NHS
Scarborough and Ryedale
Clinical Commissioning Group

CCG Primary Care Rebate Schemes Policy (PCRS) November 2017

Authorship:	Strategic Lead Pharmacist			
Committee Approved:	Finance and Governance Committee			
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	Relevant	Screening	Full / Completed	Outcome
Equality Impact Assessment	Yes	Yes	No	No Issues Identified
Sustainability Impact Assessment	Yes		Yes	No Issues Identified
Privacy Impact Assessment	No	N/A	N/A	Not applicable
Bribery Checklist	Yes		Yes	Outlined in Section 3.3
Target Audience:	All CCG Staff and General Practitioners			
Policy Reference No:	P801			
Version Number:	2.0			
Publication/Distribution	Website	Email Staff	Others (i.e. SBC)	
	Yes	*Yes*	*Yes (GPs)*	

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Ammended by	Nature of Amendment	Approved by & Date	Date on Intranet
V1	SRCCG	Final Version	Governing Body March 2015	March 15
V2	Strategic Lead Pharmacist	Full Review	F&C Committee November 2017	January 18

Approval Record

Applicable Y/N	Committee / Group	Consultation / Ratification	Date taken to group	Date last Approved
Yes	Governing Body	Ratification	March 15	March 15
	Council of Clinical Representatives	Ratification		
	SMT	Ratification		
	Remuneration Committee	Ratification		
	Audit and Governance Committee	Ratification		
Yes	Finance and Contracting Committee	Ratification	November 17	November 17
	Business Committee	Ratification		
	Communications and Engagement Committee	Ratification		
	Other	Ratification		
	All Employees	Consultation		
	Public	Consultation		
	Yorkshire and Humber Social Partnership Forum	Consultation		

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1 INTRODUCTION

A number of manufacturers have established 'rebate schemes' for medicinal products used in primary care. Under the terms of such a scheme, the NHS is charged the Drug Tariff price for primary care prescriptions dispensed, the manufacturer then provides a rebate to the primary care organisation based on an agreed discount price and verified by ePACT data. Such schemes are being offered to Clinical Commissioning Groups (CCGs) by the pharmaceutical industry in relation to named products.

A rebate scheme is a confidential contractual agreement between the manufacturer and commissioner offering a rebate of part of the cost of a specified product, or products based on usage. Most schemes offer straight percentage discounts but some more complex versions may be offered.

2 ENGAGEMENT

This policy has been developed by the Strategic Pharmacist Lead in line with policy adopted by neighbouring CCGs, namely Airedale, Wharfdale and Craven. The document is based on good practice recommendations from the London Procurement Partnership.

3 IMPACT ANALYSES

3.1 Equality

In developing this policy, an Equality Impact Analysis (EIA) has been undertaken and the results are published with this policy on the CCG website. As a result of the initial screening, the policy does not appear to have adverse effects on people who share protected characteristics and no further actions are recommended at this stage.

In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

3.2 Sustainability

The policy has been assessed against the CCG's sustainability themes using a sustainable impact assessment (SIA) and there is no anticipated detrimental impact. The results of the SIA are published with the policy on the CCG website.

3.3 Bribery Act 2010

The CCG follows good NHS business practice as outlined in the Business Conduct Policy and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the development of this policy document and it is felt that the Bribery Act is particularly relevant to this policy.

The reimbursement of expenses made to participants is in no way intended as a bribe and they should feel free to express their views openly and honestly.

CCG staff should be aware that they cannot make any promises to participants regarding influencing changes to future policies or CCG decisions in return of their support and engagement.

It should be noted that the Act makes bribery a criminal offence and there are four offences:

- bribing, or offering to bribe, another person:
- requesting, agreeing to receive, or accepting a bribe:
- bribing, or offering to bribe, a foreign public official:
- failing to prevent bribery

All individuals should be aware that in committing an act of bribery they may be subject to a penalty of up to 10 years imprisonment, an unlimited fine, or both. They may also expose the organisation to a conviction punishable with an unlimited fine because the organisation may be liable where a person associated with it commits an act of bribery.

Further information on the Bribery Act can be found at www.opsi.gov.uk/acts.

4 SCOPE

This policy applies to Scarborough & Ryedale CCG and all of its employees, members of the CCG, co-opted members, members of the Governing Body and its committees as well as employees of HaRD CCG medicines management team providing services to the CCG. All must comply with arrangements outlined in this policy.

The policy should be used in conjunction with the following policies:

- Standing Financial Orders and Instructions
- CCG Commercial sponsorship policy.

5 Confidentiality

Anyone voluntarily involved in CCG business may have access to information of a sensitive nature. Where this is the case, they will be required to sign a confidentiality agreement. It is the responsibility of the relevant Project Lead to ensure they have access to this, as appropriate.

6 POLICY PURPOSE AND AIMS

Rebate agreements usually take the form of legal agreements between the manufacturer and the CCG. The aim of this policy is to provide a framework for managing rebates in a legal and ethical way to ensure that:

- each scheme is only signed off if it provides good value for money to the public purse and its terms are in line with organisational vision, values, policies and procedures.

- the CCG is transparent in its process for considering these schemes.
- clear process for approving and scrutinising agreements is in place that is independent from formulary and prescribing decisions.

7 DEFINITIONS

Rebate: Primary care rebate schemes are contractual arrangements offered by pharmaceutical companies, or third party companies, which offer financial rebates on GP prescribing expenditure for particular branded medicine(s).

8 ROLES, RESPONSIBILITES AND DUTIES

8.1 Chief Finance Officer

- Provides oversight of all aspects of this policy to ensure organisational compliance
- Provides regular reports to the Finance & Contracting Committee
- Is authorised to sign rebate agreements of behalf of the CCG
- Ensures rebates are claimed in a timely fashion.

8.2 Medicines management team

- Review offered rebate schemes in line with criteria detailed within section 10 of this policy, including consideration of external reviews, for example those carried out by PrescQIPP.
- Provide an appraisal and recommendation to the contracts and finance teams and the Chief Finance Officer.
- Ensures this policy is adhered to in all decisions relating to acceptance or refusal of rebates.

8.3 Finance & Contracting Teams

- Contracts team will review the rebate offer prior to sign off by the Chief Finance Officer.
- Finance team will reclaim rebate monies from the administrator of the scheme.

9 Legal Advice

Legal opinion states that primary care rebate schemes are not unlawful and are within the powers of CCGs to agree to, provided they meet certain requirements. The detailed legal advice obtained by the London Procurement Partnership has been shared within the NHS. It is accepted that Scarborough & Ryedale CCG may wish to take further legal advice on any point identified and on the content of any particular scheme prior to entering into any agreement.

10 Overarching Principles

It is preferable for pharmaceutical companies to supply medicines to the NHS using transparent pricing mechanisms, which do not create an additional administrative burden to the NHS. Any medicine should only be agreed for use within a rebate scheme if it is

believed to be appropriate for a defined cohort of patients within a population. It is important that all patients continue to be treated as individuals, and acceptance of a scheme should not constrain existing local decision making processes or formulary development. This is in line with DH document (gateway reference 14802) on Strategies to Achieve Cost-Effective Prescribing (2010)[2]. This states that the following principles should underpin local strategies:

i. The decision to initiate treatment or change a patient's treatment regime should be based on up-to-date best clinical evidence or guidance, e.g. from the National Institute for Health and Clinical Excellence (NICE) or other authoritative sources;
ii. Health professionals should base their prescribing decisions on individual assessments of their patients' clinical circumstances, e.g. patients whose clinical history suggests they need a particular treatment should continue to receive it;
iii. The individual patient (and their guardian or carer where appropriate) should be informed about the action being taken and suitable arrangements should be made to involve the patient, ensuring they have an opportunity to discuss a proposed switch of medicines, and to monitor the patient following any switch;
iv. Prescribers should be able to make their choice of medicinal products on the basis of clinical suitability, risk assessment and value for money;
v. Schemes should be reviewed whenever relevant NICE or alternative guidance are updated.

11 Principles of the Primary Care Rebate Scheme

The detailed content of primary care rebate schemes offered to primary care organisations will differ between schemes. Any rebate scheme must be compatible with the effective, efficient and economic use of NHS resources. These Good Practice Principles can help the CCG in assessing these schemes. The CCG will need to be assured that the schemes offered do not breach any other UK legislation, in particular, reimbursement for pharmaceutical services according to the Drug Tariff, duty to comply with the DH's controls on pricing made under the 2006 Act, the Medicines Act, the Human Medicines Regulations 2012, the Bribery Act 2010, EU law and the public law principles of reasonableness and fairness.

Scarborough & Ryedale CCG will adopt the following Principles when deciding whether to participate in a PCRS or not.

11.1 Product Related

- PCRS will only consider a medicine that is already commissioned and included in the Scarborough & Ryedale joint formulary, and its place in a care pathway has already been established through the York and Scarborough Medicines Commissioning Committee and ratified by Scarborough & Ryedale CCG Business Committee.
- The price of a medicine will be considered but this consideration will be secondary to the clinical need for the medicine and its place in established pathways.
- Health professionals should always base their prescribing decisions primarily on assessments of the individual patient's clinical circumstances. The impact of a rebate scheme is a secondary consideration.

- The CCG will not consider or promote unlicensed or ‘off-label’ uses of medicines as part of a PCRS. Furthermore, a PCRS for a drug or product must be linked to total use of that drug and not limited to particular indications for which that drug can be used, and in line with the Specific Product Characteristics (SPC) for the drug in question.
- All recommendations for use of a medicine within a PCRS must be consistent with the UK Marketing Authorisation of the medicine in question, i.e. the PCRS should only advocate the use of the drug in line with the data sheet/Specific Product Characteristics (SPC) for the drug in question.
- Medicines recommended by NICE not to be prescribed will not be considered under a PCRS.
- Any product rejected by the S&R MCC will not be considered under a PCRS.
- PCRS are not appropriate for medicines in Category M and some medicines in Category A of the Drug tariff because of potential wider impact on community pharmacy reimbursement. Advice should be sought from the Strategic Lead Pharmacist or Head of Medicines Management for any Category A products.

11.2 Rebate Scheme Related

- All decision making processes will be clinically-led and involve all appropriate stakeholders as relevant.
- PCRS should not be linked directly to requirements to increase market share or volume of prescribing.
- Rebate schemes should be approved through robust local governance processes that include the approval of the Medicines Management Team and Medicines Commissioning Committee, involving both primary and secondary care.
- The administrative burden to the NHS of setting up and running the scheme must be factored into assessment of likely financial benefit of the scheme. Consideration should be given to audit requirements, financial governance, data collection, any other hidden costs and practical issues such as the term of agreement. There will be no requirement to collect or submit to the manufacturer any data other than volume of use as derived from ePACT data.
- All negotiations around a scheme should be expressed as being "subject to contract" i.e. not binding until the formal contract has been signed by both parties.
- PCRS agreements should include a right to terminate on notice (i.e. without having to have any reason for doing so) with a sensible notice period e.g. three or six months. The need for exit criteria and an exit strategy should be considered before a scheme is agreed. It is essential to allow flexibility to respond to emergence of significant new clinical evidence, or significant changes in market conditions. A shorter notice period should be agreed in these circumstances

12 Interface with the pharmaceutical industry

The CCG must be able to demonstrate that all suppliers wishing to offer rebates are provided with equal access. When appointments to discuss a rebate offer are requested, the supplier should be provided with a copy of this policy. Meetings to discuss rebates should be attended by a senior member of the Medicines Management Team.

Suppliers should not make guideline or formulary positioning conditional to any rebate offer. Equally, the CCG must not offer or expect any favourable positioning of a product with respect to the local formulary in return for a rebate offer. To avoid misunderstandings, meetings pertaining to rebates must not consider formulary or guidelines status, the positioning relative to competitor products, links to medicines switch programs or any other actions resulting from the rebate offer. This includes the execution of any medicines change programmes by the CCG.

Suppliers must not discuss any potential joint working arrangements, medical education goods and services, sponsorship offers or patient support programmes. Exceptions are where these elements are explicitly part of the commercial offer and are included in a legal contract (i.e. these elements must have been specified in writing in advance of any meetings to discuss rebates schemes).

In the event of the above not being adhered to in a meeting, the meeting must be terminated immediately and the incident should be reported to the Accountable Officer to ascertain appropriate action.

13 Contracts

The CCG Chief Finance Officer must ensure that a formal written contract is in place, signed by both parties to ensure:

- The terms of the scheme are clear.
- Legal protection is maximised.

All negotiations around a scheme should be expressed as being "subject to contract" i.e. not binding until the formal contract has been signed by both parties.

PCRS agreements should include a right to terminate on notice and without having to have any reason for doing so (See section 10.2).

Freedom of Information issues (see section 13 – Information Governance) should be discussed with the manufacturer before a commissioner enters into any agreement with them and should be contained in the contract.

14 Information Governance

Scarborough & Ryedale CCG supports the principles of transparency enshrined in the Freedom of Information Act. PCRS often contain confidentiality clauses which may restrict what information may be disclosed under Freedom of Information. The CCG will publish its policy for accepting rebate agreements.

Whilst manufacturers often attempt to impose requirements for confidentiality that would restrict the CCG from disclosing the existence and level of any discount to any third party, the CCG recognise that such agreements are likely not to be in the interests of the NHS. This is on the basis both that it will compromise the ability of the CCG to evaluate whether it is obtaining the best possible terms and that in the medium to longer term it is likely to lead to price inflation.

The CCG will ensure that all PCRS agreements meet the requirements of the Data Protection Act, and patient confidentiality must never be compromised.

The Freedom of Information Act 2000 provides the right of public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities, unless there is a good reason for them not to. This may be described as a presumption or assumption in favour of disclosure. The CCG fully supports the principle of openness and accountability.

There may be occasions where specific information requested is considered to be exempt under section 43 “Commercial Interests” of the Freedom of Information Act. Some information appertaining to rebate agreements may meet the criteria advised by the Information Commissioner’s Office as being “Commercial in Confidence”. This Exemption would only be applied where the information requested would be considered to prejudice the commercial interests of the company to which it relates. This would be decided on a case by case basis.

The CCG supports the principle openness about its activities. Any decision from the Information Commissioners Office to disclose information must be adhered to.

15 Use of Rebates

It is vital that any funds received by the CCG as part of a rebate are managed in a transparent, legal and ethical way. As a rebate, the funds will initially and primarily be returned to the CCG prescribing budget as a credit to expenditure.

Oversight for any spending plans, redistribution of funds and control of destination budgets will be provided by the Chief Finance Officer.

No one individual should be in a position to benefit personally from the level of rebate received by the CCG.

16 IMPLEMENTATION

This policy will be published on the CCG website and all staff will be made aware of its publication through communications and team meetings.

A CCG senior pharmacist and GP Prescribing Lead will be responsible for assessing schemes against the principles outlined in section 10 above. The ‘Rebate Scheme Decision Form’ (Appendix 4) will be used to record assessment against the principles and provide a recommendation to the Chief Finance Officer, who is responsible for final approval of rebate agreements on behalf of Scarborough & Ryedale CCG.

The CCG Finance and Contracting Committee will be presented with a copy of the “Rebate Scheme Decision Form” at the next committee meeting for scrutiny.

Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the CCG’s disciplinary procedure’.

17 TRAINING AND AWARENESS

The Senior Management Team and line managers are responsible for ensuring that all staff are aware of the policy which will be available on the CCG intranet.

18 MONITORING AND AUDIT

Primary Care rebates are monitored and authorised by the Finance and Contracting Committee.

19 POLICY REVIEW

The policy and procedure will be reviewed at least every two years by the CCG in conjunction with managers, and Trade Union representatives if appropriate, with changes made as required and the outcome published. Where review is necessary due to legislative change, this will happen immediately.

Finance and Contracting Committee has delegated responsibility for monitoring and reviewing the policy and will report any concerns to the Governing Body.

20 REFERENCES AND ASSOCIATED DOCUMENTATION

The policy should be used in conjunction with the following policies:

- Standing Financial Orders and Instructions
- CCG Commercial sponsorship policy.

20.1 References

- London Procurement Programme Legal Response from DAC Beachcroft LLP – Personnel Communication
- Department of Health. Strategies to Achieve Cost-Effective Prescribing (2010)

20.2 Associated Documents

The following were used as the basis of this policy:

- Principles and Legal Implications of Primary Care Rebate Schemes. London Procurement Programme, 2012.
- Ethical Framework for Considering Rebate Agreements from Pharmaceutical, Nutrition and Device Companies. Greater Manchester Commissioning Support Unit, 2013.
- PrescQIPP Pharmaceutical Industry Scheme Governance Review Board, 2014.

21 Appendices

Appendix 1 Equality Impact Assessment

Appendix 2 Sustainability Impact Assessment

Appendix 3 Primary Care Rebate Scheme Approval Process

Appendix 4 Primary Care Rebate Scheme Decision Form

22 APPENDIX ONE – EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Strategy Policies

General Information		
Policy:	Primary Care Prescribing Rebate Policy	
Date of Analysis:	January 2018 (review)	
Policy Lead: **(Name, job title and department)**	Strategic Lead Pharmacist	
What are the aims and intended effects of this policy?	Rebate agreements usually take the form of legal agreements between the manufacturer and CCG. It is important that Scarborough & Ryedale CCG has a policy to support evaluation and sign off of rebate schemes to ensure that each scheme is only signed off if it provides good value for money to the public purse and its terms are in line with organisation vision, values, policies and procedures and to ensure that the CCG is transparent in its process for considering these schemes. This policy provides a framework for managing rebates in a legal and ethical way. The principles outlined in this policy document allow for the objective evaluation of schemes submitted to the CCG and a clear process for approving and scrutinising agreements.	
Are there any significant changes to previous policy likely to have an impact on staff, patients or other stakeholder groups?	None	
Please list any other policies that are related to or referred to as part of this analysis	Standing Financial Orders and Instructions CCG Commercial sponsorship policy.	
Who is likely to be affected by this policy?	General Public	
	Service Users	
	Staff	X
What engagement / consultation has been done, or is planned for this policy and the equality impact assessment?		

Promoting Inclusivity and NHS Scarborough and Ryedale CCG's Equality Objectives. How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation? How does the policy promote our equality objectives	

Equality Data

Age

Data provided below is from Census 2011

Age Range	Number	%
0-14	17,672	14.9
15-44	39,530	33.2
45-64	15,427	13.0
65-74	9,083	7.6
85+	3,820	3.2

Gender

JSNA 2016

	%
Male Residents	49.6
Female Residents	50.4

Race / Nationality

BME – 2011 Census Data

	%
White	97.5
Mixed	0.8
Asian	1.2
Black	0.2
Other	0.2

Languages – 2011 Census Data

	%
English	97.5
Polish	0.8
Other EU Language	0.6
Other	1.86

Gypsy and Travellers – 2011 Census Data

Scarborough	37
Ryedale	81

Disability

2011 Census Data

	%
Long Term Health Problem/Disability	21.3
Limiting Long Term Illness	20.4

Projecting Adult Needs and Service Information (PANSI)-2017 Estimates

	Scarborough	Ryedale
Limiting Long Term Illness - day to day activities limited a little	7,507	3,455
Limiting Long Term Illness - day to day activities limited a lot	6,513	2,462
Mobility - unable to manage at least one activity on their own	5,210	2,509
Learning Disability – Including Down's syndrome	947	469
Learning Disability – Autistic Spectrum Disorders and Down's Syndrome	81	134
Visual Impairment - Moderate or severe	3,323	1,588
Hearing Impairment – some hearing loss	17,167	8,370
Hearing Impairment – Moderate or Severe	2,215	1,070
Dementia	1,973	959
Depression	2,474	1,585
Learning Disability – Baseline	1,454	708
Learning Disability – Moderate - Severe	415	1,128
Learning Disability – Autistic Spectrum Disorders	592	289
Learning Disability – Down's syndrome	38	18
Physical Disability – Moderate	5,176	2,620
Physical Disability – Serious	1,605	824
Physical Disability – Personal Care	3,198	1,639
Visual Impairment – Serious	39	19
Hearing Impairment – Some hearing loss	69,328	3,565
Hearing Impairment – Severe	395	203
Mental Health Problems	4,331	2,096

Sexual Orientation

In relation to sexual orientation, local population data is not known with any certainty. In part, this is because until recently national and local surveys of the population and people using services did not ask about an individual's sexual orientation. However, nationally, the Government estimates that 5% of the population are lesbian, gay or bisexual communities.

Gender Reassignment

There are not any official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society - www.gires.org.uk) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000, i.e. 10,000 people, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men). However, there is good reason, based on more recent data from the individual gender identity clinics, to anticipate that the gender balance may eventually become more equal.

Religion / Belief

2011 - Census Data

	%
Christian	67
Buddhist	0.3
Hindu	H0.1
Jewish	0.1
Muslim	0.5
Sikh	0.1
Other Religion	0.4
No Religion	24.3
Religion not stated	7.4

Pregnancy and Maternity

	Live Births (ONS 2016)	Still Births (ONS 2016)
Scarborough	1,034	4
Ryedale	439	2

Marriage and civil partnership

Data provided below is from Census 2011

	Number	%
Single	32,890	28.2
Married	57,934	49.7
In registered same sex civil partnership	259	0.2
Separated (incl civil partnership)	2,866	2.5
Divorced (incl civil partnership)	12,043	103
Widowed	10,486	9

This protected characteristic generally only applies in the workplace.

Assessing Impact

Is this policy (or the implementation of this policy) likely to have a particular impact on any of the protected characteristic groups?

(Based on analysis of the data / insights gathered through engagement, or your knowledge of the substance of this policy)

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and, if applicable, justification where a *Genuine Determining Reason*[1] exists (see footnote below – seek further advice in this case)
Gender	X			
Age	X			
Race / ethnicity / nationality	X			
Disability	X			
Religion or Belief	X			
Sexual Orientation	X			
Pregnancy and Maternity	X			
Transgender / Gender reassignment	X			
Marriage or civil partnership	X			

What measures have been put in place to mitigate any potential impact?

Not applicable

1. [1] *The action is proportionate to the legitimate aims of the organisation (please seek further advice)*

Action Planning:

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse impact or strengthen the promotion of equality?

Identified Risk:	Recommended Actions:	Responsible Lead:	Completion Date:	Review Date:

Sign-off

All EIAs must be signed off by a member of SMT
I agree with this assessment / action plan
Signed off by (Name/Job Title)
Signed: Richard Mellor
Date: November 2017

23 APPENDIX TWO – SUSTAINABILITY IMPACT ASSESSMENT

SUSTAINABILITY IMPACT ASSESSMENT

Instructions

Sustainability is one of the CCG's key priorities and consequently the CCG has made a corporate commitment to address the environmental effects of its activities across all service areas. The purpose of the Sustainability Impact Assessment is to record any positive or negative impacts that a Policy / Board Report / Committee Report / Service Plan / Project is likely to have on each of the CCG's sustainability themes. The Sustainability Impact Assessment enables any relevant impacts to be identified and potentially managed.

The Sustainability Impact Assessment is based on assessing the impact of the activity against a series of criteria covering environmental sustainability issues. It would be most desirable for activities to score positively in as many areas as possible, although it is likely that some areas will score positively against some themes, and negatively against others.

Using the Sustainability Impact Assessment template

To complete the Sustainability Impact Assessment template, you should consider whether the Policy / Board Report / Committee Report / Service Plan / Project will have a positive or negative impact on each of the themes by placing a mark in the appropriate column. When you think there is likely to be an impact, please provide some annotations regarding the nature of the impact, and any actions that will be taken to address that impact. Users should note that not every theme will be relevant. Where this is the case the 'No Specific Impact' column should be marked. Users should also consider the following tips:

1. Make relative not absolute judgements (e.g. a new energy efficient service would score positively even if it consumes more energy than if no service were provided).
2. Be aware that small positive changes could be outweighed by negative ones (e.g. new energy efficient lighting in the short term may outweigh the benefits of maintaining current lighting).
3. If there are both positive and negative impacts, these need to be recorded in order to give a balanced view. Be objective and unbiased.
4. Concentrate on the most key significant issues - there is the potential to consider the appraisal in a very detailed way. This should be avoided at this stage.
5. Judge a proposal over its whole lifespan and remember that some impacts may change over different timescales.

If you require assistance in completing the Sustainability Impact Assessment please contact the Corporate Services Team

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Domain	Review questions	Assessment of Impact Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes? Will it create incentives to promote prevention, healthy behaviours, mental wellbeing, living independently and self-management? Will it provide evidence-based, personalised care that achieves the best possible health and well-being outcomes with the resources available? Will it reduce avoidable hospital admissions or permanent admissions to residential care or nursing homes? Will it pay for services based on health outcomes rather than activity for example through personal budgets? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways? More info: http://www.sduhealth.org.uk/areas-of-focus/clinical-and-care-models.aspx	n/a		
Travel	Will it reduce 'care miles' (telecare, care closer) to home? Will it reduce repeat appointments? Will it provide / improve / promote alternatives to car based transport (e.g. public transport, walking and cycling)? Will it support more efficient use of cars (car sharing, low emission vehicles, community transport, environmentally friendly fuels and technologies)? Will it improve access to services and facilities for vulnerable or disadvantaged groups or individuals? More info: http://www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/travel.aspx	n/a		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? More info: http://www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/waste.aspx Will it reduce water consumption? Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)? Will it improve green space and access to green space? More info: http://www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/energy.aspx	n/a		

Adaptation to Climate Change	Will it support mitigation of the likely effects of climate change (e.g. identifying proactive and community support for vulnerable groups; contingency planning for flood, heatwave and other weather extremes)? More info: http://www.sduhealth.org.uk/areas-of-focus/community-resilience/community-resilience-copy.aspx	n/a		
Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery in line with the Public Services (Social Value) Act 2012? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it reduce waste, environmental hazards and toxic materials for example by reducing PVC, antibiotic use, air pollution, noise, mining and deforestation? Will it reduce use of natural resources such as raw materials, embedded water, and energy to promote a circular economy? Will it support the local economy through local suppliers, SMEs or engage with third sector or community groups? Will it promote ethical purchasing of goods or services e.g. increasing transparency of modern slavery in the supply chain globally? More info: http://www.sduhealth.org.uk/areas-of-focus/commissioning-and-procurement/procurement.aspx	n/a		
Workforce	Will it provide employment opportunities for local people? Will it promote or support equal employment opportunities? Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)? Will it offer employment opportunities to disadvantaged groups and pay above living wage? More info: http://www.sduhealth.org.uk/areas-of-focus/social-value.aspx	n/a		
Community Engagement	Will it promote health, increase community resilience, social cohesion, reduce social isolation and support sustainable development? Will it reduce inequalities in health and access to services? Will it increase participation including patients, the public, health professionals and elected officials to contribute to decision making? Have you sought the views of our communities in relation to the impact on sustainable development for this activity? Will it increase peer-support mechanisms? More info: http://www.sduhealth.org.uk/areas-of-focus/community-resilience.aspx	n/a		
Estimated carbon benefit	What is the estimated carbon benefit (in terms of tCO_2e) from the implementation of this project? As opposed to the current business as usual position. Speak with your sustainability manager and see the following guidance: More info: http://www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/pharmaceuticals/cspm/sustainable-care-pathways-guidance.aspx	n/a		