

**PRIORITISATION POLICY**

This policy has been co-produced with members of the public and CCG stakeholders and we offer our thanks to all those who have supported the development of this policy.

Acknowledgement must go to colleagues at **NHS Bedfordshire CCG** and **NHS North Staffordshire CCG** whose existing Prioritisation Policies were used as best practice example in developing NHS East Lancashire and NHS Blackburn with Darwen CCG’s Prioritisation policy.

**CONTENTS**

To be completed once the draft is finalised

1. **INTRODUCTION**
   1. East Lancashire Clinical Commissioning Group and Blackburn with Darwen Clinical Commissioning Group commission (the CCG’s) healthcare services across the whole of the East Lancashire and Blackburn and Darwen footprint. Combined, this has become known as Pennine Lancashire.
   2. As the CCGs commission services the aim is to ensure that they are provided in such a way as to meet the healthcare needs of the resident population of Pennine Lancashire, which are equitable and which aim to close the health inequalities gaps which exist within our communities.
   3. The CCG’s each receive a fixed allocation with which to commission acute, community, mental health and GP primary care services. Within the finite resources available to them, the CCG’s have to commission services which are of safe and of high quality, which deliver good outcomes for patients, which are efficient and which deliver value for money as well as meeting the national performance targets for example the 4 hour A&E wait target.
   4. The Five Year Forward View (NHS England et.al., 2014) describes the challenges that are facing the NHS as a whole over the next five years, and actions that need to be taken to ensure that the NHS remains a sustainable proposition, it is therefore likely that the CCG’s will have to make rational choices about which healthcare interventions they commission and the delivery models used.
2. **PURPOSE**
   1. The purpose of this policy is to set out the process by which the Pennine Lancashire CCG’s will prioritise the commissioning of healthcare services, including investment and disinvestment decisions. It details the criteria by which decisions will be evaluated and the scoring and ranking methodology to by applied in doing so.

* 1. Underpinning the process and commissioning principles will be:-
     + Applicable legislation including the Human Rights Act and the Equality Act (2010)
     + The NHS Constitution (NHS England, 2013)
     + Each organisations mission, values and strategic objectives
     + The strive for safe, high quality services and better outcomes
     + The CCG’s ethical framework (CCG policy number),
     + Commitment to achieving value for money i.e. obtaining maximum population benefit from the goods and services commissioned within the available resources.
  2. This policy will act as a mechanism to provide healthcare providers and the public, our Members and the Governing Bodies, with clarity and assurance around how the CCG’s manage their commissioning priorities and requirements, in order to act openly and transparently with all our Stakeholders.

1. **TARGET AUDIENCE**
   1. The target audience for this policy is:-
      * The CCG’s Membership
      * The CCG’s Governing Bodies
      * Commissioning staff
      * Our Commissioning Support Unit
      * Healthcare professionals
      * Members of the public
      * Healthcare providers
      * Overview and Scrutiny Committees
2. **RESPONSIBILITIES**
   1. Table 1 details individual’s roles and responsibilities in relation to this policy.

|  |  |
| --- | --- |
| **Role** | **Responsibility** |
| CCG Accountable Officer | Overall responsibility for ensuring compliance with the policy and that healthcare is commissioned in a consistent manner, promoting equity and fairness |
| Healthcare Commissioners | Comply with the policy and its relevant procedures and highlight any need for future amendments. Ensure approved priorities for investment or disinvestment are implemented and remain on track to deliver both to agreed timescale and outcomes. |
| Healthcare Providers | Refer to the policy when requesting commissioners to invest in healthcare services in order to understand CCG rationale and processes followed. |
|  | Have access to the policy so that they may be helped to understand how the policy may impact on their healthcare when expecting or requiring specific aspects of care. |
| Customer services / PALS | Support patients in understanding and use of this policy and procedures. |
| **Joint QIPP Prioritisation Group** | Oversee the implementation and ongoing development of the policy and undertake the prioritisation process |
| CCG Governing Body | Receive reports on the impact of the policy at agreed intervals; take into account the prioritisation in **all** investment decisions |

1. **APPROACH TO STRATEGIC PLANNING**
   1. For all CCG’s the most important priority setting takes place at the strategic and senior clinical level as it is that all the major decisions shaping local health services are taken.
   2. The commissioning principles which underpin the CCG’s strategic planning are:

* Robust health needs assessment
* Consultation and engagement with patients and their carers, the public and other stakeholders
* Partnership working
* Robust prioritisation
  1. The current strategic plan for each CCG, has been developed according to these principles, and in line with:
* Health and Wellbeing strategies provided by Lancashire County Council and Blackburn with Darwen Council
* Joint Strategic Needs Assessment (JSNA) Lancashire County Council and Integrated Strategic Needs Assessment (ISNA) Blackburn with Darwen Council
* The NHS White Paper, Equity and Excellence: Liberating the NHS
* The NHS Planning Document, The Five Year Forward View
* The NHS Constitution
  1. In the case of major service reconfiguration, the CCGs will demonstrate that the four key test for service change as set out in the Operating Framework for 2010-2011 have been applied.
     + Support from GP Members
     + Strengthened public and patient engagement
     + Clarity on the clinical evidence base and
     + Consistency with current and prospective patient choice.

1. **ANNUAL PRIORITY SETTING**
   1. It is during the annual prioritisation process that decisions are made about priorities and investments for the coming year. This process will involve a systematic review of the CCGs strategy and the development of plans to meet its objectives, with the aim of ensuring that annual investment / disinvestment decisions reflect the CCG’s stated priorities.
   2. The outcome of the annual priority setting process will be capture in the **annual commissioning plan**. This will then be used to performance manage the CCG’s. Throughout the year, the CCGs may need to review decisions about priorities and investments made during the planning process to ensure that the organisation complies with all its statutory duties. In this instance, the principles of the prioritisation process will be upheld. No decisions for investment or disinvestment will be made without this process being followed.
   3. Whilst the CCG’s strive to embed a culture of planning throughout the calendar year, there is a planning window between April and August within the annual business planning cycle which will be used to identify potential commissioning pathway opportunities and feed into the start of the national planning time-table with the sharing of commissioning intentions with Providers by 30 September each year. Working back from this date, the indicative timeframe is shown in Appendix A. Each year a detailed timetable will be published.
2. **PRIORITISATION PROCESS**
   1. The prioritisation process has six stages.
   2. This policy covers stages 1 through to 3 of this process.
   3. The flow chart attached at Appendix B, shows the process flow for the three stages of this process.
   4. The CCG’s have adopted a systematic review process which is a modified version of that used by the State of Oregon, USA and results in a ranked list of priorities.
3. **POTENTIAL SCHEME IDENTIFICATION**
   1. Potential schemes for investment / disinvestment, developments and commissioning plans will be identified from a wide range of sources , which include but is not limited to:

|  |  |
| --- | --- |
| * Local JSNA/ISNA | * Health & Well Being Strategies |
| * Strategic Commissioning Plan | * Quality, Safety & patient experience reports |
| * National & Local targets / operational standards | * Locality Delivery & Programme Board Plans |
| * Collaborative Commissioning Board | * Patient & Public Involvement activities including focus groups, patient surveys, project reference groups, complaints & PALS |
| * Programme Budgeting & benchmarking indicators | * Horizon scanning activities undertaken by Public Health, Medicines Management teams & NICE technology appraisal programme |
| * National directives | * Developments previously considered and not supported |
| * Clinical & strategic networks | * Development proposals from providers |
| * Specialist commissioning groups * Provider organisational performance against Key Performance Indicators and overall contractual compliance | * Existing service review |

* 1. Each commissioning manager will complete a Project Identification Template (PIT) for their area of commissioning responsibility (Appendix C).
  2. This will be considered at a special meeting of the CCG’s senior management team with additional clinical support (the Sifting Group).

1. **SIFTING PROCESS**
   1. The programme administration will assign a unique reference number to each scheme which is shortlisted and advise the commissioning manager of the outcome, stating the outcome of the shortlisting process and the time frame for the next stage of the process.
   2. A listing of the shortlisted schemes plus the proposed action will be listed on the CCG’s website ***for public and stakeholder information only***.

**10.0 TECHNICAL ASSESSMENT**

10.1 The technical assessment provides the business case on which the CCG’s prioritisation group(s) will make the recommendations to the CCG’s Governing Bodies.

10.2 Once through the sifting phase, all remaining schemes, be they to invest, re-commission or de-commission must be submitted using the Prioritisation Process Template (PPT) (Appendix D). As far as possible, schemes relating to the same Programme Areas should be co-ordinated and submitted within one template, or accompanied by an over-arching commissioning plan explaining how the schemes inter-relate and the expected outcomes from the combination of activities.

10.3 In completing the PPT, as much evidence as possible supporting the case for change should be included. This may require involvement from one or all of :-

* GP Members
* Clinicans
* Public Health,
* Medicines Management,
* Quality
* Safeguarding
* Local Authority
* CSU
* Patients

10.4 Where insufficient information is available to produce a robust and complete PPT in line with the planning process timescale, commissioners should submit as much information as is available. This will include for example, the horizon scanning activities undertaken by Public Health, Medicines Management and NICE. A judgement will then be made about which of these will be taken forward as part of the annual process or whether they need to be considered during the coming year, their financial impact and their relative priority against all other submitted commissioning plans. This will enable the CCGs to potentially set aside funding for high priority / must-do service developments where information is limited at the time of the prioritisation process.

10.5 Each PPT will need to have a supporting:

* Equality Impact Assessment
* Risk Assessment

10.6 Draft PPT’s will be posted on the CCGs website to allow consultation and invite feedback from patients, service users, providers and stakeholders. These will be posted for a **minimum period of two weeks** and there will be a communications strategy in place to promote their availability and invite comment.

10.7 Once consultation is closed, commissioners will have **one week** in which to update their PPTs in light of feedback received and submit them to the CCGs Prioritisation Group for further consideration.

10.8 The risks associated with each scheme do not get assessed or form part of the scoring process, they will be managed and reported in accordance with each CCG’s Risk Management Assurance Framework. Therefore, each risk will have a named risk owner, will have mitigating actions and be reviewed on a monthly basis.

Who will this be in each CCG or will we set up a group specifically for this purpose?

1. **PRIORITISATION PROCESS TEMPLATE SCORING**
   1. The ***QIPP prioritisation group*** will meet to score each PPT and to make a recommendation to the CCGs Governing Bodies.
   2. The tool used for scoring is a modified ***Portsmouth Scorecard*** which then feeds into a ***Priority Selector***matrix.
   3. Each scheme is scored against ten criteria, which are grouped together into factors which reflect the importance of the scheme and it’s do-ability. When scored, the criteria are weighted with the overall score for the quality based criteria in each section accounting for 80% of the overall mark and the financial criteria, 20%. The table below describes the criteria and how they are categorised.

|  |  |  |
| --- | --- | --- |
|  | **Importance** | **Do-ability** |
| **80%** | Patient Benefit | Stakeholders |
| Clinical Benefit | Building and Equipment |
| National Priority | Workforce |
| Local Priority | Service Delivery |
| **20%** | Financial Benefit | Investment Required |

* 1. Appendix E shows the marking criteria for the scheme and Appendix F shows the weighted scoring matrix.
  2. Once all the weighted scores have been agreed, the results are plotted on a prioritisation map, the threshold set in terms of capacity to deliver and the schemes identified to be recommended to be taken forward
  3. The table below shows an example of a prioritisation map

|  |  |  |  |
| --- | --- | --- | --- |
| **Priority 1** | **Priority 2** | **Priority 3** | **Priority 4** |
| 6 = Project Ref | 2 = Project Ref | 7 = Project Ref | 1 = Project Ref |
| 11 = Project Ref | 3 = Project Ref | 10 = Project Ref | 5 = Project Ref |
| 17 = Project Ref | 4 = Project Ref | 12 = Project Ref | 8 = Project Ref |
| 19 = Project Ref | 9 = Project Ref | 13 = Project Ref | 14 = Project Ref |
|  |  | 16 = Project Ref | 15 = Project Ref |
|  |  |  | 18 = Project Ref |
|  |  |  | 20 = Project Ref |
|  |  |  |  |

* 1. Once this has been agreed a recommendation for schemes to be ***approved in principle*** is made through each CCGs governance framework to take forward the projects. Depending on capacity issues, this will vary each year as to how far down the priority listing schemes which are taken forward are.
  2. The results of the prioritisation process will be published on the CCG’s websites and any decision to proceed with schemes made by the CCGs are final, therefore there is not an appeals process
  3. Prioritisation of healthcare is likely to be a sensitive issue and is liable to attract public interest and scrutiny. Good record keeping in relation to decisions and the rationale used to reach a decision is important and the policy requires that full documentation is maintained.
  4. Following the decision regarding the schemes which have been recommended to be taken forward, are to be further developed for implementation and will enter the project development and implementation stage. This will include consultation and stakeholder engagement in line with CCG policy and processes.

1. **GOVERNANCE**
   1. The ***QIPP group*** is accountable to the CCGs Governing Bodies. The CCG Governing Body makes the strategic commissioning decisions.
   2. Compliance will be maintained with all CCG governance policies including those which cover the areas of :-

* Individual Funding Requests
* Continuing Healthcare
* Risk Management
* Information Governance
* Ethical Framework

12.3 The CCGs acknowledge the key role of public health specialists in implementing this policy. The respective responsibilities of Lancashire and Blackburn with Darwen Public Health colleagues are set out in the Memorandum of Understanding with Lancashire County Council and Blackburn with Darwen Council. Public Health Colleagues have agreed to provide expertise and advice to support the prioritisation process, from providing information to support the PPTs along with supporting the scoring and recommendation of schemes.

**13.0 RISK MANAGEMENT**

13.1 The CCG’s should ensure that any priorities waiting for investment or disinvestment posing a high risk to the organisation or patients should be highlighted in the CCG risk register.

**14.0 RESOURCE IMPLICATIONS**

14.1 Commissioning budget – the aim of assessing priorities in healthcare is to identify what healthcare services or interventions are commissioned within a finite commissioning budget. Services or interventions that are deemed not to be a clinical priority for the population will be disinvested in, in order to provide more effective healthcare for the population with the aim of meeting strategic objectives for improving health.

14.2 The CCG and Public Health colleagues will ensure that the resources required in order to implement this policy and procedures and undertake the prioritisation process are identified and made available.

**15.0 TRAINING**

15.1 Training will be provided for those who are required to implement and maintain the use of this policy and relevant procedures. The staff and agencies using this policy must ensure that any new personnel that are expected to use the policy and procedures clearly understand the requirements and are able to work with them and this forms part of their local induction.

**16.0 POLICY APPROVAL AND RATIFICATION**

16.1 The policy will be ratified in accordance with each CCG’s governance process.

**17.0 AUDIT AND QUALITY ASSURANCE**

17.1 In order to ensure compliance with this policy, an annual audit should be undertaken. This will consist of a review of all the priorities deemed to be low priority and 10% of those that were approved to move on to the next stage. An audit scope will be agreed with our internal audit providers. The audit must assess consistency of the use of the prioritisation format, assessment and decision making timescale, documentation management and the ongoing monitoring and implementation of priorities. The audit will be presented to the CCG’s Audit Committees.

17.2 Key performance criteria:

* The standardised prioritisation format was used in all decision making
* 100% of decisions made have completed accurate documentation
* The CCG Governing Bodies receive an annual recommendation with regard to commissioning intentions.
* 100% of decisions have been publicised on the respective CCGs websites
* The annual audit has been completed and the policy reviewed as a result of any learning.
* The policy is to be reviewed annually.
* Prioritised projects are subject to decision and implementation by the CCGs.

**Appendix A**

**Standard Time Table for Prioritisation Process**

**Appendix B**

**Process Flow For Stages 1 – 3 of the Prioritisation Process**

The process matches the business cycle which has three main components – strategic planning, procuring services and monitoring & evaluation. This is a sub-set of the decision making / governance framework.



**Appendix C**





**Appendix D**



**PRIORITISATION PROCESS TEMPLATE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unique Reference Number** | |  | | | **Commissioning Manager / Lead Name** | |  | | |
| **Name of Project** | |  | | | | | | | |
| **Clinical Lead** | |  | | | **Sponsoring Executive** | |  | | |
|  |  |  |  |  |  |  |  |  |  |
| **Background to the Proposal** | | | | | | | | | |
| *Please provide an overview of the proposal*  *Include details of background, scope, rationale*  *What is the supporting data / comparative benchmark data?*  *Is the CCG an outlier?* | | | | | | | | | |
| **Aims and Objectives** | | | | | | | | | |
| *What are the deliverable outcomes & benefits from this proposal?*  *If it is a de-commissioning proposal, what are the potential impacts?* | | | | | | | | | |
| **Governance** | | | | | | | | | |
| *Where is the accountability for this proposal?*  *e.g. SMT / Exec Team / Locality Group / Pennine Lancashire Programme Board / Collaborative Commissioning Board* | | | | | | | | | |
| **Assumptions & Constraints** | | | | | | | | | |
| *Please provide details of any identified* | | | | | | | | | |
| **Project Milestones** | | | | | **QIPP** | | | | |
| ***Please provide indicative dates for each of these gateways. If not applicable enter N/A*** | | | | | ***Which QIPP Element does this proposal relate to ? (X)*** | | | | |
| Project Scoping | | |  | | Quality | | | |  |
| Health Needs Assessment / Evidence Gathering | | |  | | Innovation | | | |  |
| Patient Engagement & Stakeholder Assessment | | |  | | Productivity | | | |  |
| Investment Appraisal | | |  | | Prevention | | | |  |
| Service Specification | | |  | | ***Which QIPP Level ? (X)*** | | | | |
| Procurement & Contracting | | |  | | Individuals / Organisation | | | |  |
| Service Implementation & Planning / | | |  | | Pennine Lancashire | | | |  |
| Lancashire | | | |  |
| Mobilisation | | |  | | North West | | | |  |
| Service Review & Project Close | | |  | | National | | | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risks & Mitigations** | | | | **Equality Impact Assessment** | | | | |
| *Please outline the key risks & attach a copy of the risk assessment form.* | | | | *Please highlight any impact on any of the protected groups and attach a copy of the completed Pre-pare toolkit* | | | | |
| **Headline Financial Impact** | | | | | | | | |
|  | **Recurrent** | **Non-Recurrent** | | ***If non-recurrent over which financial years***  ***(where year 1 is 2015/2016)*** | | | | |
| **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| Investment |  |  | |  |  |  |  |  |
| Saving |  |  | |  |  |  |  |  |
| **Headline Activity Impact** | | | | | | | | |
| **Provider** | | | **POD / Block** | | **Impact (+ / -)** | | **Year of Impact** | |
|  | | |  | |  | |  | |
|  | | |  | |  | |  | |
|  | | |  | |  | |  | |

|  |  |
| --- | --- |
| **Outcome** | |
| **Importance Score** |  |
| **Do-ability Score** |  |
| **Prioritisation Map Quadrant** |  |
| **Outcome** *(Proceed / Hold / Cancel)* |  |

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| --- |
| **IMPORTANCE CRITERIA** |
| 1. **Patient Benefit** |
| * *How would this improve convenience and ease of access for users of the service?* * *How many patients would benefit from this service?* * *To what extent would it contribute to reducing health inequalities?* * *To what extent would it contribute to adopting a preventative and early intervention approach that promotes people’s independence and wellbeing?* * *To what extent would it contribute to patient choice* |
| 1. **Clinical Benefit** |
| * *How does this enhance the implementation of clinical practices designed to improve quality of life (eg admission avoidance or case management)* * *How does it enable the achievement of evidence-based health outcomes (eg through implementation of NSFs, NICE)* * *Give examples of the clinical evidence that supports this submission* |
| 1. **National Priority** |
| * *How does this address the key national priorities set out in the outcome frameworks, the reform agenda and the FYFV?* |
| 1. **Local Priority** |
| * *How does the scheme address key local priorities and objectives? (eg Health & Wellbeing strategies, JSNA or other local health assessments)* * *To what extent is there pressure for change in the health economy from local people or organisations outside of the health economy (eg patient groups, politicians)* * *To what extent is there pressure for change in the health economy from internal factors (eg workforce, equipment, changes in regulations, alternative providers)* |
| 1. **Financial Benefit** |
| * *Would the initiative result in financial savings?* * *What is the timeline for the release of these savings?* * *What is the risk to their release?* |
| **DO-ABILITY CRITERIA** | |
| 1. **Stakeholders** | |
| * *To what extent are Stakeholders within the local health community supportive of this scheme?* * *What is the likely reaction of local patient groups and politicians to the scheme?* | |
| 1. **Buildings & Equipment** | |
| * *To what extent would this scheme require change to buildings and equipment?* * *Are there any implications for void space* * *Have these impacts been considered as part of the financial investment / benefit criteria?* | |
| 1. **Workforce** | |
| * *Would this initiative require the current workforce to be re-deployed?* * *What new or additional skills would be required for the scheme to start or long-term training once staff have been appointed?* * *To what extent will new ways of working / skill mix be utilised differently e.g. Nurse led follow up, multi-disciplinary team working etc.* | |
| 1. **Service Delivery** | |
| * *To what extent does this require complex service change?* * *What are the interdependencies on other projects / services?* * *Does this include cross-organisational working?* * *Would this affect the viability of other services or impact on service delivery for other commissioners?* * *Is there a provider capable of delivering the service required through this project?* * *Has this scheme been implemented successfully elsewhere?* | |
| 1. **Investment Required** | |
| * *Would the initiative require any additional financial investment?* * *Is this recurrent / non recurrent?* * *Would it be funded by savings elsewhere?* * *Is it possible to release those savings?* | |

**Appendix E**



**PRIORITISATION PROCESS MARKING CRITERIA**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IMPORTANCE CRITERIA** | | | | |
| 1. **Patient Benefit** | | | | |
| * To what extend would the initiative improve convenience and ease of access for users of the service | | | | |
| **0**  No information provided | **1**  Unable to determine from the information provided | **2**  Slight improvement in access  OR  May cause small access issues | **3**  Some improvement in access  OR  May cause some access issues | **4**  Significant improvement in access to services  OR  Does not cause new access issues |
| * How many patients would benefit from improved convenience and ease of access? | | | | |
| **0**  No information provided | **1**  0% - 25%  Of impacted population | **2**  25% - 50%  Of impacted population | **3**  50% - 75%  Of impacted population | **4**  75% - 100%  Of impacted population |
| * To what extend would the initiative contribute to reducing health inequalities | | | | |
| **0**  No information provided | **1**  No reduction  OR  May create a significant HI gap | **2**  Some reduction  OR  May create a marginal HI gap | **3**  Significant reduction  OR  May create a small HI gap | **4**  HI gap completely closed  OR  Does not create a HI gap |
| 1. **Clinical Benefit** | | | | |
| * To what extent would the initiative enhance the implementation of clinical practices designed to improve the quality of life? (eg admission avoidance or case management) | | | | |
| **0**  No information provided | **1**  There would be no improvement in the quality of life of the impacted cohort OR  There could be a significant reduction in the quality of life of the impacted cohort | **2**  There would be minor improvement in the quality of life of the impacted cohort  OR  There could be some reduction in the quality of life of the impacted cohort | **3**  There would be significant improvement in the quality of life of the impacted cohort  OR  There could be minor reduction in the quality of life of the impacted cohort | **4**  There would be a huge improvement in the quality of life of the impacted cohort  OR  There would be no reduction in the quality of life of the impacted cohort |
| * To what extent would the initiative enable the achievement of evidence-based health outcomes? | | | | |
| **0**  No information provided | **1**  There is little or no clinical evidence to support this project | **2**  There is some clinical evidence to support his project | **3**  There is a lot of clinical evidence to support this project | **4**  The basis of this project is well documented best practice |
| 1. **National Priority** | | | | |
| * To what extent does the initiative address key national priorities? | | | | |
| **0**  No information provided | **1**  This scheme is not one of the key national priority areas | **2**  This scheme starts to address key national priorities | **3**  This scheme goes some way to supporting key national priorities | **4**  This scheme is proposed specifically to address key national priorities |
| 1. **Local Priority** | | | | |
| * Does the initiative address key local priorities and objectives? | | | | |
| **0**  No information provided | **1**  This scheme is not supportive of local priorities and objectives | **2**  This scheme starts to address local priorities and objectives | **3**  This scheme goes some way to supporting key local priorities and objectives | **4**  This scheme is proposed specifically to address key local priorities |
| * Is there pressure for change from people / organisations outside of the local health community? (eg patient groups / politicians) | | | | |
| **0**  No information provided | **1**  There is or would be no external interest in this scheme | **2**  There might be some external interest in this scheme | **3**  It is highly likely that there would be some external interest in this scheme | **4**  There is or would be significant external interest in this scheme |
| * Is there pressure for change in this area from within the health economy? | | | | |
| **0**  No information provided | **1**  There is or would be no local interest in this scheme | **2**  There might be some local interest in this scheme | **3**  It is highly likely that there would be some local interest in this scheme | **4**  There is or would be significant local interest in this scheme |
| 1. **Financial Benefit** | | | | |
| * Would the initiative result in financial savings? | | | | |
| **0**  No information provided | **1**  0% - 2% of total service costs saved | **2**  2% -5% of total service costs saved | **3**  5% - 7% of total service costs saved | **4**  Greater than 7% of service costs saved |
| * How long would it b before these are released or there is a return on any investment that will be required? | | | | |
| **0**  No information provided | **1**  No return on investment | **2**  Long term return ie greater than 7 years | **3**  Medium term return ie between 3 and 7 years | **4**  Short term return ie immediate to 3 years |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DO-ABILITY CRITERIA** | | | | |
| 1. **Stakeholders** | | | | |
| * Are stakeholders within the local health community supportive of this project? | | | | |
| **0**  No information provided | **1**  There is no local support for this project | **2**  There is little local support for this scheme | **3**  It is a lot of local support for this scheme | **4**  There is significant local support for this scheme |
| * What is the likely reaction of local patient groups and politicians? | | | | |
| **0**  No information provided | **1**  There is or would be no local interest in this scheme | **2**  There might be some local interest in this scheme | **3**  It is highly likely that there would be some local interest in this scheme | **4**  There is or would be significant local interest in this scheme |
| 1. **Buildings & Equipment** | | | | |
| * Does this require change to buildings and equipment | | | | |
| **0**  No information provided | **1**  There would be significant change required  OR  This would leave a significant amount of space or equipment unutilised | **2**  There would be some changes required  OR  There would be some space or equipment left unutilised | **3**  Minor cosmetic changes would be required  OR  A small amount of space or equipment would be left unutilised | **4**  There is very little or no impact on buildings or equipment  OR  The resource would be made available to be utilised more efficiently and effectively |
| 1. **Workforce** | | | | |
| * Will current workforce have to be redeployed | | | | |
| **0**  No information provided | **1**  There would be significant redeployment required  OR  Displacement of many staff | **2**  There would be some redeployment  OR  Displacement of some staff | **3**  A few staff would need to be redeployed  OR  displaced | **4**  There is very little or no impact on staffing  OR  Staff could be used more efficiently and effectively |
| * Is this project reliant on securing new or additional skills or reliant on long-term on-going training once staff are appointed? | | | | |
| **0**  No information provided | **1**  There is a skills shortage within this area & staff would be difficult to recruit  OR  Staff will need constant on-going training | **2**  It may prove difficult to recruit staff with the required skills  OR  Staff will need some on-going / refresher training | **3**  It would not be difficult to recruit new staff with the required skill set OR  There is little on-going training requirement | **4**  Staff are already recruited who have the required skill sets & this service would see them use those skills more effectively |
| 1. **Service Delivery** | | | | |
| * Does this represent a complex service change? | | | | |
| **0**  No information provided | **1**  YES | **2**  Fairly complex | **3**  Some minor redesign | **4**  NO |
| * Would this affect the viability of other services? | | | | |
| **0**  No information provided | **1**  YES | **2**  It could do | **3**  Minor impact | **4**  NO |
| * Is there a provider in the marketplace capable of providing this service? | | | | |
| **0**  No information provided | **1**  NO | **2**  Limited Choice | **3**  A few providers | **4**  Many providers |
| * Has this initiative been undertaken successfully elsewhere? | | | | |
| **0**  No information provided | **1**  NO | **2**  Limited Success | **3**  Some success | **4**  Great success  Best Practice |
| 1. **Investment Required** | | | | |
| * Would this initiative require significant financial investment? | | | | |
| **0**  No information provided | **1**  Significant recurrent investment  AND/OR  Longer term non-recurrent investment to support transition | **2**  Some recurrent investment  AND/OR  Non-recurrent transitional support required | **3**  No recurrent requirement  AND/OR  Short term non-recurrent investment | **4**  No additional financial impact  Saves money |

**Appendix F**

