NHS England

Planning, assuring and delivering service change for patients

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Directorate		
Medical	**Operations and Information**	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**04307**
Document Purpose	Guidance
Document Name	Planning, assuring and delivering service change for patients
Author	NHS England, Operations and Information, Business Unit
Publication Date	01 March 2018
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Directors of Finance, Communications Leads, Emergency Care Leads, Anyone involved in service change or reconfiguration of services including public and patients
Additional Circulation List	Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, Anyone involved in service change including public and patients, All NHS England Employees, GPs, Emergency Care Leads, NHS Trust CEs, Special HA CEs
Description	A guide for commissioners on the NHS England assurance process for service changes
Cross Reference	Planning and delivering service change for patients (c.2013)
Superseded Docs (if applicable)	Planning, assuring and delivering service change for patients (2015)
Action Required	n/a
Timing / Deadlines (if applicable)	**n/a**
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Document Status

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Planning, assuring and delivering service change for patients

A good practice guide for commissioners on the NHS England assurance process for major service changes and reconfiguration.

Version number: 3

First published: December 2013

Revised: October 2015

Updated: March 2018

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

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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Classification: OFFICIAL

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Other formats of this document are available on request

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1. Foreword

NHS England's role is to support commissioners and their local partners, including providers, to develop clear, evidence based proposals for service change, and to undertake assurance to ensure they can progress, with due consideration for the government's four tests of service change and NHS England's test for proposed bed closures.

This guidance is designed to be used by those considering and involved in service change to navigate a clear path from inception to implementation of decision made. It will support commissioners and their partners to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

It sets out how new proposals for change are tested through independent review and assurance by NHS England, taking into account the framework of Procurement, Patient Choice and Competition Regulations. The guidance sets out some of the key considerations for commissioners and their partners in designing service change including reconfiguration. Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance.

The Five Year Forward View sets out an expectation that, through Sustainability and Transformation Partnerships, clinical commissioners and their partners should think creatively about how service provision could be improved for their local populations and reduce health inequalities. In some cases, the response may be substantial change within local health economies at a service or wider level.

By following this guidance, commissioners may reduce the risk of their service changes being referred to the Secretary of State, Independent Reconfiguration Panel or challenged by judicial review. By following the process set out below and appropriately and effectively involving local diverse communities, local authorities, key stakeholders and expert review (for example from Clinical Senates), later challenge may be avoided.

Please contact your local NHS England office for more information and assistance on navigating the NHS England assurance process and a copy of *'Service Change – a support and guidance Toolkit'* www.england.nhs.uk/about/regional-area-teams

2. Executive summary

Key Messages

- There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.
- Service changes should align to local Sustainability and Transformation Partnership plans and the service, sustainability and investment priorities established within them.
- NHS commissioners and providers have duties in relation to public involvement and consultation, and local authority consultation. They should comply with these duties when planning and delivering service change.
- The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.
- NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).
- The range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement.
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.
- Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider.
- Both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. In general, where there is commissioner led consultation with the local authority on a substantial service change, full public consultation will also be required.
- In practice, where there are public involvement and consultation duties on both commissioners and providers it should be possible to coordinate and consolidate any involvement and consultation requirements so that they are run in parallel to consultation with any relevant local authorities. In those circumstances a provider can make arrangements to satisfy its duty to involve and consult service users through a commissioner led consultation. Nevertheless, providers would need to engage with commissioners and address consultation responses in order to comply with their duties.

Key Messages (cont.)

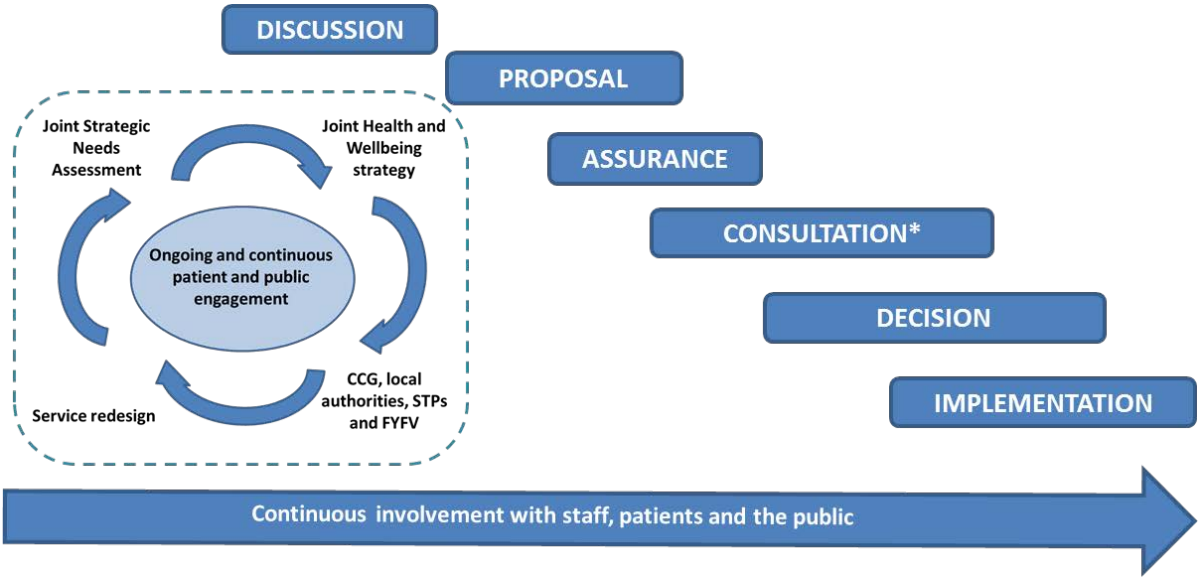
- There is no legal definition of 'substantial development or variation' and for any particular proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority engagement should continue through the lifecycle of service change.
- Service reconfiguration and service decommissioning are types of service change.
- Change of site from which services are delivered, even with no changes to the services provided, would normally be a substantial change and would therefore require consultation with the local authority and public consultation.
- Effective service change will involve full and consistent engagement with stakeholders including (but not limited to) the public, patients, clinicians, staff, neighbouring STPs and Local Authorities.
- All service change should be assured against the government's four tests:
    - Strong public and patient engagement.
    - Consistency with current and prospective need for patient choice.
    - A clear, clinical evidence base.
    - Support for proposals from clinical commissioners.
- Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England's test for proposed bed closures and commissioners should be able to evidence that they can meet one of the following three conditions:
    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
    - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).
- Prior to public consultation NHS England will assure proposals for substantial service change in accordance with the process set out within this guidance.
- For any service change requiring public consultation which also requires capital funding, NHS England and NHS Improvement will assess any proposals to provide assurance that they do not require an unsustainable level of capital expenditure and that they will be affordable in revenue terms.
- Not all substantial service changes require capital expenditure. However where this is the case and the scheme has been assessed by NHS England and NHS Improvement as having a reasonable expectation that the level of capital required will be available, public and local authority consultation should be undertaken before a Strategic Outline Case for capital funding is submitted to NHS Improvement.
- When service change proposals are being considered, early engagement with NHS England Regional Offices who can provide further information and support is recommended.

3. Overview of Roles and Responsibilities for service change

This guidance should be read by those involved with or likely to be involved with any phase of service change i.e. people working in:

- Sustainability and Transformation Partnerships (STPs)
- Integrated Care Systems (ICS)
- Clinical Commissioning Groups (CCGs)
- Providers including NHS trusts and foundation trusts
- NHS England regional and national teams
- NHS England direct commissioning teams e.g. specialist commissioning
- NHS Improvement
- Local authorities (LA),
- Chairs and members of Health & Wellbeing Boards and Health Overview and Scrutiny Committees
- Local Healthwatch and other groups representing the public

Service change has several phases from setting the strategic context to implementation. A summary of these is set out below.



*Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority.

3.1 What is service change and when is consultation with the local authority and public consultation required?

The National Health Service Act 2006 sets out the legislative framework for public involvement (Sections 13Q (NHS England), 14Z2 (CCGs) and 242 (NHS Trusts and FTs)). Consultation with local authorities is provided for in the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the s.244 Regulations") made under section 244 (2)(c) of the NHS Act 2006.

Broadly speaking, service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

There is no legal definition of 'substantial development or variation' and for any particular proposed service change, commissioners and providers should work with the local authority or local authorities Overview and Scrutiny Committee (OSC) to determine whether the change proposed is substantial. If the change is substantial it will trigger the duty to consult with the local authority under the s.244 Regulations. It is this that can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.

Public consultation, by commissioners and providers, is usually required when the requirement to consult a local authority is triggered under the s.244 Regulations because the proposal under consideration would involve a substantial change to NHS services.

Change of site from which services are delivered, with its consequent impact on patient, relative and visitor travel times, even with no changes to the services provided, would normally be a substantial change and would therefore trigger the duty to consult the local authority and would be likely to require public consultation. [1]Decommissioning a service could also be a substantial change. Tendering a service by itself is unlikely to be a significant change unless the new service specification will provide a substantial change in service.

When proposals are first considered, discussion with the local authority will help assess whether the change is considered substantial. Public consultation may not be required in every case, sometimes public engagement and involvement will be sufficient. The decision around this should be made alongside the local authority.

Any proposed changes should be aligned to Sustainability and Transformation Partnership (STP) plans. NHS Improvement and NHS England should be consulted

[1] See http://commissioning.libraryservices.nhs.uk/commissioning-cycle/disinvestment

early in the process in order to discuss assurance processes and to ensure that there is confidence in the deliverability and affordability of proposals.

[2]Changes can be made temporarily under regulation 23(2) of the s.244 Regulations because of a risk to safety or welfare of patients or staff. In these circumstances it may not be possible to undertake any public involvement or consultation with the Local Authority. The local NHS should try to undertake as much engagement as possible in the time available and discuss with NHS England and NHS Improvement how this can be assured. However, when a decision is proposed to make a temporary change permanent, the full process set out in this guidance must be followed.

3.2 Who is the decision maker around service change?

The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.

NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).

Amendments to the NHS Act 2006 introduced by the Health and Social Care Act 2012, have changed the NHS architecture and placed a number of further duties on NHS commissioners, which need to be considered and complied with in making any decision on changes to service delivery. In particular there are procurement obligations on commissioners which need to be considered when making decisions.

Where substantial changes are proposed to NHS services, there is a separate duty to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006. This is additional to the duties on commissioners and providers for involvement and consultation and can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.

Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider. Where there is a duty for the commissioner to consult the local authority under the s.244 Regulations, it will almost invariably be the case that public consultation is also required.

[2] See https://www.england.nhs.uk/publication/joint-working-protocol-when-a-hospital-services-or-facility-closes-at-short-notice/

In practice, public consultation requirements for commissioners and providers may be satisfied with one public consultation, but it is for each organisation with a public involvement duty to satisfy themselves that the consultation properly addresses their responsibilities. Therefore both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. Where there are public involvement and consultation duties on both commissioners and providers it should be possible to coordinate and consolidate any involvement and consultation requirements so that they are run in parallel to consultation with any relevant local authorities.

In practice, substantial service change consultation will normally be commissioner led and in those circumstances a provider can make arrangements to satisfy its duty to involve service users through a commissioner led consultation. Nevertheless, providers would need to engage with commissioners and address consultation responses in order to comply with their duties.

Good governance and clear and effective public decision-making are critical to effective major/ significant change programmes. Programmes must be clear who the decision-makers are and how they will go about making consultation launch, and post-consultation, service change decisions. These arrangements should be referenced in consultation documents and ensure the public are clear how and by whom decisions will be made.

3.3 Which commissioners should make decisions on service change?

Where services are commissioned by two or more commissioners, it is essential that proposals align with each organisation's commissioning intentions, including estates strategies, STP plans and national strategies (e.g. maternity review).

The number of commissioners which need to be involved in the consultation will depend on the scale of their services which are affected and the impact on their patients and public. For example, changes to accident and emergency services at any hospital potentially impact the patients of every CCG in the country. The numbers of patients involved for the vast majority of CCGs will be so small that it would be inappropriate for them to be a decision-maker.

The main commissioner(s) need to determine how and the extent to which other CCGs should be part of the decision making arrangements. Each relevant CCG should be contacted to discuss their involvement in decision making and the approach formally agreed. CCGs also need to consider whether NHS England should be a commissioner and decision-maker. For example, in considering changes to obstetric services commissioned by CCGs, neonatal intensive care is commissioned by NHS England and so it may also need to be involved in decision making.

Any CCG can respond to a consultation and their response must be taken into account along with any other response.

Having established which commissioners are to be involved in making the decision, several decision-making options are available. These are set out in annex 1.

4. Assurance of service change

4.1 The five tests of service change

There must be clear and early confidence that a proposal satisfies the governments four tests, NHS England's test for proposed bed closures (where appropriate), best practice checks[3] and is affordable in capital and revenue terms.

The government's four tests of service change are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The application of these conditions will be agreed as part of an assurance process that will be proportionate to the proposals in question - see section 6 for details.

CCGs have a statutory duty to exercise their commissioning functions consistently with the objectives in the Mandate and to act in accordance with the requirements of

[3] See Annex 9 "Best Practice Checks" taken from the service change toolkit

relevant regulations, such as Procurement, Patient Choice and Competition Regulations[4] and associated guidance from NHS Improvement.

The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

Commissioners should also pay due regard to the duties placed on them under the Equality Act 2010 regarding the public sector equality duty ('PSED') and the duty to reduce health inequalities, and duties under the NHS Act 2006 (as amended by the HSCA 2012). Service design and communications should be appropriate and accessible to meet the needs of diverse communities. Guidance for commissioners on equality and health inequalities legal duties can be found here: www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/

4.2 Determining levels of assurance and decision making

NHS England assures service change proposals prior to them launching public consultation. Most assurance of service change proposals is undertaken at a regional level, however for some proposals assurance and decision making will be undertaken by the Investment Committee (IC) or the Chief Financial Officer (CFO) of NHS England.

The level of assurance for service change including reconfiguration is determined by the criteria below:

- The NHS England Investment Committee should review the assurance conclusions and take decisions for all schemes where one of the following conditions applies:
    - Requires transition or transaction support of more than £20m from NHS England funds (not including CCG funds);
    - The total turnover of the affected services (for all sites impacted by the transition, at current prices) is above £500m in any one year; or
    - The likely capital value of the scheme is above £100m (gross capital value of the scheme, even if the actual value is lower because it is funded through capital receipts)
    - The proposed service change impacts on any NHS Trust or NHS Foundation Trust that is in tier 4 of NHS Improvement's Single Oversight Framework[5];

[4] https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance
[5] https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/

- The NHS England Chief Financial Officer should review the assurance conclusions and take decisions for all schemes where one of the following conditions applies:
    - Impact on any of the distressed health economies[6] as currently or subsequently defined;
    - Requires transition or transaction support from NHS England funds (not including CCG funds); or
    - The total turnover of the affected services (for all sites impacted by the transition, at current prices) is above £350m in any one year; or
    - The likely capital value of the scheme is above £50m (gross capital value of the scheme, even if the actual value is lower because it is funded through capital receipts).

- All other schemes to be determined by the relevant Regional Director.

NHS England has a role in making decisions in respect of directly commissioned services either as part of a joint commissioning arrangement or as lead commissioner. If there is no direct decision making element this will sit with the CCGs. If NHS England has a role in directly commissioned specialised services then the decision regarding the level of decision making will be made by Specialised Services Commissioning Committee (SSCC). For all other directly commissioned services it will sit with the appropriate commissioning committee.

5. Service change – key themes

This section sets out some of the key considerations that are taken into account during the assurance process for service change. There are many different ways to achieve positive change for patients and this guide does not attempt to cover in detail all the things that CCGs and their partners will need to take into account. Commissioners should always ensure that they are acting consistently with their regulatory obligations, including the Procurement, Patient Choice and Competition Regulations.

The Independent Reconfiguration Panel (IRP) has a series of papers 'Learning from Reviews' which set out reasons why proposals are referred. There are a number of factors such as inadequate community and stakeholder involvement in the early planning stages, and weak clinical integration across sites. www.gov.uk/government/collections/irp-learning-from-reviews

The IRP can also provide informal advice on developing proposals. Their website is: www.gov.uk/government/organisations/independent-reconfiguration-panel/about

[6] In May 2016 this was defined to mean the three success regimes, however this will continue to be re-defined as required

There is much to learn in reviewing the IRP's advice on cases previously referred which would be of benefit to all commissioners, providers and Local Authorities. The 'Learning from reviews' series of publications provide a unique insight into what has caused the NHS's service change efforts to stall and what will make successful change more likely in the future

5.1 Preparation and planning

There should be a planned and managed approach from the start which establishes clear roles, a shared approach between organisations, and builds alignment on the case for change.

All service change needs commissioner ownership, support and leadership (even if change is initiated by provider or other organisation). This is so any substantial service change aligns with commissioning intentions and plans. Where services are commissioned by two or more commissioners, it is essential that proposals align with each organisation's commissioning intentions, including estates strategies.

Commissioners (or providers leading service change) should:

- be active in leading service design and change;
- ensure commissioning intentions reflect the local commissioning plans and vice versa; and
- work closely with local authorities, who have an important role in the development of proposals as well as in discharging their scrutiny functions.

5.2 Evidence

Commissioners should:

- have early and ongoing discussions with their local NHS England team;
- ensure the governments four tests of service change, NHS England's test for bed closures (if applicable) and best practice checks are embedded into their planning process;
- set a sufficiently high bar in terms of the quality and depth of option development and evidence of engagement with NHS Improvement and other NHS stakeholders;
- work with Health and Wellbeing Boards to ensure service change proposals reflect JSNA and JHWS[7] ; and
- request regular updates to financial planning and forecasting as proposals are developed.

Service change must be evidence-based and this evidence should be publicly available during the consultation and decision making stages.

A clear clinical evidence base

[7] see section: 7.1 Link to JSNA and JHWS

This ensures service change proposals are underpinned by clear clinical evidence and align with clinical guidance and best practice.

For complex service change commissioners should consider clinical senate advice.

Commissioners should oversee the development of the clinical case for change, as part of the outline case. Medical directors and heads of clinical services of any providers involved can help build the clinical evidence base.

Assessment against this test should be overseen by an appropriate clinical lead. This ensures service change proposals are underpinned by clear clinical evidence and soundly based activity forecasts and align with clinical guidance and best practice. If not named as a joint commissioner, there should also be evidenced support from specialised commissioning that there are no material impacts for specialised commissioning services.

Where possible, the clinical lead should ensure involvement from senior clinicians not directly connected with the services under review.

It is important that front-line clinicians affected by the proposed changes are involved. Clinicians are powerful advocates and play an important role in communicating the benefits of change to a wider community.

5.3 Leadership and clinical involvement

- STP Leads, Chairs, accountable officers, chief executives and medical directors should exercise collective and personal leadership and accountability when considering the development of proposals.
- Front line clinicians and other staff should be involved in developing proposals, and in their engagement and implementation.
- Directors of public health, directors of adult social services and directors of children's social services have an important role in bringing their professional perspectives where change spans health, social care and public health.

Clinicians should determine and drive the case for change, based on the best available evidence.

5.4 Involvement of patients and the public

It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service change. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential, as well as engaging NHS Improvement where appropriate. Early

involvement will give early warning of issues likely to raise concerns in local communities and gives commissioners' time to work on the best solutions to meet those needs.

[8]Involvement should not be a standalone exercise; rather, it should be part of an ongoing dialogue taking place in stages as proposals are developed. It is good practice to document a communications and engagement plan to set out objectives and methods both to monitor engagement and to provide evidence at assurance check point.

It is also important to include MPs and councillors in the range of external stakeholders contacted during proposal development and to put due consideration into continuing communication from conception to implementation of plans.

6 The assurance process

The assurance process is rarely linear and involvement of the public, patients and stakeholders should continue throughout the life of the scheme. Consideration of financial implications, relevance to STPs and other external factors may require initial proposals to be amended as new ideas are brought forward. See 6.5 *Reducing risk through assurance.*

Each proposal will develop within its own time scale however adequate time should be included for each part of the assurance process to ensure delays are minimal and planning for national assurance meetings (where required) is factored in. It is advisable to build in periods of pause post assurance checkpoint and post consultation in order to address any queries raised or for additional work to be undertaken.

6.1 Assurance process

An effective external assurance process should give confidence to patients, staff and the public that proposals are well thought through, have taken on board their views and will deliver real benefits. NHS England's external assurance process should give confidence, be supportive and add value by helping to mitigate risk.

Effective assurance is required to secure consistency across the NHS commissioning system in respect of:

- the government and NHS England's key tests that should underpin service change proposals;
- the strength of pre consultation business cases, clinical evidence and public involvement;

[8] See https://www.england.nhs.uk/participation/about/

- proposals having regard to relevant national guidance and complying with legislation;
- the programme management that underpins the planning and delivery of schemes; and
- deliverability on the ground and affordability in capital and revenue terms.

Internal assurance
Self-assurance should be put in place as part of the programme governance. CCGs can seek advice from NHS England regional teams when putting in place arrangements. If public or patient representatives can be involved in internal assurance, this would support transparency and accountability moving forward.

6.2 NHS England's role in assuring service change

NHS England has a remit to assure CCGs against their statutory duties and other responsibilities under the CCG Assurance Framework. It has a role to both support and assure the development of proposals by commissioners. CCGs are required to consider this guidance in their exercise of commissioning functions.

Assurance will be applied proportionately to the scale of the change being proposed, with the level of assurance tailored to the service change. The process should be commissioner-led, whole system based and have consideration of arms-length bodies involvement.

Investment Committee (IC) – As well as providing assurance on service reconfiguration, the Committee has the power to confirm which business cases meet criteria for agreement at officer level (subject to compliance with the Scheme of Delegation). Membership is decided by the NHS England Board and will include (but is not limited to) the Chief Financial Officer, Chief Operating Officer and National Director: Operations and Information.

Oversight Group for Service Change and Reconfiguration (OGSCR) – Supports the Investment Committee to oversee the implementation and continued working of the assurance process. Membership includes (but is not limited to) Regional Directors, Medical Director (Acute), Director of Strategic Finance, and Director of Operations and Information.

In all cases, evidence provided for assurance should be retained in line with Department of Health and Social Care retention schedules

The level of involvement of the Investment Committee, Chief Financial Officer or Regional Director will be indicated in relation to financial thresholds therefore it is important that initial financial information is available as soon as possible, particularly where there may be a call on capital, transitional or transactional funds.

NHS England will work with NHS Improvement where reconfigurations relate to NHS Trusts or Foundation Trusts or commissioning regulations. This will help ensure consistency in quality and planning of schemes and that good practice and lessons learnt are shared.

6.3 National oversight of the assurance framework

The oversight of the national work programme for service change takes place by the sub-committee of the Investment Committee: the Oversight Group for Service Change and Reconfiguration.

NHS England will operate a two stage assurance process:

- a strategic sense check; and
- an assurance checkpoint.

An overview of the service change assurance process can be seen at Annex 2.

Decisions about the extent of assurance required by NHS England will be informed by the scale of the service change proposals under consideration.

Stage 1 - Strategic sense check
This will determine the level for the next stages of assurance and decision making. Clinical senates may at this stage be asked to review a service change proposal against the appropriate key tests (clinical evidence base). Engagement with NHS Improvement should have commenced, and if capital is likely to be required, discussions with the relevant NHS England and NHS Improvement finance teams should have begun.

Stage 2 – Assurance checkpoint
Takes place in advance of any wider public involvement or public consultation process or a decision to proceed with a particular option. For substantial service change, it is best practice to seek the clinical senate's advice on proposals again at this stage.

Support for proposals from providers and other commissioners impacted to a significant degree by the proposals' will be tested as part of the assurance process and where relevant, letters of support may be required as part of the assurance evidence. Your local NHS England regional team will be able to advise where and when these are required.

Examples of the types of questions and other evidence required at the assurance checkpoint are available in Annex 4.

Decisions about the extent of assurance required by NHS England will be informed by the scale of the service change proposals under consideration. An assurance panel will be put together consisting of suitable members and any conflict of interest will be declared. The advice of specialised commissioning colleagues should be sought to ensure that any involvement of specialist services commissioned by NHS England are considered and either included as part of consultation process or that any impact on remaining services is adequately considered through assurance.

Before public consultation is launched, proposals should be tested to ensure there is a high degree of confidence that all options would be capable of being delivered as proposed and do not imply an unsustainable level of capital expenditure or revenue funding. NHS England will review this as part of the assurance process. Service change schemes which require capital financing will require the support of NHS England and NHS Improvement (in writing) before public consultation on options requiring capital commences.

Full detail on the assurance process can be found in *'Service change - a support and guidance toolkit'* available from NHS England regional teams.

6.4 Assurance of directly commissioned services

Service reconfiguration which results in changes to NHS England directly commissioned services will require assurance. Assurance will be undertaken and overseen by an NHS England panel involving staff who are not otherwise involved in the development of the proposals. Declaration of conflict of interests is the personal responsibility of all NHS England staff.

The following assurance check will be used for all proposals (CCG and NHS England led):

> 'A full impact analysis (of the proposals) across CCG and NHS England commissioned services and shared sign up of all parties to the analysis.'

Appropriate evidence would be an analysis of the impact of a set of proposals on CCG and NHS England commissioned services, including potential co-dependencies and unintended consequences, endorsed by the relevant parties. Consideration should be given to describing these co-dependencies in the consultation document.

NHS England facilitates the sharing of service change information between commissioners so connections between commissioners and their proposals can be made. Issues of mutual interest can be identified early and discussions held to align emerging proposals.

NHS England will be mindful of both potential conflict of interest and the perception of such conflicts when assuring service change proposals. Assurance will be undertaken

and overseen by staff not involved in the development of the proposals. An NHS England assurance panel would apply a strict 'Chinese wall' around this assurance process to avoid any conflict of interest. These arrangements should be described before the second stage of the assurance process to ensure all involved are content that the assurance arrangements minimise any conflict of interest.

Each proposal will be considered on its own merit with a judgement made on the assurance requirements and the appropriate staff group to lead the assurance process. A robust assurance process, proportionate to the scale of the proposed changes, will be agreed between the appropriate teams within NHS England. When considering the extent of assurance required, NHS England will consider the same factors as a locally led proposal.

The Investment Committee thresholds will be applied to determine the level at which assurance will be considered within NHS England. This approach provides the flexibility to respond pragmatically to the variation in scope, geographical scale and complexity that will characterise proposals. These arrangements and the handling of the conflict of interest issues should be fully discussed at a strategic sense check with the appropriate NHS team and confirmed via correspondence.

Once confirmed the proposed assurance level will be shared with the national Oversight Group for Service Change and Reconfiguration. Schemes will be dealt with on a case-by-case basis to ensure that NHS England's assurance remains robust and as impartial as possible.

Where the clinical case for change is complex, commissioners may require an independent clinical review. For CCG led schemes this would most likely be through the clinical senate, although in some cases (for example, very specialist services) it may be appropriate to obtain a review from another independent source such as a royal society or clinical networks. For Specialised Commissioning this would happen via the national clinical reference groups (CRGs) for Specialised Commissioning.

"Clinical senates support commissioners to put improving outcomes and service quality at the heart of commissioning, to increase effectiveness and efficiency, and to promote the needs of patients above the needs of organisations or professions.

Senate advice is impartial. It is informed by the best available evidence and where evidence is limited clinical senates seek to build and reflect consensus."[9]

Clinical senate review process Guidance Notes

[9] http://www.yhsenate.nhs.uk/media/pdfs/clinical-senate-review-process-guidance-note-final-june2014-1.pdf

NHS England Programme Assurance team (formerly Health Gateway) – provides organisations with assurance and support for business change programmes and projects. It is designed to support successful delivery of the programme and project.

Clinical senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent. There are 12 clinical senates across the country. You can find out more about clinical senates here: www.england.nhs.uk/ourwork/part-rel/cs/

Strategic Clinical networks work in partnership with commissioners (including local government), supporting their decision making and strategic planning, by working across the boundaries of commissioner, provider and voluntary organisations as a vehicle for improvement for patients, carers and the public.

6.5 Reducing risk through assurance

NHS England works with programmes to reduce risk through a proportionate service change assurance process which helps supports programmes in 3 ways:

1. Robustness, openness and transparency

An effective external assurance process gives confidence to patients, staff and the public that proposals are well thought through, have taken on board their views and will deliver real benefits. Assurance checks alignment with the 4 tests for service change, NHS England's test for bed closures, good practice checks developed from experience of other programmes, and the impact of proposed change upon other organisations in the wider health system.

2. Risk mitigation

The support and assurance process mitigates the risk of successful challenge. Schemes can be challenged via a referral to the Secretary of State (who may ask for advice from the Independent Reconfiguration Panel), or a request for judicial review. The risk of successful challenge is greatly reduced by following the appropriate advice and application of a best practice approach.

3. The high costs of getting it wrong

A high profile programme that has been subject to both Judicial Review and referral to the Secretary of State is estimated to have cost >£6m. The proposed changes remain unimplemented.

Following a strategic sense check or assurance checkpoint, NHS England will either support or not support a commissioner taking forward their proposals in their current format. Where NHS England does not yet support a commissioner proceeding to consultation, there will be a discussion about the subsequent assurance process. This will be proportionate to the level of risk and the concerns identified.

7 Planning service change

7.1 Link to JSNA and JHWS

Effective proposals for service change are those which build on the wider considerations of the health and wellbeing needs of the population and reflect existing commissioning plans.

JSNAs and JHWSs

JSNAs – local assessments of current and future health and social care needs and assets produced by health and wellbeing boards. They are unique to each local area.

JHWS – strategies for meeting the needs identified in JSNAs. They explain the priorities Health and Wellbeing (H&WB) Boards have set in order to tackle the needs in the JSNA.

For more information please see the guidance from the Department of Health and Social Care: 'Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies':
www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

CCGs have a statutory duty to exercise their commissioning functions consistently with the objectives in the Mandate and to act in accordance with the requirements of relevant regulations, such as Procurement, Patient Choice and Competition Regulations, CCG Improvement and Assurance Framework and guidance from NHS Improvement[10]. Commissioners are under a statutory duty to consider relevant Joint Strategic Needs Assessments (JSNAs) and Joint Health & Wellbeing Board Strategies (JHWSs). Commissioners should consider keeping a record of how the duty to have regard to JSNA's and JHWS (section 116B of the Local Government and Public Involvement in Health Act 2007) have been taken into account as part of the decision-making process.

In light of the legal duty to consider JSNA and JHWS, there is an expectation that proposals will have a clear alignment to the JSNA and JHWS. There are a number of advantages to this:

[10] https://improvement.nhs.uk/

- Health & Wellbeing boards can bring a multi-service and professional perspective, meaning proposals can be considered holistically across the local health and care system.
- Health & Wellbeing boards must involve local diverse communities when preparing JSNAs and JHWSs.
- Where communities have already been involved in the shape of health services in their area it provides a strong platform for more in-depth conversations on potential changes.
- Where there is local consensus about health and care needs and priorities it creates space for conversations on what this could mean for the configuration of front line services.

You can find more information on working with the Health & Wellbeing board from the Local Government Association at https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/health-and-wellbeing-systems

7.2 Proposal development

Effective proposals for service change are those which build on the wider considerations of the health and wellbeing needs of the population and reflect existing commissioning plans and have due regard to the primacy of STPs.

Commissioners should assure themselves that they have sought a comprehensive range of perspectives for the case for change and build their proposal by identifying the range of service change options that could improve outcomes within available resources confirmed as necessary with NHS England and NHS Improvement and other NHS stakeholders holding such resources.

Proposals should be discussed with NHS England and NHS Improvement where appropriate. This will be particularly important where trusts will need to access capital to deliver options which may be consulted upon. An early indication of support for schemes with a capital requirement will ensure only those options that are assessed to have a sustainable level of capital are consulted on.

Work would be required to develop:
- **A more detailed case for change and evidence base.**
- **Specific service configuration options.**
- **The plan for involving wider stakeholders, staff, patients and the public.**

Commissioners have a statutory duty[11] to involve service users in the development of proposals. It is good practice for commissioners to involve stakeholders in the early stages of building a case for change.

A clinically-led group should oversee the design and development of proposals, and commissioners should ensure that clinical ownership and leadership of plans is part of any governance arrangements.

See also Annex 5 *Proposal Development*.

If the commissioner is content the options are viable, it should then progress with undertaking an assessment of these proposals against the government's four tests, NHS England's test for proposed bed closures (where appropriate) and best practice checks

Clinical commissioner leadership and collaborative decision making

- **Single CCG: planning and decision making through the governing body or by creating a specific committee.**
- **NHS England directly commissioned services: NHS England make arrangements for senior clinicians to be part of the governance arrangements.**
- **Multiple commissioning organisations based on two models: Committees in common or joint committees.**

For more information please see Annex 7 - Clinical commissioner leadership and collaborative decision making.

7.3 Financial considerations – revenue and capital

For each option to be shared with the public, consideration of the financial proposal in terms of both capital and revenue and its sustainability should be made in conjunction with NHS England and NHS Improvement prior to launching consultation. It is essential that only those options that are sustainable in service, economic and financial terms are offered publicly. No service change option should be exposed for public engagement/consultation unless prior to launch there is a high degree of confidence that it would be capable of being delivered as proposed, that it does not imply an unsustainable level of capital expenditure and/or projected spend profiles that cannot be reconciled to available resources and will not be affordable in revenue terms. All options must be affordable within commissioner revenue allocations and provider revenue financial targets.

Capital resources available to the NHS for transformational change are currently severely constrained and a degree of national phasing/prioritisation will be inevitable at least for the remainder of the current Spending Review Period. Service change schemes which require capital financing will require the explicit support of NHS England and NHS Improvement in writing and, where appropriate, following discussion with the Department of Health and Social Care before public consultation on options requiring capital commences.

To demonstrate this, the PCBC should set out for all options going to consultation an assessment of capital (if required for the scheme) and revenue affordability for each option which includes:

- Summary financial statements and supporting financial modelling which shows the impact of each option on commissioners/providers revenue financial position supported by activity, income and cost modelling which is sufficiently robust for both commissioners and providers to be confident that options would be sustainable;
- Confirmation of assumptions made in the financial modelling for both commissioners and providers e.g. commissioner growth in allocations, provider inflation, levels of efficiency savings;
- Reconciliation of the scheme's financial impacts to the STP financial plan
- Credible activity/throughput analysis that translates sustainably to the scale of infrastructure change anticipated;
- A clear assessment of the financial benefits of the scheme e.g. provider efficiency savings, system reductions in activity levels and the basis of these calculations;
- A high level source and application of capital funds, to demonstrate capital costs and how these are expected to be funded. It should be noted that every effort should be made to generate local capital funding including land disposals or internally generated capital and initial assessments of this should be included;
- Indicative capital costs recorded using OB forms and recognisable benchmarks and which assume compliance with all applicable design, technical, building and space standards and known site constraints, and key adjacencies should be identified;
- Indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels;
- Confirmation of support from all commissioners proposing the scheme and acknowledgement from all providers who will be significantly affected by the scheme that their views on any impact on them have been sought.

All options requiring capital will be assured prior to consultation by NHS Improvement and NHS England, and, where appropriate, through them the Department of Health and Social Care to ensure each option is sustainable in service and revenue and capital affordability terms, that the scheme size is proportionate and that it is capable of meeting applicable VFM and return on investment criteria.

Schemes requiring larger amounts of capital (i.e. over £100m) will be required to provide more detail and be subject to higher levels of scrutiny prior to going out to consultation.

Following this assurance the following letters of support will be required prior to consultation being launched:

- where all options require capital of less than £30m, a letter of support from the NHS Improvement Regional Finance Director;

- where all options require capital of between £30m and £100m, a letter of support from the NHS Improvement Chief Finance Officer:
- where options require capital above £100m the scheme will be considered by the NHS Improvement Resources Committee and a letter of support from the NHS Improvement Chief Finance Officer provided.

At this early stage, before pre-consultation business case (PCBC), , if service change options will require capital, it is helpful to take account of the requirements that individual providers' capital investment business cases will need to satisfy if they are to be able to support the formal proposals. These are set out in NHS Improvement's guidance *Capital regime, Investment and Property Business Case Approval for NHS Trusts and Foundation Trusts.*

Therefore in preparing the PCBC advice/input should be sought from NHS Improvement and NHS England (and through them, the Department of Health and Social Care and HM Treasury if appropriate) so that they can as far as possible underpin subsequent provider business case processes and NHS Improvement's subsequent assurance of them.

7.4 Pre-consultation business case

To inform assessment of proposals against the government's four tests of service change, and NHS England's best practice checks, the proposing [commissioning] body should develop a pre-consultation business case (PCBC). The lead commissioners will prepare the business case. See annex 6 Pre-Consultation Business Case.

Examples of PCBCs are available on request by contacting NHS England Regional Offices (see Key Resources annex 13).

Pre-consultation seeks to build alignment between NHS commissioners and local authorities:

- **Build on the case for change.**
- **Demonstrate -that all options, benefits and impact on service users have been considered.**
- **Demonstrate - that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals**

The PCBC can also form the starting point for a Strategic Outline Case (SOC) as required by NHS Improvement where necessary.

Where proposals concern integration across NHS, social or public health services, the relevant social services and public health directors of each impacted local service should be involved in the process.

Commissioners and providers must also give due consideration to potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an emergency. As a minimum there should be a formal modelling exercise to identify both the benefits and any potential negative impact and clear evidence of mitigating actions planned or undertaken to ensure effective Emergency Preparedness, Resilience and Response (EPRR) is maintained.

Initial implementation plans for each consultation option should be developed at this stage to test deliverability.

Robust public involvement

- **The pre-consultation business case should include clear involvement plans.**
- **Involvement activity should:**
  - **Be proactive to local populations.**
  - **Be accessible and convenient.**
  - **Take into account different information and communication needs.**
  - **Consider how clinicians should be involved.**
- **Commissioners should assure they have taken appropriate involvement for each stage of the process.**
- **Further guidance on public participation is available in NHS England's guidance 'Patient and Public Participation Policy' https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-policy.pdf**

Commissioners should consider the balance of evidence and be sensitive to any concerns raised. Final decision making, wherever it sits, should be made in public, recorded and made available to public scrutiny.

The commissioners' decision is to be based on the best balance of clinical evidence and evidence gained through public engagement and consultation. A clear audit trail to evidence how the decision was reached and the considerations taken, is to be captured.

If, following discussion with their local NHS England team, commissioners are content that the outline proposals meet the four tests, and they can evidence that they have sought and acted upon the feedback, they should progress to a formal presentation of proposals.

Support for proposals from clinical commissioners test

- **CCGs should assure themselves that those proposals have the support of their member practices.**
- **For directly commissioned services, regional teams should ensure proposals have support of their medical directors and understand the views of CCGs on the proposed change to ensure alignment between commissioners.**
- **Commissioners need to be sensitive to any actual or perceived conflicts of interest. For more information please refer too: https://www.england.nhs.uk/ourwork/coi/**
- **Disputes should be acted upon in accordance with the CCG's dispute resolution process as set out in its Constitution.**

7.5 Discussion of formal proposal with local authorities

Commissioners should discuss their proposals with local stakeholders prior to any public consultation, in particular with STP leads and local authorities. The discussion ensures alignment of the case for change, avoids proposals being developed in isolation, and ensures the wider health system is considered. Discussions should continue throughout the life of the proposal.

The purpose of this stage is to:

- Ensure commissioners' legislative requirements on consulting local authorities responsible for discharging health scrutiny functions are met.
- Follow good practice that Health & Wellbeing Boards have an opportunity to feed into the development of proposals.

Whilst it is sensible to refine options, commissioners should be aware of the drawbacks of ruling out options on which it may be helpful to undertake subsequent wider stakeholder and public feedback.

7.6 Health scrutiny

NHS bodies have a legal duty[12] to consult the local authority in certain circumstances.

Although it is strongly advised that local authority scrutiny functions are involved throughout development, commissioners should hold a separate formal discussion on the final set of proposals on which they intend to consult.

See also annex 3 Local Authority Overview and Scrutiny Committees

7.7 Health and Wellbeing boards

[12] www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf

Health &Wellbeing Boards can provide invaluable insights in a way that is complementary to the discussions with local authorities.

The extent of involvement is dependent on local circumstances and level to which the Health & Wellbeing Board has previously been involved. Local Healthwatch reports can be found https://www.patientlibrary.net/cgi-bin/library.cgi?page=Welcome;prevref=

At this time, if not already involved and engaged local MPs should be communicated with to ensure they are aware of the upcoming consultation.

7.8 Public consultation

Before moving on to consultation, financial information should be re-visited to ensure the figures remain correct and suitable sources have been identified.

Subject to feedback from local authorities, the proposing body may decide to progress to public consultation on the range of options that will be tested with staff, patients and the public, subject to assurance by NHS England.

NHS England has a role in the assurance of all commissioner-led schemes. This will ensure consistency across the NHS commissioning system and ensure that good practice and lessons learnt are shared.

It is advisable to engage an independent body to run the consultation analysis ahead of finalising any consultation documents, and to include a suitable budget for this piece of work in plans including the pre-consultation business case. There are also many private companies and organisations who can offer advice to running effective consultations.

For NHS England's advice on undertaking consultations see https://www.england.nhs.uk/commissioning/primary-care-comm/involving-the-public/

Schemes have struggled to build public support where they have not adequately addressed public concerns that:

- **The proposals are perceived to be purely financially driven.**
- **Patients and their carers will need to make journeys that may reduce access.**
- **Emergency services will be too far away, putting people at risk.**

By the time a scheme moves to public consultation, effective involvement will have identified any potential issues or barriers from within the local population and health economy which could compromise plans. Final proposals should take into consideration these concerns and seek to address them where appropriate.

Further guidance on involving the public in commissioning processes and decisions is available from NHS England's Patient and Public Involvement Hub https://www.england.nhs.uk/participation/

8 Decision

Following consultation it is important to ensure that the Decision Making Business Case (DMBC) validates consultation outcomes and that progress to implementation is fully informed by solid detailed analysis of consultation outcomes. NHS Improvement and the Department of Health and Social Care should remain sighted on any capital that has been planned for and NHS England should be informed of the proposed next steps once all feedback from the consultation has been gathered and analysed.

The commissioners' decision is to be based on the best balance of clinical evidence and evidence gained through public engagement and consultation. A clear audit trail to evidence how the decision was reached and the considerations taken, is to be captured.

Once a decision has been made as to the preferred option following consultation, organisations can develop SOCs based on this preferred option. Before individual organisations incur major cost on any scheme they should ensure that they have agreed with NHS England and NHS Improvement, including written confirmation in principle as to the availability, level and source(s) of funding for the scheme. Until approval for the SOC is in place organisations should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs), the implementation phase.

8.1 Decision making business case

The DMBC should ensure that the final proposal is sustainable in service, economic and financial terms and can be delivered within the planned for capital spend, and show how views captured by consultation were taken into account. It can be built from the PCBC and the stakeholders' work will inform the development of the SOC.

For more complex schemes it may be assured by NHS England before decision making, and should include how views captured by consultation were taken into account.

The decision on whether or not the DMBC needs to be formally assured will be discussed at the assurance checkpoint. This is to ensure that any major deviation from the original proposals have been looked at and to assure that the

new proposals have been consulted upon, are clinically sound and financially viable.

Final decision making – with whomever it sits - should be made in public.

Following decision making, the proposing organisation (whether CCG/s [Committees in Common/Joint Committee], NHS England or a combination) announces the decision and communicates to:

- **Patients and the public.**
- **Staff.**
- **Media – which should follow an existing dedicated media handling plan.**
- **Health and wellbeing board(s).**
- **Local authorities discharging heath scrutiny functions or a joint overview and scrutiny committee.**
- **Local Healthwatch, local voluntary sector and other relevant groups representing patients.**

Situations may arise where consensus over service change cannot be agreed between the commissioner and relevant local authority. Wherever possible, decisions about how the NHS is run should be made locally by those directly involved. Local authorities may refer proposals to the Secretary of State, if:

- The consultation has been inadequate in relation to the content or the amount of time allowed.
- The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
- A proposal would not be in the interests of the health service in its area.

Before making a referral, organisations involved must satisfy themselves that all other options for local resolution have been fully explored. Upon receipt of a local authority referral, the Secretary of State may ask the Independent Reconfiguration Panel (IRP) to carry out an initial assessment however this does not mean that all referrals will be reviewed in full. Further details can be found in their document 'The Review Process' found on the IRP website[13].

The Department of Health and Social Care's guidance 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' provides further information and specific guidance on the above points[14].

[13] www.gov.uk/government/organisations/independent-reconfiguration-panel

[14] www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

Early and ongoing presentation to local scrutiny committees can help reduce these situations from occurring.

8.3 Implementation

Following the decision on which option (or variant) to take forward, the implementation plan should be updated to set out how the changes will be taken forward, when and by whom. The plan should identify a clear benefits realisation timetable with key milestones against which progress can be monitored. NHS England's local teams will offer commissioners support, guidance and ongoing assurance through the implementation phase.

Commissioners may wish to undertake further independent reviews to help assure ongoing programme implementation.

It can take several years for a proposal to move into full implementation if the stages before have not been fully completed and inadequate engagement with local authorities and local populations can cause proposals to be referred to the Secretary of State or Judicial Review. All these delays cost time and money and can create a feeling of negativity around service change.

By following this guidance and using the associated toolkit and other sources of information, proposals can be developed which will benefit the local health economy, are affordable, provide a proven return on investment and support local Sustainability and Transformation Partnerships.

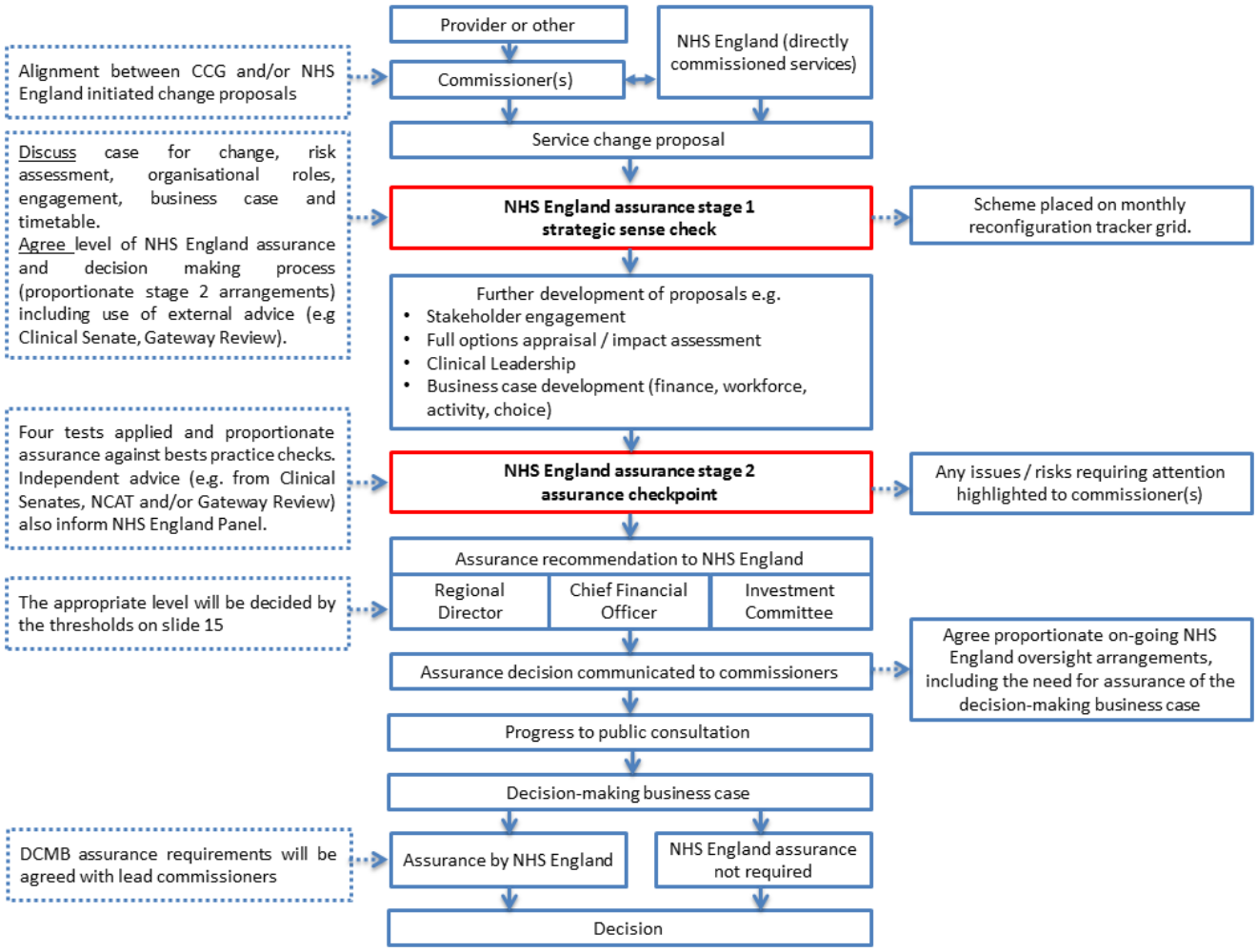
Annexes

Annex 1 Roles and Responsibilities

Organisation		Role
NHS England	General	• Service change policy framework and national partnerships (e.g. NHS Improvement, royal colleges). • Oversees delivery of NHS services. • Leads change for directly commissioned services. • Responsible for assuring that service change proposals meet the Government's 'four tests', NHS England's bed closure test and best practice checks. • Liaises with NHS Improvement to support joint letters for schemes requiring capital to allow these schemes to proceed to consultation/public engagement.
	Investment Committee (IC)	• Oversees assurance of service change and has delegated powers to make decisions on those requiring NHS England board sign off. • Responsibility for the oversight of certain capital expenditure and transactions.
	Chief Financial Officer (CFO)	• Has delegated powers to make decisions and assure schemes meeting the thresholds as set out in the IC terms of reference
	Oversight Group for Service Change and Reconfiguration (OGSCR)	• Oversees the national work programme for service change. • Provides advice and recommendations to the IC in relation to service change schemes and transactions.
	NHS England Regional Director (RD)	• Assures service change proposals within their region except those where CFO/IC sign off is required. • Has delegated powers to make decisions on certain service change schemes (in cases where NHS England is lead or a joint commissioner).
	Specialised Commissioning	• The Specialised Commissioning team work across regional and national footprints to support the commissioning and delivery of specialised services and implementation of national policies.
	Clinical Senates	• Sources of independent clinical advice hosted by NHS England.
	Assurance Gateway Service	• Provides co-ordination and support for the arrangement of assurance Gateway reviews for projects and programmes
	NHS England Directly Commissioned Services	• NHS England directly commissions services including Specialised Commissioning, Health and Justice, Armed Forces and their families, Public Health and Primary Care.

Independent Reconfiguration Panel (IRP)	• Offers expert advice on proposals referred to Panel by the Secretary of State. • Provides advice to NHS and other interested bodies on developing proposals for service reconfiguration.
Overview and Scrutiny Committee (OSC)	• A committee formed of members of the local authority. With delegated powers of oversight and scrutiny of the local health economy. • Have powers to refer proposals to the Secretary of State. (Also see Annex 1)
NHS Improvement	• Regulatory oversight, assurance of quality, governance, finance and risk in NHS trusts and foundation trusts. • Oversight of performance of NHS trusts and foundation trusts, providing support to help improve quality and sustainability of services. • Approval of NHS trust and foundation trust capital investment business cases • NHSI/ NHSE will where necessary liaise with the Department of Health and Social Care to test national capital affordability at an early stage in order to ensure only viable cases are taken forward. • Oversight of commissioning through the Procurement, Patient Choice and Competition Regulations • Liaises with NHS England to support joint letters for schemes requiring capital to allow these to proceed to consultation / public engagement.

Annex 2: Overview of the service change assurance process



Annex 3 Local Authority Overview and Scrutiny Committee

- Local authority overview and scrutiny committees have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area.

- Commissioners must consult the local authority when considering, or a provider is considering, any proposal for a substantial development or variation of the health service in the area. The local authority may scrutinise such proposals and make reports and recommendations to the NHS commissioning body (CCG or NHS England) or referrals to the Secretary of State for Health.

- As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from local Healthwatch. The overview and scrutiny process can therefore enhance public involvement in the commissioning process.

- The threshold for reporting proposals to the local authority under the overview and scrutiny process is higher than that for the duty to involve the public under section 14Z2 and 13Q. However, the duties frequently overlap, particularly where significant changes to the configuration of local health services are under consideration.

- For further information, see s.244 NHS Act 2006 and Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (http://www.legislation.gov.uk/uksi/2013/218/pdfs/uksi_20130218_en.pdf).

Annex 4 – Stage 2 Assurance Checkpoint (ACP) sample questions

NHSE Service Reconfiguration Assurance Checklist - Stage 2

Topic	Evidence (summary)	Evidence (detail)
4 Key Tests, 5th Beds test and Finance		
Public and Patient Engagement	Communications plan	Full plan for consultation and communications including: ● how feedback will be considered and built into the scheme and how this progress will be played back to the public ● how the CCG will ensure that all sections of the community, including those hard to reach, are given a full opportunity to comment ● How staff will have their say ● How stakeholders will be notified of the consultation ● How feedback and questions will be handled, including capacity and channels ● Distribution plan for hard copies of documentation ● Timescales ● Spokespeople
	Consultation Document	To include: ● how final options were identified and developed, including the role of public and patient engagement ● which options were ruled out, and why ● clinical case for change, including scenarios to show how the proposed changes would affect patients ● how the case for change fits with Five-year Forward View ● the financial drivers and issues ● staffing implications ● how changes would be implemented, including phasing ● what would happen to premises ● full arrangements for enabling all sections of the community to have their say ● the decision-making process and timescales
	Support from Scrunity	this could be minutes, but needs to show explicit approval or support for the consultation and to reflect that scrutiny were given details of likely impacts on local services, including community hospitals and MIUs
Patient Choice (and EIA)	Impact on Patient choice considered	● evidence to show how you've considered patient choice when developing the options for the scheme ● how you have protected against reduced choice or how you will mitigate this perhaps through Personal Health budgets, increased clinical quality etc
	Equality Impact Assessment	● Has an equality impact assessment taken place? ● Has engagement taken place with any groups that may be affected? ● What action will be taken to eliminate any adverse impacts identified?
Clinical Evidence	National policy/guidance/best practice	● Fit with clinical evidence and clinical best practice ● Scenarios to show how the proposed changes would affect the typical patients ● Clinical risks of implementing proposals across the whole system ● Extent to which community believes proposals will deliver real benefits ? Don't understand question fully? ● Evidence of clinical leadership and engagement in development of model and implementation plans (not just CCG staff).
Support from GP Commissioners		● Evidence from GP federation or locality meetings or stakeholder engagement sessions ● Were clinicians involved in the development of the models/the scheme? ● Will cinicians play any part in the consultation public meetings?
NHS England Bed Closures Test	Any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:	Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
		Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
		Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).
Finance	Business Case	To include: • How proposal supports commissioner and provider financial sustainability • How the proposed change improve quality and reduce cost • Expected savings in financial terms and timescales for when these savings be realised • Transitional costs and how will they be funded • finance modelling to link consistently to workforce and activity models • Capital investment implications for this scheme Other finance questions: • How does the scheme link to QIPP? • Consideration given to the most effective use of estates

NB the list above is provided to give an example of the type of questions and evidence required and should not be considered exhaustive. Full assurance support will be provided by your regional team and the details of assurance requirements should be decided during the strategic sense check (SSC) and communicated in writing shortly after. Should the proposals change substantially between SSC and assurance check point (ACP), a second sense check may be required to ensure the written requirements still match the new proposals.

Ongoing communication with your regional offices will ensure a smooth transition through assurance check points into consultation, decision making and implementation.

Inclusion of specialised commissioning in the assurance process is advisable, either as a panel member to ensure adequate consideration of the impact of proposals on specialised services, or as a joint commissioner of services affected by the proposals.

Annex 5 - Proposal Development

A proposal should cover:

- analysis of the full range of potential service changes that can achieve the desired improvement in quality and outcomes;
- the development of a range of options based on the above analysis;
- an assessment against legal duties and obligations including the Public Sector Equality Duty[15] (PSED) and the duty to have regard to the need to reduce inequalities;
- dialogue that seeks to align proposals with the plans and priorities of STPs and partners;
- consideration of whether proposals represent a substantial service change (to be agreed locally);
- assessment against the governments four tests and NHS England's tests and best practice checks;
- any potential financial implications (capital spend, transactional or transitional funds, savings, core costs etc.) which may impact on the range of deliverable options taken forward;
- any outline plans which can demonstrate how each of the options would be implemented and show that there are plans to ensure that safe services are maintained in the interim;
- consideration of whether proposals can be implemented in a phased approach in order to secure the required funding;
- a privacy impact assessment identifying requirements for lawful information sharing and, from May 2018, consideration should be given to GDPR obligations;[16];
- analysis of demographic and other factors likely to influence future demand for the service;
- service models and learning from elsewhere including national / international experience; and
- deliverability in estates terms (if the change proposals imply change to physical infrastructure);and
- show consideration of and progress towards meeting the clinical standards of seven day services.

[15] Section149 of the Equality Act 2010, section 14T and section 13G of the NHS Act 2

[16] See Annex 16 *Key Resources* for the Information Commissioner's Guidance on privacy

Annex 6 - Pre consultation business case

The PCBC will vary, however they should:

- be clear about the impact in terms of outcomes;
- outline how stakeholders, patients and the public have been involved, proposed further approaches and how their views have informed options;
- outline the case for change;
- identify governance and decision making arrangements;
- be explicit about the number of people affected and the benefits to them;
- identify indicative implementation timelines;
- include an analysis of travelling times and distances;
- outline how the proposed service changes will promote equality, tackle health inequalities and demonstrate how the commissioners have met PSED;
- explain how the proposed changes impact on local government services and the response of local government;
- demonstrate how the proposals meet the governments four tests and NHS England's test for proposed bed closures (where appropriate);
- demonstrate links to relevant JSNAs and JHWSs, STPs and CCG and NHS England commissioning plans;
- summarise information governance issues identified by the privacy impact assessment;
- identify any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of specialised or other services; and
- show that options are affordable, clinically viable and deliverable:
    - Demonstrate evaluation of options against a clear set of criteria.
    - Demonstrate affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies) and satisfaction of any applicable return on investment (ROI) criteria.
    - Demonstrate proposals are affordable in revenue and capital terms, proposals are deliverable on site, and transitional and recurrent revenue impact have been robustly identified.

Annex 7 - Clinical commissioner leadership and collaborative decision making

Proposals which involve a single CCG

- Arrange planning and decision making either through the governing body, an existing committee with a relevant remit and delegated authority or by creating a specific committee and delegating the exercise of the relevant functions to it.
- It is good practice that a clinically-led group should oversee the design and development of proposals, and commissioners should ensure that clinical ownership and leadership of plans is part of any programme and governance arrangements.
- Where schemes relate exclusively to services directly commissioned by NHS England, arrangements will be made for senior clinicians to be part of the governance structure for schemes.

Proposals which involve multiple commissioning organisations

Collaborative commissioning arrangements can be based on two models: committee in common or joint committees.

Joint committees

- The NHS Act 2006 allows CCGs to form joint committees with each other and/or NHS England.
- CCG(s) in the committee are able to delegate their decision making function to the joint committee.
- A joint committee may also be formed between NHS England and CCGs and the joint committee will exercise its management of functions in accordance with the agreement entered into between NHS England and the CCG.
- The Legislative Reform Order encourages integration and more streamlined collaborative decision making than committees in common (see below).
- CCGs constitutions and governance arrangements must permit the formation of a joint committee. Most CCGs have already amended their constitutions to allow this but if in doubt this should be checked.
- Where amendments to the constitution are required, CCGs will need to obtain the appropriate internal approvals to the proposed changes and seek the approval of their members prior to submitting their amended constitutions to NHS England.
- In joint commissioning arrangements, individual CCGs and NHS England remain accountable for meeting their own statutory duties.

The Legislative Reform (Clinical Commissioning Groups) Order 2014 (LRO) came into force on 1 October 2014. The LRO amends the National Health Service Act 2006 to enable:

- **two or more CCGs to establish a joint committee so that they can exercise their functions as a joint committee of the groups; and**
- **CCGs and NHS England to establish joint committees so that they can exercise certain CCG functions jointly.**

Committees in common

- As set out above, since the Legislative Reform (Clinical Commissioning Groups) Order 2014 (LRO) came into force, it is no longer necessary for CCGs to operate arrangements such as “committees in common” when they wish to make joint and binding decisions. However, committees in common are still an option and may be convenient when collaborating with non-NHS bodies such as local authorities.
- Each CCG can delegate any functions required for developing service change proposals to a committee consisting of its members or employees and those from other CCGs involved in the service change. That would enable all involved CCGs to have committees consisting of the same people and those committees could then meet in common for the purposes of decision making.
- It is good practice that membership of the ‘committees in common’ is drawn from CCG chairs or accountable officers (where these are GPs) or a nominated senior clinical GP lead from each CCG, and the medical director of the relevant team(s) where schemes have a component of direct commissioning.
- It is also good practice that the CCGs consider whether they should establish a separate programme (or advisory) board consisting of commissioners, providers, local authorities and other relevant stakeholders to make sure all relevant information is fed into the change process.

A programme board would not be able to exercise any function on behalf of any CCG (Section 14Z3) but could support the development of shared proposals and provide recommendations to the ‘committees in common’ or CCG governing bodies

Annex 8 – Commissioning regulations

Commissioners should always comply with the Procurement, Patient Choice and Competition Regulations

The Procurement, Patient Choice and Competition Regulations provide a framework for commissioners to drive positive change that benefits patients. Monitor's substantive guidance on the regulations sets out a series of questions commissioners should ask themselves to ensure they are meeting the needs of patients within the framework of the regulations. These questions are:

- **What are the needs of the health care service users we are responsible for?**
- **Are those needs currently being met? Have they changed since services were last reviewed?**
- **What level of involvement with the local community, patients and patient groups, clinicians and others should we undertake?**
- **How good are current services? How can we improve them?**
- **How can we make sure that the services are provided in a more joined-up way with other services so that they are seamless from the perspective of the patient? How can we get the professionals that are responsible for different elements of a patient's care to work together more effectively for patients?**
- **Could services be improved by giving patients a choice of provider to go to and/or by enabling providers to compete to provide services?**
- **How can we identify the most capable provider or providers of the services? Is the current provider the only provider capable of providing the services?**
- **Are our actions transparent? Do people know what decisions we are taking and the reasons we are taking them? Do we have appropriate records of our decisions?**
- **How can we make sure that providers have a fair opportunity to express their interest in providing services? What do we need to do to make sure that we do not discriminate against any providers?**
- **Are there any conflicts between the interests in commissioning the services and providing them? If so, how can we manage them to make sure that they do not affect or appear to affect the integrity of the award of any contract at a later point in time?**
- **Are our actions proportionate? Are they commensurate with the value, complexity and clinical risk associated with the provision of the services in question and consistent with our commissioning priorities?**

Annex 9 – Best practice checks

These are some of the best practice checks that should be undertaken. This set can also be found in the document '*Service Change – a support and guidance Toolkit'.*

Four tests		
Criteria	**Key Tests**	**Example Evidence**
4 key tests	• Strong public and patient engagement, • Consistency with current and prospective need for patient choice • A clear clinical evidence base • Support for proposals from clinical commissioners	• A narrative against the governments four tests • See also communications, clinical quality and activity sections below • Documented evidence of support
Additional test		
Bed closures	Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions: • Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or • Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or • Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).	Evidence to meet one of the three conditions, this might include: • Analysis of alternative provision and workforce plan • Clinically approved analysis of admissions reductions anticipated with new treatments or therapies (Clinical Senates and Regional Medicines Optimisation Committees may be sources of independent advice) • Analysis of hospital bed efficiency, a credible plan to improve performance and modelling of its impact
Assurance checks		
	Checks	**Example Evidence**
Finance	• Are the proposals financially deliverable, affordable and value for money? (applied to all proposals) • Are planned savings reasonable and realistic? • Is it clear how the proposal fits into the STP financial plan? Is the contribution to achieving financial balance for the health economy clearly stated and robust? • Are the impacts on providers and commissioners understood? • Is there a reasonable level of financial risk assessment undertaken with supporting sensitivity analysis and downside planning and mitigation?	• Business case or strategic outline case including worked through financial models • Evidence of aligned financial, workforce and activity models • Detail on assumptions used in financial modelling • Capital investment implications and source for all options fully described. Status of any application for capital is explicit in business case and public facing documents.
	Checks	**Example Evidence**

Finance continued	• Are the transitional costs (including non-recurrent revenue and capital) identified and properly accounted for? How will they be funded? • Have the capital investment implications been considered in terms of the viability, deliverability and sustainability of the proposal and the economic (value for money and return on investment) impact? Have a number of options been considered? • Is each option is sustainable in service and revenue and capital affordability terms and can each option demonstrate that it is proportionate and that it is capable of meeting applicable VFM and return on investment criteria? • Is there a financial model underpinning the analysis including costed models to support transformation / service reconfiguration proposals? • Does the financial modelling have a robust starting point (e.g. alignment to allocation/control totals, understanding of underlying position)? • Are demand management and activity growth assumptions reasonable in the context of national benchmarks? Is there evidence to support the expected impact of proposed new models of delivery? • Is the financial modelling consistent with the workforce and activity modelling?	• Revenue and capital affordability of each option is confirmed with appropriate modelling • NHS England and NHS Improvement correspondence indicating notional degree of confidence on availability of capital.
Clinical quality / Strategic fit	• A full impact analysis (of the proposals) across CCG and NHS England commissioned services and shared sign up of all parties to the analysis (**applied to all proposals)** • Alignment with STP delivery • What contribution do the proposals make to each of the 3 gaps described in the Five Year Forward View (health and wellbeing gap; care and quality gap; funding and efficiency gap)? • Clear articulation of quality, experience and outcome benefits quantified if possible • Clinical case fits with best practice or emerging national models • Aligned with delivery of national strategies (e.g. 7DS, U&EC, MH, cancer, maternity) • All key clinical interdependencies have been fully considered • Full options appraisal undertaken (inc.. network approach, cooperation and collaboration with other sites and/or organisations) • Macro-impact is properly considered including on other organisations / systems • Does the proposal align to the new models of care in the Five Year Forward View?	• Analysis of impact on CCG / NHS England commissioned services, including potential co-dependencies and unintended consequences, endorsed by relevant parties. • Alignment with STP delivery • Modelling demonstrating contribution to the FYFV gaps • Core narrative / communications materials • Clinical case for change • Reference to evidence base (e.g. NCD reports, NICE, Royal College, NHS Evidence or new models of care) and national strategies • Narrative demonstrating alignment / interdependencies • Options appraisal • Analysis of macro-impact

	Checks	Example Evidence
Activity	• All relevant patient flows and capacity are properly modelled, assumptions are clear and reasonable • What are the changes in bed numbers? • Activity and capacity modelling clearly linked to service change objectives • Activity links consistently to workforce and finance models • Modelling of significant activity, workforce and finance impacts on other locations / organisations	• Outputs of accurate modelling with assumptions clearly stated and sensitivity analysis • Clear explanation of changes to bed numbers • Narrative explaining link between modelling and service change objectives • Aligned financial, workforce and activity models • Analysis of key risks and any mitigating actions
Workforce	• Do you have a workforce plan integrated with finance and activity plans? • Are you making most effective use of your workforce for service delivery and is it compliant with all appropriate guidance? • Consider the implications for future workforce • Have staff been properly engaged in developing the proposed change?	• Supply high level workforce risks and mitigating actions • Statement of assurance including reference to appropriate standards • Changes to provider Learning Development Agreements • Evidence of appropriate staff engagement
Travel	• Has the travel impact of proposed change been modelled for all key populations including analysis of available transport options, public transport schedules and availability / affordability of car parking?	• Travel impact assessment
Estates / infrastructure	• Credible activity/throughput analysis and indicative designs that demonstrably reconcile to up-to-date estates strategies at site, provider and STP levels; indicative capital costs using recognisable benchmarks and based on compliance with all applicable design, technical, building and space standards; and known site constraints and key adjacencies identified and provided for.	• Outputs of activity analysis clearly linked with estates strategy • Capital costs clearly identified (see finance section) and confirmation they comply with the standards described.
Resilience	• How will the proposed change impact on the ability of the local health economy to plan for, and respond to, a major incident? • Has a business impact analysis been conducted for all impacted organisations and appropriate changes made to Business Continuity Plans? • Local Health Resilience Partnership impact assessment on resilience?	• Statement of assurance • Evidence the proposed service change and the impact on resilience has been assessed at the Local Health Resilience Partnership (LHRP)Business impact analysis
Ambulance services	• Have the implications for ambulance services (emergency and PTS) been identified and impact assessed and appropriate discussions been held with ambulance service providers?	• Impact assessment • Statement from ambulance service

	Checks	Example Evidence
Comms and Engagement	• Are there plans to appropriately and effectively engage and involve all stakeholders (to include: staff, patients, carers, the public, Healthwatch, GPs, media, local authority overview and scrutiny functions, Health and Wellbeing Boards, local authorities, MPs, other partners and organisations) and fulfil commitments under s.14Z2 and s.13Q of the Health and Social Care Act?	• Consultation plan • Draft consultation document • Public / stakeholder involvement strategy • Communications plan including stakeholder map with timelines, key messages, named clinical spokespersons, sample materials and plans to reach seldom heard groups
Equality Impact	• There has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups? • Has engagement taken place with any groups that may be affected? • What action will be taken to mitigate any adverse impacts?	• Completed EqIA and Action Plan • Evidence that decision-making arrangements will pay due regard to equalities issues
NHS Improvement	• Is NHS Improvement aware of the provider impact and supportive of the proposals? • (See also finance section for capital)	• NHS Improvement position clearly stated • Formal letter of NHS Improvement support (if available)
IT	• Does proposal make best use of technology? • Assessment of the impact on local informatics strategy & IT deployments • Are there likely to be any data migration costs or implications for specialist or network technology/equipment contracts associated with the service?	• Evidence of a review of how technology may support the service change been undertaken • Detail of any changes to local informatics strategy and deployment plan, inc. information flows and governance. Key risks are highlighted and mitigating actions identified
Others	• Consistent with rules for cooperation and competition • Consideration given to the most effective use of estates • Robust programme and risk management arrangements • Identify and reduce privacy risks	• Assurance from commissioners • Estates impact assessment • Gateway review report and response to recommendations • Conduct a privacy impact assessment (PIA)

Annex 10 - Specialised Commissioning

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to maintain and further develop their skills.

NHS England is responsible for commissioning £16 billion of specialised services to meet a wide range of health and care needs. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life threatening genetic disorders. The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England.

The Specialised Commissioning directorate of NHS England takes a consistent approach to central planning of specialised services which is delivered locally. It works to raise the standards of care for all patients receiving treatment for rare and specialised conditions, ensuring that patients have equal access to services regardless of their location.

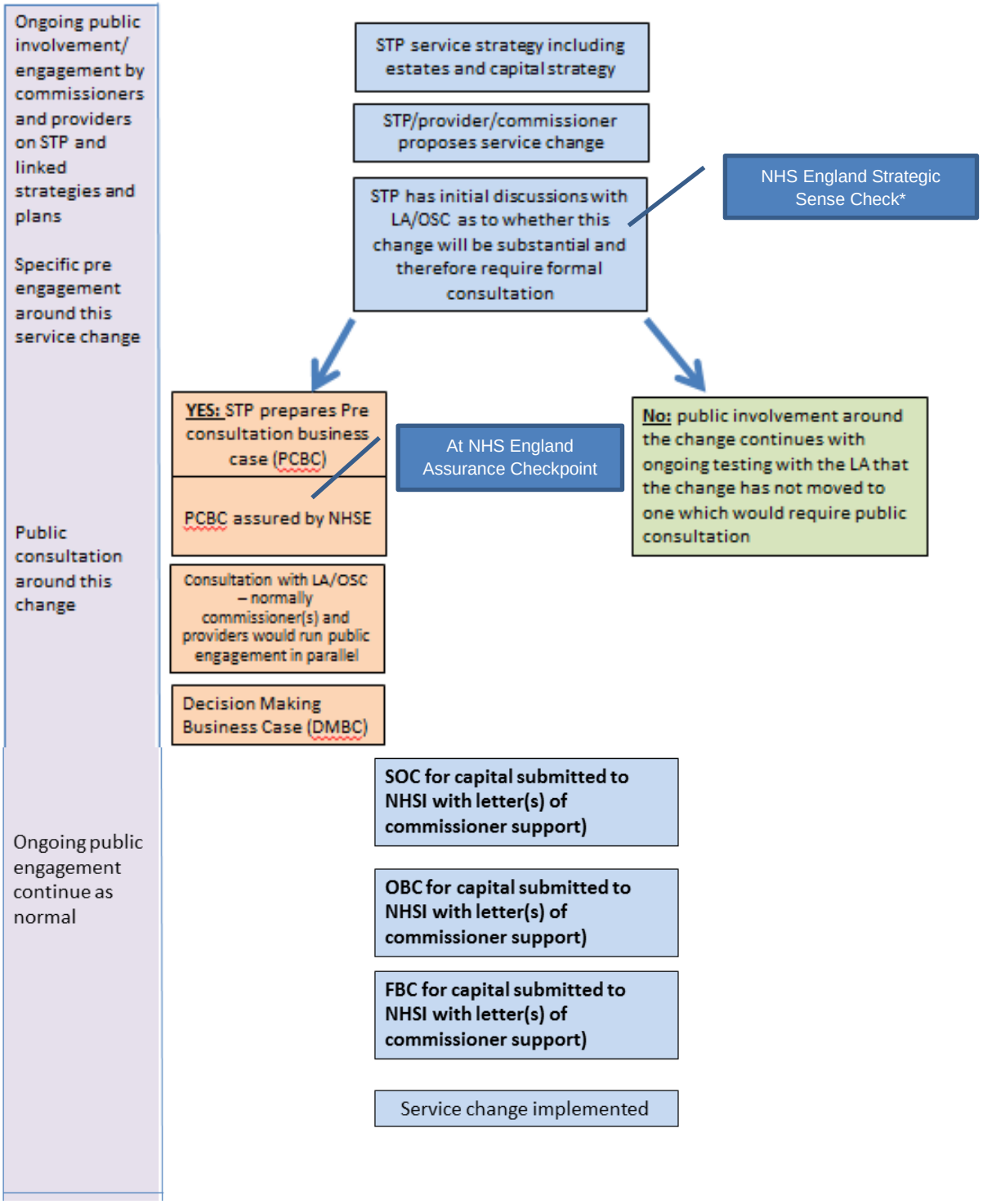
The Specialised Commissioning national support centre sets the requirements for specialised services through service specifications, clinical policies and annual commissioning intentions. It also supports the four Regions with Improving Value and transformational change, delivers national procurements and undertakes selected service reviews.

Regions are accountable for operationally commissioning specialised services through nine commissioning hubs outside of London (which is both a region and a hub for reasons of geography).

Commissioning Hubs have responsibility across England to contract and ensure consistent delivery of clinical specifications and commissioning policies. Specialised Commissioning hubs also work closely with CCGs (place based commissioning and STP).

Annex 11 - Flowchart for service change for scheme including capital.

If it does not require capital, then those elements in bold will not be required



*refer to annex 2 for an overview of NHS England's assurance process

Annex 12 Guidance for commissioners and providers on commissioner letters of support for capital business cases

This guidance sets out the requirements for commissioner letters of support which are required to be submitted to NHS Improvement in support of a capital business case. NHS England and NHS Improvement expect all commissioners and providers submitting business cases to NHS Improvement for approval to work to this guidance. The Department of Health and Social Care also support this standard approach.

When are commissioner letters of support required for business cases?

- Letters of support are required for **all** SOCs, OBCs and FBCs for capital schemes over £15m **excluding** whole life schemes (e.g. energy, managed equipment services, leases) and excluding land disposals.
- A new letter will be required for every SOC, OBC and FBC with the latest position and with more detail as appropriate to the stage of the business case.
- NHS Improvement reserves the right to request a SOC, FBC, OBC for lower value business cases if there are specific issues (e.g. novel, contentious) in which case letters of support will also be required from commissioners.
- Letters of support from commissioners including specialist commissioning should be provided at the time the business case is submitted to NHSI. Letters of support from NHS England Regional Finance Directors and the NHS England Chief Financial Officer will need to be submitted with the business case to NHS Improvement in order for assurance to start.

Who do letters of support need to come from?

- The Accountable Officer of all major commissioning CCGs (>10% of provider turnover) whose commissioned services will be affected by the change. Letters of support need to be provided for no less than 80% of the income of the services affected by the change.
- Regional Director of specialist commissioning if specialist commissioning services income is more than 10% of the total services affected by the change.
- STP lead if the capital scheme has a value between £30m and £50m (these schemes will be submitted for approval to the NHS Improvement Resources Committee).
- NHS England Regional Finance Director if the capital scheme has a value of between £30m and £50m capital (these schemes will be submitted for approval to the NHS Improvement Resources Committee)
- NHS England Chief Financial Officer if the capital scheme has a value of between £50m and £100m capital (these schemes will be submitted to the NHS Improvement Board for approval).
- Schemes over £100m will be considered by NHS England Investment Committee prior to the letter of support being issued by the NHS England Chief Financial Officer. This is a gross figure i.e. if a scheme had a value of £200m

capital, funded by £150m land disposals, it would be considered by the NHS England Investment Committee.

What must the letter include?

Letter from	Should include
Each AO of major commissioning CCGs	• Public consultation requirements - that providers and commissioners have agreed with the relevant LA whether or not the changes are sufficiently substantial to require public consultation. If so confirmation that this has been completed and the outcome. Note that if public consultation is required this **must** take place prior to the submission of a SOC. • Commissioner view of how the proposed solution assists the health system in managing present and future issues. • Commissioner and provider agreement of activity and finance levels which underlie the case including impact on all sectors i.e. acute, community, mental health and primary care. It is difficult to be totally prescriptive as each case is different but essentially each case should set out figures and supporting assumptions around new or existing commissioner activity and income on which the capital scheme business case is built. Commissioners should confirm specifically that these are agreed and provide confirmation that commissioners are not considering divesting in those activities after the investment is commissioned. Implicit support may be sufficient at SOC stage but at OBC and FBC, NHS Improvement and NHS England want to see firm commitment to values. • Confirmation that commissioners and providers are making assumptions based on 'reasonable' levels of growth in allocations/funding e.g. assuming that future trends continue in line with past trends. • Confirmation that commissioners have reviewed the provider savings assumed within the business case and believe that there is no misalignment with these and the activity/income commissioning plans. • Agreement of any additional funding which will be provided by commissioners to support the case or any savings due to them from it including baseline growth assumptions i.e. do nothing.
Regional Director of Specialist Commissioning	As CCG AO
STP lead	Confirmation that the service changes enabled by the capital scheme fits within the STP plan and supporting estates strategy. Confirmation that this scheme is a priority for the STP and has full STP support.
NHS England	Confirmation that regional assurance has been undertaken for

Regional Finance Director	the scheme and that no major issues have been identified which would mean that the scheme should not proceed.
NHS England Chief Finance Officer	Confirmation of support from NHS England that regional assurance of the scheme has been undertaken, no major issues have been identified which would mean that the scheme should not proceed and that NHS England support the scheme as being a priority for capital funding. Confirmation that NHS England Investment Committee has considered the case if it is over £100m (gross value).

Annex 13 – Key resources

- A mandate from the Government to NHS England: **https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018**

- Cabinet Office guidance on Consultation Principles **www.gov.uk/government/publications/consultation-principles-guidance**

- Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies **www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf**

- Independent Reconfiguration Panel's (IRP) 'Learning from Reviews' **www.gov.uk/government/collections/irp-learning-from-reviews**

- IRP homepage **www.gov.uk/government/organisations/independent-reconfiguration-panel/about**

- Managing conflicts of interests: **https://www.england.nhs.uk/ourwork/coi/**

- Model constitution framework for clinical commissioning groups **www.england.nhs.uk/resources/resources-for-CCG(s)/ccg-mod-cons-framework/**

- Guidance to support Local Authorities and their partners to deliver effective health scrutiny **www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf**

- The functions of clinical commissioning group **www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-CCG(s).pdf**

- Equality and Health Inequalities legal duties: Guidance for NHS Commissioners on Equality and Health Inequalities legal duties **www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/**

- The Equality Delivery System (EDS) resources **www.england.nhs.uk/ourwork/gov/edc/eds/**

- Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts **www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-5**

- Statutory guidance for Trust Special Administrators appointed to NHS Trusts **www.gov.uk/government/uploads/system/uploads/attachment_data/file/212850/statutory-guidance-trust-special-administrators.pdf**

- Terms of Reference for the NHS England Investment Committee: **https://www.england.nhs.uk/publication/board-committees-terms-of-reference/**

- NHS Improvement's substantive guidance on the Procurement, Patient Choice and Competition Regulations **www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance**

- CCG Assurance framework **www.england.nhs.uk/commissioning/ccg-auth/**

- NHS England Patient and Public Participation Policy **https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-policy.pdf**

- NHS England Statement of arrangements and guidance for involving the public in commissioning **https://www.england.nhs.uk/participation/involvementguidance/**

- Information Governance Alliance guidance on information sharing **https://digital.nhs.uk/information-governance-alliance/resources/information-sharing-resources**

- Information Commissioner's guidance on privacy by design including the *Conducting privacy impact assessments code of practice* **https://ico.org.uk/for-organisations/guide-to-data-protection/privacy-by-design/**

- The Patient Experience Library – to gain a patient's eye view of service quality. Includes an interactive map linking to local Healthwatch reports across the UK **https://www.patientlibrary.net/cgi-bin/library.cgi?page=Welcome;prevref=**

- Seven Day Services Clinical Standards - The full standards and supporting information can be downloaded here **https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/**

- For Programme Assurance Reviews contact **england.pmo@nhs.net**

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