Clinical Reference Groups: what are they doing?

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NHS England achievements

The NHS has made significant progress in implementing the Carter recommendations, but there is still some way to go. Since April 2013, NHS England has achieved the following in specialised commissioning:

- Creation of **75 multi-disciplinary Clinical Reference Groups** (CRGs) to provide expert advice on specific services;
- Development of more than **130 service specifications** and more than **40 clinical commissioning policies**
- **Recruitment of patient and public representatives** on to each CRG, along with a **wide network of stakeholders**, with whom to share ideas and test out new approaches to the way services are commissioned.
- The **development of a model of engagement for specialised services**, co-designed with NHS England's Patient and Public Engagement Steering Group.
- The **establishment of 10 area teams** with a specific responsibility for local service delivery in partnership with providers.

NHS Commissioning Board

The Membership of a Clinical Reference Group

STAKEHOLDER MAP

SUPPLIER
Supplier/commercial organisation within or outside the NHS that plays a part in the supply chain of the functions relating to the service area. This may include a company developing drugs or devices for the service area

OTHER ORGANISATION
Other organisation – this might include regulators, professional bodies, media and political organisations

HEALTH SECTOR PARTICIANT
Health and social care service provider or commissioner interested in a particular CRG service area

INDIVIDUAL PARTICIPANT
Patients, carers, members of provider staff or members of the public. These participants do not represent an organisation but as an individual are interested in influencing future service development.

PATIENT OR CARER ORGANISATION
Patient or carer organisation that directly or indirectly represents the interests of people who use the services covered by the CRG. They may provide direct support for the PPE Members on the CRG.

All stakeholders mapped into categories and a CRG specific stakeholder plan formed

CRG

Public Health / Pharmacy...
The Area Team Public Health Lead and Pharmacist will be allocated to the CRGs on an annual basis depending on the work plan

Commissioner...
Accountable lead commissioner for each CRG

Patient and carers...
Four PPE members bringing patient and carer experience to the CRG. They may be individuals or part of a patient organisation.

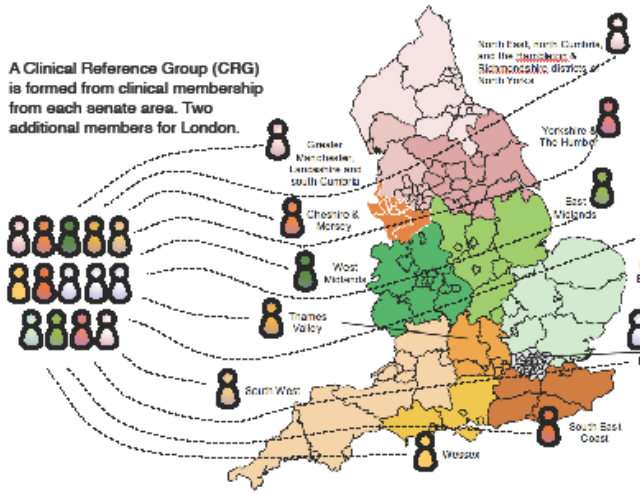
Affiliated organisations who play a key part in the coordination and assurance of training and professional leadership can hold up to four places on the CRG membership. For example Royal Colleges and Specialty

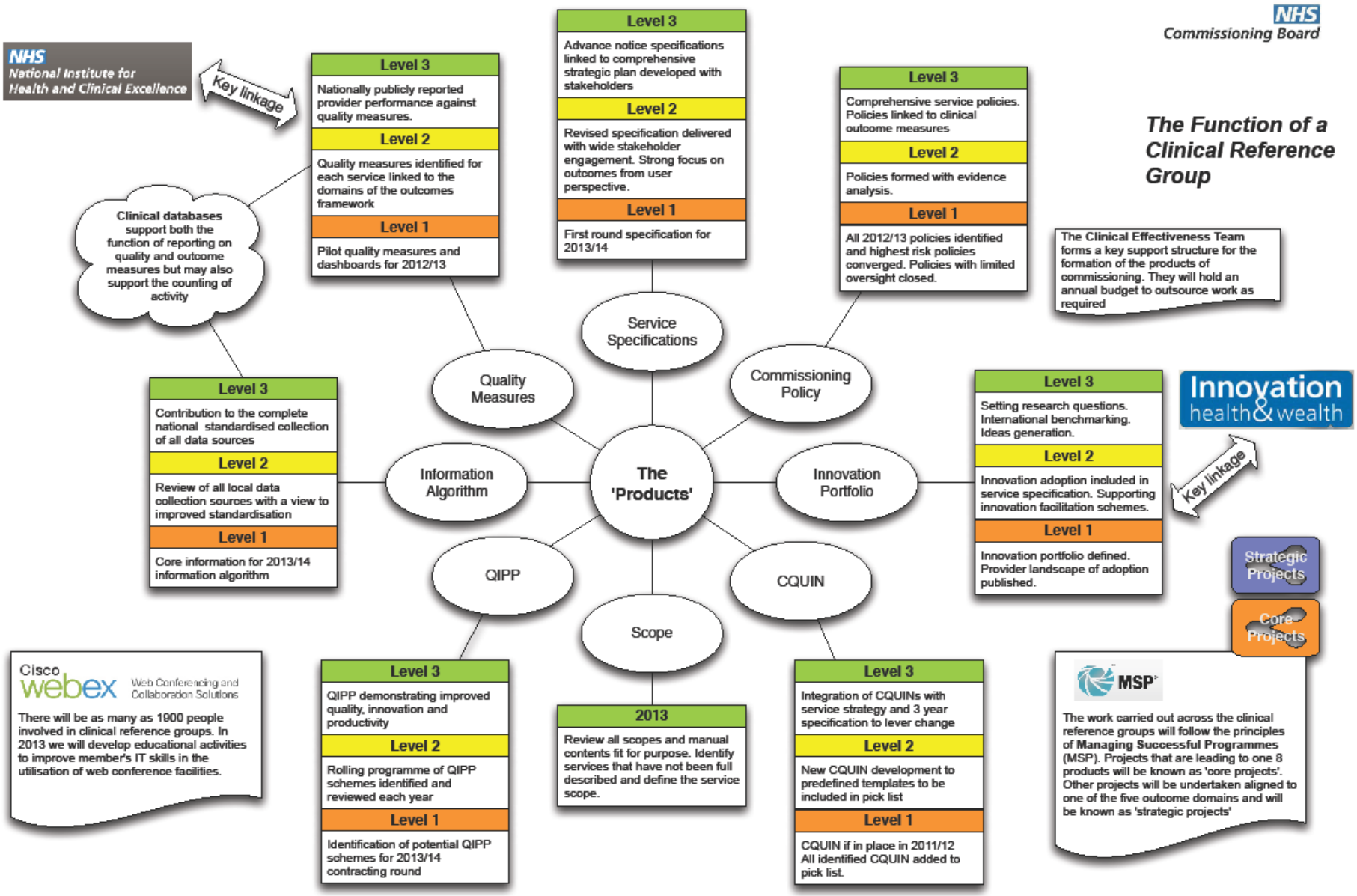
National Clinical Directors...
The National Clinical Directors will co-chair the clinical reference group related to their area of remit

Chairs appointed for each CRG...
A clinical chair is appointed for each clinical reference group who is responsible for enabling the meaningful involvement of all members

Clinical Members from each senate area...

A Clinical Reference Group (CRG) is formed from clinical membership from each senate area. Two additional members for London.




NHS Commissioning Board
NHS National Institute for Health and Clinical Excellence
Key linkage
The Function of a Clinical Reference Group
Clinical databases support both the function of reporting on quality and outcome measures but may also support the counting of activity
Level 3
Nationally publicly reported provider performance against quality measures.
Level 2
Quality measures identified for each service linked to the domains of the outcomes framework
Level 1
Pilot quality measures and dashboards for 2012/13
Level 3
Advance notice specifications linked to comprehensive strategic plan developed with stakeholders
Level 2
Revised specification delivered with wide stakeholder engagement. Strong focus on outcomes from user perspective.
Level 1
First round specification for 2013/14
Level 3
Comprehensive service policies. Policies linked to clinical outcome measures
Level 2
Policies formed with evidence analysis.
Level 1
All 2012/13 policies identified and highest risk policies converged. Policies with limited oversight closed.
The Clinical Effectiveness Team forms a key support structure for the formation of the products of commissioning. They will hold an annual budget to outsource work as required
Service Specifications
Quality Measures
Commissioning Policy
Information Algorithm
The 'Products'
Innovation Portfolio
QIPP
CQUIN
Scope
Level 3
Contribution to the complete national standardised collection of all data sources
Level 2
Review of all local data collection sources with a view to improved standardisation
Level 1
Core information for 2013/14 information algorithm
Level 3
Setting research questions. International benchmarking. Ideas generation.
Level 2
Innovation adoption included in service specification. Supporting innovation facilitation schemes.
Level 1
Innovation portfolio defined. Provider landscape of adoption published.
Innovation health & wealth
Key linkage
Strategic Projects
Core Projects
Cisco webex Web Conferencing and Collaboration Solutions
There will be as many as 1900 people involved in clinical reference groups. In 2013 we will develop educational activities to improve member's IT skills in the utilisation of web conference facilities.
Level 3
QIPP demonstrating improved quality, innovation and productivity
Level 2
Rolling programme of QIPP schemes identified and reviewed each year
Level 1
Identification of potential QIPP schemes for 2013/14 contracting round
2013
Review all scopes and manual contents fit for purpose. Identify services that have not been full described and define the service scope.
Level 3
Integration of CQUINs with service strategy and 3 year specification to lever change
Level 2
New CQUIN development to predefined templates to be included in pick list
Level 1
CQUIN if in place in 2011/12 All identified CQUIN added to pick list.
MSP
The work carried out across the clinical reference groups will follow the principles of Managing Successful Programmes (MSP). Projects that are leading to one 8 products will be known as 'core projects'. Other projects will be undertaken aligned to one of the five outcome domains and will be known as 'strategic projects'

Context

- CRGs have developed **service specifications**
- Healthcare providers have assessed compliance against **key elements**
- Single provider contract with one area team
- CRGs have also developed clinical commissioning policies & policy statements

10 Area Teams

1. Birmingham & Black Country
2. Bristol, North Somerset & South Glos
3. Cheshire, Warrington & Wirral
4. Cumbria, Northumberland & Tyne&Wear
5. East Anglia
6. Leicestershire & Lincolnshire
7. London
8. South Yorks & Bassetlaw
9. Surrey & Sussex
10. Wessex

Neurosciences CRGs

- Brain & CNS Tumours (Cancer & Blood)
- Stereotactic Radiotherapy (Trauma)
- Adult Neurosurgery (Trauma)
- Complex Spinal Surgery (Trauma)
- Neurosciences (Trauma)
- Paediatric Neurosciences (Women & Children)

Other CRGs in cancer POC

- Radiotherapy
- Chemotherapy
- PET
- TYA
- Specialised Cancer
- Complex head and neck

CNS tumours key specs

- Brain/CNS tumours service spec
  - Outcomes recorded (complications/QOL/survival)
  - MDTM discussion before treatment (as per NICE IOG)
  - Specialist care (as per NICE IOG)

- Complex NF-1 service spec
  - MDT care
  - Genetic labs accreditation & ability
  - Equal access to care
  - Appropriate facilities and support for young people
  - Named CNS in NF-1

- NF-2 service spec
  - All patients seen in MDT clinic with >40 pts
  - All patients should be able to discuss auditory rehab
  - Annual MRI with national agreed protocol
  - Appropriate facilities and support for young people
  - All patients who become deaf to discuss ABI with MDT clinic
  - All patients with rapidly growing tumour to be considered by MDT for avastin

Levels of compliance

1. Fully compliant
2. Fully compliant by 1/10/13
3. Unlikely to be fully compliant by 1/10/13 - temporary derogation application required with action plan in place to support compliance
4. Unlikely to be fully compliant - significant concerns about compliance in medium to long term or other significant concerns to be discussed

Service Specifications

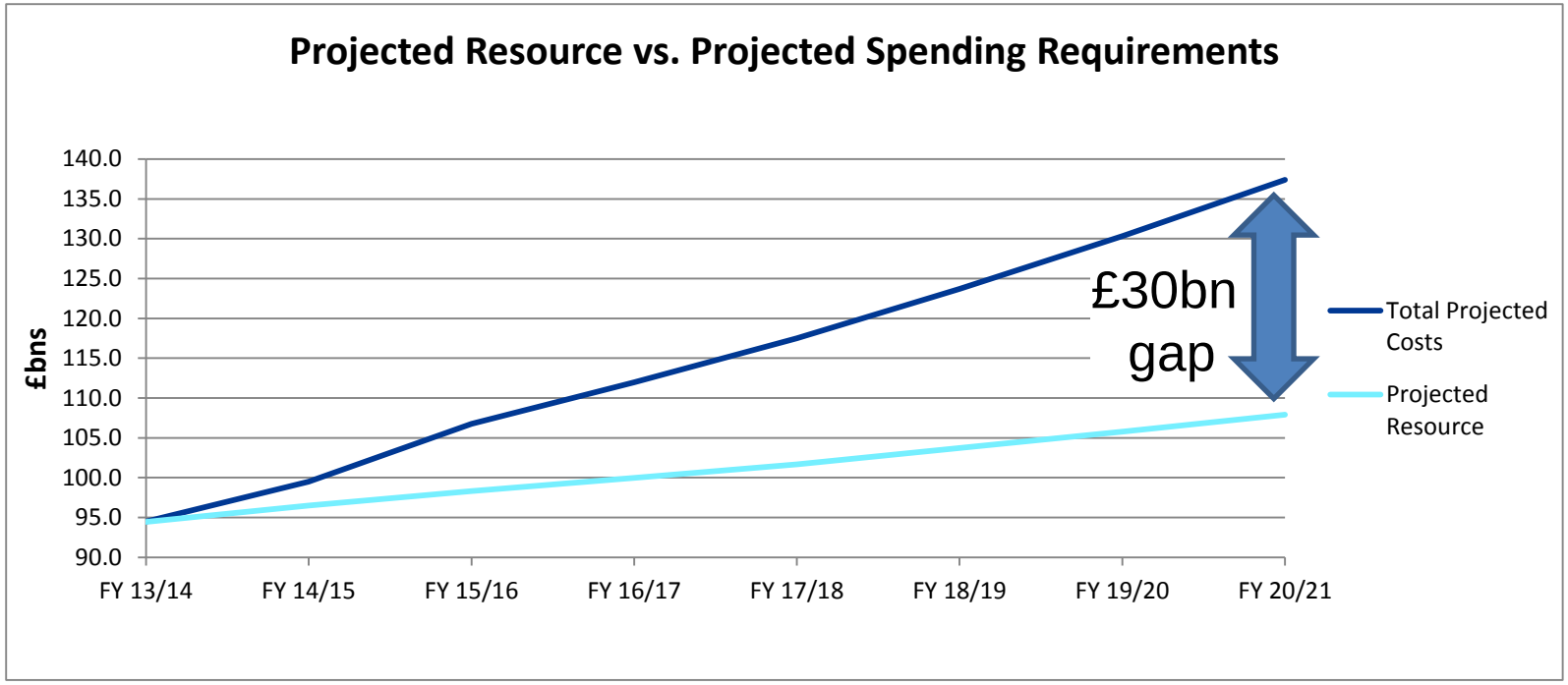
- Many moving from developmental to mandatory part of contracts
- Development of provider action plans to achieve compliance – “derogation”
- Small number require further work prior to introduction
- Area teams performance monitoring delivery of action plans
- NHSE will utilise sanctions for significant or persistent non-delivery
- NHSE does not expect service specs to drive inflation on overall costs

Brain & CNS Tumours Policies

- Commissioning policy in development
  - 5-ALA-guided resection of high-grade gliomas
- Policy statements in development
  - Rare tumours
  - Molecular markers

The Financial Challenge

- If we continue with the current model of care it is likely we will face a funding gap between projected health spending requirements and NHS England resource of around £30bn between 2013/14 and 2020/21.
- This estimate is before taking into account any productivity improvements and assumes the NHS England resource remains protected at flat real.

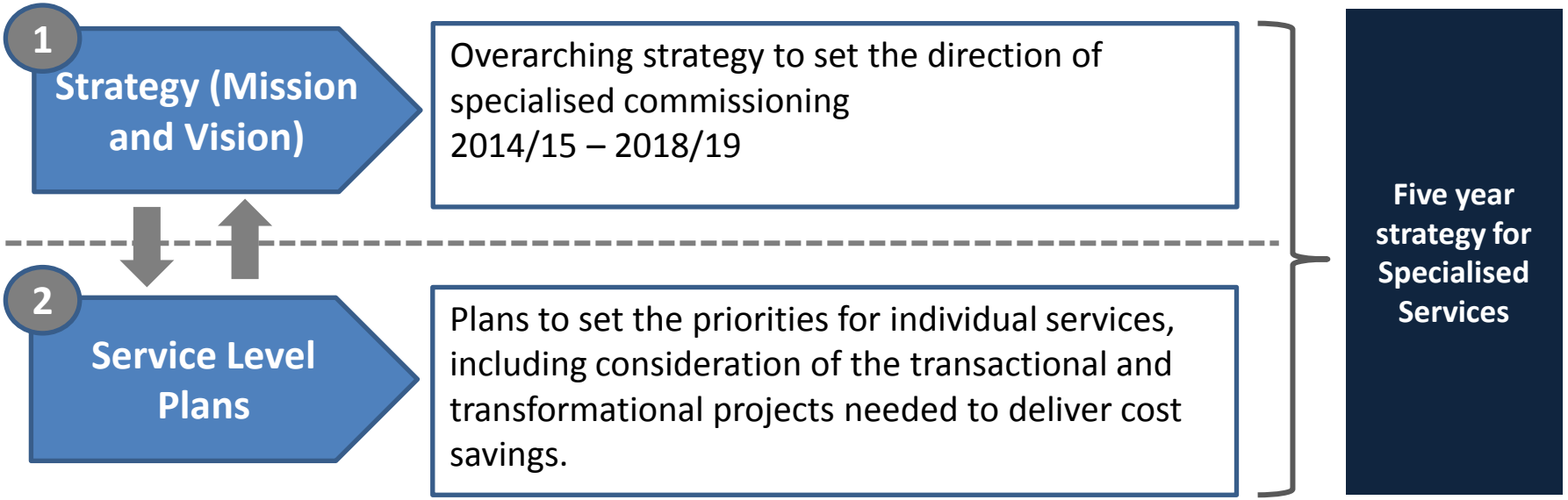


Strategic Direction

1. Ensuring consistent access to effective treatments in line with evidence based clinical policies, underpinned by audit
2. Clinical sustainability programme with providers, focused on quality and value
3. Financial sustainability programme with providers, focused on better value
4. Systematic market review of capacity, consolidating services to address clinical/financial issues
5. New commissioning approaches that promote integrated care
6. Systematic rules-based approach to in-year management of contractual service delivery

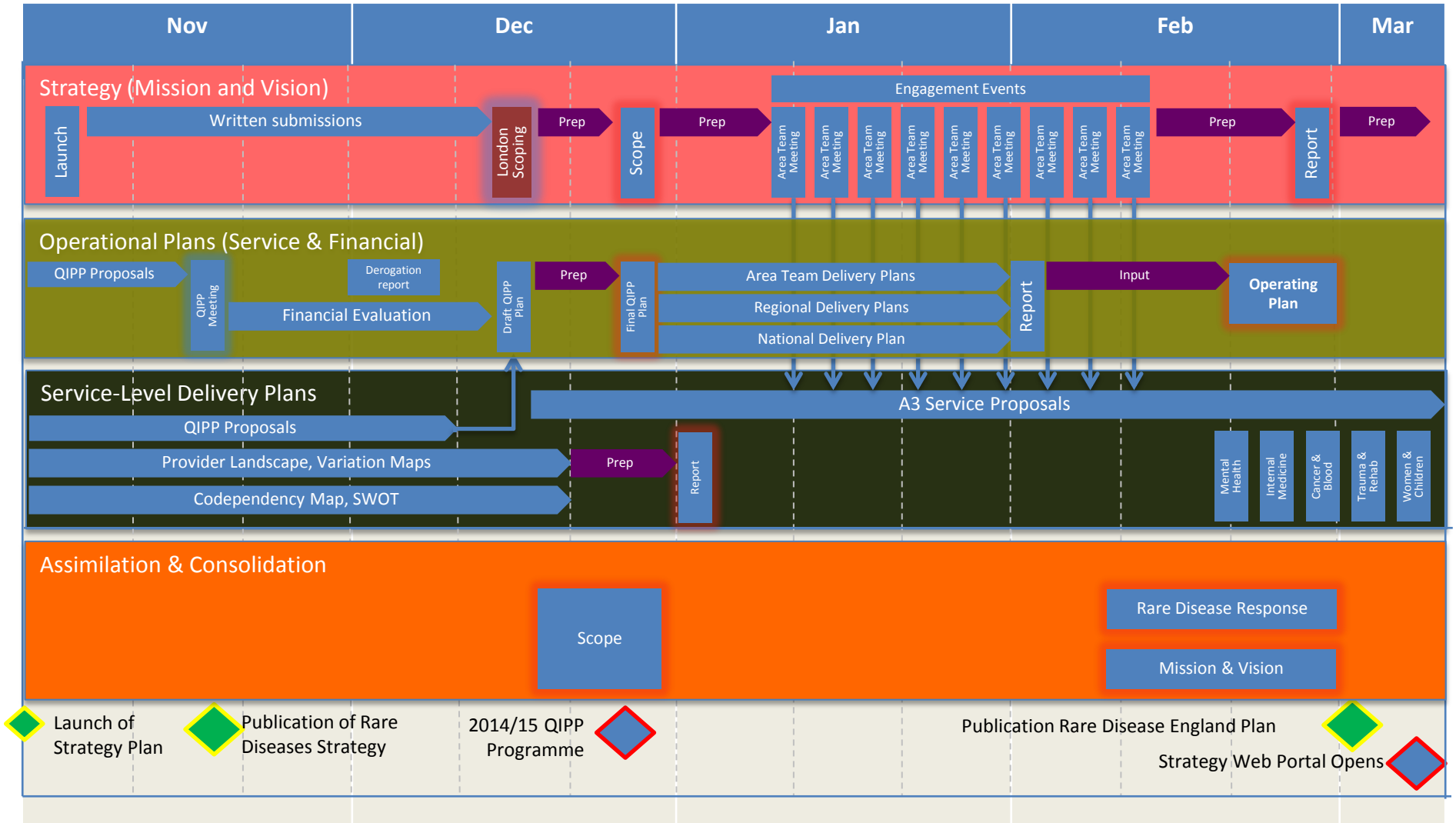
Five Year Strategy Development Process

We wish to produce a strategy which is **aspirational in its goals** and **achievable in its objectives**. Developing a five year strategy for specialised services is vitally important to drive forward the promotion of **equity and excellence in the commissioning of specialised services**.



#speccomm

Strategy Development Overview [1]



Service Delivery Work Stream: CRG toolkit

Co-Dependency Map

- Identify which service specifications are dependent upon co-location of providers for delivery, and what co-location is required:
- **H** (same hospital) | **T** (same town/city) | **A** (same area) | **R** (same region)
  X (no co-dependency)

Baseline analysis

- Consider the existing strengths and weaknesses of each service, and what threats and opportunities will need to be negotiated .
- Consider how external influences may affect and shape each service over the next five years

Provider Landscape

- For each service specification, receive and sense-check a list of providers providing a specialised service/meeting core requirements/not meeting core requirements.
- Output of this work will be a provider landscape, grouped by area team and programme of care

Baseline Analysis: SWOT

- Strengths

1. Dedicated specialists in most trusts
2. Good multi-disciplinary working
3. Improving infrastructure
4. Good CNS support
5. Patient focused services with support from charities

Baseline Analysis: SWOT

- Weaknesses

1. Difficulty adopting NICE IOG in some areas
2. Patchy rehab and lack of joint working with social care
3. Barriers to clinical trial recruitment
4. Slow to implement new technologies
5. Inequalities in accessing services

Baseline Analysis: SWOT

- Opportunities

1. Drive forward sub-specialisation to improve outcomes and reduce costs
2. Improve pathways to improve pt expereience
3. Improve rehab and psychology
4. Research and clinical trials
5. Access to SRS/SRT for metastatic cancer

Baseline Analysis: SWOT

- Threats

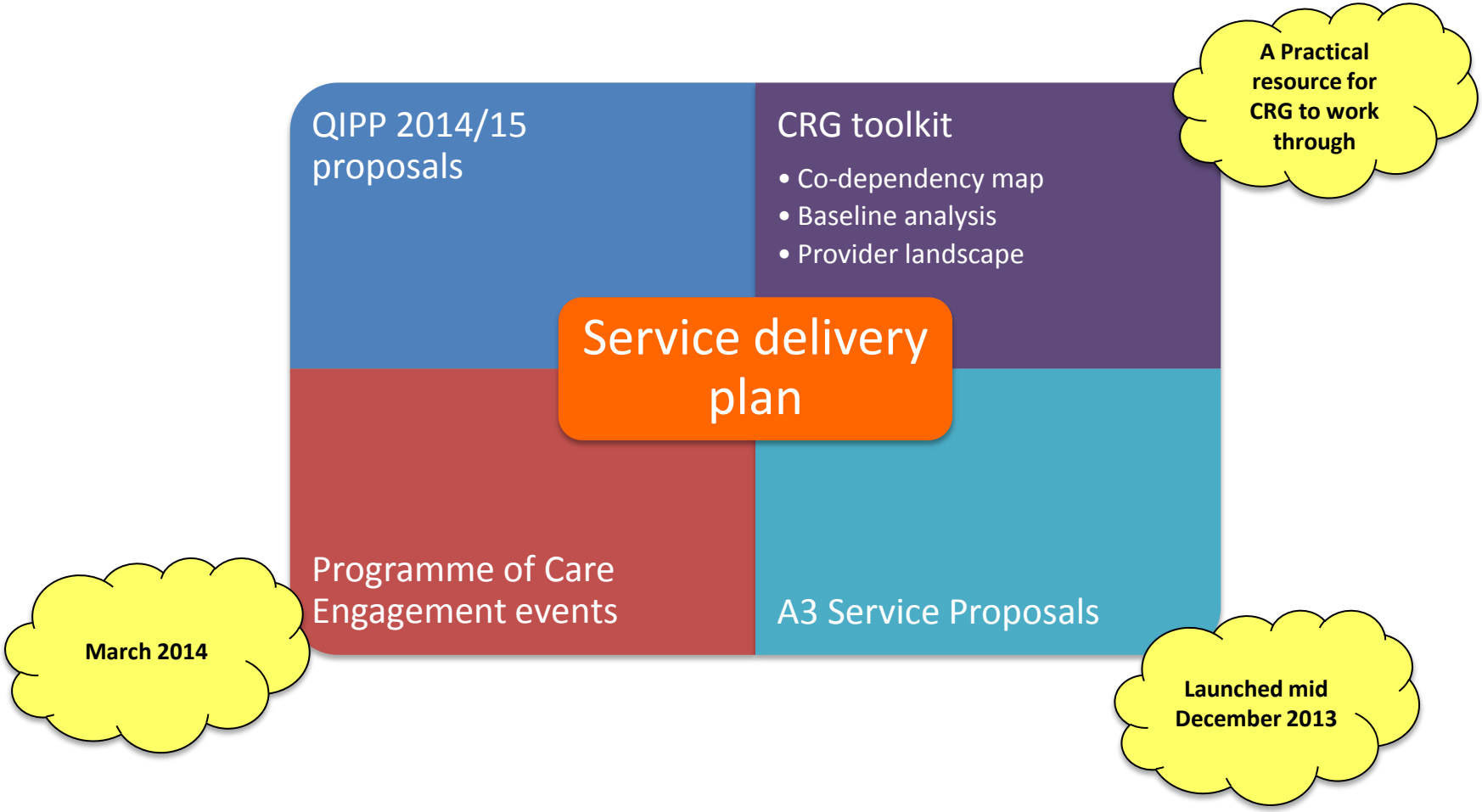
1. Lack of funding and cuts to existing services
2. Capacity and demand issues
3. Lack of evidence base for rarer conditions affecting funding
4. Not able to keep pace with new technologies
5. Uncertainty of commissioning landscape

Baseline Analysis: PEST

- Political / Economic / Sociological / Technological

1. NHS funding reducing
2. 24/7
3. Escalating costs
4. Workforce planning and training
5. National peer review
6. Capacity issues – impact on specialised services
7. Impact of national commissioning of SRS
8. Repatriation to secondary care
9. Access to rehab
10. Impact on MDTs of increasing referrals

Service Delivery Work Stream: Contents



A3 Proposals

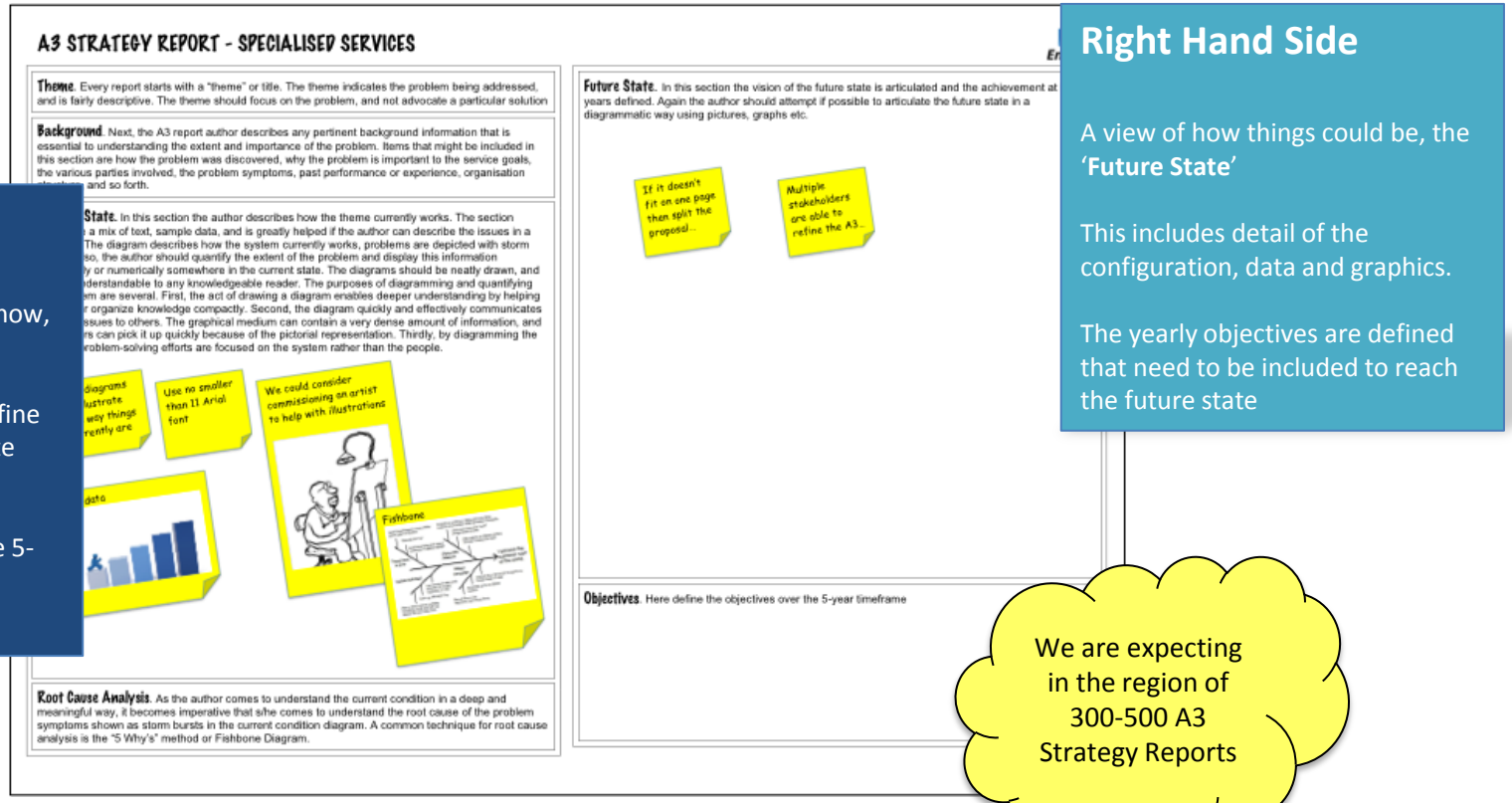
- Simple storyboard that describes a strategic change on one A3 sheet of paper
- Area Teams, CRGs and all stakeholders are all encouraged and will be helped to submit an A3 proposal.
- Each A3 will be scored in two domains: Value for the Patient and Cost/Saving to Deliver. From this a value for money assessment is made.

Left Hand Side

An analysis of how things are now, the '**Current State**'

This should include data to define the issues, graphics to illustrate change etc.

A root cause analysis using the 5-whys or Fishbone diagram is included



Right Hand Side

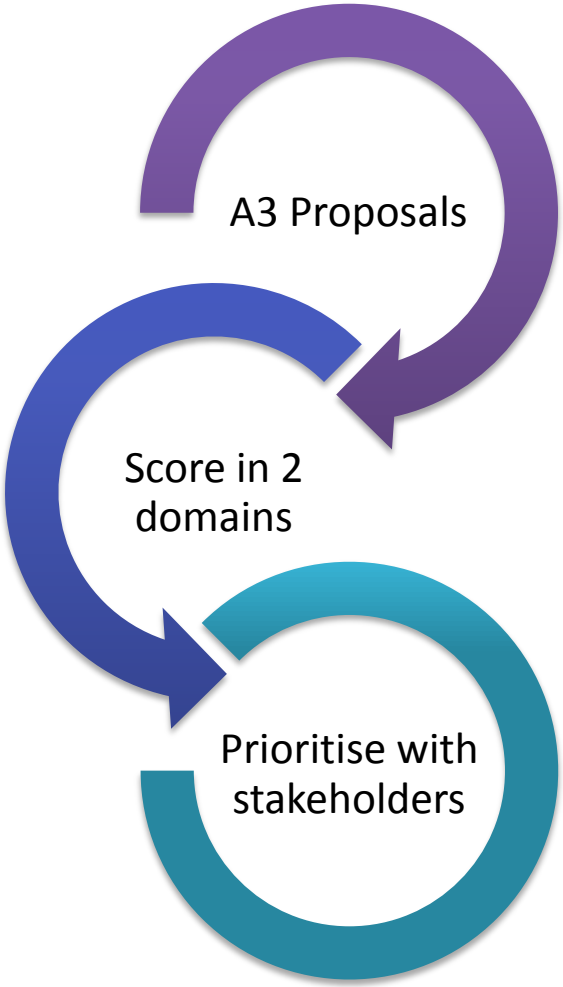
A view of how things could be, the '**Future State**'

This includes detail of the configuration, data and graphics.

The yearly objectives are defined that need to be included to reach the future state

We are expecting in the region of 300-500 A3 Strategy Reports

A3 Proposals – The Process

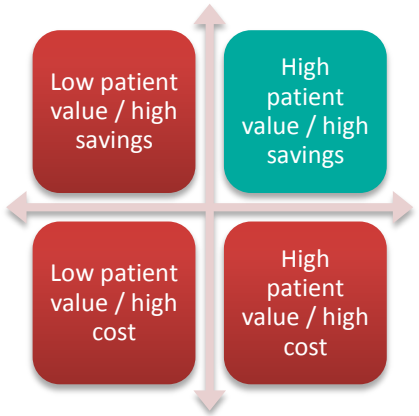


A3 Proposals come from multiple sources, built with stakeholders and developed at the engagement events

Each A3 is scored a) by value to the patient, b) by cost/saving to deliver. Process TBC

A Boston Matrix is used to map all the A3s into a framework. In year one the proposal of greatest value for the highest savings form the first objectives

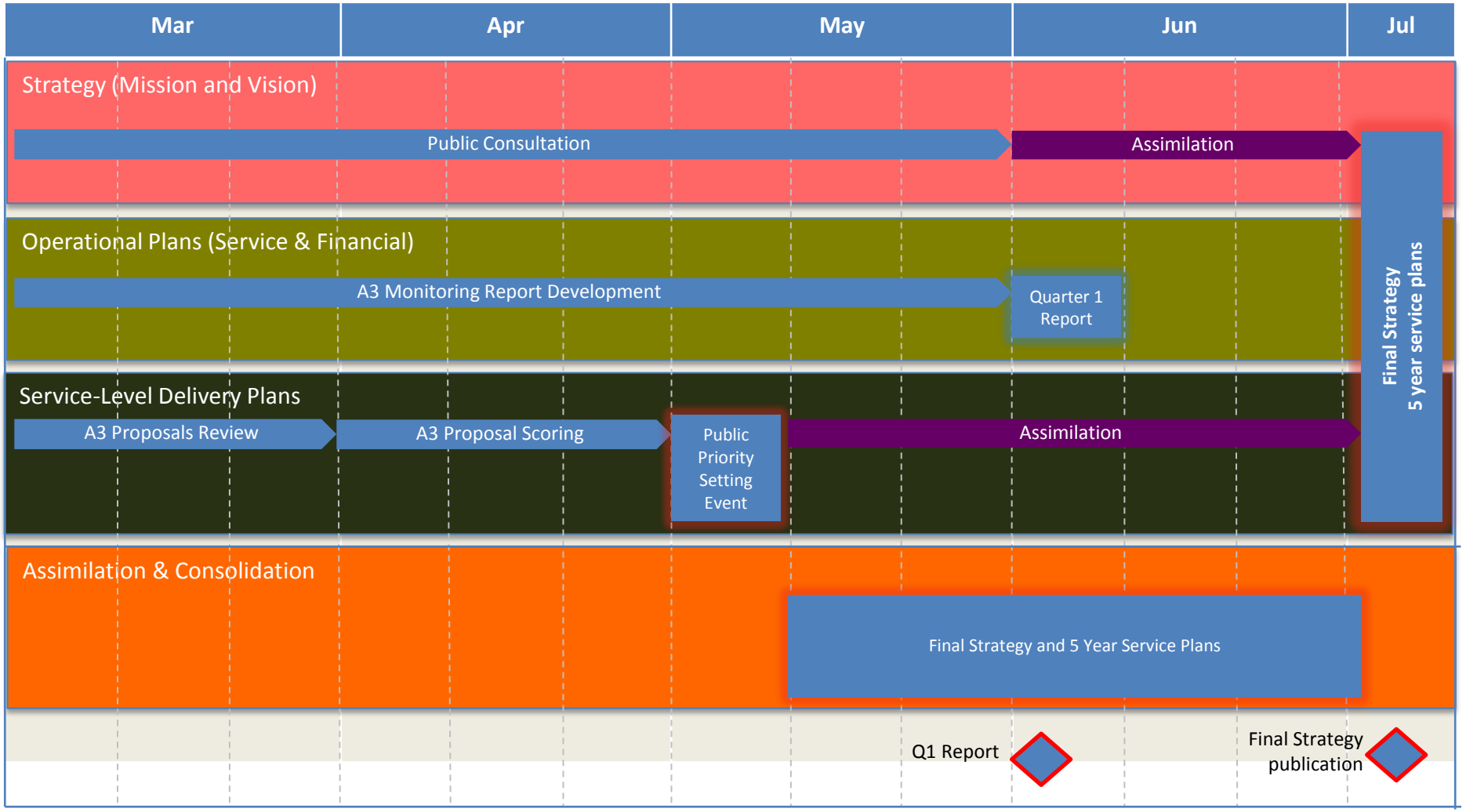
Patients, the public and commissioners score. Final priority setting proposed to be completed in public



A3 proposals: CNS tumours

- New model of cancer network MDT – rehab
- New pre-op MRI protocol with volume sequences
- Introduction of QOL measures – EORTC QLC C30 and BN20
- Brain tumour tissue banking

Strategy Development Overview [2]



EORTC QLQ - BN20

Patients sometimes report that they have the following symptoms. Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the past week:		**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
31.	Did you feel uncertain about the future?	1	2	3	4
32.	Did you feel you had setbacks in your condition?	1	2	3	4
33.	Were you concerned about disruption of family life?	1	2	3	4
34.	Did you have headaches?	1	2	3	4
35.	Did your outlook on the future worsen?	1	2	3	4
36.	Did you have double vision?	1	2	3	4
37.	Was your vision blurred?	1	2	3	4
38.	Did you have difficulty reading because of your vision?	1	2	3	4
39.	Did you have seizures?	1	2	3	4
40.	Did you have weakness on one side of your body?	1	2	3	4
41.	Did you have trouble finding the right words to express yourself?	1	2	3	4
42.	Did you have difficulty speaking?	1	2	3	4
43.	Did you have trouble communicating your thoughts?	1	2	3	4
44.	Did you feel drowsy during the daytime?	1	2	3	4
45.	Did you have trouble with your coordination?	1	2	3	4
46.	Did hair loss bother you?	1	2	3	4
47.	Did itching of your skin bother you?	1	2	3	4
48.	Did you have weakness of both legs?	1	2	3	4
49.	Did you feel unsteady on your feet?	1	2	3	4
50.	Did you have trouble controlling your bladder?	1	2	3	4

EORTC QLQ-C30 (version 3)

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials: ____

Your birthdate (Day, Month, Year): ____

Today's date (Day, Month, Year): 31 ____

	Not at All	A Little	Quite a Bit	Very Much
1. Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2. Do you have any trouble taking a long walk?	1	2	3	4
3. Do you have any trouble taking a short walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the past week:	Not at All	A Little	Quite a Bit	Very Much
6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4
16. Have you been constipated?	1	2	3	4

Please go on to the next page

During the past week:	Not at All	A Little	Quite a Bit	Very Much
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4
20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

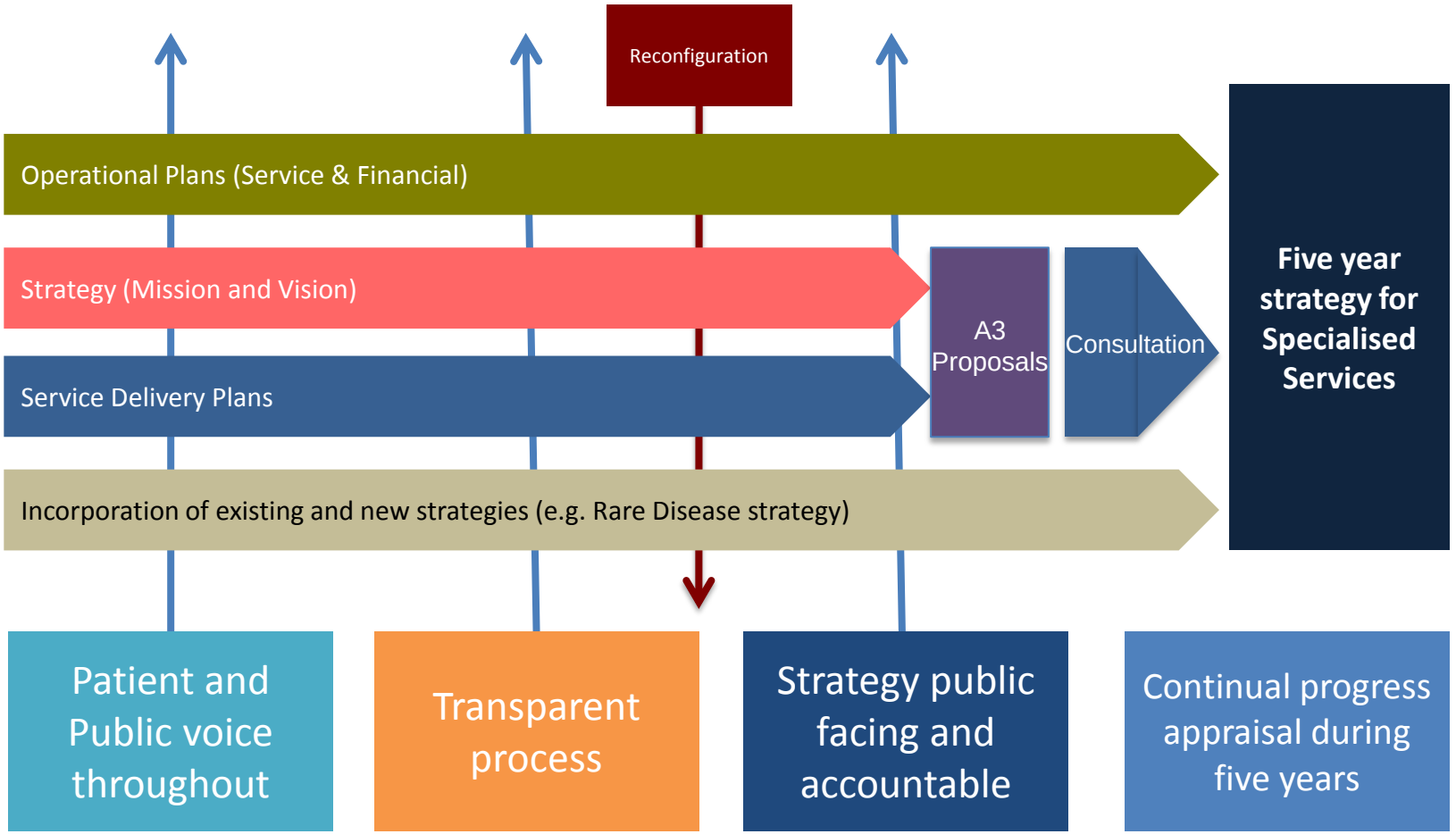
1	2	3	4	5	6	7
Very poor						Excellent

30. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

Summary of Five Year Strategy Process

All workstreams will come together to help define the strategy



The constraints

- NHS England will only commission services from providers who meet service specifications.
- Networks of care may provide the necessary infrastructure within available resources.
- Services must be safe, have good outcomes, good patient experience and demonstrate good cost control.
- Clinicians and finance directors have to think together about change.
- NHS England has to reduce expenditure by 10%. This is against a backdrop of increasing demand for services.
- NHS England wants to explore consolidation to 15/30 providers for specialised services.

Developing the Service level Strategic Plan-Plan on a Page

How: Standard template, timeline and guidance pack issued in **March**.

When:

Final Plans submitted end of **May**

Assurance and prioritisation of plans in **June**

Sign off through governance steps **June/July**

Public Consultation on full strategy expected **July-September**

CRG/Service Specification Level: Specialised Services Programme

The Vision

Describe briefly how your service looks in 2014, what you would like it to look like in around 5 years time and why. Explain which of the five domains would be addressed by moving from the current service description to the proposed vision. Try to describe how the service will look and why it would be better than it is now. The aim here is to create something short, descriptive and memorable. The detail will be in the Ambition box below
The domains are set out below as an aide memoire

Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

The Strategic Ambition

Describe your vision in more detail.
What are the problems with the current state?
Put some more detail about what the service will look like when the vision has been achieved
When will the vision be delivered?
If this is more than 5 years, why?
What are the key changes that will be seen after 1 year, 2 years, 3 years etc?
What will the key standards and core service to patient look like- use of telemedicine, technology, streamlining of services, one-stop?
What will be the key quality improvements to patients?
How will the service be integrated and work with key partners? How will the service interface with other services from your/other Programmes of Care? Operational delivery networks, potential for prime contractor delivery, part of a bundled pathway of interdependent services?
How will the service be engagement in research and innovations? Alignment to Academic Health Science Networks (AHSN)s?
How are patient accessing the service? How are patient exiting and supported in a seamless transition to the next part of the care pathway for their treatment?

The Case for Change

Why does the service need to move from its current state to that described in the vision? What outcomes will it deliver as a result) box below
Why should moving to this model should be the strategic intention?
Consider SWOT and PEST. What strengths in the baseline position does this improve? What weaknesses and threats does it mitigate? How will it capitalise on the opportunities? How does it take account of the national and local priorities identified in the PEST analysis?
How goes the new service model bring improved benefits in terms of* Accountability, Money, Integration, Quality & Safety and Innovation. *Use the output from the strategy day and the consideration of the A3s to help describe this.
Will outcomes be improved and if so in what way? Include improvements in clinical outcomes, patient experience etc.
How will the vision improve equity of access to the service?
How will changing to your strategic vision contribute to meeting the recommendations set out in the Carter review?
How will achieving the vision contribute to achieving the rare diseases strategy, if this is appropriate?
What will be the effect on providers (e.g. move to 7 day service, one stop provision, more community care, move to telemedicine, requirements for co-location with other services)
What will the delivery model look like? (e.g. fewer centres, services bundled and delivered in centres of expertise, networks)
In the context of the financial climate and QIPP, what efficiencies will the vision deliver?
Will reconfiguration be needed?
What are the consequences of not moving to this vision?

Strategic Goals

Quality & Safety	**Accountability**	**Money**	**Integration**	**Innovation**
[Using your vision and the case for change describe the key Quality and Safety strategic goal that will be achieved]	[Using your vision and the case for change describe the key Accountability goal that will be achieved]	[Using your vision and the case for change describe the key Money strategic goal that will be achieved]	[Using your vision and the case for change describe the Integration strategic goal the at will be achieved]	[Using your vision and the case for change describe the key Innovation strategic goal that will be achieved]

Clinical and Patient Outcomes

Quality & Safety	**Clinical Outcomes**	**Patient Experience**	**Access and Equity**	**Sustainability**
[i.e. reduction in pressure ulcers]	[i.e. increased 1 year survival rates]	[i.e. hand held records, one stop MDT care, 7 day access,	[ie waiting times, time to treatment, increased use of telemedicine]	[Ie economic, infrastructure, financial]

Conclusions

- Specialised commissioning processes via NHS England are evolving rapidly!
- Service specs have been set but will also evolve
- There isn’t enough money in the pot!
- We need to change to stay afloat
- 5 year strategies being developed