LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) PCTS

INDIVIDUAL CASES POLICY – (Approved by Leicester City PCT Board on 27 March 2008)

POLICY ON INDIVIDUAL ELECTIVE REFERRALS FOR CARE NOT ROUTINELY COMMISSIONED OR PROVIDED BY LLR PCTs

1. AIM OF COMMISSIONING POLICY

1.1 Within the resources available to us, LLR PCTs aim to commission and provide high quality clinical care to which access is available to all our population, equitably and consistently, based solely on clinical need. We believe that the best way to achieve this is by commissioning clear pathways of care which span the interfaces between primary and secondary care (and tertiary when required) and are supported by shared clinical protocols and arrangements for audit and outcome evaluation.

1.2 The PCTs will pursue this approach to commissioning in line with current government policy.¹ This will enable us to develop a comprehensive range of care pathways, linked to a variety of care providers, to which our population will have consistent and equitable access based on clinical need.

1.3.1 LLR PCTs accept that there may be individual cases where a patient’s needs cannot be met through existing care pathways. Each PCT has set up an Individual Cases Process to consider the circumstances of individuals for whom a referral outside existing pathways or Service Level Agreements may be appropriate. In considering individual cases, each PCT’s Individual Cases Panel will apply the Commissioning Principles and Criteria attached at Appendix 1.

1.4 It is important that decisions on individual cases are not used as a means of “creeping implementation” for new technologies. Consideration therefore needs to be given to the likelihood of other patients having the same clinical need and the danger of precedent setting for groups of patients. Decisions relating to groups of patients will therefore be reached wherever possible through the annual Local Delivery Plan process.

¹ Commissioning a Patient-Led NHS; available at:
2 CURRENT REFERRAL ARRANGEMENTS

2.1 Acute Referrals

2.1.1 The PCT’s preferred providers for acute care are detailed on the PCT’s Choice Menu and can be accessed via the patients’ General Practitioner.

2.1.2 Patients requiring elective referral will be offered a choice of provider in line with the Choose and Book requirements at the point of referral. Where the referral required is of a specialist nature for which there are capacity issues or where the patient has particular needs it may be appropriate to offer a restricted choice. The provision of choice is to allow patients the opportunity to choose the provider of the service that is to be provided. It does not entitle the patient to choose any form of treatment if this is outside of the service provision that is normally commissioned by the PCT.

2.2 Mental Health Referrals

2.2.1 The national Patient Choice Policy has not yet been extended to mental health services and LLR PCTs are not able to currently provide choice of secondary care provider.

2.2.2 Referrals using the existing Service Level Agreements to secondary care providers can be made from primary care (or secondary care if appropriate) without the need to seek prior authorisation from the PCT. The PCT believes that these pathways will meet the vast majority of care needs for their populations.

2.3 Community Services

2.3.1 The national Patient Choice Policy applies to community hospital services that are provided under Payment by Results (PBR).

2.3.2 At present, community services that are not subject to PBR are not yet included in the national or local Patient Choice arrangements apart from services developed under Practice Based Commissioning. LLR PCTs hold Service Level Agreements for community services with Leicestershire County and Rutland PCT and Leicester City PCT, for services including: Specialist Child Health Services, Community Dental Services, Adult Therapies, Nutrition and Dietetics and a range of community nursing services. LLR PCTs does not currently offer choice for this range of provision and it will be developed over time in line with national changes to community services.

2.3.3 GP Practices have started to commission and provide new community services that are not included under Payment by Results that offer new local choices of provision for patients. Referrals to these schemes are made directly by GPs.

2.4 Transport

Patients are able to access the Patient Transport Service (PTS) in order to attend for treatment. This is however, only available to those who meet the eligibility criteria for

2 www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance
3 MANAGEMENT OF THE INTRODUCTION OF NEW DRUGS AND TECHNOLOGIES

3.2 Introduction of new drugs and technologies

3.2.1 The PCT does not expect to introduce new drugs/technologies in an ad hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal clinical need. There is also the risk that diversion of resources in this way will destabilise other areas of health care which have been identified as priorities by the PCT. The PCT expect consideration of new drugs/technologies to take place within the established planning frameworks of the NHS (i.e. the Local Delivery Plan process) after consideration by the appropriate committees. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal clinical need.

3.3 NICE New Technology Appraisals

3.3.1 Drugs and technologies that are approved as the result of a NICE technology appraisal need to be implemented within 3 months of the appraisal being published. The PCT will seek to ensure implementation of NICE technology appraisals without delay but recognise that delays may be inevitable where significant service change and/or development are required as part of the implementation. NICE also produces clinical guidelines, which are a valuable source of good practice, but implementation of clinical guidelines is not mandatory in the way that applies to technology assessments.

4 ASSESSMENT OF INDIVIDUAL CASES

4.1 There are three main routes through which individual case issues are considered: Continuing Care arrangements, East Midlands Specialised Services arrangements and the PCT internal processes to manage all other cases. LLR PCTs will therefore re-direct all cases relating to continuing care needs or needs falling within the specialised services arrangements to the relevant groups:

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<table>
<thead>
<tr>
<th>Approval process to determine whether patient meets criteria or not</th>
<th>If patient is not satisfied with the outcome</th>
<th>If the patient is still not satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuing Care</strong></td>
<td>Continuing Care cases are assessed and the outcome notified to the patient.</td>
<td>Strategic Lead, Continuing Care is contacted to ask for the decision to be reconsidered. A further assessment is undertaken with the patient/family. If still dissatisfied then the patient/family has a right to request an SHA IPR panel. – see below</td>
</tr>
<tr>
<td>• Children’s cases Joint with local authority Complex Children’s Care Panel</td>
<td></td>
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<tr>
<td>• Learning Disability Joint with local authority ‘Joint Solutions Group’</td>
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<tr>
<td>• All other cases via PCT continuing care process</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual case issues falling under national Specialised Services Definitions</strong></td>
<td>East Midlands Nice and High Cost Therapy Clinical Priorities Group considers the case</td>
<td>LLR PCTs will convene appeal panel, under the process outlined in section 9 of this policy</td>
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<tr>
<td>Specialised Services team</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual case issues falling under general commissioning issues</strong></td>
<td>Consider whether there is evidence of ‘exceptional needs’ if there is consider through an Individual Case Review (ICR) Panel.</td>
<td>LLR PCTs will convene an appeal panel for patients not satisfied with the outcome of the ICR panel</td>
</tr>
<tr>
<td>Each PCT’s commissioning team (public health and contracting team)</td>
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<tr>
<td>Until April 2008, the NICE and High Cost therapy group will continue to screen requests costing more than £5,000 (at which point the process will revert to the PCT)</td>
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</table>

The SHA has established a continuing care Independent Review Panel in line with national guidance for adults age 18 and over. The purpose of the continuing care SHA Independent Review Panel is to check that proper procedures have been followed in reaching decisions about the need for continuing NHS health care and the services contributing to continuing health and social care. The panel also considers the application of the eligibility criteria for NHS continuing health care to the facts of the individual case. If the patient/family still remain dissatisfied following the continuing care SHA Independent Review Panel then they can take their case up with the Health Care Commission. (This regional process for considering continuing care cases does not currently apply to children’s cases)

Treatments not currently included in established pathways or identified for funding through the Local Delivery Plan process are not routinely funded. For a number of these interventions the PCT has published specific policy statements setting out restrictions on access based on evidence of effectiveness or relative priority for funding e.g. The Low Priority Treatment Policy.

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4 The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, Department of Health 26.6.2007
4.2 Patients with rare conditions and/or patients for whom first or second line treatments are inappropriate for some reason are unlikely to have potential treatment options that are covered by NICE or by local commissioning policies. In such circumstances the case that is being made by the treating clinician should be judged against the commissioning principles and processes (including Test A: grounds for considering whether a case is exceptional) set out in Appendix 1.

5 POLICY: CASE MANAGEMENT ISSUES

5.1 Requests to continue funding for patients coming off drugs trials

The PCT does not expect to provide funding for patients to continue medication/treatment commenced as part of a clinical trial. In line with the Medicines Act 2004 and the Declaration of Helsinki, the responsibility for ensuring a clear exit strategy from a trial AND that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. The initiators of the trial (provider Trusts and drug companies) have a moral obligation to continue funding patients benefiting from treatment until such time as the PCT agrees to fund through the LDP process. Where the treatment is not prioritised through the LDP, the responsibility remains with the trial initiators indefinitely.

5.2 Requests to switch funding of care to the NHS that was commenced privately

Patients have a right to revert to NHS funding at any point during their care. However, if they wish to exercise this right, the PCT will expect their care to be transferred to local pathways. If an individual wishes to transfer to an NHS provider who is not part of the PCT Extended Choice Network, the case will be considered under The Individual Case Review process.

5.3 Requests for referral to a specialist provider (tertiary, regional or supra-regional centre or specialist private provider)

Secondary care consultants make the majority of referrals to specialist centres. The PCT expects consultants to refer patients for tertiary/specialist care using established pathways covered by Service Level Agreements. Accordingly, requests for referrals to specialist providers outside existing pathways will usually only be considered after assessment by appropriate specialists within the existing pathway. Should a local consultant feel that a referral outside existing pathways is a priority for a particular patient, the consultant should ask for the case to be considered by the Individual Cases Panel.

5.4 Decisions inherited from other primary care trusts

Occasionally patients move into the area and become the responsibility of the PCT after a package of care or treatment option has already been approved by the PCT that was previously responsible for the patient’s care. The PCT will normally honour such decisions made by another PCT providing the care pathway that was approved has been initiated (for example the patient has been seen by the specialist and the package of care or treatment actually commenced).

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5 http://www.legislation.hmso.gov.uk/si/si2004/20041031.htm
5 http://www.wma.net/e/policy/b3.htm
5.5 Second Opinion

A patient is always entitled to a second opinion. This will normally be arranged within existing Service Level Agreements either with a different consultant in the Trust or another trust where an SLA exists. A request for a second opinion outside SLA arrangements must be handled through the Independent Case process using the same tests outlined in Appendix 1 such as Test A: grounds for considering a case exceptional. Requests for a third or fourth opinion will only be agreed in exceptional circumstances through the Independent Case Review processes.

6. CONSIDERATION OF INDIVIDUAL CASES

6.1 Where a doctor wishes to make a referral for an intervention not routinely funded within current agreements, each PCT will undertake a similar process applying the commissioning principles set out in Appendix 1. The detail of the panel may differ between the PCTs and the process for Leicestershire County and Rutland PCT is set out in Appendix 2.

7 EVALUATION AND AUDIT

On-going evaluation will take place through regular reporting to the Individual Case Panel. In addition from time to time and audit of the process, for example looking at the nature of requests and consistency of decisions, etc, will be undertaken.

8 TRAINING AND SUPPORT

8.1 Opportunities for training for Individual Case Panel and Appeals Panel members in evaluation of evidence and health care ethics will be established and provided on a rolling basis.

9. POLICY REVIEW

9.1 This policy will be reviewed at least annually by the Professional Executive Committees and Boards.
Commissioning Principles

- Leicester City (LC) and Leicestershire County and Rutland (LCR) PCTs receive a fixed budget from central government with which to commission all the healthcare required by their populations. The PCTs have insufficient resources to fund all types of healthcare that might be requested for their populations. It is inevitable that the PCTs have to make choices about which types of healthcare to commission.

- The mechanism through which these investment and disinvestment decisions are taken is the Local Delivery Plan process. The PCTs will not expect to make decisions outside this process and, in particular, will not expect to commit new resources in year to the introduction of new healthcare technologies (including new drugs, surgical procedures, public health programmes) since to do so risks ad hoc decision-making and can destabilise previously identified priorities.

- To support the LDP process, the PCTs will use a joint process to consider the clinical and cost-effectiveness of new healthcare interventions and opportunities for disinvestment from less effective services. The final decision about funding will be reached wherever possible through the Local Delivery Plan process.

The following principles will be used by LC and LCR PCTs in order to make the commissioning decisions consistent, transparent and fair. These principles have been developed in collaboration with partners across the local health community, local authorities and local people.

1). Health Outcome.

The aim of commissioning is to achieve the greatest possible improvement in health outcome for our population, within the resources that we have available. In deciding which interventions to commission, the PCTs will prioritise those which produce the greatest benefits for patients in terms of both clinical improvement and improvement in quality of life.

2). Clinical Effectiveness, Quality and Safety.

We will ensure that the care we commission is based on sound evidence of clinical effectiveness and patient safety. We will usually expect this to come from sources such as the National Institute for Health and Clinical Effectiveness, well designed systematic reviews and meta-analyses or randomised controlled trials. The PCTs will aim to commission high quality services as evidenced against national & international best practice. The quality of services will be measured where possible not only in terms of quality of outcomes and clinical effectiveness and patient safety but also in terms of process and organisational efficiency; reducing dependency on health care; the quality of patient care; and the quality of the patient experience. The PCT also recognises that evidence of effectiveness usually relates to groups rather than individuals. We have set up an “individual case” mechanism to allow individuals to be considered as an exception to commissioning policy where evidence is available to suggest that an intervention not routinely funded may be of particular benefit to them.
3). **Cost Effectiveness and Affordability.**

We will take into account cost-effectiveness analyses of healthcare interventions (where available) to assess which yield the greatest health benefits relative to the cost of providing them.

However, the PCTs may not be able to afford all interventions within their available budgets even when these are supported by evidence of clinical and cost-effectiveness. Where this is the case, further prioritisation will be undertaken based on criteria including national and local policies/strategies, local assessment of the health needs of the population, to ensure that we do not exceed our available resources. The PCT will keep existing services under constant review to ensure they continue to deliver clinical and cost-effective services at affordable cost. Where possible we will seek to divert resources from less effective services to more effective ones.

4). **Equity.**

We consider each individual within our populations to be of equal value. We will commission and provide health care services based solely on clinical need, within the resources available to us. We will not discriminate between individuals or groups on the basis of age, sex, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual/cognitive functioning or physical functioning.

The PCTs have a responsibility to address health inequalities across our population. We acknowledge the proven links between socioeconomic inequalities and inequalities in health, access to health care and health needs. Higher priority may be allocated to interventions addressing health needs in sub-groups of our population who currently have poorer than average health experience (e.g. higher morbidity or poorer rates of access to healthcare).

5). **Access.**

The PCTs will ensure that the care we commission is delivered as close to where patients live as possible. For example, we will look at opportunities to move care from hospitals to primary care where this is likely to improve access and maintain quality. Some specialist services cannot be provided in local settings and we may need to commission some services from distant providers in order to ensure quality.

6). **Patient Choice.**

The PCTs respect the right of individuals to determine the course of their own lives, including the right to be fully involved in decisions concerning their health care. However, this has to be balanced against the PCTs’ responsibility to ensure equitable and consistent access to appropriate quality healthcare for all the population. In commissioning healthcare, the PCTs will ensure, wherever possible, that within the care commissioned or provided there are a range of alternative options available, and that patients are given support to make an informed choice.
Application of the Commissioning Principles to the Individual Case Review Process (outlined in Appendix 2)

Leicester City (LC) and Leicestershire County and Rutland (LCR) PCTs will use the joint commissioning principles outlined above when considering individual patients who request treatments or packages of care that are not funded through the LDP Process but it is not the role of the Individual Case Panel to make new (or alter existing) commissioning policy on behalf of the PCTs.

The Individual Case Panel will initially determine whether the individual case meets the PCTs criteria for considering a case as exceptional. (Test A):

**Test A - Determination of whether the case is exceptional**

In order for funding to be agreed there must be some unusual or unique clinical factor about the patient that suggests that they are ‘exceptional’ compared to the cohort of patients with the same clinical condition and stage of disease. Exceptionality will be judged only on exceptional ability to benefit **clinically**, and will **not** consider social factors.

- The Individual Case Panel will determine whether the patient is significantly different from the cohort of patients with the same condition **AND** whether there is robust evidence that this difference would result in a significantly better clinical outcome from treatment when compared to this cohort.

- The consideration of whether the patient is significantly different from the cohort of patients with the same clinical condition and stage of disease will include whether they are able to tolerate usual/standard treatments.

If Test A is not met, then the request must be refused. However, in cases where the Panel feels strong evidence has been provided in support of a particular health technology they should make a recommendation for further consideration by the CAG/LDP process, but the individual funding of a specific case must still be refused.

If Test A is met, then the panel will go on to consider the case under the commissioning principles, set out above, under the following headings (Test B):

**Test B - Consideration of Case applying LLR PCTs’ Commissioning Principles:**

1. **Clinical Effectiveness, Quality and Safety**

   The panel will consider the degree to which the treatment provides clinical benefit (measured in terms of improvement in health/quality of life) balanced against any possible harm.

2. **Cost Effectiveness**

   The Panel will consider the clinical benefit to the patient relative to the cost required to provide the treatment.

3. **Affordability**
The Panel will consider the absolute cost of providing the treatment against the finite resources available to the PCT to provide health care for its population.

4. **Equity**

The Panel will consider the clinical needs of the individual patient compared with fair distribution of limited resources to the whole PCT population. The PCT considers each individual to be of equal value, and provides health care services based solely on clinical need, so the clinical needs of the individual must be balanced against those of others in the population. The PCT will not discriminate against individuals or groups on the basis of age, sex, sexuality, race, religion, lifestyle, occupation, social position, financial status, family status (including responsibility for dependants), intellectual/cognitive functioning or physical functioning.

5. **Access**

The Panel will consider the need to ensure that care is delivered as close to where the patient lives as possible providing quality of provision is maintained.

6. **Patient Choice**

The Panel will consider the right of individuals to determine the course of their own lives, including the right to be fully involved in decisions concerning their health care.
APPENDIX 2: LEICESTER CITY PCT: PROCESS FOR MANAGING INDIVIDUAL CASE REQUESTS

1. CONSIDERATION OF INDIVIDUAL CASES

1.1 Introduction
Where a doctor wishes to make a referral for an intervention not routinely funded within current agreements, each PCT will undertake a similar process applying the commissioning principles set out in Appendix 1. The detail of the panel may differ between the PCTs. The process for Leicestershire County and Rutland PCT is set out below.

1.2 Initial inquiries
The doctor can make an initial inquiry to:

- a commissioning manager who can advise about whether the existing portfolio of SLAs or current commissioning policies would cover the proposed referral.
- or a public health professional – where the situation relates to a health policy issue, such as the Low Priority Treatment Policy

A commissioning manager will advise on whether the existing portfolio of SLAs or current commissioning policies would cover the proposed referral. If not, the commissioning manager may be able to suggest an alternative that will meet the patient’s clinical needs. The commissioning manager is unable to authorise referrals outside existing arrangements and is not able to take an individual’s personal circumstances into account. The commissioning manager may request advice and information from the public health team where appropriate.

1.3 Formal referral for consideration
If the person making the referral has reason to consider that a simple application of SLAs and/or commissioning policies would be inappropriate after discussion with the commissioning team, they can refer the case formally for consideration. The referrer, who must be a health professional directly responsible for the patient’s clinical care, will be asked to complete a proforma and return this to the PCT’s Individual Case Administrator. The administrator will provide administrative support for the Head of Procurement who will oversee the ICR process for the PCT. (Note - For the purpose of this document she will be referred to as the Individual Case Manager).

Screening Tier - On receipt of the completed proforma, a public health specialist and the Individual Case Manager/ or senior commissioning manager will screen the referral to determine whether it meets Test A: grounds for considering a case as exceptional under the criteria set out in Appendix 1. The screening tier will consider two options:

- Refuse the request without reference to the Individual Cases Panel and contact the referrer explaining their reasons for doing so
- Refer the request to the Individual Cases Panel.

1.4 Refusing the request is an option where there is clear policy concerning the situation and where there is no evidence that the individual would constitute an exceptional case. Where there is uncertainty, the case should be referred to the Individual Cases Panel.
All decisions made at the screening level will be recorded and reported to the Individual Case Panel.

1.5 If the referrer is unhappy with the decision reached by the screening tier they can make representation to the PCT via the Individual Case Manager. This should however, only be in circumstances where additional information to support the case becomes available or that confirmation is required that the decision is a consistent policy decision. Should they remain unhappy they can take this up as a complaint against the PCT. Information on this can be obtained from the PCT Complaints Manager.

1.6 The Individual Cases Panel will consider all cases referred to it by the Individual Case Manager / Public Health Specialist screening tier. In reaching a decision on individual funding, the Panel will apply specific criteria (including the Test A ‘Grounds for considering the case as exceptional and Test B drawn from the PCT Commissioning Principles (Appendix 1). The Panel will set out their decision and the reasons for it in writing to the referring clinician, with a copy to the patient.

2 PREPARING A CASE FOR THE INDIVIDUAL CASES PANEL

2.1 The PCT will consider requests from a clinician who is directly involved in the patient’s care. It is the responsibility of the clinician seeking Individual Case consideration to ensure that all relevant information is forwarded to the PCT. This information should be sent using a standard proforma and will include the following:

a) An outline of the patient’s problem and the circumstances of the case, including any previous treatment;
b) A clear statement of the referral/treatment plan proposed for the patient, including at what point the patient would return to local pathways;
c) Consideration of whether the patient’s needs could be met within existing pathways;
d) If the care could be provided within existing pathways or Service Level Agreements, a statement of why an alternative referral, which would not be offered to others with similar clinical need, is a priority in this case;
e) If the care is not routinely funded by the PCT, evidence to show that the patient is significantly different to the population of patients with similar clinical needs who would not be offered the treatment. This should include evidence that the patient is likely to gain significantly more clinical benefit from the treatment than would be expected for other patients, with the same condition.

2.3 The PCT’s Individual Case Manager will write to the clinician referring the case and confirm that the request has been received and will seek further information in cases where items a-e above have not been fully covered. If information is required from third parties, written consent shall be obtained from the patient prior to seeking such information.

2.4 The Individual Case Manager will copy the patient into all formal correspondence and inform them of the individual cases process and will give them the opportunity to provide information to the Panel. The patient will be invited to provide written evidence that they would like the Panel to take into consideration. This might include: information on how their condition affects their quality of life; their understanding of
the evidence base and how this might apply to them; information from friends or family; information from clinicians or patient support groups, etc.

2.5 The Individual Case Manager may also write to other health professionals with clinical involvement in the patient’s care (for example consultant, therapist etc) for clarification of the patient’s needs, evidence base etc, if appropriate.

2.6 The Individual Case Administrator will write to the patient informing them of the date set for consideration by the Panel and provide information about how the PCT manages the process. The Individual Case Manager with support from public health, contracts team and medicines management where appropriate, will produce a summary of the case for the information of the Panel. This will act as the front sheet to the attached documentation received from the referring clinician, patient, etc.

3 INDIVIDUAL CASES PANEL

3.1 The Individual Cases Panel is a sub-committee of the PCT board. It has delegated authority from the PCT Board to make decisions in respect of funding for individual cases.

3.2 Panel Membership:

- Public Health Specialist
- Executive Director
- Clinical Members of Professional Executive Committee
- Non-executive Director (Chair)
- Commissioning and/or Finance representative

3.3 Professional Support

Members of the Panel have to declare any personal / professional conflict of interest in the case. If so, they will not be included on the Panel, and an appropriate replacement will be found.

The Panel will have the opportunity to commission external expertise if this is relevant e.g. proposed treatment is outside of expertise of local clinicians. If there is unresolved dispute of the facts in a particular case, the panel may be able to seek the advice of a separate independent ‘expert’ panel.

3.4 Frequency of Meetings

The Group will meet monthly, as required, quorum being attendance by four members including a public health specialist and non-executive director. Cases will be considered at the next available Panel meeting. If further information is required to prepare the case for consideration, this may delay presentation to the Panel until the next month. In cases where urgent consideration can be justified on the advice of a Public Health Specialist, an “extraordinary” Panel meeting will be convened, quorum being attendance by three members including a non-executive director and Public Health Specialist. The Public Health Specialist will determine the urgency of
the case based on the clinical circumstances after discussion with the patient’s clinicians. Ideally all urgent cases will be considered by a face-to-face meeting but where the urgency makes this impossible i.e. if an immediate decision is required, communication via phone or e-mail will be deemed appropriate.

3.5 The Panel aims to consider all non-urgent applications within a maximum period of 8 weeks from the day an application is received. This will be subject to the availability of all the relevant information requested.

3.6 Cases will be anonymised before consideration by the Panel. Panel members having clinical involvement with a particular case will be excluded from the discussion of that case.

3.7 Confidentiality: All members of the panels will be bound by their duty to maintain a high standard of confidentiality. The members of the panel will only receive information that is relevant and necessary for them to exercise their duties.

3.8 The Executive Director of the Panel will write, within seven working days, to the referring clinician, with a copy to the patient setting out the Panel's decision and the reasons for it. Under the Data Protection Act, the patient and/or referring practitioner have access on application to the information used by the PCT to arrive at the decision. Under the Freedom of Information Act, the duty to disclose information on request is subject to a number of exemptions. In this case, the disclosure of the information will be withheld if this is likely to cause harm to the health and safety of any person involved.

3.9 Patients or clinicians unhappy with a Panel decision may ask for further consideration or appeal

3.10 The Panel will provide a summary of its decisions to the PCT board and will highlight to the board any individual decisions, which may have implications for wider PCT policy.

3.11 The panel will have devolved responsibility to approve individual episodes or packages of care. The Executive Director will be the member with delegated authority to commit PCT funds and will apply this in line with the PCT’s Standing Orders.

4 INDIVIDUAL CASES APPEALS PANEL

4.1 If the doctor or patient is unhappy with the Panel decision they have two options open to them.

   a. If the doctor or patient feels that they have further relevant information available, which has not been considered by the Individual Cases Panel, they may ask the Panel to reconsider the case specifically in the light of this further information. The PCT screening tier will determine whether any further information submitted by the clinician or the patient significantly alters the nature of the evidence that was presented to the initial panel.

   b. If the doctor or patient feels that all the relevant information was available to the Panel when the decision was made, but they remain unhappy with the decision, they may ask for it to be reviewed by the PCT’s Appeal Panel.
Appeal Panel will consider whether the original decision of the Individual Case Review Panel was valid in terms of due process being followed and the manner in which the factors were considered and the criteria were applied. The Appeal Panel will set out their decision and the reasons for it in writing to both the referring doctor and the patient. Should the doctor or patient remain unhappy with the Appeal Panel decision, it is open to them to pursue the matter through the Health Care Commission.

4.2 **Appeal Panel Membership:**

- PCT Chief Executive or nominated Executive Director
- Non-Executive Director
- Professional Executive Committee GP

These panel members should not have previously been involved in the individual case relating to the Appeal. The panel will receive advice from a Public Health Specialist, and where needed a senior commissioning manager, but neither will be decision making members of the panel.

4.3 The Appeals Panel will be convened when necessary to consider appeals against Individual Cases Panel decisions.

4.4 Individuals wishing to appeal against an Individual Cases Panel decision must notify the PCT Chief Executive of their intention, in writing, within three months of the date of the original Panel meeting. Appellants will be offered access to the Patient Advice Liaison Service (PALS) for additional support to understand the process.

4.5 Confidentiality: All members of the panels will be bound by their duty to maintain a high standard of confidentiality. The members of the panel will only receive information that is relevant and necessary for them to exercise their duties.

4.6 The Appeals Panel will consider whether the original decision of the Individual Cases Panel was valid in terms of due process being followed and whether all the relevant factors were considered and the criteria applied. In deciding an appeal, the Appeals Panel will consider whether:

a) the decision was consistent with the principles of the PCT, as set out in the Commissioning Principles (see Appendix 1);

b) the decision was consistent with the Individual Cases Policy;

c) in reaching the decision the Panel had:

i. taken into account and weighed all relevant evidence;

ii. given proper consideration to the claims of the patient (or group of patients) under discussion and accorded proper weight to their claims against those of other groups competing for scarce resources;

iii. taken into account only material factors;

iv. acted in utmost good faith;

v. taken a decision that is in every sense reasonable

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4.7 It is important to note that the Appeals Panel will not consider new information in support of a case. If new information becomes available, the Individual Cases Panel should be asked to reconsider the case in the light of this.

4.8 The Appeal Panel chair will write to the appellant and referring clinician within seven working days with the Panel decision.

4.9 The Appeal Panel will not be able to refer a decision back to the Individual Cases for further consideration unless new information has emerged in support of the case.

4.10 If the Appeals Panel finds that there was a failing in the process, as defined in paragraph 7.4, they will also have the responsibility of making the definitive decision on whether they PCT should approve the treatment being requested. A failure in the process of handling an individual case request does not necessarily mean that the decision that was made was incorrect.

4.11 The Appeal Panel will make the final decision on behalf of the PCT’s Trust Board. Patients who remain unhappy with the Appeal Panel decision may pursue the matter with the Healthcare Commission.
INDIVIDUAL CASE PROCESS FLOW CHART

Treatment Request

Not commissioned by PCT

Are there exceptional clinical circumstances?

No

Not funded

Yes

Commissioned by PCT

Does patient meet criteria?

Yes

Funded

No

Not funded

Are there exceptional clinical circumstances?

Yes

ICR Panel

Funded

Not funded

No

Not funded

? Appeal

Yes

No