North East and North Cumbria

| Corporate | ICBP050 Individual Funding Request (IFR) Policy |
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| Version Number | Date Issued | Review Date |
|---|---|---|
| **V2.0** | April 2024 | February 2027 |

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| **Prepared By:** | IFR Team, NECS |
| **Consultation Process:** | Subject Experts |
| **Formally Approved:** | 9 April 2024 |
| **Approved By:** | Executive Committee |

## EQUALITY IMPACT ASSESSMENT

| Date | Issues |
|---|---|
| 01/12/2022 | None identified |

## POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

## ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact necsu.comms@nhs.net

# Version Control

| Version | Release Date | Author | Update comments |
|---|---|---|---|
| 1 | December 2022 | IFR Team, NECS | Review and update of previous CCG Policy |
| 2 | April 2024 | IFR Team, NECS | Updated to include audit recommendations, elements combined from the IFR SOP and updated elements of Panel TOR. |

# Approval

| Role | Name | Date |
|---|---|---|
| Approver | Executive Committee | 9 April 2024 |

## Contents

## 1. Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of the North East and North Cumbria Integrated Care Board's (NENC ICB) values. Throughout the development of this policy statement, NENC ICB have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

## 2. Introduction and Overview

The NENC ICB have a statutory responsibility for commissioning services for the patients for whom they are responsible for in accordance with the Health & Social Care Act 2012. As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the NHS.

The NHS Evidence Based Interventions programme identifies the difference between groups of procedures which are not routinely commissioned as:

a. **Category 1**
   Treatments with no or very limited evidence for effectiveness.
   Not routinely funded unless the patient is considered clinically exceptional following a successful Individual Funding Request (IFR)
b. **Category 2**
   Treatments that are more effective in groups of patients that meet clinical criteria where the health benefit is greater than the risks.
   Funded when the patient meets specified clinical criteria (Prior Approval), but not otherwise funded unless a patient is considered clinically exceptional following a successful IFR.

The NENC ICB Value Based Clinical Commissioning Policy (VBCC Policy) identifies a set of procedures as Category 1 (not funded) or Category 2 (funded in limited circumstances).
An Individual Funding Request (IFR) is a request received by the ICB from a clinician providing care to a patient in one of the following circumstances:

- a specific treatment, intervention or procedure is requested that is not commissioned by the ICB and not listed within the existing VBCC Policy; *or*
- a Category 1 treatment, intervention or procedure is requested that is specifically not commissioned under current policy ; *or*

- the patient does not meet the clinical criteria for a Category 2 commissioned service
- *and,* their clinician believes they can demonstrate clinical exceptionality in accordance with the definition.

Exceptionality is defined as:

*'The patient or their circumstances are significantly different from the general population of patients with the condition in question* ***and then*** *the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'*

The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the ICB to be considered for individuals in exceptional circumstances. It also enables officers of the ICB to exercise their responsibilities properly and transparently in relation to IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of each ICB.

## 3. Scope

This policy applies to all Individual Funding Requests (IFRs) for people registered with General Practitioners in NENC ICB, where they are the responsible commissioner for this treatment or service.

Requests may need to be made for services that fall under the commissioning remit of specialised services, managed by NHS England. This policy does not apply where NENC ICB are not the responsible commissioner, e.g. specialised commissioning, NHS England (NHSE). Where a clinician submits a request that does not fall within the commissioning responsibility of the ICB, the IFR Administration Team will advise the referring clinician of the appropriate referral route. If a request is submitted and the IFR Administration Team is unsure whether it falls within the remit of ICB commissioned services, they will contact a provider management representative for support and advice before they process the request any further.

Requests for treatment overseas are dealt with by NHS England. This process is based on the Department of Health's Article 56 guidance.

Personal Health Budgets (PHB), Continuing Healthcare (CHC) for adults, and Children's Continuing Care (CCC) fall outside of the IFR process and as such, are not covered within this policy. Applications for PHB, CHC and CCC should not be submitted via the IFR process.

## 4. Definitions, Roles and Responsibilities

A glossary to this policy can be found on page 18. It provides definitions of terms used within the policy and defines roles and responsibilities of key individuals and groups in delivery of the policy, both within the ICB and NECS.

## 5. Submission of Funding Requests – Standard Requests

Requests for funding must be submitted by a clinician. All funding requests must be submitted via the ICBs web-based system: https://checkplus.nhs.uk/ which requires a N3 connection to access. Any funding request received outside of the web-based system (including any requests directly made by patients) will not be accepted.

The IFR process only considers clinical information and it is the referring clinician's responsibility to ensure that all relevant clinical information has been included in the funding request. This could include, but is not limited to, copies of letters from secondary care consultants, details of the anticipated costs and length of treatment or copies of reports (e.g. physiotherapy assessments). The funding decision will only be made on the information which is submitted as part of the request.

Requests will be reviewed on a daily basis (Monday – Friday) by the IFR Administration Team. Completed requests will be sent to Decision Makers (DMs) on a daily basis.

**Pre-screening:**

Once an IFR has been submitted, the IFR Administration Team will review and pre-screen the detail of the request and assess whether the application is deemed appropriate. If it is felt that further information is required in order to fully assess the request, the IFR Administration Team will contact the referring clinician via the web-based system to request the additional information within 5 working days of receipt of the original request. The referrer will have two months from that date to provide the requested information.

As soon as all of the relevant information has been made available and the request is deemed complete, the IFR Clinical Support Officer will review the request against any protocols/criteria available (including the NENC Value Based Clinical Commissioning Policy and NHSE Specialised Commissioning Manual) and seek any relevant advice from specialist advisors from Commissioning, Public Health and/or Medicines Optimisation if required. The IFR Administration Team may at this stage refer requests elsewhere (for example to specialist commissioning colleagues / CHC commissioners etc.) if during their review it has become clear that an ICB IFR is not the optimum route by which the referrer should be seeking funding for the intervention requested.

**The role of Clinical Triage:**

Triage is recommended as good practice by the NHS Confederation (2008b). The role of triage is to review all applications in relation to national, regional, and local guidance and/or policies, as well as to identify any previous precedents that have been set. This stage will also identify where important and relevant documentation or information may not have been included.

Where it is clear from the application that the individual does not meet criteria, and/or there is no clear evidence supporting the treatment, or where the clinician has not made a case for exceptionality, the IFR may be recommended to the DM be declined.

Clinical triage enables requests to be returned to the referring clinician where:

- The request has not been submitted by a healthcare professional or on their behalf
- Relevant clinical information has been omitted
- The request does not need to go through the IFR process as it meets the threshold criteria for that intervention
- The request can be dealt with under another existing contract.

Clinical triage provides a summary for review to ICB appointed Decision Makers (DMs).

Once all information is available and the request is deemed complete, the IFR Administration Team or the IFR Clinical Support Officer will either:

- Send to the ICB Decision Maker (DM) to either approve/reject the application based on the evidence available. or defer the request to an IFR Panel meeting for a decision to be made.
- Refer the request to a specialist advisor. Once this further input is received, the IFR Administration Team will send to the DM to either approve or reject the request or defer the request to a full IFR Panel meeting for a decision to be made.

Requests will be sent to the DM containing all information submitted including patient identifiable information (PID) but it is important to note that as a result of this, printing of requests is discouraged. The DM is able to request further information from the referring clinician before making a decision. If this is the case, IFR Administration Team will contact the referring clinician via the web-based system for this further information and once received return to the DM for a decision.

If a case needs to go to an IFR Panel for a decision to be made, the case will be added to the agenda of the next available meeting by the IFR Administration Team.

It is expected that DMs will review cases sent to them for a decision in a timely manner (5 working days) and review the system each day where possible. However, it is expected that they will log into the system and consider all requests outstanding every week. This will enable a response to be provided for standard requests in a timely manner. It is expected that when specialist advisors have been asked to review a case or provide input, they will do so in a timely manner and usually within 5 working days of receipt of the request.

Once a decision is made by the DM (not within an IFR Panel), a decision response will be generated by the IFR Administration Team and sent to the referring clinician within 5 working days. These will be sent via the web-based system.

## 6. Making Decisions on Clinical Exceptionality

The ICB has identified via its Scheme of Reservation and Delegation individuals given authority to act as Decision Maker (DM) for Individual Funding Requests made to the ICB. Appointed decision makers may make decisions not solely reserved to the IFR Panels. These individuals will generally be senior clinicians working for the ICB (approved by the Executive Medical Director), and will follow this Policy, the Value Based Clinical Commissioning Policy (VBCCP) and related procedures in making individualised decisions about whether a patient's circumstances are exceptional enough to qualify for individual funding under the rules of the Policies.

The DMs will be supported in this task by the NECS IFR Administrative Team, by the availability of expert advice when required, and by discussion at an IFR Panel when required.

Taking into account the two-step definition of exceptionality above, DMs / IFR Panels apply a two-step process to making decisions about exceptionality. They first decide whether "*the patient or their circumstances are significantly different from the general population of patients with the condition in question"* ***and then*** whether "*the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition."*
The answer to both questions must be a "yes" in order for clinical exceptionality to be established.

There can be no exhaustive description of the situations which are likely to come within the definition of exceptional clinical circumstances (as defined above). The onus is on the referring clinician to set out the grounds for the patient's clinical exceptionality clearly in the funding request.

### Step One – Significant Difference from the General Population

'Exceptional' in IFR terms means a person to whom the general rule should not apply. To justify funding for treatment for a patient which is not available to other patients, and is not part of the established care pathway, the ICB Decision Makers and/or IFR Panel need to be satisfied that the referring clinician has demonstrated that this patient's individual clinical circumstances are clearly different to those of other patients, and that because of this difference, the general policies should not be applied. Simply put, the consideration is whether it is fair to fund this patient's treatment when the treatment is not available to others. It should be stressed that an IFR is not a route to "have another look" at the general rule, or to protest that the general rule is ungenerous.

### Clinical exceptionality: severity / failure to respond to standard care

Where a patient has failed to respond to, or is unable to be provided with, all treatment options available for a particular condition (either because of a co-morbidity or because the patient cannot tolerate the side effects of the usual treatment) is unlikely, on its own, to be sufficient to demonstrate exceptional clinical circumstances. These considerations are likely to have been taken into account in formulating the general policy.

The severity of a patient's condition does not in itself usually indicate exceptionality.

Intolerance or contraindication of a treatment does not in itself, usually indicate exceptionality.

### Clinical exceptionality: multiple grounds

There may be cases where clinicians seek to rely on multiple factors to show that their case is clinically exceptional.
If it is determined that none of the individual factors on their own mean that the patient's clinical circumstances are considered exceptional, the combined effect of those factors as a whole will be considered and this may result in the case being deemed to be exceptional.

### Clinical Exceptionality: non clinical, psychological and social factors

The IFR process only considers clinical information. Although initially it may seem reasonable to fund treatment based on reasons grounded in a moral or compassionate view of the case or because of the individual's situation, background, ambition in life, occupation or family circumstances, these reasons bring into play a judgement of 'worthiness" for treatment. As a central principle, the NHS does not make judgements about the worth of different individuals and seeks to treat everyone fairly and equitably. Consideration of these non-clinical factors would introduce this concept of 'worth' into clinical decision making. It is a core value that NHS care is available - or unavailable - equally to all. Therefore Non-clinical, psychological and social factors have to be disregarded in order for the DM / IFR Panel, to be confident of dealing in a fair manner in all cases. If these factors were to be included in the decision-making process, the ICB would not know whether they are being fair to other patients who cannot access such treatment and whose non-clinical, psychological and social factors would be the same or similar.

Consideration of social factors would also be contrary to the policy of non-discrimination in the provision of medical treatment. If, for example, treatment were to be provided on the grounds that this would enable an individual to stay in paid work, this would potentially discriminate in favour of those working compared to those not working. These are value judgements which the DMs / IFR Panels should not make.

Clinicians are asked to bear this Policy in mind and not to refer to psychological, social or non-clinical factors to seek to support the application for individual funding. In order to avoid prejudice within the IFR process, such material will be disregarded if submitted in support of applications.

### Pain

Evidence of pain should include documented assessments and/ or patient history, including:

- A description of the pain and which daily activities are no longer achievable;
- Prescribing history;

- Recorded sickness/ absence due to pain/ functional impairment;
- Evidence from functional tests/ investigations, such as gait analysis, physiotherapy/ OT assessment;
- History of the pain/ impairment and the response to/ impact/ effect of conventional therapies available.

Significant functional impairment is defined as:

- Symptoms that result in a physical/ functional inability to sustain employment/ education despite reasonable occupational adjustment, or act as a barrier to employment or undertaking educational responsibilities;
- Symptoms preventing the patient carrying out routine domestic or carer activities;
- Symptoms preventing the patient carrying out self-care or maintaining independent living.

**Photographs**

Photographs are not to be submitted for use in the consideration of exceptionality. Cosmetic appearance is not taken into account when judging exceptionality. A detailed description of any functional impairment is much more important. Any photographs received will be returned to the sender upon receipt and an incident will be logged on the Safeguard Incident and Risk Management System (SIRMS) by the IFR Administration Team.

**Step Two – Significantly more benefit from an intervention than the general population**

The applying clinician should include within the body of the application evidence for superior clinical effectiveness of the proposed intervention for the individual concerned.

Clinical effectiveness is a measure of the extent to which a treatment achieves pre-defined clinical outcomes in a specific group of patients.

Clinical evidence that considers the efficacy of a particular treatment will be carefully considered by the DM / IFR Panel. It is the sole responsibility of the referring clinician to provide this information and the IFR service will not be responsible for undertaking any evidence searches. It is important that the referring clinician makes explicit linkages between the grounds under which exceptionality is claimed and the sections of the submitted research literature that are considered to support the clinician's view regarding the differences between the patient's clinical position and that of other patients in the group, and regarding the patient's anticipated response to the requested treatment.

When considering clinical effectiveness, the DM / IFR Panel will consider:

- How closely the patient matches the patient population from whom the results are derived in any study submitted by the clinician

- The likelihood that the patient will achieve the anticipated outcomes from treatment, based on the evidence supplied

- The impact of existing co-morbidities on both the claim for exceptionality and treatment outcome

- Any complications and adverse events of the treatment including toxicity and rates of relapse. The DM / Panel will take account of side effects when considering the benefits from the treatment

- The likely impact of the treatment on quality of life using information as available

- Reported treatment outcomes and their durability over the short, medium and longer term, as relevant to the nature of the condition. The requesting clinician must demonstrate why they consider that the proposed treatment will be effective for the whole period for which it will be given.

**Experimental Treatment**

It is not generally the role of the IFR process to fund experimental treatment. Robust trials are needed for new treatments, and experimental treatment should generally be given only as part of a research trial with appropriate clinical governance arrangements. Separate mechanisms exist for ICBs to be engaged in funding for such treatments during and after appropriate trials. These are not covered by this policy.

## 7. IFR Panels

Two IFR Panels are convened to cover the NENC ICB geography. These are the North Panel (covering the North and North Cumbria areas of the ICB) and the South Panel (covering the Central and South areas of the ICB). Each IFR Panel can collectively assess IFR requests from across the ICB, and each can review cases out with their assigned geographical area. Panel meetings are held monthly. Each Panel may also act as an Appeal Panel for cases referred from the neighbouring Panel.

Each IFR Panel is a subcommittee of the ICB Executive Committee and is decision making in line with the Scheme of Reservation and Delegation as detailed within the Terms of Reference. The terms of reference can be found in the ICB's Governance Handbook.

The areas covered by each Panel are:

| Panel | Places |
|---|---|
| **North** | Gateshead<br>Newcastle<br>North Cumbria<br>North Tyneside<br>Northumberland |
| **South** | County Durham<br>Darlington |

| | |
|---|---|
| | Hartlepool<br>Middlesbrough<br>Redcar & Cleveland<br>South Tyneside<br>Stockton-on-Tees<br>Sunderland |

Membership of the relevant Panel is made up of the Clinical Decision Makers (DMs) and each Panel will be independently chaired. Further Panel members are permitted at the discretion of the ICB but must be reflected in the Terms of Reference of the Panel.

At the Panel, DMs will outline their cases and a review of each case is undertaken. For each case, a decision will be made by the Panel as to whether the case for Clinical Exceptionality is accepted (and therefore recommended for funding) or declined. Panels will generally be expected to reach consensus decisions on these matters, but in exceptional cases a vote of Panel members may be required in order to make a decision. The Chair of the meeting is independent and non-voting, therefore in the event consensus cannot be reached a DM not present will be asked to vote out with of the meeting.

In some circumstances, when a request has been presented to a Panel for a decision to be made, the Panel may feel that they cannot make a decision based on the information available and may choose to defer the decision whilst a request is made for further information. In cases such as this, the further information requested will be agreed at the Panel meeting and the IFR Administration Team will send these queries/questions to the referring clinician after the meeting has taken place. Once a response is available, the case will be either reviewed by the DM out with the Panel meeting or presented again to the next available meeting for further discussion.

Once this meeting has taken place and the case has been presented and a decision made, a response will be drafted by the IFR Administration Team and shared with all IFR Panel members by way of the minutes of the Panel meeting within 5 working days of the meeting being held. Once the IFR Panel members (at least 3 DMs) have approved the minutes and confirmed the rationale, the IFR Administration Team will generate the decision letter. Decision responses will be sent to referring clinicians within 5 working days of the decision being ratified.

Administrative support will be provided to the Panels by the IFR Administration Team and the confirmed minutes of the meetings presented to the ICB Executive Committee. Additional support for the Panels is provided in areas of Medicines Optimisation, Commissioning and Population Health through access to specialist advisers as required.

Where required reconsideration requests, appeals and urgent requests can be reviewed as part of the IFR Panel meetings.

## 8. Urgent Requests

From time to time, the clinical circumstances of an Individual Funding Request may mean that delaying a decision until the next scheduled meeting of the Panel is likely to have a significant detrimental effect on the patients' health and well-being (threat of death or serious disability) or adversely affect eligibility for that treatment. In these circumstances the request will be deemed as urgent. The referring clinician must mark the request as 'urgent' via the web-based system. Urgent requests will be considered in line with the NHS Standard Contract (SC29.27).

Once a request is received, the IFR Administration Team will prioritise the urgent request and review this. When the IFR team confirms the request is urgent and all information is available they will either:

- Send the ICB DM to either approve/reject the application based on the evidence available or defer the request to a Panel meeting for a decision to be made. If a DM feels unable to make an urgent decision due to complexity or adherence to the Value Based Clinical Commissioning Policy, then they should contact the IFR admin to establish if an urgent Panel meeting can be organised.
- Refer the request to a specialist advisor if required with a response required in 2 working days (the IFR Administrative Team will advise the specialist advisor of this timescale). Once this further input is received, the IFR Administration Team will then send to the DM to either support or reject the request or defer the request to a Panel meeting for a decision to be made.

To ensure that urgent requests are reviewed as soon as possible, the IFR Administration Team will contact the DM by email notifying them of the urgent request and ask them to log into the system to review as soon as possible. It is expected that requests are reviewed and a decision within 2 working days of receipt.

If a case needs to go to an IFR Panel for a decision to be made, the case will be added to the agenda of the next available meeting by the IFR Administration Team. If no meeting is taking place within the next 5 working days, the request will be circulated to IFR Panel members from the respective area for a decision to be made urgently via electronic correspondence. If required, a teleconference can also be arranged to discuss the case and this will be co-ordinated by the IFR Administration Team.

Once the case has been discussed, either at a meeting or electronically/via conference call and a decision made, a response will be drafted by the IFR Administration Team and shared with the IFR Panel members by way of the minutes of the Panel meeting. Once approved and the rationale has been confirmed, the IFR Administration Team will generate the decision letter. Responses will be sent to referring clinicians within 1 working day of the decision being made.

Where the decision has been made via email, the IFR Administration Team will ensure the decision is retrospectively recorded in the following month's Panel minutes.

## 9. Reconsideration Requests

Where a funding request is declined by the ICB (either by a DM or IFR Panel), the

requesting clinician has the right to request reconsideration but only on the presentation of **new clinically significant** information and/or evidence. This is not an appeal to the decision but a request for the decision to be reconsidered.

Such requests should be submitted by the referring clinician via the web-based system within three months of the original funding decision.

The request can either be from the referring clinician who made the initial request or an alternative referring clinician who is involved in the patient's case for the condition/treatment in question.

Upon receipt of an application for a reconsideration request, the IFR Administration Team will screen the original application, the notes of the original decision, all correspondence, any new information and the reconsideration request. The application will then be shared with the DM for consideration. The DM then can decide whether to make a decision on the case or refer to the IFR Panel for Panel review. Where the IFR Panel made the original decision, it would usually be expected that the DM will refer back to the next relevant IFR Panel, unless there are clear reasons why this would not be necessary.

If a reconsideration request is received outside of this three-month period, it will be classed as a new request and the referrer will be asked to submit the application as a new request. However, unless a relevant funding policy has changed between the original decision and the reconsideration request, new information must be submitted for it to be presented again. If no new information is presented, the request will be returned to the referring clinician by the IFR Administration Team advising them of this.

## 10. Appeals

An appeal will only be instigated where there are grounds for an appeal i.e. where there is evidence that the IFR Administration Team/DM/Panel may not have acted in accordance with the agreed IFR process, for example, not considered the relevant evidence, material factors or inappropriately applied the criteria (where applicable) in reaching this decision. In this case, the request will be considered as an appeal and referred to the neighbouring IFR Panel in the ICB for consideration.

The IFR Administration Team will share the information initially with the IFR Panel Chair via email and request their input into whether an appeal should be instigated. The IFR Panel Chair will review the request to assess if there are grounds for appeal.

If there is no new evidence presented as part of the appeal request and no grounds to warrant an appeal, an appeal will not be instigated and the IFR Administration Team will correspond with the referring clinician advising them of this.

Where there are grounds for appeal, a DM from the original IFR Panel must make themselves available to attend the Appeal Panel to present the case and the associated process followed. The attending DM will then be asked to leave the Panel meeting to enable Appeal Panel Members to make a decision.

The Appeal Panel will assess the case against the agreed IFR process, assess if the

original decision considered the relevant evidence, considered material factors only and appropriately applied the criteria in making the decision. The Appeal Panel will decide to either overturn the original decision and support the request or uphold the original decision and reject the request.

If further information is required, this will be determined at the Appeal Panel meeting and the IFR Administration Team will request this in writing via the web-based system from the referring clinician. Once this has been made available by the referring clinician, the IFR Administration Team will add the case to the next available appropriate Panel.

Once a case has been presented as an appeal and discussed at an Appeal Panel, the outcome will be final and no further appeal requests can be made. The IFR Administration Team will produce a decision letter and will send this to the Chair of the Appeal Panel for approval. Where the outcome of the Appeal Panel overturns the original decision, the decision letter is to be sent to the Executive Medical Director with an explanation of reason for the decision, description of deviation from process and recommendation letter to the referring clinician for approval.

Once approval is received the IFR Administration Team will then send this to the referring clinician who requested the appeal.

Applicants not satisfied with the Individual Funding Requests Panel **process** have the right to make a complaint in line with NHS national complaints regulations. This complaint should be submitted in writing to the NECS complaints team. Concerns regarding the **outcome** of the Panel will not be dealt with through the NHS complaints procedures. The complaints process does not have the right to challenge or overturn an IFR decision.

## 11. Process for requests out with of the VBCCP or not routinely commissioned by the ICB

Where a specific treatment, intervention or procedure is requested that is not commissioned by the ICB and not listed within the existing VBCC Policy, the ICB's Financial Limits will be followed by the relevant Decision Makers and the IFR Panels. This will be in accordance with the ICB's Financial Limits outlined within the current Governance Handbook and requests will be processed by the relevant authoriser in accordance with the limits. The NECS IFR Administration Team will gather the cost information prior to sharing with the DM.

If the IFR cost is over the amount set for DMs/IFR Panel, the DM or IFR Panel will consider the request and, where the request is supported make a recommendation to either the Medical Director or Executive Medical Director to consider funding the request depending on the total cost.

On the very rare occasions that an IFR is above the limit delegated to the Executive Medial Director, advice will be taken from the Executive Medical Director as to where the IFR should be taken for approval.

The web-based system will be utilised for all IFR requests and considerations of funding by the above Medical Directors. Where a request and/or a recommendation is forwarded to them for approval, this will be supported via an email to the relevant Medical Director from the IFR Administration Team with details of the IFR to be considered on the system. If required by the relevant Medical Director, they will also be briefed by the relevant DM or Chair of the IFR Panel; depending on where the request has been considered. Details of the briefing should be recorded on the system by the relevant Medical Director.

**NB: For clarity, there are no financial limits set for approval regarding any intervention or procedure that is listed within the current VBCC Policy or currently commissioned as this is based on clinical exceptionality.**

## 12. Data Collection / Sharing and Conflicts of Interest

Personal Identifiable Data (PID) is needed to allow the IFR Administration Team to effectively administer the IFR process. Appropriate agreements and safeguards have been developed to ensure legal processing of data and to seek consent of patients for the use of their data (see appendix 1).

As DMs and their supporting admin teams are often members of the communities for whom they are responsible for making decisions, conflict of interest may arise where an applicant is a patient, an employee or a friend / relative of a DM or administrator. The IFR Administration Team will screen out patients at the practice at which a DM works as a GP and divert these requests to an alternative DM. However, they cannot intercept all possible conflicts of interest. It is essential therefore those identifiable details are shared with the DMs, and that the DMs and Administrators conduct themselves with the highest standards of probity in declaring any conflicts of interest that arise. DMs must refer decisions pertaining to patients / employees / friends / relatives etc. to an alternative DM. Administrators must similarly pass cases in which they have a conflict of interest to an alternative colleague to manage.

Where a Conflict of Interest arises at the IFR Panel for a DM, the conflicted DM may be required to leave the meeting when discussion and decision making about that case is taking place, but this will be a decision made by the Chair. Any declared Conflicts of Interest are noted within the Panel minutes.

Aggregate anonymised data may be collected by the team for purposes of effective administration of the system, quality improvement, and development of commissioning policy.

## 13. IFR – Value Based Clinical Commissioning Policy (VBCCP) Interface

Sometimes an IFR presents a clinical case which needs a substantial piece of work before the ICB can reach a conclusion upon a commissioning position. This may require policy development and wider consultation. Therefore where required the IFR Administration Team if advised by the DM are able to refer such cases to the VBCCP Steering Group / Northern Treatment Advisory Group (NTAG) for consideration for inclusion in the VBCCP Policy.

## 14. IFR Web Based System

All requests will be logged on the web-based system to ensure an accurate database is available of all funding requests received. The web-based system will be managed centrally by IFR Administration Team.

IFR Administration Team will be able to assign cases to the DM and IFR Panel Members for further input where required. DMs and IFR Panel Members will be able to add their comments/input via this system also to ensure all information regarding each case is captured in one system.

The system will provide an audit trail of each case, the decisions made and new information provided should a reconsideration be requested. The system will also provide a log of the status of all requests to support the IFR Administration Team in managing all cases received and where they are in the process.

The IFR Administration Team should not keep paper copies of cases and all relevant information regarding case requests will be stored via the web-based system. This system will also support responses to FOI requests, complaints, MP letters etc.

There is one single Value Based Clinical Commissioning Policy (VBCCP) agreed across the ICB and is made available on the web-based system for users to access.

To ensure compliance with information governance regulations, explicit patient consent must be obtained from each referring clinician. To this end, the IFR web-based system will specifically request that all referring clinicians state to say that they have obtained this consent before they submit a funding request. This consent will be logged in an audit trail by the system so it can be evidenced should this be required.

## 15. Monitoring and Reporting of the IFR Process

The IFR service is provided by NECS under a service level agreement. The IFR Service Senior Manager holds overall responsibility for making any arrangements necessary to ensure effective operation of the IFR Panels, including the training requirements of all decision makers and IFR Panel members (including all specialist advisors, independent IFR Panel Chair and administration staff). A training log will be maintained by the NECS IFR Administration Team.

An IFR annual report will be provided to the ICB Executive Committee.

The Value Based Clinical Commissioning Policy will be available on the ICB website, and the web-based IFR system.

The Medical Director with lead responsibility for IFR will receive monthly KPI and performance reports to monitor the IFR process and associated timescales.

The Executive Committee will receive the confirmed minutes from the IFR Panels and also quarterly KPI and performance reports.

## 16. FOI / MP Letters / Complaints

FOIs are logged and responded to centrally by the Information Governance Team with input directly from the IFR Administration Team.

Similarly the IFR Administration Team provide content to respond to MP letters but the responses are coordinated via the Corporate Team centrally.

Complaints are logged via the NECS Complaints team who will request information from the IFR Administration Team. The NECS Complaints Team will respond to the complainant with the agreed timeframe for handling complaints.

## 17. Documentation

Other related policy documents:

- IFR Panel Terms of Reference.
- Value Based Clinical Commissioning Policy (VBCCP).

## 18. Glossary

Below are a list of definitions, roles and responsibilities used within the IFR service:

| | |
|---|---|
| **IFR System** | The web-based system used by NENC ICB for the submission and processing of IFRs. https://checkplus.nhs.uk/ |
| **IFR Administration Team (NECS)** | Provides administrative support for all IFR cases received, monitoring all applications, coordinating responses within the set time frames and communicating with referring clinicians regarding process and decisions. The IFR Administration Team coordinate and prepare cases for the IFR Panels, circulate the papers, draft the minutes and maintain the action log. |
| **IFR Clinical Support Officer** | Responsible for clinically triaging all cases before they are brought to Panel the IFR Clinical Support Officer (CSO) will make a recommendation on whether the request should be approved, declined, decide if the case should be discussed fully at Panel, or whether further information is required before a recommendation can be made. |
| **IFR Service Lead (NECS)** | Overall responsibility for the IFR Administration Team service and its performance. Providing strategic leadership to the service/team within NECS. |
| **IFR Service Senior Manager** | Responsible for managing the IFR Team and all |

| | |
|---|---|
| **(NECS)** | of its processes; provide guidance and leadership to support the IFR Administration Team and Panels. |
| **Referring Clinician** | The clinician making the request for the treatment/procedure in question on behalf of the patient. This is usually the patient's GP or the secondary care clinician proposing to undertake the said treatment/procedure. |
| **Provider** | The healthcare service provider which will or is proposing to undertake the said treatment/procedure. |
| **Clinical Decision Maker (DM)** | A GP within the ICB (as approved by Executive Medical Director) with delegated authority to make decisions on behalf of their ICB in relation to IFR applications. Decisions can be made by the Decision Maker in isolation or can be referred to the IFR Panel for consideration. |
| **IFR Panel** | The IFR Panel has delegated authority from the ICB to make decisions in respect of any cases referred by the Decision Makers. |
| **NENC ICB** | North East and North Cumbria Integrated Care Board (ICB) |
| **Value Based Clinical Commissioning Policy (VBCCP)** | Documents which outline treatments / interventions / procedures not normally provided by the NHS and a set of criteria that must be met in order for some treatments / interventions / procedures to be provided. |
| **Eligibility** | The patient's circumstances meet the defined protocols and/or criteria for the treatment/intervention/procedure at the time of application against the protocol/criteria in place at the time of the request. |
| **Standard Request** | A standard funding request is a request for a non-urgent clinical intervention for which a decision can be provided, usually within 40 working days of receipt of the request, where all relevant information required is available. |
| **Urgent Request** | In the case of urgent clinical need or a risk to patient safety the DM is able to make a timely decision to avoid inappropriate delay. Urgent request outcomes are shared at the next available IFR Panel. |
| **Pre-screening** | Once an IFR has been submitted, the IFR Administration Team will review and pre-screen the detail of the request and assess whether the application is deemed appropriate for IFR and complete |
| **VBC Checker** | This is a web-based system to use to determine if a patient meets the relevant clinical criteria. If they do meet the criteria prior approval is |

| | |
|---|---|
| | granted. If they do not meet the criteria the IFR Process should be followed. |
| **Medicines Optimisation** | The Decision Makers and IFR Panel have timely access to specialist support from the NECS Medicines Optimisation team in relation to any drug-related funding requests. |
| **Population Health Advisors (Specialist Public Health Support)** | The Decision Makers and IFR Panel have timely access to Population Health Advisors (specialist public health) advice on the review of evidence and policy. This is provided to the ICB by the Local Authorities of the region under arrangements made between the ICB and the regional Directors of Public Health (DPHs). |
| **Commissioning Support** | The Decision Makers and IFR Panel have timely access to specialist support from the NECS Provider Management/ICB colleagues (including Mental Health/Learning Disabilities), Commissioning Delivery Teams in relation to any contracting and commissioning queries. |
| **Reconsideration** | Where an application for funding has been declined, the referring clinician has the opportunity to present new clinical information in support of the application being reconsidered. |
| **Appeal** | Where the referring clinician feels that due process in considering the IFR application has not been followed, a procedural appeal can be requested. |

## 19. Contact Details

necsu.checkplusifr@nhs.net – for IFR queries

necsu.checkplus@nhs.net – for system queries (logins, EBI Checker etc)

## Appendix 1: Relevant IG agreement(s) & Clinical Safety Standards

All Data Processing Agreements can be found in Appendix F within the ICB Service Level Agreement (SLA) with NECS for commissioning support services.

The ICB has signed and retained the SLA variation sent to them by NECS to update Appendix F for GDPR in 2018, within which the Data Processing Protocol (Annex 2) specifically includes Individual Funding Request services.

NHS England Information Standards define the requirements to which the NHS and those with whom it commissions services and its IT System Suppliers must conform. As an organisation which manufactures and deploys health IT systems, NECS must put in place the mechanisms necessary to establish and maintain compliance with these relevant Clinical Safety Standards, namely DCB0129 (manufacture) and DCB0160 (implementation). When any change to the IFR system is required, to meet the national standards we follow NECS clinical safety assurance process and discuss any potential changes with the Clinical Safety Officer to define whether they are in scope and if further action is required.

## Appendix 2 – Equality Impact Assessment

### Equality Impact Assessment
### Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

**Name(s) and role(s) of person completing this assessment:**

**Name:** Kate Sutherland
**Job Title:** Senior Governance Lead
**Organisation:** NENC ICB

**Title of the service/project or policy:** Individual Funding Requests (IFR) Policy

**Is this a;**
**Strategy / Policy** ☒ **Service Review** ☐ **Project** ☐
**Other** Not Applicable

**What are the aim(s) and objectives of the service, project or policy:**
The NENC ICB have a statutory responsibility for commissioning services for the patients for whom they are responsible for in accordance with the Health & Social Care Act 2012. As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money. This policy details the process for handling Individual Funding Requests.

**Who will the project/service /policy / decision impact?**
(Consider the actual and potential impact)

- **Staff** ☐
- **Service User / Patients** ☒
- **Other Public Sector Organisations** ☐
- **Voluntary / Community groups / Trade Unions** ☐
- **Others, please specify** Click here to enter text.

| Questions | Yes | No |
|---|---|---|
| Could there be an existing or potential negative impact on any of the protected characteristic groups? | ☐ | ☒ |
| Has there been or likely to be any staff/patient/public concerns? | ☐ | ☒ |
| Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom? | ☐ | ☒ |
| Could this piece of work affect the workforce or employment practices? | ☐ | ☒ |
| Does the piece of work involve or have a negative impact on:<br>• Eliminating unlawful discrimination, victimisation and harassment<br>• Advancing quality of opportunity<br>• Fostering good relations between protected and non-protected groups in either the workforce or community | ☐ | ☒ |

**If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:**

The IFR policy is about the processing of request, the criteria regarding eligibility sits within the VBCCP.

**If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document**

| Accessible Information Standard | Yes | No |
|---|---|---|
| Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients.<br><br>https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf | ☒ | ☐ |
| Please provide the following caveat at the start of any written documentation:<br><br>**"If you require this document in an alternative format such as easy read, large text, braille or an alternative language please contact (ENTER CONTACT DETAILS HERE)"** | | |
| **If any of the above have not been implemented, please state the reason:**<br><br>Click here to enter text. | | |

## Governance, ownership and approval

| Please state here who has approved the actions and outcomes of the screening | | |
|---|---|---|
| **Name** | **Job title** | **Date** |
| Dr Neil O'Brien | Executive Medical Director | April 2024 |

**Publishing**

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

If you are not completing 'STEP 2 - Equality Impact Assessment' this screening document will need to be approved and published alongside your documentation.

**Please send a copy of this screening documentation to:**
**NECSU.Equality@nhs.net for audit purposes.**

# Equality Impact Assessment: Policy – Strategy – Guidance (STEP 2)

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment.

This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

**This document is to be completed following the STEP 1 – Initial Screening Assessment**

## STEP 2 EVIDENCE GATHERING

**Name(s) and role(s) of person completing this assessment:**

**Name:** Kate Sutherland
**Job Title:** Senior Governance Lead
**Organisation:** NENC ICB

**Title of the service/project or policy:** IFR Policy

**Existing** ☒ **New / Proposed** ☐ **Changed** ☐

**What are the intended outcomes of this policy/ service / process? (Include outline of objectives and aims;**
As outlined in screening document

**Who will the project/service /policy / decision impact?**
(Consider the actual and potential impact)

- **Consultants** ☐
- **Nurses** ☐
- **Doctors** ☐
- **Staff** ☒
- **Service User / Patients** ☒
- **Others, please specify** Click here to enter text.

| Current Evidence / Information held | Outline what current data / information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made? |
|---|---|
| (Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other) | Data held by NECS IFR Team regarding requests processed, complaints data |

## STEP 3: FULL EQUALITY IMPACT ASSESSMENT

**PLEASE NOTE THE INFORMATION OUTLINED IN THE TEXT BOXES LISTS PROMPTS FOR GUIDANCE PURPOSES. PLEASE INPUT INFORMATION OR DELETE AS APPROPRIATE.**

| **The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful.**<br>Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups: |
|---|
| **Age**<br>*A person belonging to a particular age* |
| Neutral |

| **Disability**<br>*A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities* |
|---|
| Neutral |
| **Gender reassignment (including transgender) and Gender Identity** |
| Neutral |
| **Marriage and civil partnership** |
| Neutral |
| **Pregnancy and maternity** |
| Neutral |

| Race |
| --- |
| Neutral |
| Religion or Belief |
| Neutral |
| Sex/Gender |
| Neutral |
| Sexual orientation |
| Neutral |
| Carers |
| Neutral |

| Other identified groups relating to Health Inequalities |
|---|
| Neutral |

## STEP 4: ENGAGEMENT AND INVOLVEMENT

| Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics?<br>**Guidance Notes**<br>• List the stakeholders engaged<br>• What was their feedback?<br>• List changes/improvements made as a result of their feedback<br>• List the mitigations provided following engagement for potential or actual impacts identified in the impact assessment. |
|---|
| Not applicable |
| If no engagement has taken place, please state why: |
| Not applicable |

## STEP 5: METHODS OF COMMUNICATION

| What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance? |
|---|
| ☐ Verbal – meetings ☐ Verbal - Telephone<br>☐ Written – Letter ☐ Written – Leaflets/guidance booklets<br>☐ Written - Email ☒ Internet/website ☐ Intranet page<br>☐ Other<br><br>If other please state: Click here to enter text. |

## Step 6 – Accessible Information Standard Check

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

| Tick to confirm you have you considered an agreed process for: |
|---|
| ☒ Asking people if they have any information or communication needs, and find out how to meet their needs.<br><br>☒ Have processes in place that ensure people receive information which they can access and understand, and receive communication support they need it. |
| |
| If any of the above have not been implemented, please state the reason:<br>Not applicable |

# GOVERNANCE, OWNERSHIP AND APPROVAL

| Please state here who has approved the actions and outcomes of the screening | | |
|---|---|---|
| **Name** | **Job title** | **Date** |
| Dr Neil O'Brien | Executive Medical Director | April 2024 |

| **Presented to (Appropriate Committee)** | **Publication Date** |
|---|---|
| Executive Committee | 9 April 2024 |

1. Please send the completed Equality Impact Assessment with your document to: necsu.equality@nhs.net
2. Make arrangements to have the Equality Impact Assessment added to all relevant documentation for approval at the appropriate Committee.
3. Publish this Equality Impact Assessment alongside your document.
4. File for audit purposes as appropriate

For further advice or guidance on this form, please contact the NECS Equality Team: necsu.equality@nhs.net