

## 3.5 IFR policy health check

As highlighted throughout the *Handbook* the **majority** of decisions about the funding of medicines and treatments should be taken on a population basis by PCTs in cooperation with Provider Trusts and other stakeholders. Only a small minority of decisions should be considered on an individual patient basis. It is, however, important that PCTs have a process in place to manage these requests.

The checklist in this section considers each step in the generic IFR process illustrated in **Figure six**. PCTs can use it to review their own policies and identify areas for development/consideration. The majority of questions posed in this checklist should have been considered in the development of any comprehensive IFR policy.

### 1 IFR submitted (see also Section 2.4.1)

- Do you have a policy and process for IFRs? Does this include a submission form outlining all the information normally required to make a decision? Is this available on the PCT website and on request?
- Are the processes and the timelines for communication with the patient and clinician clearly defined?
- Do you have information and guidance for clinicians and patients explaining when IFRs are appropriate?
- Do you have appropriate forms of patient information explaining the individual funding process; for example, leaflets in multiple languages or Braille?
- Who can submit a request for individual funding; is this clearly defined? Can the patient submit a request or is a clinical sponsor required?
- Who can clinicians or patients contact for advice in deciding whether an IFR is appropriate, or for help completing a submission form?
- Who receives IFRs for the PCT? Is there a standard letter acknowledging receipt and a description of the process? Are timescales for acknowledging clear?
- Who routinely receives correspondence? Do the requesting clinician and the patient both receive copies of correspondence?
- How has the patient's GP been involved in the process?

### 2 Triage (see also Section 2.4.2)

- Who screens requests initially? What competencies do they need? How are they trained and supported?
- How are existing policies, SLAs and contracts, and records of previous IFRs (possibly on a supra PCT level) accessed?
- What criteria are used for triage?
- How soon are requests triaged after receipt of a request?
- Do you have a mechanism for identifying urgent requests? What are the criteria that differentiate urgent from non-urgent? Is there a separate procedure for fast tracking these requests? Does this include minimum procedural requirements?
- What happens if the IFR request is incomplete/more information is needed? How is this communicated to the clinician/patient? What happens if requested information is not received?
- Do you have a process for managing requests which are not appropriate? How is this communicated to the patient or clinician? To where is the request referred?
- If the request is appropriate, do you have a process for referring it for consideration by the IFR panel?

### 3 Request considered (see also Sections 2.4.3 and 2.4.4)

- What is the membership of the IFR panel? Does it accurately reflect the role it is being asked to undertake?
- Do you have terms of reference that include membership of the panel, whether deputies are permitted, how a quorum is achieved (number and mix), how decisions are formalised (e.g. voting for consensus)?
- Do panel members have a 'job description'? What training is available for members? How are they supported? Do you have an induction process for new members and deputies?
- Do you have a decision-making framework? Is it freely available? Do you have an ethical framework? How is the evidence base considered; for example, where evidence is limited? Does the PCT have a definition of exceptionality?
- What is the mechanism for obtaining further input if necessary; for example, evidence appraisal or 'expert' advice?

- Do you have a mechanism for recording and minuting the meeting? Who agrees the minutes? Can they be clearly understood by those outside the panel; for example, the appeals panel or the patient?
- Do you have processes that maintain the confidentiality of all participant parties where appropriate?

#### **4 & 5 Funding agreed/not agreed**

- Do you have a process/procedure for what happens if funding is agreed/not agreed?
- What are the timescales for informing the patient/clinician?
- How is the patient informed about the decision; for example, does the patient/clinician receive the minutes of the meeting/a summary letter?
- Who contacts the patient and referring clinician? Is this by letter, telephone, email, or face-to-face? How are they trained and supported?
- Are processes in place to ensure that the decision and the basis for the decision inform any future decision-making?

#### **For agreed**

- What processes are in place to ensure that the patient receives the treatment in a timely manner?
- How is feedback received on the outcome of the treatment? What processes are in place for stopping treatment if no benefit is shown?

#### **For not agreed**

- Is the patient informed about the possibility of appeal?

#### **6 Patient appeals decision (see also Section 2.4.5)**

- Do you have a process/procedure for what happens if a patient appeals a decision? How does the patient lodge an appeal?
- Are timescales for the appeals process clearly defined?
- Do you have a mechanism for identifying urgent requests? What are the criteria that differentiate urgent from non-urgent? Is there a separate procedure for fast tracking urgent requests? Does this include minimum procedural requirements?

- Is the role of the appeals panel clearly defined? Do you specify on what grounds the patient can make an appeal? Do you specify what the appeals panel does not consider? Are these criteria freely available?
- Do you have an organisational framework that specifies where the panel's authority sits?
- What is the membership of the appeals panel? Does it accurately reflect the role it is being asked to undertake? Is it independent of the IFR panel?
- Do you have terms of reference that include the membership of the appeals panel, whether deputies are permitted, how a quorum is achieved (number and mix), how decisions are formalised (e.g. voting for consensus)?
- Do panel members have a 'job description'? What training is available for members? How are they supported? Do you have an induction process for new members and deputies?
- How is the appeal process open, giving the patient and/or their clinician opportunity to input? How are patients and panel members supported? Do you have a mechanism for recording and minuting the appeals panel meeting? Who agrees the minutes?
- Do you have processes that ensure confidentiality of all participant parties, where appropriate?

#### **7 & 8 Original PCT decision overturned/upheld**

- Do you have a clear process in place for what happens if the PCT decision is either overturned or upheld?
- What are the timescales for informing the patient/clinician?
- Who contacts the patient and referring clinician? Is this by letter, telephone, email, or face-to-face? How are individuals trained and supported?
- How is the patient informed about the decision; for example, does the patient/clinician receive the minutes of the meeting/a summary letter?
- How does the decision feed back to the IFR panel so that lessons can be learnt?

#### **For decision upheld**

- Is the patient informed about what their next options are?

Figure six: Generic IFR process

