HOW SHOULD INDIVIDUAL FUNDING REQUESTS BE CONSIDERED BY NHS COMMISSIONERS?

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2017 brought us several interesting public law decisions, including many successful judicial review claims against NHS commissioners. This article will focus on one such decision - *R (on the application of SB, by his father and litigation friend PB) v NHS England* [2017] EWHC 2000 (Admin) (8 August 2017) and consider the legal framework surrounding Individual Funding Requests **("IFR")** and how such applications should be lawfully determined. It will also consider NHS England's revised IFR Policy published on 17 November 2017.

The Facts

At the date of the hearing in July 2017, the Claimant **("S")** was 7½ years old. S has a diagnosis of severe autism with an associated severe learning disability and displays violent and challenging behaviours. S also suffers from Phenylketonuria **("PKU")**, a rare inherited metabolic condition, which inhibits his ability to digest protein causing an amino acid called phenylalanine to build up in his blood. The scientific consensus is that increasing blood phenylalanine is clearly associated with decreased cognitive function, especially in children under 12 years old (when the brain is continuing to develop) and the higher the concentration of phenylalanine in the blood, the worse the impairment is likely to be.

The objective of any treatment for PKU is to ensure that blood phenylalanine levels are consistently maintained within a safe range. For children under 12, the upper limit of the blood range is 360 µmol/L. The standard treatment for PKU is dietary management, which involves restricting the amount of natural protein consumed and the taking of a supplement (a protein substitute) to promote normal growth and development. It is recommended that the diet is continued for life.

Due to the extreme severity of S's autism and his behaviours, his family, specialist teachers and treating clinicians found it increasingly difficult to control his consumption of protein and to ensure that he took his supplements. S was also intolerant of invasive medical procedures and intubation was not a practical option and would have caused S unacceptable psychological harm in any event.

Consequently, one of S's treating consultants, Dr Santra made an IFR on behalf of S for funding to treat him with sapropterin dihydrochloride (trademarked brand name "Kuvan"). For patients who are responsive, Kuvan reduces the level of phenylalanine in the blood, thus making the patient more protein tolerant and enabling them to eat more "normal" foods. In those who respond to Kuvan, the diet is likely to be relaxed and the dietary supplement reduced by 50%.

NHS England's applicable Clinical Commissioning Policy **("CCP")**: "The use of Sapropterin in children with Phenylketonuria" confirms, *inter alia,* that *"up to 20% of children with PKU (mainly mild/moderate) are likely to gain benefit from it if used in combination with a more relaxed diet".* There is less data in respect of positive cognitive improvement and nutritional status. The CCP concludes that there is insufficient evidence to support the routine commissioning of the drug for children as *"the evidence review provided an assessment of effectiveness and safety of [Kuvan] in the short term (up to 10 weeks) and could not demonstrate the benefits of treatment on nutritional status and cognitive development"*. S did not challenge the legality of the CCP. At the date of the hearing, the CCP was under review (and remains under review as at the date of this article).

Prompted by a worsening of S's phenylalanine control, Dr Santra submitted his IFR in May 2016. In his application, Dr Santra confirmed that S's clinicians anticipated that he would not be able to comply with dietary treatment *"and will continue to run blood phenylalanine levels outside of the target range. This will put him at risk of ongoing brain damage from phenylalanine toxicity... ".* The sole clinical justification for the treatment was to eliminate the risk of S suffering ongoing brain damage due to his blood phenylalanine levels being consistently maintained above the range that is generally accepted to be safe.

In October 2016, Dr Santra provided a chart to the IFR Panel illustrating S's blood phenylalanine levels since July 2015. The chart demonstrated that for around 56%-60% of the time, S's levels had been higher than the upper limit, and even when inside the range, they had generally been close to that upper limit.

The Legal Framework

In England, clinical commissioning groups are responsible for planning and commissioning health services for their local areas[1]. Section 3B(1) of the National Health Service Act 2006 **("the NHS Act")** also provides a power to the Secretary of State for Health to require NHS England to arrange for the provision of certain services, if the Secretary of State considers that it would be more appropriate for NHS England to make those arrangements.

By regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 **("the 2012 Regulations"),** NHS England is responsible for arranging *"to such extent as it considers necessary to meet all reasonable requirements"* the provision of 144 services listed in Schedule 4 to the 2012 Regulations, of which PKU is but one[2].

The duty imposed on NHS England by the 2012 Regulations is of a general nature. The obligation is limited to providing the services identified *"to the extent that [NHS England] considers that they are necessary to meet all reasonable requirements"*[3].

By regulation 34 of the 2012 Regulations, NHS England must have in place arrangements for making decisions and adopting policies about whether a particular health care intervention is to be made available, including arrangements to determine a request for health care where there is no relevant NICE recommendation and the general policy is not to fund that intervention.

Pursuant to regulation 34, NHS England has established its IFR Policy. As at the date of the hearing before Andrews J, the applicable Policy was dated April 2013 (the first published version). A revised IFR Policy was published by NHS England on 17 November 2017 (and will be addressed in further detail below).

The April 2013 Policy confirmed that an IFR Panel had a discretion to approve funding if the patient had *"exceptional clinical circumstances".* This was defined in the IFR Policy as follows:

> *"To meet the test of "exceptional clinical circumstances" there must be an NHS [Clinical Commissioning] policy in place that describes the availability of the requested intervention and your patient must demonstrate that they are both*
>
> *Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition*
>
> *AND*
>
> *Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition"*

[1] In Wales, this responsibility falls to one of the seven Welsh University Health Boards: Local Health Boards (Directed Functions) (Wales) Regulations 2009, regulation 2(2).
[2] In Wales, the Welsh Health Specialised Services Committee **("WHSSC")** is responsible for the joint planning of specialised and tertiary services on behalf of all seven University Health Boards in Wales. WHSSC was established on 1 April 2010 under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35).
[3] The same general duty applies to University Health Boards in Wales under section 3 of the National Health Service (Wales) Act 2006.

The Decision of the IFR Panel

NHS England refused Dr Santra's IFR. In summary:

(a) it accepted that the severity of S's autism and its impact on his ability to comply with the dietary regime made him exceptional to his applicable cohort (other children of a similar age with PKU, even those with less severe autism);

(b) it was not persuaded that S met the second limb of the above test for *"exceptional clinical circumstances";* and

(c) concluded that the clinical effectiveness of Kuvan had not been demonstrated (Stage 2).

By the date of the hearing before Andrews J, NHS England accepted that S met both limbs of the exceptional clinical circumstances test (Stage 1) and that his application for funding qualified for consideration on its merits[4]. However, it maintained argument (c) above.

The Judicial Review Challenge

S (acting through his father as his litigation friend) issued a claim for judicial review challenging NHS England's refusal to grant funding to treat him with Kuvan. In summary, S's three grounds of challenge were:

(i) either the Panel misapplied or misinterpreted the Policy or reached a decision that was irrational. In particular, the Panel equated *"clinical effectiveness"* with *"long-term clinical effectiveness"* when there was no requirement in the IFR Policy that the latter be demonstrated;

(ii) the Panel failed to have regard to NHS England's statutory duty under section 11(2) of the Children Act 2004 to safeguard and promote the welfare of children;

(iii) the Panel breached the "procedural" requirement inherent in Article 8 ECHR, read together with Article 3 of the United Nations Convention on the Rights of the Child to evaluate the impact of its decision on S and assess whether it was consistent with his best interests.

This article will focus on ground (i). Grounds (ii) and (iii) were held to be *"fundamentally misconceived".* In summary, Andrews J held that there was no specific and additional obligation for the Panel to have regard to the welfare and/or best interests of S as this was *"necessarily an integral part of the decision- making process whenever an individual decision is taken in accordance with the IFR Policy"* (paragraphs 92, 98 and 102).

The Judgment of Mrs Justice Andrews

Andrews J concluded that NHS England's decision to refuse funding was irrational. She quashed the decision and remitted it for reconsideration in the light of her judgment. The Judgment properly criticises the Panel for the multiple errors made and provides clear guidance for future applications. In particular, Andrews J held:

(a) *"the IFR Policy does not define the expression "clinical effectiveness"…The question whether a drug is clinically effective, i.e.* ***whether it achieves the intended clinical outcome in respect of the relevant condition from which the patient is suffering*** *(or, as a lay person would put it, it works)* ***is self-evidently a different question from the question of how long it works for****"* (paragraph 56) (my emphasis);

[4] Although NHS England accepted that S met the "exceptionality" test, Andrews J makes clear in her decision that she did not accept its interpretation that the "exceptionality" test had two components. She held (at paragraph 46) that *"[t]he questions that the Panel must ask under Stage 1 of the decision framework are directly concerned with the complete threshold test of exceptionality, and not with just one facet of it".*

(b) ***"….clinical effectiveness must be measured against the target outcome(s). That target outcome may differ, depending on the specific context in which the question "is this drug clinically effective?" is asked"*** (paragraph 57) (my emphasis);

(c) it was important to remember that S's application for funding was not made to improve his cognition and/or nutritional uptake (on which the longer-term evidence was found to be lacking as per the CCP), but rather to avoid the deleterious effects of his brain being consistently exposed to phenylalanine blood levels above the range regarded as safe. *"The fact that the Defendant's CCP to refuse funding as a matter of course is justified by the absence of sufficient clinical evidence as to the long-term effect of taking the drug on cognition and nutritional uptake is of little relevance in this context"* (paragraph 58);

(d) had the Panel considered the target outcome to be the *"reduction of blood phenylalanine levels and improved phenylalanine dietary tolerance"* and asked itself *"is there robust evidence that this drug is clinically effective?"* by reference to this target outcome, it could not have reached the conclusion that it did. Indeed, all of the clinical evidence demonstrated that Kuvan reduced phenylalanine levels in the blood and improved dietary phenylalanine tolerance in receptive patients, with no adverse effects on safety (paragraph 59);

(e) the Panel wrongly stated that only 10-15% of patients with PKU will be responsive to Kuvan. The correct figure for children between 4 and 12 years old is 20%. ***"Of course, the fact that a drug only works in certain patients with certain characteristics does not mean that it is not clinically effective. It is still capable of achieving the intended clinical objectives in those patients who are receptive"*** (paragraph 60) (my emphasis);

(f) Andrews J emphasised the importance of the Panel correctly considering and understanding the case put forward by a patient's clinical team. She succinctly underlined the *"demonstrably incorrect"* statements made by the Panel and the fact that its decision *"was informed by error upon error**, the most fundamental of which was that the Panel misunderstood (and/or mischaracterised) what Dr Santra was saying about the clinical implications of S's inability to control his blood phenylalanine levels** ... Whilst it is open to an IFR Panel to disagree with the requesting clinicians if they have valid reasons for doing so, **a decision based on a misinterpretation of what the clinicians are saying will be fundamentally flawed, and so it is with this one**" (*paragraph 67) (my emphasis);

(g) in relation to the question of when future risks may mature in the absence of treatment, Andrews J properly draws our attention to the unacceptability of *"unethical experimentation"* and *"experimenting on children"* (paragraph 86). She states: *"the question of the period of time over which the unacceptably high phenylalanine levels have to be maintained before the risk [of irreversible neurological impairment] matures is one that self-evidently could not be answered without **unethical experimentation**, and in any event may depend on the physiology of the individual patient. **This no doubt explains why the clinical consensus is no more precise"** (*paragraph 73) (my emphasis);

(h) Andrews J also rejected the premise that *"a decision maker could rationally conclude that he needs to be able to further quantify the risk of a child sustaining brain damage from toxic levels of a chemical building up in his or her bloodstream, above and beyond the risk regarded as high enough to warrant some form of medical intervention, before being able to take a view as to whether it is justifiable to fund medical treatment that would address that risk"* (paragraph 86);

(i) in terms any concerns held by the Panel about *"long-term clinical effectiveness or benefit",* Andrews J outlines that these must be *"balanced against the carefully individualised management protocol proposed by S's treating clinicians… the fact that once [S] reaches the age of 12, [he] is expected to have an increased tolerance to phenylalanine, and the prospect that the cost of Kuvan may be greatly reduced when the existing patent expires…The Panel will no doubt also bear in mind the cost that is already being expended on treatment for S's PKU and the prospective financial burden that the NHS might incur if, due to the ineffectiveness of dietary control, S's blood phenylalanine levels do reach a level of toxicity where he suffers severe irreversible brain damage unrelated to his autism"* (paragraph 91).

Commentary

Although the Judgment is very critical of the Panel and highlights the numerous *"disturbing"* errors made, the author also considers that it is helpful to NHS commissioners for the following reasons:

(i) it provides further authority that underlines the important principle that NHS commissioners have *"considerable amount of discretion (or judgment) …, not only as to the scope of the reasonable requirements and as to the services that it considers necessary to meet them, but as to how it goes about its task"*. Andrews J cites with approval, the Judgment of Hickinbottom J in *R (Dyer) v The Welsh Ministers and others* [2015] EWHC 3712 (Admin), which succinctly summarises the previous authorities[5] (see paragraphs [17] and [105]-107] of *Dyer*);

(ii) indeed, in the final paragraph of her judgment, Andrews J cautions against raising hopes and highlights that the Panel *"could still lawfully decide to refuse funding. It is their decision, and their decision alone; and* ***provided it is taken on the basis of the correct interpretation of the IFR Policy, and a proper understanding of the case put before the Panel and the supporting evidence, it will not be open to challenge****"(my emphasis);*

(iii) the learned Judge also emphasises the importance of allocating *"limited state resources"* and the NHS's express duty to balance its budget. She cites with approval the decision of Sir Thomas Bingham MR (as he then was) in *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898 at 906, which confirmed that *"…****difficult and agonising judgments*** *have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients." (*my emphasis)*;*

(iv) at paragraph 90 of her decision, Andrews J accepts that *"…even when the risk is real rather than theoretical, the form of the action that can be taken to address that risk (i.e. the type of treatment available) may be circumscribed by budgetary constraints and the demands made on the health service by other patients"* (paragraph 90);

(v) the Judgment repeats the consistent line of authority that establishes that a decision to decline to fund a particular course of medical treatment does not constitute an interference with a patients Article 8 rights[6];

(vi) it provides clarity that there is no specific obligation for a Panel to have regard to the welfare and/or best interests of a patient over and above the extent to which those interests are already catered for in the IFR Policy.

Furthermore, although IFRs are fact-specific and each Panel must make a decision in relation to the specific individual, balanced against the interests of all patients within a system with finite resources, the Judgment provides invaluable further guidance about how IFR should be determined by commissioners. In particular:

(i) it is crucial that the Panel carefully considers the case put before it and properly understands and applies the supporting evidence presented by the patient's clinical team. In this case, there were basic *"errors after error",* including misquoting the applicable CCP and mischaracterising the evidence of Dr Santra;

(ii) the Panel must ask itself the right questions with reference to the specific application before it. In the present case, the right questions highlighted by Andrews J included:

[5] *R (JF) v NHS Sheffield Clinical Commissioning Group* [2014] EWHC 1345 (Admin) at [43]; *R (Grogan) v Bexley NHS Healthcare Trust* [2006] EWHC 44 (Admin) at [40); *CREEDNZ Inc v Governor General of New Zealand* [1981] 1 NZLR 172; *re Findlay* [1985] AC 318*; R (Khatun) v London Borough of Newham* [2004] EWCA Civ 55; [2005] QB 37 at [35].

[6] See *RR v Poland* (2011) 53 EHRR 31; *R(Condliff) v North Staffordshire PCT* [2011] EWCA Civ 910, especially per Toulson LJ (delivering the judgment of the Court of Appeal) at [40] and [41].

- whether NHS England has a Policy to cover the treatment which is made available to patients with the medical condition of this patient?

- if so, and the Policy is not to fund treatment for all patients, has the requester provided enough evidence that this patient has exceptional clinical circumstances? (Stage 1)

- does the Panel consider that there is robust evidence of the clinical effectiveness of this drug/intervention? (Stage 2)

(iii) in answering the last question about *"clinical effectiveness",* Panels must remember that:

- clinical effectiveness must be measured against a specific target outcome(s);

- a target outcome(s) may differ for each case within a particular cohort of patients depending on the specific IFR;

- commissioners must carefully consider why clinicians are seeking to use a particular treatment as a means to achieve a specific target objective and ask themselves: is there robust evidence that this drug is clinically effective, with reference to the specific target outcome identified by the clinicians for this particular patient?

- the fact that a drug only works in certain patients with certain characteristics does not mean that it is not clinically effective. It may still be capable of achieving the intended clinical objectives in patients who are receptive;

- whether a drug is clinically effective is a different question from the question of how long it works for. The answer to the latter question only arises after clinical effectiveness has been established;

- clinical *effectiveness* is also not the same thing as "long-term *benefit*". A target outcome may confer a measurable clinical *benefit* (e.g. positive improvement in behaviour) but this may not always be the case. A target outcome may only be formulated to achieve a clinical outcome (e.g. reducing toxic blood phenylalanine levels). Its effectiveness can be measured by how it achieves such outcome (with or without any additional benefit over and above standard treatment);

(iv) if a Panel is going to reject an application on the basis that that the clinical effectiveness of a drug/intervention has not been demonstrated, it must carefully set out the evidence that it relies on to support its conclusion. Put simply, the Panel must address the evidence relied upon in the IFR and set out clearly why this evidence has been rejected as insufficient or not robust for the particular patient;

(v) in cases where clinicians highlight a risk of future deterioration in the absence of treatment being provided, it is important for Panels to bear in mind that the question of when such risk may mature may not be able to be answered without *"unethical experimentation"* and in any event, may depend on the physiology of the individual patient. Clinical consensus may not always be precise and a degree of logic may need to be applied (in the present case, it was logical that the longer the exposure to unacceptably high phenylalanine levels, the higher the chance that the risk of brain damage would mature);

(vi) in relation to information to be provided by a clinical team when making an IFR, Andrews J outlined that the following should be provided in the present case (which can be helpfully transferred to other cases involving future risks of damage in the absence of treatment):

- what conclusions he (and the team) consider can be drawn from the data about S's blood phenylalanine levels and the historic pattern in terms of the existence and nature of the risk of neurological impairment;

- the reasons for drawing those conclusions, and what bringing the levels consistently within target range would achieve in terms of addressing that risk;

- if it is their view that on the basis of the current data, S risks some long-term cognitive impairment, they should express that view, and explain why they hold it;

- if the potential severity of the damage to which S is currently exposed can be measured, they should say so and explain how; if it cannot, they should say why not.

The Revised IFR Policy (17 November 2017)

On 17 November 2017, NHS England published the second version of its IFR Policy. It is supported by a revised Standard Operating Procedure (also published on 17 November 2017), which sets out how IFRs will be managed and the processes that will be followed.

The revised Policy applies three stages, which all must be satisfied to receive funding, namely:

Stage 1

(1) There is evidence that the **patient presents with exceptional clinical circumstances**, that is:

(a) There is a relevant policy that governs whether to fund or not fund the treatment for the patient's condition, and a clinician can show that their patient is in a different clinical condition when compared to the typical patient population with the same condition and (if relevant) at the same stage of progression, and because of that difference their patient is likely to receive material additional clinical benefit from treatment that would not be plausible for any typical patient

OR

(b) There is not a relevant policy for the management of the patient's condition or combination of conditions, and the patient's clinical presentation is so unusual that they could not be considered to be part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken.

Stage 2

There is a basis for considering that the **requested treatment is likely to be clinically effective** for this individual patient.

Stage 3

It is considered that the requested treatment is **likely to be a good use of NHS resources**.

Clinical Exceptionality (Stage 1)

The language used in the revised Policy is not materially different to the previous April 2013 Policy, which referred to a patient being *"likely to gain significantly more clinical benefit than others".* The new Policy refers to a patient being *"likely to receive material additional clinical benefit from treatment that would not be plausible for any typical patient".* Importantly, stage 1 now comprises a *"complete threshold test of exceptionality"* (as per paragraph 46 of Andrews J's decision).

The revised Policy sets out that *"there can be no exhaustive description of the situations which are likely to come within the definition of exceptional clinical circumstances. The onus is on the clinician making the request to set out the grounds for clinical exceptionality clearly for the IFR Panel" (*paragraph 7).

At paragraph 10, the Policy prescribes that *"the fact that a patient has failed to respond to, or is unable to be provided with, all treatment options available for a particular condition (either because of a co-morbidity or because the patient cannot tolerate the side effects of the usual treatment) is unlikely, on its own, to be sufficient to demonstrate exceptional clinical circumstances. There are common co-morbidities for many conditions. Again these considerations are likely to have been taken into account in formulating the general policy".*

Clinical Effectiveness (Stage 2)

Stage 2 maintains the language of *"clinical effectiveness".* The Policy describes *"Clinical effectiveness"* as *"a measure of the extent to which a treatment achieves pre-defined clinical outcomes in a specific group of patients"* (paragraph 23). Importantly, the Policy also recognises that *"inevitably, the evidence base put forward in support of an IFR is unlikely to be as robust as in more common presentations of the condition or the more usual use of the treatment"* (paragraph 24).

When considering clinical effectiveness, the IFR Panel will consider:

(i) How closely the patient matches the patient population from whom the results are derived in any study relied on by the clinician;
(ii) The plausibility of the argument that the patient will achieve the anticipated outcomes from treatment, based on the evidence supplied;
(iii) The impact of existing co-morbidities on both the claim for exceptionality[7] and treatment outcome;
(iv) Any complications and adverse events of the treatment including toxicity and rates of relapse. The panel will take account of side effects when considering the benefits from the treatment;
(v) The likely impact of the treatment on quality of life using information as available;
(vi) Reported treatment outcomes and their durability over the short, medium and longer term, as relevant to the nature of the condition. The requesting clinician must demonstrate why they consider that the proposed treatment will be effective for the whole period for which it will be given[8].

A Good Use of NHS Resources (Stage 3)

There is nothing surprising with stage 3. Paragraphs 26-31 of the Policy confirm that *"when determining whether a treatment would be a good use of NHS resources it is very important to consider the length of time for which funding of a treatment is being requested, in relation to the duration of the evidenced efficacy of the treatment i.e. whether the clinical evidence indicates short, medium or long term effectiveness of a particular treatment".* The Panel must also take into account its *"ability to impose conditions on any funding it agrees, for example to monitor the impact of the funded treatment".*

Summary

In my view, nothing in the revised Policy disrupts the Judgment of Andrews J and, in particular, her conclusions in relation to the correct interpretation and application of *"clinical effectiveness" (*as set out above). In short, if stage 1 is satisfied, when determining *clinical effectiveness*, the Panel must always remember that it is only concerned with the question of whether the proposed treatment is likely to work for the particular patient, with reference to the specific target outcome for that patient (as outlined by his/her clinical team). Unethical experimentation cannot take place and precise long-term benefits cannot always be identified.

[7] The author considers that this reference to "exceptionality" at stage 2 is misplaced.
[8] Arguably this should not be read as requiring evidence of "long-term effectiveness" in order to demonstrate clinical effectiveness, which was rejected by Andrews J. Moreover, in light of: (i) the need to avoid unethical experimentation; (ii) the imprecise nature of prognoses and scientific consensus; and (iii) the Policy's own acceptance that the evidence base put forward in support of an IFR is unlikely to be as robust as in more common presentations, the absence of clear evidence about "long-term" effectiveness should not present as any automatic reason to reject an IFR. Moreover, in many cases, a clinician will present an individualised management protocol to regularly review the ongoing effectiveness of any treatment after its commencement. Such approach is also supported by paragraphs 29 and 30 of the revised Policy.