

**Individual Funding Request Policy**  
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**The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.**

### POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

<b>New Version Number</b>	<b>Issued by</b>	<b>Nature of Amendment</b>	<b>Approved by &amp; Date</b>	<b>Date on Intranet</b>
1	Catherine Lightfoot		Governing Body 08/08/13	13/09/13
2	Lesley Emerson	Revision of process for considering IFR's		
3	Lesley Emerson	Revision of Chronic Fatigue and Breast Surgery criteria	CCG Engine Room 02/04/15	08/06/15
4	Samantha Helmick	Temporary Removal of Chronic Fatigue	CCG Engine Room 20/04/17	08/05/17
5	Samantha Helmick	Update and change to mirror SOP and new ratification element. Removal of application forms, photograph policy and Commissioning policies, replacement of Panel and Appeal Panel process flowcharts. EIA & SIA reviewed	CCG Engine Room 05/10/2017	

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## **1 INTRODUCTION**

- 1.1 NHS North Lincolnshire Clinical Commissioning Group (the CCG) has a statutory responsibility to commission care, including medicines and other treatments for the population it serves within available resources by prioritising between competing demands. The CCG will, therefore, ensure that it does not sue scarce resources on health care interventions that are not considered to be clinically effective or cost effective in meeting the health needs of patients. (The term 'health care intervention' includes use of a medicine or medical device, diagnostic technique, surgical procedure and other therapeutic intervention).
- 1.2 There is considerable variation in the evidence of clinical effectiveness of health care interventions, where costs may vary. Individual requests for treatments, which are not covered by existing contracts are received by the CCG. Some requests are for treatments for rare conditions where local services are not developed, while others are for health care interventions that the CCG will not commission as a matter of routine, but where the referring clinician believes there are exceptional circumstances that justify a request for referral. The CCG will ensure fairness of access to treatments which may normally be restricted but which may offer specific benefits in an individual context. By definition however, consideration by exception is likely to occur infrequently.

## **2 ENGAGEMENT**

This policy has been developed with a group of North Lincolnshire CCG Clinicians and Public Health colleagues. A similar policy has been considered and approved by a number of other CCGs across North Yorkshire and Humber locality.

## **3 IMPACT ANALYSES**

### **3.1 Equality**

3.1.1 The CCG is committed to:

- Eliminating discrimination and promoting equality and diversity in its Policies, Procedures and Guidelines
- Designing and implementing services, policies and measures that meet the diverse needs of its population and workforce, ensuring that no individual or group is disadvantaged.

3.1.2 To ensure the above, this Policy and Procedure and all commissioning policies for interventions addressed through the IFR process have been Equality Impact Assessed. Details of these assessments are attached at Appendix 8 and are available on the CCG's website.

3.1.3 Each member of the Panel should undertake an Equality and Diversity e-learning package (or the equivalent) and should be able to demonstrate an understanding of the CCG Equality strategy/objectives and the issues that may be relevant to each Individual Funding Request.

### 3.2 **Sustainability**

There are no sustainability impacts through this policy. Completed Sustainability Impact included in Appendix 9. Commissioning policies are agreed against clinical and cost effective considerations.

### 3.3 **Bribery Act 2010**

The CCG follows good NHS business practice as outlined in the Business Conduct Policy and the Conflicts of Interest Policy and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the development of this policy document and no specific risks were identified.

Further information of the Bribery Act can be found at [www.opsi.gov.uk/acts](http://www.opsi.gov.uk/acts). A list of frequently asked questions is available from the CSU Corporate Strategy and Policy Manager.

The Bribery Act is particularly relevant to this policy. Under the Bribery Act it is a criminal offence to:

- Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so.

AND

- Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and other related policies and documentation (as detailed on the CCG intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist.

Any panel member is requested to identify any conflict of interest in any funding requests from patients that are known to them, this must be declared at the onset of any panel meetings.

## **4 SCOPE**

This policy applies to:

- 4.1 All employees of the CCG, any staff who are seconded to the CCG, contract and agency staff and any other individual working on CCG premises.
- 4.2 Employees of the North of England Commissioning Support (NECS) who work within the IFR team, any staff who are seconded to the IFR team, contract and agency staff.
- 4.3 All referring clinicians within primary, secondary and tertiary care.

## **5 POLICY PURPOSE & AIMS**

The purpose of the Individual Funding Request (IFR) policy is to:

- Explain the difficult choices faced by the CCG and how the CCG has made the decision to prioritise resources to ensure the best health outcomes for the population it serves
- Set the decision making process within an ethical context and to demonstrate a clear process for decision making
- Inform health professionals about the policy in operation and how to request restricted treatments or appeal against individual decisions to decline a request for a restricted treatment
- Ensure decisions are made in a fair, open, transparent and consistent manner
- Provide a firm and robust background against which appeals can be judged
- Demonstrate a clear process for decision making
  
- Demonstrate that CCG decisions not to commission or to restrict access to certain health care interventions are lawful and taken in line with government directions.

It is recognised for patients to have timely treatment, clinicians across the community need to work together and have an understanding of what is in place across all sectors and not just in a single area. All clinicians with the ability to treat and/or refer for interventions detailed within this schedule are required to adhere to the principles

contained within this document and the contract schedule. This includes; General practitioners, Dentists, Opticians and Secondary Care Clinicians. This list is by no means exhaustive.

## 6. DEFINITIONS

- 6.1 Cost effectiveness – The cost effectiveness of a treatment or Intervention is the ration of its cost to a relevant and accepted clinical measure of its benefit. Cost effectiveness is concerned with gaining maximum health impact for the resource used on a treatment.
- 6.2 Clinical effectiveness – The application of interventions which have been shown to be efficacious to appropriate patients in a timely manner to improve patients' outcomes.
- 6.3 Randomised Controlled Trial (RCT) – A clinical trial that involves at least one test treatment and one control treatment, concurrent enrolment and follow-up of the test and control-treated groups, and in which the treatments to be administered are selected buy a random process, such as the use of a random-numbers table.
- 6.4 An Individual Funding Request is a request to the CCG to commission health care for an individual who falls outside the range of services and treatments that the CCG has agreed to commission as a matter of routine.

Individual Funding Requests are not the same as:

- Decisions that are related to care packages for patient with complex healthcare needs
- Prior approvals which are used to manage contracts with providers. For example the CCG might have agreed a prior approval scheme in a contract with an acute hospital that requires the hospital to obtain approval to treat in cases where the CCG has commissioned a better value service with another provider (such as community based service).

Individual Funding Requests generally arise in one of four circumstances:

- The Patient has a rare condition and makes the request to commission the usual way of treating the condition (i.e. referrals for the treatment are too low/unpredictable to warrant having a contract with any provider).
- The patient has a specific condition where the usual care pathway or treatment threshold is deemed inappropriate for that individual on clinical grounds (this may involve an elective tertiary referral outside agreed pathways).
- The clinicians involved in the patient's care want to take advantage of a healthcare intervention that is novel, developing or unproved, and which is not part of the CCG's commissioned treatment plans.

- The clinician would like to make available to a patient an intervention which is not medically necessary but is aesthetically desirable and the distinction between clinical and cosmetic need is not clear.

Occasionally some healthcare providers and clinicians might try to establish early access to new treatments (service developments) via an Individual Funding Request. However, the NHS Contract requires hospital providers to seek commissioning of new treatments through submission of a business case to their commissioners.

Similarly, the Individual Funding Request Panel must not be put in a position where it would be asked to make policy decisions for the CCG. Policy questions should always be referred for consideration to the Governing Body or another appropriate policy-making committee before the Individual Funding Request is considered.

This Policy in general relates to request for elective treatments and procedures. A separate contractual obligation applies to providers in cases of emergency lifesaving treatment. In such cases providers are required to notify the CCG retrospectively of any decision to treat outside the Individual Funding Request Policy. A process exists for urgent but not emergency) Individual Funding Requests where a decision is required outside of the scheduled Panel.

### **Requests for cross-border treatment and treatment outside the European Economic Area (EEA)**

Cross border health care requests i.e. requests for treatment outside of England but within the European Economic Area (EEA) should be made directly to NHS England via [nhs.cb.europeanhealthcare@nhs.net](mailto:nhs.cb.europeanhealthcare@nhs.net)

Guidance available at:

<http://www.nhs.uk/nhsengland/healthcareabroad/plannedtreatment/pages/introduction.aspx>

Requests for health care intervention outside of the EEA should be made Humber Local Area Team, providing the requested intervention is routinely commissioned locally.

For interventions which are not routinely commissioned locally, the request should first be considered through the CCG IFR process. If CCG approval is granted, the case should then be passed to Specialised Services within the NHS England North Yorkshire and Humber Local Area Team for further consideration.

## **6.2 Definition of Exceptionality**

- 6.2.1 Exceptionality is difficult to define, therefore pragmatism and Flexibility are necessary. However it may be summed up by asking the question “on what grounds can the CCG justify funding treatment for this patient when others from the same patient group are not being



funded” (“Priority setting: Managing Individual Funding Requests”, NHS Confederation 2008).

6.2.2 In making a case for special consideration in relation to a restricted treatment on grounds of exceptionality, it needs to be demonstrated that:

- The patient is significantly different from 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 normally be expected for patients with that condition.
- Only evidence of Clinical need will be considered. Factors such as gender, ethnicity, age, lifestyle or other social factors such as employment or parenthood cannot lawfully be taken into account.

6.2.3 The CCG will only allow clinical considerations (including mental health issues) to decide whether or not a patient is different to other patients. If there are clinical features that make the patient unique or unusual compared to others in the same group, the CCG would then consider whether there are sufficient grounds for believing that this unusual clinical factor means the patient would gain significantly more benefit than would be expected for the group.

6.2.4 When considering Individual Funding Requests, the CCG will use the same ethical framework and guidelines for decision making that underpin its general policies for health care interventions. Where social, demographic or employment circumstances have not been considered relevant to population based decision, these factors will equally not be considered for Individual Funding Requests.

## **7 ROLES / RESPONSIBILITIES / DUTIES**

All CCG staff (and those involved in commissioning and contracting), all members of staff in the NECS IFR team, and referring clinicians (primary, secondary and tertiary care) are responsible for following the procedures as set out in this policy.

The Director of Commissioning will be responsible for overseeing adherence to the Policy as set out below.

## **8 THE INDIVIDUAL FUNDING REQUEST POLICY**

### **8.1 Context**

This policy has been developed in response to the legal duties set out in the NHS Constitution, and a range of guidance as set out below:

- The NHS Confederation guidance on managing Individual Funding Requests (the NHS Confederation, 2008) (Ref 12.1)
- Regulation 35 of the National Health Service Commissioning Board and Clinical Commissioning Groups) Responsibility and Standing Rules). Regulations 2012 (SI 2012 No 2996) Ref 12.2) which imposes a duty to give reasons for either declining to adopt a policy on any particular intervention or declining a particular treatment for a patient where the policy is not to fund that intervention
- The NHS Constitution (DH, March 2013) (Ref 12.3). Two rights relate specifically to the availability of medicines and other treatments:
  - 1) You have the right to drugs and treatments that have been recommended by NICE for use in the NHS if your doctor says they are clinically appropriate for you.
  - 2) You have the right to expect local decision on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. 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.
- Guiding principles for processes supporting local decision making about medicines and a Handbook of good practice guidance (Department of Health/National Prescribing Centre, February 2009) (Ref 12.4).
- Guidance on NHS patients who wish to pay for additional private care (Department of Health, March 2009) (Ref 12.5).
- The Operating Framework for the NHS in England 2014/15 (Department of Health, December 2011) (Ref 12.6).
- NHS Lincolnshire CCG Commissioning Plan.

## 8.2 Development of General Policies for Interventions

- 8.2.1 Each year, the CCG plans investment in health care interventions and services as part of its operating plan development process to meet the needs of its local population. Commissioning decisions are usually made in collaboration with health care providers and other stakeholders, and are taken in the context of the CCG's available resources to ensure that care is fairly allocated to all patients and, where appropriate, measured against the CCG's other service development priorities, NICE guidance and national priorities.
- 8.2.2 When planning its investments, the CCG works with provider partners and stakeholders to identify, as far as possible, those new interventions that are likely to have a significant clinical impact and require potential commissioning; this is often referred to as horizon scanning.

- 8.2.3 Most health care interventions are commissioned as part of Contracts with provider partners. However, it is likely that during the year there will be requests for interventions not covered by the CCG's commissioning policies. The CCG, therefore, needs to be able to make decisions about these requests that are fair and consistent.
- 8.2.4 All Individual Funding Requests are triaged to identify whether a request submitted on behalf of an individual would apply to a population of patients. Where that is the case, the request may trigger the development of a new policy for that intervention and indication (called a general commissioning policy) or modification of an existing general commissioning policy. This, however, does not remove the obligation to consider the application received.
- 8.2.5 Arrangements for the development and revision of general commissioning policies by the CCG for health care interventions are available from the CCG.
- 8.2.6 The CCG will make its general commissioning policies available on request or at <http://www.NorthLincolnshireCCG.com>.

### **8.3 Health Care Interventions that the CCG will not Commission Routinely**

- 8.3.1 There are a number of health care interventions (under regular review) that the CCG will not commission as a matter of routine. The reason for the CCG taking that decision may be due to uncertainties over clinical effectiveness, cost effectiveness or patient safety. Some health care interventions are restricted in their availability by requiring specific criteria to be met.
- 8.3.2 In reviewing the procedures which will not be routinely available, the CCG will follow guidance that may be issued from time to time by the Department of Health and that complies with relevant UK law. The CCG will also seek to achieve a high degree of consistency with equivalent lists from other CCGs.
- 8.3.3 Commissioners, general practitioners, service providers and clinical staff considering treating patients from whom the CCG is responsible will be expected to consider the CCG's clinical commissioning policies in their decision making. Exceptions to the general clinical commissioning policies will only be considered for approval via an Individual Funding Request.

8.3.4 In addition to the group of health care interventions that the CCG will not commission as a matter of routine, the CCG **generally:**

- Will not commission the use of new surgical techniques until the Safety Efficacy Register of New Interventional Procedures (SERNIP) now run by the National Institute of Health and Clinical Excellence (NICE), has awarded category A or B status, unless the technique is part of a randomised controlled trial (RCT)
- Will only implement screening programmes approved by the National Screening Committee
- Will follow agreed national policy from NHS England on the continuation of treatment at the end of clinical trials
- Will follow national guidance in respect of co-payments.

## **9 IMPLEMENTATION**

The Individual Funding Request function of the CCG is supported by North of England Commissioning Support (NECS).

- Receiving IFR Requests and supporting the Panel in their considerations
- Supporting the clinician as appropriate
- Communicating Panel decisions to clinicians
- Providing regular reports to the CCG on IFR activity

Breaches of this policy may be investigated and may, if appropriate, result in the matter being treated as a disciplinary offence under the CCG's disciplinary.

## **10 TRAINING AND AWARENESS**

The IFR Policy, if agreed will be made available on the CCG's Intranet and Internet. Training is available by the NECS IFR Service to local Commissioners and clinicians as and when required. All IFR Panel members receive training prior to taking full Panel responsibilities.

## **11 MONITORING AND AUDIT**

There will be an annual report from the Individual Funding Request Team to the CCG. This report will cover compliance, effectiveness and outcomes of the Policy, together with a summary of all the Individual Funding Request Panel decisions for that financial year. In addition a monthly activity report is provided to the CCG.

## **12 POLICY REVIEW**

- 12.1 General commissioning policies and the Individual Funding Request Policy will be reviewed at least every two years (unless otherwise required by national guidance or other imperatives) and a summary of

updates will form part of the Individual Funding Request annual report to the CCG Board.

- 12.2 Minor amendments (such as changes in the title) may be made prior to the formal review, details of which will be monitored and adopted by the Director of Commissioning.

## 13 REFERENCES

- 13.1 *“Priority Setting: managing individual funding requests”*. The NHS Confederation, 2008. NHS Institute for Innovation and Improvement. Available at <http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Priority%20setting%20managing%20individual%20funding%20requests.pdf>
- 13.2 Regulation 35 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibility and Standing Rules) Regulations 2012 (SI 2012 No 2996). Available at <http://www.legislation.gov.uk/ukxi/2012/2996/made>
- 13.3 *The NHS Constitution for England*. DH. March 2013. Available at <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>
- 13.4 Support rational local decision making about medicines (and treatments), a handbook of good practice guidance. National Prescribing Centre, February 2009. Available at: [http://www.medlaw.eu/nhs\\_guidance/NHS\\_handbook\\_complete.pdf](http://www.medlaw.eu/nhs_guidance/NHS_handbook_complete.pdf)
- 13.5 Guidance on NHS patients who wish to pay for additional private care. DOH, March 2009. Available at: [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\\_096428](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_096428)
- 13.6 The Operating Framework for the NHS in England 2012/13. DoH, December 2011. Available at: <https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13>

## Appendix 1 - THE INDIVIDUAL FUNDING REQUEST PROCESS

Individual Funding Requests should originate either from the patient's GP or from a hospital consultant (to whom the patient has been referred) or, in certain circumstances (to be decided by the Panel), other registered health practitioners. Requests will not be accepted from a GP registrar unless endorsed by a salaried GP or partner of the practice.

Requests will only be accepted when submitted via the NECS Electronic IT System.

Referring clinicians are asked to note that providing relevant and clear supporting information with the referral, in sufficient details will assist in the decision making process and reduce the risk of delay. Only clinical photographs will be accepted.

Where the GP can reasonably be expected to know the intervention requires IFR, it is expected that they will apply for funding prior to referral. Where the treatment required can only be identified by a Consultant, the Consultant should apply for IFR funding. The Consultant cannot delegate their responsibility back to the GP.

To define the level of the supporting clinical evidence base, the standard hierarchy of evidence criteria is used. The higher up a methodology is ranked, the more robust and closer to objective truth it is assumed to be.

Rank	Methodology	Description
1	Systematic reviews and meta-analyses	Systematic review: Review of a body of data that uses explicit methods to locate primary studies and explicit criteria to assess their quality. Meta-analysis: A statistical analysis that combines or integrates the results of several independent clinical trials considered by the analyst to be "combinable" usually to the level of re-analysing the original data, also sometimes called pooling, quantitative syntheses. Both are sometimes called "overviews".
2	Randomised controlled trials (RCTs)	Individuals are randomly allocated to a control group and a group who receive a specific intervention. Otherwise the two groups are identical for any significant variables. They are followed up for specific end points.
3	Cohort studies	Groups of people are selected on the basis of their exposure to a particular agent and followed up for specific outcomes.
4	Case-control studies	"Cases" with the condition are matched with "controls" without, and a retrospective analysis used to look for differences between the two groups.
5	Cross sectional surveys	Survey or interview of a sample of the population of interest at one point in time.
6	Case reports	A report based on a single patient or subject, sometimes collected together into a short series.
7	Expert opinion	A consensus of experience from the good and the great.
8	Anecdotal	Something someone told you once.



An Individual Funding Request that comes from a GP will not usually be deemed to have started the 18-week Referral to Treatment (RTT), as it would be a request for a referral for treatment. Requests from secondary care consultants will need to provide an 18-week RTT 'clock start date' (the date of referral into secondary care).

In order to direct requests along the appropriate decision making pathway, the IFR team will clinical triage all requests before providing a recommended outcome for the IFR Panel to ratify. Clinical triage must be undertaken by two members of staff, one of whom must be a clinical health care professional. Where a consensus opinion cannot be reached by the two staff undertaking triage, the request should proceed to Panel for full discussion. An accurate record of all decisions taken at triage will be presented at the Panel meeting for discussion and ratification.

#### The role of Clinical Triage:

To return requests to the referring clinician where:

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

Provide a detailed summary for review and ratification by IFR Panel where it appears:

- There is no clinical case
- The request does not meet criteria outlined in an agreed commissioning policy and for which no case has been made for exceptionality
- That treatment can be commissioned because they meet pre-agreed exceptions (some of which are set through precedent)
- The request raises a major policy issue and needs further discussion and work

The CCG will convene a formal Individual Funding Request Panel which will meet monthly and will have the following membership:

- Chair of the Individual Funding Request Panel
- Vice-Chair of the Individual Funding Request Panel
- Clinical Representative(s)
- Lay Member
- Lead CCG representative
- Director of Public Health

The following attendees will be available, as and when required, in an advisory capacity but are not decision-making members of the Panel:

- Learning Disability & Mental Health Specialist or representative
- Medicines Management Lead or representative
- Secondary Care Consultant
- NECS IFR Team representative

Patients and their referring clinician will **not** be invited to attend the Panel at which their request is being considered.

Administrative support to the Panel will be provided by the NECS Individual Funding Request team.

The CCG will provide and document training for all individuals involved in decision making for Individual Funding Requests, covering legal and ethical issues as well as the CCG's own approach to priority setting.

The Panel may from time to time ask other CCG staff or other individuals with knowledge of the particular procedure or intervention being considered to attend to further inform the consideration by the Panel of the request. Where possible, however, the CCG will ensure separation between those who review the clinical evidence for a request and those who make commissioning decisions.

If there is any circumstance where any Panel member may have a conflict of interest in a case put before the Panel, they shall acknowledge this at the outset and will remove themselves from the proceedings for the time required.

To ensure effective, fair and transparent decision making the Panel must be quorate to agree decisions - two clinical members of the IFR Panel must be present to ensure the meeting is quorate.

All Individual Funding Requests received by the CCG will be given a case reference number and logged on a secure database maintained by the NECS IFR team. Correspondence and other records relating to Individual Funding Requests, whether paper or electronic, will remain confidential and records will be managed so that access is restricted to the NECS IFR team and members of the Panel.

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

Where it is clear from the application that the individual does not meet criteria, and/or there is no clear evidence supporting the treatment, or where the clinician has not made a case for exceptionality, the IFR may be declined. In the event, the referring clinician will be advised of the reason for refusal and any future submission will have to clearly address these issues.

In advance of each meeting of the Panel, a list of cases will be prepared for consideration at that meeting. Papers will be sent out by secure means 5 working days in advance to enable Panel members to review the cases prior to the meeting. Usually, requests will be taken to the next scheduled meeting of the Panel. Where further information is required, requests may be deferred for consideration until the requested information has been received. Where such additional information has



not been received within 4 weeks, the case will be considered closed. Should the requested information be received after this point then the referring clinician will need to make a new referral.

In considering requests, the Panel may decide to ask for further information from the relevant clinician and may also seek a review of the evidence of the clinical and cost effectiveness of a particular procedure or intervention.

In making a collective decision on the request, the Panel should take the following into account:

### Clinical Effectiveness and Safety

- Is the treatment effective i.e. of proven benefit for this category of patient?
- What is the nature, extent and significance of the health gain for the individual?
- How have similar cases been dealt with in the past?

### Cost Effectiveness

- The CCG does not undertake individual economic assessments itself but draws on expert reviews, clinical papers and assessments, in order to ascertain cost effectiveness estimates. In the decision making process, the cost effectiveness criteria upper threshold of £20,000 - £23,000 per QALY, which is consistent with NICE decisions is used.
- Are there alternative, comparable and more cost effective interventions and/or providers available?

### Appropriateness

- Are there agreed selection criteria? Does the patient fit the criteria? If not, what is the case for expanding the selection criteria?
- Are alternative treatments available?
- What would the impact of refusal be?
- Has appropriate clinical advice been sought?

### Equity

- Is this patient or patient subgroup being treated differently in relation to others?
- What is the priority in relation to opportunity costs and alternative spend on other needs of the whole population.

The Panel will not:

- Part-commission treatment
- Commission elective treatment requested retrospectively
- Commission equipment ordered prior to Panel approval
- Recommend alternative treatments for a particular condition or patient.

Minutes will be taken at every Panel meeting. The minutes of the meeting will include a record of the discussion and outcome of each case so as to maintain accurate documentation of the whole decision making process; the minutes will then be taken to the next available meeting of the Panel for ratification. A decision record and outcome will be maintained by the NECS Electronic IFR IT System for each request the Panel considers.

Decisions made by the Panel will be communicated on behalf of the IFR Panel by the NECS IFR team to the requesting clinician within 10 working days of the date of the Panel at which the request was considered.

### **Urgent Requests**

From time to time, the particular clinical circumstances of an Individual Funding Request may mean that delaying a decision to the next scheduled meeting of the Panel is likely to have a significant detrimental effect on the patient's health and well-being (threat of death or serious disability) or adversely affect eligibility for that treatment. In these circumstances, the request will be deemed as urgent and views of Panel members will be sought in advance of the next scheduled meeting by email, phone or in person to consider whether the requested procedure or intervention should be approved. The agreement of two members of the Panel (including a clinically qualified Panel member) will generally be required to make a decision outside of a formal meeting of the Panel. Should there be uncertainty as to the clinical rationale for the urgency of the request, the NECS IFR team can request supporting rationale from the referring clinician before confirming the status of the request as urgent.

It is understood that, at all times, the provider partner is able to fund a health care intervention pending a decision from the CCG and the CCG accepts no responsibility for the clinical consequences of any delay in responding to the request.

Where a request has been considered and a decision made in advance of a formal Panel meeting, the decision will be reported and recorded at the next meeting. Decisions made in advanced of a Panel meeting will be communicated to the referring clinician within 2 working days of the date of the decision.

In responding to an Individual Funding Request, the CCG accepts no clinical responsibility for the health care intervention or its use or for the consequences of not using the intervention. It is the responsibility of the treating clinician to determine the most appropriate treatment for a particular patient from amongst those which are available,

The CCG Patient Relations Manager will be made fully aware of the Individual Funding Request policy (not individual cases) so they can offer patients information and support throughout the processes. For patients whose first language is not English, Patient Relations staff has access to translation services. A Patient Information Leaflet is available on the North Lincolnshire CCG website to explain the Individual Funding Request and Appeal processes.

Case notes for each request to the Individual Funding Request Panel (irrelevant of outcome) will be filed securely by the Commissioning Support Unit Individual Funding Request team in accordance with *Records Management: NHS Code of Practice*, Department of Health (March 2006). Case files will be securely archived after 2 years and securely destroyed after 8 years (or 8 years after the patient's death).

## Appendix 2

### TERMS OF REFERENCE

#### **NORTH LINCOLNSHIRE CCG INDIVIDUAL FUNDING REQUEST PANEL**

#### **1 General**

- 1.1 The Individual Funding Request Panel is a Committee of the North Lincolnshire Clinical Commissioning Group Governing Body (thereafter known as CCG).

#### **2 Role and Purpose**

- 2.1 The Individual Funding Request Panel will be a confidential forum comprising of GP and Lay members of the CCG, and the Director of Public Health. The Individual Funding Request Panel will have a nominated Panel Chair and Vice Chair. The Panel will consider funding requests from NHS clinicians in respect of health care interventions for individuals where NHS North Lincolnshire's general policy is not to fund that intervention or where there is no specific policy/national guidance.
- 2.2 The Panel will be quorate if 2 clinical members are present.

#### **3 Remit**

- 3.1 The Individual Funding Request Panel works with key managers and clinicians within NHS North Lincolnshire to consider individual requests for procedures/treatment where NHS North Lincolnshire's general policy is not to fund that intervention. This will include those procedures/treatments/drugs classified as low priority, specific contract exclusions or treatments not covered by specific policy/national guidance.
- 3.2 The Individual Funding Request Panel will also consider requests for approval for treatment/procedures which have been classified as low priority or where the patient does not meet specified eligibility criteria for a specific financial year where the requesting clinician claims that there are clinically exceptional circumstances in line with the Individual Funding Request Policy.
- 3.3 The financial limit per case will be a maximum of £250,000. Requests for treatment over this limit will be referred to the Clinical Commissioning Governing Body.

The Individual Funding Request Panel will receive requests from the IFR team, including those which have been clinically triaged. A unique case number will be applied to each case by the IFR team. Decisions made will be noted by the IFR team member taking the minutes of the meeting. Minutes will be detailed and include the clinical evidence considered, any evidence disregarded and the reasons for the decision

### 3.4 **Decisions for clinically urgent cases**

Occasionally, there may be need to consider a case outside the usual panel arrangements where the referring clinician has indicated the need for *clinical* urgency (risk of death or serious disability). In the event of a request citing clinical urgency, panel members will be contacted directly by the IFR team, along with appropriate evidence to assist the decision making, and will be able to provide their individual decision by the same means. In this instance, quoracy will be 2 GP's. Where possible, these requests will be responded to within 2 working days.

Where a provider chooses to go 'at risk' in the event of an IFR decision not being made in time, the onus for cost of the intervention, the continuation of treatment and/or financial impact rests entirely with the provider.

In the event of Individual Funding Request Panel members being unable to agree, the nominated Panel Chair will make the final funding decision.

- 3.5 The Individual Funding Request Panel will not make policy decisions on behalf of the Clinical Commissioning Group Governing Body but will confine its decision making to individual treatment funding requests. If any individual case requires consideration of an extant policy, this will be referred to the Clinical Commissioning Group Governing Body.

Where a policy does not currently exist, but where it is likely that a service development requires consideration, the clinician(s) concerned will be directed to the appropriate person/committee within the CCG for the business case to receive appropriate consideration.

- 3.6 The Individual Funding Request Panel will take into account relevant clinical evidence, NICE guidance/recommendations, other regional/national policy and any other specific guidance relating to the requested treatment/procedure when considering the request.
- 3.7 Where necessary, clinical advice will be sought from appropriate specialists e.g. NHS England, national treatment Networks, to assist the decision making process.

- 3.8 All cases will be retained within a database and electronic filing system which conform to the highest standards of Information Governance, with copies of all email communication to and from the Panel including the final decisions stored electronically. All correspondence relating to specific cases should be sent via secure N3 connection using nhs.net.mail.

#### **4 Composition of the Individual Funding Request Panel**

- 4.1 Membership of the Individual Funding Request Panel will comprise of:

- Chair of the Individual Funding Request Panel
- Vice-Chair of the Individual Funding Request Panel
- Clinical Representative(s)
- Lay Member
- Lead CCG representative
- Director of Public Health

In the event that a GP member has a conflict of interest with an individual request they will not take part in the decision making to ensure that a robust process is maintained.

#### **5 Format of Cases**

- 5.1 Funding requests will be forwarded to the Individual Funding Request Panel in electronic format using the NECS IFR IT System. Each request will be recorded as an individual case with an assigned case number and will indicate very clearly whether a very urgent decision is required based on the clinical urgency of the case.

#### **6 Relationship and Reporting to the Clinical Commissioning Group Governing Body**

- 6.1 The Individual Funding Request Panel will be directly accountable to the Clinical Commissioning Governing Body.
- 6.2 Regular quarterly reports will be required by Clinical Commissioning Group Engine Room on the range of cases considered and the cost implications of decisions made.
- 6.3 The Panel will provide an anonymised Annual Report (compiled by the NECS IFR Team) to the CCG Board, summarising the decision for the previous year.

**Administrative support:** Provided by the NECS Individual Funding Request team.

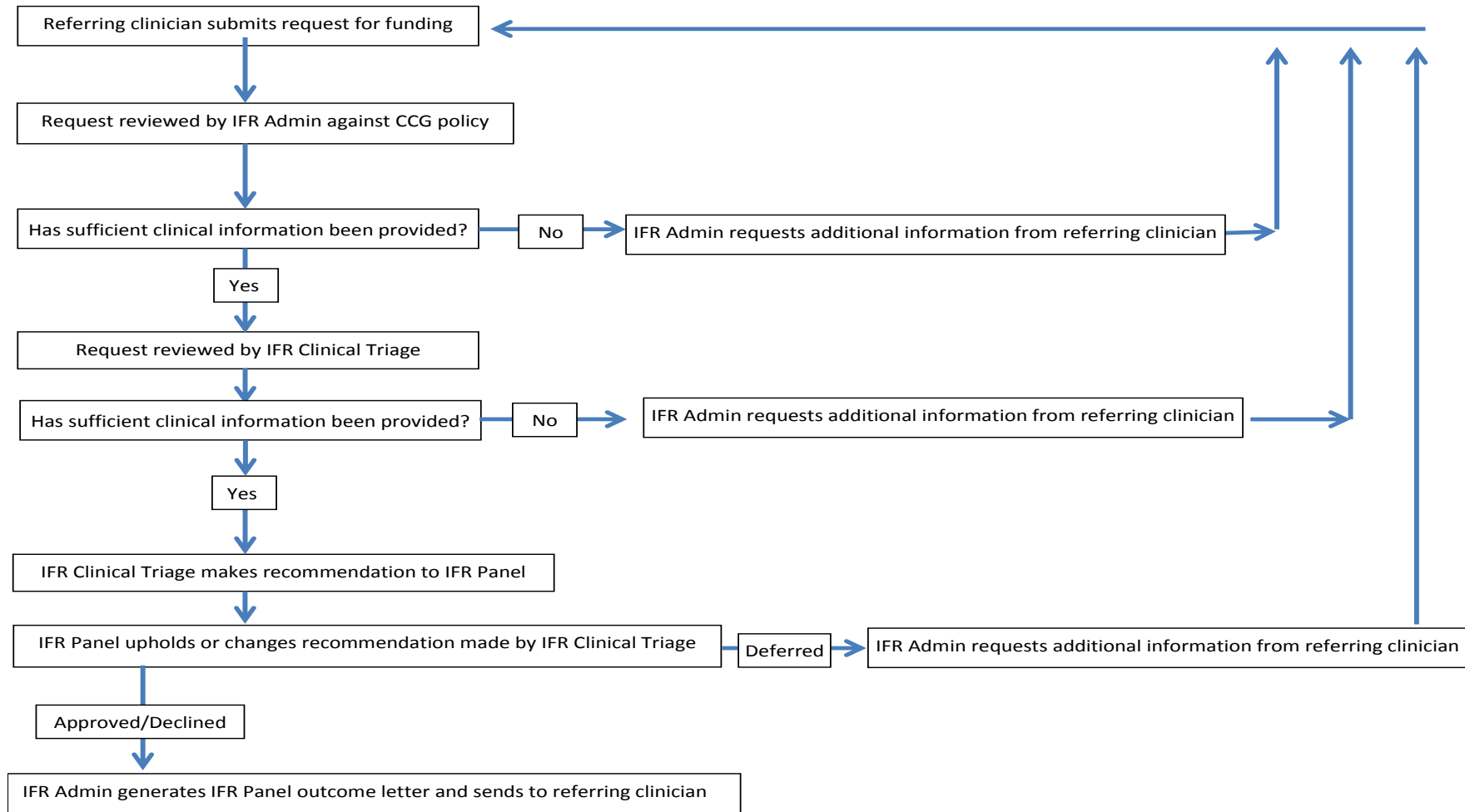
**Quorum:** To ensure effective, fair and transparent decision making a minimum of 2 clinical Panel members.

**Meeting Frequency:** The panel will meet monthly.

**Reporting:** Every Panel meeting will produce a 'decision record' so as to maintain accurate documentation of the whole decision making process. A decision record and outcome will be maintained by the NECS IFR team on the secure database for each request the Panel considers.

Decisions made by the Panel will be communicated by the Individual Funding Request team to the requesting clinician within 10 working days of the date of the Panel at which the request was considered. Case notes for each request to the Individual Funding Request panel (irrelevant of outcome) will be filed securely by the NECS Individual Funding Request team in accordance with the North Lincolnshire CCG Records Management Policy. Case files will be securely archived after 2 years and securely destroyed after 8 years (or 8 years after the patient's death).

**APPENDIX 3: IFR Panel Process Map**





## APPENDIX 4

### Terms of Reference

#### **North Lincolnshire CCG IFR Appeals Panel**

If the IFR Panel turns down a request to commission an individual request for treatment, the requesting clinician can appeal against the decision by submitting a request in writing to the CCG within three months of the date of the decision letter from the IFR Panel.

The CCG will establish a separate Appeals Panel to consider appeals against decision of the IFR Panel.

The Appeals Panel will be established on a 'quality control check' model. Under this model, the Appeals Panel would consider whether the IFR Panel:

- Followed the CCG's own procedures and policies.
- Considered all relevant factors and did not take into account immaterial factors.
- Made a decision that was not so unreasonable that it could be considered irrational or perverse in the light of the evidence.
- Had all relevant evidence before it for consideration.

#### **Terms of Reference**

- All requests to appeal against the decision of the IFR panel should be sent to the same contact details as for all other IFR requests
- Appeals will usually be considered within 30 days of the date of the CCG receiving notification of a request to appeal against the decision of the IFR Panel.
- The Appeals Panel will review the correspondence, evidence, and any other information considered by the IFR Panel in reaching its original decision.
- At the discretion of the Appeals Panel, they will either:
  - a) Reject the appeal and support the original decision of the IFR Panel
  - b) Identify a problem with the original process or consider that the evidence needs reconsideration by referral back, with full documentation to the next IFR Panel meeting.
- The patients or their clinician(s) should normally not be permitted to introduce additional evidence at the appeal stage, but if there is new evidence to support a case this does not mean that the original decision, made on evidence then available, was wrong. Instead the case should be referred back to the IFR Panel to decide whether the information is significant enough to merit reconsideration.

- The decision of the Appeals Panel will be communicated by the NECS IFR team on behalf of the Chair or other clinical representative to the requesting clinician within 10 working days of the date of the appeal decision.
- The Appeal Panel decision is the final decision of the CCG.

## **Membership**

The Appeals Panel will include the following members:

- IFR Panel Chair and Lay Member
- Director of Commissioning
- NL CCG GP

**Administrative Support:** Provided by the NECS IFR Team.

**Legal support:** Provided by the CCG's Legal and Governance Team

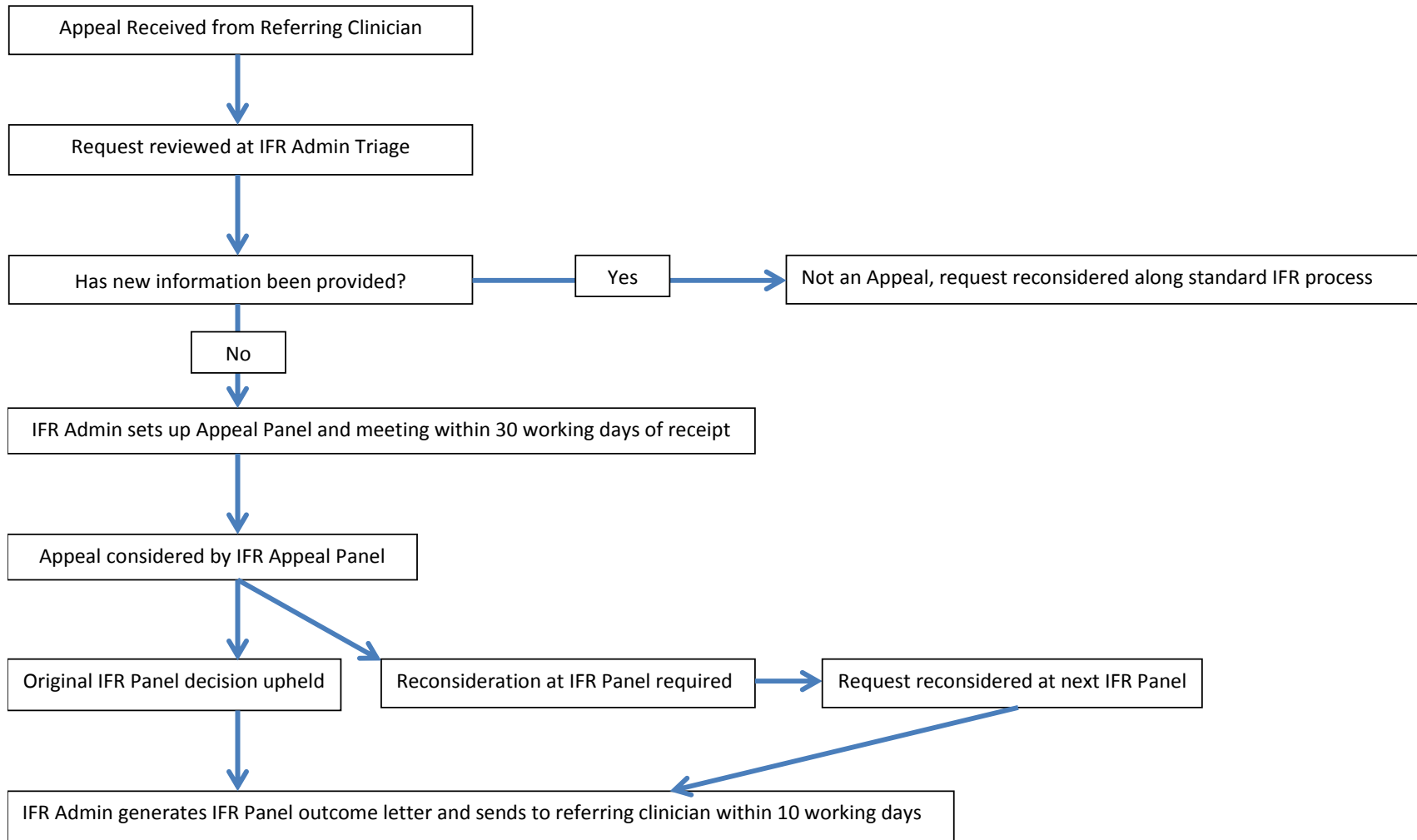
**Quorum:** The Appeals Panel will be considered quorate if all 3 members are present

**Meeting Frequency:** The Appeals Panel will meet as required (where there are cases to be considered).

**Reporting:** The business and decision of the Appeals Panel will be fully recorded and these will be reported to the Chair of the IFR Panel.

The appeals panel reports to the Clinical Commissioning Group Governing Body.

### APPENDIX 5: IFR Appeal Panel Process Map



APPENDIX 6

# Equality Impact Analysis: Individual Funding Request Policy

29<sup>th</sup> September 2017

For support with completion of this documentation, please see the accompanying guidance and/or contact the Equality Lead in the North Yorkshire and Humber Commissioning Support Unit

## 1. Equality Impact Analysis

<b>Policy / Project / Function:</b>	IFR Policy
<b>Date of Analysis:</b>	29/09/17
<b>This Equality Impact Analysis was completed by: (Name and Department)</b>	Catherine Lightfoot Service, Delivery and Assurance North of England Commissioning Support (NECS)
<b>What are the aims and intended effects of this policy, project or function?</b>	<p>The aim of the policy is to:</p> <ul style="list-style-type: none"> <li>• Identify the reasons for having an Individual Funding Request for a treatment which is restricted</li> <li>• Explain the difficult choices faced by the CCG and how the CCG has decided to prioritise resources to ensure the best health outcomes for the community</li> <li>• Set the decision making process within an ethical context</li> <li>• Inform health professionals about the IFR policy in operation and how to request restricted treatments or appeal against individual decisions to decline a request for a restricted treatment</li> <li>• Ensure decisions are made in a fair, open and consistent manner</li> <li>• Provide a background against which appeals can be judged</li> <li>• Demonstrate clear processes for decision making</li> <li>• Be able to defend legal challenges against the decision not to commission certain interventions or to limit the number of such interventions commissioned</li> </ul>
<b>Please list any other policies that are related to or referred to as part of this analysis</b>	NICE Guidance National EIA Census 2011

<p><b>Who does the policy, project or function affect?</b></p> <p>Please Tick ✓</p>	<p>Employees <input type="checkbox"/></p> <p>Service Users <input checked="" type="checkbox"/></p> <p>Members of the Public <input type="checkbox"/></p> <p>Other (List Below)</p>
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## 2. Equality Impact Analysis: Screening

	Could this policy have a positive impact on...		Could this policy have a negative impact on...		Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
<b>Race</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process race will be addressed in any screening on potential impact for each IFR if appropriate.
<b>Age</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process age will be addressed in any screening on potential impact for each IFR case if appropriate.
<b>Sexual Orientation</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process sexual orientation will be addressed in any screening on potential impact for each IFR case if appropriate.
<b>Disabled People</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process disabled people will be addressed in any screening on potential impact for each IFR case if appropriate.

<b>Gender</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process gender will be addressed in any screening on potential impact for each IFR case if appropriate.
<b>Transgender People</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process Transgender people will be addressed in any screening on potential impact for each IFR case if appropriate.
<b>Pregnancy and Maternity</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process pregnancy and maternity will be addressed in any screening on potential impact for each IFR if appropriate.
<b>Marital Status</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process marital status will be addressed in any screening on potential impact for each IFR if appropriate.
<b>Religion and Belief</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The overarching IFR policy includes the commissioning position for a number of procedures and treatments. Through the IFR process Religion and belief will be addressed in any screening on potential impact for each IFR if appropriate.

<b>Reasoning</b>	The ethos of the IFR process ensures that decisions are made based on clinical grounds and that people are not disadvantaged because of a protected characteristic, without an objectively justifiable reason.
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**If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7**



### 3. Equality Impact Analysis: Local Profile Data

<b>Local Profile/Demography of the Groups affected (population figures)</b>	
<b>General</b>	North Lincolnshire sits on the south side of the Humber estuary. There are 19 GP practices covering a population of approximately 167,400(2012)
<b>Age</b>	Population remains slightly older than the national and regional average. This trend looks to continue; by 2015 population is expected to rise by a further 8% and the older population by 26%. This compares with 5.5%and 17% respectively across the country as a whole.
<b>Race</b>	The Census 2011 indicates the race of the population in North Lincolnshire CCG as:  White 96.7% Mixed 2.7% Asian 0.3% Black 0.3 %
<b>Sex</b>	The gender split in the North Lincolnshire CCG area is 49.3 % male and 50.7 % female (2011 Census)
<b>Gender reassignment</b>	There are not any official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society - <a href="http://www.gires.org.uk">www.gires.org.uk</a> ) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000, i.e. 10,000 people, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men). However, there is good reason, based on more recent data from the individual gender identity clinics, to anticipate that the gender balance may eventually become more equal.
<b>Disability</b>	The 2011Census information showed that 19.3% were living with disabilities.
<b>Sexual Orientation</b>	In relation to sexual orientation, local population data is not known with any certainty. In part, this is because until recently national and local surveys of the population and people using services did not ask about an individual's sexual orientation. However, nationally, the

	Government estimates that 5% of the population are lesbian, gay or bisexual communities. In North Lincolnshire CCG area we can estimate the numbers to be in the region of 8,000 people
<b>Religion, faith and belief</b>	According to the 2011 Census, 66% of the population identified themselves as Christian and 0.3% of the population is made up of other religions.  The remainder of the population (31.1 %) did not state anything or stated 'no religion'.
<b>Marriage and civil partnership</b>	This protected characteristic generally only applies in the workplace. Data from the Office of National Statistics covering the period 2008-2010 indicates that there were 18,049 Civil Partnerships in England and Wales during this 3 year period – 52% men and 48% women.
<b>Pregnancy and maternity</b>	There are no figures available for pregnancy and maternity.

## 4. Equality Impact Analysis: Equality Data Available

<p><b>Is any Equality Data available relating to the use or implementation of this policy, project or function?</b></p> <p>Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine <i>Protected Characteristics</i> – referred to hereafter as '<i>Equality Groups</i>'.</p> <p>Examples of <i>Equality Data</i> include: (this list is not definitive)</p> <ol style="list-style-type: none"> <li>1. Application success rates <i>Equality Groups</i></li> <li>2. Complaints by <i>Equality Groups</i></li> <li>3. Service usage and withdrawal of services by <i>Equality Groups</i></li> <li>4. Grievances or decisions upheld and dismissed by <i>Equality Groups</i></li> <li>5. <i>Previous EIAs</i></li> </ol>	<p>Yes <input type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p> <p>Where you have answered yes, please incorporate this data when performing the <i>Equality Impact Assessment Test</i> (the next section of this document).</p> <p>Provision of relevant equality data has been agreed as part of the future commissioning arrangements for the complaints / PALS service through a voluntary questionnaire.</p>
<b>List any Consultation e.g.</b>	The policy has undergone consultation with the North

<b>with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function</b>	of England Commissioning Support (NECS).  The contents of this policy is based on similar policies which have been agreed and adopted by several North Yorkshire and Humber CCGs.
<b>Promoting Inclusivity How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation</b>	The ethos of the IFR process ensures that decisions are made based on clinical grounds and that people are not disadvantaged because of a protected characteristic, without an objectively justifiable reason.

## 5. Equality Impact Analysis: Assessment Test

**What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?**

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a <i>Genuine Determining Reason</i> exists
<b>Gender</b> (Men and Women)	✓			
<b>Race</b> (All Racial Groups)	✓			
<b>Disability</b> (Mental & Physical)	✓			
<b>Religion or Belief</b>	✓			
<b>Sexual Orientation</b> (Heterosexual, Homosexual and Bisexual)	✓			

## Equality Impact Analysis: Assessment Test (continued)

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a <i>Genuine Determining Reason</i> exists
Pregnancy and Maternity	✓			
Transgender	✓			
Marital Status	✓			
Age	✓			

## 6. Action Planning

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Identified Risk:	Recommended Actions:	Responsible Lead:	Completion Date:	Review Date:
There are no identified risks				

## 7. Equality Impact Analysis Findings

Analysis Rating:	<input type="checkbox"/> Red	<input type="checkbox"/> Red/Amber	<input type="checkbox"/> Amber	<input type="checkbox"/> Green
		Actions	Wording for Policy/Project / Function	
<b>Red</b> <b>Stop and remove</b>	<b>Red:</b> As a result of performing the analysis, it is evident that a risk of discrimination exists	<b>Remove the policy</b> Complete the action plan above to identify the areas of discrimination and the	No wording needed as policy is being removed	

<b>the policy</b>	(direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share <i>Protected Characteristics</i> . It is recommended that the use of the policy be suspended until further work or analysis is performed.	work or actions which needs to be carried out to minimise the risk of discrimination.	
<b>Red Amber</b>  <b>Continue the policy</b>	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share <i>Protected Characteristics</i> . However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.	<b>The policy can be published with the EIA</b>  List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE).  Consider if there are any potential actions which would reduce the risk of discrimination.  Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share <i>Protected Characteristics</i> . However, a genuine determining reason exists which justifies the use of this policy and further professional advice.
<b>Amber</b>  <b>Adjust the Policy</b>	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the <i>Action Planning</i> section of this document.	<b>The policy can be published with the EIA</b>  The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination.  Any changes identified and made to the service/policy/ strategy etc. should be included in the policy.  Another EIA must be	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the <i>Action Planning</i> section of this document.

		completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	
<b>Green</b>  <b>No major change</b>	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.	<b>The policy can be published with the EIA</b>  Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.
<b>Brief Summary/ Further comments</b>			
<b>Approved By</b>			
Job Title:	Name:	Date:	

## APPENDIX 7

### Sustainability Impact Assessment

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

<b>Title of the document</b>	<b>Individual Funding Request Policy and Procedure</b>
<b>What is the main purpose of the document</b>	<b>To demonstrate a clear process for decision making</b>
<b>Date completed</b>	<b>29<sup>th</sup> September 2017</b>
<b>Completed by</b>	<b>Catherine Lightfoot, NECS</b>

<b>Domain</b>	<b>Objectives</b>	<b>Impact of activity</b> Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	<b>Brief description of impact</b>	<b>If negative, how can it be mitigated? If positive, how can it be enhanced?</b>
<b>Travel</b>	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home? Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities for all groups?	0	Patients will be required to travel to providers of healthcare to receive their treatment.	
<b>Procurement</b>	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it promote ethical purchasing of goods or	1	Where possible treatments will be collaboratively commissioned seeking to maximise clinical and cost effective services.	

	<p>services?</p> <p>Will it promote greater efficiency of resource use?</p> <p>Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?</p> <p>Will it support local or regional supply chains?</p> <p>Will it promote access to local services (care closer to home)?</p> <p>Will it make current activities more efficient or alter service delivery models</p>			
<b>Facilities Management</b>	<p>Will it reduce the amount of waste produced or increase the amount of waste recycled?</p> <p>Will it reduce water consumption?</p>	n/a		
<b>Workforce</b>	<p>Will it provide employment opportunities for local people?</p> <p>Will it promote or support equal employment opportunities?</p> <p>Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?</p> <p>Will it offer employment opportunities to disadvantaged groups?</p>	n/a		
<b>Community Engagement</b>	<p>Will it promote health and sustainable development?</p> <p>Have you sought the views of our communities in relation to the impact on sustainable development for this activity?</p>	n/a		
<b>Buildings</b>	<p>Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?</p> <p>Will it increase safety and security in new buildings and developments?</p> <p>Will it reduce greenhouse gas emissions from</p>	n/a		



	<p>transport (choice of mode of transport, reducing need to travel)?</p> <p>Will it provide sympathetic and appropriate landscaping around new development?</p> <p>Will it improve access to the built environment?</p>			
<b>Adaptation to Climate Change</b>	<p>Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?</p>	n/a		
<b>Models of Care</b>	<p>Will it minimising 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?</p> <p>Will it promote prevention and self-management?</p> <p>Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?</p> <p>Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?</p>	1	<p>Commissioning policies are evidence based and where appropriate supported by clinical network structures and processes. They will also support the introduction of new technologies as appropriate.</p>	