Birmingham and Solihull
Clinical Commissioning Group

NHS Birmingham & Solihull Clinical Commissioning Group

Decommissioning and Disinvestment Policy

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Ratified by	Governing Body
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Name of originator/author	Angela Szabo
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Target audience	CCG staff (note policies cannot apply to practices)

Contents

1. Introduction

1.1. Due to the current challenging financial climate, it is important for the Clinical Commissioning Group (CCG) to demonstrate that it is making the most effective use of public money to commission the right care, in the right place, at the right time within the context of our resources, and in order to deliver our statutory responsibilities, and meet the needs of the Birmingham & Solihull population.

1.2. The CCG's long term plan, commissioning strategy and system transformation plan describes the challenges in financial sustainability that has inevitably led to the need to clarify the circumstances of when services should be decommissioned or disinvested.

1.3. To ensure that limited resources are consistently directed to the highest priority areas, the CCG has a Clinical Priorities Advisory Policy for the Prioritisation of Healthcare Resources, the decommissioning and disinvestment element of which is supported by this Decommissioning and Disinvestment policy.

2. Policy Statement & Scope

2.1. This policy sets out the approach and processes, that will be adopted to ensure decommissioning and disinvestment decisions are made in line with CCG governance processes and delegated limits as detailed in the Scheme of Reservation and Delegation, last approved by the CCG Governing Body in February 2019.

2.2. The outcome of the decommissioning and disinvestment review will generate a recommendation which may require a CCG commissioning case for change proposal to be approved through the CCG governance process as detailed in **Appendix C**.

2.3. The responsible programme lead for a service/contract will be required to complete the individual case for change proposal with support from the CCG's Clinical Prioritisation Officer. Where a responsible programme lead is not identified, the Clinical Prioritisation Officer may take a case for change proposal through CCG Governance processes.

3. Equality Statement

3.1. All public bodies have a statutory duty under the Equality Act 2010 to "set out arrangements to assess and consult on how their policies and functions impact on race equality". This obligation has been increased to include equality and human rights with regard to disability, age, gender, sexual orientation, gender reassignment and religion.

3.2. Birmingham and Solihull CCG endeavors to challenge discrimination, promote equality and respect human rights, and aims to design and implement services policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

3.3. All staff are expected to deliver services and provide care in a manner which respects the individuality of patients and their carers and as such treat them and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.

3.4. Managers, staff and providers where relevant, are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs.

4. Equality Analysis

4.1. In order to meet these requirements, a single equality impact analysis is used to assess all Birmingham and Solihull CCG policies, procedures and guidelines.

4.2. This policy was screened and found to be compliant with the philosophy of the Equality Statement.

5. Quality and Equality Impact Assessment

5.1. In order to ensure that the CCG remains alive to the potential impact of its strategic commissioning output on different groups, an equality impact assessment will be undertaken.

5.2. In order to ensure to ensure that the CCG fulfils is statutory duties in relation to patient experience, patient safety, effectiveness of service/interventions and an assessment of other impacts to the CCG financial or reputational, a quality impact assessment will be undertaken.

5.3. As part of the case for change process all services/contracts where decommissioning or disinvestment is proposed require a Quality and Equality Impact Assessment to be completed. The Quality and Equality Impact Assessment (QEIA) will be approved at the Clinical Policy Group (a sub-committee of the CCG's Quality and Safety Committee) and the QEIA score will be ratified by the Quality and Safety Committee. The QEIA includes patient safety, patient experience, effectiveness and also consideration of political, reputational and financial risk factors.

5.4. The individual commissioning case for change proposals will detail requirements for communications including whether consultation or engagement is required as a

result of the decommissioning or disinvestment decision. Where consultation or engagement is required and this includes presentation to the Health and Overview Scrutiny Committee for approval then this is expected to be completed before the CCG approves the case for change.

5.5. The individual commissioning case for change proposal will detail the Exit plan implications to be considered when decommissioning or disinvesting the service/contract. Only after the case for change proposal has been considered and approved through CCG governance processes should an exit plan be requested from the incumbent provider. The Exit plan should be completed by the provider and not the CCG although the CCG is able to provide a template for the exit plan if required. The CCG's responsible commissioner for the service/contract will be responsible for overseeing the execution of the exit plan with support provided by the CCG's contracting team as required.

6. Aims

6.1. The aims of the Decommissioning & Disinvestment policy are to: -

- Provide a rationale and process to allow services to be identified for review prior to any decision to decommission or disinvest.
- Deliver best value for money by ensuring that local health care resources are directed to the most effective services for the local population.
- Ensure all commissioned services are monitored in terms of performance, health outcomes, efficiency, demand management and fitness for purpose to allow for a robust decision to be made regarding the continuation of that service.
- Contribute to the delivery of the CCG's commissioning plan and Quality, Innovation, Productivity and Prevention (QIPP) agenda, to ensure that resources are directed to the highest priority area in order to achieve the best possible health outcomes for the local population against available resources.
- Ensure all decommissioning and disinvestment decisions are taken in a fully informed manner and follow a set procedure agreed by the CCG's Governing Body.
- Ensure the safety of patient remains paramount.

7. Responsibilities

7.1. **Clinical Priorities Advisory Group (CPAG)** – undertake technical assessments of proposals to inform investment and disinvestment decisions during the annual commissioning cycle, providing clinical advice and recommendations to Programme Leads, Executive Management Team (EMT), Clinical Investment & Disinvestment Committee (CID) and Governing Body (GB) as per delegated limits.

7.2. **Quality &Safety Committee (Q&S)** - Ratify the decisions recommended by its sub-committee the Clinical policy group in relation to Quality and Equality Impact Assessment (QEIA) scoring only.

7.3. **Finance & Performance Committee (F&P)** - F&P will only receive updates on the financial impact of disinvestments via the QIPP report and investments via the finance report. The output of the prioritisation process is not directly reported or monitored via F&P.

7.4. **Clinical Investment & Disinvestment Group (CID)** – Subject to agreed delegated financial limits, take account of prioritisation in the approval of investment and disinvestment decisions and make recommendations to the Governing Body where required.

7.5. **Governing Body (GB)** – reviews CID recommendations to inform a decision taking account of prioritisation in the approval of investment and disinvestment decisions subject to agreed delegated limits. Will receive and agree CPAG work plan and the prioritisation policy.

7.6. **Programme leads** – comply with the policy and its relevant procedures and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track, and monitor outcomes.

7.7. **Healthcare providers** – refer to the policy when requesting the CCG to invest in healthcare services in order to understand CCG rationale and processes to be followed.

7.8. **Patients (and their families/carers)**– may find it helpful to refer to the policy in order to understand how the CCG decides how best to invest finite resources for its patient population.

8. Definitions

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

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

9. Policy/Procedure

9.1. The CCG relies upon the Clinical Priorities Advisory Group and Policy for the Prioritisation of Healthcare Resources to set out the process for reviewing potential services and interventions for decommissioning and disinvestment review. The majority of decommissioning and disinvestment reviews will be carried out as part of the annual commissioning cycle although services, interventions and diagnostics can be considered at any time of year through the process.

9.2. The role of CPAG as outlined in the CPAG terms of reference included in **Appendix B** is to:

- Inform strategic planning including a disinvestment programme
- Inform annual commissioning cycle by recommending priorities for investment and disinvestment
- Advise on funding of in-year service developments

9.3. The prioritisation policy sets out a requirement for the CCG to review all current healthcare expenditure on an annual basis. Expenditure is analysed by both service line and by provider contracts for the responsible programme leads. Programme leads are responsible for categorising expenditure as requiring investment, no change or as requiring Decommissioning or Disinvestment review.

9.4. Programme leads submit all service lines and contracts that are subject to Decommissioning and Disinvestment review to the CCG's Clinical Prioritisation Officer for inclusion on the Clinical Prioritisation Advisory Group (CPAG) work plan list. As per the prioritisation policy the CPAG work plan list will be published on the CCG's website.

9.5. The CCG's approach to identifying suitable services/contracts for decommissioning and disinvestment review is to identify services where the following rationale applies:

- Where a diagnostic used on a particular pathway is considered as low value in progressing a patient through the pathway. This is scored through the CPAG process using the Diagnostic scorecard and where it scores below the commissioning threshold it is recommended for decommissioning or disinvestment
- Where an intervention is considered as low value and is scored through the CPAG process using the Intervention scorecard and where it scores below the commissioning threshold it is recommended for decommissioning or disinvestment
- Where there is a query around the value for money offered from the service

- Where there is no defined commissioned pathway in place, commissioner or robust contractual arrangement in place
- Contract/Service Review/Quality Information/local patient intelligence: Review of historical contracts or service reviews that indicate non-delivery of outcomes or query value for money for the delivery of outcomes
- Where NICE/NHSE/other national policy indicates low clinical benefit
- Inequity of service provision or Joint Statement of Needs Assessment or other Public Health Intelligence data
- Where Right Care/Model Hospital or Get It Right First Time data and best practice analysis identify delivery models with improved outcomes/costs
- Where business and usual service development cost pressures identify a need to potentially decommission a service to ensure maximised value for money to deliver required outcomes
- Where a service does not align with local operational plan strategic objectives, System Transformation Partnership objectives, Better Care Fund strategy and Health & Wellbeing Strategy
- Where a service does not align with CCG statutory duties and responsibilities

9.6. Following a Decommissioning and Disinvestment review of a service and/or contract a number of options will be available to the CCG. These will include:

- Do nothing
- Change the current service
- Disinvest the service
- Decommission the service

9.7. The outcome of the decommissioning and disinvestment review will generate a recommendation which may require a CCG commissioning case for change proposal to be approved through the CCG governance process as detailed in **Appendix C.** The responsible programme lead for a service/contract will be required to complete the individual case for change proposal with support from the CCG's Clinical Prioritisation Officer. Where a responsible programme lead is not identified, the Clinical Prioritisation Officer may take a case for change proposal through CCG Governance processes.

9.8. The action to be taken by the responsible programme lead following the decommissioning and disinvestment review are summarised below:

- Do nothing – no action required
- Minor changes in service specification – new service specification to be approved by the Clinical Policy Group and ratified by Quality and Safety Committee
- Change in service model, additional investment required, disinvestment or decommissioning the service/contract – case for change to be taken through CCG Governance Process.

10. Monitoring/Compliance/Reporting

10.1. The CCG's potential Decommissioning and Disinvestment service/contract review list is held and managed by the CCG's Clinical Prioritisation Officer and is reported to the Clinical Priorities Advisory Group.

10.2. All decommissioning and or disinvestment proposals will be allocated to delivery programme's for delivery though taking a case for change through CCG governance processes. The CCG's Programme Management Office will support programme's to monitor these proposals until the decommissioning or disinvestment is completed.

10.3. The CCG's Clinical Priorities Advisory Group work plan, including services/contracts under decommissioning and disinvestment review will be published on the CCG website.

11. Related Policies

11.1. The following CCG policies are relevant: -

- Policy for the Prioritisation of Healthcare Resources
- CCG Ethical framework for priority setting and resource allocation
- CCG In-Year Service Development Policy

11.2. All CCG policies are published online and can be found at: -
https://www.birminghamandsolihullccg.nhs.uk/about-us/publications/policies

12. Relevant Legislation/Guidance

- Human Rights Act 1998

- National Health Service Act 2006
- Equality Act 2010
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended). (Replacing Directions to Primary Care Trusts and NHS trusts concerning decisions about drugs and other treatments. DH 2009)

13. Appendices

Appendix A: Glossary
Appendix B: Terms of Reference of the Clinical Priorities Advisory Group (CPAG)
Appendix C: Governance Gateway process

Appendix A: GLOSSARY

BSOL: Birmingham & Solihull

CCG: Clinical Commissioning Group

CID: Clinical Investment & Disinvestment Committee

CPAG: Clinical Priorities Advisory Group

CSU: Commissioning Support Unit

DDMG: Decommissioning & Disinvestment Management Group

GB: Governing Body

GP: General Practitioner

HCB: Health Commissioning Board

NHS: National Health Service

NICE: National Institute for Clinical Excellence

QIPP: Quality, Innovation, Productivity and Improvement

SPB: Strategic Programme Board

STP: Sustainability & Transformation Partnership

Appendix B: Terms of Reference of the Clinical Priorities Advisory Group (CPAG)

TERMS OF REFERENCE

1. PURPOSE

1.1 The Clinical Priorities Advisory Group ("CPAG") is established by the Birmingham & Solihull CCG Governing Body in accordance with its Prioritisation Policy.

1.2 The purpose of the CPAG is to

a) Inform strategic planning
b) Inform annual commissioning cycle by recommending priorities for investment and disinvestment.
c) Advise on funding of in-year service developments
d) Make recommendations in respect of the above to the Clinical Investment & Disinvestment Committee and/or Governing Body

2. ROLES AND RESPONSIBILITIES

2.1 To manage the prioritisation framework of the CCG to inform investment and disinvestment decisions during the annual commissioning cycle.

2.2 To undertake an ongoing programme of work throughout the year providing explicit advice and recommendations to the Clinical Investment & Disinvestment (CID) Committee and/or the Governing Body regarding which healthcare interventions (including therapeutics, interventional procedures, technology, healthcare and public health programmes) should be the subject of investment or disinvestment.

2.3 To review existing and new commissioning policies.

2.4 To consider and make recommendations to the CID and/or Governing Body regarding innovations or service developments. These may be identified via a variety of mechanisms including, but not limited to:

a) the priorities set out in the BSOL Operating Plan 2017/19 and STP plan.
b) gap analysis by commissioning managers of currently commissioned services;

c) opportunities for improvement in productivity/efficiency or review of NICE guidance where a policy change (e.g. restricting/extending patient selection criteria for an intervention) would be required;
d) review of intervention(s) identified through the Individual Funding Request Panel;
e) outcomes of the STP proposals
f) review of interventions or new treatments identified through horizon scanning;
g) provider proposals to commission new interventions/innovations;
h) review of requests to consider interventions not covered by a) – f)

2.5 To ensure appropriate clinical input is in place, which has taken account of any potential conflicts of interest by such means as is appropriate to the scale of case for change, and ensuring that the principles and values set out in the CCG Constitution and the NHS Constitution are adhered to.

3. MEMBERSHIP

3.1 Members of the CPAG may be appointed from the BSOL CCG Governing Body or CCG clinical leads or members, or other external bodies as required to enable to the CPAG to fulfil its purpose.

3.2 The CPAG will include the following voting members. Members marked with * are clinical:

- A Clinical Lead or Governing Body GP*
- A Medicines Management representative*
- A nursing representative*
- Finance Senior Manager
- Chief Medical Officer Chair or nominated deputy* from BSOL CCG
- 1 patient representative from the Patient Participation Group (PPG)
- 1 lay representative – Governing Body Independent member

3.3 The following attendees will be invited in a non-voting capacity:

- Health watch (from both Birmingham & Solihull)
- Legal representative
- Consultant in public health (or their nominee)

3.3 Members can nominate a deputy to attend on their behalf when required.

3.4 The CPAG will nominate and agree its Chair and Vice Chair from the voting membership.

4 DECLARATION OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

4.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs [1] or any successor document will apply at all times.

4.2 Where a member of the CPAG is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

4.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice-Chair will act as Chair for the relevant part of the meeting.

4.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the CPAG, will be recorded in the minutes.

4.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Standards for Business Conduct Policy and may result in suspension from the CPAG.

[1] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/revsd-coi-guidance-june16.pdf

5 QUORACY

5.1 The quorum necessary for the transaction of business shall be **five of the core members with a minimum of 3 clinical members**.

5.2 A duly convened meeting of the Group at which quorum is present, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.

5.3 In respect of a primary care member conflict of interest, clinical representation will require a non-conflicted clinician to take the place of a conflicted member and count towards quorum, for example secondary care doctor, a clinical member of the executive team, or independent GP input/opinion. Their contribution may be via electronic/virtual means.

6 DECISION MAKING

6.1 The CPAG will use its best endeavours to make its advice and recommendations by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote in order to reach a final recommendation. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.

6.2 Only voting members of the CPAG set out at 3.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the CPAG will hold the casting vote.

6.3 Meetings of the CPAG may utilise tele-conferencing or other electronic methods to support the contribution of its members.

7 ACCOUNTABILITY

7.1 The CPAG is accountable to the Clinical Investment & Disinvestment Committee (CID) and through it, to the Governing Body. It has a direct relationship in terms of providing advice and recommendations to the Clinical Investment & Disinvestment Committee and/or CCG Governing Body (subject to delegated financial limits).

8 FREQUENCY OF MEETINGS

8.1 Meetings will usually be held monthly, but may be called at any other such time as the CPAG Chair may require.

9 REPORTING ARRANGEMENTS

9.1 The CPAG will report operationally to the Programme Review Group (PRG) and to the Clinical Investment & Disinvestment Committee or Governing Body, confirming all advice and recommendations made in respect of decisions being taken forwards via the CCG governance processes.

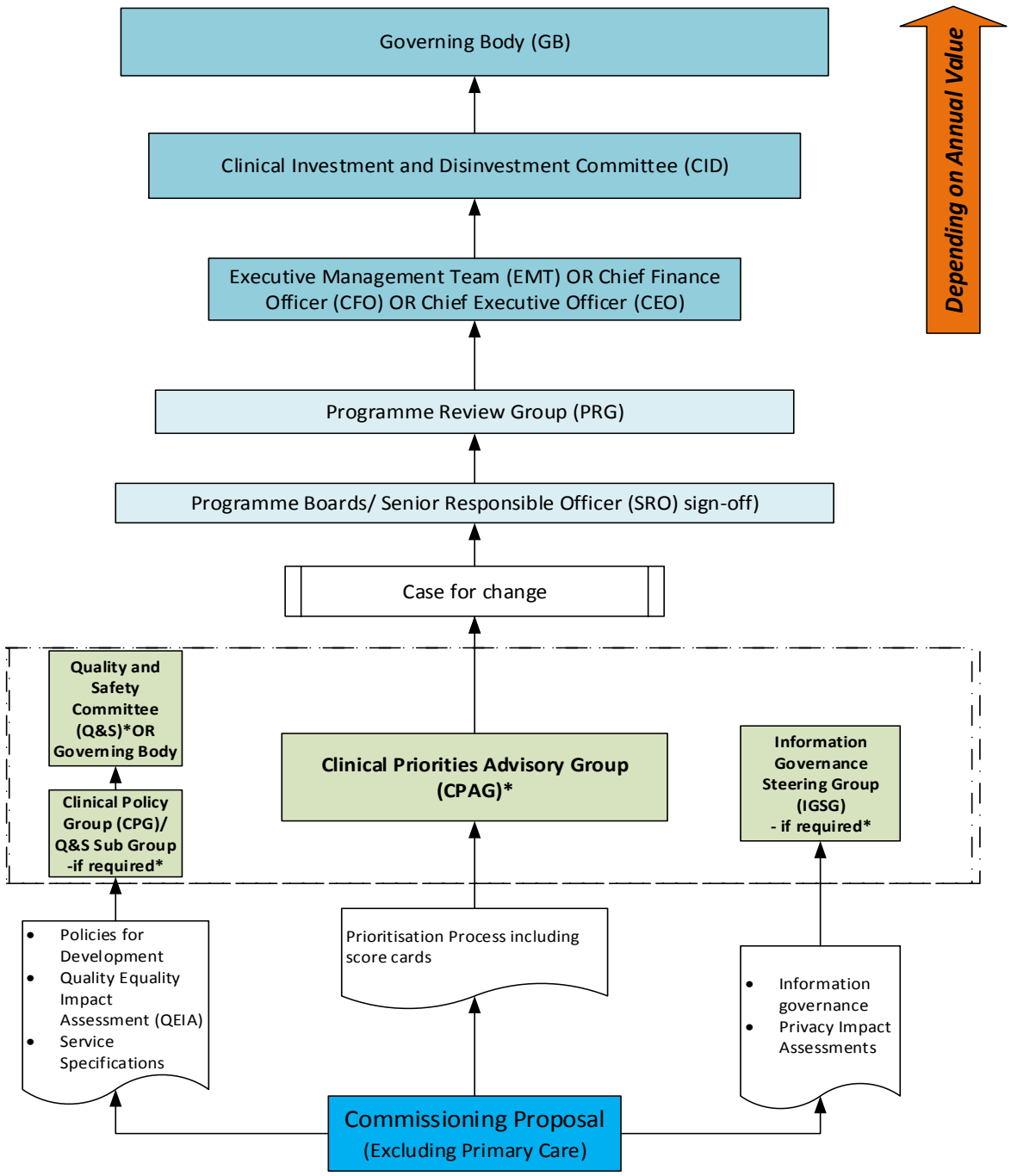
10 REVIEW DATE

10.1 These terms of reference and the effectiveness of the CPAG will be reviewed after three months and at least annually thereafter.

Appendix C: CCG governance process (subject to change)

BSOL CCG Governance

(Please refer to the Operational Delegated Limits (ODL) for specific financial limits)



*** These stages must be completed concurrently, as required before any Commissioning Proposal can proceed upwards through the Governance Process**