Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 25 October 2016

Committee:
Health and Adult Social Care Scrutiny Committee

Date: Wednesday, 2 November 2016
Time: 10.00 am
Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Adult Social Care Scrutiny Committee

Gerald Dakin (Chairman)	Tracey Huffer
Madge Shineton (Vice Chairman)	Heather Kidd
Peter Adams	Pamela Moseley
John Cadwallader	Peggy Mullock
David Evans	Peter Nutting

Your Committee Officer is:

Amanda Holyoak Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Declaration of Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes of the Last Meeting

To confirm the minutes of the meeting held on 26 September 2016 as a correct record, attached marked: 3

4 Public Question Time

To receive any public questions or petitions from the public, notice of which has been given in accordance with Procedure Rule 14. Deadline for notification is 5.00 pm on Friday 28 October 2016.

5 Member Questions

To receive any questions of which Members of the Council have given notice. Deadline for notification is 5.00 pm on Friday 28 October 2016.

6 Shropshire CCG Recommissioning and Disinvestment (Pages 1 - 70)

Simon Freeman – Accountable Officer Shropshire CCG and Ros Francké, Director of Finance Shropshire Community Health Trust will be present at the meeting.

The Committee have requested the following information:

i) An explanation of Shropshire CCG's financial situation and explanation of how it is intended to meet the necessary savings

ii) An explanation of the CCG's Recommissioning and Disinvestment Policy

iii) A clear explanation of how services proposed for disinvestment/recommissioning have been identified

iv) An explanation of how communication and engagement with your stakeholders, including the Council, Voluntary Sector and public will be carried out

The Committee will ask questions on the above areas and will also explore the impacts of the recommissioning/disinvestment in the services identified.

The following documents are attached, marked 6:

CCG Governing Body Paper 10 August 2016 – Decommissioning and Disinvestment Interim Policy

CCG Governing Body Paper 10 August 2016 – Disinvestment and Decommissioning Decision Paper

CCG Governing Body Paper 14 September 2016 - Decommissioning and Disinvestment Update Paper

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SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Minutes of the meeting held on 26 September 2016
10.00 am to 12 noon in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 252718

Present
Councillor Gerald Dakin (Chairman), Councillors Madge Shineton (Vice Chairman), Peter Adams, John Cadwallader, David Evans, Tracey Huffer, Heather Kidd, Pamela Moseley, Peggy Mullock and Peter Nutting

22 Apologies for Absence and Substitutions

There were no apologies for absence.

23 Declaration of Interests

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate

24 Minutes of the Last Meeting

The minutes of the meeting held on 25 July 2016 were confirmed as a correct record.

25 Public Question Time

Mr C Deaves asked a question related to a recent article in the Shropshire Star regarding the financial management of Shropshire CCG and referring to the '360 stakeholder survey' asking if the Committee could have sufficient confidence in the CCG analysis to accept the Disinvestment and Decommissioning Decision Paper and recommendations within it at item 8 of the agenda. (A full copy of the question and response provided is attached to the signed minutes).

In response, Mr Deaves was informed that Members of the Committee had not yet agreed a considered view of the plans. The Committee Chair had written to the CCG Accountable Officer to give him an opportunity to inform the Committee of the rationale for its plans.

Responding to a supplementary question about the powers of the Committee and a suggestion from Mr Deaves that the Committee view the '360 assessment survey' results, the Chairman confirmed that no decisions related to the CCG Paper would be made at the meeting and commented that Senior Managers at the CCG had not been in post very long. Mr Deaves was also informed that the Committee had the ability to call the CCG to account but not control it. Shropshire CCG had been placed under formal legal directions by NHS England

26 **Member Questions**

Councillor Tracey Huffer had submitted a question related to closures in recent weeks at Ludlow Minor Injuries Unit. She was thanked for making the Committee aware of the problem and an explanation would be requested from the Community Health Trust about the problem and the actions it is taking to prevent a reoccurrence and ensure there are effective measures to communicate with the local community and stakeholders such as GPs.

Councillor David Turner had submitted a question related to the proposed closure of four Pathway 2 rehabilitation beds at the Lady Forester Nursing Home in Much Wenlock, and asking if the Committee believed that closing the facility was an appropriate way to provide rehabilitation beds and thus reduce bed blocking and whether it was the best way to manage tax payer's money. He also circulated six letters to members of the Committee written to the CCG Accountable Officer expressing concern about the proposal.

In response to his question, Councillor Turner was informed that a number of concerns regarding the proposals by Shropshire CCG in relation to disinvest or decommission a range of services had been raised. The Committee would have an initial chance to review the relevant CCG papers at today's meeting and further information would be sought from the CCG.

It was agreed to take agenda item 8, Shropshire CCG Decommissioning and Disinvestment, as the next item.

27 **Shropshire CCG Decommissioning and Disinvestment**

The Chairman referred to the 10 August 2016 Shropshire CCG Governing Body papers circulated with the agenda on Shropshire CCG Decommissioning and Disinvestment (copies attached to the signed minutes). He reported that he had received a great many letters expressing concerns related to these and had asked for them to be circulated to Members of the Committee for discussion. He said that whilst the financial challenges of the CCG were accepted, it was felt that some of the changes proposed might have unintended consequences. Although the CCG Chair had stated that 'it is clear that the patients' care comes first', it was essential to see that the patient had ample chance to be consulted before a service was changed or taken away and to understand their options.

He said that this should be done as openly as possible and reiterated that discussions needed to be held with providers of services within Shropshire, including the Community Health Trust, the local authority, private sector and voluntary sector, so that they could analyse the situation and feedback on any unintended consequences that were likely to impact on the local Health and Social Care economy.

A Member referred to the need for actions to live up to the statements in the Decommissioning and Disinvestment Policy. She also referred to a step in preparing for disinvestment or decommissioning the service involving assessment of 'appropriate availability of patient choice'. She emphasised that patient choice was not often available in a large rural county like Shropshire, especially when it came to rehabilitation beds. She

reported on a major problem finding rehabilitation beds in the part of Shropshire she represented which bordered another county.

Another Member felt that the terms 'disinvestment and decommissioning' were not helpful or meaningful to the public and that clearer engagement was needed by explaining simply that some services were going to close and some would be delivered in a different way. The Chairman agreed that the Committee would want to know how messages would be conveyed.

A Member said she had received lots of questions from members of the public, and also people who ran services who did not understand the situation. She was concerned that the changes could affect some of the most vulnerable people in society who may not have any idea about what was happening. Other Members expressed concern around the apparent lack of a risk or impact assessment relating to individuals and other organisations, including the Council and that legal action might be a consequence if procedures were not followed correctly. There was no legal definition of the term 'substantial variation'.

The Chairman said it was important to avoid simple budget shifting to stabilise just one part of an economy. The Director of Adult Social Care agreed that it was necessary to take into account risk and position of services across the whole economy, and ensure any shortfalls in accuracy and consultation were addressed. In the interim period before the next meeting, a formal response from Adult Social Care had been made to the CCG and he had met with the Accountable Officer regarding commissioning arrangements in future. The enormous financial pressure facing the CCG was recognised but it was necessary to reduce costs in the system which would minimise the impact across the whole system. This also related to management of the Better Care Fund, and Governance Arrangements for the Health and Wellbeing Board and the Sustainability and Transformation Plan.

It was proposed and agreed that a Special Meeting be held on CCG Decommissioning and Disinvestment as soon as possible.

RESOLVED:

That a special meeting of the Committee be held on CCG Decommissioning and Disinvestment as soon as possible.

28 **West Midlands Ambulance Service Performance**

The Chairman welcomed the following to the meeting: Julie Davies – Director of Strategy and Service Redesign, Shropshire CCG, Gail Fortes-Mayer – Lead Commissioner Ambulance Service, Mark Docherty, Director of Clinical Commissioning and Service Development/Executive Nurse, WMAS, Barry McKinnon – Shropshire Area Manager, WMAS, Pippa Wall - Head of Strategic Planning, WMAS, and Sara Biffen – Deputy Chief Officer, SATH.

Mr Docherty gave a presentation explaining the three categories of response used by WMAS up to 2011 and from 2011 to 2016. WMAS was now a pilot site for the ambulance Response Programme introduced in June 2016. He explained that a very target service did not help patients and the new system was designed to separate responses and the

time in which the patient received the correct response. Some measures were still be perfected but it meant a move away from use of percentages to percentiles. The figures for August 2016 showed that Shropshire was in the 75th percentile which was thought to be a good performance.

Members queried the way the data was set out and what it actually meant. Mr Docherty explained that 90% of all red calls were responded to in 16 minutes. Members asked what the longest time was for the remaining 10% and he acknowledged that the remaining 10% in the most rural areas was always the problem. He explained that the aim was to get to patients with the right response as quickly as possible, and then to the right place, even if a target was missed. The old system created behaviours which were not helpful. Figures were available broken into postcodes and the Committee requested that this data be made available in future.

Members were pleased to note that a letter had been written by Dr Davies following the last meeting of the Committee to the Regional WMAS Commissioner encouraging work which would help link response times with outcomes. The Committee agreed that outcome for the patient was the ultimate measure.

Mr McKinnon continued the presentation in relation to Community First Responders (CFRs) in Shropshire, and setting out priority recruitment areas. He confirmed that WMAS was rolling out training to upskill CFRs and this would be offered to all.

A Member asked if recruitment of CFRs was a high priority and how they were recruited. The Committee heard that the Community Response Manager made approaches as necessary to Councils. Members suggested using Shropshire Association of Local Councils for targeting local parish and town councils in recruitment campaigns. Dr Davies said support from elected Members in recruiting CFRs was always welcome.

The Chairman referred to a letter he had recently received from the Chief Executive of WMAS in relation to working with the Fire Service. He asked if this had been progressed.

Mr Docherty explained that one meeting of Chief Officers had been held locally with the Fire and Rescue Service. Fire Officers would be required to complete the full role, receive training and have to log on as CFRs. He said that WMAS was awaiting a response back from Fire and Rescue colleagues in relation to this. The Regional Commissioner confirmed that she was involved in these conversations and was exploring co-response across the whole of the West Midlands and particularly Shropshire. It was agreed that the Committee would be kept appraised of any developments.

Vanessa Barrett, Healthwatch Representative, reported that Healthwatch had run WMAS as a hot topic. 27 comments had been received, 50% positive and 50% not so positive. Negative ones were across a range of issues, some relating to the speed in which the ambulance arrived, some about loss of CFRs in rural areas. The Committee suggested that it would be useful to differentiate urban and rural responses for future reports.
Mr Docherty thanked the Committee and Healthwatch for the useful comments and said that he had noted WMAS needed to take more action regarding CFR recruitment.

Update on Physician Response Unit

Dr Davies and the Regional Commissioner explained that this scheme helped to get people into the right system with their care managed in the right place. It avoided unnecessary visits to hospital and kept people out of the system who might then be difficult to discharge. In response to questions from Members, it was explained that the doctors could be despatched by the control room direct, could self determine where they attended, and could be asked to attend or give telephone advice at the request of a crew. The CCG was not sure whether the model would work in the more rural parts of the county, however it would help free up the ambulance resources to be more available for those areas.

The electronic patient record meant that crews could make a real time record which could be handed to GPs immediately. The Committee commended the investment made in rolling this out.

High Intensity Service Users

Members were updated on the scheme involving a paramedic working on a coaching basis, so far with the 10 of the most frequent WMAS callers. Calls from these patients had now dropped by 50% and two patients no longer featured on the top 20 list of callers. The challenge was to expand this work safely and it was hoped to resolve data sharing issues with SATH as soon as possible.

The Portfolio Holder of Adult Social Care asked about the target numbers for this work. The Committee heard that the project had been modelled on targeting the 100 highest users in the county. The next stage was to grow to 25, but the issues of data sharing needed to be resolved before expansion was possible. It was a very personal service which was helpful for people with complex issues. The Committee looked forward to a progress update in the near future.

Ambulance Patient Handover

Sara Biffen, Deputy Chief Operating Officer, SATH reported that there were still significant delays on handover at the hospitals.

A workshop had been held on 15 August to consider ways to improve this performance, and visits had been made to other hospitals, for example to Worcester Royal Infirmary where ambulances queued out, rather than queueing in. The aim was to have a corridor nurse in place every day but there was a 25% staffing gap in qualified nurses. It was hoped that this would be addressed by the end of September and SATH was looking with WMAS at how Hospital Ambulance Liaison officers could work differently and perhaps be on duty later in the day. A meeting had also taken place on the Directory of Services and it had been identified that this was not comprehensive. Not all of the services in the directory were open all of the time. A single point of referral system was needed and another meeting was to held on this in the next fortnight.

Dr Davies said it was essential to work on the issues together and achieve improvement before the winter period. The Deputy Chief Operating Officer said that the whole system was involved, there was not one action that could be taken to fix the problem, and being

able to get patients out and discharged from hospital was part of the solution. That morning there were 16 patients at Royal Shrewsbury Hospital waiting for a bed. A handover concordat had been put together with the idea of having zero tolerance for 15 minute delays, with a target of 30 minutes in the first instance.

The Committee thanked officers for their time and attendance at the meeting. Mr Docherty said that challenge from the Committee was welcomed by all concerned.

It was agreed to request that:

Performance information by postcode for Shropshire continue to be supplied to the Committee;

The Committee be kept appraised of developments in working with the Fire and Rescue Service;

The Committee be kept appraised of progress with the Physician Response Unit and High Intensity User Scheme;

The Committee be kept appraised of Ambulance patient handover performance.

29 **Non Emergency Passenger Transport - Update on Assessment for Eligibility Implementation**

Dr Davies presented a briefing paper (copy attached to the signed minutes) in relation to the implementation of eligibility criteria for the Non-emergency Passenger Transport Service.

She reminded the Committee of the reasons for the change and the public engagement and communication that had taken place beforehand.

The Committee was pleased to note that there had been few complaints since the implementation took place. All had been fully investigated and there had not been any appeals made to date. No patient was refused transport whilst eligibility assessment was underway and monitoring took place on a monthly basis. She emphasised that the CCG could only act on feedback received and any feedback from HealthWatch and Patient Groups was encouraged.

Vanessa Barrett, Healthwatch representative, said that comments received by Healthwatch had referred to concerns about long waits or transport not turning up. Six people had commented that they were no longer eligible. She emphasised that the outcome of Future Fit would mean a heavier demand on transport to reach both hospitals. Some members expressed concern that patient might end up in A&E if they did not attend appointments due to prohibitive transport costs. Dr Davies agreed that this needed to be discussed as a system.

The Chairman said that it was reassuring that the appeal process was unused to date and Dr Davies was thanked for providing the update.

30 **Work Programme**

It was confirmed that an extra meeting would be arranged to consider CCG Decommissioning and Disinvestment.

Signed ..... (Chairman)

Date: .....

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Agenda Item 8.3
CCG Governing Body – 10.8.16

Shropshire Clinical Commissioning Group

Date: 10th August 2016

Subject:	Decommissioning and Disinvestment Interim Policy
Report Written by:	Julie Davies Director of Strategy & Service Redesign
Presented by: Responsible Director:	Julie Davies Julie Davies

PURPOSE OF THE REPORT

To recommend for formal Governing Body approval, the interim process being followed by the CCG to decommission and disinvest in commissioned services as part of its financial recovery.

For information	☐
For decision	■
For performance monitoring	☐

WHAT OTHER SUB COMMITTEES HAVE CONSIDERED THIS REPORT; THEIR KEY POINTS OR RECOMMENDATIONS

None

KEY POINTS IN REPORT

To ensure that limited resources are consistently directed to the highest priority areas the CCG has identified the need to develop a Decommissioning and Disinvestment policy that sets out the agreed principles for decommissioning a service, in order that the CCG meets its statutory requirement to manage within its allocated resources. This is an interim policy and a further full policy will be finalised over the coming weeks that reflects the substantive governance structure required to embed an ongoing program of efficiency review within the CCG's approach to commissioning decisions.
There is also a need to ensure that when approval has been given to decommission, or disinvest in a service that a clearly defined process is followed, with clear lines of accountability and responsibility.

For the purpose of this policy the following definitions have been applied:

- **Decommissioning:** This relates to the withdrawal of funding from a provider organisation for a service that is subsequently re-commissioned in a different format.

- **Disinvestment:** This relates to the cessation of a commissioned service.

In the event that a decommissioning or disinvestment proposal is approved by the governing body, service area specific task and finish groups will carry out detailed due diligence work including engagement/consultation as appropriate. These groups will then formally make recommendations for the CCG Governing Body for consideration and final approval to decommission /disinvest in a service area.

RECOMMENDATION TO THE CCG BOARD

The Board is asked to:

- Approve the Decommissioning and Disinvestment Interim Policy.

CONTEXT AND IMPLICATIONS	
Financial implications	This policy outlines the interim process the CCG will follow to support the reduction in its expenditure and regain financial balance
HR/Personnel implications	None
Promoting equality and equity – implications	The policy includes the use of Equality Impact Assessment as part of any decommissioning / disinvestment decision making
Consideration for Quality & Safety	The policy includes the use of a Quality Impact Assessment as part of any decommissioning / disinvestment decision making
What patient and public involvement has there been in this issue, or what impact could it have on patient/public experience?	Where the decision is taken to proceed with a decommissioning/disinvestment decision, full engagement and consultation will be carried out as required, for that service area and the outcome of that will be considered by Governing Body before its final decision.

NHS
Shropshire
Clinical Commissioning Group

Decommissioning and Disinvestment Interim Policy

Contents Page

Executive Summary

Executive Summary

Due to the current challenging financial climate, it is important for the CCG to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources, and in order to deliver our statutory responsibilities, and meet the needs of the Shropshire population.
To achieve this, effective commissioning arrangements and strong performance management are essential to meet these challenges, and secure the best possible healthcare for our local population.

The CCG will ensure that our commissioning decisions are fully informed and based on health outcomes data by utilising all reliable data sources combined with public health data and clinical analysis.

To ensure that limited resources are consistently directed to the highest priority areas the CCG has identified the need to develop a Decommissioning and Disinvestment policy that sets out the agreed principles for decommissioning a service, in order that the CCG meets its statutory requirement to manage within its allocated resources. This is an interim policy and a further full policy will be finalised over the coming weeks that reflects the substantive governance structure required to embed an ongoing program of efficiency review within the CCG's approach to commissioning decisions.

There is also a need to ensure that when approval has been given to decommission, or disinvest in a service that a clearly defined process is followed, with clear lines of accountability and responsibility.

For the purpose of this policy the following definitions have been applied:

- **Decommissioning:** This relates to the withdrawal of funding from a provider organisation for a service that is subsequently re-commissioned in a different format.

- **Disinvestment:** This relates to the cessation of a commissioned service.

In the event that decommissioning or disinvestment is proposed and supported by its Governing Body, the CCG will need to recognize that a number of steps will be required prior to a final decision being taken by the CCG Governing Body.

These include consideration as to whether a consultation exercise is required with partner organisations, patients, public and the Health Overview and Scrutiny Committee.

1. Introduction

The CCG's significant current financial challenges has inevitably led to the need to clarify the circumstances of when services should be decommissioned, and the need to describe the approach and processes, that will be adopted to ensure decommissioning and disinvestment decisions are fully informed and managed.

Following any service review a number of options will be available to the CCG.

These will include:

- The need to re commission part or all of the service,
- Amend the threshold / restrict access to a service or
- Provide a modified service to ensure that there are no gaps in healthcare delivery.

The CCG describes in this document the interim structure and process that has been used to identify services that may be appropriate for decommissioning and disinvestment, including the service decommissioning/disinvest assessment tool used and the next steps required to implement final decisions

This interim disinvestment and decommissioning policy is to be applied when making both clinical and non-clinical disinvestment and decommissioning decisions pending the development of a substantive policy which will be finalised over the coming weeks..

2. Our Approach to Decommissioning and Disinvestment

The aim of this interim policy is to:-

- Provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest

- Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.

- Ensure all commissioned services are monitored in terms of performance, health outcomes, efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding the continuation of that service.

- Contribute to the delivery of the CCG's commissioning plan and QIPP agenda, to ensure that resources are directed to the highest priority area in order to achieve the best possible health outcomes for the local population against available resources.

- Ensure all decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the CCG Governing Body.

- Ensure the safety of patients remains paramount.

The principles of potential decommissioning/ disinvestment decisions are encompassed within the CCG's policy document 'Ethical framework for priority setting and resource allocation' 2013. See Appendix four.

2.1 Structure

The Governing Body has been required to take urgent action to recover its financial performance in year. Workshops have been held by the Governing Body directly to review initial assessments of services currently commissioned that may require decommissioning or disinvestment.
It is proposed that a more detailed policy is developed, over the coming weeks, which fully describes a revised governance structure that embeds an ongoing programme of service efficiency review into the CCG's committee structure and commissioning activities.

3. Decommissioning and Disinvestment Processes for Commissioned Services

The CCG has chosen to adopt a process based on a review of other CCGs equivalent policies that and the Disinvestment / Decommissioning tool flow chart in Appendix One provides at a glance the process for commissioners to follow prior to commencing decommissioning / disinvestment.

An initial draft internal desk top review was done by commissioners to identify potential areas for service review and prioritisation. The output from this was considered by governing body members at a session facilitated by the external turnaround team. Subsequent to this the review and prioritization continued via the governing body workshops described in the steps below:-

3.1 Step One

3.1.1 Identification of service for potential decommissioning or disinvestment

The Process for identifying services for review and potential decommissioning / disinvestment needs to be systematic.
An initial assessment is carried out by the responsible programme lead that provides a service summary and responses to several key criteria:-

- Is it a National 'Must Do' or a strategic fit e.g. STP, Future Fit etc.
- Is it the CCG's responsibility to commission this service
- Is there evidence to support the continuation of the service?
- Lead Commissioner perspective

Following this assessment there are two options:-

1. The service should be progressed to Step 2
2. The service is not suitable for decommissioning/disinvestment – continue usual contractual monitoring/commissioning cycle.

3.2 Step Two

In the event that a service is identified as suitable for potential decommissioning/disinvestment by the initial Step 1 assessment, the responsible programme lead will develop a detailed disinvestment impact

assessment (DIA) (Appendix Two). The Quality Team will also support the programme lead by completing a detailed Quality Impact Assessment / Equality Impact Assessment that will be included within the overarching DIA.

3.2.1 Detailed Assessment and Assessment of impact

The DIA will identify the anticipated or actual impacts of any disinvestment / decommissioning associated with the service.

The impact assessment will also include reference to: -

- Health outcomes – the effect on health outcomes will be assessed to identify potential adverse consequences of disinvestment or decommissioning and what might to done to minimise them.
- Quality of services – to ensure that the quality of services will not deteriorate following any proposed changes. The CCG will use its agreed Quality Impact Assessments tools to carry out the reviews.
- Equality and diversity implications – underpinned by the principle that people should have access to health care on the basis of need. However enshrined in law there are a number of identified protected groups, categories of the population that require specific consideration

In addition to the above, the leads will consider the following criteria

1. Does the service meet the needs of the population? (as identified through the Joint Strategic Needs Assessment, Enhanced JSNA and demand analysis)
2. Is the service low quality?
3. Does it demonstrate value for money?
4. Is it high expenditure and low outcomes?
5. Does the service have continued poor performance as identified through the contract monitoring process and / or feedback from patients, public and partners?
6. Does it 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 safety.

Once the DIAs have been prepared they will be presented to the Governing Body workshop for review, each DIA will be reviewed fully.

There are five potential outcomes for the workshop:-

1. Yes to make a recommendation to the Governing Body to proceed with next steps for potential disinvestment/decommissioning
2. Yes to manage decommissioning/disinvestment by usual commissioning processes
3. No, continue to commission and monitor via contractual processes
4. No, but improved outcomes required, pursue via contractual discussions
5. More information, analysis required before a recommendation can be made

3.3 Step three

The recommendations from the Governing Body workshop are presented to the Governing Body meeting held in public for formal approval.

3.4 Step four

3.4.1 Preparing the next steps

Following approval from the Governing Body a decommissioning/disinvestment task & finish group will be established for each area identified as outcome 1 above, to oversee the next steps, which will include for the indicated services:

- Gaps in care created by disinvestment or decommissioning the service
- Managing the negative impact on the services identified for potential disinvestment or decommissioning and mitigated against them.
- The patient experience need must be paramount in informing any decision, action should be taken to minimize the impact of gaps in service provision once the service is decommissioned or disinvested.
- An assessment against legal duties and obligations including the Public Sector Equality Duty, the duty to have regard to the need to reduce inequalities and quality in order to quantify and clarify positive or negative impact on patient care and the wider community (i.e. carers)
- The potential destabilising effect on other service and organisations e.g. third sector, of a decision to decommission/disinvest should be fully considered.

- Consideration of whether the potential disinvestment or decommissioning represents a substantial service change (this needs to be determined locally and for each service area)
- The clinical impact of decommissioning or disinvesting from the provision
- Assessment against the four tests as outlined below:
    - Strong patient and public engagement.

      The CCG is committed to engaging / consulting as appropriate with patients, carers, the public and wider stakeholders at all stages of commissioning decisions proportionate to the scale and complexity of the change being proposed.
    - Appropriate availability of patient choice
    - Clear, clinical evidence base
    - Clinical support
- A privacy impact assessment identifying requirements for lawful information sharing
- Service models and learning from elsewhere including national and international experience
- Deliverability (e.g. estate implications)

3.5 Step Five

The outputs from the Task & Finish Groups will be presented back to a Governing Body meeting held in public who will consider the recommendations and make a decision on whether to approve decommissioning /disinvestment of each service area.

4.0 Meeting Statutory Responsibilities around Consultation and Engagement

Following the governing body's approval, the Decommissioning / Disinvestment Process will commence.

The CCG will communicate clearly with all providers following any decision to disinvest in or decommission services. **Ten operational days** will be allowed for this communication and queries from providers to be dealt with before notice is served on the provider. The responsibility for serving notice on the provider is with the contract manager or as otherwise determined by the CCG Accountable Officer.

For any disinvestment proposal where the impact of the change could potentially be considered a substantial variation or development in service, the CCG will initiate informal discussions with the local Health Overview and Scrutiny Committee of the Local Authority via its Chair to establish if the proposed variation is "substantial" to warrant formal consultation. If, it is established that the proposed variation is "substantial" a formal presentation of the issue with a plan for formal consultation will be presented to the respective Health Overview and Scrutiny Committee for consideration and agreement. An appropriate period of consultation will then be undertaken before any decision to disinvest or decommission is made.

There is no legal definition of "substantial" in this context and is left to local determination by the NHS and Overview and Scrutiny Committee.

If the proposed change is not considered substantial, then the CCG may decide to undertake engagement activity (non-statutory) to support decision making or determine that existing engagement feedback is sufficient to inform the decision; no further specific engagement activity would be required at this point. The feedback from all statutory (consultation) and non-statutory (engagement) will be fully reviewed and analysed and will be used to assist in the decision making process.

5.0 Exit Plan

As already highlighted the CCG will communicate clearly with all providers following any decision to disinvest in or decommission services. **Ten operational days** will be allowed for this communication and queries from providers to be dealt with before notice is served on the provider.

The provider (following notification of decision to decommission) will be required to develop an 'Exit Plan' outlining actions required by both parties for smooth service cessation in collaboration with the commissioner. The plan will cover a minimum:

- Patient continuity of care
- Patient records
- Staff
- Estate
- Equipment
- Stock (where funded by the commissioner)
- A communications and engagement plan to support the exit

The commissioner will ensure mechanisms are in place where, in conjunction with the provider, execution of the exit plan is actively managed.
Decommissioning of any service will be managed in line with the "Principles and Rules for Co-operation and Competition" regulation (2012) and related Monitor Guidelines.
https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition

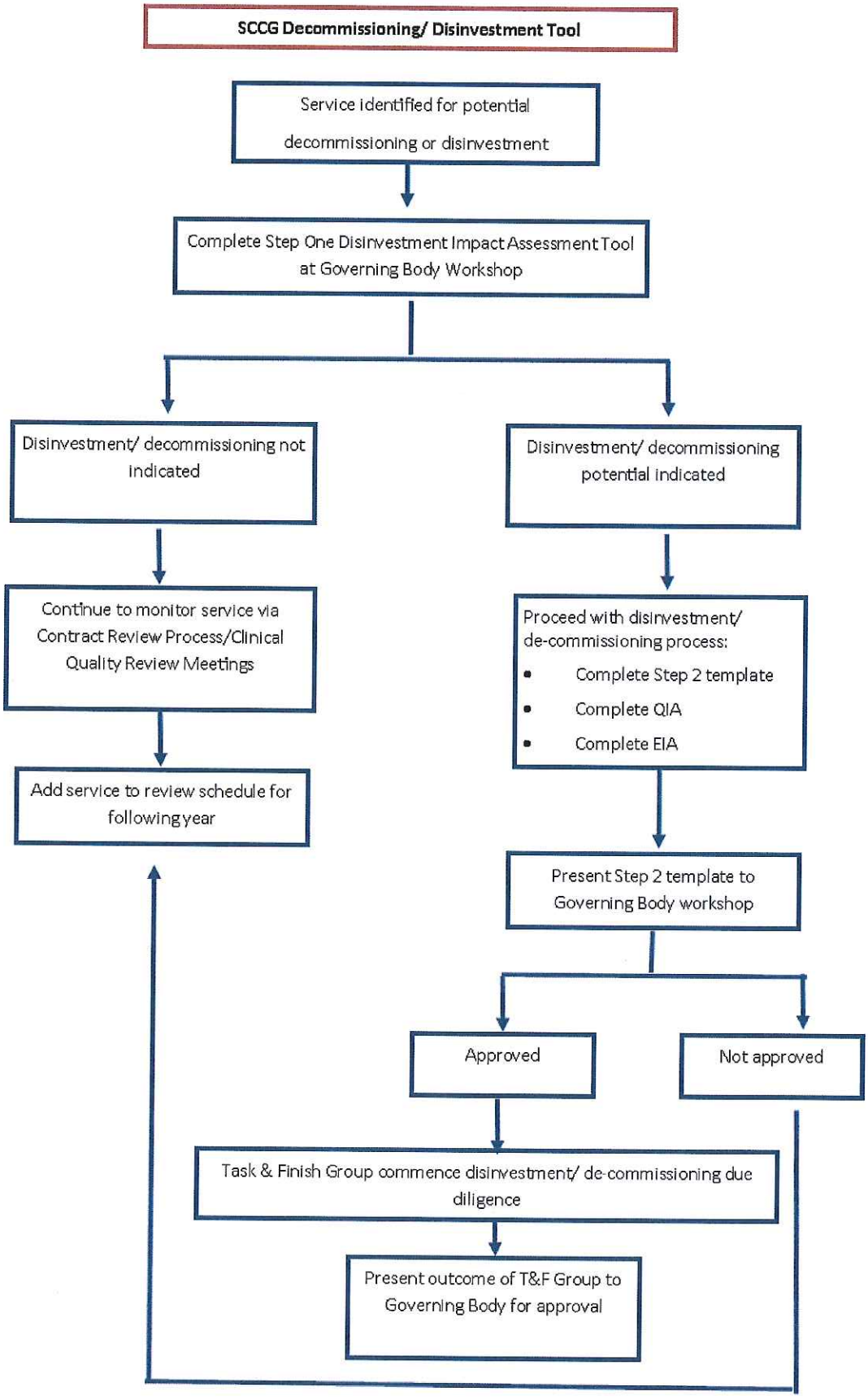
Disinvestment of any decommissioned service will also be processed in line with NHS Shropshire Standing Orders and Prime Financial Polices. In addition an assessment of potential contestability should be undertaken in line with the CCG procurement strategy.

6.0 Recordkeeping

An auditable record/trail of decision making and all communication relating to each decommissioning decision and contract termination will be kept by the CCG.

This is vital, both to demonstrate that the decommissioning process was robust and transparent, and as evidence in the event of any challenge, legal or otherwise.

Appendix One



Appendix TWO

Initial Assessment Tool

SERVICE TITLE

Service Summary

Service title	
Provider organisation	
Service description	
Contract type	
Contract duration	
Notice period required	
Service metrics (activity/outcome)	
Cost of service	

Disinvestment Review Part 1:

	Yes/No	If yes – provide further detail
National 'Must do'		
Is there evidence to support continuation of service		
Is it the CCG's commissioning responsibility to deliver this service?		
Lead Commissioner perspective		

Appendix Three

DIA Template

Service Summary

Service title	
Provider organisation	
Background	
Contract type	
Contract duration	
Notice period required	
Service metrics (activity/outcome)	
Cost of service	

Disinvestment Review

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	
Does the service deliver its contractual obligations?	
Does the service address health inequalities?	
Is the service aligned to a national or strategic 'must do'?	
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	
How does the service benchmark against similar services?	
Does the service deliver value for money?	
Are there other services in place that offer a similar service?	
Is there evidence to support the continuation of the service?	
Is there a QIPP in place related to this service?	
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	
If the answer to the question above is yes, what are the potential cost savings?	

Additional supporting information (embed docs)

Completed QIA	
Completed EIA	
Additional relevant information	

Appendix Four

Principles around decision making

Making good decisions regarding health care priorities involves the exercise of fair and rational judgment and at times discretion.

Although there is no single objective measure on which such decisions can be based, decisions will be fully informed taking into account the needs of individuals and the community, whilst recognising the CCG need to achieve a financial balance its discretion will be affected by factors such as the NHS Constitution, National Planning Framework, NICE technology appraisal guidance and Secretary of State Directions to the NHS.

The CCG will continue to use its "Ethical framework for priority setting and resource allocation" policy and adopt a robust approach to its decommissioning / disinvestment decisions by ensuring decisions are lawful and consistent.

This will be achieved by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered prior to decisions being made.
- Promoting fairness and consistency in decision making and with regard to different clinical topics, reducing the potential for inequity.
- Providing a means of explaining the reasons behind the decisions made.
- Reducing risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and adopting a decision making framework so that decisions are made in a manner which is fair, rational and lawful.
- Ensuring the Vision, values and goals of the CCG are reflected in business decisions.
- Providing a consistent approach for the development of strategy and plans across the whole health care system.

Shropshire Clinical Commissioning Group

Date: 10th August 2016

Subject:	Disinvestment and Decommissioning Decision Paper
Report Written by:	Carol McInnes
Presented by: Responsible Director:	Dr Julie Davies Dave Evans

For decision	X
For performance monitoring	
Other – please specify	

KEY POINTS IN REPORT

The purpose of this report is to:

- Provide the Board with a summary of the strategic context for the CCG in relation to addressing the CCG's significant financial challenges and the necessity for commissioners to undertake a disinvestment/de-commissioning work programme
- Provide the Board with a summary of the work undertaken to date in order to progress the work programme
- Seek approval from the Board for the implementation of the recommendations from the Governing Body workshops in relation to identified potential disinvestment/de-commissioning opportunities

RECOMMENDATION TO THE GOVERNING BODY

The Governing Body are asked to;

- **Note** the contents of this report and the interdependency of this report with the associated board paper proposing the adoption of an interim disinvestment/de-commissioning policy for the CCG
- **Note** the level of risk to delivery of the CCG's control total for both the short and medium term
- **Approve** the recommendations of the first Governing Body workshop regarding potential disinvestment/ de-commissioning opportunities for 2016/17
- **Approve** the recommendations of the first Governing Body workshop regarding potential disinvestment/ de-commissioning opportunities for 2017/18

CONTEXT AND IMPLICATIONS	
Financial implications	As noted in the report
HR/Personnel implications	NA
Promoting equality and equity – implications	Full equality and equity impact assessments are undertaken for each service considered as part of this work programme (note associated interim CCG policy re disinvestment/de-commissioning process)
Considerations for Quality & Safety	Potential impact of clinical service changes

	as a result of decisions made. To be considered and addressed via next phase of work programme.
What patient and public involvement has there been in this issue, or what impact could it have on patient/public experience?	Where the decision is taken to proceed with a decommissioning/disinvestment decision, full engagement and consultation will be carried out as required, for that service area and the outcome of that will be considered by Governing Body before any final decision is taken.
Any Conflicts of Interest to be declared	Potential GP colleagues in respect of Primary Care considerations.

1. Purpose of Report

The purpose of this report is to:

- Provide the Board with a summary of the strategic context in relation to addressing the CCG's significant financial challenges and the necessity for commissioners to undertake a disinvestment/de-commissioning work programme
- Provide the Board with a summary of the work undertaken to date in order to progress the work programme with sufficient pace
- Seek approval from the Board for the implementation of the recommendations from the Governing Body workshops in relation to the potential disinvestment/de-commissioning opportunities that have been identified

2. Strategic Context

The CCG entered 2016/17 with significant financial risk, having recorded an in year deficit of £14.5m in 2015/16. The "do nothing" scenario could see the deficit rise to circa £31m and the CCG is reliant on cash releasing QIPP savings to achieve its control total.

Initial unverified data suggests that the CCG's position is significantly off trajectory and that, unless remedied, the CCG is heading for a further significant overspend. In short, the CCG is significantly over trading and there is a significant risk that the 16/17 QIPP programme will not deliver the required cashable savings.

The CCG has a statutory duty to achieve Income & Expenditure balance and a "Business Rules" duty to deliver a 1% surplus. These duties have been waived by concession in 2016/17. The CCG will however be required to meet these financial objectives in the medium term. The required magnitude of savings, to fulfil this objective, can only be achieved through reconfiguration, disinvestment or decommissioning.

Decommissioning involves market testing a service provider, and seeking alternatives for the provision of the service. Disinvestment is the cessation of services.

Policy Development

As a consequence of the CCG's current significant financial challenges, it has been necessary for commissioners to work at pace to identify and progress opportunities for potential disinvestment/ decommissioning that could release savings both in year and in advance of the 2017/18 contracting round.

In order to ensure that while working at pace, the Governing Body can be assured that due diligence has been applied and to ensure that all decisions relating to decommissioning and disinvestment are taken in a fully informed manner, a draft interim policy that outlines the process adopted by commissioners has been produced and presented to board alongside this report. Commissioners have adopted the processes outlined within the draft interim policy in all work undertaken to date.

3. Actions Taken to Date

As outlined within the draft interim policy, in order to identify potential areas for disinvestment/ de-commissioning, commissioners have completed a desktop review of all contracted services. Further to this review, a long list of commissioned services for further consideration was produced.

This list has been broken down into two distinct areas:

A. Commissioned services that could be considered for disinvestment/de-commissioning with the potential to release savings in year
B. Commissioned services that could be considered for disinvestment/de-commissioning with potential to release savings for 2017/18

For services that could be considered to release in year savings category A, full Disinvestment Impact Assessment (DIA) templates have been completed and reviewed by a Governing Body workshop (Appendix1).

In line with the draft interim policy, the Governing Body representatives were presented with five potential outcome options when considering each of the presented services:

1. Yes - to make a recommendation to the Governing Body to proceed with next steps for potential disinvestment/decommissioning
2. Yes - to manage decommissioning/disinvestment by usual commissioning processes
3. No, continue to commission and monitor via contractual processes
4. No, but improved outcomes required, pursue via contractual discussions
5. More information/analysis required before a recommendation can be made

The outcome of this exercise is summarised within Appendix 2.

For services that could be considered to release savings for 2017/18 category B, commissioners have completed 'Step One' of the draft interim policy and completed the Initial Assessment Tools (IAT) which were presented to the Governing Body workshop. Two options were presented to the Governing Body in relation to these services:

- The service should be progressed to Step 2 of the disinvestment/ de-commissioning process
- The service is not suitable for de-commissioning/ disinvestment – continue usual contractual monitoring/commissioning cycle

The outcome of this exercise is summarised within Appendix 3.

6. **Next Steps**

Further to the approval of the Governing Body of both the proposed interim disinvestment/ de-commissioning policy and the recommendations from the workshops held to date, commissioners will proceed to implementation of 'Step Four' of the process to progress this programme of work.

7. Summary

The CCG's significant current financial challenges has inevitably led to the need for commissioners to review all commissioned services to ensure that the services in place deliver the best value for money, provide services that meet the needs of the population and that they are in line with the CCG's commissioning responsibilities.

Due to the imperative for the CCG to achieve the agreed financial control total for this year and next, It has been necessary for commissioners to work at pace to produce and commence implementation of the process to be used to ensure that disinvestment and de-commissioning decisions are fully informed and appropriately managed.

A draft interim policy outlining this process has been produced and is due to be presented to the August Board meeting. Commissioners have progressed the first phase of this work programme (steps 1-3) and subject to Board approval of this interim policy, will proceed to the next step (step four).

6. Recommendations

The Governing Body are asked to;

- **Note** the contents of this report and the interdependency of this report with the associated board paper proposing the adoption of an interim disinvestment/de-commissioning policy for the CCG
- **Note** the level of risk to delivery of the CCG's control total for both the short and medium term
- **Approve** the recommendations of the first Governing Body workshop regarding potential disinvestment/ de-commissioning opportunities for 2016/17 (Appendix 2)

- **Approve** the recommendations of the first Governing Body workshop regarding potential disinvestment/ de-commissioning opportunities for 2017/18 (Appendix 3)

APPENDIX 1

Individual Disinvestment Templates

Service Summary – Integrated Community Services (ICS)

Service title	**Integrated Community Services (ICS)**
Provider organisation	Shropshire Community Health NHS Trust (lead provider) in partnership with Shropshire Council
Background	Following the launch of ICS in 2013 Shropshire Community Health Trust (SCHT) became lead provider for ICS. In order to fully embrace an integrated model the Local Authority (LA) retained some provider function and also commissioning responsibilities under the remit of the Better Care Fund. Phase 1 of ICS, which focused upon early supported discharge within the central locality, demonstrated great success. The pilot phase of this project provided strong evidence that the model of the service was credible, outcomes for patients were much improved and there was an associated improvement in patient flow within the acute hospitals. It also began the first phase introduction of a system-wide discharge to assess model. The full roll out of ICS (the early supported discharge component) commenced in 2014. It was from this point that the operational delivery of ICS became strained and the commitment to deliver the service from SCHT appeared to significantly decline. This poor performance continued into the introduction of admission avoidance from October 2015. A key contributory factor to the provider poor performance is the lack of consistent senior operational management and leadership which meant the required cultural change needed to embed a truly integrated service was not and has not been achieved. Commissioning leads have done everything possible to hold the provider to account for delivering the required model and its associated activity levels for both early supported discharge and admission avoidance over the last 9 months however performance continues to be below target despite a recent 8 week rapid improvement programme led by the Local Authority. During the course of the above 8 week project it became evident that the review was undertaken from the perspective of a community based preventative model for social care and investigating potential savings for the local authority rather than against the requirements of a high acuity/post trauma care service model. This has led to conversations between the CCG and LA regarding the basic principles of the model – this was not included within the initial scope for the recovery plan. It was always intended that the introduction of ICS would be through a prototype phased approach. We are now at the 3 year point and the original trajectory would have us in steady state following transformation and realisation of release of efficiency savings from an integrated model with an optimised workforce across organisations and functions. This is not the place we find ourselves at.
Contract type	The funding for ICS is agreed within the Shropcom contract but the service specification is not. A detailed service specification was agreed with the provider (both SCHT and LA) in November 2015 however during this year's contract negotiations SCHT challenged the content of the specification and would not agree its inclusion in this year's contract so it has been and

	remains in long stop. It could be argued that some elements of ICS are in the core contract as ICS was created by aligning existing related intermediate care services which would have been in Shropcom's core contract and funding together with additional pump priming transitional non-recurring monies.
Contract duration	As above
Notice period required	As above
Service metrics (activity/outcome)	There are a number of metrics within the service specification related to both activity and patient outcomes, however, as mentioned above the specification has not been agreed for inclusion in this year's contract. Key metrics include:- Early supported discharge – 45 per week Admission avoidance – 31 per week
Is there a service specification? Is it up-to-date?	Yes however see narrative in 'contract type' section above
Cost of service	For 2016-17 the total agreed additional funding on top of pre-existing aligned intermediate care budgets is £1,195,000.

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	Meets 2 of the 4 overarching areas highlighted in the JSNA – ageing population and long term conditions
Does the service deliver its contractual obligations?	There are currently no formal contractual obligations as SCHT have not yet agreed the inclusion of the service specification in their core contract. If it had been agreed the provider would have consistently not delivered its contractual obligations.
Does the service address health inequalities?	I have no reason to believe it is not.
Is the service aligned to a national or strategic 'must do'?	The Care Act 2014 stipulates a statutory responsibility to provide intermediate care which is defined as a structured programme of care provided for a limited period of time, to assist a person to maintain or regain the ability to live independently at home. The National Audit of Intermediate Care categorises 4 types of intermediate care: crisis response – services providing short-term care (up to 48 hours); home-based intermediate care – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; bed-based intermediate care – services delivered away from home, for example, in a community hospital; and reablement – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals. The next iteration of Sir Bruce Keogh's modernisation plan for urgent and emergency care services is soon to be published. Early indications are that it contains a requirement for all health systems to have in place a discharge to assess model within the next 12 months if they have not already. Other examples of national regulations/guidance in relation to intermediate care include:-

	The National Audit for Intermediate Care 2015 www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf NICE Guidance NG27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs December 2015 www.nice.org.uk/guidance/ng27/resources/transition-between-inpatienthospital-settings-and-community-or-care-home-settings-for-adults-withsocial-care-needs-1837336935877 The Care Act 2014 www.legislation.gov.uk/ukpga/2014/23/contents/enacted The Care and Support (Preventing Needs for Care and Support) Regulations 2014 www.legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf The Care and Support (Charging and Assessment of Resources) Regulations 2014 www.legislation.gov.uk/uksi/2014/2672/contents/made Care and Support Statutory Guidance issued under the Care Act 2014 www.gov.uk/guidance/care-and-support-statutory-guidance Introducing models of integrated care is also a national mandate as set out originally in 'Integrated Care and Support: Our Shared Commitment' (May 2013) from the National Collaboration for Integrated Care and Support which included the Department of Health, the Local Government Association, NICE and Monitor as signatories. The document states 'Our shared vision is for integrated care and support to become the norm in the next five years. We want you all to take action to help achieve this ambitious vision'. The underpinning funding and affordability assumptions associated with the recently submitted Sustainability and Transformation Plan and Futurefit/Community Fit and Better Care Fund are built on the continuation current investment in ICS as well as the additional top up agreed for this year.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	Integration of health and social care working is not per se innovative but our local model was innovative in that it aimed to achieve true integration of health and social care process, function and workforce (including generic roles) with the needs of the patient at the centre rather than simply an aligned approach. There are a number of research documents by The Kings Fund, the Nuffield Institute and others which highlight the benefits that can be realised for patients, the local system and optimisation of resources from an integrated care approach.
How does the service benchmark against similar services?	Not available.
Does the service deliver value for money?	The service is not delivering value for money as it has never been able to consistently achieve the planned level of activity for both early supported discharge and more particularly admission avoidance.
Are there other services in place that	There are no other integrated health and social care similar services in

offer a similar service?	place. All pre-existing intermediate care services were aligned to ICS as part of its creation. There are elements of admission avoidance services sitting outside of ICS which include Community IDTs/Matrons and LA People to People.
Is there evidence to support the continuation of the service?	Yes – The Provider has consistently not delivered a service in line with the commissioned and agreed model. CCG Commissioning leads fundamentally believe the original commissioned integrated model is the right one and that failure to deliver the project impact is down to the lack of leadership and ownership of delivery and the method of delivery employed by the provider. This model is in line with national policy and guidance. A meeting is being set up with LA, Shropcom and LA Directors to resolve the operational issues with the aim that the model as commissioned is implemented and tested for impact before any decisions are taken on disinvestment.
Is there a QIPP in place related to this service?	Yes x 2. Excess bed days and Admission Avoidance
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	LA could withdraw their support for the integrated model Increased pressure on acute front door with less admissions avoided Reduced flow through acute due to reduced focus on early supported discharge and discharge to assess – risks heightened levels of escalation, longer LoS and potentially decompensation A&E Recovery Plan trajectory relies on ICS delivering avoidable admissions Integrated care runs through all national and local system transformation plans – decommissioning or disinvesting in ICS gives a contradictory and confusing message
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	SCHT has not been able to demonstrate any evidence over the 3 years since ICS inception that they have implemented the commissioned and agreed model and therefore continuation of the service as the provider is currently delivering it is not recommended. However the commissioning leads strongly recommend that the model is the right one and should continue to be supported rather than disinvestment. There are peripheral elements of service provision and budget which were part of the aligned existing services where there is potential to disinvest.
If the answer to the question above is yes, what are the potential cost savings?	START (Short Term Assessment and Reablement Team) – this is a LA commissioned and provided in-house domiciliary care service. The total budget allocation is £353,397, the CCG pays £264,397. There is potential for cost savings through a move from in-house to private sector provision through a framework agreement. This would require LA to agree and lead the tender process. The CCG believes that the LA has already made changes to START services in the interests of releasing savings for their bottom line but for which the CCG has received no proportion of. Subject to LA agreement – likely savings in year is 3 months Q4 which equates to £33,000. START beds – 3 residential beds in Shrewsbury, Oswestry and Bridgnorth which the CCG pays a proportion towards because of intermediate care guidance however the number of community hospital beds the CCG

	currently commissions means that we more than evidence meeting this statutory requirement - £15,600 pa. Projected saving is 7 months which equates to £9,191. Stroke Social Worker - £49,000 – purpose to have a dedicated social worker on the stroke rehab wards and link in with ICS. There is no evidence that such a post exists nor has been subsumed within ICS. Projected savings is 8 months which equates to £32,666. Red Cross Voluntary Worker– rapid improvement review has highlighted that the voluntary worker in Central is not being used for the purpose intended, and was funded originally in phase 1 Shrewsbury & Atcham as a pilot to explore the benefits and impact of integrating with health, social care and voluntary sector. If the benefits of keeping this post have been defined then the provider should look to flex its workforce and use vacancies to fund within existing resources as has been the case in North locality. If the benefits have not been defined after 3 years then this component of the model should be disinvested in. Projected savings is 5 months which equates to £11,666. All the above are listed in the BCF programme/budget for this year.

Additional supporting information (embed docs)

Completed QIA Completed EIA	 QIA ICS START Dom Care 19 July 2016 HB.:  19 July 2016 HB.xlsx QIA ICS START beds  July 2016 HB.xlsx QIA ICS Red cross 19  care 19 July 2016 HB.› QIA stroke Social
Additional relevant information	

Service Summary – EOL project

Service title	**End of Life care project to support people to die at home at the end of life**
Provider organisation	Severn Hospice
Background	This is a partnership with Severn Hospice to deliver a service to support people at the end of life, to avoid hospital admissions and allow them to die in their pace of choosing. The need to provide additional care to support patients and their relatives/carers was identified by the CCG and the hospice as being key to reducing hospital admissions and improving quality. The CAP and QPR have supported the initial pilot phase of this proof of concept scheme, and then the further roll-out across the whole of Shropshire. Note that the budget for this sits within the Better Care Fund.
Contract type	Not a formal contract – monthly monitoring and bi-monthly steering group meeting
Contract duration	Currently runs until the end of 2016-17
Notice period required	3 months should be given, but we have given a clear undertaking that we intend to fund this project for the whole of 2016-17 and Severn Hospice have employed staff accordingly
Service metrics (activity/outcome)	We are counting the number of interventions where patients have been supported to avoid a hospital admission. We cannot directly relate this to hospital activity as we do not have HRG codes to identify EOL patients. The latest QIPP report shows that in the first 2 months of 2016-17 we have recorded 21 avoided admissions, against a target of 16.
Cost of service	£80k investment in 2016-17 by the CCG, the hospice is matching this investment

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	Yes – CAP supported the analysis that more care was needed to support people to stay out of hospital at end of life. The nature of community services is such that there is inequitable coverage across Shropshire, so this service attempts to address this. The rurality and demographics of Shropshire also means that there are many people who are comparatively isolated and would benefit from more services delivered at home. End of life services are delivered through a number of contracts held by a number of commissioning organisations. Services have developed over the years in a fairly ad hoc way. This has resulted in some areas of good practice but also a lack of clarity around responsibility and some gaps and duplication in delivery. The most recent figures (average for the 3 years 2010-12) for deaths in Shropshire show that the biggest single cause of death recorded is cancer (28.1%), followed by cardiovascular disease (27.7%) . Over half of the CVD patients died in hospital, whereas for cancer it was 38%. Shropshire compares well with both the West Midlands and nationally for numbers dying in hospital.
Does the service deliver its contractual obligations?	Yes – the project has exceeded the QIPP expectations, assuming that the metrics currently used within the QIPP are accepted.
Does the service address health	Yes – the scheme is open to all patients so addresses any inequity where

inequalities?	some people do not have support at the end of life. These are likely to be the oldest and most frail patients in the county.
Is the service aligned to a national or strategic 'must do'?	Partly – Department of Health 'Our Commitment to you for end of life care - The Government Response to the Review of Choice in End of Life Care ' (2016) states that 'Performance around the country will be assessed based on indicators of quality and patient experience in end of life care'
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	This is a 'proof of concept' to discover whether the approach of providing additional care resources is effective. The initial pilot phase was proven to be effective and CAP supported the roll-out to all Shropshire practices for 2016-17
How does the service benchmark against similar services?	The nationally produced evidence from the Nuffield Trust 'The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life' was used as the basis for this project
Does the service deliver value for money?	Yes – this is an effective QIPP scheme. Each avoided admission is priced at £3k based on the above evidence and research looking at actual costs to the CCG and also across the West Midlands
Are there other services in place that offer a similar service?	The CHC fast track process could cover some patients to some extent
Is there evidence to support the continuation of the service?	The project has delivered the expected QIPP services and will be evaluated in year to check that it meets expected outcomes in terms of quality and cost effectiveness
Is there a QIPP in place related to this service?	yes
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	This would increase hospital admissions, increase pressure on CHC fast track funding, lead to a reduction in people being able to die in their place of choosing and also cause Severn Hospice problems as they have employed staff on the basis of receiving our funding. This may also lead to a less effective working relationship with Severn Hospice in the future.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	The project should be continued, subject to evaluation during 2016-17 to consider whether the project should continue further
If the answer to the question above is yes, what are the potential cost savings?	The QIPP scheme is for £288k in 2016-17, weighed against the CCG upfront investment of £80k. This assumes that the current metrics are accepted as being an accurate reflection of the performance of the project. If they are not found to be sufficient, the costs savings for ending the service in year would equate to £53,333

Additional supporting information (embed docs)

Completed QIA Completed EIA	EOL DISINVEST EQIA.xlsx 19 July 2016
Additional relevant information	CAP EOL Feb 15.docx CAP where the original proof of concept was agreed QPR paper where agreement for full roll out in 2016-17, but for this year

	 QPR EOL PoC Feb 16.doc only initially

Service Summary – Path House

Service title	**Path House**
Provider organisation	Trident Reach The Charity
Background	PATH House, a "crisis house" located in Ludlow, is a three bedded facility that offers people experiencing mental health issues a community based alternative to hospital. PATH house was first established in 2001. Originally owned by the LA and staffed through the then PCT, it has since undergone a number of different management arrangements. At present the service, commissioned by the CCG to be provided in a LA owned premises is provided by Trident Reach the Charity. Shropshire Crisis Resolution and Home Treatment Team (CR/HTT) was established in the latter Quarter of 2015/16 and a second crisis house was established in August of 2008. This new facility, "Oak Paddock" is a four bedded facility based in Shrewsbury. The demand for PATH House has steadily declined from 73% occupancy in the final quarter of 2014/15, to 50.9% occupancy in the final quarter of 2015/16. This reduced demand perhaps owing to the developing quality of service provided by the CR/HTT, and the more convenient location of Oak Paddock, being situated within 500 meters of the CR/HTT base. Recent stakeholder engagement has demonstrated a perception held that PATH House is located in the wrong part of the county. Statistics derived from the last two quarterly reports endorse this perception with 72.3% of current demand being from service users based either in the Shrewsbury area; North Shropshire, or from places farther afield. Commissioning intentions towards PATH House have been under review for some time. The most recent report submitted to CAP (Nov, 2015) cited recommendations to decommission the service and redistribute some of the funds to alternative community based support services. The CAP paper relating to this report highlighted the following points for further exploration, concluding that no decision to de-commission could be made at the time: 1. The impact of PATH closure upon section 136 detentions needed to be understood. 2. A suitable replacement would need to be made available to ensure additional volume of demand was not placed upon A&E. In relation to the first point, Police Chief Inspector Paul Moxley who covers the local area has since explained that he does not foresee any impact upon police service demand as a result of decommissioning PATH House. From a clinical perspective, this may be due to PATH House tending to provide for service users considered to be at the lower-end of the risk spectrum. Qualitative data collected as part of this service review endorses the perception that there is a need for a suitable replacement to PATH house. There have been a number of options explored including the provision of Crash Pads which could be provided by third sector providers, or the bolstering of existing secondary mental health services.

Contract type	NHS Standard Contract 2016/17 (Shorter Version)
Contract duration	12 months (commenced 1st April 2016)
Notice period required	12 months (n/a as service only has a 12 month contract)
Service metrics (activity/outcome)	The most recent data provided by staff at PATH house suggest occupancy of 51.4% for the first quarter of this year/last quarter of 2015/16. Should this facility run at this level of occupancy for the remainder of the year, the £197,914.51 cost of the service would equate to a total cost of £351.64 per night for the people using the service. Additional data from Oak Paddock will enable a like-for-like comparison in terms of costing. Unfortunately PATH House does not collect data regarding the number of unique individuals accessing their service per quarter, and as such a quantitative understanding of failure demand is not possible at this time. However qualitative data suggests that there are a number of "regular guests" using the service implying that a level of failure demand is in existence.
Cost of service	£197,914.51

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	PATH House is underperforming in terms of capacity and demand and as such it is not meeting the needs of the population at this time. A full review of crisis care and support is advised to enable further service efficiencies.
Does the service deliver its contractual obligations?	No • PATH House has run at arguably marked under occupancy for a number of years, recent findings suggest a 51.4% occupancy rate. • Qualitative data suggests that PATH house does experience "regular guests" and that as such it does not promote recovery as well as it could do. • As the majority of demand for PATH house is from Shrewsbury and North Shropshire, it is not in practice a local support for the majority of its users.
Does the service address health inequalities?	No • There is no equivalent of PATH house in the North of the County although the demand for such services from this area is reported to be low. This could suggest that community services in the North of Shropshire have developed an enhanced level of skill in managing people in the community, thus arguably promoting health inequalities in community services.
Is the service aligned to a national or strategic 'must do'?	No
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	No • The PATH House model was conceived 15 years ago. Mental health services in Shropshire have seen radical transformation since this time with a reduction of over 60% of inpatient beds and a heavy emphasis upon recovery now in place. PATH House is suggested to have helped reduce dependence upon hospital, but in turn has

	generated its own form of dependence evidenced by the "regular guest" phenomenon reported within the qualitative data.
How does the service benchmark against similar services?	Oak Paddock – a similar service to PATH House can be used to establish a performance benchmark. Oak Paddock, a four bedded crisis house costs £224,186.00 per annum. This facility has run at 87% occupancy for the last two financial quarters and as such presents a cost of £176.50 per bed per night. This is £175.14 cheaper than the nightly bed rate currently being offered by PATH House.
Does the service deliver value for money?	No
Are there other services in place that offer a similar service?	Yes
Is there evidence to support the continuation of the service?	There is little evidence to support continuation of PATH House as a service unless there is no alternative available to replace it.
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	It has been identified that an alternative form of provision would need to be in place should PATH House be decommissioned. It is suggested that should no replacement service be provided, the impact would be felt mostly across the acute care pathway leading to increased pressure being placed upon acute community based mental health services, and potentially increased inpatient demand.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Disinvest.
If the answer to the question above is yes, what are the potential cost savings?	£197,914.51 fye If the service was to cease in year with an assumed 3 months notice period savings would equate to £82,464

Additional supporting information (embed docs)

Completed QIA	 PATH house QIA 19 July 2016 SB.xlsx
Completed EIA	
Additional relevant information	

Service Summary – GP Counselling

Service title	**GP Counselling**
Provider organisation	Relate, Confide, TRACS and 7 individual counsellors
Background	A review of primary care counselling services was conducted in 2014. This highlighted several issues. • Limited or no clinical supervision or governance • No performance monitoring or outcomes reported • Not equitable across primary care – long waits for some • No assurance on quality or evidence based interventions • Providing a very similar service to IAPT The recommendation was to undertake a procurement exercise to have one lead provider who would subcontract to smaller voluntary and third sector organisations and sole counsellors. However this was not completed. Currently there are • 5 x individual Counsellors funded directly by the CCG, • 2 x Counsellors funded by the CCG via the GP Practice (i.e. money paid directly to the Practice) • 3 x independent organisations providing counselling services funded directly by the CCG Historically there has been input from the CCG and SSSFT to get the counsellors reporting and contributing to IAPT and provide quality assurance around training, clinical governance and reporting but the offer was not taken up. The SSSFT did TUPE some of the counsellors into IAPT.
Contract type	NHS Standard Contract (Shorter Form)
Contract duration	9 months (1st June 2016 – 31st March 2017)
Notice period required	3 months
Service metrics (activity/outcome)	None reported
Cost of service	£202,911.80 annual value across all counsellors

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	Identified population is the same as that for IAPT which is 23,173, there is a national target of treating at least 15% of this population, which is expected to increase to 25% by 2020. Currently the counsellors do not report to HSCIC in order to contribute to this target so it is unknown how many people they are treating, for how long, their effectiveness and consequently whether they are meeting the needs of the population.
Does the service deliver its contractual obligations?	There is no contract monitoring and reporting in place so it is unknown
Does the service address health inequalities?	It is unlikely because of the lack of continuity across the primary care and lack of quality assurance or evidence based interventions
Is the service aligned to a national or strategic 'must do'?	It could contribute to the IAPT access target but infrastructure to ensure this can happen was too onerous for the counsellors and the SSSFT to manage.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	It is highly unlikely
How does the service benchmark against similar services?	It cannot be benchmarked because they do not report their activity and outcomes.

Does the service deliver value for money?	It is unknown because they do not repot their activity and outcomes
Are there other services in place that offer a similar service?	Yes the IAPT service
Is there evidence to support the continuation of the service?	No
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	The counsellors are supported by the GP practices in which they work, they are seen as part of their teams and disinvestment in this service may not be supported by Primary Care.. There is a belief that the IAPT service has long waits and does not deliver the same service as the counsellors. The IAPT service has a history of poor access, however the CCG commissioned an additional 3% capacity from the FT in the 16/17 contract round at no additional cost to address this issue. Primary Care colleagues have on occasion expressed concerns around potential hidden waits in the service from the point of first assessment. This has been and continues to be addressed by the MH Commissioner. In order to deliver this disinvestment and mitigate the potential concerns regarding access a specific communication plan would need to be implemented in partnership with the locality boards.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Disinvest
If the answer to the question above is yes, what are the potential cost savings?	£202,911.80 per year In year saving potential - £84,456 based upon a 3 month notice period

Additional supporting information (embed docs)

Completed QIA	
Completed EIA	GP Counselling 19 July 2016 SB.xlsx
Additional relevant information	

Service Summary – The Movement Centre

<table>
<tr><td>Service title</td><td>The Movement Centre</td></tr>
<tr><td>Provider organisation</td><td>The Movement Centre</td></tr>
<tr><td>Background</td><td>The Children's Movement Centre based at Oswestry Orthopaedic Hospital is a registered charity which helps to address movement control issues that children with a neurological condition such as cerebral palsy or a disability may experience. Specialised therapy is provided called Targeted Training to help children regain movement control to improve functioning and independence.

Shropshire CCG does not commission services from The Children's Movement Centre; however, the CCG receives individual funding requests for children who are believed would benefit from targeted training therapy that is offered by the centre. A review of this service has recently been undertaken to provide an overview of the service delivered by The Movement Centre at Oswestry which will inform CCG decision making with regards to individual funding requests in the future.

The founder of The Movement Centre, Dr P Butler has undertaken research during the 1990's and early 2000's in support of developing Targeted Training as a specific therapy. The Movement Centre has also compared the outcomes of their own patient audit data with another author's published data, exploring functional development for children with cerebral palsy (3). The Centre's results support the fact that the addition of Targeted Training to regular physiotherapy input enhances functional ability.
However, there is a lack of independent evidence available with regards to the effectiveness of Targeted Training therapy specifically.</td></tr>
<tr><td>Contract type</td><td>None – payment made on an individual funding request basis.</td></tr>
<tr><td>Contract duration</td><td>Not applicable.</td></tr>
<tr><td>Notice period required</td><td>To be determined – some notice may be required as payment has been made for this service for several years.</td></tr>
<tr><td>Service metrics (activity/outcome)</td><td>
<table>
<tr><th>Year</th><th>Number of invoices approved and paid by Shropshire CCG</th></tr>
<tr><td>2013</td><td>2</td></tr>
<tr><td>2014</td><td>2</td></tr>
<tr><td>2015</td><td>6</td></tr>
<tr><td>2016 YTD</td><td>1</td></tr>
</table>
To date, 3 invoices have been received since April 2016. Two are awaiting approval.

Since 1996 to date, The Movement Centre has supported a small number of children, around 500, who have been referred from a variety of locations across the country.

The Movement Service operates 37.5 hours per week, Monday – Friday 9.00 - 5.00pm.
The service has a maximum capacity of undertaking four assessments per day; however typically the initial assessments and the following three - four assessments take 2-3 hours each.</td></tr>
<tr><td>Cost of service</td><td>The cost of each 9-12 month course is £6250.00</td></tr>
</table>

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	The service meets the needs of a very small portion of the population, contributes to the "starting well" objectives identified in the JSNA.
Does the service deliver its contractual obligations?	Not applicable.
Does the service address health inequalities?	Partly, contributes to "starting well" objective identified in JSNA to reduce health inequalities.
Is the service aligned to a national or strategic 'must do'?	No.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	NICE guidelines for the management of cerebral palsy are yet to be published. There is some evidence to show that trunk control specifically, is a fundamental contributor to the walking ability of children with developmental disabilities such as spastic dysplasia (2). The founder of The Movement Centre, Dr P Butler has undertaken research during the 1990's and early 2000's in support of developing Targeted Training as a specific therapy. The Movement Centre has also compared the outcomes of their own patient audit data with another author's published data, exploring functional development for children with cerebral palsy (3). The Centre's results support the fact that the addition of Targeted Training to regular physiotherapy input enhances functional ability. However, there is a lack of independent evidence available with regards to the effectiveness of Targeted Training therapy specifically.
How does the service benchmark against similar services?	The Movement Centre is the only provider of Targeted Training, therefore difficult to benchmark.
Does the service deliver value for money?	Recent review undertaken. There is evidence to support the fact that The Movement Centre delivers a high standard of treatment however it is high cost and benefits a small number of patients, so arguably does not deliver value for money.
Are there other services in place that offer a similar service?	Yes – Paediatric Physiotherapy and ORLAU.
Is there evidence to support the continuation of the service?	There is no evidence to support continuation of the service when there are existing commissioned services that provide treatment for children with neurological global developmental conditions
Is there a QIPP in place related to this service?	No – but savings would be made if the CCG ceased funding individual requests.
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	Consequences likely to be minimal. Current alternative services are commissioned. Generally, children who are referred to the Movement Centre are on the CCP case load. Currently commissioned children's community physiotherapy (CCP) services have skills and competencies to assess and treat children with cerebral palsy and other neurological conditions. SCCG also commission within the general RJAH contract, ORLAU (orthopaedic research and locomotor assessment unit) to provide assessment for children and adults with mobility problems and advise patients and referring clinicians on treatment options and strategies.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Disinvested
If the answer to the question above is yes, what are the potential cost	If trends of increased requests for funding continue, up to 12 requests could be received (three have been received in Q1 2016/17) which would equate

savings?	to £75,000 per year. In year savings if the service was ceased with immediate effect could equate to £50,000 (based upon current average spend)

Additional supporting information (embed docs)

Completed QIA	 QIA Movement centre 19 July 2016 DC.xlsx
Completed EIA	
Additional relevant information	

Service Summary - ENABLE

Service title	**ENABLE**
Provider organisation	Shropshire Council
Background	Enable is an employment service designed to support people with mental health problems towards engaging in employment. Employment is seen as a key part of the recovery of people with mental health problems. It brings structure, value, independence, status, networks, relationships and financial wealth which all have an impact on self-confidence, self-esteem and the creation of a life outside of mental health services. The supported employment service in Shropshire is based on the Individuals Placement and Support (IPS) model, which has been identified as the most successful approach to helping people with severe mental health problems into employment This involves a number of key principles: • Competitive paid employment is the primary goal • Everyone who wants it is eligible for employment support • Job search is consistent with individual preferences • Job search is rapid, beginning within 6 weeks • Employment specialists and clinical teams work and are located together • Support is time unlimited and is individualized to both the employer and the employee • Welfare benefits advice supports the person from benefits to work • Employer engagement builds positive relationship with a wide range of employers The employment service, with mental health teams, ensures an integrated approach of employment and clinical interventions to support the recovery process of individuals with mental health problems. This is available to service users within both community and hospital based mental health services and is embedded with the CPA approach.
Contract type	No contract, a SLA is in place
Contract duration	No specified duration
Notice period required	No specified period although consultation with E.C. suggests 3 months.
Service metrics (activity/outcome)	Service metrics exist, although due to inconsistencies in expected destination of reporting, and issues relating to staff turnover within both organisations, they are not available at time of writing. They have been requested and are to be provided 13/7/2016.
Cost of service	£54,374

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	The Marmot review (2010) is cited within the JSNA, this document outlines six policy objectives, one of which is creating fair employment and good work for all. Although quantitative data is not available at time of writing, qualitative data suggests that Enable does meet the needs of the population in this regard, although whether it ensures equitable service provision across the county is difficult to surmise in the absence of quantitative data.

Does the service deliver its contractual obligations?	It is difficult to draw conclusions in this regards based upon the absence of quantitative data.
Does the service address health inequalities?	The service arguably does address health needs although does so indirectly through reducing social inequalities.
Is the service aligned to a national or strategic 'must do'?	From the stand point of public health policy drivers (Local action on health inequalities: Reducing the number of young people not in employment, education or training, 2014) this service is well aligned with a strategic must do.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	There is an evidence base to support the notion of employment helping to address mental health issues through reduction of poverty and social isolation. However recruitment into randomised control trials for this group of people is shown to be difficult (Howard et al, 2009) and as such the notion that strong evidence exists should be regarded as questionable.
How does the service benchmark against similar services?	There are no other similar services locally to benchmark against.
Does the service deliver value for money?	It could be considered that Enable offer value for money although it should be disputed as to whether the financial burden for the service should rest with the CCG.
Are there other services in place that offer a similar service?	Mainstream employment services should be accessible to all people within the population groups that they serve. Should individuals require support with accessing these services, it should be expected that this be built into care planning to promote integration into mainstream society.
Is there evidence to support the continuation of the service?	There is evidence to support the continuation of the service although a more compelling argument to promote use of supporting individuals to access existing employment services emerges.
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	It may be that should the service continue to be provided through local authority based funding streams in light of CCG disinvestment, then health and local authority relationships may suffer as a consequence. However it should also be considered that disinvestment may force current service design to be reconsidered, which should arguably take place in favour of a more integrated model of assisting people with mental health problems find employment.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Disinvested.
If the answer to the question above is yes, what are the potential cost savings?	£54,374 fye Based upon a 3 month notice period (no current contract in place) savings in year would equate to £22,656

Additional supporting information (embed docs)

Completed QIA	
Completed EIA	Enable DISINVEST QEIA.xlsx 19 July.xlsx
Additional relevant information	

Service Summary – Pathway 2 Rehabilitation Beds

Service title	**Pathway 2 rehabilitation beds**
Provider organisation	Lady Forrester Nursing Home
Background	The creation of 'pathway 2' was based on existing resource within the system and used the step down element of the community hospitals and the three independent care homes Isle Court, The Uplands and Lady Forrester. The beds within the Shrewsbury area were initially commissioned as the central location of the county do not have community hospitals and this consequently provided the resource needed to promote care/rehab 'closer to home'. Lady Forrester is located within The Much Wenlock area and the beds were initially commissioned as a local project created by GP's 10 years ago to support patients to access resources within their own community post hospital discharge and for admission avoidance. The beds over the last 12 months have run at 100% occupancy and are a resource to support ICS with admission avoidance.
Contract type	Block contract with care home. GP cover – no formal contract/ SLA or service spec with practice a rolling agreement in relation to funding 1 session per week for all 4 beds.
Contract duration	
Notice period required	3 months
Service metrics (activity/outcome)	Lady Forrester provides a quarterly report of the LOS for each patient and if they were an appropriate admission for the period April 2014- April 2015 average length of stay for patients was 21 days. In November 2015 CAP approved a service spec for the beds with more detail in relation to KPI's much of this relies upon the reporting and intervention from ICS and due to delays in that element of the pathway/ service spec being formally incorporated into the SCHT contract the reports have not yet been provided to commissioners.
Cost of service	4 rehab beds at a cost of £750/bed - £156,000 per anum GP's provide 1 session per week to Lady Forester at £260 per session. - £13,780 **TOTAL COST - £169,780**

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	The 4 beds have supported with the principles of Shropshire's JSNA in relation to Ageing population and Health Inequalities. There is however a strong evidence base that Shropshire CCG are complying with this through the community hospitals and other independent beds commissioned in Shropshire and that the closure of these beds would not impact significantly enough to contradict and main themes outlined within the JNSA.

Does the service deliver its contractual obligations?	Yes
Does the service address health inequalities?	Yes
Is the service aligned to a national or strategic 'must do'?	Yes – Intermediate care – The National Audit of Intermediate Care recommends bed based rehab provision should be available locally for patients. The example they provide however community hospitals are and again because of the amount of community hospital provision Shropshire has there is evidence this stator requirement is still being delivered.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	No however commissioning in the independent sector has provided Shropshire CCG with a greater understanding of how rehabilitation and step down support can be facilitated outside of a community hospital setting. The care home beds have enabled a more therapeutic setting for patients and have also demonstrated that bed based rehabilitation can be purchased outside of a community hospital setting. If this approach was to be replicated further in the future as an alternative to commissioning community hospital activity this could equate to substantial savings for the CCG.
How does the service benchmark against similar services?	Comparisons are made with the community hospitals length of stay. The target for community hospitals is 17 days and Lady Forrester are currently at 21 days.
Does the service deliver value for money?	Yes in comparison to the cost of a community hospital bed is approx £2,450 The beds are able to offer the same level of rehabilitation at a considerable lower rate. In terms of long term direction and decisions for the CCG a 'shift' in activity from community hospitals is a potential cost saving for the future and by maintaining the care home beds this will provide an evidence base that rehabilitation can be successfully delivered in an alternative setting to a community hospital. Reducing activity in the community hospitals is more cost effective than reducing the beds in the independent sector.
Are there other services in place that offer a similar service?	Yes – Community hospital beds
Is there evidence to support the continuation of the service?	No however as the above indicates the independent beds do offer an alternative to a high cost community hospital bed.
Is there a QIPP in place related to this service?	Yes – although not directly relating to a CCG QIPP there is risk that removal of these beds may impact the excess bed days QIPP and the ICS admission avoidance QIPP.
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	• Potential rise in DTOC patients awaiting further non acute NHS care. • GP's from Much Wenlock are likely to raise concerns around the impact to the local population and due to their historical role with the Lady Forrester beds it is predicted that there will be a great deal of challenge from GP's and local patients if beds are to be de commissioned. A comms plan would be required to manage this. • In terms of admission avoidance Lady Forrester do support ICS out of hours to prevent • The beds are currently utilised patients with plaster of paris casts without the block beds these may need to be spot purchased and it is likely that the spot purchase cost will equate higher than that of the block contract costs. • If we apply the 3 month termination of contract with immediate effect the beds will then close at the start of winter pressures, this

	could impact on the system.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	In an 'ideal world' the recommendation would be to actually disinvest from the more costly community hospital resource. The reality is however that in the interests of expediency to release money in year the removal of the four independent beds from the system is the only option to rapidly release finances.
If the answer to the question above is yes, what are the potential cost savings?	Yes - TOTAL COST - £169,780 In year savings based upon 3 months notice period £70,742

Additional supporting information (embed docs)

Completed QIA	 QIA Lady Forrester 19 July 2016.xlsx
Completed EIA	
Additional relevant information	

Service Summary - CHAS

Service title	Care Homes Advanced Scheme (CHAS)
Provider organisation	Primary Care (GP practices)
Background	The CHAS is delivered by GP Practices (GPs and Nurses) and has been in place since 2013/14. The service has the following objectives: • The aim of the Care Home Advanced Scheme (CHAS) is to provide pro-active care to those residents at high risk of emergency admission to hospital by adopting pro-active case management. This will be led by the GP but using a multi-disciplinary team (MDT) approach that fully includes the staff of the care homes, the resident and their relatives, as well as other primary and community care professionals and services as appropriate. • This will provide additional support to the Care Homes to assist them to continue to meet the needs of their highest risk residents and reduce unnecessary admissions to Acute Hospitals and the inappropriate use of West Midlands Ambulance Services and Out of Hours services. • Shropshire has one of the highest number of care home beds per head of population in the region. This is growing rapidly. • Care home beds are occupied largely by people who are 'frail and complex' and, as such, form one cohort of a much larger total number of frail and complex patients, most of whom continue to live in their own homes. • Emergency admissions to hospital are dominated by frail and complex patients and residents of care homes form a disproportionate number of these. Once admitted, they have poorer outcomes than the general population. During the six month period from 1st Feb- 31st July 2013, there were 486 admissions from Care Homes, at a cost of £1.4 million. Based on these figures, the admission rate from care homes is >1:4 residents per year. • Adopting pro-active care through active case management, care planning and multidisciplinary review for this group of patients is effective in improving quality and outcomes as well as reducing un-necessary hospital admissions. • The Care Homes Advanced Scheme (CHAS) provides pro-active care to residents of nursing homes. Aims • Identification and risk stratification of the residents at highest risk

	• Developing a clinical care plan using an MDT approach • Employing consistent documentation • Planned regular visits to the Care Home • Medication reviews • Flagging every patient with a clinical care plan to the Out of Hours service. • Significant event analysis undertaken for any care home resident in the event of an unplanned admission or A and E attendance Outcomes • Reduced hospitalisation of patients from care homes – A&E attendances and emergency admissions • Improved life for care home residents and enhances the quality of life for people with long-term conditions (NHS Outcomes Framework domain -2) • Promotes positive working relationships between care home and GP – fixed regular visits allowing communication and consistency
Contract type	Enhanced service
Contract duration	N/A
Notice period required	N/A
Service metrics (activity/outcome)	• To identify and undertake risk stratification for all patients who are resident in the Care Home and identify those deemed at high risk who would therefore benefit from the CHAS. • An assessment by the GP of each patient on this risk stratified list and the development of a clinical care plan jointly agreed by the GP, family members, care home staff and other community professionals as appropriate. • To use the clinical care plan template provided to employ agreed and consistent documentation. This includes an avoiding admission 'manage me here' plan and, where appropriate, an End of Life / DNAR form. • Pro-active care to be delivered as agreed in the care plan for the duration of the project. • Cross referencing of those patients with mental health needs or

	learning disabilities who are in receipt of other services and on other practice registers. • To undertake a Significant Event Analysis for any care home resident following an unplanned admission to an acute hospital bed or A&E attendance to determine cause and avoidable factors • To flag each care home resident with a clinical care plan to the Out of Hours Service.
Cost of service	£150,000

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	No
Does the service deliver its contractual obligations?	Yes
Does the service address health inequalities?	I have no reason to believe it does not
Is the service aligned to a national or strategic 'must do'?	No
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	• The Care Homes Advanced Scheme was based upon a strong evidence-based approach to care planning • It has led to an overall cultural change in approach to supporting patients in primary care and the joint working between care homes and practices has proved invaluable – indeed evaluation of the project highlighted this aspect as one of the key benefits of the service to both care homes and practices • Many CCGs commission services similar to the CHAS and indeed the unplanned admissions enhanced service could be viewed as a similar approach adopted by NHS England • Therefore, the service has possibly run its course and could be viewed as a disinvestment opportunity.
How does the service benchmark against similar services?	Not known.
Does the service deliver value for	• The reduction in hospitalisation in this increasingly frail and elderly

money?	group of patients has been difficult to quantify.
Are there other services in place that offer a similar service?	The unplanned admissions enhanced service could be viewed as offering practices the opportunity to provide a similar service for their patients (practices cannot benefit from both services for their patient cohort – practices must offer either CHAS or unplanned admissions enhanced service for patients in care homes – not both).
Is there evidence to support the continuation of the service?	The service has provided a means by which to streamline the practice with care homes and so has achieved many of the aims that were originally only aspirational. This work continues and both practices and care homes recognise the value in this approach and therefore this practice is now embedded. However, overall, the reduction in hospitalisation has been difficult to prove and so the benefits of the scheme are probably time-expired. Therefore, the service could be decommissioned.
Is there a QIPP in place related to this service?	Not currently
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	• The unintended consequence would be the disengagement of GP practices in the aims of the CCG. • This would be the perceived reduction in funding streams into primary care at a time when workload is being shifted into the community.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	The service could be decommissioned. However, it would be beneficial to consider this in conjunction with evaluation of other enhanced services to ensure that funding and support is consistent and enables practices to deliver services in line with the direction of travel identified in Community Fit and the draft Sustainability and Transformation Plan.
If the answer to the question above is yes, what are the potential cost savings?	£150,000

Additional supporting information (embed docs)

Completed QIA	
Completed EIA	QIA CHAS 19 July 2016 TK.xlsx
Additional relevant information	

Service Summary – Lifestyle Physiotherapy

Service title	**Lifestyle Physiotherapy**
Provider organisation	Lifestyle Fitness
Background	Lifestyle Fitness services are commissioned to deliver outpatient physiotherapy services for all service users over the age of 16 years who meet the access criteria and are registered with the following CCG GP Practices serving a total population of 32,824 (all ages): • Radbrook Green Surgery • South Hermitage Medical Practice • Mytton Oak Medical Practice • Bayston Hill Medical Practice This arrangement came about at a time when Physiotherapy triage was introduced at Shropdoc and the above practices declined to participate in this pathway approach. Lifestyle Fitness Physiotherapy has provided a service for at least 8 years without a contract review nor monitoring.
Contract type	There is currently no contractual paperwork associated with this service, invoices are received on a quarterly basis , based on historical contract value and activity.
Contract duration	As above
Notice period required	The absence of a contract means that the notice period would be whatever the CCG feels fair and reasonable
Service metrics (activity/outcome)	Planned activity is agreed with the provider annually
Is there a service specification? Is it up-to-date?	In draft but not signed off by Executive for submission to CAP.
Cost of service	Lifestyle fitness contract value: £109,260 Planned activity: 5314 £ per contact based on historical plan: £20.56 £ per contact based on activity: £19.19

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	No
Does the service deliver its contractual obligations?	Yes – In 15-16 the provider over performed on plan by 379 contacts.
Does the service address health inequalities?	I have no reason to believe it is not.
Is the service aligned to a national or strategic 'must do'?	It is not a national 'must do' but fits with the Any Qualified Provider national approach. Supports RTT target delivery.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	Yes, they are providing MSK self referral which is nationally recognised as best practice. Other local providers are not offering this service.
How does the service benchmark	Cheaper than national benchmark costs - National Benchmark figures (DoH

against similar services?	2011) suggest costs of £35-49 per patient
Does the service deliver value for money?	It is difficult to accurately calculate as cost of SCHT physiotherapy is block rather than unit cost but commissioners believe that it is an expensive service for just a small proportion of our population which if it could be absorbed within the SCHT at no extra cost would release savings.
Are there other services in place that offer a similar service?	Yes, via SaTH and SCHT
Is there evidence to support the continuation of the service?	The need of patients from these GP practices for this service will continue but does not have to be delivered through this provider.
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	Referrals would need to go to other local providers for this service Longer waiting times for these and other patients for physio Patients default to using other services such as A&E
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Yes decommission, assuming the activity can be absorbed within the existing SCHT block contract
If the answer to the question above is yes, what are the potential cost savings?	£45,417 in year

Additional supporting information (embed docs)

Completed QIA Completed EIA	QIA Lifestyle physio 19 July 2016.xlsx
Additional relevant information	

Service Summary – Voluntary Sector Home from Hospital Services

Service title	**Red Cross – Home from Hospital service (Central and North of the county)** **Age UK – Home from Hospital (South)**
Provider organisation	Red Cross and Age UK
Background	The CCG has two providers currently funded to provide Home from Hospital Services: Age UK and British Red Cross The last review completed on the service was in 2014. Home from Hospital service provides support for patients requiring Practical assistance or personal care to enable people to return home following hospital discharge or support to allow an individual to remain at home following a crisis instead of an admission to hospital. The core functions of the service include: • Prepare the home for discharge, to include making sure the house is warn, cleaning the fridge, changing bed linen, buying food • Welcome the person home • Assist with meals and beverages • Assist with mobility • Assist with shopping to include collecting prescriptions and pensions • Provide short term respite for carers • Loan Mobility Aids • Transport Service • Installation of pendant alarms The main refers into the service are ICS, Adult social care (P2P), GP's and ward staff. The current contract for both services includes administration costs, training for volunteers, line management of volunteers and the coordination, triage and processing of the referrals.
Contract type	Service Level Agreement
Contract duration	
Notice period required	3 months – there is no detail of the notice period in SLA
Service metrics (activity/outcome)	Activity reports are received every 6 months and include: • Name and profession of reviewer, • type of patient, • ward referred from, • number of visits made, • length of visit, • purpose of visit, • average duration per visit, • length of service required, • training provided to volunteers, • support provided to carers • case study

	The services receive over 1000 referrals per year and approx 75% of these result in face to face contact and patient support. The current SLA does not require either provider to collate any information on outcomes. As part of the discussion with the providers some case studies have been provided, but there is currently no robust methodology in place to assess the difference that an intervention has made.
Cost of service	£70,259 Red Cross (£28k is aligned with ICS) and £64,738 Age UK

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	The service compliments two of the four JSNA identified areas affecting the health population of Shropshire - Ageing population and Health Inequalities.
Does the service deliver its contractual obligations?	As far as can be evidenced- The SLAs in place do not reflect current good practice regarding commissioning for outcomes and the provision of a clear evidence basis for the service is not fully transparent.
Does the service address health inequalities?	Yes –No evidence to indicate otherwise.
Is the service aligned to a national or strategic 'must do'?	NO – However The Better Care Fund (BCF) is intended to provide a means for joint investment in integrated care and therefore to reduce the pressure on social care and hospitals by providing a co-ordinated approach to prevention, long term conditions and supporting people in crisis. Decommissioning the voluntary sector Home from Hospital service would conflict with this fundamental principle and there is a risk will impact upon effective joint commissioning and working relationships with the local authority in the future.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	Yes – The local health and social care economy have collectively shared a vison that the VCS is likely to have a significant and growing role in terms of preventive work and supporting people to stay at home longer and more independently. Dis investment would therefore conflict with this previously agreed direction and plans.
How does the service benchmark against similar services?	No bench marking data available
Does the service deliver value for money?	Due to the lack of outcome measures in place and an implemented contract monitoring process, it is difficult to evaluate the efficacy and value for money of the services provided. However, both organisations are receiving and responding to several hundred referrals across the County and anecdotal information suggests the services are well used and meet a substantial area of need in the population. For the last 2 winters SaTH have requested an enhancement of the services as part of winter planning as they have stated that the service provides a valuable role specifically with complex discharge.
Are there other services in place that offer a similar service?	There is risk of duplication in relation to the loan of equipment and hospital discharge transport it could be argued that this activity should and could be picked up within the CES and MSL contracts.

	The local authority also run 'lets talk local' sessions across the county to support with low level intervention- there is scope that patients could be referred to this service on discharge.
Is there evidence to support the continuation of the service?	The Voluntary and Community Sector (VCS) is likely to have a significant and growing role in terms of preventive work and supporting people to stay at home longer and more independently and will need to be appropriately resourced to deliver this activity.
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	The Primary referrer to both services is the acute hospital nursing staff. To ensure hospital staff feel confident to discharge patients there needs to be reassurance that an alternative service is in place to support vulnerable patients. The risk is without assurances hospital staff will delay discharge from hospital and subsequently the patient length of stay will increase and the number of delayed discharges rise. This could impact upon the excess bed days QIPP. There is also risk that without the Home from Hospital service in place acute staff will increase referrals to ICS as part of managing/ mitigating risk for complex discharge. As part of the 'discharge to asses' model this could result in ICS assessing patients with a lot lower needs that would not have previously been sign posted through the service. This would impact upon ICS capacity and efficiency and also is a less cost effective approach to supporting this cohort of patients that require minimal support that can be provided by a lower level intervention than that of ICS.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	The service should continue however it is not clear that this is the CCG's commissioning responsibility. The review in 2014 and activity reports indicate that the service is having a positive impact on patient flow, prevention, admission avoidance and patient experience. The reality however is that its primary role is to meet 'social needs'. The service is mainly responding to requests for support with transport, be friending, maintaining environments and meal preparation. These needs are detailed within the Care Act 2014 as imperative factors contributing to an individual's wellbeing. It is therefore the local authority responsibility to 'commission' and ensure such provision is made available.
If the answer to the question above is yes, what are the potential cost savings?	£70,259 Red Cross and £64,738 Age UK TOTAL AMOUNT - £134,997 In year potential, if it is assumed that cost does not sit with the CCG but should be transferred to the LA , based upon 3 month notice period £44,582

Additional supporting information (embed docs)

Completed QIA Completed EIA	QIA Red Cross DISINVEST QEIA.xlsx QIA Red Cross-Age UK DISINVEST QEIA.xl
Additional relevant information	

Service Summary - Moving and Handling Service

Service title	**Moving and Handling Service**
Provider organisation	Independent Living Partnership (ILP)
Background	The Independent Living Centre (ILC) Service is currently led by Health Profession Council registered Occupational Therapists who provide the service alongside regularly supervised Trusted Assessors – the service is mainly used by people living with long term conditions, carers supporting people with dementia and older people experiencing mobility loss. The ILP are commissioned to support patients so that their carers (both paid and non-paid) can have access to appropriate moving and handling assessments also assessments for the most appropriate style of hoist or standing frame.
Contract type	Service Level Agreement
Contract duration	
Notice period required	3 months – there is no detail of the notice period in SLA
Service metrics (activity/outcome)	Quarterly activity report submitted that details number of referrals. The current SLA does not require ILP to collate any information on outcomes. As part of the discussion with the providers some case studies have been provided, but there is currently no robust methodology in place to assess the difference that an intervention has made. Current activity reports indicate that the service is underutilised.
Cost of service	£32,100

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	The service compliments THREE of the four JSNA identified areas affecting the health population of Shropshire - Ageing population, supporting long term conditions and Health Inequalities.
Does the service deliver its contractual obligations?	As far as can be evidenced- The SLAs in place do not reflect current good practice regarding commissioning for outcomes and the provision of a clear evidence basis for the service is not fully transparent.
Does the service address health inequalities?	Yes –No evidence to indicate otherwise.
Is the service aligned to a national or strategic 'must do'?	NO – However The Better Care Fund (BCF) is intended to provide a means for joint investment in integrated care and therefore to reduce the pressure on social care and hospitals by providing a co-ordinated approach to prevention, supporting patients to remain in their own homes, promoting independence, long term conditions and supporting people in crisis. Decommissioning ILP would conflict with the above principles and there is a risk this will impact upon effective joint commissioning and working relationships with the local authority in the future.
Does the service have an innovative and modern approach to service	Yes- The service bases its self around looking at alternative ways a patient can be supported to remain at home if they require high level

delivery that has a strong clinical evidence base?	input and support they are able to look at how to empower individual to reduce the amount of physical intervention received and also empower carers to have a more active part in the delivery of a loved one's care plan.
How does the service benchmark against similar services?	No evidence available- could be sourced through comparisons with Telford and Wrekin CCG who commission a similar service who's main provider is SCHT.
Does the service deliver value for money?	Due to the lack of outcome measures in place and an implemented contract monitoring process, it is difficult to evaluate the efficacy and value for money of the services provided. The low activity levels indicate that it is not at this moment in time.
Are there other services in place that offer a similar service?	There is potential that the services provided by ILP could be aligned with ICS and IDT's as part of a holistic care plan and that all trust clinicians should hold core skills within this areas that they could apply to assessing risk around moving and handling and referrals for equipment. The CES contract also included a clinical lead OT this individual could/ should therefore offer appropriate advice in relation to hoists etc.
Is there evidence to support the continuation of the service?	No – The full delivery and impact of this service has not however been fully analysed and assessed as the service are not measured against outcomes.
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	Potential loss of knowledge and skill from the specialist service this could result in delays for patient assessments and an increased in paid support as alternative options may not be as easily assessed.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	Disinvestment is an option providing a detailed QIA is completed to fully scope the impact this would have on patient experience, safety and clinical risk.
If the answer to the question above is yes, what are the potential cost savings?	£32,100 current invoices are quarterly next is due September therefore the potential in year saving could be: £16,050

Additional supporting information (embed docs)

Completed QIA	 QIA Moving and Handling 19 July 2016
Completed EIA	
Additional relevant information	

Service Summary - Pain Services

Service title	**Pain Services**
Provider organisation	Pain Management Solutions
Background	• Pain Management Solutions Ltd (PMS) has been delivering a community pain service in Shropshire through a proof of concept approach at 80% of the National PbR tariff. The service was developed to support capacity issues within secondary care clinics and in response to NICE guidance • The contract for this pilot service has been in place since April 2014. In August 2015 it was agreed to extend the contract until 30 November 2016 • Local secondary care providers are still experiencing challenges in relation to capacity • The implementation of a community service identified an unmet need within primary care in Shropshire however, for many patients living with chronic pain, secondary care interventions are not deemed appropriate • An audit carried out by the Commissioner in 2015 showed that there was no evidence of discharged patients being further referred into secondary care • A procurement process has recently taken place with Board Approval being sought on Wednesday, 13th July 2016 to progress to award. The service specification for the new service delivery includes a requirement for flexibility to enhance pathways which support other services e.g. MSK, Headache Pathway • It should be noted that in an effort to address the continuous increase in referrals, commissioners suggested increasing the time period for primary care management from 3 months to six, this was not supported by CAP
Contract type	**Current Contract** is fixed term to 30 November 2016 - NHS Standard Contract (Full contract) **New Contract** would be 3yrs with a break clause of 12 months notice from either party planned to start from 1 December 2016 – NHS Standard Contract (Full contract) – not awarded yet
Contract duration	**Current contract** ends 30 November 2016, **following** 2month extension **New Contract** from 1 December 2016 to 30 November 2019 with the option to extend by a further 12 months – not awarded yet
Notice period required	**Current Contract** - due to expire on 30 November 2016, however if decommissioning prior to this there may be redundancy implications for the incumbent service provider **New Contract** – 12 months (however contract has not been awarded yet)
Service metrics (activity/outcome)	**HRG Code** / **Description** / **Actual Activity** AB05Z – Intermediate Pain Procedures – 15 AB11Z – Cognitive Behavioural Therapy – 3,579

	WF01B	1st OP Attendance	952
	WF01A	Follow up OP Attendance	1,155
	AB06Z	Minor Pain Procedures	1,375
	AB08Z	Pain Radiofrequency Treatments	334
	AB09Z	Other Specified Pain Procedures	5
	WF01C	Telephone Contact OP Attendance	692
	Total		8,107
Cost of service	CCG Annual Budget for this service is £819,214		

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	Not known.
Does the service deliver its contractual obligations?	Yes, the service delivered meets the current service specification requirements
Does the service address health inequalities?	Service provision is provided in a range of centres across the county, enabling local access
Is the service aligned to a national or strategic 'must do'?	No. The service is aligned however with NICE Guidance.
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	The Service Specification for the new delivery from October states that the Service shall:- • Provide a community based pain management service • Provide a service which complies with latest guidance • Provide equity of access to service users • Provide access to a range of disciplines and interventions that can deal with the physical, psychological and social needs of service users with chronic pain • Provide a service which ensures that patient needs can be met within community settings wherever clinically appropriate reducing the need for secondary care intervention • Work in partnership with a range of providers to identify further pathway development
How does the service benchmark against similar services?	Since the introduction of the service overall injection rates across Shropshire have reduced from an average of 26% in 13/14 to 6% 15/16.
Does the service deliver value for money?	There are two views to consider – 1. The new service could be considered to have generated new demand that has created cost pressure for the CCG as cost for pain services have increased since 2013/14. 2. Conversely, the service could be considered to have addressed an unmet need for Shropshire patients who were previously managed within primary care. The budget for pain services for Shropshire CCG has had to increase since 2013/14 to address the new demand flowing from primary care.

	The service commissioned from PMS is delivered at 80% of the national tariff so can be considered value for money in comparison to secondary care providers. However, the community service cannot be fairly compared to secondary care providers as this is as service they do not currently deliver.
Are there other services in place that offer a similar service?	Primary care offer support to patients presenting with chronic pain. Secondary care pain services support patients presenting with more acute pain related conditions such as pain of unknown cause, post trauma complications and patients presenting with red flags. The community service provides support to patients who have been managed by their GP for a minimum of 3 months and where medication has been optimised but don't require a secondary care referral.
Is there evidence to support the continuation of the service?	• This service meets the requirements of NICE Guidance • This service could be considered to support the CCG to deliver the PLCV thresholds in relation to pain management • The community service shows a reduction in injection rates (and subsequent costs) from services provided at secondary care • There has been a strong suggestion that Robert Jones and Agnes Hunt Hospital are likely to serve notice in year on their Pain Service as they are undertaking a strategic review of their service portfolio under their new Chief Executive. The community service could grow to meet any additional demand transferred from secondary care required
Is there a QIPP in place related to this service?	No – the CCG did have a QIPP in place against savings from injection costs last year however this has now been fully realised.
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	• Increased demand for primary care services – this would be likely to have an impact upon the CCG's relationship with its members • There would be an increased demand for secondary care activity particularly in relation to access for injections as this cannot currently be managed in primary care. The threshold for access to secondary care would need to be reviewed to mitigate against this • There would be a requirement to upskill primary care staff to deliver components of this service and there may be costs associated with this • Some of the activity that we are currently paying at 80% of the tariff would need to be paid for at 100% of tariff (further work is required to quantify the amount of activity that would transfer) • There is a reputational risk to the CCG in not following through on the tender process that is at the stage of awarding the tender • There is a view that without a community based second tier service in between primary and secondary care that patient experience would be affected • It should be noted that currently both acute providers within Shropshire are considering serving notice on their acute pain services – there could be an effort to support this move and consolidate all pain services via one provider which could be more cost effective for commissioners
After taking all of the above into account, should the service be decommissioned/disinvested	The service could be disinvested in if it was accepted that this activity could be absorbed by primary care with a small increase in secondary care activity.

in/continued?	However, it is proposed that further work is undertaken to fully assess the risk associated with this potential disinvestment due to the complexity of the current service provision.
If the answer to the question above is yes, what are the potential cost savings?	If the assumption is that the service could be fully decommissioned without any further financial impact upon commissioners for the service transfer savings could equate to: £258,627 (from current contract end point 30th November). However, this needs to be balanced with the potential increase in activity and associated cost for secondary care referrals when paying 100% of tariff. Due to the complexity of this disinvestment proposal, Commissioners propose that an urgent task and finish group is established to work through the options, undertake cost and activity modelling against the various scenarios and present this to executives for review.

Additional supporting information (embed docs)

Completed QIA	 QIA pain 19 July 2016.xlsx
Completed EIA	
Additional relevant information	

Service Summary – Oak House

Service title	**Oak House**
Provider organisation	SSSFT
Background	Oak house is a 10 bedded health funded establishment which provides 24/7 specialist nursing care support to adults 18+ who have profound intellectual and multiple disabilities, physical and/or sensory disability and/or visual impairment and provides support to families or other carers. The service comprises of skilled professionals delivering • Assessment, health review, general health screening, treatment plans and clinical interventions. It works collaboratively with SaTH to support individuals with learning disabilities who have medical needs requiring specialist support and access to general acute services and where appropriate step down from inpatient admission is also provided. • Social care respite for short term breaks to support family/carers. All those using the service normally live at home with their families or carers. The staff team know the service users very well and the service is highly values by those that use the service. Although the primary purpose of the service is to provide health assessment and interventions the nursing team are tied to the respite part of the service. The current bed base is commissioned on a 60:40 split with Telford CCG In January 2015 the SSSFT presented a proposed new service model for an alternative service to Oak House which is based upon a quick response highly flexible and multi-disciplinary team that can response to people with LD and complex health problems. The plan was presented this to CAP to see if they would consent to further extensive work taking place on formal consultation, presenting to HOSC and other work streams required to advance the proposals. This has revealed some specific reservations about large scale changes to the service.
Contract type	NHS standard contract – unknown if there is an up to date specification
Contract duration	12 months
Notice period required	12 months
Service metrics (activity/outcome)	1,249 OCBD
Cost of service	1,249 OCBD @ 568 = £709,432

Disinvestment Assessment Tool

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	T&W CCG has undertaken a service review that revealed data that shows that Oak House is not fit for purpose and is not delivering the service in line with the agreed service specification. 90% of the service provided is respite (not commissioned by CCG's), and the respite that is provided is "institutionalised" and not in accordance

	with current respite guidelines. Oak House does not accept emergencies as detailed in the service spec. The service is not accessed by the whole population as originally intended.
Does the service deliver its contractual obligations?	The service is dominated by delivering respite therefore it cannot meet its full contractual obligations
Does the service address health inequalities?	The service is accessed by a small cohort of the population therefore it will not address inequalities
Is the service aligned to a national or strategic 'must do'?	CIPOLD and Transforming Care
Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?	No
How does the service benchmark against similar services?	
Does the service deliver value for money?	No
Are there other services in place that offer a similar service?	No
Is there evidence to support the continuation of the service?	No
Is there a QIPP in place related to this service?	No
Would there be any likely unintended consequences if this service was decommissioned or disinvested in?	It is widely acknowledged by SSSFT that the service needs to change and there is the opportunity to deliver some of these changes, modernising and make the service fit for purpose whist making savings. It is likely that full consultation would need to be undertaken prior to any full decision to disinvest or decommission.
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	There is potential to disinvest – further review required
If the answer to the question above is yes, what are the potential cost savings?	Disinvest – savings of £740,544 fye Part year effect assuming 6 months notice period at the same time as consultation (to be agreed by provider) would equate to in year savings of £123,424

Additional supporting information (embed docs)

Completed QIA	 QIA Oak house 19 July 2016 SB.xlsx
Completed EIA	
Additional relevant information	

Appendix 2

Workshop One Recommendations

Service	Workshop Outcome (1-5)	Potential in-year saving	Full Year Effect
PaTH House	1	£82k	£198k
Oak House	1	£123k	£740k
GP Counselling Services	1	£84k	£202k
Integrated Community Services (ICS) associated services	2	£86k	£224k
Care Home Advanced Service (CHAS)	2	£113k	£150k
End of Life Project	3	0	0
Community Pain Service	5	TBD	TBD
Community beds x 4	2	£70k	£170k
The Movement Centre	2	£50k	£75k
Enable	2	£22k	£54k
Lifestyle Fitness Physio	2	£45k	£109k
Red Cross Home from Hospital	3	0	0
Age UK Home from Hospital	3	0	0
ILP Moving & Handling	2	£15k	£30k
Total – indicative savings subject to outcome of due diligence which may require some re-investment		**£690k**	**£1952k**

Appendix 3

Workshop Two Recommendations

Service	Workshop Outcome Progress to step 2 / Not suitable
Community Neuro Rehabilitation Team (CNRT)	Progress
Rapid Assessment, Interface & Discharge Team (RAID)	Progress
Rural Diagnostics, Assessment and Access to Rehabilitation and Treatment service (DAART)	Progress
Integrated Community Service (ICS)	Not suitable
Personal Health Budgets(PHB's)	Not suitable
Voluntary Service Grants	Not suitable
Community & Care Coordinators	Not suitable
Local Enhanced Service (LES) arrangements	Not suitable

Subject:	Decommissioning and Disinvestment Update Paper
Report Written by:	Julie Davies
Presented by: Responsible Director:	Julie Davies Dave Evans

For decision	X
For performance monitoring	
Other – please specify	

KEY POINTS IN REPORT

The purpose of this report is to:

- Update the Board on the work to date on decommissioning and disinvestment project since the last Governing Body meeting

RECOMMENDATION TO THE GOVERNING BODY

The Governing Body are asked to;

- **Note** the contents of this report and the progress made in the last month on the decommissioning and disinvestment project.
- **Approve** the recommendation to not renew the Lifestyle Physio Contract

CONTEXT AND IMPLICATIONS	
Financial implications	As noted in the report
HR/Personnel implications	NA
Promoting equality and equity – implications	Full equality and equity impact assessments are undertaken for each service considered as part of this work programme
Considerations for Quality & Safety	Quality impact assessments completed as required within the Decommissioning and Disinvestment Policy
What patient and public involvement has there been in this issue, or what impact could it have on patient/public experience?	The issue of decommissioning and disinvestment must be effectively managed with our patients and the public perception. The CCG has committed to all necessary engagement and consultation on a service by service basis as required and the outcome of that will be considered by Governing Body before any final decision is taken.
Any Conflicts of Interest to be declared	Potential GP colleagues in respect of Primary Care considerations.

1. Purpose of Report

The purpose of this report is to:

- Provide the Board with an update on the work to date on the decommissioning and disinvestment project since the last Governing Body meeting and the next steps and timescales where available.

2. Background

A shortlist of services that had the potential for decommissioning/disinvestment in year was presented to the August Governing Body meeting and the recommendations for progressing to the next stage were approved. Two service areas (GP Counselling and Care Homes Advanced Scheme) were not considered by the Governing Body due to GP conflicts of interest and they were considered and approved at the SCCG Primary Care Commissioning Committee on the 17th August. Appendix 1 is the full list of the services proposed in the original paper taken to the governing body in August. In addition the other potential areas approved to progress to step two of the policy are listed in Appendix 2 of this paper.

3. Overarching actions

All correspondence received by the CCG was formally responded to and any issues of accuracy with regard to information on the services were passed to the respective commissioning leads and the templates are being updated accordingly.
Weekly meetings have been held to progress the work and updates on the individual schemes will follow in the section below. An enabling team has been set up to provide generic advice and support of communications & engagement, business intelligence and finance to the commissioning leads as required. This will continue indefinitely. The work on each service area includes a communications and engagement plan on a page and the necessary equality assessments.

4. Status of Current Schemes

<u>Path House</u>

- A paper will be taken to CAP on 7th September regarding Path House, this advises that the current service is not fit for purpose but that mental health crisis provision would need to be re-commissioned as a replacement for this service.
- If approved by CAP, a business case for the recommissioning will need to go to Finance & Performance Committee before a final decision would be brought back to governing body in October.

Oak House

- As this service is also commissioned by Telford & Wrekin CCG, the disinvestment template for Oak House is being completed on behalf of both CCGs.
- The commissioning lead has advised that the process must have disinvestment as an option but it is likely that re-investment will be required. If re-investment is the recommendation then the timescales will not be as tight.
- The Provider of this service has themselves stated that the facilities are not fit for purpose and the service needs to be more community based.
- Further work is required on the QIA.

GP Counselling

- The commissioning lead has now met with all practices affected.
- A number of patient concerns have been raised with regard to the withdrawal of this scheme.
- Clinical safety and governance must be given focus and due process must be followed.
- It was noted that some reassurance around system governance was urgently required
- At this time it is not anticipated that this scheme will give any in-year savings.

CHAS

- The Task & Finish Group to look at value for money and alternative options for the service has been set up.
- Scheme is linked to avoiding admissions and work will be led by Tracy Savage.
- CHAS is no longer having desired effect but could be amended and the funding used more effectively.
- A letter has been sent to all practices asking for their views on whether more care home emergency admissions could be avoided if this investment was used in a more targeted way, and if so what that could be.
- A PID is currently being written and timelines will need to be agreed for inclusion within this. It was suggested that funding will likely be re-invested and will therefore not be cash releasing although it was noted that there could be a part-year gain.
- This will need to go to Finance & Performance to endorse any recommendation before going back to the Primary Care Committee for a final decision

Community Pain Services

- It has been confirmed that the Community PMS Tender has now been awarded so will not be cash releasing. It is however, to be noted that the new PMS service re-specification will permit a downsizing of pain management activity undertaken in the acute setting.

Community Beds – Lady Forrester

- Following correspondence between the CCG CFO and the provider a Task & Finish group is being set up to progress step four of the policy and the output from this will be brought back to the October governing body meeting.

Movement Centre

- This is not a commissioned service and therefore should not have been included within a formal decommissioning /disinvestment programme.
- A review paper on the will be taken to CAP on 7th September which recommends any future requests for access to this service should be treated on a case by case basis through the IFR approval process.

ICS associated services, Enable and ILP

- The CCG is continuing to working with the local authority on these areas as they fall within the Better Care Fund.

Lifestyle Physio

- It has been confirmed that this contract has already lapsed. A verbal discussion has taken place with the provider explaining that we are recommending the contract not be renewed. If this recommendation is ratified by the Board, written notification will be issued to the provider. Commissioners will ensure that adequate access to other community physiotherapy services will be maintained.

- The other potential areas approved at August governing body to progress to step two of the policy are listed in Appendix 2.

CNRT

- A review of this service has been undertaken and is being presented to CAP on 7th September. The outcome from that will be included in the update to the governing body in October.

- The remaining areas of RAID and DAART have not been progressed further at this time as the CCG mental health commissioning lead has been leading the work on Path House and GP counselling and the urgent care commissioning lead has been focussed on admission avoidance related savings. The executive team are currently reviewing workload and the resource required to progress all priority work streams to ensure we can deliver this in the near future.

5. Next Steps

This work will continue to be progressed as a matter of urgency and monthly updates brought back to the governing body which will contain final decisions and supporting evidence as required.

6. Recommendations

The Governing Body is asked to;

- **Note** the contents of this report and the progress made in the last month on the decommissioning and disinvestment project.
- **Approve** the recommendation to not renew the Lifestyle Physio Contract.

Appendix 1

Workshop One Recommendations

Service	Workshop Outcome (1-5)	Potential in-year saving	Full Year Effect
PaTH House	1	£82k	£198k
Oak House	1	£123k	£740k
GP Counselling Services	1	£84k	£202k
Integrated Community Services (ICS) associated services	2	£86k	£224k
Care Home Advanced Service (CHAS)	2	£113k	£150k
End of Life Project	3	0	0
Community Pain Service	5	TBD	TBD
Community beds x 4	2	£70k	£170k
The Movement Centre	2	£50k	£75k
Enable	2	£22k	£54k
Lifestyle Fitness Physio	2	£45k	£109k
Red Cross Home from Hospital	3	0	0
Age UK Home from Hospital	3	0	0
ILP Moving & Handling	2	£15k	£30k
Total – indicative savings subject to outcome of due diligence which may require some re-investment		**£690k**	**£1952k**

Appendix 2

Workshop Two Recommendations

Service	Workshop Outcome Progress to step 2 / Not suitable
Community Neuro Rehabilitation Team (CNRT)	Progress
Rapid Assessment, Interface & Discharge Team (RAID)	Progress
Rural Diagnostics, Assessment and Access to Rehabilitation and Treatment service (DAART)	Progress
Integrated Community Service (ICS)	Not suitable
Personal Health Budgets(PHB's)	Not suitable
Voluntary Service Grants	Not suitable
Community & Care Coordinators	Not suitable
Local Enhanced Service (LES) arrangements	Not suitable