# WRITTEN STATEMENT

# BY

# THE WELSH GOVERNMENT

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| **TITLE** | Individual Patient Funding Request (IPFR) Review |
| **DATE** | **10 October 2018** |
| **BY** | Vaughan Gething, Cabinet Secretary for Health and Social Services |

An Individual Patient Funding Request (IPFR) is the process health boards and the Welsh Health Specialised Services Committee (WHSSC) use to consider providing a patient with a treatment which is not routinely available in NHS Wales.

In July 2016, I announced an independent review of the IPFR process, to consider the criterion used to make IPFR decisions - clinical exceptionality - and the potential to reduce the number of IPFR panels.

In January last year I published the report and sought feedback on it. In March I announced that I accepted and would implement the recommendations contained in the report.

The report concluded that, rather than attempting to prove a patient was clinically exceptional, a clinician should prove the patient would gain significant clinical benefit from the treatment requested and that the treatment offered reasonable value for money for NHS Wales (recommendation 11). In May 2017, NHS Wales issued new national guidance *NHS Wales Policy: Making Decisions on Individual Patient Funding Requests*, which incorporates these new criteria. All health board IPFR panels are adhering to the new guidance.

The report recommended that each health board should continue to have its own IPFR panel, rather than establishing a single national panel, so this practice has continued (recommendation 20). A single panel was considered impracticable, due to the number of IPFRs and the logistics of managing a single panel. The application form was re-designed to reflect the new criteria (recommendation 27) and the electronic version launched in December. A standard template for the IPFR panel meeting minutes was developed to record a broad estimate of the IPFR’s benefit and value (recommendation 15) by September.

Ten recommendations (9, 12-14, 16-18 and 20-22) endorsed current practice in the NHS such as disregarding the availability of a treatment, affordability or non-clinical factors when the IPFR panel makes its decision; seeking expert advice for the IPFR panel when

necessary; monitoring the outcomes of IPFRs and documenting the reasons for the IPFR panel’s decision. They were implemented immediately by continuing current practice.

Seven recommendations (2-8) addressed commissioning issues, which can impact on IPFRs. NHS Wales produced all-Wales prior approval process guidance and an application form (2 and 5). Health board commissioners held meetings to share good practice and co-ordinate commissioned services (3). The All-Wales Therapeutics and Toxicology Centre website has updated information on how the IPFR process works and the alternative commissioning routes for access to medicines and non-medicines (4 and 6). Health boards are using agreed standard text to explain why patients in Wales may not choose their place of treatment (7), even though their health board may send them to another healthcare provider for treatment. The WHSSC website has been revised to give clearer information about which services it does or does not commission (8). These recommendations were implemented by October.

An NHS staff working group has been established to draft the new commissioning framework (recommendation 1), reflecting the changes brought about by implementing the other recommendations. The framework is still in development.

One recommendation (10) was to set a consistent national policy on the use of inexpensive interventions requested via IPFR. Health boards and WHSSC already have arrangements in place to maximise the use of interventions of equal effectiveness but lower cost; for example, health boards already routinely use generic and biosimilar medicines over more expensive branded medicines without the need for bureaucratic approval arrangements. There will be occasions where it is appropriate to use the IPFR process even where an intervention is inexpensive; simply because a medicine is less expensive does not mean it is appropriate to deviate from the usual treatment pathway.

There were three recommendations (24-26) to improve the training for clinicians. By September, clinicians had received training sessions as part of their continuing professional development (24); there were guidance notes for clinicians about explaining the IPFR process to patients (25); a decision-making guide had been developed to help clinicians with the IPFR application process and each health board had a single point of contact for help with the application (26).

A Quality Assurance Advisory Group was established, and held its first meeting in January, to review randomly selected IPFRs from each health board (recommendation 19). The Group reports to medical directors and to the Welsh Government’s Chief Medical Officer. Members have been involved in developing new training materials for patients and clinicians (recommendation 23).

I would like to reiterate my thanks to the members of the review group, for carrying out such a demanding task amongst all their other commitments; to the patients and organisations who provided evidence, and to everyone who has worked so diligently to make the IPFR process simpler and better understood.