NHS
Herts Valleys
Clinical Commissioning Group

NHS
East and North
Hertfordshire
Clinical Commissioning Group

Individual Funding Requests and Prior Approval Policy

DOCUMENT CONTROL SHEET

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Change History:

Version	Date	Reviewer(s)	Revision Description
V2.0	1/8/16	Geraldine Woods Sheilagh Reavey Rachel Joyce	• General housekeeping • New section 2.5 regarding mental health requests • Up to date wording detailing IFR. • Change to daily triage process of Prior Approvals, where clinical decisions nurse can decline without public health opinion. • Inclusion of process • Algorithms. • Definitions added on what will and will not be considered via IFR. • New section- Drug Requests. • Sentence added to include the IFR team's role in signposting referrals for adults and children with complex disabilities. • New section-Retrospective funding. • New section- experimental treatments
V2.1	11/12/17	Geraldine Woods Sheilagh Reavey Rachel Joyce	• The following services added to the list of procedures which are prior approved(page 22) Fertility, Tier 3 and 4 Obesity services, adult grommets, Septoplasty, septorhinoplasty, rhinoplasty, blepharoplasty/brow lift.

Version	Date	Reviewer(s)	Revision Description
V2.2	23/07/18	Linda Mercy Geraldine Woods	Section 5.8. The phrase 'medically qualified' removed from description of public health consultant. Rephrased 6.5.2 to read - Completed applications are sent electronically to the Prior Approval team and then reviewed by the Clinical Decisions Manager/Nurse and/or a medically qualified Clinical Fellow. Algorithms 1 and 2 updated
V3	22/03/19		Complete policy rewrite. Aligned where possible with NHSE IFR policy in agreement from NHSE IFR team. Interventions added to PA list and additional wording within policy body in order to align with NHSE Evidenced based interventions guidance.
V3.1	29/04/2019	Miranda Sutters	Added HVCCG cobranding to the policy, no material change to content

Implementation Plan:

Development and Consultation	ENHCCG: Director of Nursing, Director of Finance, Director of Commissioning, Medical Director, Senior Pharmaceutical Adviser, Consultant Public health, Lay Member Deputy Chair and Audit
Dissemination	The policy is available to all CCG staff, independent contractors and members of the public via the main CCG website and CCG clinical policies website. Information about the policy is provided by email notification to GP Practices and secondary care commissioners and is also available as documentation associated with the main provider contracts.
Training	In House training provided to all members of the team.
Monitoring	Key Performance Indicators reported quarterly to executive team. Internal and external audit.
Review	TBC

Equality, Diversity and Privacy	06/02/2019 Equality Impact Assessment - Privacy Impact Assessment
Associated Documents	▪ Existing Beds and Herts Priorities forum clinical policies and Hertfordshire Medicines Management Committee policies relevant to this process. ▪ East of England Priorities Advisory Committee

	▪ The Individual Funding Requests form
References	Brunton G et al, (2013) *Psychosocial predictors, assessment and outcomes of cosmetic interventions.* Institute of Education London. Soest, Tilmann M. von; Kvalem, I. Lundin; W ichstrøm, L. (2012) *Predictors of cosmetic surgery and its effects on psychological factors and mental health: a population-based follow-up study among Norwegian females*. Psychological Medicine, 42(3):617-626 NHS Commissioning Board (2013) *Commissioning Policy (ref: NHSCB/CP/06) Experimental and unproven treatments.* NHS Hertfordshire Commissioning policy (PAC /14) October (2010) *Experimental, Uncertain and Unproven Treatments Version 2.* *The NHS Constitution (2015) Department of Health.* *NHS England (2018) Evidence Based Interventions: Guidance for CCG's* *NHS England (2017) Commissioning Policy: Individual Funding Requests*

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Table of Contents

1. Introduction

1.1. This policy defines the responsibilities of East and North Hertfordshire Clinical Commissioning Group (ENHCCG) and Herts Valleys Clinical Commissioning Group (HVCCG) and the activities of the Clinical Funding Team who manage Individual Funding Requests (IFR) and Prior Approvals (PA).

1.2. This policy will ensure a clear and transparent process is in place for decision making and provide reassurance to patients and clinicians that decisions are made in a fair, open, equitable and consistent manner.

1.3. Clinical Commissioning Groups (CCGs) commission local NHS health services, including primary care services and NHS England commissions highly specialised health services. Both organisations use national and local policies to prioritise treatments based on available resources and competing demands. This policy relates solely to services commissioned by ENHCCG/HVCCG. Local policies are available on our website.

1.4. This policy is in conjunction with the Evidence-Based Interventions Policy, published by NHS England (November 2018). This national statutory policy relates to the commissioning of interventions which are clinically inappropriate or which are appropriate only when performed in specific circumstances. ENHCCG/HVCCG are committed to ensuring compliance to the Evidence-Based Interventions program which is mandated by NHS England through the NHS Standard Contract.

1.5. The NHS exists to serve the needs of all of its patients but there is also widespread clinical consensus that NHS resources could be more appropriately targeted towards more clinically appropriate interventions. At a time when demand is exceeding the capacity available, effective use of resources is both a national and local priority. ENHCCG and HVCCG have a responsibility to provide health benefit for the whole of its population, whilst commissioning appropriate care to meet the clinical needs of individual patients.

1.6. On an individual basis, there may be situations where a clinician believes that their patient's clinical situation is so different to other patients with the same condition that they should have their treatment paid for when other patients would not. In such cases, NHS clinicians can ask ENHCCG/HVCCG, on behalf of a patient, to fund a treatment which would not usually be provided by ENHCCG/HVCCG for that patient. This request is called an Individual Funding Request (IFR).

1.7. Funding for additional treatments outside of what is routinely commissioned by ENHCCG/HVCCG can only be done by reducing the funding that is available for other established treatments. There is not an allocated separate budget to meet the costs of providing treatments agreed through the IFR process. It is because of this that very careful consideration is required before the decision is taken to fund a treatment for an individual that is not usually available.

1.8. The NHS Constitution (July 2015) informs patients they have the right to expect local decisions on funding of drug and non-drug treatments to be made rationally following a proper consideration of the evidence. It states: "If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."

1.9. In order to ensure that good quality services are available to those patients with the greatest need, it is necessary to restrict the funding of procedures which have limited or no clinical benefit. These procedures may also be referred to as low priority procedures. Therefore ENHCCG and HVCCG have a Prior Approval system in place which ensures that these elective procedures are subject to threshold criteria. This will mean that these low priority procedures will only be available for patients who meet a defined set of criteria in line with ENHCCG/HVCCG policies. The clinicians within the clinical funding team assess applications for such procedures against the set criteria. (See Appendix 1). This ensures optimal clinical effectiveness and appropriateness in a patient's clinical pathway.

1.10. Promoting equality and addressing health inequalities are at the heart of the CCG's values. Throughout the development of this policy statement, we 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. Scope

2.1 This policy applies to all CCG staff members, including Governing Body Members and Practice Representatives, involved in the CCG's policy-making processes, whether permanent, temporary or contracted-in (either as an individual or through a third party supplier).

2.2 This Policy covers the following:

- All IFR and PA requests for adults and children that ENHCCG and HVCCG have responsibility for and excludes treatments that are the responsibility of NHS England.
- The arrangements to consider funding requests that do not fall within existing contracts or are considered low priority.
- The processes in place to respond to these requests and appeals.
- The structure and function of the Individual Funding Team and IFR panel.

2.3 This policy applies, as appropriate, to any patient for whom ENHCCG or HVCCG is the responsible commissioner and who are registered with either an ENHCCG or HVCCG General Practice. The CCG is responsible for commissioning services to meet the health needs of its population and is required to commission services which are evidence based clinically and cost effective, improve health outcomes and reduce health inequalities whilst representing value for money.

2.4 ENHCCG and HVCCG commissions its mental health services for adults and children from Hertfordshire Partnership Foundation NHS Trust (HPFT). The majority of mental health services are available through contracts held by the Integrated Health and Care Commissioning Team (IHCCT) on behalf of ENHCCG/HVCCG and are accessed through referral to HPFT, the IFR team does not process requests for mental health services which fall outside of these contracts.

2.5 Requests for mental health services are managed by IHCCT in line with the 'Requests for Mental Health Services outside the Main Contractual Arrangements' document. Requests are sent by clinicians securely to a mental health clinical lead at Ihcct.quality@nhs.net for consideration of individual funding. On occasions the mental health commissioner may request the IFR panel to consider funding advice for complex cases and/or appeals. In such cases the mental health commissioner will be expected to present the case including all relevant history and clinical information to the panel. The IFR panel will make a funding decision and/or provide advice in line with section 6.8 of this policy. IHCCT remain responsible for the administration process of the case in question and the dissemination of the outcome.

3. Definitions

3.1 **Prior Approval (PA) -** Is a process in which clinicians demonstrate how a patient meets set threshold criteria prior to referring to secondary care and/or by consultants prior to listing for surgery for procedures which ENHCCG/HVCCG routinely commission and are within agreed contracts.

- Prior Approval means that a General Practitioner and/or treating clinician in line with (appendix 1) must seek the agreement of the responsible commissioner to fund a treatment/referral for an individual for an intervention for which there is a CCG policy as listed in appendix 1, before that treatment/referral is carried out. The clinical funding team then compares the request against a set of threshold criteria in line with the Prior Approval process.

3.2 **Individual Funding Request (IFR) -** Is a request received from a clinician providing care to a patient, for a specific treatment that is not covered by existing policy or for a service which is not commissioned by ENHCCG/HVCCG (an Individual Case). It also applies where the CCG is responsible for commissioning the service/treatment in question and/or a local policy is in place but the patient does not meet the criteria and is deemed to be clinically exceptional (an exceptional case). In either case there is a basis for considering that the requested intervention is likely to be clinically effective for the patient and is considered to be a good use of NHS resources.

3.3 Individual Case - This is where there is no relevant clinical commissioning policy, NICE Technology Appraisal (TA) guidance or Highly Specialised Technology (HST) Appraisal guidance in place for the management of the patient's condition or combination of conditions, and the patient's clinical presentation is so unusual that they could not be considered to be part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken.

3.4 **Exceptional Case -** This is where there is a clinical commissioning policy, NICE Technology Appraisal (TA) guidance or Highly Specialised Technology (HST) Appraisal guidance that governs whether to fund or not fund the treatment for the patient's condition, and a clinician can demonstrate that their patient is in a different clinical condition when compared to the typical patient population with the same condition and (if relevant) at the same stage of progression, and because of that difference their patient is likely to receive material additional clinical benefit from treatment that would not be plausible for any typical patient.

3.5 **Pre-screen Panel-** Consists of the Clinical Decisions Manager or the Clinical Decisions Nurse, Public Health Consultant and when required, a Pharmaceutical advisor. The pre-screen panel can be used to review complex cases or appeals prior to consideration of presentation to full IFR panel.

3.6 **IFR Panel-** Is the Panel that represents both ENHCCG and HVCCG that has been authorised to take decisions on its behalf on *Individual Funding Requests*. (See separate terms of reference document Appendix 4). This is a jointly constituted Panel between ENHCCG and HVCCG.

4. Policy Statement

4.1. The clinical funding process only considers **clinical** information. Information that is immaterial to the decision, including information about the social, economic or personal circumstances of the patient which does not have a direct connection to the patient's clinical circumstances, shall **not be** considered.

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. Whilst everyone's individual circumstances are, by definition, unique and on compassionate grounds, reasons can always be advanced to support a case for funding, it is likely that the same or similar arguments could be made for all or many of the patients who cannot routinely access the care requested.

4.2. IFR does not generally fund equipment or on-going maintenance, or placements in long term care. Personal Health Budget's and voucher schemes are available through the Continuing Health Care Team.

4.3. ENHCCG and HVCCG want the best for its patients. It is important that when a patient reaches a stage in their treatment pathway that requires a specialist intervention, we would expect our patients to be referred to officially designated, accredited centres (usually commissioned by NHSE) to ensure high quality of care. The CCG will not support specialised treatment at un-designated, non-accredited centres.

4.4. ENHCCG and HVCCG do not discriminate on grounds of sex, age, sexual orientation, ethnicity, educational level, employment, disability, marital status or religion. ENHCCG/HVCCG does not generally make treatment for patients under its policies dependent on the patient's social or personal circumstances. Accordingly, when making decisions as to whether treatment should be provided to a patient which is not provided to patients generally, the Panel shall adopt the same approach.

4.5. Very occasionally an Individual Funding Request presents a new issue which needs a substantial piece of work before the CCG can reach a conclusion upon its position. This may include wider consultation. Where this occurs the IFR team may postpone a decision on an individual case until that work has been completed.

4.6. This may not always be clinically appropriate should the patient have clinical needs where a delay in funding would be inappropriate. In such cases funding in the interim may be considered.

5. Roles and Responsibilities

5.1. CCG Governing Body/Commissioning Executive- Is responsible for approving this policy.

5.2. Chief Executive – Accountable Officer - Has overriding accountability for the actions of the IFR team and Panel.

5.3. Executive Team - Has oversight of the IFR quarterly report and will escalate any serious risks and/or concerns to the Governing Body.

5.4. HVCCG Director of Primary Care and ENHCCG Director for Nursing and Quality - Has delegated responsibility to ensure this policy is applied and adhered to.

5.5. ENHCCG Medical Director - Provides overall supervision to the clinical fellows in terms of competence and training, and provides medical advice on difficult cases when the clinical funding team and the public health consultant between them believe they need a more senior medical view on an individual case. The Medical Director chairs the Beds, Herts, West Essex and Milton Keynes Priorities Forum. The Medical Director engages with the Clinical funding team and adapts ENHCCG/HVCCG guidance based on feedback from the team, and ensures that ENHCCG/HVCCG guidance is produced with sufficient clarity that the clinical funding team can interpret it for either prior approval or IFR purposes in line with this policy.

5.6. ENHCCG Associate Director – Nursing and Quality - Has delegated responsibility in the absence of the Director for Nursing and Quality to ensure this policy is applied and adhered to and provides support to the Clinical Decisions Manager.

5.7. Clinical Decisions Manager (ENHCCG) - Responsible for managing the Clinical Funding Team and all of its processes, ensuring that this policy is consistently applied and supports the triage of applications. Implements changes to enhance the team's effectiveness and reviews processes. The Clinical Decisions Manager will report any issues and/or concerns to the Director for Nursing and Quality

5.8. The Clinical Decisions Nurse (ENHCCG) - Is responsible for applying this policy in a consistent manner when performing daily triage of funding applications and has oversight of the administration team. The Clinical Decisions Nurse (CDN) will report any issues and/or concerns to the Clinical Decisions Manager.

5.9. Public Health Consultant - Provides clinical support and advice to the IFR team, pre-screen panel meetings and IFR Panel. Their role is to give public health advice in relation to clinical appropriateness, clinical effectiveness and cost effectiveness of a treatment. They also perform systematic reviews of the literature and perform individual case reviews based on clinical evidence. Public Health consultants will interface with the Beds, Herts, West Essex and Milton Keynes Priorities Forum and Hertfordshire's Medicine Management Committee.

5.10. Clinical Fellow - Medically qualified doctor who provides clinical support and advice to the clinical funding team. They perform daily triage of funding applications in line with this policy. Supports the team to perform internal audits. They also perform systematic reviews of the literature and perform individual case reviews based on clinical evidence.

5.11. Pharmaceutical Advisor – Provides specialist pharmaceutical support and advice concerning drug IFR cases to the IFR team, pre-screen panel meetings and IFR Panel. Provides specialist input on IFR drug cases including efficacy, safety, cost and cost-effectiveness.

5.12. **The Clinical Funding Administration team** - Provides administrative support to the clinical decisions manager/nurse. They are responsible for logging and monitoring all applications (excluding mental health requests), coordinating responses within the set time frames and communicating with patients and clinicians regarding process and decisions. The clinical funding admin team will co-ordinate and prepare cases for the weekly pre-screen panel meeting and the monthly IFR Panel meeting.

The Panel decisions will be sent to the referring clinician and the patient within 5 working days of the monthly Panel meeting. If the Panel decides not to fund a drug or treatment the decision letter will include an appropriate explanation. The clinical funding team has an enhanced role of signposting some referrers to the appropriate department or services. The team logs requests for adults, children and children with complex disabilities on to Blueteq (the electronic data management system) which assures monitoring and follow-up if required.

5.13. **The IFR Panel -** The IFR panel has delegated authority from the CCGs to make decisions in respect of funding for individual cases. Accountability for those decisions rests with the CCG representatives on the Panel. Decisions will usually be made on the basis of consensus. Should the Panel members not agree on the response to a request, the case will be escalated to either respective ENHCCG or HVCCG Executive Teams. The panel may also be asked to review cases previously considered by other external CCG panels in line with their IFR process. The IFR panel will report any significant issues and risks arising to the Executive Team via the IFR quarterly report.

6. Processes and Procedures

6.1 Principles

6.1.1. The IFR team shall apply the following principles when considering exceptionality:

Principle 1 Failure to Respond:
The fact that 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.

There are common co-morbidities for many conditions. Again these considerations are likely to have been taken into account in formulating the general policy.

In order to support an IFR on the basis of failure to respond to standard care, the IFR team would normally need to be satisfied that the patient's inability to respond to, or be provided with, the usual treatment was a genuinely exceptional circumstance, which lies outside the natural history of the condition and is not characteristic of the relevant group of patients with the condition.
For example: If the usual treatment is only effective for a proportion of patients (even if a high proportion), this leaves a proportion of patients within the group for whom it is already known that the usual treatment is not available or is not clinically effective. The fact that this particular patient falls into that group is unlikely to be a proper grounds on which to base a claim that they are an exceptional case.

As regards side effects, as an example, all patients who are treated with long-term high-dose steroids will develop side-effects (typical and well-recognised) and thus developing these side effects and wishing to be treated with something else does not make the patient exceptional.

Principle 2 Severity:

Many conditions are progressive and thus inevitably there will be a more severe form of the condition – severity of a patient's condition does not in itself usually indicate exceptionality.

Many treatments have side effects or contraindications, and thus intolerance or contraindication of a treatment does not in itself, usually indicate exceptionality.

Principle 3 Co-Morbidity:

If the usual treatment cannot be given because of a pre-existing co-morbidity which is unrelated to the condition for which the treatment is being sought under the IFR or is not unusual in the relevant patient group or generally.

The fact that the co-morbidity is present in this patient and its impact on treatment options for this patient is unlikely to make the patient clinically exceptional. As an illustration, some comorbidities are common in the general population, for example, diabetes which affects around 7% of adults, or asthma which affects at least 10% of the population. Diabetes and its treatments affect many other conditions; for example, steroids make glucose control more difficult. With any condition there will be a recognised proportion who also have a comorbidity which is common in the general population, and thus a patient cannot be exceptional by virtue of also having a comorbidity which is common in the general population.

If the proposed intervention is thought to offer a benefit to patients in these groups generally (i.e. those with more severe disease or those with common co-morbidities), the question is whether there is sufficient justification, including consideration of factors such as clinical effectiveness of the treatment in question, likely value for money, priority and affordability, for making a change to the clinical commissioning policy that covers the patient pathway. In this way, an improvement can be made to that policy to benefit the whole subgroup of patients of which the requesting patient is potentially just one such person. This change needs to be considered as a service development and not as an IFR.

Should severity be cited by the requesting clinician as part of the argument for exceptionality, the application should make clear whether there is evidence that the patient's presentation lies outside the normal spectrum for that condition. Preferably, a recognised scoring or classification system should be used to describe the patient's condition:

- Whether there is evidence that the patient has progressed to a very severe form of the condition much more rapidly than the range of progression that is documented and usually observed within the natural history of the condition.
- How the patient is expected to benefit from the treatment sought and in what quantifiable way.
- That there is evidence that the impact of the condition on this patient's health is significantly greater than its impact on the rest of the patient group, e.g. the condition is usually a mild disease but the presenting case is an extremely severe presentation; and that there is a plausible argument that the severity of the condition is prognostic of good response to treatment.

When the argument for clinical exceptionality is based on the patient having a specific genotype (genetic profile), the IFR team will require evidence of the prevalence of the genotype in the patient group. The applicant will need to show how the specific genotype would make the patient a) different to others in terms of clinical management and b) able to benefit from the treatment to a greater degree than others with the same or different symptoms of the condition. There may be cases where clinicians seek to rely on multiple factors to show that their case is clinically exceptional. In such cases each factor will be looked at individually to determine:
(a) whether the factor is capable, potentially, of making the case exceptional
(b) whether it does in fact make the patient's case exceptional.

One factor may be incapable of supporting a case of exceptionality (and should therefore be ignored), but it might be relevant on another factor. That is a judgment within the discretion of the IFR team. 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.

In this way a decision can be reached on whether the patient's clinical circumstances are exceptional, bearing in mind the difference between the range of factors that can always be found between individuals and the definitions used here of exceptional clinical circumstances.

Principle 4 Social Factors: Non-clinical and social factors have to be disregarded in order for the IFR team, to be confident of dealing in a fair manner in comparable cases.

If these factors were to be included in the decision making process, ENHCCG/HVCCG would not know whether it is being fair to other patients who cannot access such treatment and whose non-clinical and social factors would be the same or similar. Consideration of social factors would also be contrary to the CCG's 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 IFR team should not make.

Principle 5 Clinical Effectiveness: 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 IFR team. It is the sole responsibility of the referring clinician to provide this information and the IFR teams will not be responsible for undertaking any evidence searches.

Inevitably, the evidence base put forward in support of an IFR is unlikely to be as robust as in more common presentations of the condition or the more usual use of the treatment. However, 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 IFR team will consider:

- How closely the patient matches the patient population from whom the results are derived in any study relied on by the clinician.
- The plausibility of the argument 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 IFR team 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.

<u>Principle 6 Good Use of Resource:</u> The requesting clinician will be expected to explain why they consider the treatment for which funding has been applied for will be a good use of NHS resources.
This criterion is only applied where the IFR team has already concluded that the criteria of clinical exceptionality and clinical effectiveness have been met. Against this criterion the IFR team balances the degree of benefit likely to be obtained for the patient from funding the treatment against cost.

Having regard to the evidence submitted and the analysis they have carried out when considering clinical exceptionality and clinical effectiveness, the IFR team will consider the nature and extent of the benefit the patient is likely to gain from the treatment, the certainty or otherwise of the anticipated outcome from the treatment and the opportunity costs for funding the treatment. This means considering, for example, how significant a benefit is likely to be gained for the patient, and for how long that benefit will last. These factors need to be balanced against the cost of the treatment and the impact on other patients of withdrawing funding from other areas in order to fulfil the IFR. When determining whether a treatment would be a good use of NHS resources it is very important to consider the length of time for which funding of a treatment is being requested, in relation to the duration of the evidenced efficacy of the treatment i.e. whether the clinical evidence indicates short, medium or long term effectiveness of a particular treatment.

Due to the nature of the cases considered by the IFR team, the degree to which effectiveness can be considered certain is likely to be limited, and this will be a relevant factor when considering whether funding would be a good use of NHS resources. However, the IFR team should also take into account its ability to impose conditions on any funding it agrees, for example to monitor the impact of the funded treatment. In applying this criterion the IFR team will draw upon their professional and analytical skills and knowledge of the NHS system and how it works.

6.1.2. The IFR process is clinician led and all applications must be made by a clinician. Deliberations at Pre-screen and Panel will be based on evidence of individual clinical exceptionality and will not take into account issues relating to social or personal circumstances. It is therefore not appropriate for patients to attend the Pre-screen or the Panel and the Commissioners are not legally bound to invite them. However, patients may submit a supporting statement but this needs to be limited to clinical issues i.e.: what effect the condition has on the patient's activities of day to day living.

6.1.3. On occasions the clinical funding team may receive rare requests for treatments, drugs or services where the responsible commissioner is unclear, or there is no existing commissioned service. Such requests will be considered on an individual basis until commissioning responsibility can be ascertained. Should a patient group be identified the clinical funding team will treat this as a service development requiring consideration of a commissioning policy. Any emerging patient groups will be highlighted to the CCG directors via quarterly reporting for consideration and raised at the Beds, Herts, West Essex and Milton Keynes Priorities Forum and the and Hertfordshire Medicines Management Committee. The clinical funding team may consider patients within the group on their individual clinical circumstances in the interim, until a commissioning decision and/or policy is made. Following review in line with this policy, should the patient have individual clinical circumstances which prevents them from utilising other existing commissioned services and the intervention is clinically appropriate funding may be approved by the clinical funding team on behalf of the CCG, (see appendix 3).

6.1.4. Individual requests cannot be used as a means of 'creeping implementation' for new technologies, services or policies. 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 is likely to be a defined group of patients in similar clinical circumstances to that patient, the application will be classified as a request for development of a new policy or

service specification and a business case should be submitted via an alternative route through the CCG to determine whether it will be routinely commissioned. The request will not be progressed through the IFR route from that point.

6.1.5. The CCG 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.

It is standard practice for CCGs not to fund treatments which are still considered experimental, irrespective of the 'potential' health benefit for either individuals or groups of patients. Therefore treatments which are judged experimental, uncertain or not to be of proven effectiveness will not routinely be funded and funding for individual patients or groups of patients within poorly designed trials will not be supported.

6.2. Experimental and unproven treatments

6.2.1. Treatments which are judged experimental, uncertain or not to be of proven effectiveness will not routinely be funded.

6.2.2. The East and North Hertfordshire CCG clinical funding team (on behalf of HVCCG) will adopt the following criteria when considering a treatment as experimental:

- The treatment is still undergoing clinical trials for the indication in question
- There are no relevant articles published in the peer-reviewed journals available on the treatment for the indication in question
- The treatment does not have approval from the relevant government body.
- The treatment does not conform to usual clinical practice in the view of the majority of medical practitioners in the relevant field
- The treatment is being used in a way other than that previously studied or that for which it has been granted approval by the relevant government body
- The treatment is rarely used, novel, or unknown and there is a lack of authoritative evidence of safety and efficacy

6.2.3. There may at times be exceptions to the above where the CCG may consider funding. The clinical funding team will apply the NHS Hertfordshire Commissioning policy (PAC /14) October (2010) *Experimental, Uncertain and Unproven Treatments Version 2* when considering such requests.

6.3. Drug Requests

6.3.1. The IFR team processes requests for drugs not routinely commissioned including:

- High cost drugs excluded from contracts
- Treatments where no policies exist
- Treatments that we as a CCG have decided we will not fund routinely, or only fund in certain circumstances. This may include primary care prescribing or requests from Trusts and other providers

6.3.2. During daily triage should a request meet routine commissioning criteria this will be sent to the Pharmacy and Medicines Optimisation Team (PMOT) for processing. Drug requests will be considered in line with this policy on the grounds of clinical exceptionality and the same principles will be applied. The clinical funding team will work collaboratively with PMOT in responding to requests and draw upon their knowledge and expertise.

6.4. Urgent Treatment Decisions

6.4.1. ENHCCG and HVCCG recognises that there will be occasions when an urgent decision

needs to be made to consider approving funding for treatment for an individual patient outside of CCG policies. In such circumstances the CCG recognises that an urgent decision may have to be made before a Pre-screen or Panel meeting can be convened. The following provisions apply to such a situation.

6.4.2. An urgent request is one which requires urgent consideration and a decision because the patient faces a substantial risk of significant harm (the patient's life may be in danger) if a decision is not made before the next scheduled Pre-screen meeting and/or Panel. The Clinical Decisions Manager/Nurse or Clinical Fellow and Consultant in Public Health are responsible for agreeing whether a case requires urgent decision after considering the nature and severity of the patient's clinical condition. Urgency under this policy cannot arise as the result of a failure by the clinical team expeditiously to seek funding through the appropriate route and/or where the patient's legitimate expectations have been raised by a commitment being given by the provider trust to provide a specific treatment to the patient. In such circumstances the CCG expects the provider trust to go ahead with treatment; however funding will not be guaranteed and may be at their financial risk.

6.4.3. Provider trusts must take all reasonable steps to minimise the need for urgent requests to be made through the IFR process. If clinicians from any provider trust are considered by the CCG not to be taking all reasonable steps to minimise urgent requests, the CCG may refer the matter to the provider Trust Chief Executive.

6.4.4. Where an urgent decision needs to be made to consider funding for an individual patient, who is the responsibility of ENHCCG the Clinical Decisions Manager/Nurse or Clinical Fellow may request a virtual discussion on the case. The time period within which the decision needs to be taken will be 5 working days of receiving the case request, or earlier depending on the individual case.

6.4.5. The urgent decision will be made by "virtual discussion" via Bluteq entries, email or phone between the Pre-screen and/or Panel members. In exceptionally urgent circumstances the ENHCCG/HVCCG panel members will decide on the case if urgent input from other Panel members is not possible.

6.4.6. The "virtual discussion" will, as far as possible within the constraints of the urgent situation, follow the policy set out in making the decision. The Panel office shall collect as much information about both the patient's condition and the treatment as is feasible in the time available.

6.4.7. ENHCCG/HVCCG Pre-screen and panel members shall be entitled to reach the view that the decision is not of sufficient urgency or of sufficient importance that a decision needs to be made outside of the usual process.

6.4.8. Decisions will be sent to the referring clinician, and/or GP within 5 working days of receiving the case request for a virtual Panel meeting. If the Panel decides not to fund a drug or treatment the decision letter will include an appropriate explanation.

6.5. Prior Approvals Process (see Appendix 1)

6.5.1. ENHCCG/HVCCG Primary and Secondary care clinicians are required to submit an application proforma to demonstrate how the patient meets current thresholds. Relevant clinical letters and/or objective data to support the patients application can be useful and may often be requested, for example x-ray reports, scan results, optician reports, medical photography, clinical scores, clinic letters etc. For the list of procedures see (Appendix 1)

6.5.2. Completed applications are sent electronically to the clinical funding team and then reviewed by the Clinical Decisions Manager/Nurse and/or a medically qualified Clinical Fellow. All applications will be dealt with within a five working day turnaround for routine

applications and two working days for urgent applications, the clock starts on the first full working day after the application has been received. The Clinical Decisions Manager/Nurse or Clinical Fellow determines whether or not the patient meets the threshold criteria within ENHCCG/HVCCG clinical policy and considers any additional information provided. The requests are then - **Approved**, **Further Information Required** (insufficient information to make a decision), or **Declined**. A request for further information will stop the clock and it will not restart until the information requested is received. Requests which clearly do not meet the criteria and where no additional information has been provided can be directly declined by the Clinical Decisions Manager/Nurse. Those that do not meet criteria but contain additional information and/or clinic letters are then reviewed by a Public Health Consultant or clinical fellow who advises the clinical funding team on whether this seems a reasonable decision.

When triaging applications the Clinical Decisions Manager/Nurse or Clinical Fellow will aim to:

- Promote consistency, fairness and equity.
- Ensure effective use of resources, but also ensure that the decisions are based on clinical evidence.
- Improve the rigor of the processes ensuring decisions are rational, reasonable and transparent.

6.5.3. Treatments, and services, referred to in this Policy should not be undertaken or provided without Prior Approval being obtained as indicated. Where Prior Approval has not been appropriately obtained, then any treatments or services provided will have not been legitimately delivered, and will not be funded by the relevant commissioner (ENHCCG/HVCCG). Therefore funding will not be given in retrospect after the procedure has been carried out without Prior Approval funding in place.

6.5.4. Validation of activity against approved requests takes place quarterly and activity which does not meet criteria and was not authorised will not be reimbursed.

6.5.5. The majority of Prior Approval applications are usually approved. However where a Prior Approval application is declined clinicians can appeal the decision by submitting a case for exceptionality to the policy. These requests will be processed as an IFR and will be considered by the Clinical Decisions Manager/Nurse or Clinical Fellow and Public Health Consultant. Should a second request be declined as no grounds for exceptionality have been established and the clinician appeals with new clinical information this will be presented at a panel pre-screen meeting for discussion.

6.5.6. Should the clinician wish to challenge the clinical policy, they should contact the chair of the relevant committee directly as this is not relevant to the prior approval process.

6.6. IFR Process (see Appendix 2)

6.6.1. Daily triage

6.6.2. All IFR applications to the clinical funding team must be on the approved request form (appendix 4). The form should be referred to for further detailed instructions on completing it. Written support and evidence should be provided by the clinician treating the patient using the request form and include any relevant research findings where appropriate.

6.6.3. On receipt of the funding request, the case is recorded on the database and an acknowledgement is sent to the referring clinician. The Clinical Decisions Manager/Nurse or Clinical Fellow will verify whether sufficient information is included in the request form, and ask the referring clinician for more information if required.

6.6.4. The majority of IFR cases will be screened by the Clinical Decisions Manager/Nurse or Clinical Fellow on a daily basis. If an individual meets the CCG criteria or other existing CCG approved contract or commissioning policy or there are clearly defined grounds for exceptionality in line with this policy's definition then a decision to agree funding can be made at this point. Complex cases will automatically be sent to pre- screen panel meeting for discussion with a Public Health Consultant, Drug cases will be discussed with the relevant CCG pharmaceutical advisor and referred to pre- screen meetings as appropriate.

6.6.5. The skills and expertise required of the screening function by the Clinical Decisions Manager/Nurse or Clinical Fellow are the ability to:

- Determine who is responsible for commissioning the intervention
- Determine whether an existing ENHCCG/HVCCG policy covers the intervention (guidance can be found at) https://www.enhertsccg.nhs.uk/resources or https://hertsvalleysccg.nhs.uk/clinicians/clinical-policies/topic/352/Low_Priority__Threshold_Procedures
- Determine if the intervention is already funded though contracts? Are there suitable alternatives?
- Is this the correct point in the agreed clinical pathway for this treatment?
- Interpret the CCG definitions of exceptionality and individuality in the context of the clinical information that is presented

The Clinical Decisions Manager/Nurse or Clinical Fellow will be able to consider the following options:

- Send the request on to the responsible commissioner should this not be ENHCCG/HVCCG
- Refer drug cases to the CCG pharmaceutical advisor
- Gain advice from Commissioners/contract managers regarding suitable commissioned services or possible alternatives.
- Defer the request, and ask for more information from the referring clinician
- Approve the request if covered by an existing contract/ commissioning policy
- Approve if exceptionality is clearly demonstrated
- Take the request to the pre-screen panel
- Decline the request without reference to the pre-screen or IFR Panel (only where the patient meets the conditions detailed in sections 6.6.4 and 6.6.5)
- Discuss the request directly with a Public Health Consultant and decline with their agreement.

6.6.6. The clinical funding team will inform the applying clinician and/or patient (as appropriate) of the decision via letter within the allocated turnaround times

Most Urgent	Decision needed within a week as the patient's life may be in danger
Immediate	Decision needed within 3 weeks as delay will not be clinically appropriate
Routine	Decision needed in 4 to 6 weeks

6.6.7. Where a request is declined directly by the Clinical Decisions Manager/Nurse or Clinical Fellow requests will be audited weekly with a Public Health Consultant to ensure consistency to policy.

6.6.8. Where an IFR request is declined the patient's clinician can appeal. Where the appeal contains new clinical information the case will be discussed at a panel pre-screen meeting with Public Health and other professionals relevant to the case.

6.7 Panel pre-screen meetings

6.7.1. More complex IFR's will be reviewed weekly in a panel pre- screen meeting if required, depending on volume received by the IFR team by the Clinical Decisions Manager/Nurse or

Clinical Fellow, Public Health Consultant and a CCG Pharmaceutical Advisor (for drug requests) for advice and consideration if approval can be given, or, in the case of appeals, if funding can be approved after consideration of new clinical information following a decline.

The decision may be made to present the case to the monthly IFR Panel if a decision cannot be reached. Requests to submit a case to the IFR Panel can be made by the Clinical Decisions Manager/Nurse or Clinical Fellow, Consultant in Public Health or CCG Pharmaceutical Advisor.

6.7.2. The cases will be reviewed and decisions taken using the same methodology as detailed in this policy, and will make one of the following decisions:

- Approve the funding request
- Decline the funding request
- Uphold an initial decision to decline funding
- Defer the request, and ask for more information from the referring clinician
- Refer the case to the monthly IFR Panel meeting – for complex cases, where decisions cannot be taken by members of the weekly pre-screen meeting or if the initial appeals/complaints have been heard and no decision could be made, or following further appeal
- Where a clinician appeals the Panel pre-screen decision new clinical information which is relevant to the case should be presented to the Pre- screen panel for further review. The case could then be prepared for consideration at the next IFR Panel meeting

6.8. Monthly Panel Meeting

6.8.1. The monthly Panel meeting will usually consider cases where there is either:

- Uncertainty about whether the treatment falls within existing policy
- Evidence for exceptionality is unclear.

Or

- Where complaints and appeals have been heard by the weekly pre- screen Panel and no decision could be made. These cases will usually be more complex ones

Or

- Where the referring clinician appeals against the decision made by the pre- screen panel and there is new clinical information to consider which following review by the Pre-screen panel a decision that full IFR panel is required

Or

- The panel may also be asked to review cases previously considered by other external CCG panels in line with their IFR process

In considering the funding requests, the Panel will aim to:

- Promote consistency, fairness and equity
- Ensure effective use of resources, but also ensure that the decisions are based on clinical evidence
- Improve the rigor of the processes ensuring decisions are rational, reasonable and transparent
- Explore the grounds for any relevant clinical exceptionality presented and apply the definitions and principles of this IFR policy

6.8.2. Decisions will be reached by consensus where possible, but if a consensus cannot be achieved, the case will be decided by a vote of the Panel members. If the Panel's vote is equally split following extensive discussion then the decision will be escalated to the relevant CCG executive team.

6.8.3. The Panel shall be entitled to approve/decline or defer Individual Funding Requests. The

following will be considered:

- Both the Pre-screen panel and the IFR Panel are not authorised to approve funding for cases which are considered to form part of a service development.
- Providers are expected to seek funding for new treatments and services through commissioning managers by submitting a business case and not through the IFR system. However the panel can consider approving funding for individual cases where the patient is clinically exceptional to the patient group in question and the requested intervention has evidence of safety, efficacy and cost effectiveness.
- In rare circumstances, if a new (first time) request for a non commissioned service is received for an individual patient, consideration for individual funding may be appropriate whilst a business case is being developed for consideration of funding for the patient group. In these circumstances this IFR policy will be applied and it must be demonstrated that the treatment for this patient would be safe, effective and cost effective, as demonstrated by critical review of the literature. In these cases, a recommendation to develop a policy for the CCG would be made. In addition, the CCG may decide that funding for a rare condition will only be considered individually rather than commissioning a service for a patient group. In these circumstances it would be expected that a commissioning policy is developed to support decisions.
- The Panel is not required to accept the views expressed by the patient or the requesting clinicians concerning the likely clinical outcomes for the individual patient of the proposed treatment.
- The Panel 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.
- 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.
- The Panel shall be entitled to approve requests on the basis of exceptionality as defined within this IFR policy.

6.8.4. The case summaries and the meeting notes will form the minutes for these cases.

The panel will make one of the following decisions:

- Approve the funding request
- Decline the funding request
- Defer the request and ask for more information from the referring clinician

6.9. Appeals to IFR panel decisions

6.9.1. The patient's clinician shall be entitled to lodge an appeal against the decision of the Panel. Any such appeal will be heard at the different steps as detailed below.

6.9.2. **The first step in the appeals process:** If a clinician indicates that he or she wishes to appeal the IFR panel decision, it is for them to set out the reasons for their appeal in writing. The clinical funding team should consider the appeal and decide whether it discloses relevant and significant material or information which was not originally before the Panel. If the appeal does contain new relevant and significant material or information then the Panel should be able to reconsider the decision, and the case will be represented at the next Panel meeting. If there is no additional information, the case will not be represented to the Panel for further consideration. The clinical funding team will write back to the referring clinician and/or the patient explaining this and uphold any Panel decision.

6.9.3. **The second step within the appeals process:** Should the clinician continue to challenge the panel's decision and no new information has been presented for the panel to

reconsider, the case can be reviewed by another CCG's IFR Panel outside of Hertfordshire which is familiar with the Beds, Herts, West Essex and Milton Keynes Priorities forum and Hertfordshire Medicines Management Committee policies.

The clinician has the right to have the matter considered afresh by the external Panel. All members of the Panel should have had no prior involvement with the case.

6.9.4. The External IFR Panel shall consider all the papers which were before the originating Panel and any further material provided by the patient or those acting on his or her behalf. It may request that the Clinical Decisions Manager/Nurse or Clinical Fellow attends and makes their case for refusing funding and the patient and/or their representatives shall be entitled to put their case in writing for consideration by the External Panel. The External Panel will be able to question (if in attendance) the clinical funding team to get more clarity about the case.

6.9.5. In reaching its decision the External Panel should apply the same approach and tests as set out in this policy.

6.9.6. The External Panel will be able to uphold the Panel's decision. Or uphold the appeal and shall refer the case for reconsideration by the originating Panel in the event that the External Panel considers that the originating Panel has:

- failed in a material way properly to consider the evidence presented to it
- (e.g. by taking account of an immaterial fact or by failing to take account of a material fact); and/or
- come to a decision that no reasonable Panel could have reached on the evidence before the Panel;

6.9.7. The External Panel shall not have power to authorise funding for the requested treatment, but shall have the right to make recommendations to the originating Panel and to request the Chair to take urgent decisions.

6.9.8. All patients also have the option of putting in a formal complaint to their relevant commissioner (ENHCCG or HVCCG) concerning the policy, the process or the decision. The patient is also entitled to make a complaint to the Ombudsman and to request a judicial review of their case in line with the CCG complaints policy http://www.enhertsccg.nhs.uk/patient-feedback
https://hertsvalleysccg.nhs.uk/contact-us/feedback-services

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APPENDIX 1

Prior Approval

GP stage

- Hip/Knee (referral stage) (ENHCCG only)
- Cataract (ENHCCG only)
- Tier 3 Obesity services
- Dupuytrens contracture (ENHCCG only)
- Ganglion (ENHCCG only)
- Cosmetic treatments (non-skin)

Secondary Care/community providers Stage

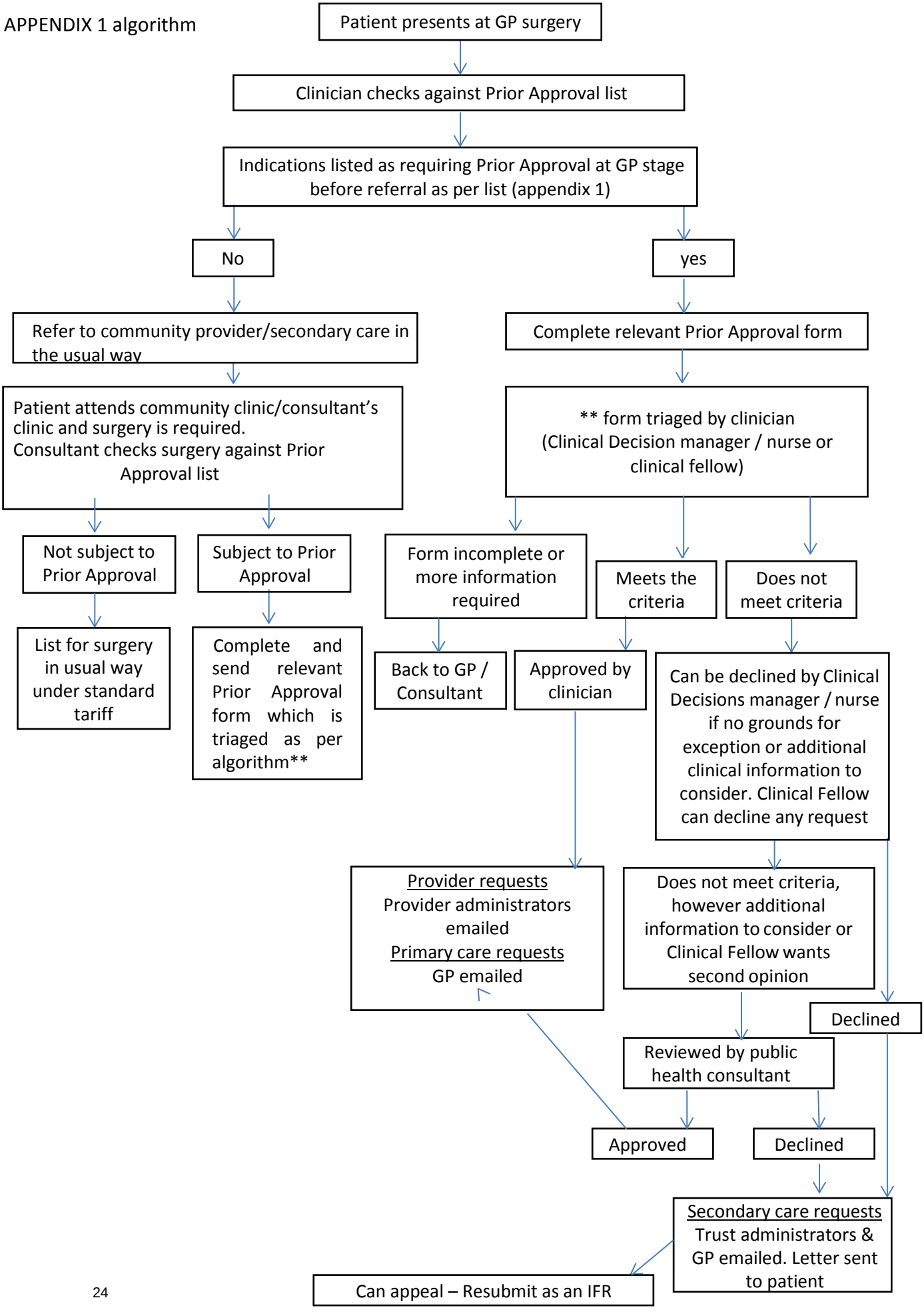
- Back injections- facet joint, epidural, Radio Frequency denervation, medial branch block
- Blepharoplasty / brow lift
- Bunions
- Cataracts (only if no approval at referral stage)
- Chalazia
- ENT- tonsillectomy, adenoidectomy, adenoid / tonsillectomy (children & adults)
- ENT- grommets (children & adults)
- Fertility
- Hand surgery - carpal tunnel, trigger finger, ganglion, fasciectomy.
- Haemorrhoids
- Hernias
- Hysterectomy
- Knee arthroscopy
- Minor skin surgery
- Septoplasty, Septorhinoplasty, Rhinoplasty
- Shoulder arthroscopy
- Tier 4 Obesity services
- Total hip replacement
- Total knee replacement
- Varicose Veins
- Video capsule endoscopy

This list could be subject to change as required and with the approval of the governing body

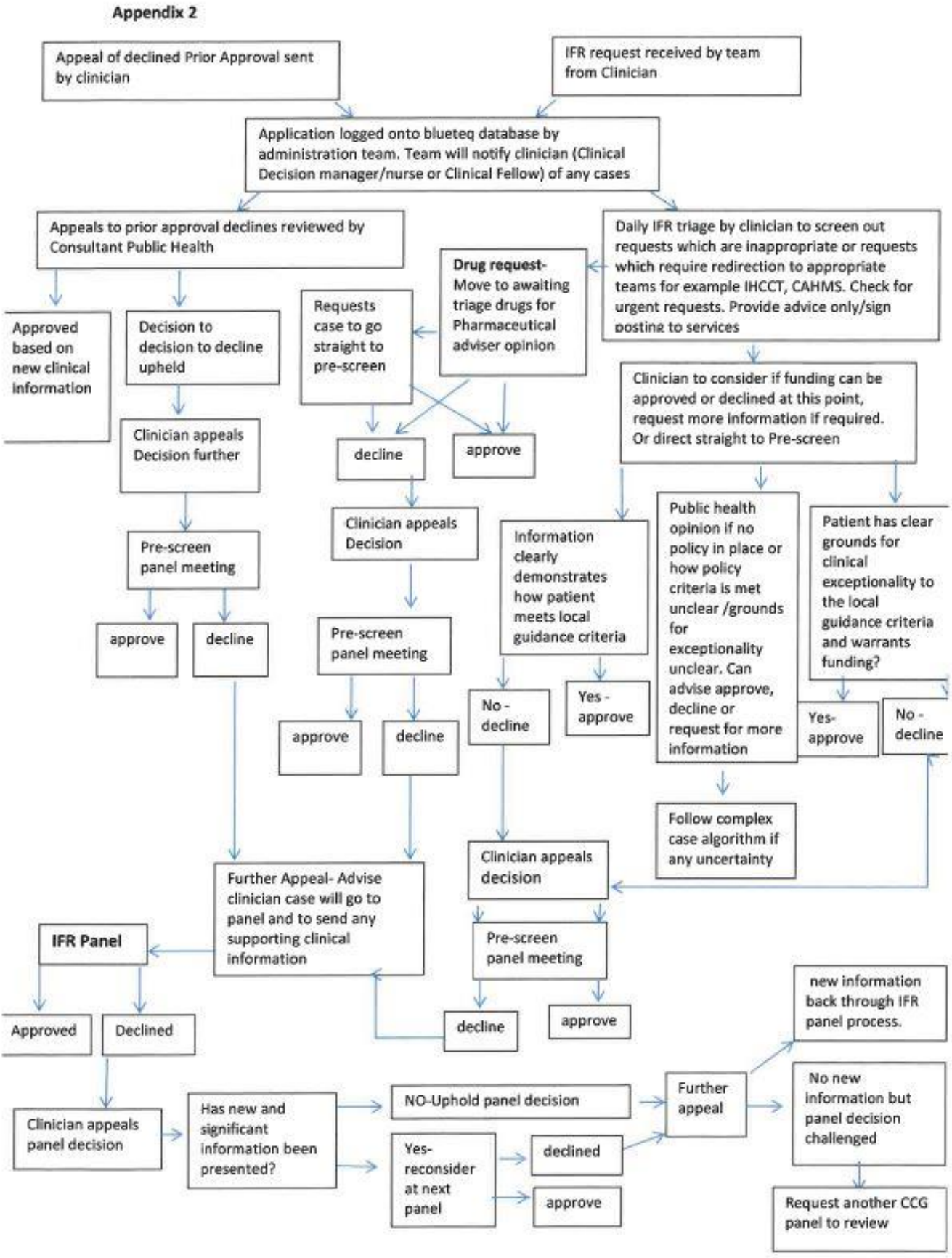
(All repeat treatments, reinsertions or revisions also require approval)

Appendix 1 continued see algorithm below

APPENDIX 1 algorithm

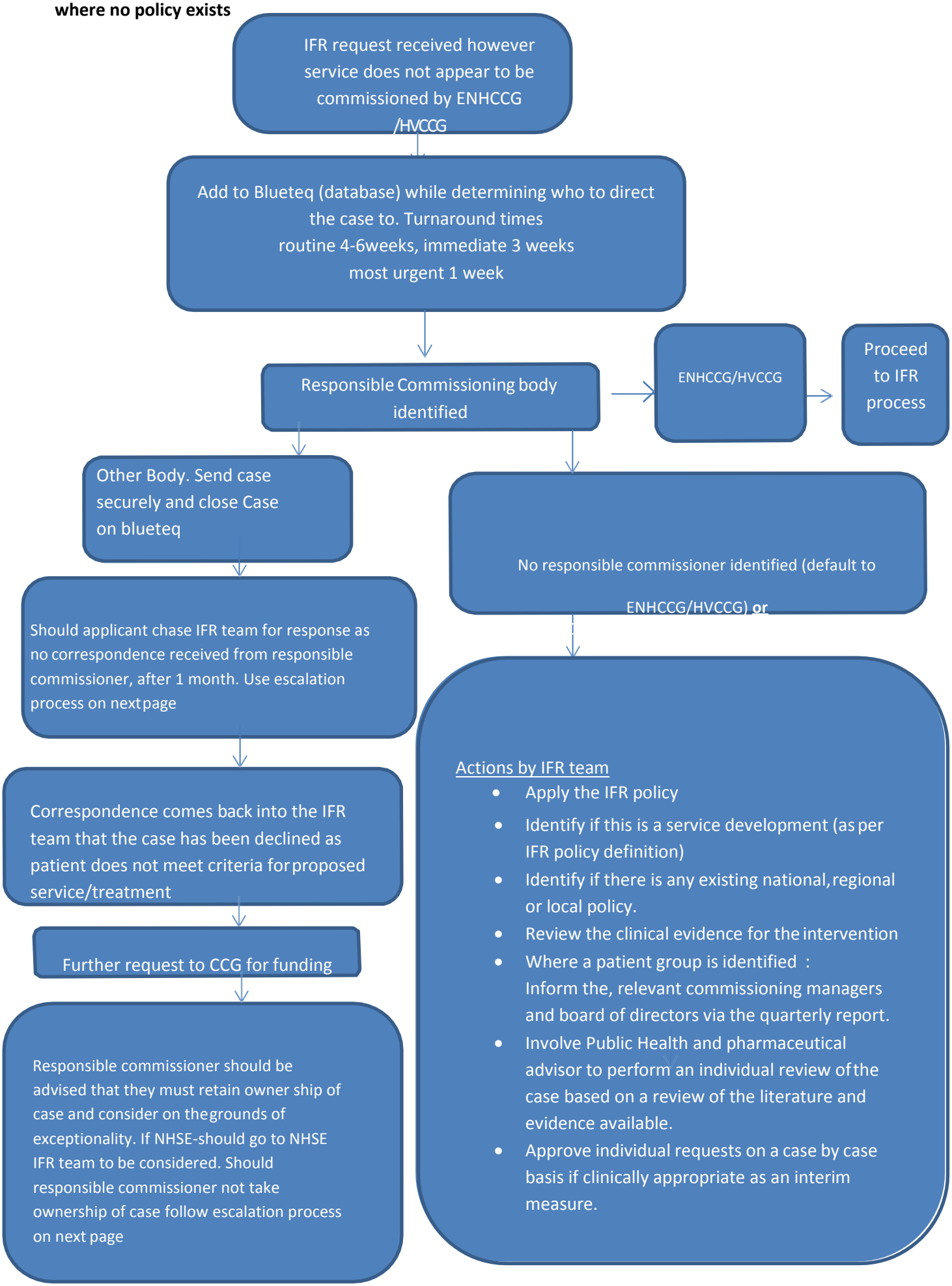


Appendix 2


Appendix 2
Appeal of declined Prior Approval sent by clinician
IFR request received by team from Clinician
Application logged onto blueteq database by administration team. Team will notify clinician (Clinical Decision manager/nurse or Clinical Fellow) of any cases
Appeals to prior approval declines reviewed by Consultant Public Health
Daily IFR triage by clinician to screen out requests which are inappropriate or requests which require redirection to appropriate teams for example IHCCT, CAHMS. Check for urgent requests. Provide advice only/sign posting to services
Drug request- Move to awaiting triage drugs for Pharmaceutical adviser opinion
Approved based on new clinical information
Decision to decision to decline upheld
Requests case to go straight to pre-screen
Clinician to consider if funding can be approved or declined at this point, request more information if required. Or direct straight to Pre-screen
Clinician appeals Decision further
decline
approve
Clinician appeals Decision
Pre-screen panel meeting
Information clearly demonstrates how patient meets local guidance criteria
Public health opinion if no policy in place or how policy criteria is met unclear /grounds for exceptionality unclear. Can advise approve, decline or request for more information
Patient has clear grounds for clinical exceptionality to the local guidance criteria and warrants funding?
approve
decline
Pre-screen panel meeting
No - decline
Yes - approve
Yes- approve
No - decline
approve
decline
Follow complex case algorithm if any uncertainty
Clinician appeals decision
Further Appeal- Advise clinician case will go to panel and to send any supporting clinical information
IFR Panel
Pre-screen panel meeting
new information back through IFR panel process.
Approved
Declined
decline
approve
Clinician appeals panel decision
Has new and significant information been presented?
NO-Uphold panel decision
Yes- reconsider at next panel
declined
approve
Further appeal
No new information but panel decision challenged
Request another CCG panel to review

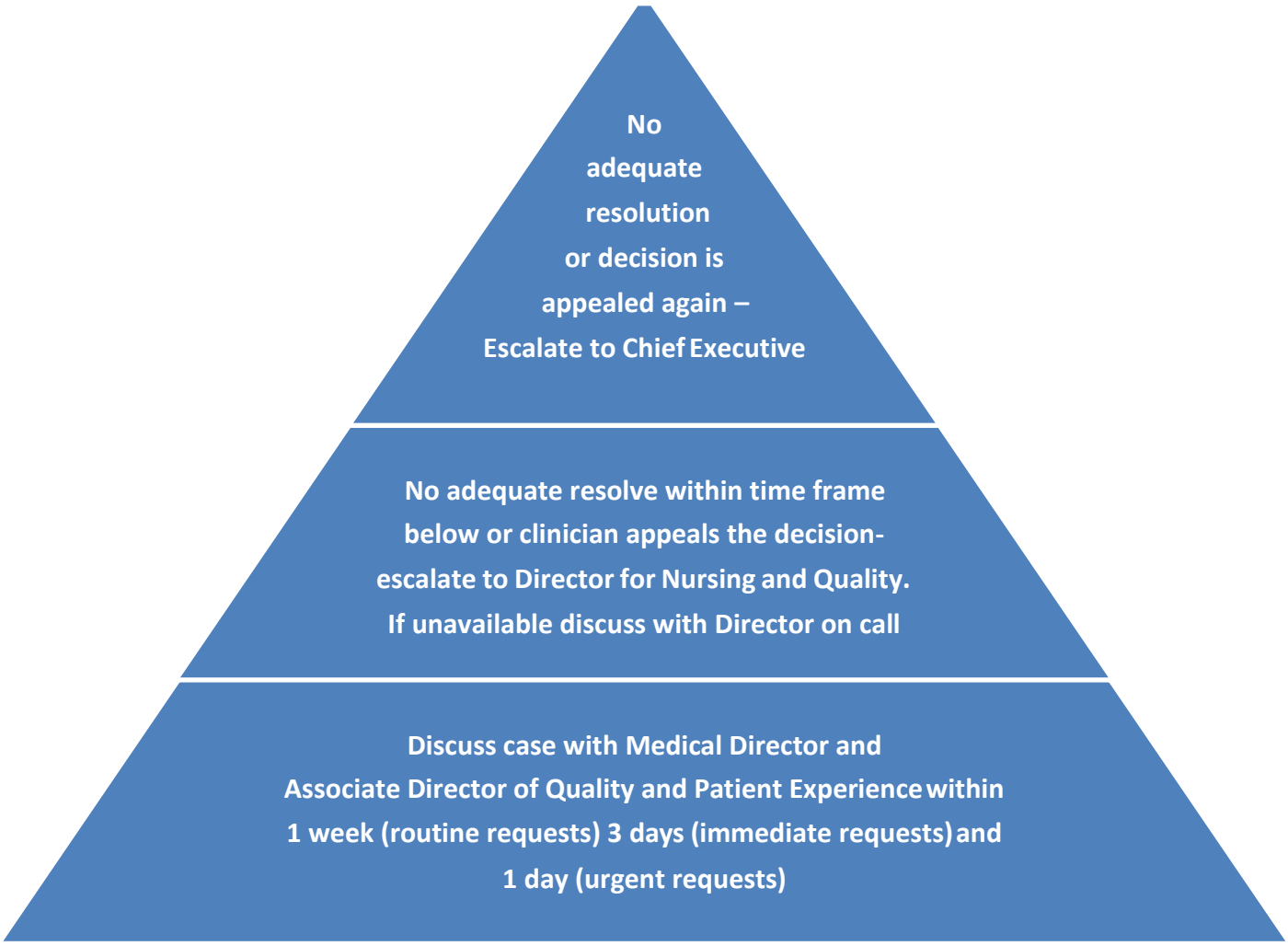
APPENDIX 3

IFR algorithm for the management of requests for rare and/or uncommission services/treatments where no policy exists



APPENDIX 3

Escalation process where responsible commissioner fail to accept/progress case



Appendix 4 Individual Funding Request Panel Terms of Reference version 1

1. Introduction

1.1 The Individual Funding Request (IFR) Panel (the IFR panel) is the committee the CCG has authorised to take decisions on its behalf on individual/exceptional funding requests. The purpose of the IFR panel is to consider funding requests on behalf of ENHCCG and HVCCG. The IFR Panel will decide in each case whether funding should be approved or declined in line with the Individual Funding Requests policy for East and North Hertfordshire Clinical Commissioning Group.

1.2 The IFR Panel meeting will usually consider cases where there is uncertainty about whether the treatment falls within existing policy or the evidence for exceptionality is unclear. Or where complaints and appeals have been heard by the weekly pre-screen Panel and no decision could be made. These cases will usually be more complex ones. Or if the referring clinician appeals against the decision made by the pre-screen panel and there is new clinical information to consider and following further review by the Prescreen panel a full IFR panel is required.

1.3 The IFR panel may also be asked to review cases previously considered by other external CCG panels in line with their IFR process.

2. Membership

2.1 The membership of the IFR panel shall include:

- Lay member for governance and audit (Chair)
- GP representative from East and North Herts CCG or nominated deputy
- GP representative from Herts Valleys CCG or nominated deputy
- Secondary care representative or nominated deputy
- Pharmaceutical Advisor HVCCG or ENHCCG or nominated deputy(only where required for drug cases)
- Public Health Consultant / Specialist or nominated deputy
- Clinical Decisions Manger or nominated deputy

2.2 In the event of the Chair of the committee being unable to attend all or part of the meeting, they will nominate a replacement from within the Membership to deputise for that meeting.

2.2.2 Additional members may be co-opted, and the IFR Panel may decide whether they have decision making rights in the IFR Panel discussions, e.g. Public Health Registrars and Commissioners

2.2.3 For particularly complex cases, other individuals with clinical expertise and skills may also be included on the IFR panel. Public Health trainees can also contribute to the work of the IFR process as part of their training. They can attend IFR panels as non-voting members.

3. Quorum

3.1 The panel will be quorate if three of the members are present; this should include one of the GP representatives, one public health representative and the clinical decision manager or nominated deputy. Any members unable to attend will be expected to leave their comments on each case for discussion at the IFR panel meeting. Comments will be tabled at the meeting from members who are not present. However, an IFR Panel meeting with only three members present should be the exception.

3.2 No formal business shall be transacted where a quorum is not reached.

4. Frequency of meetings and attendance

4.1 IFR Panel is held on monthly basis dependent on cases being presented. Where there are no cases for discussion IFR Panel will not be required to meet.

4.2 Members of the IFR Panel should make every effort to attend every scheduled panel meeting. The secretary of the panel will monitor attendance and will report on this annually.

5. Authority

5.1 The IFR panel has delegated authority from the CCGs to make decisions in respect of funding for individual cases. Accountability for those decisions rests with the Panel. Decisions will be usually made on the basis of consensus. Should the respective Panel members not agree the response to a request the case will be escalated to the executive team.

5.2 The IFR panel is not obliged to allow patients to attend Panel. The IFR process is clinician led and all deliberations at IFR Panel will be based on evidence of individual clinical exceptionality and will not take into account issues relating to social or personal circumstances. It is therefore not appropriate for patients to attend the IFR Panel and the Commissioners are not legally bound to invite them. However, patients may submit a supporting statement but this needs to be limited to clinical issues i.e.: what effect the condition has on the patient's activities of day to day living.

5.3 The IFR panel is authorised to make the following conclusions:

- Approve the funding request.
- Decline the funding request.
- Defer the request and ask for more information from the referring clinician.

6. Emergency powers

6.1 Should the case need IFR Panel consideration the urgent decision will be made by virtual discussion, via blueteq entries, email or phone between the Panel members using the same quoracy principles set out in section 3 (See IFR policy regarding urgent requests). The exercise of such powers shall be reported and minuted at the next panel meeting.

7. Duties

7.1 **Decision making at IFR panel-** In considering the funding requests, the IFR Panel will aim to promote consistency, fairness and equity. Ensure effective use of

resources, but also ensure that the decisions are based on clinical evidence. Improve the rigor of the processes ensuring decisions are rational, reasonable and transparent. Explore the grounds for any relevant clinical exceptionality presented and apply the IFR policy. Consider rare cases where no commissioning policy/service exists on an individual basis.

7.1.1 The Panel is not authorised to make case by case decision making for service developments where the patient represents a group of patients who may benefit from the same treatment. The IFR Panel shall routinely screen individual funding requests to see whether they represent a service development. The key question used to screen out as a service development will be 'are there likely to be other similar patients in the CCG?' If there is evidence that this patient is representative of other similar patients and forms a cohort, the request will be considered on an individual basis (as per IFR policy) but the provider will be requested to follow normal procedures for introducing new services, in line with the CCG's Principles.

7.1.2 The IFR Panel is not required to accept the views expressed by the patient or the requesting clinicians concerning the likely clinical outcomes for the individual patient of the proposed treatment. The Panel 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.

7.1.3 The IFR 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.

7.1.4 The Panel shall be entitled to approve requests on the basis of exceptionality in line with the IFR policy.

7.1.5 The IFR panel will be audio recorded with the sole purpose of forming the response letter. This will form the minutes for the meeting. Audio recordings are immediately deleted after the panel once the minutes and response letter are agreed.

8. Reporting arrangements to the Governing Body

8.1 The IFR panel will report any significant issues and risks arising to the executive team via the IFR quarterly report.

9. Reporting arrangements of other Committees and Groups

9.1 The IFR panel does not feed into any other committees and/or groups.

10. Annual review of the IFR panel

10.1 The IFR panel will undertake a yearly self-assessment to:

- Review that these Terms of Reference have been complied with and whether they remain fit for purpose;
- Determine whether its planned activities and responsibilities for the previous year

have been sufficiently discharged; and,

- Recommend any changes and / or actions it considers necessary, in respect of the above.
- Provide the Governing Body with an annual report, which details the outcome of the annual review.

11. Committee servicing

11.1 The IFR panel shall be supported administratively by the Clinical Funding Coordinator and Clinical decisions Nurse (or other nominated representative), who's duties in this respect will include:

- Prepare clinical cases and inform panel members not less than 5 working days before the meeting.
- The funding coordinator will seek agreement of the Agenda with the Clinical decisions Nurse and collation of papers in-line with the IFR Policy.
- Providing written notice of meetings to panel members, and the papers, not less than 5 working days before the meeting;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Producing a single document to track the panels agreed actions and report progress to the panel;
- Producing draft minutes for approval within 5 working days of the meeting.

APPENDIX 5

Request Form for the Individual Funding (Exceptional) Requests Panel

The Individual Funding (Exceptional) Requests Panel considers whether funding should be granted for individual patients who are being considered for a treatment (procedure or drug) that:

- Does not fall within existing contracts; or
- Is a low priority procedure which would only be funded in exceptional circumstances and falls outside group prior approval arrangements; or
- Is a threshold treatment usually subject to group prior approval, but the patient does not meet the threshold and there are extenuating circumstances where treatment should be considered, or the circumstances for meeting the threshold may be considered subjective, e.g. psychological distress; or
- Is not funded for routine prescribing e.g. primary care Red List or drugs outside secondary care contracts which practices may be asked to prescribe or support for their patients.

Background

Referrals to the Panel can only be made on an individual, named patient basis and should be made by an appropriate referring clinician PRIOR to referral for treatment.

For treatments that are urgently required, where significant harm may occur through delay, it must be provided to the patient and retrospective approval funding should be sought; treatment provided in this way may subsequently not be funded.

Requests for secondary care drugs or therapeutics must have approval by the relevant secondary care committee prior to this referral.

Decisions made by the Panel will relate to the individual patient only and are not an indication of CCG policy for the provision of this procedure. Neither are positive decisions an absolute approval for the treatment to go ahead. A decision to treat is a clinical decision and responsibility which rests with the clinician to whom the patient is referred in consultation with the patients themselves.
It is worth remembering that marginally better clinical effectiveness by using new treatments is frequently associated with disproportionately higher costs, thus representing poor value for money. There are many competing demands on CCG's limited financial resources. Thus, disproportionately expensive treatments can threaten the viability of other routine healthcare services that may have greater patient and population benefit.

Action Required

Please fill in all the sections of this form. The review process by the panel will be expedited by the availability of as much information as you provide in response to each question. If you do not have information, please complete the box to say 'not applicable' or 'not known'.

It is also important to include any relevant background information and clinical correspondence to familiarise the panel on the case. It is essential to complete the sections on the criteria for exceptionality and quantification of the benefits of the proposed treatment.

Please ensure you complete consent details and then send the completed forms electronically to: ifr.hertfordshire@nhs.net

We would encourage you to complete the forms electronically and then submit to us via email. Please note forms submitted via email will need to have the electronic signature.

This document is available in other languages, and alternative formats on request.

If you have any problems or difficulties completing this form please contact the Individual Funding Request team for assistance.

Individual Funding Requests Team - Contact Number: 01707 685353

Clinician Requesting Funding:	
Contact Details:	
Tel No and Bleep:	
Email:	
Address:	
Name of Trust Providing Treatment:	
Speciality:	
What is the funding request for:	
Submission Date:	

How urgent is this request? – Most urgent/ Immediate/ Routine

Most Urgent – Decision needed within a week as the patient's life might be in danger.

Immediate – Decision needed within 3 weeks as delay will not be clinically appropriate.

Routine – Decision needed in 4 to 6 weeks

For treatments that are urgently required, where significant harm may occur through delay, it must be provided to the patient and retrospective approval for funding should be sought, treatment provided in this way may subsequently not be funded.

Signature of requesting Clinician and date:	

Date funding request received by the CCG:	

(For CCG use only – the clock starts from this date)

The CCG response of how this request will be processed will be sent within 3 working days.

Patient Consent

Is the patient aware of this referral and the contents of this form and supporting documents?	YES/NO
I confirm that the patient consents to the CCG IFR Team accessing personal clinical information about them that is held by IFR staff to enable full consideration of this funding request?	YES/NO

By submitting this request you are confirming that you have fully explained to the patient the proposed treatment and they have consented to you raising this request on their behalf.

It is the East & North Hertfordshire and Herts Valleys CCG's policy to let the patient know the outcome of the funding request application unless it is not clinically appropriate to do so.

ALL FIELDS MUST BE COMPLETED

Name of Patient:	
Date of birth:	
NHS Number:	
Hospital Number:	
Address:	
Registered GP Name: **GP Address:** **GP Tel No:**	

1. Patient Diagnosis Please attach details of relevant clinical correspondence and background information.	
2. Please list other co-existing conditions To what extent is each of these likely to improve or impair the patient's response to the intervention for which funding has been requested?	
3. Treatment/ Management so far Include summary of previous intervention(s) for condition to be treated	
4. Description of proposed treatment	

5. Why choose this particular treatment over other options?	
6. Does it meet local guidance? (Please specify how) If yes, please provide brief summary and/ or reference of the relevant paragraphs	
7. Does it meet national guidance? (e.g. NICE) Please specify how If yes, please provide brief summary and/ or reference of the relevant paragraphs.	
8. What is the evidence to support the use of the proposed intervention? And what harms are associated with this treatment? Give information about NNT, NNH For example a systematic review, major RCT or other research evidence. Please attach copies of literature or relevant paragraphs	

9. If this is a drug, when was this request approved by the Trust's Drug and Therapeutic Committee or equivalent and for what indication?	
10. What are the specific goals expected outcomes of this treatment for this patient? **Please quantify the added benefits of using this treatment compared to alternative options** E.g. QOL, life expectancy, impact on or facilitating subsequent treatment etc. NB in the case of cancer patients, please consider attaching a summary of PEPSI-COLA holistic assessment where appropriate In the case of life-extending, as opposed to curative cancer treatments, please provide assurance that the patient is aware of the likely outcomes of treatment and alternatives	
11. What other treatment options are available for this condition? If any, please provide details and state reasons why they are not being considered in this case	

12. What are the implications of not providing this intervention for the patient or carer? E.g. potential future illness or disability or costs.	For Patient: For Carer:
13. Is there any information on the cost effectiveness of this intervention? If yes, please provide details	
14. Please state the estimated duration and total costs (cost of drug/ procedure and services) The Panel is required to consider the anticipated health gain and justify the extra cost for this treatment.	
15. Please state any cost savings to be gained from this procedure such as likely downstream procedures/ admissions avoided. **When would you expect these savings to be realised against current treatment costs?**	
16. If this is not a one-off treatment or procedure, please set out by whom treatment effectiveness will be reviewed, what are the criteria to measure effectiveness, when to measure these and criteria to stop treatment	

17. What are the exceptional circumstances, if any, that would merit consideration It is important that such circumstances are fully articulated (please see definition footnote)	
18. If this is a drug that is secondary care initiated and then continued in primary care, have appropriate shared care protocols been agreed? If yes, please provide details	
19. Is the requested intervention part of a clinical trial with LREC approval? If yes, please attach trial protocol. What does the trial protocol say about continuity of treatment after end of trial?	
20. Location of proposed intervention. (E.g. which hospital, treatment centre) Are there appropriate clinical governance systems in place?	
21. Please state the number of cases submitted for exceptional funding of this intervention by the trust in the last 12 months. For provider Trust only	

22. How many other similar patients you may see over the next 12 months For provider Trust only	
23. Please declare any potential conflicts of interest with respect to any contractual arrangement Support in research projects should also be declared	

Signature of requesting Clinician:	
Date:	

Policy on Exceptionality

The CCG does not offer treatment to a named individual that would not be offered to all patients with equal clinical need.

In making a good case for special consideration, it needs to be demonstrated that:

- The patient is significantly different to the general population of patients with the condition in question; and

- The patient is likely to gain significantly more benefit from the intervention than might be normally expected for patients with that condition

The fact that a treatment is likely to be efficacious for a patient is not, in itself, as basis for exceptionality.

Appeals Process

An appeal process allows the case to be re-considered and allows the CCG to examine its own processes to check that they are legally and clinically robust. If the clinician does not agree with the Panel's decision, the first step should be to phone or email the Individual Funding (Exceptional) Request Administrator, to get more details about the appeals process.

If you wish to proceed further, you need to apply in writing setting out the reasons for the appeal within 30 days of written notification of the outcome of the first appeal.

Appendix 6

Equality Analysis – Full Equality Impact Assessment

This template is an adapted version of the NHS England Equality template which was published in September 2014 and is the current standard.

Title of policy, service, proposal etc. being assessed:
Individual Funding requests and Prior Approval Policy

What are the intended outcomes of this work? Include outline of objectives and function aims **To Inform clinicians and patients about the rationale and process of individual funding and prior approval. Update the existing policy and ensure it remains relevant and in line with NHSE**
How will these outcomes be achieved? What is it that will actually be done? **The team will apply this policy equally and fairly to all. Regular audits will be performed to assess cases against the policy**.
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc. If you believe that there is no likely impact on people explain how you've reached that decision and send the form to the equality and diversity manager for agreement and sign off **Patients, CCG staff, external staff, consultants, GP's, Public health.**

Evidence **What evidence have you considered?** Against each of the protected characteristics categories below list the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section of this template. If you are submitting no evidence against a protected characteristic, please explain why.
Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issues. **No age discrimination within policy**
Disability Detail and consider disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities. **No discrimination within policy, however this group of patients may require additional support from clinicians to have the processes within the policy explained. As this policy is for clinicians no plain text or large print version available.**
Gender reassignment (including transgender) Detail and consider evidence on transgender people. This can include issues such as privacy of data and harassment. **No impact on this group**

Marriage and civil partnership Detail and consider evidence on marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities. **No impact on this group**
Pregnancy and maternity Detail and consider evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities. **No impact on this group**
Race Detail and consider race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travelers, nationalities, cultures, and language barriers. **No impact on this group**
Religion or belief Detail and consider evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues. **No impact on this group**
Sex Detail and consider evidence on men and women. This could include access to services and employment. **No impact on this group**
Sexual orientation Detail and consider evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers. **No impact on this group**
Carers Detail and consider evidence on part-time working, shift-patterns, general caring responsibilities. **No impact on this group**
Other identified groups Detail and considers evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers). **The clinical funding team can only process applications for patients who are registered with a GP in Hertfordshire. Socio-economic status does not impact on the decision making process.**

Engagement and involvement
How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available? **This is not a new process, policy update only**
How have you engaged stakeholders in testing the policy or program proposals? **This is not a new process, policy update only**
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Now consider and detail below how the proposals could support the elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups (the General Duty of the Public Sector Equality Duty).

Eliminate discrimination, harassment and victimisation

This policy is applied equally and fairly to all patients regardless of sex, age, sexual orientation, ethnicity, educational level, employment, disability, marital status or religion, social or personal circumstances are not general used as a means to obtain funding over others.

Advance equality of opportunity

As above

Promote good relations between groups

As above

Next Steps

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research. This is your action plan and should be SMART.

We will ensure that all clinicians involved in applying for funding on behalf of patients are aware of this policy and its contents; we will do as much as we can to ensure that all patients have this policy applied to them in an equal and consistent manner. We will regularly audit our funding decisions.

How will you share the findings of the Equality analysis? This can include sharing through corporate governance or sharing with, for example, other directorates, partner organisations or the public. The completed EqIA will be published on the East and North Herts and Herts Valleys CCG website.

This will be reviewed and a governing body public meeting and then published alongside the policy which is publicly available.

Data Protection Impact Assessment (DPIA) APPENDIX 7

NHS East and North Hertfordshire Clinical Commissioning Group's data processing activity MUST comply with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. The Data Protection Impact Assessment process helps managers identify how the collection and use of people's personal data may affect their privacy.

NHS East and North Hertfordshire Clinical Commissioning Group

This form should be used for both internal and partnership projects which require the collection and / or use of personal data. The form should be completed with the assistance of David Hodson, Head of Information or Sarah Feal, Company Secretary.

Project name	Individual Funding Request & Prior Approval Policy		
Department	Nursing & Quality		
Lead officer	Geraldine Woods		
Job title	Clinical Decisions Manager		
Unit name	Clinical Funding Manager	Unit ID	
Telephone	01707685340	Email	g.woods1@nhs.net

List all agencies which will have access to the personal data collected and used for this project.

Individual users of our blueteq database employed by ENHCCG, IHCCT, HVCCG. The applicants responsible for the patient care who send the data to us.

What personal data do you intend to use, and why (list all categories)?

Name- So we can liaise with the patient directly and send a written response to the correct person in the household
Address-As above
NHS number- As a security measure when discussing case with other health professional/departments. To enable us to check the patients name and address matches the application to avoid any IG breaches.
Date of Birth- Required in establishing if the patient is a child or adult as services vary. Also required as some clinical policies stipulate an age cut off.
Sex-Different clinical criteria apply to men and women, some blood reference ranges are different for men Vs women.
Relationship Status- Only used when triaging IVF applications as policy only applies to couples not singles.
Health Data- The patient current condition and past medical history is used in order to determine if a patient meets the set threshold criteria for surgery.

Can you achieve your objectives using anonymised data?

Yes	☐		
No	☒	Why not?	Because this is direct patient care and it would not be safe to make clinical decisions without the health data of the patient. The team would not be able to contact the patient and involve them in their case without their contact details.

What are the benefits to the individual of their personal data being used for this project?

They will receive appropriate, safe, evidence based care at an appropriate stage of their condition. They will kept informed about funding decisions relating to their care.

What are the organisational benefits of the individual's personal data being used for this project?			
The IFR and Prior approval process ensures that the patient is receiving the appropriate care and an appropriate stage. Upholds the organisations reputation by protecting patients from receiving care that could be potentially harmful. If ensures that resources are allocated equally and fairly to all.			
What are the potential negative impacts to the individual of their personal data being used for this project?			
There is a risk of their information being seen by someone not involved in the process or their care (an IG breach)			
How will you avoid causing unwarranted or substantial damage / distress to the individual when using their personal data for this project?			
All personal data will be respected and protected. Only data that has a direct relation to the application will be used. Only staff directly involved in the processing of the application will have access to the data. All staff is aware and trained in the importance of protecting patient's personal data. Only allocated staffs are given secure access to our database. When staff leave their access is removed. The patient's personal information is not shared for non-clinical purposes.			
Is the data already held by NHS East and North Hertfordshire Clinical Commissioning Group?			
Yes	☐		
No	☒	The funding function within the CCG requires specific and detailed handling of patient data .	
Is it held by one of the partner agencies involved with this project?			
Yes	☒	IHCCT will hold the data for mental health requests	
No	☐	Which agency will be collecting the data?	
Have you told the individuals whose personal data you want to use for this project how and why you intend to use their data?			
Yes	☒	The contracted provider has to gain the patients consent prior to sending an application to us; we ensure the consent section of the form is complete.	
No	☐		
If not, are you intending to tell them?			
Yes	☐		
No	☐	Why not?	
Do you already have the individual's permission to use their data for this project?			
Yes	☒		
No	☐		
If not, are you going to ask for their permission?			
Yes	☐		
No	☐	Why not?	

Have individuals been given the opportunity to refuse us permission to use their data for this project?		
Yes	☒	They could tell the surgeon who completes the request that they do not consent to the request
No	☐	

Is your project driven by any statutory / legal obligations?			
Yes	☒	Please list	NHS constitution 2015. NHSE Evidence Based Interventions Guidance NHSE IFR policy
No	☐		

How will you make sure that the personal data you are using is kept accurate and up to date?
The team are trained to double check applicants details against the national spine to ensure name, address, GP etc. are all up to date. Any information corrected by the patient or clinician is immediately amended on the patients file.

How long will you need to hold the personal data for?
For as long as the case is open and for a period of time if subsequent funding is to be authorised. All paper applications are destroyed once the case is closed.

How will you make sure that you are holding data for the appropriate length of time, and no longer?
As soon as the case is closed the application is destroyed securely, processes for storing information is reviewed annually as part of the annual data flow mapping exercise and is reported on the team's Information Asset register with appropriate up to date risk assessments.

How will the data be held / stored?
In paper format initially and then uploaded to our secure NHS Bluteq database, records not being used for continued patient care will be deleted in line with retention policy (to be identified and clarified)

What technical security measures will be in place?
Secure UK servers. Individual user password protection Access using encrypted devices only The teams manager has full control on who can and cannot obtain access and have a process of auditing access to the bluteq system to ensure that only authorised staff have access to the data.

How will personal data be transferred / shared between the agencies involved in this project?
Via secure email

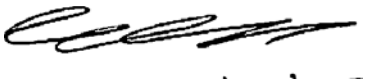
Will you be transferring personal data to a country or territory outside of the EEA?		
Yes	☐	
No	☒	

How will you ensure that third parties will comply with data protection obligations?
The third parties the team communicate with have NHS contracts and are therefore bound by the national statutory contract requirements, data protection being one of them.

What organisational measures are in place to ensure only appropriate and authorised access to, and use of, personal data?
Staff have annual IG/data awareness training which is mandatory. Processes for storing information is reviewed annually as part of the annual data flow mapping exercise and is reported on the team's Information Asset register with appropriate up to date risk assessments. Root cause analysis of IG breaches is undertaken.
How will technical and organisational security be monitored / audited?
Quarterly audit of access to Bluteq. Annual data flow mapping exercise and information asset register management.
NHS East and North Hertfordshire Clinical Commissioning Group's Information Governance Team conclusions regarding this project's overall compliance with the GDPR and Data Protection Act 2018 and recommendations for changes / refinements to the project which are required to ensure compliance.
• Records management retention of electronic health records in blueteq to be explored with Provider to ensure records can be appraised and disposed of securely. • 'Look-up records' audit trail to be discussed with blueteq. • Communications to providers requesting that only necessary and relevant PID is sent in support of funding applications.

DPIA reference number	018

As lead officer, I confirm that the information recorded on this form is, to the best of my knowledge, an accurate and complete assessment of the potential privacy impacts of this project.

Name	Signature	Date
Geraldine Woods		18/02/2019

Please return your signed and dated form to:

Data Controller's Information Governance Team:

- David Hodson, Head of Information 01707 684 441 or 07585 404432 and
- Sarah Feal, Company Secretary 01707 685242 or 07920 765395

Via enhertsccg.information@nhs.net

If you have any questions about the **Data Protection Impact Assessment** process, or if you need any help completing this form, please contact us using the email address, above, or by telephoning:

Data Protection Impact Assessment reviewed and approved on behalf of the NHS East and North Hertfordshire Clinical Commissioning Group's Information Governance Team] by:

Name	Signature	Date
Sarah Feal	*Sarah Feal*	19-02-19