NHS
Southport and Formby
Clinical Commissioning Group

NHS Southport and Formby CCG Disinvestment Policy and Procedure (Cessation and Significant Reduction of Services)

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Title:	Disinvestment Policy and Procedure (Cessation and Significant Reduction of Services)
Version:	1
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Consultation and Communication:	Merseyside Equality and Inclusion Service Leadership Team Joint QIPP Committee
Approved by:	NHS Southport and Formby CCG Governing Body
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1. Background

It is important for NHS Southport and Formby 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 unprecedented financial challenges within the NHS. This policy's main objective is to connect all key programmes within the CCG that generates proposals for disinvestment with one single process and oversight procedure.

To ensure that limited resources are consistently directed to the highest priority areas, the CCG has identified the need to develop a Disinvestment (cessation and reduction of services) Policy and Procedure that sets out the agreed principles for disinvesting in a service, so that either funds can be saved or redirected where appropriate.

Disinvestment decisions will take account of clinical quality and outcomes, cost effectiveness, usage, duplication, patient satisfaction and priority of service and are made on the information and evidence available. The decisions will follow a defined process with clear stages and clear lines of accountability and responsibility. These include consideration around all our legal requirements such as: Equality legislation; Human Rights legislation and consultation with the public, providers and all interested parties.

For the purpose of this policy the following definition has been applied:

Disinvestment: This relates to the withdrawal of funding from a provider organisation such that services are ceased or significantly reduced.

Please note: When a service is going through the normal cycle or decommissioning and re commissioning, without any significant change; this process will be outside this policy and treated as business as usual.

When a programme has been identified as one of significant change but not disinvestment then the principles and process in this policy can be used.

2. Introduction

The CCG's long term commissioning strategy and financial challenges require clarity on when and how services should be disinvested and a robust procedure that will be adopted to ensure these decisions are rational and properly managed.

Where key programme reviews such as QIPP Programmes, contracts cycles or other sources identify the need to disinvest in a service, a number of stages will required to make the case for change. These will include:

- Project Initiation Document (PID) process (identifying potential savings and filtering viable ideas).
- Rightcare – Review commissioning for value
- Business case for change and evidence of usage and performance (prioritisation tool)
- Equality implications (Both pre and post consultation)

- Clinical Quality implications (Quality Impact Assessment and prioritisation)
- Consultation /engagement and communication requirements
- Correct governance and decision making processes

3. The CCG's Approach to Disinvestment

The objective of the policy is to:

- Connect with all the key programmes that generate proposals for disinvestment with one single process and oversight

The aims of this policy are to:

- Provide a lawful, rationale and robust process that demonstrates how the proposal to disinvest has been identified and actioned
- Contribute to the delivery of the CCG's commissioning strategy and priorities.
- Highlight the process in which commissioners need to take when disinvesting
- Ensure the CCG is operating within its legal parameters

4. Structure, Roles and Responsibilities

4.1 The Governing Body

The Governing Body, as the legally accountable body for NHS resources on behalf of the membership of the CCG ultimately take the decision with regard to the disinvestment of any service following the criteria and process set out in this document. The Governing Body has delegated the responsibility for oversight and delivery of QIPP and disinvestment to the Joint QIPP Committee. The Governing Body ultimately has sign off of all decisions.

4.2 Joint QIPP Committee – monitors progress of all schemes and can call in any scheme for additional scrutiny at any time.

No final decision will be made by the Joint QIPP committee on behalf of Governing Body without consideration to:

- Business case for change and evidence of usage and performance
- Equality implications
- Quality implications
- Consultation /engagement findings
- Lawfulness
- Rationality of the process
- Rationality and efficacy (clear thought through process).

4.3 Clinical QIPP Advisory Group – Is not a decision making group. It supports the QIPP Committee by ensuring there is robust clinical input and advice into clinical QIPP schemes.

The Clinical QIPP Advisory Group is the key mechanism for:

- Providing full clinical assessment of all schemes
- Evaluating potential ideas and initial proposals regarding disinvestment
- Ensuring that all legal requirements have been considered
- Reviewing the case for change and weigh the savings against the risks and prioritise accordingly
- Ensuring relevant subject matter experts from equality, clinical quality, consultation and engagement and legal
- Quality assuring and overseeing the disinvestment process
- Making recommendations to the Joint QIPP Committee for those cases the group believe should be progressed
- Advising the Joint QIPP Committee of those cases that shall not be progressed setting out the reasons why
- Reviewing and evaluating full business case (Stage 2), including equality and quality assessments
- Identifying which services will be subject to further work through the disinvestment process
- Overseeing timelines for consultation and engagement and ensure timescales are built into performance and planning
- Providing assurance that proposals are evidence based and are compliant with clinical guidelines (including NICE), the law, good practice and this policy/procedure
- Making recommendations to the Joint QIPP Committee on any other matter relevant to disinvestment or reduction in service provision

4.4 All groups, committees, wider membership and the Governing Body will operate under the following principles:

- Any conflict of interest will be declared in accordance with the CCGs policy (July 2016)
- The process will be clear and transparent
- All areas of spend will be considered
- Consideration will be given to consequences (clinical, quality, financial or otherwise)
- Work will seek to maximise in year savings as well as areas with longer term opportunities
- Proposals must consider the trade-off between scale of benefit and resource required to implement
- Recommendations should not undermine the CCG's longer term plan or Commissioning Strategy
- Recommendations must be evidently reasonable
- Recommendations must be compliant with CCG's statutory duties and responsibilities

4.5 CCG Senior Responsible Officers

4.5.1 Chief Operating Officer (and QIPP Lead)

Has responsibility for creating the governance and reporting structures to enable monitoring of QIPP plans and for providing assurance to the Governing Bodies that appropriate arrangements are in place.

4.5.2 Senior responsible Officers (SRO's)

This includes the CCG's commissioning managers and QIPP work stream leads. SRO's are responsible for the commissioned services.

They are required to undertake the following actions:

- Identify services for consideration of disinvestment or reduction in provision
- Provide an initial case for change of the service to be reviewed

Subject to recommendation by Clinical QIPP Advisory Group to the Joint QIPP Committee for approval, the SRO needs to further develop proposals by:

- Develop the full business case
- Develop equality analysis report and consultation / engagement plan, (in conjunction with subject matter experts)
- Assist the Clinical QIPP Advisory Group and joint QIPP Committee in its recommendation to the Governing Body on the disinvestment or reduction in provision of a service
- Ensure that the evidence behind why the case is being proposed for a disinvestment or reduction in service provision decision is clear and appropriate
- Ensure appropriate communications and engagement with other stakeholders via the Communications and Engagement team
- Secure any appropriate legal advice if necessary

5. Disinvestment Procedures

1) Case for change - Identification of service / idea for saving for review
2) Review and assessment by Clinical QIPP Advisory Group that will then make a recommendation for approval or advise of rejection to the Joint QIPP Committee
3) Approval to proceed, Joint QIPP Committee
4) Ratification of approval by the Governing Body
5) Full business case
6) Pre consultation equality analysis
7) Quality Impact Assessment
8) Engagement and consultation process
9) Final reports including full equality analysis, consultation report and all evidence relied on business case
10) Contractual requirements
11) Clinical QIPP Advisory Group final recommendations

12) Joint QIPP Committee approval or rejection
13) Governing Body sign off
14) Implementation
15) Exit strategy

5.1 Generating the case for change

5.1.1 The initial case for change will identify the anticipated or actual impacts of any disinvestment, including legal and reputational risks and anticipated savings.

5.1.2 The process must show that the savings will be realistic and achievable.

5.1.3 The full business case

In addition to the above, the SRO will consider the following areas:

- Workforce implications
- Market implications
- Geographic implications e.g. impact on transport links etc.
- Over supply of services
- Impact on partner organisations
- Impact on patients and public
- Political implications
- Potential exit strategy

The aim of the business case is to identify if the service:

- is no longer the statutory responsibility of the CCG
- is no longer shown to be a component of the CCG's core provision
- is not linked to a CCG priority
- no longer meets the needs of the population
- is of low or poor quality
- does not demonstrate value for money
- is of high expense and low outcomes (Rightcare)
- is demonstrating ongoing poor performance identified through the contract monitoring process and / or feedback from patients, public and partners, there is evidence of poor patient experience
- is not sufficiently meeting the health needs of the population
- does not maximise the health gain that could be achieved by reinvesting the funding elsewhere
- does not meet the standards of a modern NHS as defined by: NHS England / NICE
- is linked to professionally driven change i.e. a provider driven business case which delivers modern innovative service.
- Is linked to nationally driven change i.e. national policy or guidance requires change in service delivery.
- is over supplying due to professional assessments (need for CCG to control quality and quantity of referrals)

- is of limited clinical evidence, quality or safety
- is linked to efficiencies in delivering services (provider Cost Improvement Programmes)
- is linked to oversupply of services (duplication/ market place for patients has changed)
- Is not demonstrating value for money
- was a pilot and funding has been rolled over
- was funded through non recurrent monies and has been rolled over
- benefits and assumptions have not been realised
- is unable to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract
- does not maximise the health gain that could be achieved by reinvesting an element of the funding elsewhere
- fails to meet the standards of a modern NHS as defined by the NHS Constitution, professionally driven change and nationally driven changes

5.2 Clinical QIPP Advisory Group recommendations

Once the initial case for change has been prepared it will be presented to the Clinical QIPP Advisory Group for review.

The following will be considered by the Clinical QIPP Advisory Group when developing the case for change:

- Rational process
- Polycentric decision making (whole system approach, which is proportionate across the system)
- Managing the negative impact on the services identified for potential disinvestment and mitigating against them
- The potential destabilising effect on other services and organisations e.g.
- Council or neighbouring CCG commissioned services
- Exit Strategy
- Evidence for the recommendations taken in information such as:
    - Like for like comparisons (comparing apples and apples when considering ceasing one service of many that provide similar services).
    - Gaps in care created by disinvestment
    - Patient experience
    - Cost and performance
    - Any positive or negative impact on patient care and the wider community (i.e. carers)

Until the Clinical QIPP Advisory Group is satisfied that the case for change is robust the case for change will not be considered by any other committee.

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

Although there is no single objective measure on which such recommendations can be based, these will be fully informed taking into account the needs of individuals and the community, whilst recognising the CCG needs to achieve a financial balance, its discernment will be affected by factors such as the NHS Constitution, Sustainability and Transformation Plans (STP) guidance, NICE technology appraisal guidance and Secretary of State Directions to the NHS.

The Clinical QIPP Advisory Group will adopt a robust approach to its disinvestment or reduction in service provision recommendations by ensuring decisions are lawful and consistent.

This will be achieved by:

- Providing a coherent structure for discussion, ensuring all important aspects of each issue are considered prior to decisions being made
- Assuring that appropriate engagement and or formal consultation has taken place when and where necessary and is fed into the full equality analysis report
- Promoting fairness and consistency in decision making and with regard to different clinical topics, reducing the potential for inequity
- Providing a means of explaining the reasons behind the decisions made
- Managing the risk of judicial review by implementation of robust decision-making processes that are based on evidence of clinical and cost effectiveness and adopting a decision making framework so that decisions are made in a manner which is fair, rational and lawful
- Ensuring the vision, values and goals of the CCG are reflected in business decisions
- Ensuring any perceived or actual conflicts of interest are identified

5.3 Criteria for developing proposals for disinvesting services case for change

Legitimate reasons for disinvesting a service may be some of the following:

- The service provided is no longer the statutory responsibility of the CCG
- The service is no longer shown to be a component of the CCG's core provision
- Service not linked to a CCG priority
- No longer meet the needs of the population
- Are of low quality
- Do not demonstrate value for money
- Are of high expenditure and low outcomes (Rightcare)
- Have continued poor performance identified through the contract monitoring process and / or feedback from patients, public and partners (poor patient experience)
- Are not sufficiently meeting the health needs of the population
- Do not maximise the health gain that could be achieved by reinvesting the funding elsewhere
- Do not meet the standards of a modern NHS as defined by: NHS England / NICE
- Are linked to professionally driven change i.e. a provider driven business case which delivers modern innovative service.

- Are linked to nationally driven change i.e. national policy or guidance requires change in service delivery.
- is of limited clinical evidence, quality or safety
- Are linked to efficiencies in delivering services (Cost Improvement Programmes)
- Are linked to oversupply of services (duplication/ market place for patients has changed)
- Are possible savings linked to estates
- Are not value for money
- Over supply due to professional assessments (need for CCG to control quality and quantity of referrals)
- The original service was a pilot and funding has been rolled over
- The original service was funded through non recurrent monies and has been rolled over
- The original decision to fund a service was made on assumptions that have not realised
- There is an inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract
- The service does not deliver value for money, as demonstrated through financial review
- The investment in a service does not maximise the health gain that could be achieved by reinvesting an element of the funding elsewhere
- Service fails to meet the standards of a modern NHS as defined by the NHS Constitution, professionally driven change and nationally driven changes

No disinvestment of the service will commence until the relevant statutory requirements have been met. This would include the engagement/ consultation report and full equality analysis report and quality impact report presented to the Joint QIPP Committee for their consideration, prior to making a final decision/ recommendation to Governing Body.

5.4 Engagement and Consultation Process

Following the development of a proposal, the engagement and consultation process will commence. Advice on engagement should be sought from the Communications and Engagement Team, and Equality Teams

The CCG will communicate clearly, fully and continuously with the provider of the service and all stakeholders and **all interested parties** following any proposal for potential disinvestment or the reduction in provision of services.

The engagement and consultation will include the appropriate methods and timescales to engage with the public, patients and stakeholders and this will be informed by the pre consultation equality analysis, stakeholder analysis and matrix

An appropriate period of consultation will be undertaken and the outputs fully considered before any decision to disinvest or reduce service provision is made.

The feedback from all statutory and non-statutory consultation will be fully reviewed and analysed and will be used to assist in the decision making process.

Sefton Metropolitan Borough Council's Overview and Scrutiny Committee will be involved in line with current guidance.

5.5 Clinical QIPP Advisory Group final recommendation

Following the engagement and consultation process, the SRO will present a final report to the Clinical QIPP Advisory Group. Once the group has reviewed the information provided, a final recommendation will be presented to the Joint QIPP Committee.

The recommendation will first be shared with the provider so as to enable them to raise any final matters which may then be considered by the Joint QIPP Committee

Following the completion of statutory reports, should any indicate that disinvestment is not viable or appropriate, the outcome will be submitted to Clinical QIPP Advisory Group with a recommendation from the SRO to accept the findings and remove the proposal from the disinvestment programme. The Joint QIPP Committee will be notified and given the reason behind the decision. The Joint QIPP Committee will in turn advise the Governing Body through its key issues reporting process.

5.6 Joint QIPP Committee Approval

The Joint QIPP Committee, as the committee with delegated responsibility for QIPP decisions, will ultimately make the decision with regard to the disinvestment of any service following the criteria and process set out in this policy. The Governing Body will asked to ratify that decision.

The committee will make the appropriate decision following their review of the information:

1. **Non approval to the disinvestment recommendation**
   If the committee does not agree to the disinvestment of the service, this outcome will be communicated back to the Clinical QIPP Advisory Group, the provider and the local stakeholders. The SRO shall complete these actions.

2. **Approval to the disinvestment recommendation**
   If the Joint QIPP Committee agrees to the disinvestment of the service, this outcome will be communicated back to the Clinical QIPP Advisory group, the Governing Body, the provider and the local stakeholders. The SRO shall complete these actions and implement the exit strategy.

3. **Request more information**
   The Joint QIPP Committee may request more information if they are unable to make a final decision, this will developed and presented back to the committee within the agreed time period. The SRO shall complete these actions.

5.7 Implementation

5.7.1 Actions subsequent to approval to disinvest

Following the Joint QIPP Committee's decision to disinvest, the CCG will commence the disinvestment process.

The responsibility for serving notice to the provider is with the executive lead for that provide contract and will be done via the relevant contract manager or as otherwise determined by the CCG Accountable Officer.
The CCG, in line with the approach for transparency and openness, will provide intelligence to the provider (as part of the notification letter) as to why the service has been ceased or significantly reduced through disinvestment, *for example, the disinvestment of a service has been based on assessment of the current providers' performance, value for money and the need for service redesign to improve services for patients.*

The CCG will also communicate clearly what 'next steps' will be undertaken in the process.

5.8 Exit process

The SRO and contracts team will work closely with the provider (following notification of a decision to disinvest) on delivering the 'Exit Plan' outlining actions required by both parties for smooth service cessation/ significant reduction.

The plan will cover at a minimum:

- Patient continuity of care
- Patient records(if applicable)
- Staff
- Estate
- Equipment
- Stock (where funded by the commissioner)

The commissioner will ensure mechanisms are in place where, in conjunction with the provider, execution of the exit plan is actively managed.

Disinvestment of any service will be managed in line with the "Principles and Rules for Cooperation and Competition" regulation (2012) and related Monitor Guidelines.

https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-andcompetition

Disinvestment of any service will also be processed in line with the CCG's Financial Polices and contractual requirements.

5.9 Recordkeeping and reporting

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

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

6. Disinvestment: Stages and Flow Charts

The stages outlined below will be addressed via the CCG's QIPP process via relevant documentation (including PIDs, Business case, plans on a page, equality and quality impact assessments and other supporting materials including prioritisation tool, Rightcare, like for like assessments etc.)

The stages will enable the CCG to develop a longer term and SMART disinvestment plan.

Pre-disinvestment: CCG leaders, clinical leads and subject matter experts will produce global costings and a map of cost structure (a financial map). This will be linked with prioritisation or commissioning strategy to demonstrate:

- Where is the CCG currently spending money, across the system?
- How this spend can be explained to the public?
- How savings be identified and to understand the difference between *theoretical (when a saving can be identified but in reality can never be saved) and practical* savings- (this is when savings can be made no matter how difficult will be).
- The 'financial map' is designed to show cost centres or subject centres – This is a way of rationalising the spending to make it easier to identify where reductions can be made and where reductions are initially being targeted (this allows for a more controlled action to identify 'hard to get' savings and the process to get them, as well as easy savings and thus avoiding stripping away assets).
- The CCG will run sessions to support the development of the financial map and this will highlight potential targets for savings

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Pre-stages to disinvestment

Identify all costing

Can savings be identified (theoretical & Practical)

Financial mapping (Linked to priorities)

Stage 1: Case for change

Develop ideas linked to the financial mapping above and or any idea the SRO has identified for savings via case for change process.

The process must show:

- The initial idea
- The legal position and driver?
- The current contractual position? (is the service being delivered against this)
- The potential savings (general outline Practical over theoretical)-see above
- The proportionate saving across the whole system?
- The potential risks (legal (equality), financial reputational strategic)
- The cost structure it will be taken from?
    - Identify whether it is (and explain why):
        - Hard to implement and long term (e.g. 2 hospital services duplication- move to one service)
        - Hard to implement medium term
        - Hard to implement short term
        - Easy to implement long term
        - Easy to implement middle term
        - Easy to implement short term (recruitment freeze, non-recurrent monies)

Stage 1 Case for Change (SRO's identifying ideas for savings)

This will enable Clinical QIPP Advisory Group (QIPP) to provide over view and authorise ideas

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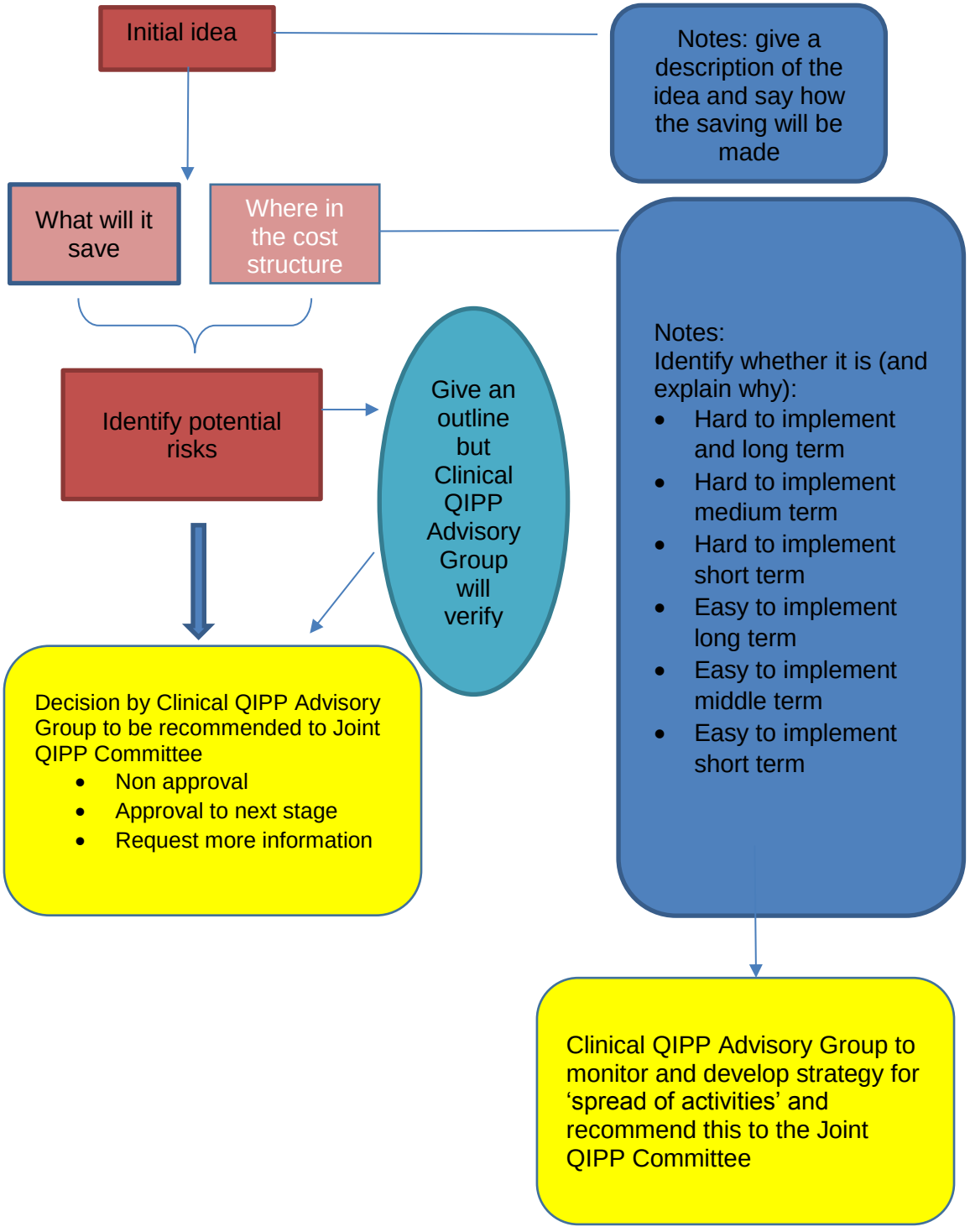


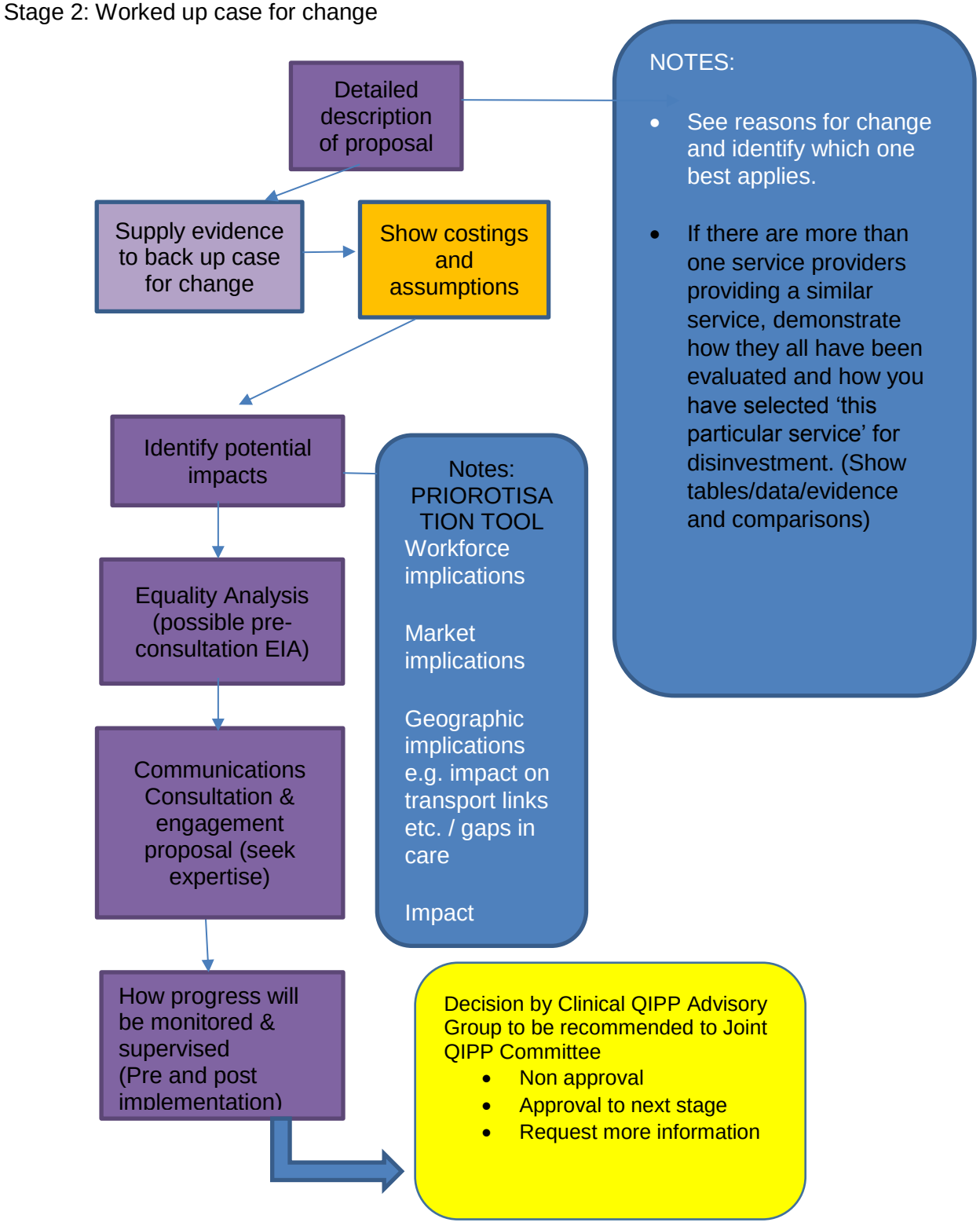
Stage 2: Project Management Office (PMO)

Fully worked up idea and developing into a case for change proposal

- Detailed description of the proposal*
- Evidence to back up case for change inc Rightcare
- Show costings and assumptions
- How process will be monitored
- Identify potential impacts
    - Workforce implications
    - Market implications
    - Geographic implications e.g. impact on transport links etc. / gaps in care
    - Impact on partner organisations
    - Impact on patients and public
    - Political implications
    - Potential exit strategy
    - Equality impact
    - Quality impact

- Pre- Equality Analysis form
- Quality Impact assessment
- Communications Plan
- Consultation/ engagement plan if required (incl: stakeholder analysis and matrix)
- implement consultation process
- analyses and present results
- Full equality assessment
- All presented to decision makers, prior to making the decision

Stage 2: Worked up case for change



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*If a service is being disinvested or there is to be a reduction in service provision – explain 'why this service was chosen':

A range of legitimate reasons for disinvestment or service reduction is given below. Please note that if one of the reasons below is not given then there is potential that the decision is of higher legal and reputational risk.

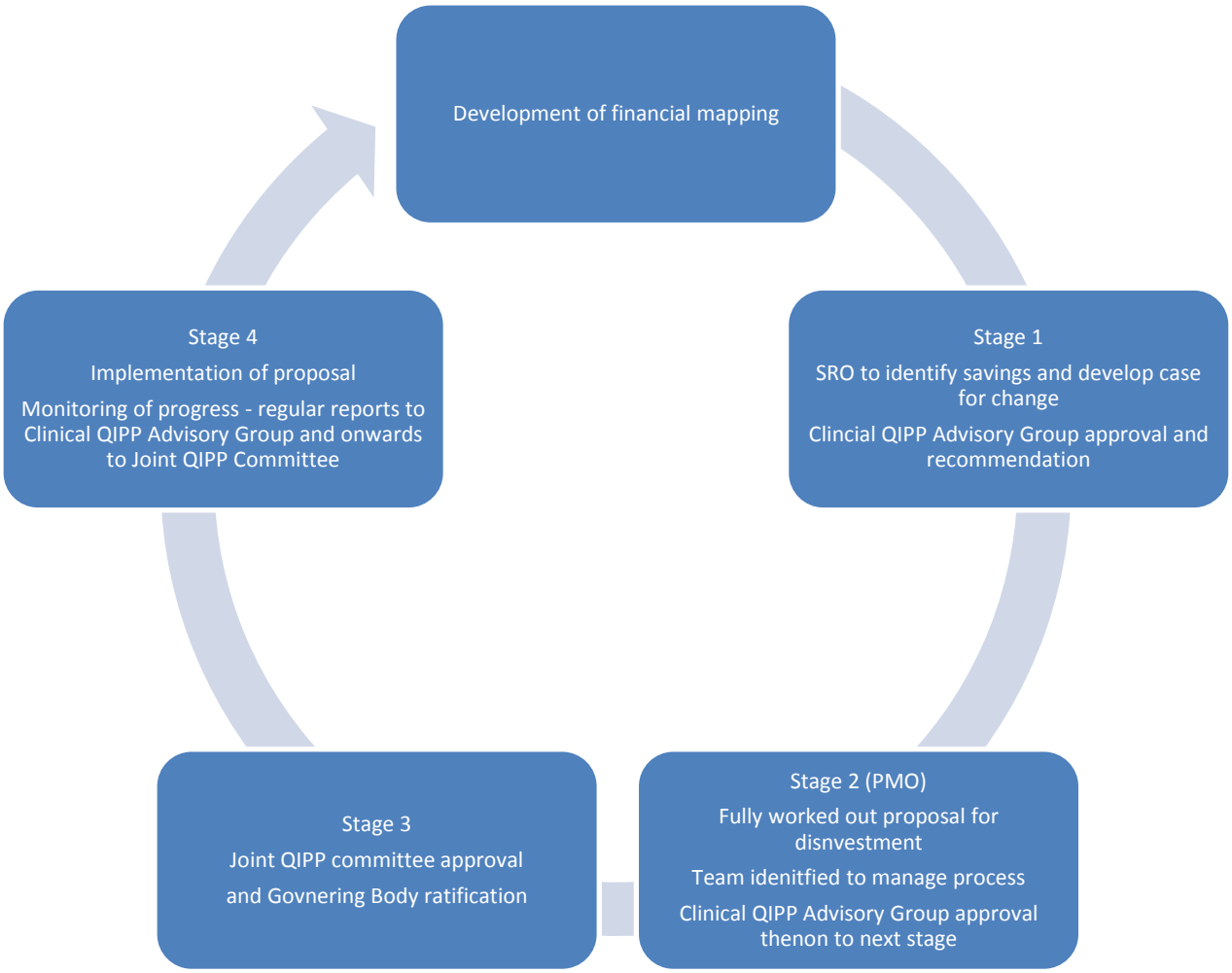
Legitimate reasons if the service;

- is no longer the statutory responsibility of the CCG
- is no longer shown to be a component of the CCG's core provision
- is not linked to a CCG priority
- no longer meets the needs of the population
- is of low or poor quality
- does not demonstrate value for money
- is of high expense and low outcomes
- is demonstrating ongoing poor performance identified through the contract monitoring process and / or feedback from patients, public and partners, there is evidence of poor patient experience
- is not sufficiently meeting the health needs of the population
- does not maximise the health gain that could be achieved by reinvesting the funding elsewhere
- does not meet the standards of a modern NHS as defined by: NHS England / NICE
- is linked to professionally driven change i.e. a provider driven business case which delivers modern innovative service.
- Is linked to nationally driven change i.e. national policy or guidance requires change in service delivery.
- is over supplying due to professional assessments (need for CCG to control quality and quantity of referrals)
- is of limited clinical evidence, quality or safety
- is linked to efficiencies in delivering services (provider Cost Improvement Programmes)
- is linked to oversupply of services (duplication/ market place for patients has changed)
- Is not demonstrating value for money
- was a pilot and funding has been rolled over
- was funded through non recurrent monies and has been rolled over
- benefits and assumptions have not been realised
- is unable to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract
- does not maximise the health gain that could be achieved by reinvesting an element of the funding elsewhere
- fails to meet the standards of a modern NHS as defined by the NHS Constitution, professionally driven change and nationally driven changes

If all above have been explored and none apply, then explain your grounds for the need to make financial savings.

*If there are more than one service provider, demonstrate how they all have been evaluated and how you have selected 'this particular service' for disinvestment. (Show tables/data/evidence and comparisons)

Work Flow



7. Prioritisation principles and Tools

7.1 Background

Distributing NHS resources is a complex activity. To date, it has been carried out mainly according to:

- historical patterns of activity and spend;
- demand as expressed by patients and healthcare professionals;
- the arrival of new technological and/or service innovations; and
- ad-hoc service pressures arising during the year.

However, allocating NHS resources today requires a different approach; demand for NHS services now exceeds the current available supply and the NHS is facing unprecedented financial challenges. This is not expected to change in the foreseeable future. This means that not all services can be provided and so prioritisation and decision making has become a pressing consideration. It is vital that decisions to prioritise services are not based on intuitive methods, incomplete information or conflict with the CCG's overall strategic goals. It is important that the impact on health is explicit when decisions are made to provide resource for some areas and not others.

Any prioritisation framework must therefore provide a robust, transparent and fair process to:

- maintain or improve (were possible) clinical quality and the health and wellbeing of the population
- be operationally more efficient;
- increase public and patient confidence;
- lawful
- achieve financial balance and ongoing financial sustainability;
- meet the requirements of good corporate governance;
- and be underpinned by a sound evidence base wherever possible

7.2 Application of the prioritisation tools

Ideas to disinvest can be based on a prioritisation tool for each service or intervention under consideration so that the evidence base can be assessed later and comparisons made. The tool sets out four evidence areas for assessing services and interventions:

- Does it work and how close is it to core priority?
- Does it add value to society/ health inequalities?
- Is it a reasonable cost to the public?
- Is it the best way of delivering the service?

Evidence in each of these areas is assessed against 18 criteria or ‘factors to consider’; they are defined in the tool and they will be subject of rigorous testing by Clinical QIPP Advisory Group and the Joint QIPP Committee

The completed information for each service/intervention/proposal under consideration will be presented by its compilers in stage 2 .

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Prioritisation Tool

Does it work?		
1.	Quality Clinical effectiveness • Patient experience • Patient Safety • effectiveness	If not effective, this does not need to go through further process, can make decision to disinvest. See Quality Impact Assessment
2.	Health gain and outcomes	Life expectancy, healthy life expectancy, quality of life and risk factors Review Rightcare – Performance compared to peer group
3	Is it over subscribed / is there an over demand	• Is there any way of controlling through put? • Are providers creating over demand (is this clinically appropriate?) • Is service underfunded?
Does it add value to society?		
4.	Strategic fit with CCG priorities and legal duties	How close is it to core priorities Is there a statutory duty to provide the service/ function? If it is a statutory duty can efficiencies be made?
5	Strategic fit with 5 Year forward view	https://www.england.nhs.uk/ourwork/futurenhs/
6	Strategic fit SDP	
7	Population and individual impact	Proportionality: a balance between the needs of a group of patients, and that of the wider community Does this only affect one particular group?
8	Health Inequities	Reduce or widen?

9	Equality implication PSED	Equality Analysis Report
Is it a reasonable cost to the public?		
10	Affordability/ efficiencies	Can we release resources for alternative uses to achieve the same aim? Can this be bought from a cheaper source? Pooling budgets with partners (What are the opportunity costs for other services or interventions (including those of partners)?
11	Cost effectiveness and value for money	Expenditure in relation to outcomes Review Rightcare – Performance compared to peer group
12	Is there over supply of services	Duplication of services
13	Through put of patients/ service users	Low through put of patients for service provision?
Is it the best way of delivering the service?		
14	Alternative services	Ward based services compared to community based services Private and Public sector versus Community Voluntary/ Third sector?
15	Impact on services elsewhere	Is there an impact for other health service (For example A&E)? Is there an impact for non-health services? For example, social services
16	Workforce implications	Will it increase or decrease or change human resources and skills mix? Will it have legal HR implications? (TUPE, redundancy, recruitment/ retention)

17	Geography	Is it in the best place to deliver the service? Rural issues Transport issues Parking access
18	Physical buildings and estates	Is it beyond service Does it need decommissioning Is it operating at full potential/ capacity