Individual Funding Requests Policy for East and North Herts Clinical Commissioning Group

1. Introduction and Background

In preparation for hand-over of the Individual Funding Requests (IFR) function from the Hertfordshire Primary Care Trust to the Hertfordshire Clinical Commissioning Groups (Herts Valleys CCG and East and North Herts CCG) from 1 April 2013, it is proposed that the current system (at NHS Hertfordshire/Hertfordshire Commissioning Support Unit) should be maintained under the same policies and processes. This will support the transition in the short term during which time the policy and management of the IFR function can be reviewed if necessary. This policy defines the responsibility of East and North Hertfordshire Clinical commissioning Group (ENHCCG) and the activities of the IFR team after transition to a single team serving two CCGs. It draws on the NHS Hertfordshire policy which was initially endorsed in June 2010.

The NHS Constitution (March 2012) 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.”

This Policy, covering all IFR requests that ENHCCG has responsibility for and excludes treatments that are the responsibility of the NHS Commissioning Board

- 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

Requests for such non-commissioned care usually come under Individual Funding Requests and this policy is designed to provide assurance that the CCG processes are compatible with the requirements in the NHS Constitution.

The East of England Priorities Advisory Committee has developed regional policies and recommended that they are adopted by the local Commissioning Authorities to inform their processes for handling Individual Funding Requests.

This policy applies to any patient for whom the ENHCCG is the Responsible Commissioner. As such, 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.

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.

The policy should be read alongside:

- Existing Bedfordshire and Hertfordshire Priorities Forum and Hertfordshire Medicines Management Committee policies relevant to this process.
- East of England Priorities Advisory Committee policies endorsed by the Commissioning Authority.
- The Individual Funding Requests form – see Appendix 1.
Clinicians are entitled to make a request to the Commissioning Authority for treatment to be funded outside of its established policies on the grounds of individuality or exceptionality.

2. Definitions

**An individual funding request (IFR)** is a request received from a provider, or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment that is not covered by existing Commissioning Authority policy.

In these cases, the patient is suffering from a presenting medical condition and the Commissioning Authority has no policy for the treatment requested (‘an individual request’).

Arguments on the basis of exceptionality are requests where a patient is deemed to have **exceptional clinical circumstances**, ie a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at a similar stage of progression as the patient.

In these cases, the patient is suffering from a presenting medical condition for which the Commissioning Authority has a policy for the medical condition and/or its treatment, but where the patient’s particular clinical circumstances fall outside what the Commissioning Authority has agreed to fund (‘an exceptionality request; an exception to the policy’).

**Individual Funding Request Panel (the Panel)** is the committee of the Commissioning Authority (the CCG) that has been authorised to take decisions on its behalf on **individual funding requests**.

3. Individual Funding Request Panel

The purpose of the Individual Funding Request Panel (the Panel) is to consider funding requests on behalf of the CCGs. The Panel will decide in each case whether funding should be approved.

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 and not solely on clinical constraints.
- Improve the rigour of the processes ensuring decisions are rational, reasonable and transparent.

**Structure and Membership of the Panel**

The Panel office will be staffed by:

- Assistant Director (IFR) part time
- Administrative support officers (2 posts) part time

Supported by:

- Senior Pharmaceutical Advisor (on a sessional basis)
- Consultant in Public Health (on a sessional basis)

The office staff will be responsible for the administration of the funding requests that come to the Panel, initial triaging and screening of requests and preparing the cases for Panel meetings.
Chair of the Panel
The Panel will be chaired by a Lay Member of the CCG Governing Body. The Deputy Chair will be a GP, who will be one of the CCG leads. The Chair and Deputy Chair would be appointed by the CCG.

Membership
- Chair of the Panel – Lay Member.
- Deputy Chair – GP.
- One more GP and an acute clinician
- Public Health Consultants – to provide PH advice, which would include advice on policies, literature review and evidence base, for high cost drugs as well as non-drugs.
- Commissioning Authority Contracts/Commissioning manager, who is aware of the full range of contracts and Commissioning Authority responsibilities.
- Senior Pharmaceutical Advisor.
- Assistant Director IFR

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

Quorum
As a minimum, the Panel will consist of:
- Chair or Deputy Chair.
- At least one GP (who could be the Deputy Chair).
- At least one Public Health Consultant.
- Commissioning Authority Contracts/Commissioning Manager
- Pharmacist.

4 Applications to the Panel
All applications to the Panel must be on the approved request form. The form should be referred to for further detailed instructions on completing it. Written support and evidence should be provided by the clinical team treating the patient using the request form and explaining:
- Why the request is an individual funding request
- The clinical circumstance of the patient.

The Clinical Team are required to present a full report to the Panel which sets out a comprehensive and balanced clinical picture of the history and present state of the patient’s medical condition, the nature of the treatment requested and the anticipated benefits of the treatment.

The planned treatment and the expected benefits and risks of treatment.
The Clinical Team shall describe the anticipated clinical outcomes for the individual patient of the proposed treatment and the degree of confidence of the Clinical Team that the outcomes will be delivered for this particular patient.

The evidence on which the clinical opinion is based.
The Clinical Team shall refer to, and include, copies of any clinical research material which supports, questions or undermines the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
The Costs of Treatment.
The patient and the Clinical Team shall set out the full attributable costs of and connected to the treatment. The Panel shall be entitled, but not obliged, to commission its own reports from any duly qualified or experienced clinician or other duly qualified person concerning the full attributable costs of and connected to the treatment. The Panel will consider:

Are there likely to be Similar Patients within the local population?  
For exceptionality requests the clinician must also provide the case for treating this patient and not other apparently similar patients.

Any other clinical information to support the case.  
Information that is immaterial to the decision, including information about the social or personal circumstances of the patient which does not have a direct connection to the patient’s clinical circumstances, shall not be considered by the Panel.

The CCG and/or the 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 or Midlands and East of England?’ If there is evidence that this patient is representative of other similar patients, the request will be considered as per policy but the provider will be requested to follow normal procedures for introducing new services, in line with the Commissioning Authority Commissioning Principles.

5 Co-operation of Providers

ENHCCG requires provider trusts and clinicians to take the commissioning policies of the CCG into account in the advice and guidance given to patients prior to making the decision to treat a patient, as set out in the NHS Contract.

The CCG expects the provider trusts to have oversight of this process. The CCG would expect every exceptional and individual funding request to be sanctioned by provider trust management/authorised clinician before sending it to the CCG and reserves the right to refer recurrent inappropriate funding requests to the Chief Executive of the relevant provider trust.

6. Process for Considering Funding Requests by the Panel

On receipt of the funding request, the case is recorded on the database and an acknowledgement is sent to the referring clinician.

The Panel office staff will verify whether sufficient information is included in the request form, and ask the referring clinician for more information if required.

7. Daily triage

The majority of cases will be screened by the AD IFR, three days a week.

The AD IFR within HICS working on behalf of the CCG will follow the CCG IFR policy

If an individual meets the criteria within the IFR policy or other existing CCG approved SLA or commissioning policy, a decision to agree funding can be made at this point by the AD.

The skills and expertise required of the screening function are the ability to:

- Determine whether an existing policy or SLA adequately covers the treatment request
- Interpret the CCG definitions of exceptionality and individuality in the context of the clinical information that is presented

The AD will be able to consider three options:
- Defer the request, and ask for more information from the referring clinician
- Approve the request if covered by an existing SLA/commissioning policy
- Take the request to the pre screen panel
- Refuse the request without reference to the pre screen or IFR Panel

8. Prescreen Panels

Funding requests will be considered fortnightly or weekly if required depending on volume received by the AD IFR, Consultant in Public Health and the Senior Pharmaceutical advisor. 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.
- Refuse the funding request.
- Defer the request, and ask for more information from the referring clinician.
- Refer the case to the monthly Panel meeting – for complex cases, where decisions cannot be taken by the fortnightly panel, or the initial appeals/complaints have been heard and no decision could be made.

9 Monthly Panel Meeting

The monthly 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. In some cases, the complaints and appeals have been heard by the fortnightly pre screen Panel and no decision could be made. These cases will usually be more complex ones.

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

The Panel decisions will be sent to the referring clinician and/or 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 IFR Panel will be a joint panel with Herts Valley CCG, it 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 of the Panel. Decisions will be usually made on the basis of consensus. Should the respective CCG members not agree the response to a request the case will be escalated to the relevant CCG Board.

10 Approval of Funding Requests

The Panel shall be entitled to approve individual funding requests where all the following conditions are met:

- The Panel is not authorised to make case by case decision making for service developments. There is sufficient evidence to show that, for the individual patient, the proposed treatment is likely to be clinically effective and cost-effective.

- The Panel is not required to accept the views expressed by the patient or the clinical team 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 exception where the following condition is met:

The Panel concludes that the criteria for exceptionality in the context of the relevant commissioning policy/policies and guidance note/s have been met.

In determining whether a patient is able to demonstrate exceptional circumstances the Panel shall compare the patient to other patients with the same presenting medical condition at a similar stage of progression. The Panel shall determine, based upon the evidence provided to the panel, whether the patient has demonstrated exceptional clinical circumstances. The evidence to show that, for the individual patient, the proposed treatment is likely to be clinically effective may be part of the case that the patient's clinical circumstances are asserted to be exceptional.

ENHCCG does not discriminate on grounds of sex, age, sexual orientation, ethnicity, educational level, employment, disability, marital status or religion. ENHCCG 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.

The Panel shall take care to avoid adopting the approach described in the 'the rule of rescue'. The fact that a patient has exhausted all NHS treatment options available for a particular condition is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances. Equally, the fact that the patient is refractory to existing treatments where a recognised proportion of patients with the same presenting medical condition at this stage are, to a greater or lesser extent, refractory to existing treatments is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances.

The Panel will consider whether treating the patient is higher priority than other unfunded developments and the treatment can be afforded.

The Panel shall have a broad discretion to determine whether the proposed treatment is a justifiable expenditure of the ENHCCG resources. The panel is, however, required to bear in mind that the resources requested to support the individual patient will reduce the availability of resources for other investments.

The Panel may make such approval contingent on the fulfilment of such conditions as it considers fit. 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. Examples in the past have included surrogacy and aspects of genetic testing. Where this occurs the Panel may adjourn a decision on an individual case until that work has been completed.

11 Urgent Treatment Decisions
ENHCCG 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 the Commissioning Authority policies. In such circumstances the CCG recognises that an urgent decision may have to be made before the Panel can be convened. The following provisions apply to such a situation.
An urgent request is one which requires urgent consideration and a decision because the patient faces a substantial risk of significant harm if a decision is not made before the next scheduled meeting of the Panel. The AD IFR 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.

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

Where an urgent decision needs to be made to authorise treatment for an individual patient, who is the responsibility of East and North Herts CCG the AD IFR will request the office staff to initiate 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.

The urgent decision will be made by virtual discussion via email or phone between the Panel members. In exceptionally urgent circumstances the East and North Herts CCG panel members will decide on the case if urgent input from other panel members is not possible. The virtual discussion will, as far as possible within the constraints of the urgent situation, follow the policy set out above in making the decision. The Panel office shall collect as much information about both the patient’s illness and the treatment as is feasible in the time available.

East and North Herts 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.

East and North Herts CCG panel members shall be entitled to reach the view that the request is properly analysed, a request for a service development and so should be refused and/or appropriately referred for policy consideration.

The Panel decisions will be sent to the referring clinician, and/or GP, and/or the patient 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.

12 Appeals

The patient 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.

**The first step in the appeals process:** If a clinician indicates that he or she wishes to appeal, it is for them to set out the reasons for their appeal in writing. The Panel office 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 reconsider the decision by taking it to the next Pre screen Panel meeting. If there is no additional information, the Panel will not consider the case and write back to the referring clinician and/or the patient refusing the funding. The appeal should be sent to the monthly Panel meeting in one of the two circumstances – if the pre-screen Panel is unable to decide because of the complexity of the case; or it has upheld the original decision not to fund and there is a re-appeal. The
The monthly Panel may uphold the decision not to fund or may decide to approve funding based on the new information received with the appeal. If there is an appeal against the monthly Panel decision, the case should be sent to the second step of the appeals process.

*The second step within the appeals process is for the case to be reviewed by another Clinical Commissioning Group IFR Panel outside of Hertfordshire who are familiar with the Bedfordshire and Hertfordshire Priorities Forum and Hertfordshire Medicines Management Committee policies relevant to this process. The patient has the right to have the matter considered afresh by the external Panel A. All members of the Panel should have had no prior involvement with the case.*

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 AD for IFR attends and make 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 AD IFR to get more clarity about the case.

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

The External Panel will be able to uphold the patient’s 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 this decision on the evidence before the Panel;

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.

Any challenges to the Clinical Priorities Policies or statements will be referred by the External panel to the Chair of the Clinical Priorities Forum to review the policy and request a report once the policy is reviewed.

All patients also have the option of putting in a formal complaint to ENHCCG 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.

**13 Guidance Notes**

**Seeking Treatment Abroad**
The Panel will consider requests to fund treatment outside the UK in line with the current Department of Health guidance ‘Overseas Treatment for NHS Patients’. Further information on the application process will be available on writing to the Panel office.
East of England Priorities Advisory Committee Policies
Where relevant, the Panel will apply the relevant East of England Commissioning Authority’s Priorities Advisory Group Commissioning Policy, adopted by NHS Hertfordshire. Some important points from these policies are given below, and for further information on the detailed policy wording, these policies can be accessed through the IFR office.

Guidance Note (GN/2): The role of commissioners in the evaluation of individual treatments and the funding of clinical research.
It is standard practice for Commissioning Authorities not to fund treatments which are still considered experimental, irrespective of the ‘potential’ health benefit for either individuals or groups of patients.

Commissioning Policy (PAC/2): Orphan Drugs
An orphan drug is one that could treat a disease with a prevalence of less than five per 10,000 of the population. The Commissioning Authority will, in the absence of Direction made by the Secretary of State, commission both existing and new orphan drugs using the same decision making principles and processes as are applied to the commissioning of other treatments.

Commissioning Policy (PAC/3): On going access to treatment following the ending of industry sponsored clinical trials or funding.
The Commissioning Authority will not pick up funding of treatments, at the end of clinical trials or when company sponsored funding is withdrawn, without prior agreement of an NHS commissioning organisation (past or present). Providers trusts will need to provide evidence of any such agreement.
The responsibility for providing on going access to a treatment is the responsibility of those individuals or parties that have initiated and sponsored treatment.
It is the clinician’s responsibility to ensure that patients are fully informed of and agree to their management plan at the end of the trial. This includes making patients aware of this commissioning policy and, where relevant, any unsuccessful request for post-trial funding.
The patient’s consent should be documented.

Should the Commissioning Authority agree to pick up funding, in this context, it does not represent a policy decision in relation to that treatment and, as such, sets no precedent for the funding of other patients. The treatment in question will be assessed and prioritised as a service development in the normal way.

Commissioning Policy (PAC/5): Guidance produced by the National Institute for Health and Clinical Excellence.
The Commissioning Authority will implement NICE technology appraisals in line with the Secretary of State’s Directions. The Commissioning Authority accepts that it has a legal duty to make treatments available to patients whose clinical conditions come within the definitions in the appraisals, unless the treatments have been exempted by the Secretary of State within 3 months of the date of publication of the appraisal. These treatments will receive the highest priority during prioritisation.
All other NICE Guidance is advisory and will be carefully considered when developing strategies, planning services and prioritising resources. The Commissioning Authority reserves the right to depart from NICE Guidance, other than Guidance which relates to treatments for patients that are within the specific remit of the Secretary of State’s Directions, if the Commissioning Authority has good reasons to do so.

Commissioning Policy (PAC/7): Choice
The Commissioning Authority will offer choice only within services normally commissioned by the Commissioning Authority.
The Commissioning Authority will normally support a patient seeking a second opinion for the same condition, but will not fund a third or subsequent opinions unless extenuating circumstances apply.
Commissioning Policy (PAC/8): In-Year Service Developments and the Commissioning Authority’s approach to treatments not yet assessed and prioritised. Until a service development has been assessed and a policy decision has been taken as the result of prioritisation, whether in-year or during the annual commissioning round, the Commissioning Authority default policy will usually be not to fund a treatment unless otherwise stated.

A patient’s entitlement to access NHS healthcare should not be affected by a decision by a patient to fund part or all of their healthcare needs privately. An individual who is receiving treatment that would have been commissioned by the Commissioning Authority, but who has commenced that treatment on a private basis, can at any stage request to transfer to complete the treatment within the NHS. In this event, the patient will, as far as possible, be provided with the same treatment as the patient would have received if the patient had had NHS treatment throughout. However, at the point that the patient seeks to transfer back to NHS care, the patient should: be reassessed by the NHS clinician; not be given any preferential treatment by virtue of having accessed part of their care privately; and be subject to standard NHS waiting times. The Commissioning Authority will not reimburse the patient for any treatment received as a private patient before a request is made to move back into the NHS. If a patient commences a course of treatment that the Commissioning Authority would not normally fund, the Commissioning Authority will not pick up the costs of the patient either completing the course of treatment or to receive ongoing treatment.

Commissioning Policy (PAC/14): Experimental, Uncertain and Unproven Treatments
Treatments which are judged experimental, uncertain or not to be of proven effectiveness will not routinely be funded.

Anne Southworth
AD Public Health (IFR)
21 February 2013
NHS Core Principles
1. The NHS will provide a universal service for all based on clinical need, not ability to pay
Healthcare is a basic human right. Unlike private systems the NHS will not exclude people because of their health status or ability to pay. Access to the NHS will continue to depend upon clinical need, not ability to pay.

2. The NHS will provide a comprehensive range of services
The NHS will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital based care. The NHS will also provide information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after care. The NHS will continue to provide clinically appropriate cost-effective services.

3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers
The NHS of the 21st century must be responsive to the needs of different patients and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients' needs.

4. The NHS will respond to different needs of different populations
Health services will continue to be funded nationally, and available to all citizens of the UK. Within this framework, the NHS must also be responsive to the different needs of different populations in the devolved nations and throughout the regions and localities. Efforts will continually be made to reduce unjustified variations and raise standards to achieve a truly National Health Service.

5. The NHS will work continuously to improve quality services and to minimise errors
The NHS will ensure that services are driven by a cycle of continuous quality improvement. Quality will not just be restricted to the clinical aspects of care, but include quality of life and the entire patient experience. Healthcare organisations and professions will establish ways to identify procedures that should be modified or abandoned and new practices that will lead to improved patient care. All those providing care will work to make it ever safer, and support a culture where we can learn from and effectively reduce mistakes. The NHS will continuously improve its efficiency, productivity and performance.

6. The NHS will support and value its staff
The strength of the NHS lies in its staff, whose skills, expertise and dedication underpin all that it does. They have the right to be treated with respect and dignity. The NHS will continue to support, recognise, reward and invest in individuals and organisations, providing opportunities for individual staff to progress in their careers and encouraging education, training and personal development. Professionals and organisations will have opportunities and responsibilities to exercise their judgement within the context of nationally agreed policies and standards.

7. Public funds for healthcare will be devoted solely to NHS patients
The NHS is funded out of public expenditure, primarily by taxation. This is a fair and efficient means for raising funds for healthcare services. Individuals will remain free to spend their own money as they see fit, but public funds will be devoted solely to NHS patients, and not be used to subsidise individuals' privately funded healthcare.

8. The NHS will work together with others to ensure a seamless service for patients
The health and social care system must be shaped around the needs of the patient, not the other way round. The NHS will develop partnerships and cooperation at all levels of care - between patients, their carers and families and NHS staff; between the health and social
9. **The NHS will help keep people healthy and work to reduce health inequalities**

The NHS will focus efforts on preventing, as well as treating ill-health. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition, the NHS will work with other public services to intervene not just after but before ill health occurs. It will work with others to reduce health inequalities.

10. **The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance**

Patient confidentiality will be respected throughout the process of care. The NHS will be open with information about health and healthcare services. It will continue to use information to improve the quality of services for all and to generate new knowledge about future medical benefits. Developments in science such as the new genetics offer important possibilities for disease prevention and treatment in the future. As a national service, the NHS is well placed to take advantage of the opportunities offered by scientific developments, and will ensure that new technologies are harnessed and developed in the interests of society as a whole and available to all on the basis of need.
### 1. Policy

<table>
<thead>
<tr>
<th>Title: IFR Policy</th>
<th>EIA Completion Details</th>
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<tr>
<td>x Proposed</td>
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<tr>
<td>Existing</td>
<td>Names &amp; Titles of staff involved in completing the</td>
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<tr>
<td>Review Date:</td>
<td>EIA: Sheilagh Reavey</td>
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#### 2. Details of the Policy. Who is likely to be affected by this policy?

- [ ] Staff
- [ ] Patients
- [x] Public

#### 3. Impact on Groups with Protected Characteristics

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<thead>
<tr>
<th>Probable impact on group?</th>
<th>High, Medium or Low</th>
<th>Please explain your answers</th>
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<tbody>
<tr>
<td>Age</td>
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<td>Being married or in a civil partnership</td>
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<td>Disability, inc. learning difficulties, physical disability, sensory impairment etc.</td>
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<td>Having just had a baby or being pregnant</td>
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<td>Race, ethnicity, nationality, language etc</td>
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<td>Religion or belief</td>
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<td>Sex (inc. being a transsexual person)</td>
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<td>Sexual Orientation</td>
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<tr>
<td>Other:</td>
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<tr>
<td>No impact on any of the groups above.</td>
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<td>The NHS of the 21st century must be responsive to the needs of different patients and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients' needs. ENHCCG does not discriminate on grounds of sex, age, sexual orientation, ethnicity, educational level, employment, disability, marital status or religion.</td>
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#### 4. Which equality legislative Act applies to the policy?

- [x] Equality Act 2010
- [ ] Mental Health Act 1983
- [ ] Mental Capacity Act 2005
- [ ] Health & Safety Regulations
- [ ] Mental Health Act 1983
- [x] Mental Capacity Act 2005

#### 5. How could the identified adverse effects be minimised or eradicated?

#### 6. How is the effect of the policy on different Impact Groups going to be monitored?

— Privacy Impact Assessment Stage 1 Screening
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<thead>
<tr>
<th>2. Details of the Policy. Who is likely to be affected by this policy?</th>
<th>Yes</th>
<th>No</th>
<th>Please explain your answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Staff</td>
<td>□ Patients</td>
<td>□ Public</td>
<td></td>
</tr>
</tbody>
</table>

**Technology**
Does the policy apply new or additional information technologies that have the potential for privacy intrusion?
*(Example: use of smartcards)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☒</td>
<td></td>
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</tbody>
</table>

**Identity**
By adhering to the policy content does it involve the use or re-use of existing identifiers, intrusive identification or authentication?
*(Example: digital signatures, presentation of identity documents, biometrics etc.)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</tbody>
</table>

By adhering to the policy content is there a risk of denying anonymity and de-identification or converting previously anonymous or de-identified data into identifiable formats?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</tbody>
</table>

**Multiple Organisations**
Does the policy affect multiple organisations?
*(Example: joint working initiatives with other government departments or private sector organisations)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☒</td>
<td></td>
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</tbody>
</table>

**Data**
By adhering to the policy is there likelihood that the data handling processes are changed?
*(Example: this would include a more intensive processing of data than that which was originally expected)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

If Yes to any of the above have the risks been assessed, can they be evidenced, has the policy content and its implications been understood and approved by the department?