NHS England

Methods: National Service Specifications

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Methods: National Service Specifications

Methods of development and approval of national service specifications for directly commissioned specialised services

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Equality and Health Inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the service specifications 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

Introduction

Proposals for new or revised service specifications are coordinated by Clinical Reference Groups (CRGs) during the 'Clinical Build' phase and the relevant Programme of Care (PoC) Board determines which topics are then included in its work programme.

The second phase is the 'Impact Analysis' managed by the national Programme of Care team and concludes through a gateway at the national Programme of Care Board.

The third and final stage is the 'Decision' through the Clinical Priorities Advisory Group (CPAG), Specialised Commissioning Oversight Group (SCOG) and the Specialised Services Commissioning Committee (SSCC).

A. CLINICAL BUILD

The **clinical build** is the first of three phases to form a national service specification for a directly commissioned specialised service. It is coordinated and managed by the relevant PoC team. A clinical evidence review will form part of this phase for service specifications only by exception.

Step A1. **Topic Identification.** The Clinical Reference Groups (CRGs) co-ordinate the identification of services that might benefit from either new or revised national service specifications.

A1.1. The CRG receives advice on the timetable for identifying topics for new or revised service specifications for potential inclusion in the annual PoC work programme.

A1.2. Topics are identified by the CRG itself alongside the list of specifications that may be required as part of a planned procurement or as a result of a national service review.

A1.3. The CRG Chair liaises with other chairs to clarify whether or not it is the CRG best placed to lead the development of a specification and/or other CRGs that may wish to have active involvement.

Step A2. **Clinical Lead Identification and Endorsement.** The CRG considers and puts forward a proposal for a suitable clinical lead with the national credibility and expertise to lead the drafting and development of the specification.

A2.1. The CRG considers potential candidates able to lead the national development of a service specification, giving particular consideration to potential conflicts of interest.

A2.2. The CRG reaches a final decision on who to put forward as its preferred clinical lead, to become the Chair of a working group should the topic be agreed for inclusion in the work programme.

Step A3. Drafting a Preliminary Service Specification Proposal (PSSP)

A3.1. A PSSP is drafted by the proposed Clinical Lead and CRG Lead Commissioner using the template provided.

A3.2. This is then considered and signed off by the CRG as ready for consideration as part of the relevant PoC's work programme.

A3.3. The PSSP is submitted to the National Programme of Care Senior Manager (NPoCSM).

Step A4. Programme of Care (PoC) Board Determines the Work Programme.
The PoC Board considers and determines its work programme within available project resources, prioritising service specifications for inclusion alongside other programme priorities including clinical policies, national service reviews, commissioning for value initiatives, currency and tariff developments and the development of national quality standards and dashboards.

A4.1. Service Specification topics are considered alongside other potential work plan priorities at the POC Board, checking first that they legitimately fall within NHS England's direct commissioning responsibilities and that there are no other barriers to development at that time.

A4.2. The POC Board determines its work programme (noting that clinical policies for inclusion in the work programme are subject to an additional governance gateway via the Clinical Panel), ensuring this can be delivered within available programme resources

A4.3. The PoC Board considers, by exception, whether any of the service specifications agreed for inclusion in the work programme might require a supporting evidence review within the guidance provided. Where this is agreed the CET team is notified.

A4.4. A Unique Reference Number (URN) is allocated to each service specification in development.

A4.5. The CRG and Lead Commissioner receive feedback on whether or not individual service specification proposals have been included in the work programme.

A4.6. The PoC's work programme list is made available to stakeholders.

Step A5. Specification Working Group Established. A Specification Working Group (SWG) is formed for each of the specifications agreed for inclusion on the work programme.

A5.1. A SWG is formed for each specification agreed on the annual wok programme in line with the agreed Terms of Reference (ToRs).

A5.2. The CET team confirms the Public Health representative.

A5.3. The Lead Commissioner confirms the membership of the CRG to the PoC Project Team.

A5.4. The Service Specification Methods document is circulated to all members of the SWG, to provide an overview of the steps to be followed in developing a service specification.

Step A6. Evidence Review Completed. This step is only completed for those service specifications for which the PoC Board has agreed that a supporting evidence review should be produced. The SWG helps shape the scope and focus of the evidence review, which is then undertaken by the public health representative on the SWG.

A6.1. The nominated public health lead on the SWG supports the Clinical Lead and wider SWG membership to identify the scope of the evidence review, producing a PICO ([Population, Indicators, Comparators and Outcomes) summary.

A6.2. The proposed PICO is submitted by the SWG Public Health lead to the Public Health Advisor, Clinical Effectiveness, who reviews the PICO and provides assurance on behalf of the CET. Subject to this sign off, the evidence review can now proceed.

A6.3. The public health lead produces the evidence review within the scope agreed, together with a shorter evidence summary which will ultimately be included in the final service specification document.

Step A7. Service Specification Proposition Developed. The SWG now begins to populate a draft service specification, which can be tested with stakeholders at a later stage and will ultimately form, if adopted, the final service specification document for inclusion in the contract with commissioned providers.

A7.1. The Clinical Lead and Lead Commissioner now work with other members of the SWG to create a Service Specification Proposition (SSP) document, using the template provided.

A7.2. The SWG takes into account whether it is appropriate to reference or reflect other national guidance in the draft specification, and considers how the specification might improve clinical and patient outcomes and value for money for the taxpayer.

A7.3. The SWG is guided to use the word 'must' for standards that are mandatory for all commissioned providers, and 'should' for all other developmental standards.

A7.4. The SSP should use concise, clear and accessible language, explaining any acronyms, so that it is a meaningful reference documents for patients and the wider public as well as clinicians and potential/commissioned providers.

A7.5. A member of the Quality Surveillance Team (QST) provides expert guidance to the SWG on completing the quality standards section of the draft document to test and capture the most valuable metrics covering clinical outcomes, patient experience and measures of structure and process, recorded against the NHS Outcomes Framework Domains.

A7.6. Where an evidence review has been undertaken, an evidence summary will be included in the SSP and the SSP must reflect the available evidence in the model, configuration or standards of care proposed.

A7.7. Commissioned providers should only be listed in the SSP where a restricted list of providers has already determined on the basis of a procurement or other formal selection process.

Step A8. Clinical Panel Assurance. As per step A6, this step is only undertaken for those service specifications for which, by exception, an evidence review has been undertaken. The Clinical Panel considers whether the draft Service Specification Proposition (SSP) appropriately reflects the available evidence.

A8.1. The SSP is completed ready for submission to the Clinical Panel, alongside the completed Evidence Review.

A8.2. Submissions are made via the Acute Team Project Manager, at least two weeks ahead of the next Clinical Panel meeting.

A8.3. The Acute Team Project Manager submits the completed PSSP, SSP, Evidence Review and CPAG Summary Report to the Clinical Effectiveness Team Business Manager for inclusion in the next Clinical Panel's meeting papers.

A8.4. The papers are presented at the meeting by a member of the Clinical Panel, nominated by the Clinical Panel Chair. The Clinical Panel will consider the documents submitted to determine whether it is content that the evidence review and evidence review summary have been completed satisfactorily and that the draft SSP adequately reflects the available evidence.

A8.5 Where the Clinical Panel determines that supporting evidence is not satisfactory the PWG is advised accordingly through the Clinical Panel report, which also outlines any relevant further action, for example asking the working group to consider amending specific sections before resubmission. See A8.7.

A8.6 The NPoCSM drafts the Clinical Panel's report on the SSP, capturing the discussion and conclusions of the meeting. The CET Business Manager then signs off the draft report with the Clinical Panel Chair.

A8.7 The CET Business Manager sends out the agreed report to the Clinical Lead, copying in the Lead Commissioner, the Head of Clinical Effectiveness, the Head of Highly Specialised Services (for HSS topics) and the NPoCSM.

B. IMPACT ANALYSIS

The **impact analysis** is the second of three phases to form a national service specification. It is coordinated and managed by the NPoC and concludes through a gateway managed by the NPoC Board.

Step B1. Collation of Papers for Stakeholder Testing.

B1.1. The Lead Commissioner compiles the documents for stakeholder testing; the Service Specification Proposal; the Evidence Review (if required) including the PICO provided to the reviewer of the evidence; the Search Criteria supporting the Evidence Review; the literature search publication list; the Evidence Summary); the Clinical Panel Report (if passed through panel).

Step B2. Stakeholder Testing. A 2-week period of informal stakeholder testing is completed. The SWG then considers stakeholder responses, amending the draft Service Specification Proposition (SSP) as appropriate, and completes a summary Engagement Report.

B2.1. The Specification Working Group (SWG) prepares to test the Service Specification Proposition (SSP) with stakeholders, including those who have already registered as having an interest in the work of the CRG(s).

B2.2. The SWG considers any additional stakeholders whose views would be relevant and who it would be appropriate to ask to contribute at this stage, forwarding details to the communications team.

B2.3. The draft SSP is sent out to the complete list of stakeholders (with evidence review related documentation, if one has been undertaken), together with a response form.

B2.4. The SWG considers, particularly for more contentious or complex topics, whether a formal stakeholder event should be arranged to supplement testing by email. Otherwise responses are received via a generic email and acknowledged. Collated responses are sent to the Lead Commissioner.

B2.5. The SWG reviews responses, and updates the SSP as appropriate based on the feedback received.

B2.6. An Engagement Report is completed.

Step B3. Completion of an Impact Analysis. An Impact Assessment is completed with advice from a finance specialist. Key assumptions are debated and captured within a supporting spreadsheet.

B3.1. The Lead Commissioner confirms to the NPoCSM that stakeholder testing is complete and receives their agreement to proceed to impact assessment.

B3.2. The NPoC Senior Manager with the NPoC Finance Lead identifies the finance lead available to support the completion of the financial aspects of the impact report.

B3.3. The Impact Assessment is undertaken, identifying the service, patient and financial impact of moving from current pathways of care and/or service configuration to the one(s) proposed in the draft SSP. A supporting spreadsheet is produced to capture workings and assumptions.

B3.4. Impact is modelled over 5 years, or by exception over 10 years (for example if significant demographic changes are expected over an extended period).

B3.5. Section II of the CPAG Summary Report is compiled containing the finance report with information including: budget impact and the net cost per patient over 5 years (calculated as cost to NHS England over 5 years divided by the number of patients receiving treatment over 5 years).

B3.6. The NHS England specialised commissioning finance team checks and approves the cost per patient information, budget impact and also identifies and considers areas of uncertainty**.**

Step B4. The NPoC Board Considers Readiness for Public Consultation. The Board receives the draft SSP and supporting documentation and considers readiness for consultation. If approved, the Board determines an appropriate length of time for the public consultation to run.

B4.1. Key documents are submitted for inclusion in the next PoC Board meeting, including a CPAG cover sheet.

B4.2. The PoC Board considers documentation and confirms whether or not it considers these are ready for public consultation. If so, the Board determines the length of the consultation to be undertaken.

Step B5. Public Consultation. The public consultation is undertaken, and responses collated for subsequent consideration by the SWG. Changes are made as appropriate on the basis of the feedback received and a Consultation Report is produced.

B5.1. Documentation is prepared for consultation, actioning any amendments required by the PoC Board.

B5.2. The following documents are prepared to be included in the consultation:

- Service specification proposition
- Clinical evidence review, if completed
- Engagement report
- Clinical Panel report/s, if relevant
- Impact analysis report
- CPAG summary report

B5.3. The public consultation goes live, via NHS England's web site. Key stakeholders are alerted to the consultation.

B5.4. At the end of the consultation period, the collated consultation responses are then forwarded to the Lead Commissioner. The SWG meets to consider consultation responses and amends the SSP and impact assessment as appropriate taking into account consultation responses. A Consultation Report is produced.

B5.5. Should the nature of the consultation responses indicate that it is appropriate for the SSP be put on hold at this stage, a 'status change report' is completed. PoC Boards will then determine when or if proposals re-enter the process as part of the published work programme.

B5.6. Otherwise an Equality Impact Assessment report is completed, having regard to the feedback from the consultation.

Step B6. National Programme of Care Sign Off. Documentation is submitted and 'signed off' by the PoC Board, and additionally by RDAG for propositions covering Highly Specialised Services (HSS).

B6.1. A complete set of paperwork is now collated ready for the next PoC Board meeting.

B6.2. If applicable, the NPoC Board considers any challenges to the supporting evidence review. The NPoC Public Health Lead will review and provide advice on whether any omission identified is material. If the NPoC Board determines a material concern the evidence review will be returned to the Clinical Effectiveness Team for resolution.

B6.3. The Lead Commissioner ensures that the Board is advised of any changes made in response to the consultation. The NPoC Board determines whether the consultation materially affects the impact analysis report or the policy proposition. Amendments are made as

appropriate and either approved by re-submission to the Board or by Chair's action.

B6.4. The Board considers whether the documentation is now ready to be forwarded to the Clinical Priorities Advisory Group (CPAG,) confirming any amendments it requires ahead of submission.

B6.5. For policy and service specification propositions relating to highly specialised services for rare conditions, an additional summary from the Rare Diseases Advisory Group (RDAG) will be provided to CPAG, to describe the feasibility of generating evidence of the clinical benefit to the relevant patient group given the rare nature of the condition.

The RDAG report also describes the feasibility of generating additional clinical evidence through the provision of the proposed intervention compared with the evidence presented to support the policy or service specification proposition. Where it is deemed that the generation of further evidence is feasible, and the evidence presented is insufficient, CPAG will be advised accordingly. Conversely, if the limited evidence available is considered to be reflective of the rarity of the condition, and generation of additional evidence is deemed unfeasible, CPAG would be provided with that advice.

Step B7. Handover to the CET. A complete set of paperwork is collated in readiness for CPAG and a Commissioning Plan is produced.

B7.1. A completed set of documentation is forwarded to the Acute Project Manager.

B7.2. A Commissioning Plan is completed.

B7.3. The Plan is submitted to the CET team in readiness for CPAG's consideration of recommendation to SCOG in Phase C.

C. DECISION

The **DECISION** is the final stage of three phases to form a national service specification. It is coordinated between the PoC Team and the CET. There are three gateways within this phase: Clinical Priorities Advisory Group (CPAG); Specialised Commissioning Oversight Group (SCOG); and Specialised Services Commissioning Committee (SSCC).

Step C1. Clinical Effectiveness Team Receives the Papers from the National Programme of Care Team. On completion of Phase B by the NPoC team there is a formal handover of key documents to the PoC Project Team and Clinical Effectiveness Team (CET) to enable them to support the process of proposals reaching key governance committees.

C1.1. Key documents completed and handed over from Phases A and B are: the PSSP; the revised final Service Specification Proposition; the Integrated Impact Analysis Report, finance spreadsheet, the Engagement Report (which includes the membership list of the Specification Working Group and list of registered stakeholders), the Consultation Report, the Equality Report and the Commissioning Implementation Plan.

C1.2. Additionally, where by exception an evidence review has been completed, hand over documents also include the Population, Intervention, Comparators and Outcomes (PICO) summary; the Clinical Evidence Review (including the search strategy and literature list); the Clinical Evidence Summary, the Clinical Panel report and potentially a Public Health Lead report (as referred to in B6.2, only produced where an evidence review has been undertaken and there have been any significant challenges to the Clinical Evidence Review during stakeholder testing or consultation).

Step C2. Editorial Checking and Preparation. The editorial team checks the final Service Specification Proposition for consistency, accuracy and to ensure that it is written in accessible language. Two packs of papers are collated: a library pack and an evaluation pack. A Summary Report is populated in preparation for the CPAG meeting.

C2.1. An editorial staff member reviews each Service Specification Proposition, and where necessary corrects formatting and language, ensuring consistency and cross checking statements to ensure accuracy. The NPoCSM signs off the final document.

C2.2. A CPAG Summary Report is compiled and approved by the Head of Clinical Effectiveness to include; service impact information that the NPoC determine needs to be considered by CPAG and, where undertaken, the key facts from the evidence review (including the key health metrics from the evidence review and patient benefits) and the quality of the evidence. The summary report includes a section (part II) containing the finance report with information including: budget impact and the net cost per patient over 5 years. The NHS England specialised

commissioning finance team assures the cost per patient information, budget impact and also identifies and considers areas of uncertainty.

C2.3. The library pack is compiled to include:

- The Provisional Service Specification Proposal
- Integrated Impact Analysis Report
- Finance Spreadsheet
- Engagement Report
- Consultation Report
- Commissioning Implementation Plan

And where undertaken:

- The PICO, which includes the search criteria and the literature search
- Clinical Evidence Review

C2.4. The evaluation pack is compiled to include:

- Summary Report Part I (evidence and service impact)
- Summary Report Part II (finance)
- Clinical Evidence Summary (where undertaken)
- Clinical Panel Report (where undertaken)
- Consultation Report
- Public Health Lead Report (where required)
- Equality Report
- Final Service Specification Proposition

Step C3. Clinical Priorities Advisory Group. CPAG receives draft service specification proposals and makes a recommendation on their adoption. Only those proposals that would require additional investment to enable implementation are considered via the relative prioritization process.

C3.1. **Service developments considered outside the relative prioritisation process**. For service specifications to be considered through this route they have to be confirmed as cost neutral or cost saving to NHS England as a commissioner or satisfy the other factors stated in the Service Development Policy (see Service Development Policy). The members of CPAG receive the evaluation pack including the Summary Report II. CPAG then considers the clinical patient benefit and financial impact that would be delivered through implementation of the service specification. On the basis of this information, CPAG makes a commissioning recommendation to the Specialised Commissioning Oversight Group (SCOG), and proceed to step C6.

C3.2. **Appraisal of Cost/Benefit for Service Specification Proposals Requiring Investment (Relative Prioritisation).** The members of

CPAG receive the evaluation pack(s) (except the Summary Report II and the financial information it contains). CPAG considers the patient benefit that would be delivered through implementation of the service specification and then determines the relative patient benefit of all the proposals being considered as part of the relative prioritisation process (including clinical commissioning policies). This is done without reference to the costs of implementation. Propositions are allocated in equal proportion into one of the three categories of patient benefit: low, medium and high.

C3.3. CPAG members receive the evaluation pack a minimum of two weeks before the relative prioritisations meeting. Members are asked to identify any questions of interpretation before the meeting and consider their opinion for each prioritisation position in three categories. Assurance from all parties outlined in the CPAG Summary Report is confirmed.

C3.4. The CPAG meeting begins with a discussion and questions about each of the final propositions. Members of the CET, NPoC Senior Managers and Heads of Acute and Mental Health Programmes are in attendance to support CPAG discussion and to provide answers to questions raised. The library pack is available at the meeting for reference if required.

C3.5. The CET separates all of the proposals into 5 groupings, depending on the consensus of CPAG, determined by the Chair. These 5 groupings are an intermediate grouping pending final allocation of proposals in equal proportion to low, medium and high patient benefit categories:

- Low
- Low/Medium
- Medium
- Medium/High
- High

C3.6. The number of available positions in the three categories (low/medium/high) is determined by the total number of propositions presented. An equal number of propositions will be placed in each group. Where propositions clearly provide low or high benefit they are placed in the corresponding category. If there is any uncertainty they will be placed in either the low/medium or medium/high catergory. The members then focus on the low/medium and medium/high grouping and move them through deliberative debate filling the available slots in each catergory of low, medium or high. An equal number of proposals are now placed in each catergory.

C3.7. All members review the allocations together as a group to determine whether any further adjustment is required.

C3.8. The Chair calls a close to the discussion on patient benefit.

Step C4. Clinical Priorities Advisory Group - Application of Relative Cost (Relative Prioritisation). The cost per patient is identified and a matrix of cost and benefit is formed and presented to CPAG members.

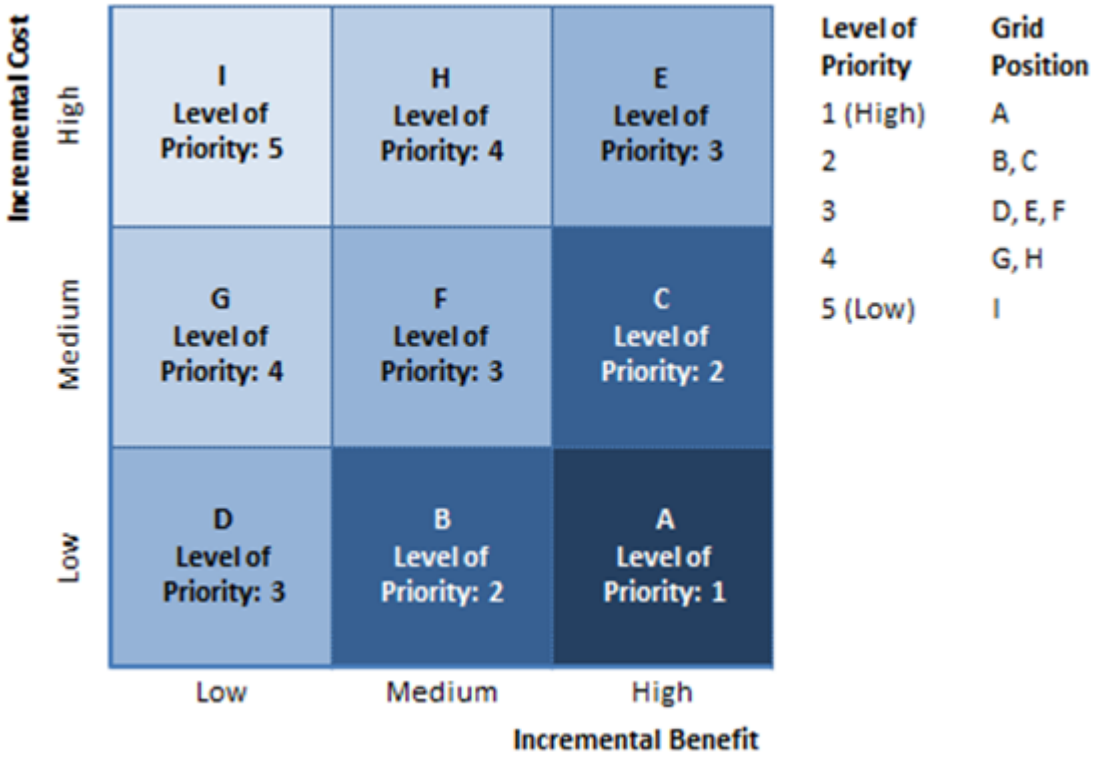
C4.1. While CPAG members are in recess the CET, with finance analytical support, determine the cost-per-patient ranges that will result in the equal division of the propositions into three categories of cost; low, medium and high.

C4.2. CPAG receives the Summary Report Part II and the proposals are allocated to each of the three cost categories, identifying those that may potentially straddle categories due to uncertainties regarding the cost calculations.

C4.3. A three by three 9-box matrix is populated (Figure A). All proposals are thus now presented in five levels of equivalent cost-benefit per patient. Level I is the highest benefit at lowest cost, Level V is the lowest benefit at highest cost.

C4.4. The **unadjusted cost-benefit list** is locked at this point

Figure A Three by three 9-box matrix



Step C5. Clinical Priorities Advisory Group – Consideration of the Strategic Principles (Relative Prioritisation). The members of CPAG consider

whether the relative priority of any of the propositions should be considered for adjustment based upon NHS England's strategic principles. Any adjustment is supported by a narrative of the reasons for the adjustment.

C5.1. The strategic principles that should be considered include:

- The intervention should benefit the wider health and care system
- The intervention should advance parity between mental and physical health
- Consider the benefit of stimulating innovation
- Reduce health inequalities

C5.2. Once each proposition is reviewed an **adjusted cost-benefit list** is locked at this point.

Step C6. Specialised Commissioning Oversight Group – Consideration of Budget Impact

C6.1. **Service developments considered outside the relative prioritisation process**. SCOG receives in-year service development recommendations from CPAG and determines the budget/affordability impact (if applicable) and makes a final recommendation on the commissioning position. The associated Commissioning Implementation Plans are considered for approval. Feedback is provided to the Senior Programme of Care Manager and Lead Commissioner if further amendments and resubmission are required before approval can be considered.

C6.2. **Relative Prioritisation Products**. SCOG receives the unadjusted and adjusted cost benefit assessment from CPAG, and considers these against the available resource for discretionary investment, and makes investment recommendations to the Specialised Services Commissioning Committee (SSCC.) The associated Commissioning Plans are considered for approval.

C6.3. The Clinical Director presents the unadjusted and adjusted (using NHS England's strategic principles) cost-benefit assessment from CPAG, and the narrative for the adjustments. The budget impact for each of the propositions is presented, and the total budget impact for each of the 5 levels of cost-benefit is presented.

C6.4. SCOG considers whether they support or reject the adjustments on individual propositions forming a **revised adjusted cost-benefit list**, if required. The budget impact of the revisions to the levels is reviewed.

C6.5. SCOG notes the available discretionary spend. The proposals within each of the cost-benefit levels are recommended for funding in order, the best value level first, until the available funding is exhausted. The members determine whether propositions from the cost-benefit level that could not all be afforded (the **marginal level**) should be considered and recommended to the SSCC for funding or whether CPAG should be asked to prioritise items within this level.

C6.6. SCOG considers the associated Commissioning Plans and approves these, where adoption is recommended. Feedback is provided to the NPoC Senior Managers where further amendments are required to individual plans prior to implementation, should SSCC approve the adoption and publication of the associated service specification

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Step C7. Specialised Services Commissioning Committee- Board Approval

C7.1. **Service developments considered outside the relative prioritisation process.** The SSCC receives, considers and where appropriate endorses the recommendations made by SCOG.

C7.2. **Relative Prioritisation.** The SSCC receives the cost-benefit level assessments, receives the recommendations from SCOG and determines the final investment decisions.

C7.3. The SSCC receives the unadjusted and revised adjusted cost-benefit list. They receive the recommendations for investment from SCOG and the supporting recommendation for prioritisation of policy and service specification propositions within the marginal level, where applicable.

C7.4. The SSCC considers the recommendations and makes a final decision on investment and considers whether to ask CPAG to prioritise propositions in the marginal level. The decisions are fed back to SCOG and CPAG members, and to members of the PoC teams.

C7.5. The PoC teams work with the gateway and communications teams to complete the final stages of service specification approval for publication and accompanying communications.

C7.6. The final service specifications are published on the NHS England website.

C7.7. A communication circular and accompanying provider letter is drafted detailing the service specifications which are due for publication and confirming the date of publication for distribution to local commissioning teams. This will reflect the relevant elements of the agreed Commissioning Plan.

Glossary

CET	Clinical Effectiveness Team (NHS England)
CPAG	Clinical Priorities Advisory Group
CRG	Clinical Reference Group
CSP	Commissioning Support Programme
HST	Highly Specialised Technology
IFR	Individual Funding Request
MIB	Medical Innovation Briefing
NPOC	National Programme of Care
PSSP	Preliminary Service Specification Proposal
SWG	Specification Working Group
RER	Rapid Evidence Review
SCOG	Specialised Commissioning Oversight Group
SSCC	Specialised Services Commissioning Committee
TA	Technology Appraisal
NPoCSM	National Programme of Care Senior Manager

Appendix A

A GUIDE TO CREATING SERVICE SPECIFICATIONS

NHS England

NHS England directly commissions specialised services for the whole population of England to ensure that everyone has access to treatments and services which are effective and a good use of NHS resources. **Service specifications** are an important component of the NHS contract with each commissioned provider, and help to ensure equitable provision and standards of care for the patients for whom NHS England holds direct commissioning (funding) responsibility. Service specifications are developed via the work of the **Clinical Reference Groups (CRGs)** following a standard process that has three phases.

Phase A Clinical Build

The clinical build is the first of three phases to form a national service specification for a directly commissioned specialised service. It is coordinated and managed by the relevant Programme of Care (PoC). This phase has a focus on identifying appropriate topic areas where significant benefit would be derived from a new or revised national service specification. Specification Working Groups (SWGs) are formed, chaired by a clinical lead, and the SWG produces an initial draft of the service specification. A clinical evidence review will form part of this phase for service specifications only by exception.

The Clinical Reference Groups co-ordinate the **identification** of services that might benefit from either a new or revised service specification.

The relevant CRG nominates a **Clinical Lead** with national credibility and expertise

The Clinical Lead forms a **Preliminary Service Specification Proposal** (PSSP)

The PoC Board considers and determines its annual work programme within available project resources, prioritising service specifications for inclusion alongside other programme priorities

An **Evidence Review** is commissioned if the POC Board considers it required.

Evidence Review

Evidence Reviews can follow different routes

Clinically Urgent	Rapid Evidence Review (RER)
Limited Evidence Base	Public Health England Evidence Review
Complex Evidence Base	Independent Evidence Review

A Specification Working Group (SWG) is formed for each of the specifications agreed for inclusion on the annual work programme. A Service Specification Proposition is developed

The **Clinical Panel** provides assurance that the proposition appropriately reflects the available evidence review (where undertaken)

The proposal moves to the impact analysis Phase B.

A GUIDE TO CREATING SERVICE SPECIFICATIONS

NHS England

Phase B Impact Analysis

The impact analysis is the second of three phases to form a national service specification. It is coordinated and managed by the national Programme of Care team and concludes through a Gateway managed by the relevant Programme of Care Board. During this phase, the draft service specification proposition is subject to informal stakeholder testing, impact assessment, formal public consultation and an equality assessment. A Commissioning Implementation Plan is developed to consider in advance the timing and method of implementation if the service specification is then approved during Phase C (Decision).

The Lead commissioner compiles the documents for stakeholder testing

Stakeholder Testing. The NPoC confirms the stakeholders have been identified and tests the work completed by the Working Group. The responses are reviewed and the Proposition updated. An Engagement Report is completed

An **Impact Assessment** is completed identifying the impact of moving from current pathways of care and/or service configuration to the one(s) proposed in the draft SSP. Key assumptions are debated and captured. The financial Impact is modelled over 5 years.

The **NPOC Board** receives the draft proposition and supporting documentation and considers its readiness for consultation determining the appropriate length of time for the public consultation to run

In Year Service Development

The great majority of propositions should follow the path to 'relative prioritisation' with decisions of investment being made once a year. Propositions that are cost neutral or cost saving, clinically urgent or low cost can be considered 'In Year'. Those which seek additional resource can be considered 'In Year' if the following three criteria are met:

- It is very likely that the proposed service would have been supported by NHS England in the last annual commissioning round, as it represents as **high or higher priority** than other service developments which were approved
- The proposed service to be developed is both **highly clinically effective and has a cost benefit priority level that is being commissioned by NHS England**; and the evidence is robust enough to achieve a high level of certainty
- The proposed service is **affordable** in the current financial year and for the foreseeable future.

Levels of Consultation

Level 1: Minor changes – no further consultation
Level 2: Medium changes that are broadly supported by stakeholder engagement - up to 6 week consultation, limited engagement activity during the live consultation
Level 3: Significant changes that are broadly supported by stakeholder engagement - up to 10 weeks consultation to include some proactive engagement activities during the live consultation period
Level 4: Significant change with some contentious aspects 12 week consultation to include some proactive engagement activities during the live consultation period
Level 5: Highly contentious/ high volume impact on numbers of stakeholders/ high levels of dissent/ high financial implications/ high media or political profile. 12 week consultation plus an extensive range of pre and during engagement activity

Categories of Consultation Outcome

Category 1. Recommendation for approval with no significant service change or convergence cost to implement product. **Category 2.** Recommendation for approval with potential for service change or convergence costs that requires further analysis and discussion
Category 3. Recommendation for further development as the revisions required are substantial, require service reconfiguration, and/or have a known convergence cost and may need further consultation before approval.

A **public consultation** is undertaken, and responses collated. Changes are made as appropriate on the basis of the feedback received and **Consultation and Equality Reports** are produced.

The NPoC approves the specification documents, that effective patient and public engagement has been undertaken, and the finance impact of the proposition is fully defined.

The suite of papers are handed to the Clinical Effectiveness Team for submission to CPAG

A GUIDE TO CREATING SERVICE SPECIFICATIONS

NHS England

Phase C Decision

The **decision** is the final stage of three phases to form a national clinical commissioning policy. It is coordinated and managed by the Clinical Effectiveness Team (CET) and concludes with the publication of the service specification. There are three Gateways within this phase: Clinical Priorities Advisory Group (CPAG); Specialised Commissioning Oversight Group (SCOG); Specialised Services Commissioning Committee (SSCC).

On completion of Phase B there is a formal handover of key documents to the Clinical Effectiveness Team (CET).

The final proposition is checked for consistency, accuracy and to ensure that it is written in plain language. A **library pack** and an **evaluation pack** is prepared. **A Summary Report** is populated in preparation for the CPAG.

The **Clinical Priorities Advisory Group** (CPAG) receives the evaluation pack for all the propositions to be considered for relative prioritisation. As a group they determine the relative patient benefit of each proposition in Low, Medium, and High.

The **Cost per Patient** is determined and the propositions equally divided by rank into the highest, medium, and lowest cost.

A 3x3 matrix is then established with cost on the Y axis and patient benefit on the X axis.

Cost per patient

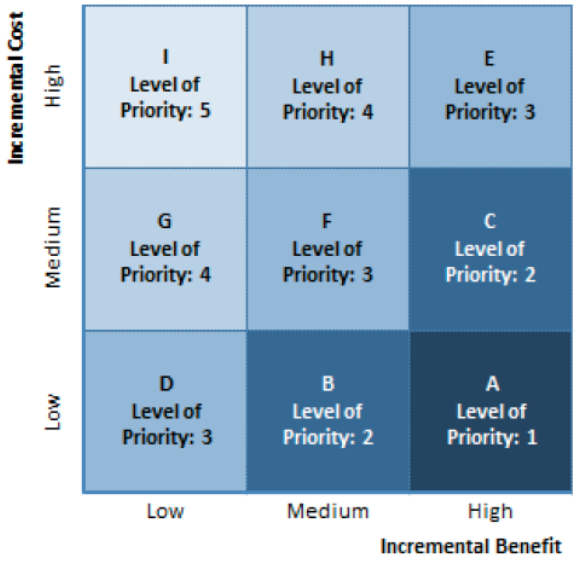
The cost to NHS England over 5 years divided by the number of patients receiving the treatment over the 5 years.

Evaluation Pack

- Summary Report Part I (evidence and service impact)
- Summary Report Part II (finance)
- Clinical Evidence Summary (if relevant)
- Clinical Panel Report
- Consultation Report
- Public Health Lead Report where required
- Equality Report
- Final Proposition

Publication

In Year Service Developments are published throughout the year. Relative prioritisation decisions are published as soon after the SSCC as possible. A circular, with a letter to providers, is distributed to the local commissioning teams to support the introduction of the new clinical policy.



Level of Priority	Grid Position
1 (High)	A
2	B, C
3	D, E, F
4	G, H
5 (Low)	I

The **relative priority** is determined into 5 levels. Level 1 having the lowest cost and highest benefit, level 5 the highest cost and lowest benefit.

The members of CPAG consider whether the relative priority of any of the propositions should be considered for adjustment based upon NHS England's strategic principles.

SCOG receives the cost-benefit assessment, determines the available resource for discretionary investment, and makes recommendations to the SSCC.

The **SSCC** receives the priority order, and makes the investment decisions.

Change Notice for Published Specifications and Products

Amendment **to the Published Products**

Product Name	Methods: National Service Specifications
Ref No	06181

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
Step A8.3 stated that the Clinical Panel received the original Preliminary Service Specification, Evidence Summary, and the Service Specification Proposition.	Step A8.3 has been amended to clarify that the Clinical Panel, in addition to the documents outlined, receives the CPAG Summary Report.	A8.3 (page 7)	CPAG Summary Report not included in original text in error.	Jo Keats, Project Manager,	