

**INDIVIDUAL
FUNDING REQUEST
(IFR) POLICY 2015-16**

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1.0 INTRODUCTION

- 1.1 This policy has been based on the legacy policy produced by the Staffordshire Cluster of Primary Care Trusts in January 2012 to govern the Individual Funding Request (IFR) process. The policy has been produced on behalf of the four South Staffordshire CCGs (Cannock Chase, East Staffordshire, Stafford & Surrounds and South East Staffordshire and Seisdon peninsular CCGs) under the collaborative commissioning arrangements. Once authorised, each CCG will be a statutory NHS commissioning body, and therefore each CCG will be required to ratify this policy.
- 1.2 Throughout the policy reference is made to “the CCG” which means the CCG for which the patient request under consideration is the responsible commissioner.

2.0 PURPOSE

- 2.1 The CCG recognises that there may be individual cases where a patient’s needs cannot be met through existing care pathways and therapies.
- 2.2 This Policy sets out the principles and process to be adopted when the CCG is considering any request for treatment that falls outside of national, regional or local commissioning arrangements or service level agreements
- 2.3 All requests falling within 2.1 and 2.2 will only be considered for funding on an exceptional basis, other than as provided under 2.5
- 2.4 This Policy is not intended to be applied to cases where the failure of a provider to provide adequate care and treatment has precipitated the need for the intervention for which funding is sought. Funding for any such intervention will be the responsibility of the provider concerned.
- 2.5 The IFR process will also consider requests for treatments that are considered sufficiently rare for the CCG to have developed a commissioning policy. Rarity for the purposes of this policy is defined as an incidence of no greater than 2 in a population of 1 million or a prevalence not exceeding 10 cases per million population.

3.0 GOVERNANCE ARRANGEMENTS

3.1 Legal Framework

- 3.1.1 Each CCG is a public, statutory NHS body, with delegated responsibility from the Secretary of State for Health for commissioning healthcare for its patients and for protecting and improving the health of its population.
- 3.1.2 The National Health Service Act 2006 sets out a general duty to provide services to support the prevention, diagnosis and treatment of illness.¹ This is a target duty, rather than a specific legal duty owed to each and every individual in the CCG’s population. In consequence, the provision

¹ National Health Service Act 2006, Section 3

of healthcare services is legitimately subject to a decision as to what is considered appropriate and affordable within the overall annual prioritisation of healthcare interventions.

3.1.3 The CCG has a statutory responsibility to maintain financial balance² and, as part of discharging this obligation, has to decide how and where finite local resources are allocated.

3.1.4 In performing these functions, the CCG has regard to the NHS Constitution, in the knowledge that patients have a right to expect that the CCG will assess the health requirements of the local community and commission the services to meet those needs as considered necessary. In discharging its obligations under this Policy, in particular, the CCG acknowledges that patients also have a right to expect that local decisions on the funding of drugs and treatments which have not been recommended by the National Institute for Health and Clinical Excellence will be made rationally following a proper consideration of the evidence.

3.2 Responsibility

3.2.1 The Host CCG (South East Staffordshire and Seisdon Peninsular CCG) is responsible for ensuring that the necessary processes are in place to underpin the delivery of the IFR process in accordance with this Policy.

3.2.2 Individual CCGs have a responsibility to provide details of their duly authorised representatives and deputies to the co-ordinating team.

3.3 Accountability & Reporting

3.3.1 A formally constituted IFR panel (see S5) will be a standing committee, with duly designated CCG representatives having delegated authority to make decisions on behalf of the CCG they represent.

3.3.2 The IFR Team will produce a summary report of panel decisions no less frequently than every 6 months. These reports will be submitted to the CCG Governing Bodies for consideration, in September and March

4.0 POLICY PRINCIPLES

4.1 Basic Principles

4.1.1 Wherever possible, patients will be referred to services covered by an existing service level agreement and prescribing should, wherever possible, be in line with existing local and national prescribing guidelines, including guidance from the National Institute for Health and Clinical Excellence.

4.1.2 Where a particular treatment or procedure is not part of an agreed pathway or existing commissioned service, it will not be routinely funded. The patient's request for funding for such a treatment or procedure will be considered under the terms of this Policy, only in such instances that the CCG would be deemed the "responsible commissioner" for the service

² National Health Service Act 2006, Section 229 & 230

under consideration.

- 4.1.3 This Policy is intended to govern the consideration of IFRs where, following an initial determination stage and screening stage there is deemed to be prima facie evidence of exceptionality as defined at 4.2 and in Appendix 1.
- 4.1.4 The IFR process is not a mechanism to endorse, implement or introduce new therapies, procedures or services in-year that are not routinely commissioned. These will be treated as new service developments and considered through the CCG's annual prioritisation process. To do otherwise would risk destabilising previously identified funding priorities and would impair the responsibility for ensuring that treatments and services are offered in an equitable and consistent manner.
- 4.1.5 Where a patient moves into the CCG's area, having already commenced treatment approved by their previous local primary care trust or CCG, the responsible CCG will honour the funding decision of the originating commissioner, even where the CCG, had it been the recipient of the original funding request, may have decided that funding was not appropriate in the particular clinical circumstances.
- 4.1.6 The provisions of paragraph 4.1.5 only apply under this policy for those treatments and services for which the CCG is considered the responsible commissioner. CCGs will, under no circumstance consider funding treatments and services which fall under the responsibility of the National Commissioning Board or Local Authority.

4.2 Exceptionality

- 4.2.1 Where the CCG considers that the IFR submitted is supported by prima facie evidence of exceptionality, the request will be further considered under the terms of this Policy and via the supporting process.
- 4.2.2 The request is legally that of the patient, who should provide his or her consent to involvement in the IFR process, at the outset. Although the patient may submit the request themselves, the CCG acknowledges that in most cases the IFR will be formally made, and supporting evidence provided, by the patient's treating consultant, GP or other clinician ('the Clinician'). Indeed, the CCG recommends this approach. The individual submitting the collated IFR information is referred to within the Policy as 'the Requester'. Where the patient lacks capacity, the Requester must disclose whether or not a best interest's assessment has been undertaken. The CCG will not process the application, in such cases, until a positive confirmation has been provided that the treatment for which funding is sought is in the patient's best interests.
- 4.2.3 The CCG will respond by way of correspondence to the Requester. Where the Requester is not the patient, the correspondence will be copied to the patient unless the Clinician has advised on the IFR application that direct correspondence with the patient would not be in his or her best interests for clinical reasons. Other than in such cases, the patient will receive with the copy correspondence a leaflet intended as a patient's guide to the process.
- 4.2.4 Satisfaction of each of the following three criteria is one way in which

exceptionality might be demonstrated:

- i. That the application does not, in fact, seek to introduce a new treatment for a definable group (however small). Such cases constitute service developments and should be introduced via the CCG's annual prioritisation process.
 - ii. That the patient is significantly different from the general population of patients with the condition in question, at the same stage of progression, who are currently excluded from funding; and
 - iii. That the patient is likely to gain significantly more benefit from the intervention than the average patient with the condition, at the same stage of progression.
- 4.2.5 Although this should not be regarded as the only way in which exceptional clinical circumstances can be made out and the IFR Panel will consider each case on its merits.
- 4.2.6 In respect of consideration of cases that might be considered sufficiently rare, to be considered exceptional, rarity is defined as either and incidence of no greater than 2 per million population or a prevalence of no more than 10 per million population.
- 4.2.7 Non-clinical social factors (for example, but not limited to, age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors) will not be taken into account in determining whether exceptionality has been established.
- 4.2.8 The onus is on the Requester to set out clearly for the IFR Panel ('the Panel') the grounds on which it is said that the patient is exceptional. Further guidance can be found at Appendix 1 to this Policy. This guidance is not intended to be exhaustive but provides more detailed information and assistance to those making and adjudicating upon IFR applications.
- 4.2.9 If prima facie evidence of exceptionality has been provided, the case will be referred to the next IFR Panel.

4.3 Framework for Decision Making

- 4.3.0 To ensure consistency in approach, all decisions on funding taken under this Policy will be made against a common framework of commissioning standards, as detailed below:

4.3.1 Evidence – clinical and cost effectiveness

The decision to fund any intervention or treatment may be taken only after the Panel has satisfied itself that there is a sound evidence base for the likely clinical effectiveness and cost-effectiveness of the proposed treatment.

Appendix 1 provides further information in respect of the evidence required to support a request for individual funding in accordance with this Policy.

4.3.2 Affordability

Each CCG has a statutory duty to achieve financial balance despite the infinite demands placed on its finite resources. The affordability of treatment is therefore an inevitable and important consideration, when the CCG decides what specific aspects of health care it will commission for its patient population. This means that some treatments will not be routinely provided, whilst the cost of supporting one funding request may mean no funding being available for another request. Within these financial constraints, the CCG seeks to commission healthcare equitably amongst its population.

4.3.3 Equity

Each CCG is continually seeking to deliver improved healthcare outcomes to its population and to promote the health of the wider community. With finite resources, however, the CCG needs to reach decisions to ensure that those resources are utilised to provide the greatest overall health benefits for patients. The needs of the community may therefore conflict with the needs of the individual patient; and treatment will not generally be commissioned solely because an individual patient requests it.

4.3.4 National standards

National guidance and policy may direct the CCG to give priority to particular categories of patients or treatments and this may influence conclusions reached and investment decisions made.

4.4 Right to Appeal

4.4.1 If the patient or Requester is not satisfied that the correct process has been followed by the IFR Panel in reaching a decision on a funding request, the patient or Requester may ask for the matter to be considered by an Appeal Panel. (See 6.1 below for the appeal process).

4.4.2 The Appeal Panel will consider whether the procedure under this Policy was correctly applied in the IFR Panel's consideration of the request. If the Appeal Panel identifies a failure in process, the Appeal Panel will return the case to an appropriately constituted IFR Panel for reassessment (see 6.1.8).

4.5 Triggers for Service Development

4.5.1 All requests for treatments that are not routinely commissioned, where the patient fails to establish exceptionality, will be treated as service developments and will not be funded in-year unless there are compelling reasons, in terms of safety, clinical effectiveness and cost effectiveness, to consider them outside of the CCG's annual prioritisation process.

4.5.2 If multiple IFRs are received, on behalf of different patients, for the same treatment, the IFR Panel will notify the CCG prioritisation group (CPAG). The CCG will then review the need for a commissioning policy, in the usual way, but such requests cannot be considered exceptional and cannot be dealt with under this policy.

4.6 Emergency Decisions

- 4.6.1 Where, in the opinion of the Clinician supporting the request, an immediate decision needs to be made for emergency treatment purposes, the CCG will support the principle that treatment should be provided and agreement then reached with the Provider on who is responsible for the costs involved.
- 4.6.2 If a case is deemed urgent, but not an emergency, the Requester should email or fax the proforma request form to the CCG co-ordinating team and then follow this up with a telephone call to the IFR co-ordinator or administrator, in the first instance, to discuss and agree a reasonable timetable for the CCG to consider this request and make a decision.
- 4.6.3 For the purposes of this paragraph 4.6.2 and the operation of the Policy, “emergency” means “immediately life-threatening”. A case is deemed “urgent” if a decision needs to be reached more expeditiously than normal circumstances and process would allow, even though the patient’s condition is not immediately life-threatening.

4.7 Support for Patients

- 4.7.1 The IFR Co-ordinator can be accessed by patients and their representatives to provide general information and guidance prior to submission of a funding request,
- 4.7.2 If a patient is notified that their IFR will be considered by a Panel on a specific date, the notification letter will provide the name of an IFR Co-ordinator to whom all future enquiries about the request should be directed.
- 4.7.3 The patient, the Requester or the Clinician can contact the named IFR Co-ordinator at any stage throughout the process. However, the named IFR Co-ordinator will be unable to advise of the Panel decision or enter into discussions regarding the decision over the telephone with the patient, the Requester or the Clinician, other than such cases as described in 4.6.1 and 4.6.2 when any delay may compromise the care of the patient.

4.8 Requests to Continue the Funding of Care Commenced Privately

- 4.8.1 Patients have a right to revert to NHS care and funding at any point during their treatment. However, if they wish to exercise this right, the CCG will expect their care to be transferred to local pathways. Funding for the patient to continue to receive care in a private facility, or to transfer to an NHS provider with which a clinician consulted privately has a link, will not routinely be authorised and the patient would have to demonstrate that they were exceptional within the terms of this Policy for such funding to be considered appropriate. Private treatment is not funded retrospectively.

5.0 THE REQUEST PROCESS

5.1 Initial Determination Stage

- 5.1.1 Each IFR will be considered and decided on its own merits.
- 5.1.2 Any request for funding made under this Policy will be considered, in the first instance, by the IFR Co-ordinator (or a nominated deputy) or a senior Clinical Commissioning Group ('CCG') commissioning officer.
- 5.1.3 Any incomplete applications will be returned to the Requester at this stage.
- 5.1.4 The aim of the initial determination stage is to establish whether the funding request is properly categorised as an IFR, with a potential basis of exceptionality, or whether the request represents another type of Commissioning Enquiry.
- 5.1.5 In the event of the request meeting the acceptance criteria of an existing commissioning policy, the request will be prior-approved
- 5.1.6 To meet this end, the IFR Co-ordinator, a nominated deputy, or senior CCG commissioning officer may seek advice from one or more senior colleagues in Commissioning, Public Health and/or Medicines Management, as appropriate.
- 5.1.7 In the event that a request is for a service which is the commissioning responsibility of another organisation i.e. NHS England or Local Authority, the referrer will be signposted to that responsible commissioner.
- 5.1.8 A request for an effective intervention needed for a population of patients (however small) should be referred as a service development for potential inclusion in the prioritisation process and not couched in the form of an IFR application.
- 5.1.9 Once the IFR & Commissioning Policy Manager or senior CCG commissioning officer is satisfied that the request is properly categorised as an IFR, the following steps will be taken:

5.2 The Screening Stage

- 5.2.1 The IFR Co-ordinator (or a nominated deputy) or senior CCG commissioning officer, together with one or more senior colleagues in Commissioning, Public Health and/or Medicines Management, as appropriate, will establish whether prima facie evidence of exceptionality has been provided. The outcome of the screening process, and the reasoning on which the decision reached was based, will be documented.
- 5.2.2 If prima facie evidence of exceptionality has not been provided, the request will be refused and the IFR Co-ordinator will write to the Requester to give him/her the opportunity to provide such evidence. Such requests will not proceed through the IFR process, but will instead be designated as service developments and treated as such unless and until prima facie evidence of exceptionality is provided.

5.3 The IFR Panel Stage – decision on Exceptionality

5.3.0 Where prima facie evidence of clinical exceptionality has been provided by or on behalf of the patient, the request will be submitted for consideration under this Policy by the IFR Panel. Key elements of the discussion and the decision reached will be documented. Unless there are extenuating circumstances, the Panel will meet monthly. See paragraph 4.6 and 5.6 for the procedure relating to urgent and emergency decisions.

5.4 IFR Panel - Membership

5.4.1 An IFR Panel will consist of four principal members or deputies all of which must be present for the Panel to be quorate, including a CCG lay member, who will chair the Panel;

- i. A CCG Lay-member - Chair (voting)
- ii. A General Medical Practitioner (not responsible for the care of the individual for whom the IFR application is made, but being a member of the CCG with commissioning responsibility for the case under consideration) (voting). To this end, a Panel considering a number of cases on behalf of different CCGs may have a number of GP representatives present to ensure the delegated decision making responsibility is adequately addressed. Whilst all members will be entitled to enter into discussions on the cases, only the GP representing the relevant CCG will be entitled to vote.
- iii. A Director of Public Health or senior Public Health officer, as nominated by the Director (voting)
- iv. A senior representative from Medicines Management (voting)

5.4.2 The IFR Co-ordinator and Administrator or suitable deputies will join the Panel for administrative purposes but will not be entitled to vote on any decision.

5.4.3 Other professionals and advisors may be invited to attend, as relevant, to support and advise on discussions. Similarly NHS staff may attend as observers by prior agreement for the purposes of education, quality or assurance. They will not be entitled to vote on any decision.

5.5 IFR Panel - Role

5.5.1 All evidence supporting a claim to exceptionality should be submitted in appropriate documentary form, in advance of the Panel meeting, for the consideration of the Panel members. Neither Patients nor their Clinicians will be invited to attend Panel meetings and therefore the Requester should ensure that the Panel has all the documentation necessary for an informed consideration of the case. Patients may, however, submit a personal statement for the Panel's consideration, if they so wish, provided that this relies upon and refers only to their clinical circumstances and not to non-clinical social factors. The Panel will make its determination after careful scrutiny and discussion of the documentary evidence.

5.5.2 If the view of the voting members of the Panel is not unanimous, the decision will be carried by a majority vote. In the event of a tied vote, the Chair will have a casting vote.

5.5.3 The Panel must:

- i. Confirm that there is no existing service level agreement or commissioning policy under which the treatment sought could be funded.
- ii. Take into account all the relevant information submitted to it by the Requester.
- iii. Consistently apply the decision making framework in considering applications, to ensure that all cases are dealt with fairly and equitably.
- iv. Give proper consideration to the expressed needs of the patient, as described and evidenced by the Clinician and the patient themselves.
- v. Take into account all relevant factors, including the clinical effectiveness and cost-effectiveness of the requested treatment.
- vi. Ensure that any issues and concerns, identified either by the Panel or by the Requester, which are outside the remit of this Policy, are noted and passed through to the appropriate area of the CCG for further consideration and response.
- vii. Set out its decision and the reasons for that decision in writing to the Requester and the patient (unless such communication is contra-indicated by the Clinician - see section 4.2.3 above).

5.5.4 Any conflicts of interest or potential conflicts should be identified and declared to the IFR coordinator (or deputy), or Chair, at the earliest opportunity once the paperwork has been sent to the members so that a substitute member may be found as soon as possible, to avoid postponement of consideration of the case. Where the conflict or potential conflict only becomes apparent at the start of or during the course of the Panel discussions, the member should declare it immediately and a decision will be taken as to whether the conflict requires the withdrawal of that Panel member, in which case consideration of the case is likely to have to be postponed.

5.6 The Virtual Panel

5.6.1 It is anticipated that, in normal circumstances, the Panel will meet face to face. When circumstances require an urgent decision and a face to face meeting cannot be convened, a virtual meeting may be held, whereby discussions take place by telephone and/or by email (as the nature of the discussions require), with all nominated members of the Panel contributing to the discussions.

5.6.2 Any Virtual Panel will be expected to ensure that auditable standards of documentation supporting the discussions are maintained and that its meeting is conducted in accordance with the following procedure:

5.6.3 Procedure

- i. All paperwork concerning the matter for decision will be emailed or posted to all members, together with any supporting documentation
- ii. The treatment upon which a decision is sought from the Panel will be clearly stated.
- iii. All queries, comments and discussion points will be shared with the members via email, or by telephone conferencing.
- iv. A clear deadline for the decision will be identified.
- v. The Chair of the Panel will normally be a Lay member of a CCG
- vi. Any conflicts of interest or potential conflicts should be declared to the IFR co-ordinator, or Chair, at the earliest opportunity once the paperwork has been sent to the members or, where the conflict or potential conflict only becomes apparent during the course of the virtual discussions, as soon as the Virtual Panel member becomes aware of it.
- vii. If the view of the Virtual Panel is not unanimous, the decision will be carried by majority vote. In the event of a tied vote, the Chair will have a casting vote.
- viii. The outcome of the Virtual Panel meeting will be advised formally in writing to all members of the Panel. The decision and the reasons for that decision will be set out in writing to the Requester and the patient (unless this is contra-indicated by the Clinician -see section 4.2.3 above).
- ix. Given the confidential nature of the material to be considered under this virtual process, all emails will be marked as CONFIDENTIAL and HIGH PRIORITY and documents will be protected in line with the following CCG policies: "Confidentiality: Staff Code of Conduct" and "Information Governance Policy".
- x. It is recommended that all Panel members and deputies have access to NHS.Net email accounts for use in the event of a virtual panel.

5.7 Fresh evidence

5.7.1 Where a request for funding for a particular treatment has been refused by a Panel or Virtual Panel, the case will nonetheless remain on file. In the event that fresh evidence subsequently comes to light which may, potentially, be capable of demonstrating exceptional clinical circumstances, the Requester may submit this, in appropriate documentary form, to the IFR & Commissioning Policy Manager, or IFR Co-ordinator. The new material will be examined and screened in accordance with Paragraphs 5.1 and 5.2 above. If it is considered to demonstrate prima facie evidence of exceptionality, it will go before the next IFR Panel for consideration. The IFR Panel will consider the fresh evidence in the context of the original evidence submitted rather than in isolation i.e.: it will consider the totality of the evidence, old and new.

5.7.2 The submission of fresh evidence should not be confused with an

appeal. Where fresh evidence is submitted but the request for reconsideration is incorrectly couched as a request for an “appeal”, it will be dealt with in accordance with Paragraph 5.7.1

6.0 THE APPEAL PROCESS

6.1 Appeal Panel - Function

- 6.1.1 If the Requester or patient is not satisfied that the correct process has been followed by the Panel in reaching a decision on a funding request, the patient or requester may ask for the matter to be considered by an Appeal Panel. This is the only ground on which an appeal may be requested.
- 6.1.2 If an IFR has been refused in accordance with the screening criteria (at 5.2 above), because no prima facie evidence of exceptionality has been submitted, an appeal cannot be requested. Instead, the Requester will be given the opportunity to provide such evidence.
- 6.1.3 In order to support an impartial approach to the appeal process the South Staffordshire CCGs have agreed to consider any appeals on behalf of a neighbouring CCG. The Requester should submit a request for an appeal, in writing, to the Accountable Officer as follows:-
- i. Appeals relating to patients registers with Cannock Chase CCG should be addressed to the Accountable Officer of South East Staffordshire & Seisdon Peninsular CCG and vice versa.
 - ii. Appeals relating to patients registered with Stafford and Surrounds CCG should be addressed to the Accountable Officer of East Staffordshire CCG and vice versa.

Appeals should be made within three months of receipt of the notification letter detailing the outcome of the decision of the initial IFR Panel. The appropriate Accountable Officer may agree to consider an appeal received outside of this timescale, if it considers that the Requester has good reasons for failing to observe the three month time limit for submission of an appeal. The decision to consider, or to decline to consider, an appeal submitted out of time is entirely within the Accountable Officers discretion and will be reached after consideration of the particular circumstances.

- 6.1.4 The sole purpose of the Appeal Panel will be to consider whether, having regard to the appeal papers submitted by or on behalf of the patient, the decision of the initial Panel was valid, having regard to the process followed, the factors and information considered and the criteria applied.
- 6.1.5 It is not appropriate for an appeal to be requested solely on the grounds that an individual disagrees with the decision made by the IFR Panel. The decision itself will not be reviewed; only the process which the Panel followed in order to reach that decision. Patients who merely disagree with the decision made will be advised of their right to pursue the matter

via the NHS Complaints system and thence, if appropriate, the Parliamentary and Health Service Ombudsman.

- 6.1.6 Given that the sole purpose of the Appeal Panel, as outlined at 6.1.4 above, is to consider whether the decision of the initial Panel is valid, having regard to the process followed, the factors and information considered and the criteria applied, patients, Requesters and their Clinicians will not routinely be invited to attend Appeal Panel hearings.
- 6.1.7 In deciding an Appeal, the Appeal Panel will consider whether:
- i. The decision was consistent with the "Policy Principles" set out at section 4.0 above
 - ii. The decision was consistent with previous analogous decisions
 - iii. In reaching the decision, the Panel had taken into account and weighed all the relevant evidence given proper consideration to the claims of the patient and accorded proper weight to their claims against those of other groups competing for scarce resources
 - iv. Taken into account only material factors
 - v. Acted in utmost good faith
 - vi. Reached a decision that is in every sense reasonable
- 6.1.8 If the Appeal Panel concludes that there was a failing in the original decision-making process, it will return the case to an appropriately constituted IFR Panel for reassessment, having outlined the areas in which the panel is deemed to have failed to follow process.
- 6.1.9 Any conflicts of interest or potential conflicts should be identified and declared to the IFR Co-ordinator, or Chair, at the earliest opportunity once the paperwork has been sent to the Appeal Panel members so that a substitute member may be found as soon as possible, to avoid postponement of consideration of the case. Where the conflict or potential conflict only becomes apparent at the start of or during the course of the Appeal Panel discussions, the member should declare it immediately and a decision will be taken as to whether the conflict requires the withdrawal of that Panel member, in which case consideration of the case is likely to have to be postponed.

6.2 Appeal Panel - Structure

- 6.2.1 Appeal Panels will have five members:
- i. CCG Accountable Officer or Chief Operating Officer (or equivalent) (Appeal Panel Chair)
 - ii. Director of Quality and Nursing (or deputy)
 - iii. A Lay member not involved in the original panel
 - iv. Director of Public Health or a senior Public Health officer, as nominated

by the Director. (voting)

v. CCG clinical chair or nominated Clinical Director

6.2.2 If the view of the Appeal Panel is not unanimous, the decision will be carried by a majority vote. In the event of a tie, the Chair will have the casting vote.

6.2.3 The decision of the Appeal Panel will be final.

6.2.4 If the patient or Requester remains dissatisfied with the Appeal Panel's decision, it is open to them to pursue the matter through the NHS Complaints process and subsequently, if appropriate, with the Parliamentary and Health Service Ombudsman.

6.2.5 All Appeals Panel decisions will be reported promptly to the IFR manager, with a view to scheduling a review of the case by an appropriate panel or closing the case as appropriate.

7.0 TIMESCALES

7.1 All requests for the consideration of an IFR or an appeal will be acknowledged within 3 working days of receipt.

7.2 The outcome of the screening process will be notified to the Requester within 15 working days of receipt of the initial application. Where the request has been refused, the Requester will be offered the opportunity to submit further evidence.

7.3 Where the screening process determines that prima facie evidence of exceptionality has been provided, the case will usually be considered by the next scheduled Panel (panels are usually scheduled to meet monthly). The Requester will be notified in writing of the Panel's decision within 5 working days of the Panel meeting. CCG staff will not enter into verbal or written correspondence with the patient or their Clinician during this 5 working day period, with the exception of urgent requests where delayed communication may compromise the patients care

7.4 The Appeal Panel will meet as and when required. The Appeal Panel will be convened within 30 days of receipt of an appeal.

7.5 The IFR Co-ordinator will notify the Requester of the decision of the Appeal Panel within 5 working days of the Appeal Panel meeting.

8.0 MANAGING INFORMATION

8.1 Patient Confidentiality

8.1.1 All information received and considered under this Policy remains confidential and will be managed in accordance with the Data Protection Act 1998 and will be held, processed and shared only as required for the purposes of delivering services in accordance with the principles of the

Policy.

- 8.1.2 A patient who has mental capacity must consent to all relevant information being shared with the IFR Panel. The IFR application form requires the Requester to confirm that the patient has consented to an IFR application being made and processed. Written permission will be obtained from the patient at any time that the sharing of identifiable data, beyond CCG or Area Team staff involved in handling the request, is envisaged.
- 8.1.3 Where the patient lacks mental capacity, the Clinician will be asked to confirm on the application form that a best interest's assessment has been undertaken. The Clinician must be able to supply documentary evidence of the assessment and the resulting decision, should the CCG request this, although this should not be submitted with the application.
- 8.1.4 All patient identifiable data will be transmitted in accordance with the CCG's policy on the handling of sensitive personal data as set out in the following policies: "Confidentiality: Staff Code of Conduct" and "Information Governance Policy".

8.2 Communicating Decisions

- 8.1.1 The CCG will provide the Requester and the patient (unless this is contra-indicated by the Clinician, or Requester - see 4.2.3) with an explanation of the reason(s) for any decision not to fund the treatment sought.
- 8.1.2 Where the Panel declines a request for funding, the Requester and patient (unless contra-indicated) will be clearly advised of the grounds on which an appeal may be lodged.

8.3 Responsible Commissioner

- 8.3.0 Where the CCG receives a request for treatment that falls within a service area not directly managed by the CCG, the request will be referred to the relevant host organisation for review and consideration under their local policy and procedures.

8.4 Other Matters Identified

- 8.4.0 Where the Panel or Appeal Panel, in the course of considering a funding request, identifies issues which lie outside the purpose and remit of the IFR process, the Panel or Appeal Panel will formally note the concern or issue for follow up within the relevant CCG

9.0 EVALUATION & REVIEW

- 9.1 This Policy will be reviewed on a two-yearly basis, unless circumstances suggest that earlier review is appropriate.

- 9.2 The review will include an equality analysis and an audit of decisions made, to ensure that the Policy has been applied consistently and to identify any changes required to the process, in the light of existing practice and other factors such as developing legislation, reform and case law.

10.0 TRAINING SUPPORT

- 10.0 Training to support members of the Panels and Appeal Panels will be provided, to ensure that respective roles are understood and to provide members with the necessary skills to fulfil their role as a Panel member.

APPENDIX 1 - Guidance for Panels

1. The determination of exceptionality

Funding will only be provided for a patient outside the CCG's annual prioritisation process if the Requester is able to demonstrate that the patient's clinical circumstances are exceptional.

a. What is meant by "exceptional" circumstances?

There can be no exhaustive definition of the conditions which are likely to come within the definition of an exceptional individual case. The word "exception" means "a person, thing or case to which the general rule is not applicable"³.

The Panel should bear in mind that, whilst everyone's individual circumstances are, by definition, unique, very few patients have circumstances which are exceptional, so as to justify funding for treatment for that patient which is not available to other patients. The following points constitute general guidance to assist the Panel. However, the overriding question which the Panel needs to ask itself remains "Has it been demonstrated that this patient's clinical circumstances are exceptional?"

- It may be possible to demonstrate exceptionality where the patient has a medical condition which is so rare that the result of the CCG's annual prioritisation process provides no established treatment care pathway for that condition.
- If a patient has a condition for which there is an established care pathway, the Panel may find it helpful to ask itself whether the clinical circumstances of the patient are such that they are exceptional as compared with the relevant subset of patients with that medical condition at the same stage of progression of the condition.
- The fact that a patient failed to respond to, or is unable to be provided with, one or more treatments usually provided to a patient with his or her medical condition (either because of a generic other medical condition or because the patient cannot tolerate the side effects of the "usual" treatment) may be a basis upon which a Panel could find that a patient is exceptional.

However, the Panel would normally need to be satisfied that the patient's inability to respond to, or be provided with, the "usual" treatment was a genuinely exceptional circumstance. For example:

- If the "usual" treatment is only effective for a proportion of patients (even a high proportion), this leaves a proportion of patients for whom the "usual" treatment is not available or is not clinically effective. If there is likely to be a significant number of patients for whom the "usual" treatment is not clinically effective or not otherwise appropriate (for any reason), the fact that the requesting patient falls into that group is unlikely to be a proper ground on which to base a claim that the requesting patient is exceptional.
- If the "usual" treatment cannot be given because of a pre-existing co-morbidity which could not itself be described as exceptional in this patient group, the fact of the co-morbidity and its impact on treatment options for the requesting patient is unlikely to

³ Definition in the Shorter Oxford English Dictionary.

make the patient exceptional.

b. Non-clinical factors:

Patients often seek to support an application for individual funding on the grounds that their personal circumstances are exceptional. This assertion can include details about the extent to which other persons rely on the patient, or the degree to which the patient has contributed, or is continuing to contribute, to society. The CCG understands that everyone's life is different and that such factors may seem to be of vital importance to patients in justifying investment for them in their individual case. However, including such non-clinical, social factors in any decision-making raises at least three significant problems for the CCG:

- Across the population of patients who make such applications, the CCG is unable to make an objective assessment of material put before it relating to non-clinical factors. This makes it very difficult for the Panel to be confident of dealing in a fair and even-handed manner in comparable cases.
- The essence of an individual funding application is that the CCG is making funding available on a one-off basis to a patient where other patients with similar conditions would not get such funding. If non-clinical factors are included in the decision making process, the CCG does not know whether it is being fair to other patients who are denied such treatment and whose social factors are entirely unknown.
- The CCG is committed to a policy of non-discrimination in the provision of medical treatment. If, for example, treatment were provided which had the effect of keeping someone in paid work, this would tend to discriminate in favour of those of working age and against the retired. If a treatment were provided differentially to patients who were carers, this would tend to favour treatment for women over men. If treatment were provided, in part, on the basis that a medical condition had affected a person at a younger age than that at which the condition normally presents, this would constitute direct age discrimination.

Generally, the NHS does not take into account social factors in deciding what treatment to provide. It does not seek to deny treatment to smokers on the grounds that they may have caused or contributed to their own illnesses through smoking, nor does it deny treatment to those injured in dangerous sports in which they were voluntary participants.

In general, the NHS treats the presenting medical condition and does not inquire into the background factors which led to the condition. The policy of the CCGT is that it should continue to apply these broad principles in individual applications for funding approval. The CCG will therefore seek to commission treatment based on the presenting clinical condition of the patient and not based on the patient's non-clinical social circumstances.

In reaching a decision as to whether a patient's circumstances are exceptional, the Panel is required to follow the principle that non-clinical or social factors including social value judgments about the underlying medical condition or the patient's circumstances are never relevant.

Patients and referring Clinicians are asked to bear this policy in mind and not to refer to social or non-clinical factors to seek to support the application for individual funding.

c. Proving the case that the patient's circumstances are exceptional

The onus is on the Requester to set out the grounds clearly for the Panel on which it is said that this patient is exceptional. The grounds will usually arise out of an exceptional clinical manifestation of the medical condition, as compared to the general population of patients with the medical condition which the patient has.

These grounds must be set out on the form provided by the CCG and should clearly set out any factors that the patient invites the Panel to consider as constituting a case of exceptional circumstances. If, for example, it is said that the patient cannot tolerate the “usual” treatment because of the side effects of another treatment, the patient or the referring Clinician (who is often the expert with detailed knowledge) must explain how unusual it is for patients with this condition not to be able to be provided with the “usual” treatment.

If a clear case as to why the patient’s circumstances are said to be exceptional is not made out, then the Panel is obliged to refuse the application. The Panel recognises that the patient’s referring Clinician is often in the best position to provide information about the patient’s clinical condition as compared to a subset of patients with that condition. The CCG therefore requires the referring Clinician, as part of their duty of care to the patient, to explain why the patient’s circumstances are said to be exceptional.

The policy of the CCG is that there is no duty on the Panel to carry out its own investigations about the patient’s circumstances in order to try to find a ground upon which the patient may be considered to be exceptional nor to make assumptions in favour of the patient if one or more matters are not made clear in the application. Therefore, if a clear case of exceptionality is not made out by the Requester, the Panel is obliged to turn down the application.

d. Multiple claimed grounds of exceptionality

There may be cases where patients seek to rely on multiple grounds to show their case is exceptional. In such cases the Panel should look at each factor individually to determine (a) whether the factor was capable of making the case exceptional and (b) whether it did in fact make the patient’s case exceptional. The Panel may conclude, for example, that a factor was incapable of supporting a case of exceptionality and should therefore be ignored. That is a judgment within the discretion of the Panel.

If the Panel is of the view that none of the individual factors on their own make the patient’s circumstances exceptional, the Panel should then look at the combined effect of those factors which are, in the Panel’s judgment, capable of supporting a finding of exceptionality. The Panel should consider whether, in the round, these combined factors prove that the patient’s circumstances are exceptional. In reaching that decision the Panel should remind itself of the difference between individually distinct circumstances and exceptional circumstances.

2. The determination of clinical effectiveness

It is the responsibility of the Requester to explain to the Panel the basis upon which it is said that the requested treatment would be likely to be clinically effective for that individual patient. Details should be provided of the anticipated benefits for the patient, the level of confidence that the referring Clinician has that the benefits will be shown and the likely duration of any benefit.

Reference should be made to published material including RCT trials, NICE or other Guidance, recommendations of specialist medical bodies and any other materials relied upon.

The Panel is entitled but not obliged to seek its own specialist advice about whether a treatment is likely to be clinically effective.

A case which comes before the Panel for approval for individual funding will be subject to the same principles of assessing clinical effectiveness as treatments where a population-wide approach is taken (as far as that is possible given the inherent difficulties in an individual case).

No treatment will be approved for funding by the CCG unless the Panel is satisfied that the treatment is likely to be clinically effective. If the Panel is not provided with sufficient material so

that it can be reasonably confident that the treatment is likely to be clinically effective, then it must refuse the application.

3. The determination of cost-effectiveness

It is the responsibility of the Requester to explain to the Panel the basis upon which it is said that the requested treatment is likely to be cost-effective for the individual patient.

Reference should be made to published Incremental Cost-Effectiveness Ratio/Quality Adjusted Life Year ("ICER/QALY") material or other guidance, recommendations of specialist medical bodies and any other materials relied upon. If the referring Clinician is aware of any material relating to cost-effectiveness, including any adverse observations on the cost-effectiveness of the requested treatment, he or she is required to put this material before the Panel.

The Panel is entitled but not obliged to seek its own specialist advice about whether a treatment is likely to be cost-effective.

A case which comes before the Panel for approval for individual funding will be subject to the same principles of assessing cost-effectiveness as treatments where a population-wide approach is taken (as far as that is possible given the inherent difficulties in an individual case). No treatment should be approved for funding unless the Panel is satisfied that the treatment is likely to be cost-effective. If the Panel is not provided with sufficient material so that they can be reasonably confident that the treatment is likely to be cost-effective then it must refuse the application.