Individual Funding Request Policy

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| Target Audience | * This policy applies to any referring clinician, all ICB staff members, including Board Members of the ICB, Governing Body Members and Practice Representatives, involved in the ICB’s policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third party supplier).
* This Policy also applies to patients registered with a GP within the MSE ICB region.

  |
| Stakeholders engaged in development of Policy (internal and external)  | Chief of StaffHead of Governance and Risk |
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# Version History

| Version | Date | Author (Name and Title) | Summary of amendments made |
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| 0.3 | 27/09/22 | Maggie Pacini | Review of Version 0.2 |
| 0.4 | 05/10/22 | Kaye Lawson  | Minor changes, cleaned up comments |
| 0.5 | 17/10/22 | James Hickling | Minor changes, cleaned up comments |
| 0.6 | 19/10/22 | Kaye Lawson  | Minor changes, cleaned up comments ready for review by CliMPC  |
| 0.7 | 23/10/22 | Nicola Adams | Minor changes, to committee responsibility – added Quality Committee. |
| 0.8 | 27/10/22 | James Hickling | Updating with comments from Clinical Multiprofessional Congress and EIA |
| 0.9 | 14/12/22 | Kaye Lawson  | Minor changes, cleaned up comments following CliMPC |
| 0.10 | 04/01/23 | Kaye Lawson | Final review, tidy up against ICB Policy Review Checklist |
| 1.0 | 01/02/23 | Kaye Lawson | Final version complete |

# Contents

[1. Introduction 5](#_Toc126164276)

[2. Purpose / Policy Statement 6](#_Toc126164277)

[3. Scope 7](#_Toc126164278)

[4. Definitions 8](#_Toc126164279)

[5. Roles and Responsibilities 10](#_Toc126164280)

[5.1. IFR Panel 10](#_Toc126164281)

[5.2. ICB Board 11](#_Toc126164282)

[5.3. Clinical and Multi-Professional Congress (CliMPC) 11](#_Toc126164283)

[5.4. Quality Committee 11](#_Toc126164284)

[5.5. Chief Executive 11](#_Toc126164285)

[5.6. Medical Director 11](#_Toc126164286)

[5.7. Policy Authors 11](#_Toc126164287)

[5.8. Associate Medical Director for Quality Assurance & Governance 11](#_Toc126164288)

[5.9. IFR Manager 12](#_Toc126164289)

[5.10. IFR form or clinic letter received and logged by Funding team. 12](#_Toc126164290)

[5.11. Initial triaging 13](#_Toc126164291)

[5.12. Timeframes. 13](#_Toc126164292)

[5.13. Applications covered by existing commissioned services 13](#_Toc126164293)

[5.14. Applications not covered by existing commissioned services 13](#_Toc126164294)

[5.15. Request is processed as a ‘Fast Track’ case 14](#_Toc126164295)

[5.16. Referrer informed 14](#_Toc126164296)

[5.17. IFR Panel convened 15](#_Toc126164297)

[5.18. Outcome of the IFR Panel 17](#_Toc126164298)

[5.19. New Information 17](#_Toc126164299)

[5.20. Appeal Process 17](#_Toc126164300)

[6. Monitoring Compliance 19](#_Toc126164301)

[7. ICB commissioning principles that underpin IFR decision making 19](#_Toc126164302)

[7.4. Specific commissioning position with respect to different categories of IPG is laid out below: 20](#_Toc126164303)

[8. Staff Training 25](#_Toc126164304)

[9. Arrangements For Review 26](#_Toc126164305)

[10. Associated Policies, Guidance And Documents 26](#_Toc126164306)

[11. References 26](#_Toc126164307)

[12. Equality Impact Assessment 26](#_Toc126164308)

[Appendix A - Equality Impact Assessment 28](#_Toc126164309)

[Appendix B – Exceptional Test Example 32](#_Toc126164310)

[Appendix C – Terms of Reference (ToR) for the IFR Panel 33](#_Toc126164311)

[Appendix D - References 37](#_Toc126164312)

## Introduction

The NHS exists to serve the needs of all patients but also has a statutory duty to break even financially (National Health Service Act 2006). Integrated Care Boards (ICBs) have responsibility to provide health benefits for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

Mid and South Essex (MSE) ICB receives a fixed budget from Central Government with which to commission healthcare services required by its population. Commissioned services include those provided through primary, secondary and tertiary care NHS providers, the independent sector, voluntary agencies and independent NHS contractors.

ICB investment and disinvestment decisions are driven by the annual planning guidance and set out in its commissioning intentions. ICBs do not expect to make significant decisions outside this process and, in particular, do not expect to commit significant new resources in year to the introduction of new healthcare technologies (including drugs, surgical procedures, public health programmes, equipment) since to do so risks ad-hoc decision making and destabilisation of previously identified priorities.

The commissioning process, by its very nature, focuses on cohorts of patients with more common clinical conditions. It cannot meet every healthcare need of all patients in any one clinical group or address the specific needs of patients with less common clinical conditions. The fact that a ICB is not meeting a healthcare need due to resource constraints is an inevitable fact of life in the NHS and does not indicate that that the ICB is breaching its statutory obligations.

ICBs are required to have a process for considering funding for individuals who seek NHS commissioned services outside established commissioning policies. There are, in general two types of requests (Category 1 and 2) that come before an Individual Funding Request (IFR) Panel, namely:

**Category 1** - Requests for funding treatments for medical conditions where the ICB has no established commissioning policy (commonly called IFR requests), and

**Category 2** - Requests for funding treatments for medical conditions where the ICB does have an established commissioning policy for that condition but where the requested individual treatment is not in the ICB policy or does not meet the criteria set out in the policy.

This policy requires requests in **Category 1** to be considered against the tests of clinical effectiveness, cost effectiveness and affordability provided that the requesting clinician is able to demonstrate that the patient represents an ‘Individual Patient’ (as defined in Section 4) and is not typical of a group of patients e.g., the patient is the first in a cohort.

For patients in **Category 2,** the policy requires the requesting clinician to demonstrate that the patient has exceptional clinical circumstances. If the clinician demonstrates that the patient has exceptional clinical circumstances (as defined in Section 4) the request will also be considered against tests of clinical and cost effectiveness and affordability.

This approach ensures that decisions relating to resource allocation are made transparently and consistently in relation to:

* Treatment for those patients with rare conditions
* Those patients for whom treatments of uncertain or unproven medical benefit are sought, or
* Where treatment costs requested may be out of proportion with the benefit to the patient.

The IFR Policy and supporting documentation is available at <https://www.midandsouthessex.ics.nhs.uk/>

## Purpose / Policy Statement

This policy will be used to consider Individual Funding Requests (IFRs) where a service, intervention or treatment falls outside existing service agreements.

All decisions will be made in accordance with the following principles:

* The ICB requires clear evidence of clinical and cost effectiveness before NHS resources are invested in the treatment.
* The affordability of the treatment for this patient and others within any anticipated cohort is a relevant factor.
* The ICB will consider the extent to which the individual or patient group will gain a benefit from the treatment.
* The ICB will balance the needs of an individual against the benefit that could be gained by alternative investment possibilities to meet the needs of the community.
* The ICB will consider all relevant national standards and all proper and authoritative guidance.
* Where a treatment is approved, the ICB will respect patient choice, within existing commissioned pathways and ICB policies, as to where a treatment is delivered.

When considering an application, the ICB will also ensure that decisions:

* Comply with relevant national policies or local policies and priorities that have been adopted by the ICB concerning specific conditions or treatments.
* Are based on the available evidence concerning the clinical, cost effectiveness and affordability of the proposed treatment.
* Are taken without undue delay.

The ICB considers the lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sex gender, and sexual orientation, save where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated clinical benefits for this individual to be derived from a proposed form of treatment.

These principles and the following process will ensure that each request for funding is considered in a fair and transparent way.

## Scope

This policy applies to any referring clinician, all ICB staff members, including Board Members of the ICB, Governing Body Members and Practice Representatives, involved in the ICB’s policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third-party supplier).

This policy also applies to patients registered with a GP practice within the boundary of the MSE ICB. If unregistered, the patient’s usual residence must be within the MSE boundary.

This policy does not cover treatments normally commissioned by other bodies. For example, specialised cancer services are commissioned by the Specialised Commissioning Teams at NHS England.

## Definitions

* **Funding team** - This refers to the team which maintains overall responsibility for the management, processing and triaging of funding applications received for patients registered with a GP within the MSE ICB area.
* **IFR Request** – An application to an NHS commissioning organisation (such as an ICB) to fund healthcare for an individual who falls outside the range of services and treatments that the organisation has agreed to commission (NHS Confederation 2008).
* **IFR Panel** – A multi-disciplinary professional group responsible for making decision on IFRs when clear evidence of clinical and cost effectiveness/affordability have been identified within the patients case.
* **Exceptionality** – The words “exceptional”, "exceptionality" and “exceptional clinical circumstances” bear their natural meanings as defined in the Oxford English Dictionary. However, the ICB recognises that the meaning of these words has given rise to considerable difficulty in the past and offers the following guidance to assist the IFR Team, Panel and clinicians as to how to approach the meaning of the words.

There is a difference between “individual” and “exceptional”. Every patient has features of their condition which are specific to that individual and are not likely to be repeated in other patients with the same clinical condition at the same stage of progression of the condition. Exceptionality is not the same as individuality.

To consider whether a patient has exceptional clinical circumstances the IFR Panel will focus on the following issues:

* + - Are there any clinical features of the patient’s case which make the patient significantly different to the general population of patients with the condition in question at the same stage of progression of the condition?
		- Would the patient be likely to gain significantly more clinical benefit from the requested intervention than might be normally expected for the general population of patients with the condition at the same stage of the progression of the condition?

In line with the principle that patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon where treatments, devices or pieces of equipment can be used to treat various conditions, it is the presenting need that will be assessed against the same criteria as everyone else requiring the intervention. This applies particularly to equipment requests – **Examples can be found in Appendix B**

* **Individual Patient** – For the purposes of this policy, an Individual Patient is determined by reviewing the incidence and prevalence of the requested intervention for a particular condition at the same stage of progression of that condition. If the ICB has no policy for the intervention being requested for a particular condition, then an IFR Panel can only consider the request if both the incidence and prevalence criteria that are set out are met or the patient has exceptional clinical circumstances compared to the cohort of patients (however small) with the presenting condition.

In some cases, ICBs may have adopted policies for small numbers of patients which have often been developed regionally. If the request is covered by such a policy, then it should be viewed as a request to change the policy and therefore will not be considered by the IFR Panel, even if the incidence and prevalence criteria are met.

An IFR application for an individual patient will be considered by the IFR Panel on its individual merits with the decision on whether to fund a requested intervention based on the evidence of clinical/cost effectiveness and affordability.

If both the prevalence and incidence criteria are not met, then the ICB will not consider that the request represents an individual patient. In these circumstances, funding can only be provided if a decision is made by the ICB to develop a policy for the requested intervention for a group of patients, including the requesting patient; unless the patient has exceptional clinical circumstances compared to the cohort of patients (however small) with the presenting condition.

* **Incidence** - The number of new cases of a disease in a defined population within a specified period of time. The intervention for a particular condition at the same stage of progression of that condition is expected to be initiated for two or fewer patients per million population per year
* **Prevalence** - The number of cases of a disease in a defined population at a point in time. The total number of patients on the intervention for a particular condition at the same stage of progression of that condition is less than 10 patients per million population at any one time.
* **Triage** – The Funding team will determine whether IFR applications have sufficient evidence of clinical, cost effectiveness and affordability to proceed to an IFR Panel.
* **Cohort -** For the purpose of this policy a cohort is a group of patients who have shared a particular event together during a particular time span.
* **Declarations of interest and conflicts of interest –** a conflict of interest might arise as a result ofan IFR Panel member’s involvement with pharmaceutical companies or membership of committees. It can also include personal experience (they, or a close relative/friend, suffer from / receive treatment for the same condition that the IFR relates to).

Conflicts can also arise as a result of involvement with support/charitable groups relating to the condition for which treatment is being requested or if an IFR Panel member has recently been involved with the care of the patient. In the event of a potential conflict of interest, the Chair / non-conflicted Panel members will take a view as to whether the conflicted member should be involved in consideration of the request. Action taken to manage the conflict must be documented within the minutes of the Panel meeting. Further information regarding the management of conflicts of interest is available within the [Management of Conflicts of Interest Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies).

Where Panel members have a conflict of interest either by virtue of a connection with the patient or in terms of a vested interest as a potential service provider, this must be declared as soon as it becomes apparent. An alternative individual will need to be agreed to replace them **(Appendix C – Terms of Reference (TOR)**

The Panel will consider on an individual basis; what action is required where the Panel member knows the patient

All Panel members should follow their local conflicts of interest policy.

## Roles and Responsibilities

### IFR Panel

* + 1. The MSE, ICB, IFR Panel is responsible for considering IFRs which have been assessed through the IFR team’s triage process as falling outside approved policy, demonstrate clinical exceptionality and where no precedent can be established as a basis for approving funding.
		2. The IFR Panel works on behalf of the ICB and makes decisions in respect of funding for individual cases which have been deemed as having evidence of clinical exceptionality, clinical and cost effectiveness, and affordability. It is not the role of the IFR Panel, by its decisions, to make a clinical commissioning Policy on behalf of the ICB.

### ICB Board

* + 1. The ICB Board is accountable and responsible for ensuring that the ICB has effective processes for managing IFRs in accordance with relevant legislation and best practice guidance. The Board is assured through the work of the Clinical and Multi-Professional Congress (CliMPC).

### Clinical and Multi-Professional Congress (CliMPC)

* + 1. The role of CliMPC is to ensure clinical effectiveness is achieved across the system, with consistent adoption of best practice and common clinical policies and standards. The Congress will review and provide strategic recommendations with regards to the IFR Policy to the ICB.

### Quality Committee

* + 1. The Quality Committee is responsible for oversight of compliance with the principles of the policy (not clinical decision making) and thus will monitor the effectiveness of the policy and receive update reports from the Funding Team.

### Chief Executive

* + 1. The Chief Executive Officer of the ICB has overall accountability for the IFR Policy.

### Medical Director

* + 1. The Medical Director is the Executive Board member with delegated responsibility for development and implementation of this policy.

### Policy Authors

* + 1. The policy author will have responsibility for reviewing and updating the policy in line with **Section 8.**

###  Associate Medical Director for Quality Assurance & Governance

* + 1. The Associate Medical Director for Quality Assurance & Governance is responsible for the oversight of the operational implementation of policy and line management of the Funding Team Manager and to lead on the monitoring and compliance with this policy.

### IFR Manager

* + 1. The IFR Manager or deputy is responsible for supporting the IFR Panels as a non-voting member to:
	+ Ensure consistency in the decision-making processes and ensuring the maintenance of a record of prior decisions to enable reference to precent where relevant.
	+ Share experience gained in dealing with requests for individual patients within the ICB.
	+ Ensure the Funding Team and Panel operate according to best practice with regards to this policy.
	+ To provide adequate, appropriate, and transparent reporting to the ICB board and its committees, stakeholders and the public when required.

### IFR form or clinic letter received and logged by Funding team.

* + 1. An NHS doctor, or other appropriate NHS health care professional directly involved in the care of a patient, can make a request for an intervention not routinely funded by the ICB. It is the responsibility of the treating clinician (the referrer) to ensure the IFR Form is completed as accurately and comprehensively as possible to avoid possible delays in considering the request.
		2. Hand written and incomplete forms will be returned and might result in a delay in the decision-making process.
		3. A patient, a non-clinical representative, or a non-NHS clinician cannot submit an IFR as an NHS clinical sponsor is required. However, the Funding team will provide guidance on the correct process to any patient who submits a request for treatment.
		4. Correspondence from the treating clinician/patients (advocate) can be submitted via email or letter. The Funding Team’s Contact details can be found on the ICB website. [Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/)
		5. All correspondence will be processed and logged onto the ICB secure database by the Funding team at this point.
		6. For each request received, a unique reference number will be generated with all paperwork pertinent to the case kept in chronological order electronically. All decisions will be fully documented, and all communication will be in writing (either by letter or email). When telephone conversations take place, a file note will be added as a record of the conversation. Both the evidence considered, and the decision made will be recorded in writing. National and local NHS policies regarding confidentiality, retention and destruction of records will be adhered to.

### Initial triaging

* + 1. Cases are initially dealt with and triaged by the Funding team who will advise the referrer whether the Service Restriction Policy (SRP), portfolio of contracts, Service Level Agreement (SLA), or current commissioning policies would cover the request.

* + 1. The Funding team will determine which set of ICB policies need to be applied to each case. (All policies can be found on the ICB website [Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/)

### Timeframes.

* + 1. Requests will be managed within a maximum period of 40 working days from the date of the receipt of an application to the date of the letter from either the Funding team or Panel (excluding appeals/undue delays in responding to requests for further information)
		2. Where a request is triaged as a ‘Fast Track’ IFR **(see section 5.15)** the request will be managed within a maximum of 5 working days from the date of the receipt of the application to the date of the communication from the Funding team informing the requestor of the decision.
		3. See **Section 5.18** relating to Panel decisions timeframes.
		4. At certain points in the process the Funding team have the option to “pause” the 40-day target, e.g., when the Funding team are awaiting further correspondence from the referrer.

### Applications covered by existing commissioned services

* + 1. If a patient meets the criteria within a policy, and a decision to agree funding can be made at this point by the Funding team, then a response will be sent to the treating clinician.

### Applications not covered by existing commissioned services

* + 1. If an application is not covered by an existing commissioned service, the Funding team will advise the treating clinician of the next steps within the process.
		2. If the Funding team has reason to consider that simple application of SLAs and/or current commissioning policies would be inappropriate for a case, then they will advise the treating clinician and the Patient/Advocate that an IFR application should be submitted by the treating clinician to the Funding team using an IFR Form. A copy of the Guidance Notes for submission of the IFR should be included and the Patient Information Leaflet explaining the process. If a clinician wishes to discuss whether submission of an IFR Form is appropriate or would like help with completing the form, then they should contact the Funding team. (A copy of these documents can be found on the ICB website - [Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/))

### Request is processed as a ‘Fast Track’ case

* + 1. Where the Funding team have been notified that a case requires an urgent decision, for example the patient has a disease or condition requiring urgent medically necessary treatment, they will fast-track that case ahead of others and convene an IFR Panel at short notice if required. It is expected that the Funding team will consult the Chair, (Deputy Medical Director), Medical Director or Public Health Specialist, on the handling of any cases which are either considered as urgent by the referring clinician or which the Funding team considers may warrant urgent consideration.
		2. Ideally all ‘Fast Track’ cases will be considered by a Microsoft Teams (or equivalent) meeting, but exceptionally, where the clinical need makes this impossible, communication via phone or e-mail will be deemed appropriate. Decisions that are made urgently outside of a formal IFR Panel will be ratified by the Panel members as soon as possible.
		3. ‘Fast-track’ Panels will also have different quoracy arrangements to facilitate them being convened at short notice. See **Appendix C**, IFR Panel Terms of Reference (ToR) for more information. ([Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/))
		4. Patients (supported by their clinicians) will have full access to the appeals process, (see **Appendix C**, IFR Panel ToR for information on External Review Panels). ([Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/))

### Referrer informed

* + 1. An approval letter will be sent to the treating clinician, copied to the patient, within 5 working days after the decision has been made.
		2. If an application is refused, a letter will be sent to the treating clinician and the patient explaining the reasons for the decision and outlining the options that are available, including using the NHS Complaints Procedure as set out in the [Complaints, Compliments and Concerns Management Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies) (‘the Complaints Policy’).
		3. The Funding team will communicate with the referrer regarding the key stages of progression of the application. When a decision is made, the Funding team will inform the referrer and copy in the patient by post, or secure electronic email if available, where possible. The referrer will be responsible for keeping the patient informed regarding the progress of the application. If it is not possible for the Funding team to contact the patient regarding the decision, the Funding team will notify the referrer and request that they inform the patient themselves.

### IFR Panel convened

* + 1. The Funding team will arrange Panel dates and contact the treating clinician to ask if they wish to submit any further information. The IFR Panel will take place either virtually or face to face.
		2. The Funding team will provide written confirmation to the referrer, Patient/Advocate to inform them that a Panel date has been scheduled to consider their application. Patients are welcome to attend the Panel hearing if they wish to do so, however this is not mandatory and decisions will be made in their absence.
		3. If the patient choses to attend the Panel hearing, once the details of their case have been presented and the patient has had the opportunity to discuss their case, they will be asked to leave to allow private deliberations to enable a decision to be made.
		4. The patient may wish to provide written information to the Panel if preferable. If a patient wishes to provide written information, they should be directed to seek assistance from their treating clinician who completed the application.
		5. The Funding team shall remind the patient that decisions can only be made on the grounds of the patient’s clinical circumstances and not on the patient’s social or personal circumstances.
		6. The Funding team may also write to other health professionals with clinical involvement in the patient’s care (for example consultant, therapist etc.), or to others with specialist knowledge of the condition/intervention, for clarification of the patient’s needs, evidence base etc., if appropriate.
		7. The Funding team, with the support of Panel members will produce a summary of the case which will be considered by the Panel. All documentation that has been received regarding the request will be made available to the Panel members in an anonymised form to protect confidentiality unless the patient has opted to attend.
		8. The Panel shall determine, based upon the evidence provided, whether exceptional clinical circumstances have been demonstrated. The evidence to show that, for the individual patient, the proposed treatment is likely to be clinically, and cost effective may be part of the case that the patient’s clinical circumstances are asserted to be exceptional.
		9. In determining whether a clinician can demonstrate that a patient has exceptional circumstances the IFR Panel shall compare the patient to other patients with the same presenting medical condition at the same stage of progression.
		10. The Panel shall take care to avoid adopting the approach described in “the rule of rescue”. The fact that a patient has exhausted all NHS treatment options available for a particular condition is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances. Equally, the fact that the patient is resistant to existing treatments where a recognised proportion of patients with same presenting medical condition at this stage are, to a greater or lesser extent, refractory to existing treatments is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances.
		11. The Panel shall be entitled but not obliged to commission its own reports from any duly qualified or experienced clinician, medical scientist or other person having relevant skills concerning the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
		12. The Panel is not required to accept the views expressed by the treating clinician concerning the likely clinical outcomes for the individual patient of the proposed treatment but is entitled to reach its own views on:
* The likely clinical outcomes for the individual patient of the proposed treatment; and
* The quality of the evidence to support that decision and/or the degree of confidence that the Panel has about the likelihood of the proposed treatment delivering the proposed clinical outcomes for the individual patient.
* Cost effectiveness. Acknowledging that the NHS has limited financial resources the Panel shall have a broad discretion to determine whether the proposed treatment is a justifiable expenditure of the ICB’s resources.
* The IFR process is not designed to create precedents which may result in the ICB providing or being obliged to provide the same or similar treatment to other patients. Accordingly, if the IFR Panel considers this is not a request about an individual patient then funding can only be provided for the requested treatment if a decision is made by the ICB to amend its policies to provide the treatment for a group of patients, including the requesting patient.

### Outcome of the IFR Panel

* + 1. *Funding of treatment is approved*
	+ The Funding team will inform the treating clinician, patient/advocate that funding has been approved within 10 working days of the Panel hearing, detailing the overall reason funding has been agreed (giving a full rationale as to why the patient has been deemed clinically exceptional).
	+ The Funding team will develop a mechanism to monitor the clinical outcomes in order to determine whether the treatment has resulted in benefit to the patient.
		1. *Funding is not approved for treatment*
* If funding is declined, the Funding team will inform the treating clinician, patient/advocate in writing within 10 working days of the Panel, detailing the overall reason (not exceptional or not individual) and the appeals process.

### New Information

* + 1. Any new information/evidence should be submitted within three months of the original decision, via documented correspondence stating why the clinician has requested a reconsideration of the decision.
		2. On receipt of any new information / evidence application the Funding Team will triage all correspondence relating to the original request in addition to any new information / evidence.
		3. Where it is evident that substantial new information has been made available over and above the contents of the original application the request should be reconsidered by the Panel.

### Appeal Process

* + 1. The IFR Appeals Panel exists to undertake a ‘quality assurance check’ on the decision-making procedure following an appeal being lodged. The IFR Process Appeals Panel’s role is to independently assess whether the IFR Panel’s decision are reasonable in terms of process, factors considered, and criteria applied. The IFR Appeals Panel will not consider the case itself.
		2. Where there are grounds for an appeal hearing, a recommendation will be made to send the case to another IFR Panel within a i.e., where there is evidence that the IFR Team / Panel may not have acted in accordance with the agreed IFR process, considered the relevant evidence, considered material factors only or appropriately applied the criteria in making this decision, a recommendation will be made to send the case to another IFR Panel within a neighbouring ICB (known as **External Appeal**).
		3. An **External Appeal Panel** will be able to reach one of two decisions:
* To confirm that the correct process was followed by the IFR Panel and therefore the decision reached is legitimate, or
* It shall refer the matter back to the IFR Panel with specific points for reconsideration in the event that the External Appeal Panel consider that either:
* the decision may not have been consistent with the ICB Commissioning Principles; or
* the Panel may not have taken into account and weighed all the relevant evidence; or
* the Panel may have taken into account irrelevant factors; or
* the Panel may have reached a decision which a reasonable panel was not entitled to reach.
	+ 1. If the original Panel decision is upheld, the Funding team will inform the treating clinician, patient/advocate, of their remaining options - either to pursue a complaint through the relevant ICB Complaints Procedure or to take their case to the Parliamentary and Health Service Ombudsman. The [ICB Complaints Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies) may be used to review the decision making process for an individual case and may result in the matter being reconsidered by the Panel.
		2. If the External Appeal Panel determines that the IFR Panel needs to reconsider the case, a Panel date will be scheduled. The IFR Panel will reconsider its decision and in doing so will formally address the detailed points raised by the External Appeal Panel. The IFR Panel is not bound to change its decision as a result of the case being referred for reconsideration, but if it confirms its original decision, then reasons will be given for not agreeing to fund the treatment request.

## Monitoring Compliance

The IFR process will be monitored and reviewed by the Quality Committee, both to ensure that decision-making to be fair and consistent, and to make sure that the Panel are considering the appropriate cases e.g. that both the triage of requests and the Panel work effectively, in accordance with this policy.

The Funding team will present a quarterly report for the Quality Committee (or equivalent) that reviews:

• compliance with the timescales laid out in this policy, and

• consistency of decision making,

The ICB will also put in place a mechanism to receive feedback by patients and requesting clinicians as part of the evaluation of the IFR policy and to contribute to on-going process improvement.

The Funding Team will produce an annual report of Panel outcomes to be presented to the Committee (or equivalent) for learning opportunities for clinical decision maker.

## ICB commissioning principles that underpin IFR decision making

Introduction of New Drugs and Technologies

* + 1. The ICBs will not introduce new drugs/technologies on an ad-hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will destabilise other areas of health care which have been identified as priorities by the ICB/s. The ICBs expects consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need

NICE New Technology Appraisals (TAs).

* + 1. Drugs and technologies that are approved as the result of a NICE Technology Appraisal (TA) need to be implemented within 3 months of the appraisal being published. The ICB will, within resource constraints, seek to ensure implementation of NICE TAs without delay but recognises that the ICB may take the full period of 3 months before a new commissioning policy can be brought into place where significant service change and/or development are required as part of the implementation. NICE also produces other guidelines which are a valuable source of good practice which the ICB will take into account in developing policy, but the ICB retains discretion and is not mandated by Directions to implement such Guidance within a fixed time period or at all.

NICE Interventional Procedural Guidance

NICE issues Interventional Procedure Guidance (IPGs) with the aim of protecting the safety of patients and supporting the NHS in the process of introducing new procedures.The ICB will not fund, and providers must not introduce new interventional procedures where NICE has considered them to be safe, but which give rise to additional cost/activity without approval of a business case by the ICB.

### Specific commissioning position with respect to different categories of IPG is laid out below:

* + 1. **Special Arrangements**
* The ICB will not fund health care interventions that are subject to a NICE IPG where the IPG states:
* Current evidence on safety is inadequate.
* Current evidence on efficacy is inadequate.
* Evidence of safety and efficacy is on small numbers of patients and of limited quality.
* No major safety concerns, but efficacy has not been shown
* Evidence is limited to a small number of patients. Good short-term efficacy but little evidence of long-term efficacy
* There is adequate evidence of safety and efficacy, but the technical demands are such that is should not be used without special arrangements
* Evidence for short term efficacy is limited and long-term outcomes are uncertain.
	+ 1. **Research Only**
* The ICB will not fund health care interventions that the NICE IPG programme has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfil the normal requirements for undertaking research.
* Where there is a possibility that NHS funded care may be impacted following the cessation of the trial, or a patient’s completion of a trial, clinicians must agree this with M&SECCGs before the trial commences.
	+ 1. **Do not use**
* The ICB will not fund health care interventions where a NICE IPG recommends that the intervention should not be used in the NHS.

**NICE Medical Technologies Guidance (MTG)**

* + 1. The NICE Medical Technologies Evaluation Programme (MTEP) identifies and selects medical devices and diagnostic technologies and routes them to appropriate evaluation programmes at NICE. A small number of technologies annually are mandated for funding through the MedTech Mandate Policy. Other than those technologies named in the annual mandate, the ICB will not fund, and providers must not introduce new medical devices, diagnostics or digital technology recommended by NICE which give rise to additional cost / activity without approval of a business case by the ICB.

**Treatments Covered by ICB Commissioning Policies**

* + 1. The ICB policy is that treatments not currently included in established care pathways (as identified for example in the Schedules to the service agreements with acute care providers) or identified for funding through the commissioning process are not routinely funded. For a number of these interventions the ICB has published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding. These are available on the ICB website.
		2. In respect of medicines, the ICB policy is that medicines not currently included in formulary or prescribing polices or guidelines are not routinely funded. For a number of medicines/devices including High Cost Drugs the ICB have published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding. The medicines formulary, prescribing guidelines and policies can be found on the Medicines Optimisation pages of the website [Mid and South Essex Integrated Care System (ics.nhs.uk)](https://www.midandsouthessex.ics.nhs.uk/)
		3. Providers **must not assume** that because treatment is not included in a policy on the website or listed on the medicines Optimisations pages that by default it will be funded.
		4. **Legacy patients** – it is acknowledged where funding criteria has changed there will be patients who have received funding for a treatment under a previous policy which is no longer funded, or previously funded treatments needs repeating / revision / replacement the current policy applies.
		5. Policy development is an on-going process and future policy on further treatments, in response to NICE Guidance/Guidelines, health technology assessments etc. will be procedure and published periodically

**Treatments Not Covered by ICB Commissioning Policies**

* + 1. Specific groups of patients may not be covered by ICB Commissioning Policy including:
* Patients with conditions for which the ICB does not have an agreed policy, including patients with rare conditions and whose proposed treatment is outside agreed service agreements.
* Patients with conditions for which the ICB does have an agreed policy but who may have exceptional clinical circumstances which lead to their clinician seeking a treatment that is not routinely available
* Patients with conditions that are the commissioning responsibility of NHS England, including patients with rare conditions and whose proposed treatment is outside agreed service agreements. Many of these will be covered by the National Commissioning Board Specialist Commissioning Policies. <http://www.england.nhs.uk/ourwork/d-com/policies/>. Consideration of funding against these policies is outside the remit of the ICB.
	+ 1. In such circumstances the ICB will not have given approval in advance to fund the treatment and approval will therefore be required under this policy. The treating clinician should consider, before making the application, whether the requested treatment is an appropriate request judged against the ICB Commissioning Principles
		2. The role of the IFR Panel is to make decisions on individual cases. It cannot be used as a means of ‘creeping implementation’ for new technologies. Consideration therefore needs to be given as to the likelihood of other patients having the same clinical need who could also benefit from the proposed treatment. If there are or are likely to be other patients then, properly considered, the request is for a service development and not an individual application. Where a decision may affect other patients, the application should be considered as a service development and not through the IFR process.
		3. Patients with rare conditions should neither be advantaged nor disadvantaged simply because their condition is uncommon. This means that the same approach will be taken in applying the principles of clinical effectiveness and cost effectiveness to patients with rare conditions as should be applied to all other patients.

**Requests to continue funding for patients coming off drugs trials**

* + 1. The ICB does not expect to provide funding for patients to continue medication/treatment commenced as part of a clinical trial. In line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki, the responsibility lies with those conducting the trial to ensure a clear exit strategy from a trial AND that those benefiting from treatments provided within the trial setting will have on-going access to those treatments. The initiators of the trial (provider trusts and drug companies) have a moral obligation to continue funding patients benefiting from treatment until such time as the ICB agrees to fund through the commissioning process. Where the treatment is not prioritised through commissioning, the responsibility remains with the trial initiators. The Research Ethics Committee should require this assurance as part of the approval for the trial.

**Requests to Continue Funding for Treatments Commenced ‘at risk’ by Providers or by others (Including Patients)**

* + 1. On occasions, a request is received where a provider Trust has commenced an unfunded treatment prior to asking for or receiving confirmation that the ICB will approve. Evidence that the patient is responding to the treatment is then presented as part of the request for ICB funding.

* + 1. The provider trust’s decision to commence treatment in advance of any decision by the ICB is a clear risk taken by the trust and/or patient. The ICB accepts no responsibility for the decision taken by the provider trust in these circumstances.
		2. In considering a request for funding the ICB will apply the criteria set out in this policy as it would for any other request and accords no special privileges because the unfunded drug was given by a provider trust.
		3. The ICB policy is that, unless a decision has been taken to approve routine funding for a treatment, the treatment will only be commissioned for an individual patient if the clinician is able to demonstrate that the patient has exceptional clinical circumstances. The fact that a patient has responded to a drug or other treatment in a manner which was anticipated for a proportion of patients who are commenced on the treatment is unlikely to be sufficient to demonstrate exceptional clinical circumstances.
		4. Where such an application is approved on the basis of the clinician demonstrating that the patient has exceptional clinical circumstances (as defined in this policy), the ICB will not accept responsibility for the costs of any treatment provided by the provider trust prior to authorisation being given by the ICB.
		5. A similar approach will be adopted if a treatment has been funded initially by a pharmaceutical company or other third party.
		6. There are occasions where the initial stages of an unfunded treatment have been funded privately by the patient. The ICB will consider any information submitted on behalf of a patient in support of their case that the patient has exceptional clinical circumstances. This may include evidence derived from treatment that has been purchased privately and used by the patient. However, this potentially opens the way for a limited group of patients who can afford to fund a treatment that the ICB does not usually fund to be able to demonstrate benefit by virtue of access to private care and then submit this as a reason to justify NHS funding for the treatment in their particular case. This is a potentially inequitable approach and, in order to ensure that the ICB does not act in an inequitable manner, the issue of exceptional clinical circumstances will therefore continue to be the criteria applied by the IFR process. Accordingly, the ICB adopts no presumption in favour of continuing treatment which has been previously paid for privately by the patient. As stated above, evidence that a treatment works as anticipated for a proportion of patients in the patient’s clinical circumstances is unlikely, in itself, to provide evidence of exceptionality. (see also ICB policy ‘Defining Boundaries between NHS and private care’)

**Requests to continue funding of care commenced privately e.g., reverting to NHS care**

* + 1. Patients who are having private treatment have a right to revert to NHS funded treatment at any point during their care. However, if they wish to exercise this right, the ICB will expect their care to be transferred to local pathways but not necessarily with the same clinician who the patient had consulted with when a private patient even if the clinician is contracted by the NHS. Where personal clinical circumstances may make such funding appropriate the case will require consideration by the IFR process

See ICB policy ‘**Defining Boundaries between NHS and private care’**.

**Decisions inherited from other Commissioners e.g., patients who move**

* + 1. Occasionally patients move into the area and become the responsibility of the ICB (by registering with a GP outside of MSE ICB) when a package of care or treatment option has already been approved by the ICB that was previously responsible for the patient’s care. The MSE ICB’s IFR policy is that, subject to resource constraints, it will normally agree to continue the treatment where the ICB is the responsible commissioner in line with policies in place at the time of application to the new ICB. Approval for applications to continue treatment will only be given if to do so is equitable and in line with treatments commissioned for the ICB population. The care pathway will have been initiated by a responsible NHS consultant and the requested treatment remains clinically appropriate. The ICB retains the right to ask for a review of treatment and benefit.

**Equality and Diversity** – The Equality Act 2010 protects people against unfair treatment (discrimination) on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Equality Act defines ‘disability’ as a physical or mental impairment which has a substantial and long-term adverse effect on your ability to carry out normal day to day activities. Providers are reminded that under this Act they must make adequate and reasonable adjustment to services, which includes provision for interpreters, carers and for others from whom patients may require assistance, providing information and/or signage in an appropriate range of formats, media and languages. Providers shall ensure that service and customer care is delivered in an inclusive manner which respects the diversity of users. It is therefore unlikely that an application for additional funding for such adjustments will be successful.

**Treatment in another country**

* + 1. Requests for treatment in an EU, EEU country or Switzerland will be considered in accordance with arrangements set out by NHS England.

Applications must be submitted by the patient to the NHS England European Team using the application form available on the NHS Choices website: [www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment](http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment)

Enquiries can be addressed to: england.europeanhealthcare@nhs.net

## Staff Training

Members of the IFR Panel and Appeal Panel should together have the skills and expertise necessary to enable them to make effective decisions. Members will need on-going training to undertake this role, in particular to enable them to comprehend and interpret complex data, and also in the legal and ethical aspects of the Panel’s work. It is also important to establish a ‘core’ group of individuals who are regularly involved in decision making to gain the necessary breadth of experience from handling a wide range of clinical cases.

All Clinicians on the IFR Panel, Fast Track Panel and Appeal Panel will have up to date registrations or equivalent.

All members of an IFR Panel (and the Appeal Panel), in addition to their mandatory and statutory training, will undergo induction training organised by Mid and South Essex Integrated Care Board. This will cover both the legal and ethical framework for IFR decision making, the ICB commissioning processes and structures, and technical aspects of the interpretation of clinical evidence and research. This training will be regularly refreshed to ensure that all panel members maintain the appropriate skills and expertise to function effectively.

## Arrangements For Review

This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

## Associated Policies, Guidance And Documents

#### Service Restriction Policy (SRP) <https://www.midandsouthessex.ics.nhs.uk/publications/srp/>

* National Institute for Health and Care Excellence (NICE)

<https://www.nice.org.uk/>

* NHS England

<https://www.nice.org.uk/>

#### Associated [Policies](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies#230d3b8e)

* Management of Conflicts of Interest Policy.
* [Complaints, Compliments and Concerns Management Policy](https://www.midandsouthessex.ics.nhs.uk/publications/?publications_category=icb-policies)

## References

* Please see **Appendix D** for the list of documents that have informed or contributed to this policy.

## Equality Impact Assessment

Issues identified in the EIA by the Clinical and Multi-Professional Congress have been documented in **Appendix A.** These will be addressed by ensuring clinicians are fully aware of the IFR policy and their role as advocates on behalf of patients less able to assert their needs.

The EIA has been included as **Appendix A.**

## Appendix A - Equality Impact Assessment

**INITIAL INFORMATION**

|  |  |
| --- | --- |
| **Name of policy:** Individual Funding Request Policy **Version number (if relevant):** 1.0 | **Directorate/Service**: Clinical & Professional Leadership Directorate |
| **Assessor’s Name and Job Title:** Kaye Lawson, Funding Team Manager Funding Team / Clinical & Professional Leadership Directorate | **Date:** 01/02/2023 |

|  |
| --- |
| **OUTCOMES** |
| *Briefly describe the aim of the policy and state the intended outcomes for staff*  |
| The policy sets out a transparent and fair process for handling Individual Funding Requests for patients in Mid & South Essex. It provides staff with a clear pathway for handling decisions to ensure these are made correctly. |
| **EVIDENCE** |
| *What data / information have you used to assess how this policy might impact on protected groups?* |
| The policy is intended to be used by clinicians who believe their patient has a need for treatments that are not currently commissioned, either because they are novel and have not yet been considered, or because they are specifically not commissioned owing to a lack of evidence for a beneficial cost effectiveness outcome. Impacts on protected groups are mainly addressed through the associated Service Restriction Policy which defines any restrictions on care.  |
| *Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?*  |
| Clinical and Multi-Professional Congress.System Clinical Lead for SRP, members of Clinical & Professional Leadership Directorate |

**ANALYSIS OF IMPACT ON EQUALITY**

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
* ***Negative outcome*** *–**protected group(s) could be disadvantaged or discriminated against*
* ***Neutral outcome***  *–**there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

| ProtectedGroup | Positiveoutcome | Negativeoutcome | Neutraloutcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age |  |  | √ | No age discrimination in this policy |
| Disability(Physical and Mental/Learning) |  | √ |  | No discrimination within policy, however this group of patients may require additional support from clinicians to have the processes within the policy explained. In addition, patients within this group may be less inclined to ask their clinicians to apply for IFRs such as those with LD.As this policy is for clinicians no plain text or large print version available. |
| Religion or belief |  |  | √ | No impact on this group |
| Sex (Gender) |  |  | √ | No impact on this group |
| Sexual Orientation |  |  | √ | No impact on this group |
| Transgender / Gender Reassignment |  |  | √ | No impact on this group |
| Race and ethnicity |  | √ |  | No impact on this group, however Travellers and migrants may be less able to take advantage of IFRs if they move out of area frequently. |
| Pregnancy and maternity (including breastfeeding mothers) |  |  | √ | No impact on this group |
| Marriage or Civil Partnership |  |  | √ | No impact on this group |
| Other identified groups |  |  | √ | The clinical funding team can only process applications for patients who are registered with a GP within Mid and South Essex. Socio-economic status does not impact on the decision making process |

|  |
| --- |
| **MONITORING OUTCOMES** |
| Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals. |
| *What methods will you use to monitor outcomes on protected groups?* |
| We will update the IFR application form to request details of protected characteristics for the patient. We will analyse protected characteristics of patients who have had IFR applications made and of those who were successful to see if these differ from the general population. |

|  |
| --- |
| **REVIEW** |
| *How often will you review this policy / service?*  |
| Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice. |
| *If a review process is not in place, what plans do you have to establish one?* |
| N/A |

#### Implementing The Policy/Service

#### Negative outcomes – action plan

If there are no negative outcomes, please remove this section.

An Equality Impact Assessment cannot be signed off until negative outcomes are addressed. What actions you have taken/plan to take to remove/reduce negative outcomes?

|  |  |  |
| --- | --- | --- |
| Action taken/to be taken | Date | Person Responsible |
| Disability: Clinician awareness of the policy will be promoted to ensure clinicians are encouraged to apply for IFRs for their patients as advocates for patient care where patients are less able to assert these personally. | 01/04/23 | SCL for SRP |
| Travellers & migrants: We will ensure that timescales are kept to the minimum as specified by this policy1 | 26/10/22 (Already in place) | Kaye Lawson |

## Appendix B – Exceptional Test Example

A woman has a rare form of a disease which requires her to use a wheelchair. There are no other patients with this form of the disease which require their use of a wheelchair.  She will be assessed for wheelchair funding against the same eligibility criteria in the same way that other people with more common conditions requiring similar equipment is undertaken, i.e., for her mobility needs rather than the rarity of her form of the disease.

The implications of this approach are that if a patient can be seen to be part of a group of patients for whom a treatment is not made available by the ICB under the ICB’s existing policies then exceptionality for this individual patient is unlikely to be demonstrable. In this case the appropriate process for obtaining funding for the requested treatment will be for the ICB to change its policy. Such a change must happen through the commissioning process (which will require the development of a business case and for the treatment to be prioritised against other developments) or through the ICB agreeing to make a change to its policy outside the commissioning process. If the change is made it will apply to all similar patients. However, the IFR Process is not the procedure for the ICB to make such policy changes.

The ICB is required to achieve financial balance each year and therefore has a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the ICB has not previously been asked to fund an intervention that has the potential to affect a number of patients, the application should be made by clinicians for the ICB to consider the intervention through its general commissioning policy and not by way of an IFR application.

The ICB policy is that the IFR Panel should consider requests for treatments that are not routinely available based on the patient’s clinical circumstances. This means that social and personal factors such as age, gender, education, caring responsibilities and family circumstances can only be taken into account where they are relevant to the patient’s clinical outcome. Whilst a patient's professional, economic or social standing or their family responsibilities are important to individuals, the ICB policy is that they are not relevant in assessing whether a patient has exceptional clinical circumstances.

## Appendix C – Terms of Reference (ToR) for the IFR Panel

**Mid and South Essex Integrated Care Board**

**Individual Funding Requests (IFR) Panel**

**Terms of Reference**

1. **Purpose**
	1. The IFR Panel will be scheduled to meet Monthly or as required (to consider Fast Track cases) to review requests for funding for treatments not currently covered by commissioning arrangements or for treatments excluded from those arrangements.
	2. The Panel will adopt a consensus approach to decision making where unanimous view cannot be reached on an individual request. The Panel will consider requests on an individual named basis for treatments either not covered by commissioning arrangements or where a treatment is specifically excluded from those arrangements.
	3. The Panel will be responsible for assessing the clinical effectiveness of the procedure and then cost effectiveness and affordability of the requested treatment based on the evidence available to them at the time. For requests where a treatment is excluded from commissioning arrangements the Panel will review the evidence to determine whether or not the request under consideration is clinically exceptional and should therefore have access to that treatment funded by the NHS.
2. **Membership**
	1. The core members of the Panel/Appeal consist of:
* A Public Health Specialist
* A Senior Commissioner
* A GP (Present as a Clinical Commissioner for the purpose of the IFR Panel)
* A Chief Nurse
1. **Chair**
	1. A Deputy Medical Director of the ICB
2. **Co-opted members will be invited as necessary. The following are examples of co-opted members, but others may be invited as needed:**
* ICB Governance Leads
* Medicines Optimisation Team
* Children’s Service’s team
* Mental Health team
1. **Administrative Support**
	1. Panels will be arranged and administered by the IFR Manager or deputy.
	2. Preparation of agendas and all request papers, recording the outcomes of the meeting, taking any actions arising and ensuring letters are sent to the requesting clinician and patient within agreed timescales is the responsibility of the Funding team on behalf of the ICB.
2. **Quoracy and Virtual Panels**
	1. The quorum shall be the Chair and core members as set out in **section 2.**
	2. There is no requirement for the same individuals to attend the Panel on each occasion. Whilst in some respects this would be preferable in order to maintain continuity and consistency, the main tool for ensuring consistency and organisational memory is through the IFR Manager or deputy who will attend Panels and advise members as to the existence of any relevant previous case decisions.
3. **For Panels convened to consider urgent cases (Fast track)**

7.1Panels that are convened to consider cases defined as urgent/fast-track have a reduced quorum to facilitate quick decision-making. In such cases the following members will be required:

* The Chair
* Either a public health specialist, GP, a member of the Medicines Optimisation Team, Executive Nurse or senior commissioner from the ICB.

7.2 Ideally all ‘Fast Track’ cases will be considered by a Microsoft Teams (or equivalent) meeting, but exceptionality, where the clinical need makes this impossible, communication via phone or e-mail will be deemed appropriate. Decision that are made urgently outside of a formal IFR Panel will be ratified by Panel members as soon as possible.

7.3 The non-availability of funding from the ICB should not be a reason for withholding treatment where this has been started by a provider outside the standard NHS contract. The NHS contract between Commissioners and providers identifies the conditions when a Trust can discontinue providing a service to a patient. However, if the reason to stop the service does not fit the criteria identified in the standard NHS contract, then providers are required to continue to provide the service. The non-availability of funding is not a criterion with withholding and/or discontinuing treatment, if the clinical team consider it appropriate to continue treatment for their patient; the Trust must continue treatment at their own financial risk.

1. **Voting Rights**
	1. Only the Chair and core members have a vote on recommendations for funding. The aim will be to agree a consensus if possible. Where this is not possible a vote with a simple majority will be used
2. **Frequency of meetings**
	1. The Panel will be scheduled monthly to secure Panel members time; however, Panels will be on an ‘ad hoc’ basis or as frequently as required by its caseload.
3. **Reporting**
	1. IFR Panel cases will only be reported to a ICB’s Governing Body where an appeal has been submitted and considered by the External Appeal Panel and where the External Appeal Panel has disagreed with the original decision.
	2. In cases where the External Appeal Panel disagrees with the original decision, the ICB’s Governing Body shall determine whether to uphold the original decision or to accept the recommendation of the External Appeal Panel
	3. In cases where the External Appeal Panel uphold the decision of the IFR Panel, then the IFR Panel’s decision will be the final decision and there will be no recourse to the ICB’s Governing Body.
4. **Confidentiality**
	1. All requests will be treated as highly confidential as the majority will contain sensitive and/ or clinical information.
	2. Anonymised papers will be sent to members via either registered post or a secure e-mail service, e.g., NHS.net. Consent will be obtained from the patient prior to the meeting.
5. **Review**
	1. The Terms of Reference will be reviewed at the same time as the IFR Policy is reviewed and need to be agreed by the Panel and ratified by the Governance Committees (or equivalent) of the Mid and South Essex ICB

## Appendix D - References

1. National Prescribing Centre and Department of Health. Supporting rational local decision-making about medicines (and treatments) (February 2009). Available from:

 [www.npc.co.uk/policy/resources/handbook\_executive.pdf](http://www.npc.co.uk/policy/resources/handbook_executive.pdf)

2. National Prescribing Centre and Department of Health. Defining DH guiding principles for processes supporting local decision-making about medicines (January 2009). Available from:

[www.dh.gov.uk/en/managingyourorganisation/commissioningdh\_093414](http://www.dh.gov.uk/en/managingyourorganisation/commissioningdh_093414)

3. Improving Access to medicines for NHS patients. A report for the Secretary of State for Health by Professor Mike Richards CBE. (November 2008). Available from: [www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\_089927](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_089927)

4. NHS Confederation. Priority setting: an overview. (2007). Available from: [www.nhsconfed.org/publications/prioritysetting/pages/prioritysettingoverview.aspx](http://www.nhsconfed.org/publications/prioritysetting/pages/prioritysettingoverview.aspx)

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6. NHS Confederation. Priority setting: managing individual funding requests. (2008). Available from:

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7. NHS Confederation. Priority setting: legal considerations. (2008). Available from :

 [www.nhsconfed.org/publications/prioritysetting/pages/prioritysettinglegal.asp](http://www.nhsconfed.org/publications/prioritysetting/pages/prioritysettinglegal.asp)