NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Collaborative Commissioning Policy
Individual Funding Request
Version 2.1 – October 2018

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Collaborative Individual Funding Request Policy Version 2.1 – October 2018		
EA Author	AGEM CSU	**Team**	IFR Team
Date Started	March 2019	**Date Completed**	April 2019
EA Version	Version 2.0	**Reviewed by E&D**	29 April 2019

What are the intended outcomes of this work? Include outline of objectives and function aims

Clinical Commissioning Groups (CCGs) were created by the Health and Social Care Act 2012, and established in accordance with rules set out in the National Health Service Act 2006, as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible.

The CCG receives a fixed budget from the NHS Commissioning Board to enable it to fulfil this duty. It has a statutory responsibility to maintain financial balance[1] and, as part of discharging this obligation, has to decide how and where finite local resources are allocated.

The need and demand for health care is always greater than the resources available to a society to meet it. It is evident, therefore, that it will not be possible for the CCG to commission all the health care that is needed or wanted by the population it serves and, as a result, it will need to prioritise its commissioning intentions, based on the needs of the local population.

In carrying out these functions, the CCG will act with a view to securing that health services are provided in a way which promotes the NHS Constitution and will promote awareness of the NHS Constitution among patients, staff and members of the public. Patients have a right to expect that the CCG will assess and prioritise the health requirements of the local community and commission the services to meet those needs as considered necessary. In discharging its obligations under this Policy, in particular, the CCG acknowledges that patients also have a right to expect that local decisions on the funding of treatments which have not been considered by the National Institute for Health and Care Excellence in its technology appraisal programme will be made rationally following a proper consideration of the evidence.

Those with responsibility for healthcare budgets have to take decisions about priorities at three levels: when developing strategic plans (the main priorities), when deciding year on year which investment and disinvestments to make, and at the individual patient level.

[1] Section 223H National Health Service Act 2006: Financial duties of clinical commissioning groups: expenditure

The individual funding request process is the means by which the CCG takes into account and prioritises requests for individuals with unusual clinical circumstances, which cannot be accommodated through its other commissioning processes. Being part of the CCG's priority setting processes, the decisions taken by the IFR Panel must be guided by the same principles as priority setting in the rest of the organisation. These are set out in the CCG's *Ethical framework for priority setting and resource allocation document*. These principles include taking affordability and relative priority vis-à-vis other needs into account.

In order to carry out its functions, the CCG has entered into an arrangement with the other CCGs listed at the beginning of this document and sought support from the Arden & Greater East Midlands Commissioning Support Unit (AGEM CSU) to administer the IFR process (See Appendix 1 – Terms of Reference for IFR Team). It is, nonetheless, for the CCG which is the responsible commissioner for the patient to decide whether or not an IFR application will be granted.

The AGEM CSU is not a statutory body, although it is currently hosted by the NHS Commissioning Board. Each CCG, as a separate statutory organisation, remains individually responsible for the fulfilment of its legal obligations and its duties and responsibilities to its own patient population as set out in the National Health Service Act 2006.

This policy sets out the decision making framework for individual funding requests and how they will be managed.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Patients, staff, service users, partner organisations, healthcare professionals

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
• The CCG's Commissioning Policy: Ethical Framework for priority setting and resource allocation • The CCG's Commissioning Policy: Experimental and Unproven treatments • The National Health Service Act 2006 http://www.legislation.gov.uk/ukpga/2006/41/contents	• IFR Team • CCG IFR Leads/Authorised Officers • IFR Panel Members including Medicines, GP and Local	

• Department of Health, The NHS Constitution for England, 2015, https://www.gov.uk/government/publications/the-nhs-constitution-for-england • NHS Confederation Priority Setting Series, 2008 Priority setting: an overview Priority setting: legal consideration Priority setting: strategic planning Priority setting: managing new treatments Priority setting: managing individual funding requests http://www.nhsconfed.org/resources/2008/12/priority-setting-an-overview	Authority Public Health Consultant • Mills & Reeve Solicitors • Clinical Policies Sub-group Committee	

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

This policy has the potential to affect all individuals served by the Clinical Commissioning Group because it shapes how resources will be allocated. Because the needs of the population are greater than the ability of the NHS to meet those needs, it is inevitable that not all needs can be met and some patients will suffer as a result. Given this fact, this Policy aims to provide a coherent framework for decision making, promote fairness and consistency in decision making and to provide a means of expressing the reasons behind decisions that have been taken. The Policy specifically requires that the Clinical Commissioning Group does not offer unjustifiable disadvantage or advantage particular groups. No adverse impacts have been identified for any protected characteristic. All individual patients will have the same access to the IFR process regardless of any protected characteristic.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

No impact

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

No impact

3. Impact and Evidence:

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

No impact

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

No impact

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

No impact

Race: Describe race related impact and evidence**.** This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

No impact

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

No impact

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

No impact

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

No impact

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

No impact

3. Impact and Evidence:
Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive) No impact

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	
Is there any impact for groups or communities living in particular geographical areas?	No	
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	
How will you ensure the proposals reduce health inequalities?		

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	No impact
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No impact
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No impact
	How will this affect a person's right to freedom of thought, conscience and religion?	No impact
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	No impact
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	No impact

Right to **Life**	Will or could it affect someone's right to life? How?	No impact
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	No impact
Comments	We do not consider that infringes a person's human rights, however if it is considered that this policy does infringe on a person's human rights legal advice will be sought before proceeding.	

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	
Create fair employment and good work for all	
Create and develop health and sustainable places and communities	
Strengthen the role and impact of ill-health prevention	

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	**Protected Characteristic/ Group/ Community**	**Date**

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

Engagement has been undertaken with the following groups and committees:

- IFR Team
- CCG IFR Leads/Authorised Officers
- IFR Panel Members including Medicines, GP and Local Authority Public Health Consultant
- Mills & Reeve Solicitors
- Clinical Policies Sub-group Committee

Further engagement with patients is not required at this stage as no adverse impact for any protected characteristic has been identified.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

This policy has the potential to affect all individuals served by the Clinical Commissioning Group because it shapes how resources will be allocated. Because the needs of the population are greater than the ability of the NHS to meet those needs, it is inevitable that not all needs can be met and some patients will suffer as a result. Given this fact, this Policy aims to provide a coherent framework for decision making, promote fairness and consistency in decision making and to provide a means of expressing the reasons behind decisions that have been taken. The Policy specifically requires that the Clinical Commissioning Group does not offer unjustifiable disadvantage or advantage particular groups

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

This policy is what mitigates and identifies patients with exceptional clinical circumstances whereby a patient may receive treatment if they are deemed to be clinically exceptional compared to a cohort of patients that may also benefit from a treatment/intervention.

This policy allows the CCG to meet its statutory requirements and comply with the NHS Constitution.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

KPI would be monitored through NHS Standard Contract.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

Not applicable

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.

Clinical Policies Sub-group Committee
Governing Body
CCG website

Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:	Balvinder Everitt – Senior Manager Equality Inclusion	29-04-19
Which Committee will be considering the findings and signing off the EA?	Clinical Policies Sub-Group Committee and Quality and Safety Committee	03 May 2019
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net