

# Decommissioning health care: identifying best practice through primary and secondary research – a prospective mixed-methods study

Iestyn Williams,<sup>1\*</sup> Jenny Harlock,<sup>1</sup> Glenn Robert,<sup>2</sup>  
Russell Mannion,<sup>1</sup> Sally Brearley<sup>2</sup> and Kelly Hall<sup>3</sup>

<sup>1</sup>Health Services Management Centre, University of Birmingham, Birmingham, UK

<sup>2</sup>Florence Nightingale Faculty of Nursing & Midwifery, King's College London, London, UK

<sup>3</sup>Department of Social Policy and Social Work, University of Birmingham, Birmingham, UK

\*Corresponding author [i.p.williams@bham.ac.uk](mailto:i.p.williams@bham.ac.uk)

**Declared competing interests of authors:** Iestyn Williams is a member of the Health Services and Delivery Research (HSDR) Prioritisation Commissioning Panel. Glenn Robert is a member of the HSDR Prioritisation Researcher-led Panel.

**Disclaimer:** This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

Published July 2017

DOI: 10.3310/hsdr05220

## Scientific summary

### Identifying best practice for decommissioning health care

Health Services and Delivery Research 2017; Vol. 5: No. 22

DOI: 10.3310/hsdr05220

NIHR Journals Library [www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)

# Scientific summary

## Background

Running any health system efficiently requires the development, adoption and use of new interventions, technologies and services. Arguably, in a context of limited resources, it is equally important to replace and remove interventions and services as these become obsolete or superseded (decommissioning). However, theory and evidence in this area suggest that perceived and real losses associated with decommissioning can make it difficult to implement, adding to financial and administrative pressures on publicly funded health systems. Policy-makers, researchers and local health leaders are increasingly turning their attention to how these challenges can be overcome in ways that maintain and/or improve overall health outcomes for patient populations.

## Research questions

The primary aim of this study was to formulate theoretically grounded, best-practice guidance for health-care managers by identifying the factors and processes that influence successful implementation and outcomes when decommissioning health services. The study addressed four research questions:

1. What is the international evidence and expert opinion regarding best practice for decommissioning in health care?
2. How and to what extent are NHS organisations currently implementing decommissioning?
3. What factors and processes facilitate the successful implementation of decisions to decommission NHS services?
4. What are the perspectives and experiences of citizens, patient/service user representatives, carers, third-sector organisations and local community groups in relation to decommissioning?

## Methods

The study comprised a multilevel investigation of decommissioning policies and programmes and was structured into four interconnecting work packages. Work package 1 scoped the project and included a summary and synthesis of published reviews on decommissioning; a mapping exercise of the national landscape of decommissioning; qualitative decommissioning narratives collected via interviews with seven leaders of previous decommissioning programmes within health and local government contexts in England; and a Delphi study of research, policy and practice designed to elucidate a consensus on current 'best practice' in relation to the decommissioning of health-care services (30 participants).

Work package 2 involved a national survey of Clinical Commissioning Groups (CCGs) in England to assess the extent and nature of current experiences of decommissioning; aims and intended outcomes of planned decommissioning; methods adopted; challenges and issues experienced in the decommissioning process; and attitudes and competencies in relation to decommissioning. In total, 56 CCGs responded (27%) and results were subjected to descriptive statistical analysis and content analysis of free-text responses.

Work package 3 involved four in-depth case studies of decommissioning programmes at varying stages of progression, ranging from initiation and development to full implementation. These varied according to the stage of decommissioning reached, geography, the scale and complexity of the decommissioning plans, expected levels of opposition and conflict, and the tier at which the decommissioning was instigated (i.e. national or local). Data collection included documentary analysis, semistructured interviews and

non-participant observation. In total, 59 interviews and 18 observations were carried out with interview samples comprising individuals involved in the design and implementation of the decommissioning programmes.

Work package 4 investigated the perspectives and experiences of citizens, patient/service user representatives, carers, third-sector organisations and local community groups in relation to decommissioning. This involved three deliberative focus group discussions with open-ended questions. During the focus groups, we co-designed, with participants, a second Delphi study (26 participants). This was intended to facilitate a consensus on best practice for the engagement of patients and the public in decommissioning processes and to enable comparison with the results from the Delphi study in work package 1 with regard to the ideal and actual drivers of decommissioning programmes.

The overall approach to data collection and analysis was informed by a conceptual framework drawing on elements of political science (interests, institutions and ideas), complex service change, aspects of actor–network theory (ANT) and a stages heuristic. We also drew on the psychological concept of loss aversion, which holds that individuals fear loss more than they value equivalent gains. In work package 1, narrative review was used to structure the evidence synthesis, and qualitative data were analysed thematically. Both Delphi studies employed consensus-building analytical methods. Case studies were analysed individually and common themes across the case study sites were identified using comparative case study methods and pattern matching.

Work package 1 informed the foci of the subsequent national survey of CCGs and case studies. Work packages 1 and 2 informed the analysis of findings from work package 3 and enabled reflections on transferability of findings. The case studies explored gaps and unanswered questions identified in work packages 1 and 2. Finally, work package 4 enabled us to compare and contrast the perspectives of policy-makers, researchers and practitioners with those of citizens, patient/service users, carers, third-sector organisations and local community groups. External validity and transferability were addressed through detailed description and data triangulation between the four work packages.

## Results

There is a developing evidence base on decommissioning processes in health care, especially in relation to the identification of therapeutic interventions for removal or replacement. The evidence is less developed in relation to the decommissioning of services, programmes and organisations and the implementation of such decisions. In these areas, there is little in the way of guidance to inform policy and practice. The study of decommissioning therefore does not extend far beyond removal and replacement of clinical interventions from within an evidence-based decision-making paradigm.

In our first Delphi survey we employed a broad definition of decommissioning that included multiple forms. Participants identified the following good-practice principles for decommissioning:

- identify and establish a strong leadership team
- engage and involve clinical leaders from an early stage
- establish a clear rationale and narrative for change
- ensure clear and thorough project planning and governance
- secure high-level political support (national and local) at an early stage
- base decisions on evidence of what works
- adopt a whole-systems perspective from the beginning.

Participants believed there to be a significant gap between the criteria that should inform decommissioning (quality and patient experience) and those that do in practice (cost and political considerations).

Survey results indicate that of the 56 responding CCGs, 77% had decommissioning activities planned. The most common intended outcome was improved cost-effectiveness, reported by 38% of CCGs, followed by patient experience (36%) and improved clinical effectiveness and greater alignment with strategic priorities (both 30%). The most common type of decommissioning activity reported by CCGs was relocation or replacement of a service from an acute to a community setting (28%), followed by removal or replacement of a service as part of reconfiguration of a service (25%) and closure of a service (14%). This suggests a mismatch between the predominant focus in the literature on the removal of individual treatments and the preoccupation in the system with other forms of decommissioning. Respondents identified limitations in the support they received and the resources and capabilities at their disposal to carry out this role.

The experiences of our case studies differed considerably. Case study 1 involved a national reorganisation of specialist services for paediatric burn care. This was led by NHS England's Trauma National Programme of Care and the national Burn Care Clinical Reference Group (CRG). The review process had been under way since 2013 and included proposals for at least one centre to lose intensive care provider status. However, the period of case study fieldwork (September 2014 to May 2016) coincided with an impasse and no significant further progress was made. Those advocating change had formulated reorganisation and decommissioning plans, but appeared to lack access to the range of resources required to implement these. The political arena in which the CRG operated was felt to be either disengaged or non-committal in respect of its plans, reflecting a perception that the service itself was somewhat lacking in profile and voice.

Case study 2 involved CCG-led decommissioning of an end-of-life home support service provided by an independent organisation to approximately 800 patients over a 4-year period. Decommissioning took place following a review by the CCG (October 2012 to March 2013). Notwithstanding apparently high patient satisfaction with the service, the review made the case for decommissioning on the grounds of weak clinical effectiveness and potential cost savings, and the CCG was able to propose and subsequently manage the closing down of the service over the period April–July 2014. Key to the success of implementing the decision to decommission was the management of the relationship with the provider who acquiesced in the proposed changes. Some concerns were nevertheless expressed regarding the availability of alternative patient pathways during service changes and arrangements for post-discharge patient monitoring.

Case study 3 focused on the decommissioning activity of an Area Prescribing Committee (APC) based in a coastal area of the south of England. Although the APC had previously sought to decommission medicines, no examples were observed during the data collection phase (November 2014 to May 2016). The shared formulary appeared to be the main mechanism by which to enact replacement or removal and the implementation of such changes was typically addressed through a gradual process of incremental patient initiation, with some historical prescribing permitted. Previous experiences of decommissioning that had not been implemented as planned had led the APC to be cautious over future plans. When decommissioning had been instigated (e.g. the deprescribing of gluten-free products), this had achieved mixed results in terms of implementation or else decisions were enacted only when supported by National Institute for Health and Care Excellence guidance. Respondents called for political leadership and enhanced evidence support from national-level health-care bodies.

Case study 4 was a CCG-led review and planned reorganisation of local primary and acute care services, involving decommissioning of a local hospital and centralisation of acute services at alternative sites. Extensive review and strategic planning for the reorganisation took place over a period of 18 months between 2014 and 2016 and involved the development of a comprehensive governance structure and engagement strategy with stakeholders, co-ordinated by a designated programme manager. The CCG made progress with planning the reorganisation but implementation subsequently stalled. Points of tension included reconciling travelling distances and access to acute services for different communities in the area, non-coterminous provider and CCG boundaries, disruption to clinical systems and pathways for treatment, and resistance by provider organisations. This case study highlights the importance of relationships between the providers involved, the system complexity, and the scale and scope of the proposed reorganisation.

Taken together, the case studies highlight the need for leaders of decommissioning processes to:

- draw on evidence, reviews and policies to frame the ‘problem’ that decommissioning is required to solve
- build actor alliances in order to legitimise decommissioning as a solution to this problem
- seek wider involvement, including of patients and community-based interest groups, in all stages of decommissioning
- devise implementation plans and time scales that take account of the structures of authority and mechanisms of enactment that are available to those leading decommissioning.

These conclusions are dependent on context. For example, the role of evidence and actors in identifying and framing a need for decommissioning rests on factors such as the scope of the project and the number of actors implicated/affected, as well as the resources that these can mobilise to oppose plans. Similarly, the unusual circumstances in the one successfully implemented case study process appear to have negated the requirement for securing high-level political support, engaging service users and stakeholders, and adopting a whole-systems perspective. By contrast, the more elaborate and well-resourced plans of other case studies had not been implemented by the time of completion of data collection.

Findings from work package 4 suggest some commonalities between the views of our second Delphi panel (made up of citizens, patient/service user representatives, carers, third-sector organisations and local community groups) with those expressed by the first Delphi panel. For example, support was given to the principle that decommissioning is not inherently illegitimate and, therefore, that there are circumstances in which replacing or removing services is both necessary and justified (although the same consensus was not found in relation to *moving* services). Both Delphi panels also considered decommissioning, in practice, to be at least partly a function of financial pressures and the need to make cost savings. However, the majority of participants in work package 4 felt this to be an unjustified basis upon which to make decisions. Their rejection of cost pressures as a basis for decommissioning was, therefore, emphatic. In this regard, our two Delphi studies indicate something of a fissure between perspectives from research, policy and practice and those of citizens, patient/service user representatives, carers, third-sector organisations and local community groups, especially with regard to the acceptability of financial constraint as a factor in decision-making.

Results from across the work packages suggest that patients and the public are unlikely to be influential in decommissioning decision-making. Opinions diverged, however, on the normative question of engagement: participants in the first Delphi survey did not rank patient and public engagement high on the list of good-practice principles, whereas participants in the second Delphi survey expressed an appetite for substantive engagement and even coproduction of decisions.

Overall, the language with which participants in work package 4 discussed decommissioning was notably different from that employed by those involved in work packages 1–3, with more emphasis on the lived effects and consequences of changes to services on users and carers, and on the losses experienced in the process.

## Conclusions

This study expands and refines an understanding of the processes related to decommissioning across a range of health-care settings and contexts. It is the first internationally to combine longitudinal case studies with a national survey and expert Delphi panel, and the first to target such a wide range of respondents. The study found that the broad categories of factors that appear to shape the outcomes of decommissioning include change management and implementation, evidence and information, and relationships and politics. The study has far-reaching implications for future practice. Overall, it finds that no decommissioning ‘blueprint’ exists and that outcomes, especially of more ambitious programmes, are hard to predict.

Managerial approaches adopted elsewhere in the system may not be sufficient in the face of the additional tensions and opposition encountered in decommissioning. For example, our findings suggest that established approaches to engagement and involvement require rethinking. In particular cases in which decommissioning is driven in part by financial pressure, we find that attempts to downplay cost savings run the risk of increasing cynicism and challenge from stakeholders who are often fully aware of the financial 'big picture'. The study confirms and adds to the theoretical literature on loss aversion via an extended appreciation of the ways in which organisations and systems attach greater value to losses than to potential gains.

Study limitations include limited opportunities for patient and public engagement in early phases of the research; however, this was mitigated by the addition of work package 4. We were unable to track outcomes of decommissioning activities within the time scales of the project and the CCG survey response rate was lower than intended. Future work should explore systematically the relationships between contexts, mechanisms and outcomes in decommissioning and further develop the notion of loss aversion in health service contexts. Longitudinal research should explore the long-term impact of decommissioning across health economies and the impact on patient care and outcomes.

## Funding

Funding for this study was provided by the Health Services and Delivery Research programme of the National Institute for Health Research.

# Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) ([www.publicationethics.org/](http://www.publicationethics.org/)).

Editorial contact: [journals.library@nihr.ac.uk](mailto:journals.library@nihr.ac.uk)

The full HS&DR archive is freely available to view online at [www.journalslibrary.nihr.ac.uk/hsdr](http://www.journalslibrary.nihr.ac.uk/hsdr). Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: [www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)

## Criteria for inclusion in the *Health Services and Delivery Research* journal

Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

## HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: <http://www.nets.nihr.ac.uk/programmes/hsdr>

## This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its preceding programmes as project number 12/5001/25. The contractual start date was in May 2013. The final report began editorial review in September 2016 and was accepted for publication in March 2017. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

**© Queen's Printer and Controller of HMSO 2017. This work was produced by Williams *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.**

Published by the NIHR Journals Library ([www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)), produced by Prepress Projects Ltd, Perth, Scotland ([www.prepress-projects.co.uk](http://www.prepress-projects.co.uk)).

## **Health Services and Delivery Research Editor-in-Chief**

**Professor Jo Rycroft-Malone** Professor of Health Services and Implementation Research, Bangor University, UK

## **NIHR Journals Library Editor-in-Chief**

**Professor Tom Walley** Director, NIHR Evaluation, Trials and Studies and Director of the EME Programme, UK

## **NIHR Journals Library Editors**

**Professor Ken Stein** Chair of HTA and EME Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

**Professor Andree Le May** Chair of NIHR Journals Library Editorial Group (HS&DR, PGfAR, PHR journals)

**Dr Martin Ashton-Key** Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

**Professor Matthias Beck** Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

**Dr Tessa Crilly** Director, Crystal Blue Consulting Ltd, UK

**Dr Eugenia Cronin** Senior Scientific Advisor, Wessex Institute, UK

**Ms Tara Lamont** Scientific Advisor, NETSCC, UK

**Dr Catriona McDaid** Senior Research Fellow, York Trials Unit, Department of Health Sciences, University of York, UK

**Professor William McGuire** Professor of Child Health, Hull York Medical School, University of York, UK

**Professor Geoffrey Meads** Professor of Health Sciences Research, Health and Wellbeing Research Group, University of Winchester, UK

**Professor John Norrie** Chair in Medical Statistics, University of Edinburgh, UK

**Professor John Powell** Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

**Professor James Raftery** Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

**Dr Rob Riemsma** Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

**Professor Helen Roberts** Professor of Child Health Research, UCL Institute of Child Health, UK

**Professor Jonathan Ross** Professor of Sexual Health and HIV, University Hospital Birmingham, UK

**Professor Helen Snooks** Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

**Professor Jim Thornton** Professor of Obstetrics and Gynaecology, Faculty of Medicine and Health Sciences, University of Nottingham, UK

**Professor Martin Underwood** Director, Warwick Clinical Trials Unit, Warwick Medical School, University of Warwick, UK

Please visit the website for a list of members of the NIHR Journals Library Board:  
[www.journalslibrary.nihr.ac.uk/about/editors](http://www.journalslibrary.nihr.ac.uk/about/editors)

**Editorial contact:** [journals.library@nihr.ac.uk](mailto:journals.library@nihr.ac.uk)