



MIDLANDS AND LANCASHIRE
COMMISSIONING SUPPORT UNIT

Strategy Unit



Decommissioning Evidence Review

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Summary

Decommissioning is viewed as an integral part of the commissioning cycle. The National Audit Office defines decommissioning as a “process of planning and managing a reduction in service activity or terminating a contract in line with commissioning objectives” (National Audit Office, 2011). The evidence base to support decommissioning is relatively small but is developing focusing on the challenges faced by decision makers.

79% of PCT’s were involved in decommissioning activity in 2009/10 with the majority of disinvestment activities of PCT’s focused on interventions which could be immediately removed such as low- clinical value treatments. The National Audit Office estimated that PCT’s identified approximately 250 different procedures with limited clinical value (2011 a) and NICE have established a Do Not Do list to support commissioners (pages 4-6).

The importance and of evidence to inform decision making runs through the literature. Epidemiological data is the most influential, followed by predictive modelling and low economic data. Tools such as the PBMA are least likely to be used by commissioners though much of the empirical evidence revolves around the use of the PBMA tool (pages 9-11) Additional tools to support commissioners are being developed such as STAR supported by the Health Foundation and a series of toolkits to support decommissioning have been created both within and outside the NHS (pages 16-18).

Barriers in making and implementing decisions were highlighted within the evidence and there was a consensus that the commissioning process has lacked an explicit process, poor engagement from stakeholders and the public and often a limited evidence base to support decommissioning decisions (page 14).

The evidence identified strong leadership, clinical support, stakeholder engagement, a clear rationale and narrative to support the change and whole system approach as critical success factors in the decommissioning process (page 15).

The evidence base for decommissioning is a small but emerging one with a number of ongoing research projects (page 18).



Introduction

This review identifies evidence to support the decommissioning process and covers decommissioning activity within the NHS, priority setting, tools used to inform decommissioning activity such as the PBMA. Several case studies were identified included in this review and examples of toolkits to support decommissioning are also included.

Context

The Quality, Innovation, Productivity and Prevention (QIPP) programme launched in 2011 was designed to support the NHS to improve productivity and patient care and deliver £15 to £20 billion by 2014/15 in savings. A growing demand for health care due to meeting the needs of an ageing population and more chronic conditions means that costs pressures on the NHS continue to grow. The Nuffield Trust estimate t cost projections of around four per cent a year up to 2021/22. (Roberts et al, 2012)., It has been estimated that there will be a need to review total expenditure to make 15 to 20% efficiency savings (Robinson et al 2011) with services which add little value will needing to be reduced.

Decommissioning and the Commissioning Cycle

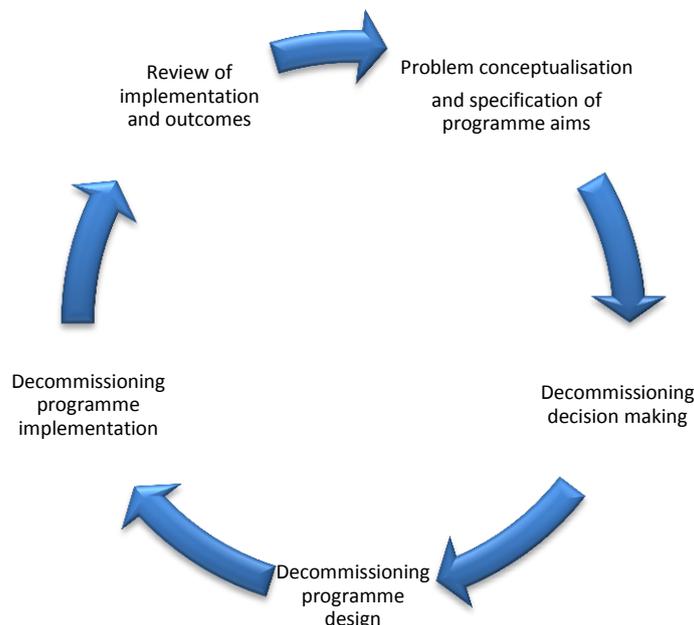
Decommissioning is considered as being an integral part of the commissioning cycle, interconnected with commissioning and re-commissioning in the NHS, such activities are planned. (NICE, 2013)

The National Audit Office defines decommissioning as a “process of planning and managing a reduction in service activity or terminating a contract in line with commissioning objectives”. (National Audit Office, 2011) Taken at its broadest level the term decommissioning includes the removal, or reduction and/or the replacement of a service or intervention and within the empirical literature the terms decommissioning and disinvestment are used inter-changeably. Increasingly within the NHS the terms decommissioning and disinvestments are not used interchangeably and are defined as:

- Decommissioning: This relates to the withdrawal of funding from a provider organization where the service is subsequently re-commissioned in a different format.
- Disinvestment: This relates to the withdrawal of funding from a provider organization and the subsequent stopping of the service.

For the purpose of this review the National Audit Office definition is used.

The evidence base for decommissioning is small but literature focusing on priority setting and tools to support decommissioning decisions has increased during the past five year. A current NIHR project is examining the decommissioning process and researchers have developed a notional model of the ‘stages’ necessary for a typical decommissioning cycle.



Proposed Decommissioning Cycle (Williams et al 2011)

Decommissioning activity within the NHS

The most recent figures identified for decommissioning activity within the NHS come from the Nuffield Trust. In 2009/2010 they found that:

- 79% of PCTs were involved in decommissioning activity.
- 54% of PCTs making significant disinvestment decisions.
- Just over half of those PCT's who had made significant disinvestment decisions have reinvested saving in the same disease/service area.(Robinson et al (2011)

Tools to Inform Decommissioning Decisions

The Commissioning Intelligence identified various tools to inform decommissioning, these include: Programme budgeting, PBMA, Pathway modelling, return on investment tools (NHS England, 2012) Epidemiological data most influential, the PBMA the least influential Robinson et al (2011)

- 96% of PCTS used epidemiological data,
- 76% used predictive modelling
- 73% reviewed local economic data
- 45% had used the PMBA

The evidence highlighted challenges to the decommissioning process around the priority setting process, identifying treatments of low-clinical value and engaging stakeholders and implementing decommissioning decisions.



Treatments of Low-Clinical Value

Disinvestment activities of PCT's were focused on interventions which could be immediately removed such as low- clinical value treatments (Robinson et al 2011). In 2011, the National Audit Office estimated that PCT's had identified approximately 250 different procedures with limited clinical value (2011 a). The NAO identified Croydon PCT as a PCT who had made significant progress in this area having developed a list of low-value clinical treatments which the National Audit Office estimated that in 2009/10, the total spend in England on the procedures on the Croydon list was £1.9 billion. Since then many CCG's have developed policies on low clinical value treatments (Shropshire CCG, 2013, Sandwell and West Birmingham CCG).

Various sources of evidence are used by PCT's to identify low value clinical treatments included:

- NICE www.nice.org.uk
- Health Information Resources www.library.nhs.uk
- NHS Evidence www.evidence.nhs.uk
- Clinical Knowledge Summaries www.cks.nhs.uk/home
- National Prescribing Centre www.npc.co.uk
- Evidence-Based Commissioning PDF on DH website
- Turning Research into Practice www.tripdatabase.com
- Map of Medicine www.mapofmedicine.com
- The NHS Atlas of Variation www.rightcare.nhs.uk/atlas/

NICE produce a "[Do not do](#)" list which is a compilation of all of the technologies that they recommend that should not be used. NICE estimate that the NHS has made savings of over £600 million (NICE, 2010)

Concerns have been expressed by the the Federation of Surgical Specialty Associations (FSSA), around the evidence to support lists of treatments of low-clinical value. The FSSA argue that the evidence base is not robust (FSSA, 2011). The Royal College of Surgeons have argued that many of the procedures deemed of low value prevent complications and more serious conditions developing later and that "Procedures which alleviate pain, improve mobility and quality of life, but the benefits of which are not seen immediately, should remain core NHS activity" (Royal College of Surgeons, 2011)

Two literature reviews have questioned NICE's approach. Sabiu and Lie (2008) argue that NICE focuses on examining new technologies for cost-effectiveness, where the determining factor rests on the consideration of technical evidence of proven effect and costs of the procedure in relation to a pre-set level of cost-effectiveness, in doing so Sabiu and Lie argue that NICE "resembles more a traditional technology assessment agency, rather than a body with a mandate to involve the public in an open dialogue about the difficult moral choices in health care priority setting." NICE's focus on new technologies have also been questioned by Leggert (2012).



The evidence highlighted that one of the challenges that commissioners face in identifying low value clinical treatments was the evidence base. For older treatments that were introduced before the current standards of evidence there is often an absence of evidence, particularly for subgroups, rather than evidence of no effect or harm (Garner and Littlejohn ,2011).

As well as challenges to identifying treatments of low-clinical value the literature also highlighted the difficulty in implementing evidence from systematic reviews. In a qualitative study (Shepperd et al, 2013) examined the barriers to using evidence from systematic reviews to stop ineffective practice, the authors identified various generic and intervention-specific factors which prevented evidence being put into practice (see table below) and concluded that “decommissioningas a social process and one that lacked structure to monitor the process”.

| Barriers in using evidence from systematic reviews (Shepperd et al, 2013) | |
|---|--|
| Generic barriers | Intervention-specific barriers |
| <ul style="list-style-type: none"> • lack of structure to the process. • Managing a high volume of evidence • Patient experiences • Difficulty in applying evidence to local context • Focus on interventions which are likely to release the greatest amount of funding | <ul style="list-style-type: none"> • an absence of systems for monitoring local implementation of guidance • Clinical uncertainty • prevailing opinion • skills and training |

Robinson et al (2011) reported that decommissioning activities within PCTs focused on interventions which could easily be replaced and those ambitious programmes of decommissioning were planned but had not been delivered. In a qualitative study involving commissioners the authors concluded that there was a consensus within the evidence that larger scale disinvestment programmes were the most difficult to implement due to various factors including public perception. (Daniels et al, 2012)

Robinson et al (2012) argues that the challenges faced by commissioners to ‘improve the technical dimensions of decision making, while developing processes that can combine these technical aspects with meaningful involvement of all relevant stakeholder groups, including the public’.

The difficulties faced by commissioners in combining the technical, political and social aspects of the commissioning process has led to an increase in research in explicit priority setting processes and tools to inform the process.

Priority Setting

Priority setting and resource allocation represent an increasing challenge within healthcare systems. Priority-setting is defined as the “process by which healthcare resources are allocated among competing programs or people” (Guindo et al 2010).



Examples of explicit priority setting processes which seek to engage stakeholders and members of the public were reported within the literature. A literature review, by Sabiu and Lie (2008) examined explicit priority setting efforts in Norway, Sweden, Israel, the Netherlands, Denmark, New Zealand, the United Kingdom and the state of Oregon in the US and concluded that the “bodies established to recommend or decide prioritized interventions have been relatively successful. However, the public is not engaged in the envisaged debate about what trade-offs need to be made and how to balance different principles”. The authors argued that challenges facing engaging the public revolved around the need for transparency in providing reasons for decisions and the level of public involvement in the priority setting process.

In England a survey of PCT’s by Robinson et al (2012) found that 86% of respondents had established priority-setting boards, 70% operated at PCT level, 6% operated at strategic health authority level. Only 6% of respondents reported that their boards worked in collaboration with other PCT’s. 78% of respondents reported that their boards’ decisions related to ‘new developments’. Respondents highlighted that disinvestments was considered a weakness in the priority setting process.

As reported by NHS England commissioners are using a variety of tools and data to inform commissioning. In a mixed methods study exploring the tools and methods used by commissioners (Robinson et al, 2012), The authors found that a perceived strength of priority setting processes was the transparency of using tools such as the PBMA to formalize the process. The inability to engage with stakeholders were perceived weakness of priority setting tool, the authors concluded that “there are a series of remaining challenges such as ensuring priority-setting goes beyond the margins and is embedded in budget management, and the development of disinvestment as well as investment strategies.”

A systematic review (Guindo et al, 2012) examining the decision criteria reported within the literature reported that the most frequently mentioned criteria were:

- equity/fairness (32 times),
- efficacy/effectiveness (29),
- stakeholder interests and pressures (28),
- cost-effectiveness (23),
- strength of evidence (20),
- safety(19),
- mission and mandate of health system (19),
- organizational requirements and capacity (17),
- patient-reported outcomes (17)
- need (16).

Similar findings to those of Guindo et al (2012) were reported in two studies (Hasman et al, 2008 and Robert et al 2014). In a small qualitative study (Hasman et al, 2008), interviews conducted with members of committees with responsibility for making resource allocation decisions identified four reasons that almost all participants considered key reasons that should be taken into account: cost effectiveness, clinical effectiveness, equality and gross cost. Participants in the study pointed out that bureaucratic structure affected the criteria that are taken into account and participants



believed that this “often worked in ways that distorted the ethically right decisions”. The authors argued that when examining resource allocation the wider context in which the process takes place, claiming that “political directives, the guidance from national bodies and fear of litigation might affect the decisions in ways that are not ethically justified.” In a Delphi study with 30 experts on commissioning also identified quality and patient safety, clinical effectiveness and cost-effectiveness (Robert et al 2014).

Program Budgeting and Marginal Analysis (PBMA)

There is an emphasis within the empirical literature on the use of PBMA, despite the apparent low use of the tool amongst those involved in commissioning (NHS England, 2012). The PBMA is based on the concept of opportunity cost and the margin. Changes for increased funding and decreased funding can be addressed relative to existing practice. A multiple critical decision analysis (MCDA) can be used in determining the level of benefit associated with the proposed change and involves a set of evaluation criteria and then rating each service option against each criterion to come up with a “benefit score” reflecting the level of benefit associated with the given proposal (Mitton et al, 2014)

Within the literature there are a number of examples demonstrating the implementation of the PBMA. The PBMA was used in Alberta Canada to provide a systematic framework for priority setting within the province and led to reducing the budget deficit by \$40m (Patten et al, 2006). Vancouver Island Health Authority also adopted the PBMA in a priority setting exercise (Dionn et al 2009).

Case Study: Public Health Wales

Public Health Wales undertook PBMA exercises on 25 initiatives, accounting for a total of £15.1 million spend. An expert panel list of 30 potential members was established with representatives from: Public Health Wales, Welsh Government, NHS Health Boards, third sector, local government and primary care. The panel then drew upon evidence collated for each initiative from the review sub-groups, stake holder consultation and an NHS/ primary care sub-group to explore potential alternative modes of health improvement delivery across Wales.

These assessment criteria were as follows:

- considered a priority health issue for Welsh Government,
- opinions of experts,
- stakeholder views,
- presence and robustness of evidence of effectiveness,
- presence and robustness of evidence of cost effectiveness
- impact or potential impact on reducing inequalities in health.

The review established five operational sub-groups to support the review, as outlined below. Information from each of these groups was summarised and then combined and collated into summary booklets for each initiative.



Due to lack of evidence the panel recommended total disinvestment in 7 out of 25 initiatives releasing £1.5 million of resources, and partial disinvestment in a further 3 interventions releasing £7.3 million of resources. The panel did not recommend increasing investment in any of the 25 initiatives under review. The marginal analyses prioritised child health, mental health and wellbeing and tobacco control as key areas for future investment.

(Edwards et al 2014)

Case Study: Norfolk Mental Health PBMA Pilot Project

The Norfolk Mental Health established a PBMA pilot project to review expenditure on mental health. An advisory group was formed with representatives from NHS Trusts, primary care, carers, service users and the voluntary sector. The group was responsible for: developing relevant criteria and weights; identifying options for change; preparing, assessing and scoring business cases and agreeing on a model to combine the scores and weights. Four criteria and 23 sub-criteria were identified by the advisory group and weighted:

- Effectiveness (30%),
- Quality of Service (30%),
- Policy and Strategy (20%)
- Feasibility (20%).

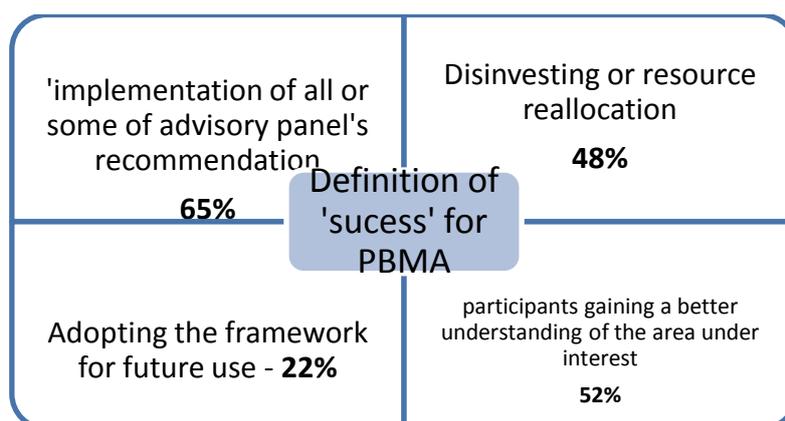
The advisory group agreed on eleven possible areas for service expansion and nine items for disinvestment. It was calculated that under a neutral/fixed programme budget there was the potential to release and reallocate £3.77m to fund the eleven service expansion options. Six business cases for service change were developed, scored and prioritised. These included additional investment for Gardening for Health Project, Young People's One-stop Shop, Assertive Outreach Services, Floating Support, Holistic Mental Well-being Service and Nurse Led Eating Disorders Service.

(Kemp et al, 2007)



Success of the PBMA

Tsourapas and Frew (2011) conducted a systematic review to evaluate success in the use of the PMBA. The review identified 28 applications of the PBMA, ten of which were in Canada, the rest were spread across the UK, Australia and New Zealand. The definition of 'success' influenced whether the PBMA was considered successful, (see below) and the authors argue for a more broadly accepted definition of success to allow greater comparability within the field.



Recently, Polisen (2013) reviewed 14 case studies, 11 involved the use of PBMA and 2 the HTA and found that the majority of stakeholders agreed to the proposed changes on the reduction or termination of services and that the PBMA was found to be transparent. Several of the case studies identified from the literature identified various benefits to using the PBMA including:

- PBMA puts commissioners in a strong position when it faces the public as it helps to document and justify the process.
- Encourages everyone involved to discuss service problems.

But interviewees identified difficulties around identifying criteria, data quality, and a lack of evaluation on implementing.

Mitton et al (2011) argues that regardless of financial drivers the advantage of the PBMA remains as a process which can guide decision making towards optimal allocation of resources and that “the process should focus on the net impact, in terms of ability to meet system objectives, for the entire population being served.”

In a literature review Mortimer (2010) identified case studies which achieved disinvestment via PBMA, the author identified a series of challenges in using the PBMA tool, namely around the failure of projects to scope the budget, specification of budget constraint and the composition and role of the advisory group which often existed of clinicians with competing interests. Mortimer identified four features to develop the PBMA to support those involved in decision making these include:

- budget constraint with budgetary pressure;
- programme budgets with broad scope but specific investment proposals linked to disinvestment proposals with similar input requirements;



- advisory/working groups that include equal representation of sectional interests plus additional members with responsibility for advocating in favour of disinvestment,
- Shift lists' populated and developed prior to 'wish lists' and investment proposals linked to disinvestment proposals within a relatively narrow budget area.

Socio-Technical Allocation of Resources (STAR Tool)

The Socio-Technical Allocation Resources (STAR) tool was developed by academics at LSE and the Health Foundation and uses decision conferencing where stakeholders work in groups with an impartial facilitator to explore an issue from different perspectives and decide a way forward. For each intervention under consideration, stakeholders make use of any available hard data and fill any gaps using their own knowledge. Visual models are then produced and developed interactively with stakeholders, so that everyone involved can understand the nature of the choices to be made, and the disadvantages of not changing current practices.

Case Study – The Star Project in Sheffield

The Star project was piloted with NHS Sheffield in 2011/12. Programme budgeting data had highlighted three key commissioning areas where Sheffield's spending appeared excessive: cancer, dentistry and mental health. The pilot project focused on one well-defined area within mental health services – eating disorders.

NHS Sheffield and the LSE team organised a decision conference over two days. The conference involved about 25 stakeholders, including clinicians and managers from all local providers of eating disorder services, as well as GPs and representatives from the voluntary sector and the local authority. Four service users also played a full part throughout

For each intervention, NHS Sheffield supplied the data it had on costs, the number of people benefiting and the severity of their conditions, and any available evidence of health gain. The first task of the decision conference was to generate the inevitably missing data on health gain. Participants split into four mixed groups to do this, and followed the three-step process:

- Identify how many patients benefit from the intervention in one year, using routinely collected data.
- Use data or participants' expert judgement, to create a profile of the intervention's 'average' beneficiary in terms of gender, age, socio-economic background and the severity of their condition.
- Use value judgements to assess each intervention's average benefit per patient treated.

The committee proposed increasing expenditure on two early interventions: the University eating disorder primary care clinics (UniEDOC) and Sheffield Eating Disorder Service (SEDS). This was predicted to reduce the need for – and high expenditure on – intensive care.

By 2012, indications suggested the new strategy would achieve savings of £220,000 from the £400,000 previously spent on inpatient services for eating disorders.



(Health Foundation, 2012)

The Health Foundation has developed a series of resources to support commissioners and is available at: <http://www.health.org.uk/learning/star/>

A limitation of the STAR Tool is that it has not been evaluated independently. The longer-term impact of the groups decisions have also not be assessed.

In 'Commissioning for Effective Service Transformation' NHS England argue that co-production whereby decision-makers and service providers and users, work together to create a decision or a service which works for them all is essential to support commissioning services within health and social care (NHS England, 2014).

Co-producing decommissioning: Thurrock Council's Adult Social Care

In 2005, Thurrock Council, provided the majority of its care services for adults with learning disabilities through dedicated, multipurpose day Centres. They were relatively large and costly and unpopular with users.

Thurrock's Director of Adult Social Care and the Service Manager for provider services came together with service users to redesign services with a more effective, personalised alternative to institutional care. All of its multipurpose day centres were closed and moved towards a contracting model, supporting the development of a specially created social enterprise run by and for service users – Thurrock Lifestyle Solutions – to provide more targeted, personalised support for adults with learning disabilities.

Closing the day centres was an extremely contentious process with resistance from day centre officers, trades unions fearful about job losses and from service users and their families who were fearful that closing day centres would leave them without adequate support.

Success was mainly due to a tangible, practical model which appealed to a significant majority of service users and gave them democratic control. The project had its critics, and some team members left the council.

(Bunt and Leadbeater, 2012)

Government policy is increasingly focusing on joint commissioning of health and social care (Secretary of State for Health, 2010). In a recent review by Dickinson et al (2013) the authors argue that though much has been written about joint commissioning there is little evidence to link it to changes in outcomes. Evidence to support joint decommissioning is currently underdeveloped in the UK but a body of qualitative research on decommissioning activity within social care has developed and provides lessons which are relevant to disinvestment in health care (Robert et al 2014, Robinson et al 2013). Robinson et al (2013) in a series of semi-structured interviews with 12 Directors of Adult Social Services involved in decommissioning older people's services identified a number of success factors including: strong leadership, strong evidence for the need for change, stakeholder engagement, good communication and a fair decision-making process.



Barriers

- Lack of evidence – In Wales, a lack of evidence was cited in decommissioning 7 of the 25 initiatives that were under review. Reported difficulty to find evidence of effectiveness and cost-effectiveness relating specifically to different time horizons or national versus local provision. (Edwards et al, 2014)
- High volume of evidence and difficulty in applying evidence from systematic reviews to local context and population. An absence of systems for monitoring local implementation of guidance and the availability of different codes for the same procedure which made monitoring some practices difficult. (Shepperd et al, 2013)
- Public perception that decommissioning is a cost-cutting exercise or admission of service failure (Schmidt et al, 2012)
- PBMA is a time consuming process where as the commissioning development plan only has a short time scale (Kemp, 2007)
- When using the PBMA some individuals (members of the public) admitted to not feeling comfortable openly discussing commissioning decisions with such a range of other perspectives being present (Kemp, 2007)
- When using the PBMA Mitton et al(2011) identified the issue of how to identify disinvestments alongside options for investment
- Robert et al (2014) contrast between these ideal drivers and the factors that are most influential in practice. This gap between the rhetoric and reality of decommissioning is at the heart of the decommissioning challenge in healthcare policy and practice;
- PCT's focused on interventions which could easily be replaced and that ambitious programmes of decommissioning were planned but had not been delivered.(Robert et al 2012)
- No agreed numbers for advisory groups especially to deliver the PBMA, and 'expert members find it difficult to put aside sectional interests.

Key Barriers:

Lack of evidence to support decision making

Public perception around decommissioning activity

Changes in Government policy

Engaging stakeholders and clinicians



Critical Success Factors

- Strong leadership team and professional understanding and support for commissioning process (Daniels et al 2012, Robert et al 2014, Kemp et al 2007)
- Engage and involve clinical leaders from an early stage.(Daniels et al 2012, Robert et al 2014)
- Ensure timing fits in with stakeholders agenda. Kemp et al (2007)
- Importance of local-national relationships (Daniels et al, 2012)
- Horizontal co-ordination and collaboration (within and across sectors)
- Importance of wider public perception and popular opinion (Daniels et al 2012) and ensure a narrative for change with a clear rational (Robert et al 2014)
- Clear and thorough project planning and governance and base decisions on evidence of what works.(Robert et al 2014)
- Adopt a whole systems perspective from the beginning (Robert et al 2014)

Key Critical Success Factors:

Strong leadership

High level support from an early stage (national & local)

Professional understanding & support

Whole process change

Establish a clear rational for change

Base decisions on evidence of what works

STAR Toolkit- specific success factors (Health Foundation, 2012)

- Individual commitment and knowledge of the local NHS
- Clinicians' support was considered vital, and the financial model must work too. If issues with the service arise it is essential that clinicians are able to stand up and support it.
- Senior relations between commissioner and provider must be good.
- Choose a service in which it is possible to define a typical patient is important too
- Focus on a small, well-defined project to establish the principles of the Star approach before applying it more widely.



Resources and Toolkits

Decommissioning Checklist and Guidance – DH Care networks Care Services Efficiency Delivery

An example of a Decommissioning Checklist and Guidance from care services. This simple tool is a six-page checklist of questions, useful advice and further sources of information for those considering decommissioning specific services. Available at:

<http://www.navca.org.uk/existing/NR/rdonlyres/f8975bc9-a008-4015-bd91-e6ab40b7af58/0/decommissioningtoolputtingpeoplefirst.pdf>

Right Care Commissioning for Value Programme

A range of resources have been developed to support Clinical Commissioning Groups including Commissioning for Value packs which includes data packs and online tools and a series of case studies. Available at: <http://www.rightcare.nhs.uk/index.php/commissioning-for-value/>

Castlepoint and Rochford Clinical Commissioning Group (2013) Decommissioning and Disinvestment Toolkit, 2013 – 2014 available at: http://castlepointandrochfordccg.nhs.uk/our-governing-body/governing-body-meetings/doc_download/256-item-10-decommissioning-disinvestment-strategy-appendix-1-250713

This toolkit includes a series of criteria for decommissioning and disinvestment.

“Criteria for Decommissioning

The following points will be considered when making the decision to decommission a service.

- The patient experience and health need must be paramount and gaps in service provision minimized once the service ceases.
- The potential destabilizing effect on other organizations e.g. third sector, of a decision to decommission/disinvest should be considered.

Criteria for Disinvestment

- A health needs Assessment demonstrates existing services are not meeting the health needs of the population.
- There is a clear and objective reason for the decommissioning of a service that is based on assessment of the current providers’ performance, value for money and the need for service redesign to improve services for patients.
- The original decision was made on assumptions that were not realized.
- There are demonstrable benefits for the decommissioning of a service, as shown through utilizing the tools set out on pages 25 to 42.
- There is inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract.



- Service does not deliver value for money, as demonstrated through financial review, utilizing programme budgeting tools such as the Spend and Outcome Tool (see page 27).
- The investment in a service does not maximize the health gain that could be achieved by reinvesting the funding elsewhere.
- Service fails to meet the standards of a modern NHS as defined by:
- Professionally driven change i.e. provider driven business case which delivers modern innovative service.
- Nationally driven change i.e. National policy or guidance requires change in service delivery.
- The service is one with limited clinical evidence, quality or service “

Cannock Chase Clinical Commissioning Group, Cannock Chase Decommissioning & Disinvestment of Services Available at:

http://www.cannockchaseccg.nhs.uk/commissioning/policies/commissioning/?eID=dam_frontend_push&docID=695.

Essex PCT Decommissioning and Disinvestment Toolkit 2010 – 11 available at:

<http://commissioning.libraryservices.nhs.uk/wp-content/uploads/2013/06/7-july-2010-decommissioning-disinvestment-toolkit.pdf>

Manchester Clinical Commissioning Group Investment and Disinvestment Policy, available at:

[http://www.manchester.nhs.uk/document_uploads/Policies_Procedures/NMCCG%20Investment%20and%20Disinvestment%20Policy%20%20\(Final\)_7065f.pdf](http://www.manchester.nhs.uk/document_uploads/Policies_Procedures/NMCCG%20Investment%20and%20Disinvestment%20Policy%20%20(Final)_7065f.pdf).

Gateshead Clinical Commissioning Group - Decommissioning Procedure includes drivers for decommissioning a service, decommissioning principles and process including appeals and an contract review checklist, available at:

<http://www.gatesheadccg.nhs.uk/wp-content/uploads/sites/4/2014/03/CCG-SOP03-Decommissioning-Procedure-v12.pdf>

Torbay Care Trust. Available at:

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Decommissioning%20Policy.pdf>

Toolkits Available Outside of the NHS

How to decommission public services delivered by third sector organizations and maintain value for money Available at: <http://www.nao.org.uk/decommissioning/> (National Audit Office)

The National Audit Office has developed a decommissioning toolkit corresponding to the various stages of decommissioning which are linked to their ‘Successful Commissioning’ toolkit. The toolkit includes:

- Making a decision to decommission is associated with the Successful Commissioning stage: Assessing needs



- Re-designing services – the case for change and planning for decommissioning which is associated with the Successful Commissioning stage: Designing services
- Planning decommissioning associated with the Successful Commissioning stage: Sourcing providers
- Carrying out decommissioning associated with the Successful Commissioning stage: Delivering to users
- The impact of decommissioning associated with the Successful Commissioning stage: Monitoring and review

Yorkshire & the Humber Joint Improvement Partnership, 2010 Decommissioning and reconfiguring services: a good practice guide for commissioners of adult social care. Available at: http://ipc.brookes.ac.uk/publications/pdf/Decommissioning_and_reconfiguring_services.pdf.

Includes a set of general principles for decommissioning including: transparency and fairness, value for money, risk management, and communication. A checklist is included covering aspects of the decommissioning process.

Ongoing research

Decommissioning health care: identifying best practice through primary and secondary research - a research project (2013-2016) based at Health Services Management Centre, University of Birmingham. The research output so far from this project is:

Robert et al (2014) Disentangling rhetoric and reality: an international Delphi study of factors and processes that facilitate the successful implementation of decisions to decommission healthcare services. *Implementation Science*, 9:123. Available at: <http://www.implementationscience.com/content/9/1/123>

Implementation of NICE Disinvestment tools- PenCLAHRC - this project will use NICE's 'disinvestment tools' to develop a single evidence-based approach towards disinvestment which will be piloted across the Peninsula before national rollout. The research protocol is available at: <http://clahrc-peninsula.nihr.ac.uk/includes/site/files/files/NICE%20Disinvestment%20project%20Protocol.pdf>

Presentation link discussing the project in more detail

[http://clahrc-peninsula.nihr.ac.uk/includes/site/files/files/PenCLAHRC%20Learning%20Together%20Event%2012/4_%20NICE%20Disinvestment%20project%20\(H%20Flynn\).pdf](http://clahrc-peninsula.nihr.ac.uk/includes/site/files/files/PenCLAHRC%20Learning%20Together%20Event%2012/4_%20NICE%20Disinvestment%20project%20(H%20Flynn).pdf)



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APPENDIX

Methodology

Searches were undertaken in the MEDLINE and HMIC databases. Relevant organisation websites were also searched. The search strategy and list of organisations are included below.

The following organization websites were searched: The Kings Fund, Health Foundation, Department of Health, The Nuffield Trust and NHS Evidence. Additional Google searches were also undertaken.

MEDLINE search strategy

1. `disinvest*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]` (117)
- 2 `decommission*.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]` (310)
- 3 `priority-setting.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]` (1398)
- 4 `rationing.tw.` (2432)
- 5 `("low value" adj2 (treatment* or service* or intervention* or activit*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]` (41)
- 6 `1 or 2 or 3 or 4 or 5` (4192)
- 7 `limit 6 to (english language and yr="2004 -Current")` (1822)