

## Shropshire Clinical Commissioning Group

Date: 10<sup>th</sup> August 2016

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

For decision	<input checked="" type="checkbox"/>
For performance monitoring	<input type="checkbox"/>
Other – please specify	<input type="checkbox"/>

### 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	<b>Integrated Community Services (ICS)</b>
Provider organisation	Shropshire Community Health NHS Trust (lead provider) in partnership with Shropshire Council
Background	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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:-







	<p>The National Audit for Intermediate Care 2015  <a href="http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINAL4printableversion.pdf">www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINAL4printableversion.pdf</a></p> <p>NICE Guidance NG27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs December 2015  <a href="http://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877">www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877</a></p>
	<p>The Care Act 2014  <a href="http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted">www.legislation.gov.uk/ukpga/2014/23/contents/enacted</a></p> <p>The Care and Support (Preventing Needs for Care and Support) Regulations 2014  <a href="http://www.legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf">www.legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf</a></p> <p>The Care and Support (Charging and Assessment of Resources) Regulations 2014  <a href="http://www.legislation.gov.uk/uksi/2014/2672/contents/made">www.legislation.gov.uk/uksi/2014/2672/contents/made</a></p> <p>Care and Support Statutory Guidance issued under the Care Act 2014  <a href="http://www.gov.uk/guidance/care-and-support-statutory-guidance">www.gov.uk/guidance/care-and-support-statutory-guidance</a></p> <p>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'.</p> <p>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.</p>
<p>Does the service have an innovative and modern approach to service delivery that has a strong clinical evidence base?</p>	<p>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.</p>
<p>How does the service benchmark against similar services?</p>	<p>Not available.</p>
<p>Does the service deliver value for money?</p>	<p>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.</p>
<p>Are there other services in place that</p>	<p>There are no other integrated health and social care similar services in</p>

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?	<p>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.</p> <p>This model is in line with national policy and guidance.</p> <p>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.</p>
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?	<p>LA could withdraw their support for the integrated model</p> <p>Increased pressure on acute front door with less admissions avoided</p> <p>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</p> <p>A&amp;E Recovery Plan trajectory relies on ICS delivering avoidable admissions</p> <p>Integrated care runs through all national and local system transformation plans – decommissioning or disinvesting in ICS gives a contradictory and confusing message</p>
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	<p>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.</p> <p>There are peripheral elements of service provision and budget which were part of the aligned existing services where there is potential to disinvest.</p>
If the answer to the question above is yes, what are the potential cost savings?	<p>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.</p> <p>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</p>

	<p>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.</p> <p>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.</p> <p>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 &amp; 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.</p> <p>All the above are listed in the BCF programme/budget for this year.</p>
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Additional supporting information (embed docs)

Completed QIA	   
Completed EIA	<p>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 July 2016 HB.xlsx    QIA stroke Social care 19 July 2016 HB.&gt;</p>
Additional relevant information	

## Service Summary – EOL project

Service title	<b>End of Life care project to support people to die at home at the end of life</b>
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)?	<p>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.</p> <p>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.</p> <p>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.</p>
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 ' <a href="#">The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life</a> ' 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	 EOL DISINVEST EQIA.xlsx 19 July 2016
Completed EIA	
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	<b>Path House</b>
Provider organisation	Trident Reach The Charity
Background	<p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. The impact of PATH closure upon section 136 detentions needed to be understood.</li> <li>2. A suitable replacement would need to be made available to ensure additional volume of demand was not placed upon A&amp;E.</li> </ol> <p>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.</p> <p>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.</p>

Contract type	NHS Standard Contract 2016/17 (Shorter Version)
Contract duration	12 months (commenced 1 <sup>st</sup> April 2016)
Notice period required	12 months (n/a as service only has a 12 month contract)
Service metrics (activity/outcome)	<p>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.</p> <p>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.</p>
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?	<p>No</p> <ul style="list-style-type: none"> <li>• PATH House has run at arguably marked under occupancy for a number of years, recent findings suggest a 51.4% occupancy rate.</li> <li>• 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.</li> <li>• 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.</li> </ul>
Does the service address health inequalities?	<p>No</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>
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?	<p>No</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>



	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	<b>GP Counselling</b>
Provider organisation	Relate, Confide, TRACS and 7 individual counsellors
Background	<p>A review of primary care counselling services was conducted in 2014. This highlighted several issues.</p> <ul style="list-style-type: none"> <li>• Limited or no clinical supervision or governance</li> <li>• No performance monitoring or outcomes reported</li> <li>• Not equitable across primary care – long waits for some</li> <li>• No assurance on quality or evidence based interventions</li> <li>• Providing a very similar service to IAPT</li> </ul> <p>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</p> <ul style="list-style-type: none"> <li>• 5 x individual Counsellors funded directly by the CCG,</li> <li>• 2 x Counsellors funded by the CCG via the GP Practice (i.e. money paid directly to the Practice)</li> <li>• 3 x independent organisations providing counselling services funded directly by the CCG</li> </ul> <p>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.</p>
Contract type	NHS Standard Contract (Shorter Form)
Contract duration	9 months (1 <sup>st</sup> June 2016 – 31 <sup>st</sup> 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 report 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?	<p>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..</p> <p>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.</p>
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?	<p>£202,911.80 per year</p> <p>In year saving potential - £84,456 based upon a 3 month notice period</p>

#### Additional supporting information (embed docs)

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

**Service Summary – The Movement Centre**

Service title	<b>The Movement Centre</b>											
Provider organisation	The Movement Centre											
Background	<p>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.</p> <p>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.</p> <p>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.</p>											
Contract type	None – payment made on an individual funding request basis.											
Contract duration	Not applicable.											
Notice period required	To be determined – some notice may be required as payment has been made for this service for several years.											
Service metrics (activity/outcome)	<table border="1"> <thead> <tr> <th>Year</th> <th>Number of invoices approved and paid by Shropshire CCG</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>To date, 3 invoices have been received since April 2016. Two are awaiting approval.</p> <p>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.</p> <p>The Movement Service operates 37.5 hours per week, Monday – Friday 9.00 - 5.00pm.</p> <p>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.</p>		Year	Number of invoices approved and paid by Shropshire CCG	2013	2	2014	2	2015	6	2016 YTD	1
Year	Number of invoices approved and paid by Shropshire CCG											
2013	2											
2014	2											
2015	6											
2016 YTD	1											
Cost of service	The cost of each 9-12 month course is £6250.00											

## 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)
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**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	<b>ENABLE</b>
Provider organisation	Shropshire Council
Background	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Competitive paid employment is the primary goal</li> <li>• Everyone who wants it is eligible for employment support</li> <li>• Job search is consistent with individual preferences</li> <li>• Job search is rapid, beginning within 6 weeks</li> <li>• Employment specialists and clinical teams work and are located together</li> <li>• Support is time unlimited and is individualized to both the employer and the employee</li> <li>• Welfare benefits advice supports the person from benefits to work</li> <li>• Employer engagement builds positive relationship with a wide range of employers</li> </ul> <p>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.</p>
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.
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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	 Enable DISINVEST QEIA.xlsx 19 July.xlsx
Completed EIA	
Additional relevant information	



**Service Summary – Pathway 2 Rehabilitation Beds**

Service title	<b>Pathway 2 rehabilitation beds</b>
Provider organisation	Lady Forrester Nursing Home
Background	<p>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.</p> <p>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'.</p> <p>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.</p> <p>The beds over the last 12 months have run at 100% occupancy and are a resource to support ICS with admission avoidance.</p>
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)	<p>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.</p> <p>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.</p>
Cost of service	<p>4 rehab beds at a cost of £750/bed - £156,000 per annum GP's provide 1 session per week to Lady Forester at £260 per session. - £13,780 <b>TOTAL COST - £169,780</b></p>


**Disinvestment Assessment Tool**

Does the service meet the needs of the population (as identified via JSNA/needs analysis)?	<p>The 4 beds have supported with the principles of Shropshire's JSNA in relation to Ageing population and Health Inequalities.</p> <p>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.</p>
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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?	<ul style="list-style-type: none"> <li>• Potential rise in DTOC patients awaiting further non acute NHS care.</li> <li>• 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 decommissioned. A comms plan would be required to manage this.</li> <li>• In terms of admission avoidance Lady Forrester do support ICS out of hours to prevent</li> <li>• 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.</li> <li>• If we apply the 3 month termination of contract with immediate effect the beds will then close at the start of winter pressures, this</li> </ul>

	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	<p>The CHAS is delivered by GP Practices (GPs and Nurses) and has been in place since 2013/14. The service has the following objectives:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Shropshire has one of the highest number of care home beds per head of population in the region. This is growing rapidly.</li> <li>• 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.</li> <li>• 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 &gt;1:4 residents per year.</li> <li>• 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 unnecessary hospital admissions.</li> <li>• The Care Homes Advanced Scheme (CHAS) provides pro-active care to residents of nursing homes.</li> </ul> <p>Aims</p> <ul style="list-style-type: none"> <li>• Identification and risk stratification of the residents at highest risk</li> </ul>

	<ul style="list-style-type: none"> <li>• Developing a clinical care plan using an MDT approach</li> <li>• Employing consistent documentation</li> <li>• Planned regular visits to the Care Home</li> <li>• Medication reviews</li> <li>• Flagging every patient with a clinical care plan to the Out of Hours service.</li> <li>• Significant event analysis undertaken for any care home resident in the event of an unplanned admission or A and E attendance</li> </ul> <p>Outcomes</p> <ul style="list-style-type: none"> <li>• Reduced hospitalisation of patients from care homes – A&amp;E attendances and emergency admissions</li> <li>• Improved life for care home residents and enhances the quality of life for people with long-term conditions (NHS Outcomes Framework domain -2)</li> <li>• Promotes positive working relationships between care home and GP – fixed regular visits allowing communication and consistency</li> </ul>
Contract type	Enhanced service
Contract duration	N/A
Notice period required	N/A
Service metrics (activity/outcome)	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• Pro-active care to be delivered as agreed in the care plan for the duration of the project.</li> <li>• Cross referencing of those patients with mental health needs or</li> </ul>


	<p>learning disabilities who are in receipt of other services and on other practice registers.</p> <ul style="list-style-type: none"> <li>• To undertake a Significant Event Analysis for any care home resident following an unplanned admission to an acute hospital bed or A&amp;E attendance to determine cause and avoidable factors</li> <li>• To flag each care home resident with a clinical care plan to the Out of Hours Service.</li> </ul>
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?	<ul style="list-style-type: none"> <li>• The Care Homes Advanced Scheme was based upon a strong evidence-based approach to care planning</li> <li>• 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</li> <li>• 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</li> <li>• Therefore, the service has possibly run its course and could be viewed as a disinvestment opportunity.</li> </ul>
How does the service benchmark against similar services?	Not known.
Does the service deliver value for	<ul style="list-style-type: none"> <li>• The reduction in hospitalisation in this increasingly frail and elderly</li> </ul>

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?	<ul style="list-style-type: none"> <li>• The unintended consequence would be the disengagement of GP practices in the aims of the CCG.</li> <li>• This would be the perceived reduction in funding streams into primary care at a time when workload is being shifted into the community.</li> </ul>
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	 QIA CHAS 19 July 2016 TK.xlsx
Completed EIA	
Additional relevant information	

## Service Summary – Lifestyle Physiotherapy

Service title	<b>Lifestyle Physiotherapy</b>								
Provider organisation	Lifestyle Fitness								
Background	<p>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):</p> <ul style="list-style-type: none"> <li>• Radbrook Green Surgery</li> <li>• South Hermitage Medical Practice</li> <li>• Mytton Oak Medical Practice</li> <li>• Bayston Hill Medical Practice</li> </ul> <p>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.</p> <p>Lifestyle Fitness Physiotherapy has provided a service for at least 8 years without a contract review nor monitoring.</p>								
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	<table border="1"> <tr> <td>Lifestyle fitness contract value</td> <td>£109,260</td> </tr> <tr> <td>Planned activity</td> <td>5314</td> </tr> <tr> <td>£ per contact based on historical plan</td> <td>£20.56</td> </tr> <tr> <td>£ per contact based on activity</td> <td>£19.19</td> </tr> </table>	Lifestyle fitness contract value	£109,260	Planned activity	5314	£ per contact based on historical plan	£20.56	£ per contact based on activity	£19.19
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 SCHAT 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 SCHAT at no extra cost would release savings.
Are there other services in place that offer a similar service?	Yes, via SaTH and SCHAT
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 SCHAT 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	 QIA Lifestyle physio 19 July 2016.xlsx
Completed EIA	
Additional relevant information	

**Service Summary – Voluntary Sector Home from Hospital Services**

Service title	<p><b>Red Cross – Home from Hospital service (Central and North of the county)</b>  <b>Age UK – Home from Hospital (South)</b></p>
Provider organisation	Red Cross and Age UK
Background	<p>The CCG has two providers currently funded to provide Home from Hospital Services: Age UK and British Red Cross</p> <p>The last review completed on the service was in 2014.</p> <p>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.</p> <p>The core functions of the service include:</p> <ul style="list-style-type: none"> <li>• Prepare the home for discharge, to include making sure the house is warm, cleaning the fridge, changing bed linen, buying food</li> <li>• Welcome the person home</li> <li>• Assist with meals and beverages</li> <li>• Assist with mobility</li> <li>• Assist with shopping to include collecting prescriptions and pensions</li> <li>• Provide short term respite for carers</li> <li>• Loan Mobility Aids</li> <li>• Transport Service</li> <li>• Installation of pendant alarms</li> </ul> <p>The main refers into the service are ICS, Adult social care (P2P), GP's and ward staff.</p> <p>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.</p>
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)	<p>Activity reports are received every 6 months and include:</p> <ul style="list-style-type: none"> <li>• Name and profession of reviewer,</li> <li>• type of patient,</li> <li>• ward referred from,</li> <li>• number of visits made,</li> <li>• length of visit,</li> <li>• purpose of visit,</li> <li>• average duration per visit,</li> <li>• length of service required,</li> <li>• training provided to volunteers,</li> <li>• support provided to carers</li> <li>• case study</li> </ul>



	<p>The services receive over 1000 referrals per year and approx 75% of these result in face to face contact and patient support.</p> <p>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.</p>
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 vision 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?	<p>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.</p> <p>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.</p>
After taking all of the above into account, should the service be decommissioned/disinvested in/continued?	<p>The service should continue however it is not clear that this is the CCG's commissioning responsibility.</p> <p>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, befriending, 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.</p>
If the answer to the question above is yes, what are the potential cost savings?	<p>£70,259 Red Cross and £64,738 Age UK</p> <p>TOTAL AMOUNT - £134,997</p> <p>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</p>

#### Additional supporting information (embed docs)

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

### Service Summary - Moving and Handling Service

Service title	<b>Moving and Handling Service</b>
Provider organisation	Independent Living Partnership (ILP)
Background	<p>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.</p> <p>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.</p>
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)	<p>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.</p> <p>Current activity reports indicate that the service is underutilised.</p>
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 SCHAT.
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	<b>Pain Services</b>		
Provider organisation	Pain Management Solutions		
Background	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• Local secondary care providers are still experiencing challenges in relation to capacity</li> <li>• 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</li> <li>• An audit carried out by the Commissioner in 2015 showed that there was no evidence of discharged patients being further referred into secondary care</li> <li>• A procurement process has recently taken place with Board Approval being sought on Wednesday, 13<sup>th</sup> 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</li> <li>• 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</li> </ul>		
Contract type	<p><b>Current Contract</b> is fixed term to 30 November 2016 - NHS Standard Contract (Full contract)</p> <p><b>New Contract</b> 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</p>		
Contract duration	<p><b>Current contract</b> ends 30 November 2016, <b>following</b> 2month extension</p> <p><b>New Contract</b> from 1 December 2016 to 30 November 2019 with the option to extend by a further 12 months – not awarded yet</p>		
Notice period required	<p><b>Current Contract</b> - due to expire on 30 November 2016, however if decommissioning prior to this there may be redundancy implications for the incumbent service provider</p> <p><b>New Contract</b> – 12 months (however contract has not been awarded yet)</p>		
Service metrics (activity/outcome)	<b>HRG Code</b>	<b>Description</b>	<b>Actual Activity</b>
	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
	<b>Total</b>		<b>8,107</b>
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?	<p>The Service Specification for the new delivery from October states that the Service shall:-</p> <ul style="list-style-type: none"> <li>• Provide a community based pain management service</li> <li>• Provide a service which complies with latest guidance</li> <li>• Provide equity of access to service users</li> <li>• 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</li> <li>• Provide a service which ensures that patient needs can be met within community settings wherever clinically appropriate reducing the need for secondary care intervention</li> <li>• Work in partnership with a range of providers to identify further pathway development</li> </ul>
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?	<p>There are two views to consider –</p> <ol style="list-style-type: none"> <li>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.</li> <li>2. Conversely, the service could be considered to have addressed an unmet need for Shropshire patients who were previously managed within primary care.</li> </ol> <p>The budget for pain services for Shropshire CCG has had to increase since 2013/14 to address the new demand flowing from primary care.</p>



	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 a 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?	<ul style="list-style-type: none"> <li>• This service meets the requirements of NICE Guidance</li> <li>• This service could be considered to support the CCG to deliver the PLCV thresholds in relation to pain management</li> <li>• The community service shows a reduction in injection rates (and subsequent costs) from services provided at secondary care</li> <li>• 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</li> </ul>
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?	<ul style="list-style-type: none"> <li>• Increased demand for primary care services – this would be likely to have an impact upon the CCG's relationship with its members</li> <li>• 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</li> <li>• There would be a requirement to upskill primary care staff to deliver components of this service and there may be costs associated with this</li> <li>• 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)</li> <li>• 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</li> <li>• There is a view that without a community based second tier service in between primary and secondary care that patient experience would be affected</li> <li>• 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</li> </ul>
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?	<p>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 30<sup>th</sup> November).</p> <p>However, this needs to be balanced with the potential increase in activity and associated cost for secondary care referrals when paying 100% of tariff.</p> <p>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.</p>

**Additional supporting information (embed docs)**

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

## Service Summary – Oak House


Service title	<b>Oak House</b>
Provider organisation	SSSFT
Background	<p>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.</p> <p>The service comprises of skilled professionals delivering</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>The staff team know the service users very well and the service is highly valued by those that use the service.</p> <p>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.</p> <p>The current bed base is commissioned on a 60:40 split with Telford CCG</p> <p>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 respond to people with LD and complex health problems. The plan was presented 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.</p>
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
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	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 whilst 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

<b>Service</b>	<b>Workshop Outcome (1-5)</b>	<b>Potential in-year saving</b>	<b>Full Year Effect</b>
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
<b>Total – indicative savings subject to outcome of due diligence which may require some re-investment</b>		<b>£690k</b>	<b>£1952k</b>

### Appendix 3

#### Workshop Two Recommendations

<b>Service</b>	<b>Workshop Outcome Progress to step 2 / Not suitable</b>
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