NHS
Harrogate and Rural District
Clinical Commissioning Group

POLICY ON PRIMARY CARE REBATE SCHEMES (PCRS)

December 2014

Authorship :	Dr Rob Penman GB GP Member
Committee Approved :	CCG Governing Body
Approved Date :	December 2014
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Equality Impact Assessment :	Completed
Sustainability Impact Assessment :	Completed
Target Audience :	Council of Members, Governing Body and its Committees and Sub-Committees and CCG Staff
Policy Reference No :	HaRD 041
Version Number :	1

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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	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet
1.0		New policy	Governing Body 04 December 2014	27 January 2015

CONTENTS

1. INTRODUCTION

A number of manufacturers have established 'rebate schemes' for drugs used in primary care. Their motive for this could be speculated on for some time, but it is recognised that any rebate could help the NHS QIPP agenda. 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.

2. SCOPE

This policy applies to Harrogate and Rural District (HaRD) 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 Yorkshire and Humber Commissioning Support 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
- Commercial sponsorship policy.

3. AIMS AND OBJECTIVES

Rebate agreements usually take the form of legal agreements between the manufacturer and CCG. It is important that HaRD 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.

4. RESPONSIBILITIES

4.1 Chief Finance Officer

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

4.2 CCG Prescribing Lead

- Ensures this policy is adhered to in all decisions relating to acceptance or refusal of rebates.

4.3 Finance Performance and Commissioning Committee

- Monitors the Compliance and Effectiveness of this Policy.

5. LEGAL ADVICE

There have been concerns raised by some CCGs on the lack of clarity on whether such schemes are allowed under the current regulations. The London Primary Care Medicines Use and Procurement QIPP group as part of the London Procurement Partnership agreed that it was unclear whether these schemes were allowed within the current regulations and sought legal opinion from DAC Beechcroft LLP.

In conclusion, 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 HaRD CCG may wish to take further legal advice on any point identified (detailed legal advice from DAC Beechcroft[1] is available from Yorkshire and Humber Commissioning Support Medicines Management Team) and on the content of any particular scheme prior to entering into any agreement.

6. 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.

Scheme terms, including details of relevant therapeutic evaluations underpinning the scheme, should be published on the CCG's website.

7. GOOD PRACTICE PRINCIPLES FOR PRIMARY CARE REBATE SCHEMES

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, EU law and the public law principles of reasonableness and fairness (see section 3 – Legal Advice - above).

HaRD CCG will adopt the following Principles when deciding whether to participate in a PCRS or not :

7.1. Product Related

- PCRS will only consider a medicine that is already commissioned and included in the joint Harrogate and Rural District joint formulary, and its place in a care pathway has already been established through the CCG Quality and Clinical Governance Committee or the Harrogate and Rural District Area Prescribing 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 not recommended by NICE will not be considered under a PCRS.
- Any product rejected by the HaRD APC 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 for any Category A products.

7.2 Rebate Scheme Related

- Any and all decision making processes will be clinically-led and involve all appropriate stakeholders, including patients where appropriate.
- 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 Area Prescribing Committee, involving both primary and secondary care and Director level approval.
- 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.

8. 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 and the GP Prescribing Lead.

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, positioning relative to competitor products 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.

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

9. CONTRACTS

The CCG Prescribing Lead and 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 (see 7.2, 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.

Freedom of Information issues (see section 11 – Information Governance) should be discussed with the manufacturer before a commissioner enters into any agreement with them and should be contained in the contract.

10. ACCOUNTABILITY

The CCG's Strategic Lead Pharmacist and GP Prescribing Lead will be responsible for assessing schemes against the principles outlined in section 5 above. The 'Rebate Scheme Decision Form' (Appendix 2) 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 HaRD CCG.

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

11. INFORMATION GOVERNANCE

HaRD 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 along with the list of products for which rebate agreements exist on its publically available website.

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.

11.1. Sharing of Information with prescribers and other stakeholders

Individual contracts will contain details of any confidentiality agreements but such agreements must not preclude the sharing of information, including discounts and scheme details, within the wider NHS.

11.2. Freedom of Information Requests

Any decision from the Information Commissioners Office to disclose information must be adhered to.

12. 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. Oversight for any spending plans, redistribution of funds and control of destination budgets will be provided by the Finance Performance and Commissioning Committee.

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

Examples of <u>unacceptable</u> practice :

- A GP LES for diabetes is funded by an insulin rebate. The higher the rebate payment, the more funds will be available for the LES.
- The Medicines Management Team create a budget for special projects. All rebates are paid into this budget and the Team can use this for short term posts.

Examples of acceptable practice :

- A diabetes 'invest to save' project is approved by the CCG. The business case includes an investment that is offset by a rebate scheme. The projected savings are in line with analysis of appropriate use and the project funding is secure even if rebate savings are not fully realised. Any surplus is not automatically allocated to the project.

13. EQUALITY AND DIVERSITY

As a result of performing the analysis, the policy does not appear to have any adverse effects on people who are Protected Characteristics and no further actions are commended at this stage.

14. POLICY REVIEW

This policy will be reviewed by a period of no longer than two years as stated or in response to any relevant changes in local and / or national policies and guidance, whichever is sooner.

15. ACKNOWLEDGEMENTS

The following were used as the basis of this policy :

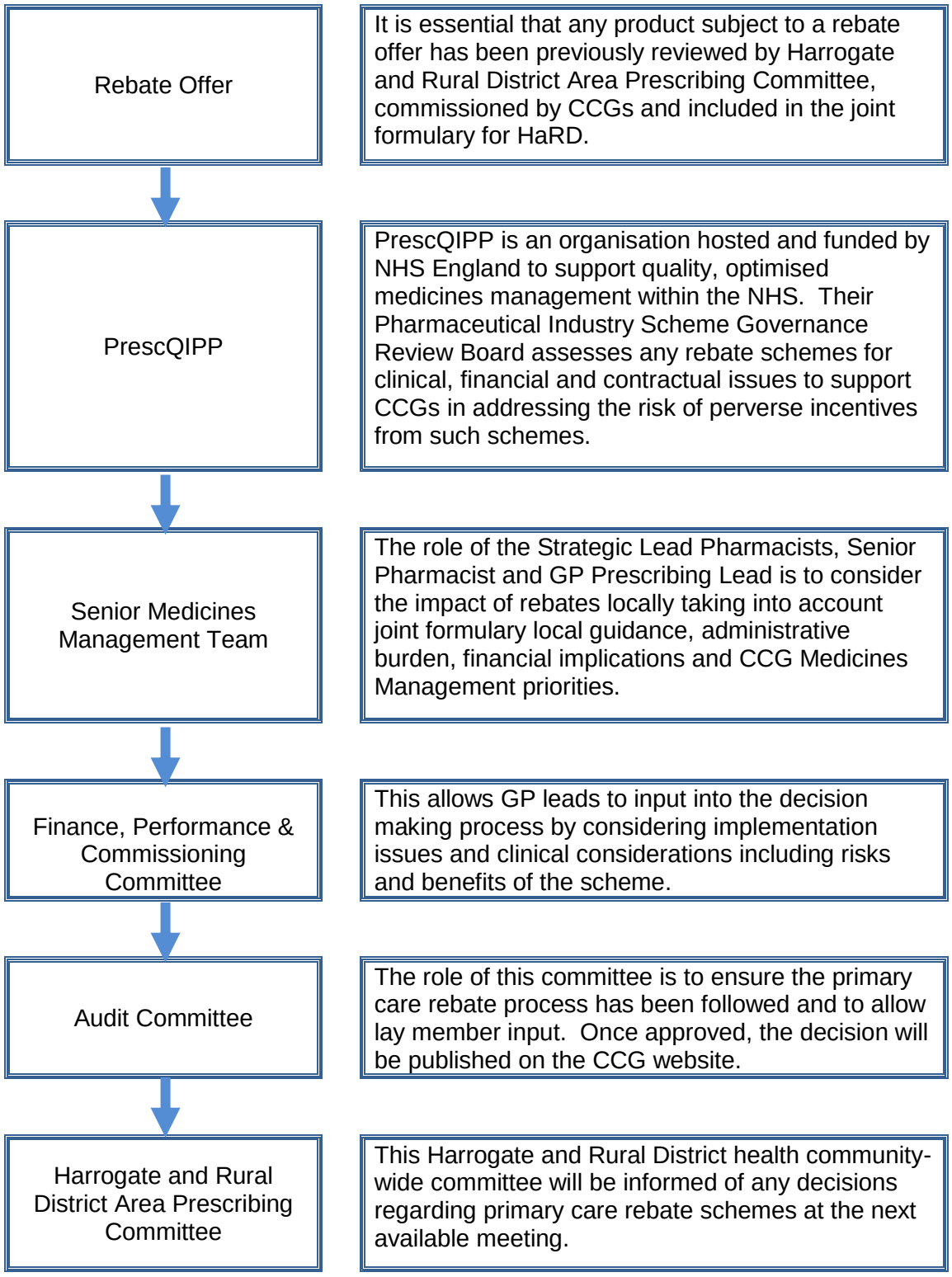
- Principles and Legal Implications of Primary Care Rebate Schemes. London Procurement Programme, 2012.
- Ethical Framework for Considering Rebate Agreements from Pharmaceutical, Nutrition and Device Companies. Greater Manchester Commissioning Support Unit, 2013.
- PrescQIPP Pharmaceutical Industry Scheme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

References:

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

Appendix 1

PRIMARY CARE REBATE SCHEME APPROVAL PROCESS



Appendix 2

PRIMARY CARE REBATE SCHEME DECISION FORM
CONFIDENTIAL

Product	
Manufacturer	
Contact Details	

Brief details of rebate scheme	

Assessment Criteria	Yes / No
If the product is a medicine, is it licensed in the UK?	
The product does not have a negative decision from NICE?	
Is the product listed in the joint CCG/HDFT Formulary?	
The contract does not include any requirement for a directive or guideline to be given to health care professionals to prescribe the specific product?	
The rebate scheme is not designed to increase off label use of the drug?	
If the product is a device or nutritional supplement is it contained in the current Drug Tariff?	
If it is not a medicine, it has not been excluded from use within primary care?	
If the product is a vitamin and classed as a food supplement, is it recommended for use in HaRD CCG?	
The rebate scheme does not require exclusive use of a specific brand?	
The product is not contained in Category A or M of the Drug Tariff?	
The rebate scheme is not linked directly to a requirement for an increase in market share or volume of prescribing?	
The rebate scheme does not prevent consideration of other schemes?	
There is no requirement to submit additional information beyond the volume of prescribing of the product?	
There is no requirement to collect patient specific data?	

Other Considerations :

PrescQIPP Pharmaceutical Industry Scheme Governance Board assessment		
No. of years scheme is available? (Is it >2 years?)		
Estimated potential savings (per patient and for HaRD population per annum)?	**£** /pt/annum	**£** /HaRD/annum
Have any other contractual or legal issues been identified during the evaluation?		
Further information ***For example :*** ***• Administrative burden*** ***• Governance issues*** ***• Freedom of Information issues*** ***• Any other pertinent issues***		
Recommendation		
Rationale		
Evaluation carried out by **(Name, Title and Date)**		
Reviewed by **(Name, Title and Date)**		

FPCC Decision

The Committee does / does not support the decision to agree to this primary care rebate scheme

Title	Name	Signature	Date
FPCC Chair			
CCG Chief Finance Officer			

Date sent to Audit Committee :

Appendix 3

1. Equality Impact Analysis

Policy / Project / Function:	Policy on Primary Care Rebate Schemes (PCRS)
Date of Analysis:	22 January 2015
This Equality Impact Analysis was completed by: **(Name and Department)**	Emma Parker Corporate Services, Yorkshire and Humber Commissioning Support
What are the aims and intended effects of this policy, project or function ?	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.
Please list any other policies that are related to or referred to as part of this analysis	N/A
Who does the policy, project or function affect ? Please Tick ✔	Employees X Service Users ☐ Members of the Public ☐ Other (List Below) X • Service Providers

2. Equality Impact Analysis: Screening

	Could this policy have a positive impact on…		Could this policy have a negative impact on…		Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
Race	☐	X	☐	X	
Age	☐	X	☐	X	
Sexual Orientation	☐	X	☐	X	
Disabled People	☐	X	☐	X	
Gender	☐	X	☐	X	
Transgender People	☐	X	☐	X	
Pregnancy and Maternity	☐	X	☐	X	
Marital Status	☐	X	☐	X	
Religion and Belief	☐	X	☐	X	
Reasoning					

If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7

3. Equality Impact Analysis: Local Profile Data

Local Profile / Demography of the Groups affected (population figures)	
General	
Age	
Race	
Sex	
Gender reassignment	
Disability	
Sexual Orientation	
Religion, faith and belief	
Marriage and civil partnership	
Pregnancy and maternity	

4. Equality Impact Analysis: Equality Data Available	
Is any Equality Data available relating to the use or implementation of this policy, project or function? Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.* Examples of *Equality Data* include: (this list is not definitive) 1. Application success rates *Equality Groups* 2. Complaints by *Equality Groups* 3. Service usage and withdrawal of services by *Equality Groups* *4.* Grievances or decisions upheld and dismissed by *Equality Groups* 5. *Previous EIAs*	Yes ☐ No ☐ Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).
List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function	
Promoting Inclusivity **How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation**	

5. Equality Impact Analysis: Assessment Test

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Gender (Men and Women)				
Race (All Racial Groups)				
Disability (Mental and Physical)				
Religion or Belief				
Sexual Orientation (Heterosexual, Homosexual and Bisexual)				

Equality Impact Analysis: Assessment Test (continued)

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Pregnancy and Maternity				
Transgender				
Marital Status				
Age				

6. Action Planning

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

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

7. Equality Impact Analysis Findings				
Analysis Rating:	☐ Red	☐ Red/Amber	☐ Amber	X Green

		Actions	Wording for Policy / Project / Function
Red **Stop and remove the policy**	**Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.	**Remove the policy** Complete the action plan above to identify the areas of discrimination and the work or actions which needs to be carried out to minimise the risk of discrimination.	No wording needed as policy is being removed
Red Amber **Continue the policy**	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.	**The policy can be published with the EIA** List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE). Consider if there are any potential actions which would reduce the risk of discrimination. Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists which justifies the use of this policy and further professional advice. ***[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]***

Equality Impact Findings (continued):			
		Actions	Wording for Policy / Project / Function
Amber **Adjust the Policy**	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.	**The policy can be published with the EIA** The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination. Any changes identified and made to the service/policy/ strategy etc. should be included in the policy. Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document. ***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]***
Green **No major change**	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.	**The policy can be published with the EIA** Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Brief Summary/Further comments	

Approved By		
Job Title:	Name:	Date:

Appendix 4

SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document :	Policy on Primary Care Rebate Schemes (PCRS) HaRD 041
What is the main purpose of the document :	The purpose of this document is to set out the CCG's approach to applicable rebate schemes.
Date completed :	22 January 2015
Completed by :	Rachael Simmons, Corporate Affairs Officer

Domain	**Objectives**	**Impact of activity** 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?**
Travel	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home? Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities for all groups?	0		

Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it promote ethical purchasing of goods or services? Will it promote greater efficiency of resource use? Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)? Will it support local or regional supply chains? Will it promote access to local services (care closer to home)? Will it make current activities more efficient or alter service delivery models	?		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		
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?	0		

Community Engagement	Will it promote health and sustainable development? Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	0		
Buildings	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 increase safety and security in new buildings and developments? Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)? Will it provide sympathetic and appropriate landscaping around new development? Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
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 promote prevention and self-management? Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		