the introduction of new technologies to the NHS, a dedicated Specialised Services Commissioning Innovation Fund (SSCIF) is proposed to be established by the NHS CB during 2013. An Advisory Board reporting to the Medical Director of the NHS CB will be established to oversee this process.
107. The SSCIF will fund innovations such as new pathways, approaches, devices, technologies and medicines which are already developed and available and have an evidence base, or if a product, completed safety testing. The evaluation projects will seek to fill the information gaps for commissioners such as on cost, quality or scope of benefitting population.
108. If it can be demonstrated through the evaluation projects that the innovations can deliver significant improvements in quality or value, commissioners can ensure that they are adopted and diffused at pace and scale across the NHS.
109. The CRGs will have a key role to play in innovation through horizon scanning, identifying potential innovations within each service area.

Glossary

Acute Services		Medical and surgical treatment provided mainly in hospitals, including A&E services, inpatient and outpatient services and, in some cases, very specialist medical care.
Area Team		The 27 Area Teams are 'local outposts' of the NHS Commissioning Board. Core functions include primary care, Public Health, and local relationship management. 10 of the Area Teams are also responsible for specialised commissioning contracting across England.
Clinical Advisory Group	CAG	A national group, providing formal clinical advice to ministers, the CAG tested the scope of each specialised service against the four factors in the Health and Social Care Bill to determine whether a service were truly 'specialised' or not.
Clinical Commissioning Group	CCG	Established as statutory organisations from 1 April 2013, these are groups of GP practices which will be responsible for buying the majority of hospital and community-based health services for patients within their local communities, taking over the role previously performed by Primary Care Trusts.
Clinical Reference Group	CRG	The key delivery mechanism for the development and assurance of specialised services contract products. The CRGs cover the full range of specialised services and comprise clinicians, commissioners, patients and Public Health experts. The CRGs provide clinical advice to the NHS Commissioning Board.
Commissioning for Quality and Innovation	CQUIN	The CQUIN framework was established as part of the 2009/10 NHS Operating Framework as an incentive scheme which forms part of a contract between a commissioner and a provider. CQUIN schemes link the successful delivery of specific outcomes and actions with the release of an additional payment to the provider, with the overall aim of driving quality improvement.
Commissioning Policy		Describes the healthcare treatment that the NHS proposes routinely to commission for a defined patient group.
Domains		The five improvement 'Domains', as set out in the 2011/12 NHS Outcomes Framework, articulate the responsibilities of the NHS in terms of improving patient outcomes.
Highly Specialised Services	HSS	There are around 70 highly specialised services which are commissioned nationally. These are services which

		usually affect fewer than 500 people across England or involve services where fewer than 500 procedures are undertaken each year e.g. heart transplantation and secure forensic mental health services for young people.
Innovation Health & Wealth	IHW	Department of Health response to the Government's 2011 'Plan for Growth' report. This document outlines the NHS commitment to innovation in terms of its support for research and the rapid adoption and diffusion of innovative ideas, products, services and clinical practices.
National Programme of Care	NPoC	CRGs are organised into five National Programmes of Care – mental health, women and children, cancer and blood, trauma, and internal medicine. The NPOCs will work at both a national and regional level and will be responsible for the development of clear and consistent clinical strategies and standards of care.
Operational Delivery Network	ODN	Provider-based networks, focused on the coordination of patient pathways and delivery of nationally-set strategy. ODNs will ensure that quality standards are in place and will support providers in improving quality of, and access to, services.
Patient & Public Engagement	PPE	From 1 April 2013, the NHS Commissioning Board will have a statutory duty to engage with patients and carers and involve the public in making decisions about, and managing, their own care. The presence of patients and carers on CRGs is invaluable in ensuring that the patient perspective and focus is at the heart of the CRGs' work.
Quality Dashboard		Tool used by commissioners to specify quality standards to be achieved for individual services. They incorporate measures of clinical outcome, patient experience, service effectiveness and efficiency. Providers of specialised services complete the Quality Dashboards which are then used to monitor performance and identify where improvements are required.
Quality Standard		A key component of the national service specification template. Where Quality Standards are prioritised and summarised as part of a Quality Dashboard, they provide a helpful and credible level for improvement at service delivery levels.
NHS Commissioning Board	NHS CB	Established in October 2012 as an executive non-departmental public body, the NHS CB will take on its full statutory responsibilities from 1 April 2013. The NHS CB is responsible for improving health outcomes for people in England; supporting, developing and holding CCGs to

		account; overseeing emergency resilience of the NHS system, and directly commissioning primary care, specialised services, military and offender health.
Pathfinder Group		These time-limited groups will be sponsored by the five Domain Directors and will be responsible for developing innovative ideas to deliver meaningful change across patient pathways, with particular emphasis on the revision and/or development of service specifications and clinical access policies, and the development of guidance for commissioners.
Quality, Innovation, Productivity and Prevention	QIPP	A large-scale transformation programme for the NHS, aimed at improving quality of care and ensuring that the NHS delivers high quality services whilst making up to £20bn of efficiency savings by 2014, which will be reinvested in frontline care.
Scope		CRGs played a lead role in defining and reviewing the scope of each specialised service and setting out how best the specialised elements of a service could be defined and quantified.
Senate		Hosted by the NHS Commissioning Board, Clinical Senates are advisory groups of experts from health and social care, each covering one of 12 broad geographical areas of England. They will provide advice and leadership at a strategic level to Clinical Commissioning Groups, Health and Wellbeing Boards and the NHS Commissioning Board.
Service Specification		CRGs have developed a set of 130 nationally-consistent service specifications for each of the specialised services. These, together with the 70 national service specifications for highly specialised services, determine the nature of the service to be commissioned from a provider.
Specialised Commissioning Innovation Fund	SSCIF	A dedicated fund which will be officially launched early in 2013, the SSCIF will fund innovations such as new pathways, approaches, devices, technologies and medicines which are already developed and available, and have an evidence base or, if a product, have completed safety testing. The aim of the SSCIF is to accelerate the introduction of new technologies to the NHS.
Specialised Services National Definition Sets	SSNDS	Describe in detail those services which are deemed to be 'specialised' i.e. with a planning population of more than 1 million people. The definitions provide a helpful basis for service reviews and strategic planning and help with the

		identification of activity that is regarded as specialised. The third edition of the SSNDS was published in 2009/10.
Specialised Services Summit		Held every six months and hosted by a specialised services provider, the Summit provides a networking opportunity for CRG Chairs and co-Chairs to meet together, and with members of the national team, to discuss the CRG work programme.
Strategic Clinical Network	SCN	Hosted by the NHS Commissioning Board, they will be established across England from April 2013 within the 12 geographical areas covered by Clinical Senates. The first SCNs will cover cancer, cardiovascular disease, maternity and children's services, and mental health, dementia and neurological conditions, and will provide advice to Clinical Commissioning Groups and the NHS Commissioning Board.
Strategic Portfolios		There are three Strategic Portfolios – acute, highly specialised, and mental health. Portfolio Directors and their teams will maintain oversight of the National Programmes of Care.

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