Greater Manchester Shared Services

Greater Manchester Effective Use of Resources:

Operational Policy

Version: 3.0 (24 Nov 2017)

Greater Manchester Shared Services
Hosted by NHS Oldham CCG
on behalf of the Greater Manchester CCGs

Best Care • Best Health • Best Value

Contents

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Equality Analysis

An Equality Analysis has been carried out on this policy. For more information please email: policyfeedback.gmscu@nhs.net

1. Introduction and Purpose

1.1 The government's priorities for modernising the NHS are underpinned by achieving careful management of overall NHS resources. The priorities are designed to ensure that people, wherever they live, have access to high quality services and care. Consequently, the commissioners of services in Greater Manchester (GM) are working to improve the cost effectiveness of services. The aim is to secure the greatest health gain from the resources available by making decisions based on evidence about clinical effectiveness balanced with known population needs. The commissioning process leads to resource allocation decisions following a strict process that includes careful deliberation of population needs in the context of the evidence base for the services to be provided, using a clear prioritisation process which decides what is and isn't commissioned.

1.2 This process takes account of, the recommendations issued by the National Institute for Clinical Excellence (NICE), and independent advice and expertise, e.g. the Cochrane database to further support the objective allocation of resources based on evidence.

1.3 This policy document sets out the operational framework that will underpin the part of this process relating to Individual Funding Requests (IFRs) (exceptional cases) and Individual Prior Approvals (IPAs). This policy will enable the commissioning of "one off" provider services for named patient requests for a treatment or drug not covered by existing contracting arrangements to be carried out in a similarly robust manner to the main contracting round. This decision making process needs to be ethical, equitable and firmly embedded in the governance structure. This decision making process is managed on behalf of GM Clinical Commissioning Groups (GMCCGs) by the GMSS EUR Team. The governance and accountability arrangements are detailed at Appendix 2.

1.4 This policy does NOT apply to those areas managed by other commissioners, e.g. NHS England or areas which are excluded from the EUR service. Current exclusions to the GMSS EUR Team are: mental health referrals; placements for mental health, learning disabilities, children's placements and services for children which are jointly commissioned by the NHS and other statutory organisations; or continuing care and other high cost and/or long term placements, unless by prior agreement with GMSS and costed accordingly.

1.5 This policy DOES cover requests where the following applies:

- The patient is either a temporary or permanent resident within a GMCCG area and is eligible for NHS services.
- The drug, procedure or device is not covered by contracts or service level agreements with current service providers or by other collaborative and consortium commissioning arrangements, or it falls within a CCG Effective Use of Resources Policy, and there is a

requirement for commissioner funding approval, because the treatment is not routinely commissioned, or should only be commissioned in specific circumstances.

- The referrer is the patient's GP or NHS hospital consultant or other clinician. Requests will not be accepted from patients or their relatives/carers.
- The use of e-requests. GP practices will be encouraged, through appropriate support, to use the electronic version of the procedure/treatment specific funding request forms from the 1st April 2017. This is in line with the move to a paperless NHS by 2018.
- The scope of the treatment requests are detailed in section 2.3.

1.6 This policy operates within the Ethical Framework attached as Appendix 1.

2. Background and Scope

2.1 The NHS is under a statutory duty 'to promote comprehensive healthcare within the resources available'. It is not under an absolute obligation to provide every treatment that a patient, or group of patients, may demand. The NHS is entitled to take into account the resources available to it and the competing demands on those resources. The precise allocation of resources and the process for prioritising the allocation of those resources is a matter of judgement. This policy aims to facilitate and support making those judgements at a named patient level by identifying those individuals who should receive care on the NHS where their request is an exception to current contracting arrangements/commissioning policies.

2.2 This policy should support the planning and prioritisation process undertaken by commissioners. It is not intended to be used as a population tool and will not act as a short cut in place of the formal system that agrees service developments. It may however, flag areas where there is a need for a service development and ensure that this need is brought to the attention of the appropriate commissioner.

2.3 This policy does however cover those occasions when a clinician on behalf of a patient may wish to request funding for a treatment which is not routinely commissioned or where they believe that there are exceptional clinical circumstance(s) which will make the treatment more effective for the individual in question. Examples of when this may occur are:

- When there is a commissioning policy for the patient's presenting condition which does not currently fund the treatment in question because the available evidence does not support prioritising that treatment for population use within the available resource constraints (this is usually because the treatment falls below commonly accepted thresholds of clinical effectiveness or cost effectiveness, or a combination of both).

OR

- When the commissioner has undergone a prioritisation of competing service developments for available resources and the treatment in question is a low priority for NHS resources when compared to the other health needs of the population.

OR

- When the commissioner has not yet considered the available evidence and so has not yet made a decision as to whether or not the requested treatment should be made available.

This policy also covers:

- those requests where the condition is extremely rare and it is unlikely there will ever be evidence of cost effectiveness at a population level for the normal commissioning process to apply.

AND

- those requests where there is a contract but where agreed criteria must apply in each case for the procedure/drug to be commissioned and/or where the commissioner has stipulated that

prior funding approval must be given. These are also referred to as Individual Prior Approvals (IPAs).

2.4 Where a decision is made on an IFR and where further requests for the same treatment are anticipated, the GM EUR Steering Group may develop commissioning policies or commissioning decision making guidance to be ratified by CCGs. Any such policies/guidance will then be used to inform the decision making process of any future similar or related requests (see section 12.3).

2.5 Referring clinicians acting on behalf of a patient to compile and submit a clinically appropriate funding request, will be responsible for ensuring that all relevant supporting information is provided to the GMSS EUR Team to enable full and due consideration of the request. All requests will be sent to the GMSS EUR Team. Anyone enquiring about individual funding will be informed of the process and the GM or respective local CCG's EUR treatment policy. Some GM EUR policies require specific clinicians to submit an application, please see individual policies for further details. Depending on the nature of the request further action at this stage could include:

- Clarification of the needs of the patient, if necessary, through further discussion with the referring clinician if not already included in the request.
- Consideration of whether the needs of the patient could be met within existing service agreements, and clarifying the reasons why this might not be appropriate if not already included in the request.
- Consideration of the evidence for effectiveness of the treatment, if it is not offered within an existing service agreement. This could include reviewing relevant literature and taking opinion from relevant specialists, locally and elsewhere.
- Consideration of other relevant information – for example, previous funding decisions, previous decisions regarding commissioning priority value, existing policy documents etc.
- Review of the available evidence to determine if the patient meets the criteria where restricted access has been agreed for low clinical value procedures or to clarify that a patient meets criteria in relevant guidance, e.g. NICE.
- Seek further views, if appropriate from the patient (if this is not clear from the requesting doctor's information) and/or a relevant patient support or disorder based organisations (e.g. British Thoracic Society) and/or professional associations (e.g. Royal College of Physicians).
- In some requests, it may be considered appropriate to suggest that the patient is referred to a named relevant specialist – usually within a service agreement – for a second opinion and further advice before a formal request is made or as part of the request consideration process.
- Requesting non-identifiable photographs, preferably medical illustrations if available to support the decision making process. It should be noted that it is <u>not</u> mandatory for photographs to be provided by the patient and any photographs received will not form the sole basis of the decision. These should be and relevant to the request. If not supplied when requested, a decision will be made on the basis of the information available at the time.

2.6 Individual Funding Requests to be considered for funding will need to meet the following five conditions to be funded (this does not apply in the case of IPAs):

- The clinician makes an individual request for funding for treatment in connection with a presenting medical condition for which the CCGs have a policy, but the patient does not meet the criteria, and the clinician is claiming that the patient has exceptional clinical circumstances;

AND

- There is sufficient evidence to show that, for the individual patient, the proposed treatment is likely to be clinically effective;

AND

- Applying the approach that the CCGs take to the assessments of costs for other treatments outside this policy, the cost to the CCGs of providing funding to support the requested treatment is justified in the light of the benefits likely to be delivered for the individual patient by the requested treatment;

AND

- There are unlikely to be further requests on behalf of patients similar to the patient for whom the request is being made (unless this is a "test case", i.e. an urgent request ahead of a commissioning policy being developed/adopted).

AND

- The IFR Panel determine that the patient is clinically exceptional to other patients (see section 3 below)

3. Determination of Clinical Exceptionality

3.1 Clinical Exceptionality means 'a person to which the general rule is not applicable'. GM sets out the following guidance in terms of determining clinical exceptionality; however the over-riding question which the IFR process must answer is whether each clinician claiming clinical exceptionality on behalf of their patient has demonstrated that his/her circumstances are clinically exceptional. A clinician together with the patient may be able to demonstrate clinical exceptionality by showing that s/he is:

- Significantly different to the general population of patients with the condition in question and as a result of that difference, they are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

NOTE*:*

- The fact that a treatment is likely to be efficacious for a patient is not a basis for exception.
- Social and/or psychological factors alone will not be taken into account to determine clinical exceptionality. However, they may be taken into account when considering all of the patient's circumstances in the round.
- In determining clinical exceptionality the patient will be compared with other patients with that particular condition, and or any other relevant peer group, and not with patients generally.
- If a patient's clinical condition matches the 'accepted indications' for a treatment that has been through a prioritisation process and has not been funded as a result of that process then their circumstances are not, by definition, clinically exceptional.
- It is the responsibility of the referring clinician, together with the patient, to provide evidence for an IFR Panel to determine whether the patient's request is clinically exceptional. The referring clinician should also provide all other relevant clinical information in support of the request when submitting an application. This is because GMSS EUR service doesn't have access to a patient's clinical records and therefore a decision will be made on the basis of the information presented to them.

4. Ongoing Treatment

4.1 Patients moving into the GM area should have their care transferred to an existing pathway as soon as clinically appropriate. Inclusion within a local pathway offers clinical benefits to patients. Where a patient is already on a waiting list for a procedure at another provider when s/he moves into the GM area, s/he should be offered the option of transferring to the local pathway. Patients may choose to maintain their position on the other provider's waiting list on the understanding that ongoing or subsequent care will be transferred to the relevant GM pathways at the appropriate time.

4.2 Patients undergoing treatment approved outside of GM will need to apply for continuing funding using the IFR process. If there is evidence of effectiveness at an individual level, even if this is not the case at a population level, then ongoing treatment is likely to be approved. Where approval was time limited or subject to evidence of effectiveness, funding approval for continued treatment would need to be sought at the end of the agreed period.

4.3 Continuation of a treatment at the end of a clinical trial will only be considered as an IFR in clinically exceptional circumstances because appropriate post trial arrangements should have been agreed in advance of the trial taking place.

4.4 Patients may access treatment in line with patient choice and if they have been receiving treatment elsewhere in the country when they move into the GM area, they can choose to remain with their existing provider outside of GM.

4.5 If an IFR Panel has approved treatment previously and has not advised of any restrictions on ongoing care, continuation of treatment can be agreed by the Clinical Triage Team if clinically appropriate. The case will be referred back to Panel if the Clinical Triage Team believes this is indicated.

4.6 Patients are entitled to request a second consultant opinion within an NHS funded clinic. Third or fourth opinions for the same clinical condition will not normally be supported unless there are extenuating circumstances.

5. Continuing or Additional Privately Funded Care

5.1 Patients have a right to revert from privately funded care to NHS funding at any point during their care, providing the treatment is routinely available. In such circumstances GMCCGs will expect their care to be transferred to NHS pathways. Where the individual is requesting funding to continue their care within the private facility, which is outside of NHS contracted arrangements, or where the treatment is not routinely available, an IFR would need to be submitted for consideration through the EUR process. Patients will need to meet the conditions for approval (see paragraph 2.6).

5.2 Relating to co-payment of treatment GM will follow the "*Guidance on NHS Patients Who Wish to Pay for Additional Private Care"* (Department of Health, 23 March 2009), the key points of which are:

- NHS organisations should not withdraw NHS care simply because a patient chooses to buy additional private care.
- Any additional private care must be delivered **separately** from NHS care.
- The NHS must never charge for NHS care (except where there is specific legislation in place to allow charges) and the NHS should never subsidise private care.
- The NHS should continue to provide free of charge all care that the patient would have been entitled to had he or she not chosen to have additional private care.
- NHS Trusts and Foundation Trusts should have clear policies in place, in line with these principles, to ensure effective implementation of this guidance in their organisations. This includes protocols for working with other NHS or private providers where the NHS Trust or Foundation Trust has chosen not to provide additional private care.

5.3 If a request is made for the continuation of a course of treatment that has been initiated privately for a treatment that is not normally commissioned, e.g. alternative therapies the request will be managed as a new request for that treatment. In the event that funding is approved this will start from the date of approval (retrospective funding will not be approved).

6. Retrospective Funding

6.1 Funding requests received relating to treatment delivered in the past will NOT be funded retrospectively or 6.2 applies.

6.2 If a case is deemed by the Clinician in charge to be too urgent to await the completion of the GM EUR process, then the provider can take the risk of commencing treatment prior to a decision being made (this only applies if requests are received by the GMSS EUR Team before the date

treatment starts). The case will then be put through due process as for any other request without those responsible for the decision knowing that treatment has commenced. The request will be managed in the same way as all other requests to ensure equity; the fact that treatment has started will not then affect the decision in any way.

7. Referral to Treatment Times (RTT)

7.1 The GMSS EUR Team is aware of the national patient access target for the NHS, which measures the patient's journey from referral to first definitive treatment, which should not exceed 18 weeks. The GMSS EUR Team will endeavour to process IPA requests to support CCGs/Trusts in achieving these targets. However, Trusts should be mindful of the timescales for consideration of requests via the EUR process (see section 10). Where possible, funding approval should be sought by the patient's GP, for treatments included within CCG EUR policies, prior to referral to NHS Trusts.

7.2 Where a clinician is submitting a funding request for consideration on the grounds of clinical exceptionality RTT will only apply once a CCG has confirmed funding approval.

8. Request Process and Stages (for Individual Funding Requests and Prior Approvals)

8.1 Acknowledgement

8.1.1 All requests for CCG approval will be acknowledged within 1 working day of receipt (as date stamped).

8.2 Checking

8.2.1 All relevant requests will be received by the GMSS EUR Team on behalf of all GMCCGs. These will be checked to ensure that they should not be sent to another commissioning organisation, e.g. NHS England (NSHE) see https://www.england.nhs.uk/commissioning/

NOTE: it is the responsibility of the referring clinician to ensure that the request is sent to the appropriate organisation. Where a clinician is unsure they should contact the relevant organisation (NHSE for example) to discuss the case.

8.3 Screening

8.3.1 Appropriate requests will be screened by the GMSS EUR Team. Applications need to contain sufficient information to allow the request to be assessed against the mandatory criteria in the policy. They will be checked for completeness and further information requested from the appropriate clinician and/or the patient where indicated. The request will then be checked against prior approval criteria, commissioning policies or commissioning decision making guidance. These will be the GM EUR policies or where applicable local policy statements inherited from local predecessor organisations.

8.3.2 If the required information has been provided and the necessary evidence is available a decision will be made at screening in accordance with GM EUR Policy criteria or local policy statements (where appropriate). Where information is missing this will be requested from the requestor and the request reviewed when this is forthcoming. However in some cases to avoid unfairly raising expectations a decision will be made on the information provided in the application submitted by the referrer.

8.3.3 Any requests clearly meeting the EUR Policy criteria will be approved and the clinician and patient will be notified within two working days of the date of the decision.

8.3.4 Any requests clearly not meeting the required EUR Policy criteria will be refused funding and the clinician and patient will be notified within two working days of the date of the decision.

8.3.5 Any request where there is doubt relating to agreed EUR Policy criteria or where clinical exceptionality is being claimed will be passed to the Clinical Triage Team for review. Where clinical exceptionality is claimed on the basis of conditions normally cited the request will be declined in line with the appropriate GMEUR policy or local policy statement.

8.4 Clinical Triage

8.4.1 The Clinical Triage Team comprises of a GP, Consultant in Public Health/Specialty Doctor in Public Health, Medicines Management lead and a representative from the GMSS EUR Team. This group convenes on a regular basis to review all requests which require clinical input and to determine if the clinical circumstances presented meet the criteria specified in the CCG EUR local Policy or GM EUR treatment policy not dealt with at the screening stage. There must be agreement by all the parties involved before a decision can be signed off. It is the role of the Clinical Triage Team to make clinical decisions in accordance with the CCG EUR local policy or GM EUR treatment policy, or where delegated authority has been given following a precedent decision made by a CCG IFR Panel. The Clinical Triage Team may not take decisions on requests which require consideration of clinical exceptionality, but may decide whether a request contains such evidence of clinical exceptionality, which would require further consideration by a CCG IFR Panel. However the Clinical Triage Team may decline a request if they feel that clinical exceptionality is not demonstrated in an individual case.

8.4.2 If the Clinical Triage Team cannot reach consensus, or there is evidence of clinical exceptionality, or this could be a precedent decision for a number of patients or the request is of a complex nature that will benefit from a full IFR Panel decision then the request will be taken to the IFR Panel of the patient's host CCG.

8.4.3 Decisions will be notified within two working days of the date of the Clinical Triage meeting.

8.4.4 The Clinical Triage Team will approve requests for ongoing care where they deem treatment to still be clinically appropriate. The case will be referred to Panel if Clinical Triage believes this is indicated.

8.5 IFR Panels

8.5.1 The exact constitution and membership of IFR Panels will be determined by individual GM CCGs. Model Terms of Reference for IFR Panels and Process Review Panels are attached as appendices 3 and 4. These Panels will be convened and resourced by the CCGs but the preparation of papers, agendas, minutes and action arising will be managed by the GMSS EUR Team.

8.5.2 Patients/clinicians will be notified of the decision within two working days of the date when the GMSS EUR Team received the approved minutes of the IFR Panel meeting. Draft minutes of the IFR Panel meeting will be forwarded to the IFR Panel Chair for approval, within 2 working days of the IFR Panel meeting.

8.5.3 Details of all decisions made at screening and Clinical Triage for routine and urgent requests will be made available to all CCG IFR Panel meetings; the management information report will be a standing item on the agenda

8.5.4 Patients are not able to attend an IFR Panel to present their case.

8.5.5 Decisions will be notified within two working days of the date of the minutes being ratified by the Chair of the IFR Panel.

8.6. Urgent requests / priority cases

8.6.1 The GMSS EUR Service identifies an urgent request as one where a failure to provide the specifically requested treatment within 72 hours will have very serious negative consequences for the patient. In these requests, the provider may initiate treatment whilst awaiting a funding decision (the IFR Panel will assess the request without knowing that treatment has commenced) or when a provider believes the IFR request requires a quick decision (i.e. before the next meeting of the CCG IFR Panel) and where the GMSS EUR Clinical Triage Team believes the Trust has appropriately managed the request and it genuinely cannot wait until the next CCG IFR Panel meeting.

Note: if the request requires a quick decision because, in the view of the GMSS EUR Clinical Triage Team the Trust has not appropriately managed the request (i.e. given the patient a date for surgery before asking whether or not funding is available) the Trust will need to act in good faith and carry the financial risk of the request being declined and the request will be handled in the usual way.

8.6.2 The GMSS EUR Service has agreed with each GMCCG a process for handling urgent requests that require IFR Panel consideration.

8.6.3 Priority cases are those where a treatment needs to be given within a certain timeframe that does not allow enough time for the request to be prepared for panel consideration. **NOTE:** This excludes those cases where treatment has been booked prior to authorisation being received**.**

Where a clinician has stated that a case requires an urgent response but that case does not meet the GM EUR definition of urgent i.e. intervention within 72, then provided a clinical case has been made by the referring clinician that case will treated as a priority case. Cases where the GMSS EUR Team whilst screening the request is of the opinion that a request is time sensitive this will then be prioritised.

Examples are:

- Drugs needed for severe cases of the disease being treated.
- Eating disorders where there is rapid weight loss or the BMI is dangerously low.
- EEA/Cross Border Team requests that have a short response time attached to them.
- Negative Pressure Wound Therapy (NPWT/VAC).
- IVF if female is nearing the age cut-off for accessing the treatment and delay in processing will prevent treatment starting before the cut-off date.
- Mental health cases (not excluded from the service) where a place of safety is needed.

8.7 Clarification of the IFR process – meetings with patients

8.7.1 At any stage during the process of considering a funding request, the patient can ask for an informal meeting with the GMSS EUR Team and the relevant PALS/Patient Services if appropriate, who can advise the patient of the process. This is a non-clinical meeting and the GMSS EUR team are unable to discuss clinical aspects of the case. Patients may bring someone along to provide support.

9. Appeal Process

9.1 If the requesting clinician feels that not all the available evidence has been considered when the decision was made they can ask for the request to be reconsidered at any stage of the process (with the exception of when an IFR Panel made the decision – see below). The requesting clinician should include his/her grounds for appeal. Appeals will not be accepted simply because the requesting clinician and/or the patient disagree with the decision, unless they are of the opinion a key piece of information has not been taken into consideration. Should new information/evidence

be submitted then the request will be reconsidered by the GMSS EUR Team. NOTE: Appeals against a decision made by an IFR Panel cannot be considered as an IFR Panel decision is final; however, if further information is submitted which the IFR Panel has not considered then a case will be reviewed and if this information has not been previously considered will be referred back to an IFR Panel in order for further consideration.

9.2 Where a case has been declined by a CCG IFR Panel a clinician can request a Process Review to determine whether the process outlined in this document has been followed. The request for a Process Review should clearly indicate which element of the process wasn't followed and/or which piece of evidence wasn't considered when the IFR Panel reached their conclusion.

9.3 It is the responsibility of the relevant CCG to convene and resource the Process Review Panel within 3 months of receiving a written request for a Process Review from a clinician. If the patient or clinician request the Process Review to be re-arranged or a conflict of interest is discovered, the CCG will have 3 months to reconvene and resource the Process Review Panel from the date of this being notified to the CCG. The CCG will however make every effort to reconvene as soon as possible. The GMSS EUR Team will provide all the required information, prepare the papers and support the CCG Process Review Panel meeting.

9.4 The role of the CCG Process Review Panel is to review the request and the actions taken at each stage, to ensure that the process described in the GM EUR Operational Policy has been followed and all relevant actions taken. It is not the role of the CCG Process Review Panel to make a further funding decision in respect of the request.

9.5 Should the CCG Process Review Panel decide that due process had been followed, and the IFR Panel decision stands, there will be no further recourse of appeal within the CCG. If the CCG IFR Panel did not follow due process, it will return the request to the CCG IFR Panel to address any issues identified by the Process Review Panel.

9.6 This process does not in any way affect the individual's right to seek redress via alternative routes (e.g. the Parliamentary and Healthcare Ombudsman, Judicial Review).

9.7 Any new funding request for the same condition/treatment that has previously been considered by an IFR Panel must contain new clinical information e.g. a change in severity of symptoms. The new funding request will be reviewed against the previous request by the Clinical Triage Team and if it does not contain any new clinical information the request will be rejected and closed and will not progress through the EUR Process.

10. Timescales

10.1 All requests for CCG approval will be acknowledged within 1 working day of receipt (as date stamped).

10.2 The timescales below are for a first decision and excludes the time taken to process any appeals. An appeal against a decision to decline funding will be processed in accordance with Section 9 of this policy. The timescales below do not cover requests being submitted to the incorrect organisation for consideration (e.g. requests sent to CCGs for consideration rather than NHS England or vice versa).

For treatments/procedures that require IPA the GMSS EUR Service will process these within 28 operational days following the date the request was received, subject to the timely provision of all of the information specified within a Prior Approval Scheme. Treatment must not commence until the provider has received written notice of funding approval (see section 7.2).

For treatment/procedures where funding is being requested on the grounds of clinical exceptionality (IFR) the GMSS EUR Service will process these within 90 operational days following

the date of the request was received, subject to the timely provision of all of the information specified within a Prior Approval Scheme. Treatment must not commence until the provider has received written notice of funding approval (see section 7.2).

10.3 If the additional information is not received within 15 working days of the date the additional information had been requested, then a decision will be made on the basis of the information available or the file closed if there is insufficient information to reach a decision. However a clinician and/or the patient may contact the service and request an extension to the timescales to allow the further information to be submitted.

11. Implementation and Process Improvement

11.1 The GMSS Head of EUR in partnership with the Chairpersons of the CCG IFR Panels is responsible for implementing the GM EUR Operational Policy and GM policies related to drugs, procedures and devices, and for EUR decision making and budgetary control.

11.2 A review of EUR decisions will be performed intermittently by the GMSS EUR Service, providing an assurance process to decision-making arrangements, and to enable learning to be incorporated into reviews of the standards set in this process.

11.3 A GMCCG may request an audit of EUR decisions undertaken on their behalf by the GMSS EUR Service. Such audits would be organised by the CCG using their internal audit processes. Requests should be submitted to the GMSS EUR Team Manager.

12. Policy Development

12.1 Within the GMSS EUR service there is a Policy Development Team that will support the development and implementation of commissioning Policy Recommendations at a GM level. This area of work will be overseen by the GM EUR Steering Group on behalf of the GMCCGs. The Policy Development Team will manage an ongoing programme of work, which has been prioritised by the GM EUR Steering Group. The Terms of Reference for the GM EUR Steering Group are detailed at Appendix 5. This work schedule will be reviewed on a bi-monthly basis by the GM EUR Steering Group to allow insertion of any high priority or pressing issues. Any urgent policy requirements may also be prioritised by the GM EUR Steering Group outside of scheduled meetings via email.

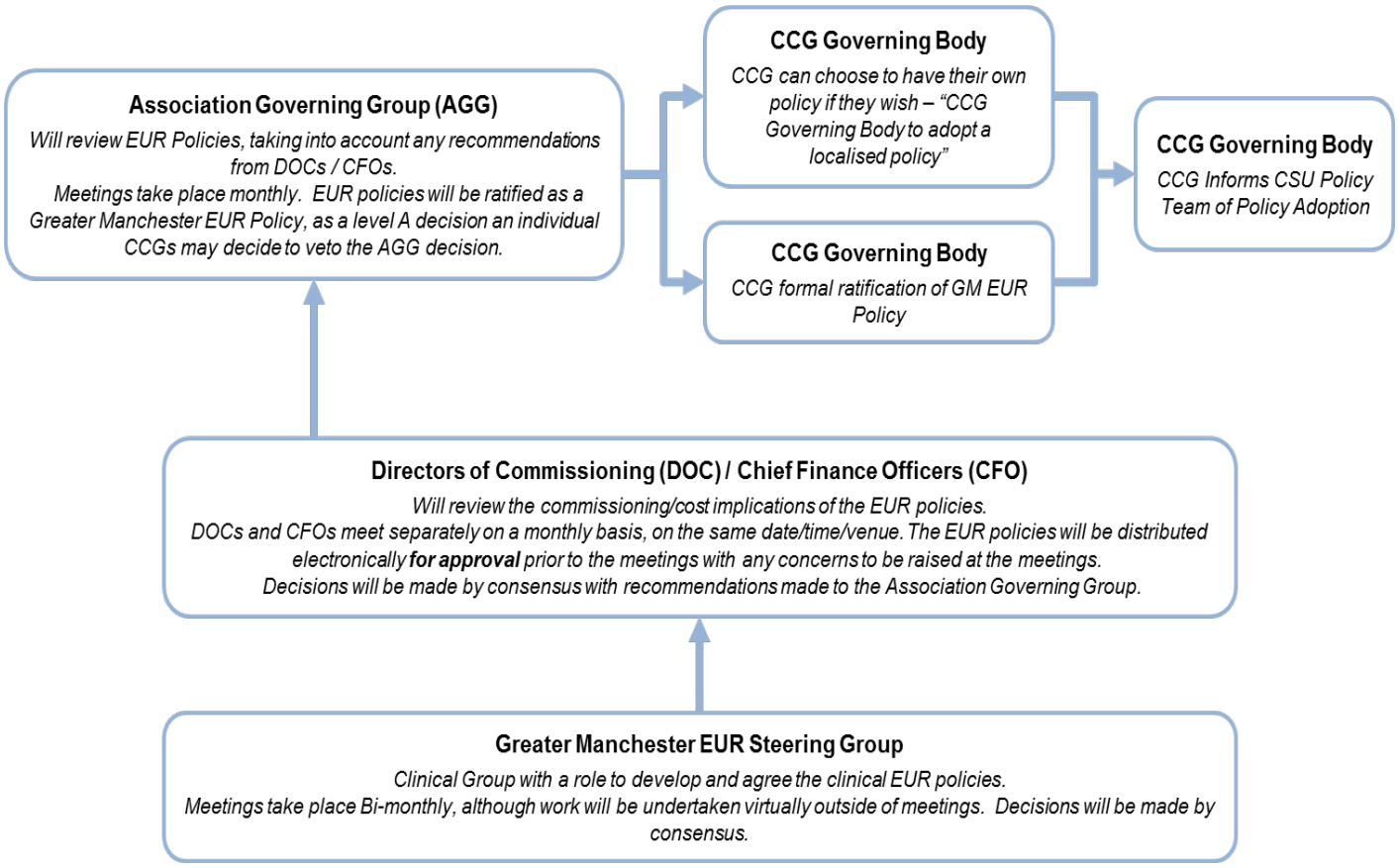
12.2 An initial work schedule was produced by the Policy Development Team from the list of inherited policies (those developed by GM PCTs and adopted by their successor GMCCGs). The rationale for prioritisation of policies for development by the GM EUR Steering Group has predominantly been driven by the inherited variation of local CCG policies particularly, those where there are large numbers of funding request received or which are considered to be contentious. Now the majority of the variations have been addressed and GM EUR policies are in place the GM EUR Steering Group will work with CCG Directors of Commissioning (DOC) and Chief Finance Officers (CFO) to identify future GM EUR policies for development.

New topics will be prioritised by the GM EUR Steering Group and added to the work plan as each policy is finalised. The GMSS EUR screening and Clinical Triage process will continue to identify new topics to be added to the list of potential policies to be developed. Horizon scanning will also be undertaken to determine any potential high priority policy requirements. A maximum of 8 GM Policy Recommendations will be under development at any one time to allow time for regular review of existing GM EUR policies.

12.3 When 5 or more similar requests for treatments are received from clinicians these will either be identified to CCG commissioning leads for possible service development or added to the list of topics for policy development. The length of time taken to reach 5 requests will affect the priority of the topic on the policy development list – 5 in 6 months will have a higher priority than 5 in 6 years.

12.4 GM EUR Policy Recommendations will be formally agreed by the GM EUR Steering Group. Once a GM EUR Policy Recommendation has been formally agreed by the GM EUR Steering Group the policy will be sent to Mersey Internal Audit Agency to identify which procedure and diagnostic code are relevant to the policy. GM EUR Policy Recommendations that have been formally agreed by the GM EUR Steering Group will be considered by GM DOC/CFOs. GM DOC/CFOs meet on a monthly basis and will consider the cost/commissioning implications of the proposed policy. For joint decisions, the DOC/CFO Chairs will liaise and agree the recommendations to the Association Governing Group (AGG). EUR Policy Recommendations will be ratified by the AGG as a GM policy, taking into account any recommendations from GM DOC/CFOs. CCGs may choose to veto the AGG decision, which will allow them to consider GM EUR Policy Recommendations through their own governance route, or to implement alternative policies that it has developed through its own mechanisms. GM EUR Policy Recommendations once ratified by the AGG will be formally ratified through individual GM CCG governance arrangements, following which they will replace local CCG policy for that treatment/procedure. Any future requests for that treatment/procedure will be assessed against the GM EUR policy. CCGs will be required to inform the GMSS Policy Team when the policy has been ratified through their governance process. Where a CCG choses to veto an AGG decision, the CCG will be required to inform the GMSS Policy Team of the decision taken following their internal consideration of a GM Policy Recommendation and provide a copy of their policy, if the GM Policy Recommendation has not been adopted in full. Any future funding requests will then be managed in accordance with the CCG policy. Where a GM EUR Policy Recommendation has not been adopted in full, the policy would become a local CCG policy and any reference to GM should be removed.

The flowchart below highlights the governance arrangements that will be taken for each GM EUR Policy Recommendation



12.5 For each policy a full literature and evidence review will be undertaken as well as an equality analysis. A description of epidemiology and need may also be provided, where appropriate, along with an economic assessment. Based on the evidence the commissioning policy statement will be drafted and where appropriate criteria for access to the service or treatment will be developed. The development of new GM Policy Recommendation will also draw on the information contained in inherited PCT policies unless there is a more up to date source.

12.6 GM Policy Recommendations will be approved by the GM EUR Steering Group, prior to being published for a period of clinical engagement. Feedback from the period of clinical engagement will be fed into the policy development, as appropriate; before the final Policy Recommendation is agreed by the GM Steering Group for consideration by the GM DOC/CFOs and the AGG.

12.7 GM EUR Policy Recommendations will be reviewed one year from the date of approval by the AGG and thereafter at a date agreed by the GM EUR Steering Group unless new evidence warrants earlier review (see section 13 – Policy Review).

12.8 The GM EUR Steering Group may review GM EUR Policies within the timeframe for review, following the release of new national guidance, e.g. NICE.

12.9 Appeals against a GM EUR Steering Group policy on the basis of the evidence used (either because it is believed that insufficient evidence was taken into account or there is new evidence available) will be reviewed by the GM EUR Steering Group and depending on the nature of the appeal; a policy revision may be undertaken. Such policy reviews will be prioritised alongside other policies requiring development.

12.10 GM EUR Steering Group members will be responsible for ensuring their respective CCGs are fully engaged with the policy development at the clinical engagement stage and for ensuring their CCG's views are represented. GM EUR Steering Group members will also be responsible for driving the consideration of GM Policy Recommendations within their CCG. GM EUR Policy Recommendations will be presented to the GM DOC/CFOs, and the AGG by a nominated CCG EUR sponsor.

12.11 The Clinical Governance structures of the AGG and the CCGs will be used to provide the required quality assurance for this area of work.

13. Policy Review

13.1 GM EUR Policy Recommendations will be reviewed one year from the date of approval by the AGG and thereafter at a date agreed by the GM EUR Steering Group unless new evidence warrants earlier review (detailed in section 12).

13.2 The GMSS Policy Team will review the related evidence and inform the GM EUR Steering Group of the outcome of this review. The GM EUR Steering Group will decide if there is substantial new evidence to support a full policy review. Policies requiring a full review will be prioritised by the GM EUR Steering Group against other policies that may require development and will follow the GM EUR Policy Development Process.

13.2 The GM EUR Steering Group may decide, based on the outcome of the evidence review, that the GM EUR Policy Recommendation remains current and recommend that the policy is reviewed again after an agreed period of time or amended or withdrawn. If the GM EUR Steering Group feel there is a significant change to what can and cannot be commissioned in the policy, the policy will go out for a further period of clinical engagement and then go through the CCG governance process again for approval.

14. Delivery Outputs

14.1 Delivery Outputs from the EUR Policy Development Process:

- Support to GMCCG Commissioners with the production of a GM EUR policy - Benchmarking report to assist commissioners in determining the effectiveness of adherence/compliance to GM EUR policies.
- Support to GM Primary Care clinicians with the production of summary GM EUR policies and treatment specific funding request forms to be upload to their clinical systems.
- Support to GMCCG Contract Leads with the production of the EUR Schedules and in year Contract Variations.

Appendix 1: Ethical Framework

The Ethical Framework is the tool that underpins decision making in priority setting, both for policy-making and when considering individual patients' requests for funding of treatments 'not normally funded' by the GMCCGs.

Evidence of clinical and cost effectiveness

The GMSS EUR Team will seek to obtain the best available evidence of clinical and cost effectiveness using robust and reproducible methods. Methods to assess clinical and cost effectiveness are well established. The key success factors are the need to search effectively and systematically for relevant evidence, and then to extract, analyse, and present this in a consistent way. Choice of appropriate clinically and patient-defined outcomes needs to be given careful consideration, and where possible quality of life measures and cost utility analysis should be considered.

The GMCCGs will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients and will not normally commission a treatment unless it has been shown to be clinically effective.

Issues such as safety and drug licensing will also be carefully considered. When assessing evidence of clinical effectiveness the outcome measures that will be given greatest importance are those considered important to patients' health status. Patient satisfaction will not necessarily be taken as evidence of clinical effectiveness. Trials of longer duration and clinically relevant outcomes data may be considered more reliable than those of shorter duration with surrogate outcomes. Reliable evidence will often be available from good quality, rigorously appraised studies. Evidence may be available from other sources and this will also be considered. Patients' evidence of significant clinical benefit is relevant.

When weighing the relative priority of different treatments the GMCCGs will consider the strength of health benefit; the size of any potential health benefit (deaths prevented, quality of life years gained) and the probability of individual and population health benefit.

The GMCCGs will compare the cost of a new treatment to the existing care provided and will also compare the cost of the treatment to its overall benefit, both to the individual and the community. They will consider technical cost-benefit calculations (e.g. quality adjusted life years), but these will not by themselves be decisive. The GMSS EUR Team and CCG IFR Panels may use the ethical framework to guide context-specific judgment about the relative priority that should be given to each topic.

In considering very high cost interventions, the GMCCGs may conclude that an intervention is not cost effective even if it is proven to be clinically effective in saving or extending the lives of patients. Where a decision is made that a high cost intervention is not to be routinely funded, the GMCCGs via the GMSS EUR Team and IFR Panels will always consider the exceptional circumstances of an individual request for a high cost intervention.

Equity

GMCCGs believe that people should have access to health care on the basis of need. There may also be times when some categories of care are given priority in order to address health inequalities in the community. However, save as set out below, the GMCCGs will not discriminate on the grounds of personal characteristics, such as age, gender, sexual orientation, gender identity, race, religion, lifestyle, social position, family or financial status, intelligence, disability, physical or cognitive functioning. In some circumstances the above factors may be relevant to the clinical effectiveness of a proposed treatment or the cost effectiveness of an intervention. These factors, along with other medical conditions from which a patient is suffering, may affect the capacity of an individual or groups within the population to benefit from the treatment. In such circumstances, as an exception to the above policy, the GMCCGs are entitled to limit access to defined treatments by reference to some of the above factors.

Health care need and capacity to benefit

Health care should be allocated justly and fairly according to need and capacity to benefit, such that the health of the population is maximised within the resources available. The GMCCGs will consider the health needs of people and populations according to their capacity to benefit from health care interventions. So far as possible, they will respect the wishes of patients to choose between different clinically and cost effective treatment options, subject to the support of clinical evidence. This approach leads to three important principles:

In the absence of evidence of health need, treatment will not generally be given solely because a patient requests it.

A treatment of little benefit will not be provided simply because it is the only treatment available.

A treatment which effectively treats 'life-time' or a long-term condition is considered equally to urgent and life prolonging treatments.

Cost of treatment and opportunity costs

The GMCCGs are required by the Health and Social Care Act 2012 not to exceed their annual budget. The GMCCGs therefore have a legal duty to take account of the cost of treatment. The cost of treatment is significant because investing in one area of health care inevitably diverts resources from other uses. This is known as opportunity costs and is defined as benefit foregone, or value opportunities lost, that would accrue from the notion of scarcity of resources. Prioritisation decisions must be taken with full consideration of the consequences for funding other priorities.

Needs of the community

One of the GMCCGs' key objectives is to make decisions to improve the health of its population and reduce health inequalities. Some of these decisions are promoted nationally. Others are produced locally and should be made with reference to local Joint Strategic Needs Assessment and local public engagement processes. Sometimes the needs of the community may conflict with the needs of individuals. There can be difficult decisions where an individual patient needs a considerable investment to support their health but where the same money could be used to greater overall effect for a group of patients, and the GMCCGs cannot afford both sets of treatment.

Policy drivers

The Department of Health issues guidance and directions to NHS organisations.

Directions require the GMCCGs to give priority to some categories of treatment for some patients. The CCGs are legally required to consider (but not necessarily implement in full) Department of Health Guidance. Both directions and guidance may affect the way in which health service resources are allocated by the GMCCGs.

Clinical exceptional need

It is good practice not to impose a blanket ban on any treatment, GMCCGs recognise that there may be requests in which a patient has exceptional clinical circumstances which may justify funding for treatment that is denied to other patients. Each request of this sort will be considered on its own merits in the light of the clinical evidence. The GM EUR operational policy outlines the procedures that are in place to consider such requests that a referring clinician considers to be clinically exceptional, on their individual merits.

Appendix 2: Governance and Accountability

GMCCGs retain overall responsibility for the effective use of resources and for the availability, implementation and resourcing of an IFR process.

GMSS is under a contractual agreement with the CCGs in GM to manage the EUR/IFR process on behalf of the CCGs.

The GMSS EUR Team will manage all requests in line with the GM EUR Operational Policy and will further support that process through the development of commissioning policies for procedures of limited clinical effectiveness and services not currently included in contracts, which result in IFR requests. These policies will be based on the best available evidence of effectiveness and will be reviewed regularly (see section 11 of the GM EUR Operational Policy).

GMCCGs will retain responsibility for ensuring they have effective IFR Panels and a process for convening and delivering a Process Review Panel when required.

Ultimate responsibility in the case of a judicial review rests with the CCG.

The GMSS Head of EUR will ensure that the GMSS EUR Team adheres to set standards for making decisions in a timely way. The length of time taking to reach a decision can vary depending on the individual complexities of each case.

The GMSS EUR Team will provide a summary of all funding decisions on individual requests to the relevant CCG IFR Panels and will flag up through the Governance arrangements any issues that may have implications for wider GMCCG policy, particularly candidates for service developments.

The GMSS EUR Senior Officers will produce a monthly report summarising the outcomes of relevant decisions to the IFR Panels.

All funding decision letters will outline the reasons for the decision that has been made.

If patients, or referring clinicians, feel that they have been dealt with unfairly, they can ask for a review of the decision making process.

The recording of reasons for decisions made by the relevant teams at each stage of the process, including the minutes of the relevant IFR Panel, are available on request by the individual concerned in accordance with the Data Protection Act 1998) subject to any exemptions that may be applicable to the disclosure).

It is the responsibility of the GMSS Head of EUR to ensure that the GMSS EUR Team meets the required competencies for their roles, and has access to appropriate training to maintain their competence.

Training of IFR Panel members and Process Review Panel members will be the responsibility of the individual CCGs.

The GM EUR Steering Group (see Appendix 5) has oversight for the development of all EUR Policy Recommendations on behalf of the CCGs.

The AGG will ratify GM EUR Policy Recommendations as a Level A decision. However, CCGs may choose to veto this decision, which will allow them to locally ratify GM EUR Policy Recommendations through their own governance route, or to implement alternative policies that it has developed through its own mechanisms.

Appendix 3: Example Terms of Reference for a CCG Individual Funding Request Panel

(Please refer to individual GM CCG's own ToR)

Purpose

The CCG IFR Panel will meet monthly to review requests for funding for treatments not currently covered by commissioning arrangements or for treatments excluded from those arrangements

The Panel will adopt a consensus approach to decision making where unanimous view cannot be reached on an individual request.

The Panel will consider requests on an individual named basis for treatments either not covered by commissioning arrangements or where a treatment is specifically excluded from those arrangements.

The Panel will be responsible for assessing the clinical effectiveness of the procedure and then the cost effectiveness of the requested treatment based on the evidence available to them at the time. For requests where a treatment is excluded from commissioning arrangements the Panel will review the evidence to determine whether or not the request under consideration is exceptional and should therefore have access to that treatment funded by the NHS.

Membership

- General Practitioner representative
- 2 additional members with a clinical background
- Finance representative
- Medicines Management representative
- Public Health representative
- Lay representative (expert patient/patient participation)
- A Senior Commissioner from the CCG

The Chair of the Panel will be determined by the CCG lead.

The Panel may co-opt additional members (with or without voting rights as deemed necessary) when required, particularly when specialist expertise is needed and may be establish as sub group to deal with decisions that may include co-opted members, Where a person is to be co-opted onto the Panel for the purposes of participating in any of its meetings the decision to co-opt that individual (along with whether or not he or she may have voting rights) shall be put to a vote of the regular voting members at the start of the relevant meeting.

Administrative support

Meetings will be arranged and resourced by the CCG and managed by their nominated lead officer.

Preparation of agendas and all request papers, recording the outcomes of the meeting, taking any actions arising and ensuring letters are sent to the requesting clinician and patient within agreed timescales is the responsibility of the GMSS EUR team on behalf of the CCG.

Ensuring a suitable venue is available is the responsibility of the CCG lead for IFR.

Quoracy

At least 4 members of the Panel should be present, one of which should be medically qualified, e.g. a doctor and one clinically qualified, e.g. nurse, allied health professional etc.

Chairs action / urgent decisions

In clinically urgent situations a request may be considered in advance of the Panel using the mechanism agreed in the GM EUR Operational Policy/Standard Operating Procedures.

Training of IFR Panel members

Training of IFR Panel members is the responsibility of the CCG but will be supported by the GMSS EUR Team.

Members should attend at least one meeting per quarter to maintain continuity and expertise.

Confidentiality

All requests will treated as highly confidential as the majority will contain sensitive and/ or clinical information.

Papers will be sent to members via either registered post or a secure e-mail service, e.g. NHS.net.

Consent will be obtained from the patient prior to the meeting.

All confidential papers will be gathered for shredding at the end of the meeting.

Review

These terms of reference will be reviewed annually or sooner if there are relevant changes in legislation or local/national guidance.

Appendix 4: Example Terms of Reference for a CCG Process Review Panel
(Please refer to individual CCG's own ToR)

Purpose

The CCG Process Review Panel will meet on an adhoc basis when a clinician acting on a patient's behalf has appealed a Panel decision and they have not submitted additional evidence which would require the request to be further considered by the IFR Panel in accordance with the EUR Process.

The Panel will meet in private but the patient and or a representative will be asked to attend to ensure that their views are fully accounted for. A member of the original IFR Panel will attend the Process Review Panel to present the case and answer any questions.

The Panel will adopt a consensus approach to decision making where a unanimous view cannot be reached. If consensus cannot be reached on any point the decision of the chairperson will be final.

The Panel will consider each stage of the process that the request has gone through to ensure that all reasonable attempts have been made to find relevant evidence of effectiveness and that all aspects of the request have been considered in the round.

The Panel should assure itself that all stages of the process have been recorded.

The Panel is there to decide if due process has been followed and to identify any areas where further consideration needs to be made if any.

It is not the role of the CCG process review Panel to make a further funding decision or overturn the IFR Panel decision; however, it may return the request to the IFR Panel to address any issues identified following the process review.

Panels may consider more than one request at a time provided there is sufficient time for each request to be dealt with fully.

Membership

The chair of the CCG process review Panel will be the lay person representing the CCG provided they have had the necessary training, if not an alternative chair must be agreed prior to the meeting.

- Lay representative of the CCG
- General Practitioner member of the CCG commissioning group (not currently a member of the IFR Panel)
- A representative of the CCG board (in addition to the GP representative)
- The CCG Accountable Officer
- A Public Health Consultant

Panel members may cover more than one of these representative functions, e.g. the lay representative could also be the Board representative if one of the Non-Executive Directors is nominated.

All CCG Process Review Panel members must not have been involved in any of the IFR decision making stages.

Administrative support

Meetings will be arranged and resourced by the CCG and managed by their nominated lead officer.

Preparation of agendas and all request papers, recording the outcomes of the meeting, taking any actions arising and ensuring letters are sent to the requesting clinician and patient within agreed timescales is the responsibility of the GMSS EUR Team on behalf of the CCG.

Ensuring a suitable venue is available is the responsibility of the CCG lead for IFR.

Quoracy

All members of the Panel must be present.

Training of Process Review Panel members

Training of IFR Panel members is the responsibility of the CCG but will be supported by the GMSS EUR Team.

CCG Process Review Panel members should ensure that they have received adequate and appropriate training.

Confidentiality

All appeals will treated as highly confidential as the majority will contain sensitive and/or clinical information.

Papers will be sent to members via either registered post or a secure e-mail service (NHS net).

Consent will be obtained from the patient prior to the meeting.

All confidential papers will be gathered for shredding at the end of the meeting.

Review

These Terms of Reference will be reviewed annually or sooner if there are relevant changes in legislation or local/national guidance.

Appendix 5: Terms of Reference – Greater Manchester Effective Use of Resources (EUR) Steering Group

Purpose

The Greater Manchester Effective Use of Resources Steering Group (GMEURSG) has been established to support Greater Manchester Clinical Commissioning Groups (GMCCGs) to deliver quality healthcare by developing policy recommendations for the purpose of managing access to healthcare interventions that are unlikely to be clinically effective, or should only be performed in specific circumstances.

Responsibilities

The GMEURSG **will**:

- Manage a GM EUR work programme.
- Prioritise specific policies for development.
- Produce EUR guidance and Policy Recommendations for GMCCGs, including input into policy development and final approval.
- Drive the consideration of GM Policy Recommendations within GMCCGs.
- Make policy recommendations on non-prescribeable devices in collaboration with the Greater Manchester Medicines Management Group (GMMMG) as Clinical Standards Board for Medicines.

The GMEURSG **will not**:

- Make policy or commissioning decisions on behalf of GMCCGs.
- Make Policy Recommendations on drugs/medicines (this falls under the responsibility of GMMMG.
- Make Policy Recommendations on interventions covered by a relevant specialist commissioning policy (this falls under the responsibility of NHS England's national specialist commissioning teams).

Membership

The GMEURSG is a clinical decision making group working on behalf of GMCCGs and members will need to have delegated authority from their individual CCG.

The GMEURSG will seek representation from all GMCCGs and the membership will consist of:

- Chair (GP EUR / IFR Panel Chair)
- Representatives of GMCCGs (IFR Clinical Panel Chairs/Members)
- Representatives of GM Shared Services (GMSS)

Each member of the group is nominated by the relevant CCG with the understanding that those nominated should be recognised by their respective organisation as representing their views.

Deputising arrangements

- Each CCG **must** appoint a nominated deputy to attend meetings on their behalf. Members must send a representative, preferably with a clinical background, and appropriate authority and experience, wherever possible, if they are unable to attend. If a CCG is unable to send a clinical representative to the meeting, any decisions taken at the meeting will need to be ratified by the CCG's clinical representative after the meeting, as per the arrangement for a meeting that is not quorate.

- In the absence of the Chair, the meeting will be chaired by the Deputy Chair. The Deputy Chair should be a clinical professional elected by the group.

Responsibilities of individual members and deputies

- Accept ownership of GMEURSG decisions.
- Undertake work, as necessary, between meetings, including the review of policies during the development phase.
- Promote communication between the GMEURSG and relevant GMCCG colleagues, including the GM Association of CCGs.
- Take specific views, as appropriate, from the GMEURSG to individual GMCCGs for comment and feed the responses back.
- Commit to regular attendance of GMEURSG meetings to ensure continuity and balance of input into decision making.
- Be an enthusiastic, motivated and active participant in the GMEURSG.

In attendance

Other individuals may be invited to attend the meeting for the purpose of providing advice and/or clarification to the group, for example:

- Secondary care clinicians
- Specialist commissioning representatives
- Clinical network representatives
- Health economic specialists representatives
- GMCCG commissioning representatives

Quorum

For the group to be quorate it will require every CCG to be present and represented at each meeting. Where quoracy cannot be achieved, due to unexpected events, the Chair may decide to proceed with the meeting and ratify any decisions outside of the meeting. In such circumstances, the chair will seek the views of the absent party in order to ratify the decisions taken. It is the chair's responsibility to liaise with the GMSS EUR Policy Team to record such decisions.

Membership of the group will be reviewed annually.

Meeting frequency

The group will meet bi-monthly. Ad-hoc meetings may be arranged as required.

Communication

Draft minutes and recommendations will be circulated following the meeting to members and ratified in the subsequent meeting. Any inaccuracies within the minutes should be communicated prior to the subsequent meeting, where possible.

Decision making

- Decisions will be made following a full evidence review of the intervention. The group will take into consideration evidence of clinical effectiveness, safety and patient benefits.

- The group believes that health care should be allocated justly and fairly, according to need and the capacity to benefit, such that the health of the population is maximised within the resources available. This means that a treatment of little or no, benefit will not be recommended for commissioning, simply because it is the only treatment available.
- The group will take a consensus approach to decision making where a unanimous view cannot be reached.
- Where there is limited or ambiguous evidence or the topic is clinically controversial, specialists in a particular field may be co-opted to offer expert advice for specific meetings when required, e.g. clinical specialists or health economists. This is at the discretion of the group members and is dependent on the particular intervention being discussed.
- If any upcoming interventions are of particular interest to clinicians, then a written report summary on the new intervention can be submitted for prioritisation by the group. A copy of the report must be received by the GMSS EUR Policy Team two weeks prior to the meeting of the group.
- Reviews: GM EUR Policy Recommendations will be reviewed one year from the date of approval by the AGG and thereafter at a date agreed by the GM EUR Steering Group unless new evidence warrants earlier review.

Declaration of conflict of interest

Members will be expected to declare any conflicts of interests and/or an unusual interest or specialist knowledge of a particular area at all meetings and the chair will determine how those discussions will be conducted.

National Institute for Health and Care Excellence (NICE) Guidance

Where a policy statement is subsequently superseded by new NICE Clinical Guidance, the policy statement will be reviewed in line with the new NICE recommendation.

Challenge to policy

All challenges to Policy will be considered by the GMEUR Steering Group.

Appeals against a GMEUR Steering Group policy statement on the basis of the evidence used (either because it is believed that insufficient evidence was taken into account or there is new evidence available) should be directed to the GMSS EUR Policy Team at policyfeedback.gmcsu@nhs.net. Such appeals will be reviewed by the GM EUR Steering Group and depending on the nature of the appeal; a policy revision will be undertaken. Such policy revisions will be prioritised alongside other policies requiring development.

Reporting

The GMEURSG is accountable to the GM Association Governing Group (AGG). Reports containing details of GM EUR policy recommendations that have been developed; along with adoption by each CCG will be provided routinely.

Reporting to the group

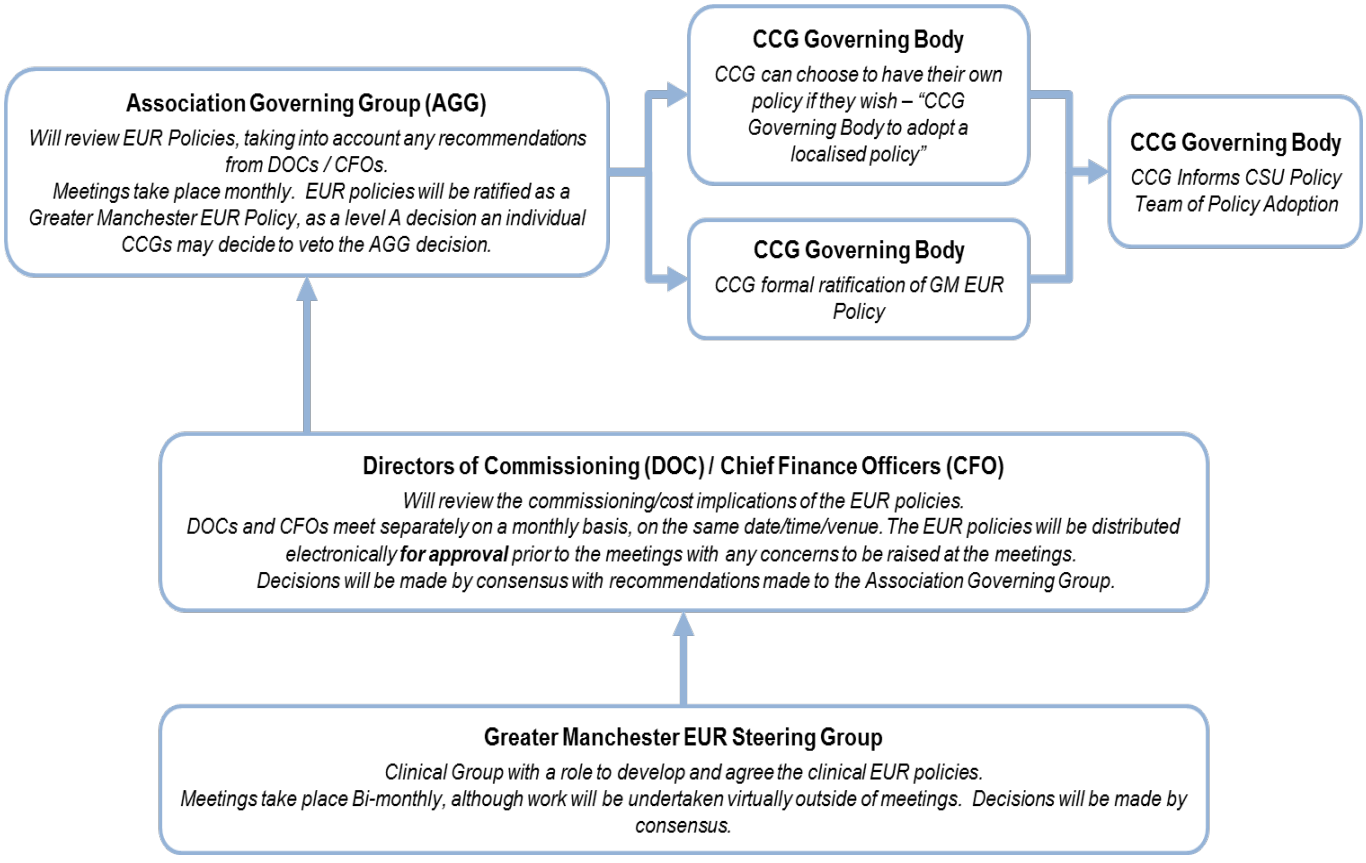
Any sub-group established to undertake business as required, will be accountable to and report to the GMEURSG.

Governance

- GM EUR Policy Recommendations will be formally agreed by the GMEURSG.
- GM EUR Policy Recommendations that have been formally agreed by the GM EUR Steering Group will be considered by GM Directors of Commissioning (DOC)/Chief Finance Officers (CFO). GM

DOC/CFOs meet on a monthly basis and will consider the cost/commissioning implications of the proposed policy. For joint decisions, the DOC/CFO Chairs will liaise and agree the recommendations to the AGG.

- GM EUR Policy Recommendations will be ratified by the AGG as a GM EUR Policy, taking into account any recommendations from GM DOC/CFOs.
- GM EUR Policy Recommendations once ratified by the AGG will be formally ratified through individual CCG governance arrangements, following which they will replace any local CCG policy for that particular treatment or procedure and any future requests for that treatment will be assessed against the GM EUR Policy Recommendation. CCGs will be required to inform the GMSS EUR Policy Team when the policy has been ratified through their governance process.
- CCGs may choose to veto the AGG decision, which will allow them to consider GM EUR Policy Recommendations through their own governance route, or to implement alternative policies that it has developed through its own mechanisms. Where a GMCCG choses to veto an AGG decision, the CCG will be required to inform the GMSS EUR Policy Team of the decision taken following their internal consideration of a GM Policy Recommendation and provide a copy of their policy, if the GM Policy Recommendation has not been adopted in full. Any future IFRs will then be managed in accordance with the GMCCG policy. Where a GM EUR Policy Recommendation has not been adopted in full, the policy would become a local GMCCG policy and any reference to GM should be removed.
- The flowchart below highlights the governance arrangements that will be taken for each GM EUR Policy Recommendation:



Administrative support

- Administrative support, relating to the scheduling of meetings and associated room bookings; ensuring that the meetings are quorate and the cancellation of meetings, where necessary, will be provided by the GMSS EUR Policy Team.

- The GMSS EUR Team will provide administration support for each meeting, this includes: the preparation and dissemination of agenda and papers in advance of the meeting; attendance at each meeting to present policy statements; production of formal minutes to record the decisions taken by the group, and undertaking any necessary actions required by the group.
- Any queries relating to GM Policies will be handled by the GMSS EUR Policy Team.

Media enquiries

All media enquiries relating to outputs from the GM EUR Steering Group will be dealt with by the Chair of the Group and the GMSS Head of EUR with support from the GMSS Communications Team.

Date TOR agreed

August 2013

Date last updated

November 2017

Glossary

Term	Definition
Annual commissioning process	Is the process by which major funding decisions are taken, including the allocation of new money coming into the NHS. This involves a complex process of prioritisation informed by a series of decisions.
Clinical effectiveness	A measure of the extent to which a treatment achieves pre-defined clinical outcomes in a target patient population.
Clinical Exceptionality	Described in this document means 'a person to which the general rule is not applicable'.
Clinical Triage	A clinical team which is part of the GMSS EUR service that will consider the appropriateness of funding an IFR/IPA on behalf of GMCCGs.
Cost effectiveness	An assessment as to whether a healthcare intervention provides value for money.
Effective Use of Resources	An aim to secure the greatest health gain from the resources available for the local population.
Effective Use of Resources Policy	Sets out the funding criteria for specific treatments which may be considered to be of limited clinical value or inappropriate to be funded by the NHS.
Individual Funding Request (IFR) (Exceptional Case)	Is a request submitted by a clinician when a decision has been taken not to commission a specific treatment. Funding will only be approved if there is evidence of clinical exceptional circumstances.
Individual Funding Request (IFR) Panel	The process used by a GMCCG to consider the appropriateness of funding an IFR.

Individual Prior Approval (IPA)	A request submitted by a healthcare provider in accordance with contractual arrangements, which specify that for certain procedures, funding approval is required prior to initiating treatment.
Resource allocation	The process of allocating funding to healthcare providers to meet the health needs of the local population based on pre-determined priorities.
Screening	An administrative process to determine if an IFR/IPA meets the criteria specified in EUR policies.

Appendix 5: Version History

Version	Date	Details
0.2	14/06/2013	Consultation – sent to Greater Manchester stakeholders for comments.
0.3	24/07/2013	Review of comments received following consultation. The following significant changes were made: • Inclusion of version control • Inclusion of contact details • Clarification of children's services in paragraph 1.4. • Confirmation that paragraph 2.6 does not apply to prior approvals • Replacement of the word 'or' in paragraph 3.1 with 'and as a result of that difference' • Insertion of a paragraph relating to retrospective funding (paragraph 6 – all following paragraph numbers have been amended to reflect this). • IFR Appeal Panel has been changed to Process Review Panel throughout, including Appendix 4. • Clarification of the role of the Process Review Panel has been included in paragraph 8.5, 8.6 and Appendix 4. • Inclusion of a section relating to roles and responsibilities in Appendix 2. • Amendment to Membership in Appendix 4 to reflect that panel members may cover more than one representative function. • Inclusion of a paragraph in Appendix 5 (Challenge to Policy Section) to reflect that where an appeal is received on the basis of the evidence used to develop the policy, these will be considered by the GM EUR Steering Group.
0.4	07/08/2013	Amended following comments from Greater Manchester EUR Steering Group: • Appendix 5 TOR, GM EUR Steering Group: Membership – second bullet point amended to state 'IFR **Clinical** Panel Chairs/Members. • Deputising Arrangements – first bullet point amended to clarify that nominated deputies do not need to be clinical but must have a clinical background. It would also be the CCG who must appoint a deputy and not individual members. • Insertion of a paragraph relating to conflict of interests.
0.5	03/09/2013	• Amendment to sections 12.4, 12.6, Appendix 2 and Appendix 5 to reflect the governance arrangements agreed by CCG Chief Operating Officers. • Amendment to Quorum paragraph in Appendix 5.
0.6	19/09/2013	Insertion of section 7 to incorporate Referral to Treatment (RTT) Guidance.
0.7	08/10/2013	Amendment to 8.2.1 to reflect that only requests which are the commissioning responsibility of CCGs will be acknowledged within 1 working day.
0.8	20/12/2013	Amendments to sections 12.4, 12.6, 13.0 and final paragraph on page 20 to reflect the governance arrangements agreed by the AGG on the 03/12/2013.
0.9	08/01/2014	Amendments to reflect the current process – amendments made to sections, 2.5, 4.2, 11.2 and 12.7. Removal of section 4.3 (section 4.4 has now been renumbered 4.3). Insertion of section, 11.3.
0.10	16/01/2014	Inclusion of governance arrangements in GM EUR Steering Group Terms of Reference
0.10	14/01/2014	Policy considered by Greater Manchester Heads of Commissioning and Greater Manchester Chief Finance Officers.

1.0	04/02/2014	Policy ratified by Greater Manchester Association Governing Group (AGG).
1.1	07/02/2014	Amendment to section 3.1 (second bullet point in notes) to read: *'Social and/or psychological factors alone will not be taken into account to determine exceptionality. However, they may be taken into account when considering all of the patient's circumstances in the round.'*
1.2	04/06/2014	• Amendment to section 12.4 to reflect revised Greater Manchester Governance arrangements. • Amendment to Appendix 5 – Governance Arrangements to reflect revised Greater Manchester Governance arrangements. • Inclusion of new paragraphs related to GM EUR Policy Review – 12.7, 12.8 and 12.9. Paragraphs 12.10 and 12.11 have been renumbered. • Changed all reference to GMCSU to NWCSU • Amendments to section 1 as follows:- 1.5 clarified what is meant by procedures classed as low clinical value in bullet point 2 - It falls within a CCG Effective Use of Resources Policy, and there is a requirement for commissioner funding approval, because the treatment is not routinely commissioned, or should only be commissioned in specific circumstances.
1.3	12/12/2014	• Amendment to Section 1.5 Bullet point 3 reworded to read – The referrer is the patient's GP or NHS hospital consultant or other clinician. Requests will not be accepted from patients or their relatives/carers. • Amendment to Section 1.5 Bullet point 4 - The CCG has agreed that there should be a prior approval process managed by the GMCSU EUR Service on their behalf has been removed from this section as it is covered in second bullet point in this section. • Amendment to Section 1.5 additional bullet point added to advise the scope of the treatment requests are detailed in section 2.3 • Amendment to Section 2.3 Bullet point 1 - word 'either' removed. • Amendment to Section 2.3 Bullet point 4 changed to read 'those requests where the condition is extremely rare and there is therefore insufficient evidence of cost effectiveness at a population level for the normal commissioning process to apply. • Amendment to Section 2.4 wording changed to read Where a decision is made on an IFR basis and where further requests for the same treatment are anticipated, the NWCSU EUR team will develop commissioning policies or commissioning decision making guidance to be ratified by CCGs. Any such policies/guidance will then be used to inform the decision making process of any future similar or related requests (see section 12.3) This will then be used to inform the decision making process for any future similar or related requests (see section 11.3). • Amendment to Section 2.5 Bullet point 6 to start with 'Review of the available evidence to determine if the…. • Amendment to Section 2.6 Bullet point 1 to read Either the clinician makes an individual request for funding for treatment in connection with a presenting medical condition for which the CCGs have a policy, but the patient does not meet the criteria, and the clinician is claiming that the patient has exceptional clinical circumstances; • Amendment to Section 2.6 Bullet point 4 – slight change to working 'no' removed and likely changed to unlikely. • Removed Section 2.7 • Addition to Section 4 to include 4.4 Patients may access treatment in line with patient choice and if they have been receiving treatment elsewhere in the country when they move back into the Greater Manchester area, they

		can choose to remain with their existing provider outside of Greater Manchester. • Amendment to Section 5.1 to read as follows: Patients have a right to revert from privately funded care to NHS funding at any point during their care, providing the treatment is routinely available. In such circumstances Greater Manchester CCGs will expect their care to transferred to NHS pathways. Where the individual is requesting funding to continue their care within the private facility, which is outside of NHS contracted arrangements, or where the treatment is not routinely available, funding would need to be considered through the IFR process. Patients will need to meet the conditions for approval (see paragraph 2.6). • Amendment to Section 5.2 – following words added to start of first paragraph – 'Relating to co-payment of treatment' …… • 8.4.1; 8.4.2; 8.4.3; 8.5.1; 8.5.2 – the words 'EUR Policy' added before criteria. • 8..5.1 – additional sentences added - It is the role of the clinical triage team to make clinical decisions in accordance with the CCG EUR policy, or where delegated authority has been given following a precedent decision made by a CCG IFR Panel. The clinical triage team may not take decisions on requests which require consideration of exceptionality, but may decide whether a request contains such evidence of clinical exceptionality, which would require consideration by a CCG IFR Panel. • 8.5.2. – removed as this is not the current process • 8.5.3 (now 2) reworded to include '....consensus, or there is evidence of clinical exceptionality or.....' • Added point 8.6.4. Patients are not able to attend panel to present their case • 8.8.1 added the following sentence. Patients may bring along someone to provide support. • 8.7.1 amended to now read 'the provider may initiate treatment, whilst awaiting a funding decision' • Amendment to Section 9 – Appeals Process – taken out that the patient has the right to appeal a decision. Appeals will only be accepted from the requesting clinician. • Amendment to Section 9.1 replaced the word reviewed with reconsidered • Amendment to Section 9.6 to include a final sentence stating 'should the process review panel decide that due process had not been followed, and the IFR panel decision stands, there will be no further recourse of appeal within the CCG.' • Amendment to Appendix 3 – Model Terms of Reference for a CCG Individual Funding Request Panel – Membership – to include:- 'The Panel may co-opt additional members (with or without voting rights as deemed necessary) when required, particularly when specialist expertise is needed and may be establish as sub group to deal with decisions that may include co-opted members, Where a person is to be co-opted onto the panel for the purposes of participating in any of its meetings the decision to co-opt that individual (along with whether or not he or she may have voting rights) shall be put to a vote of the regular voting members at the start of the relevant meeting.' • Amendment to Appendix 4 – Model Terms of Reference for a CCG Process Review - first paragraph reworded to provide further clarity, now reads 'The CCG process review panel will meet on an ad-DoC basis when a clinician acting on a patient's behalf has appealed a panel decision and they have not submitted additional evidence which would require the request to be further considered by the IFR Panel in accordance with the EUR Process. • Membership to include that a member of the original IFR Panel will attend to

		present the case and answer any questions. • Amendments to Appendix 5 – Terms of Reference – Greater Manchester Effective Use of Resources (EUR) Steering Group – Decision Making Under deputising arrangement section changed the work representative to deputy in the second sentence. • Reviews – an annual rather than 2 year review date will be applied to each policy.
1.4	07/06/2016 09/06/2016	Format of policy and references to NWCSU and North West Commissioning Support Unit changed to GMSS and Greater Manchester Shared Services. New GMSS footer added to cover page.
1.5	01/09/2016	• The version control of the document has been moved to end of the document. • Throughout the document 'Head of Effectiveness and Equitable Access' amended to read Head of Effective Use of Resources' <u>Background and Scope</u> • Section 2.3 – The 4th bullet point amended – words 'there is therefore insufficient' replaced by 'it is unlikely there will ever be' • Section 2.4 - The word 'basis' removed from the first sentence and 'GMSS EUR Team will' amended to read EUR Steering Group may'. Last sentence of this section removed. • Section 2.5 - The 3rd sentence in the first paragraph the following has been added '*the Greater Manchester or'*. The following sentence added to the first paragraph '*Some GM EUR policies require specific clinicians to submit an application, please see individual policies for further details*.' The 1st bullet point regarding consent removed. • Following sentence added to the final bullet point *'If not supplied when requested a decision will be made on the basis of the information available at the time.'* • Section 2.6 - The first sentence words *'to be considered'* added after Individual Requests. Also amended to read following *'five'* conditions rather than *'four'* with 5th bullet point added. <u>Determination of Clinical Exceptionality</u> • Section 3 - The word 'clinical' added before each reference to exceptionality. Under '*Note:'* The 1st sentence of the 5th bullet point amended and 2 further sentences added. <u>Ongoing Treatment</u> • Section 4.1 - words 'at the appropriate time' added to final sentence. • Section 4.3 - word 'clinically' added before exceptional circumstances. • Section 4.5 - added <u>Continuing or Additional Privately Funded Care</u> • Section 5.1 – 3rd sentence amended from *'funding would need to be considered through the IFR process'* to read *'an IFR would need to be submitted for consideration through the EUR process'* <u>Retrospective Funding</u> • Section 6.1 - 'IRFs' amended to read 'funding requests' • Section 6.2 - '*GM IFR'* amended to read '*GM EUR'* <u>Request Process and Stages (for Individual Funding Requests and Prior Approvals</u> <u>Acknowledgement</u> • Section 8.1 - removed *'For details of the stages outlined below please refer to the GMSS EUR Standard Operating Procedures document. A copy of the GMSS EUR Standard Operating Procedures may be requested by emailing the GMSS policy team at policyfeedback.gmcsu@nhs.net.'*

		Checking • Section 8.2.1 – The following NOTE' has been added *'it is the responsibility of the referring clinician to ensure that the request is sent to the appropriate organisation. Where a clinician is unsure they should contact the relevant organisation (NHSE for example) to discuss the case'.* Screening • Section 8.3.1 – Following added as the second sentence '*Applications need to contain sufficient information to allow the request to be assessed against the mandatory criteria in the policy.'* • The final 2 sentences have been amended from '*Initially, these will be the EUR policies developed by the relevant PCT. PCT policies will gradually be replaced by GM policies, agreed and ratified by the CCGs'* to read '*These will be the Greater Manchester EUR policies or where applicable local policy statements inherited from local predecessor organisations'.* • Section 8.3.2 - has been amended regarding information contained in the funding application. • Section 8.3.5 – Following words added to the first section *'(this is not ordinarily cited by others)'* and a second sentence added as follows '*Where clinical exceptionality is claimed on the basis of conditions normally cited the request will be declined in line with the appropriate GM EUR policy or local policy statement.'* Clinical Triage • Section 8.4.1 - has been amended regarding the clinical triage group • Section 8.4.4 – added regarding requests for ongoing treatment. IFR Panels • Section 8.5.5 – added regarding notification of panel decisions Clarification of the IFR Process – Meetings with Patients • Section 8.7.1 – amended Appeals Process • Section 9.1 – has been amended regarding if a clinician disagrees with the decision • Section 9.2 – amended. • Section 9.3 – removed *'If the above stages have all been followed and the patient and the requesting clinician is still disagrees with the decision they can request a CCG process review panel, who will undertake a review of the process followed to reach that decision.'* • Section 9.3 (previously 9.4) – In first sentence words *'the appeal against an IFR panel been received* replaced with *'receiving a written request for a process review from a clinician.'* • Section 9.7 – added regarding new funding requests for the same condition/treatment that have previously been declined by an IFR Panel. Timescales • Section 10.1 – removed regarding timescales in the Standard Operating Procedures. • Section 10.2 now 10.1 - first sentence amended and sentence added to the end of the paragraph. Policy Development • Sections 12.2 & 12.3 – have been amended to reflect the current position. • Section 12.4 – Following sentence added after the first sentence:- '*Once a GM EUR policy recommendation has been formally agreed by the GM EUR Steering Group the policy will be sent to Mersey Internal Audit Agency to identify which procedure and diagnostic code are relevant to the policy*.' • Section 12.6 – *'full/restricted consultation'* amended to read '*a period of clinical engagement'* • Section 12.7 - In the first sentence *'and annually thereafter*' amended to

		read *'and thereafter at a date agreed by the GM EUR Steering Group unless new evidence warrants earlier review* (*see section 13 – Policy Review)..*' The rest of this section has been moved to Section 13 – Policy Review. • Section 12.10 – 'consultation' amended to 'clinical engagement' in the first sentence. <u>Policy Review</u> • Amended to reflect the new arrangements for review of GM EUR Policies. <u>Appendix 1: Ethical Framework</u> • Clinical Exceptional Need - 'Exceptional Need' amended to read 'Clinical Exceptional Need' • Third sentence amended from *'The GM EUR operational policy outlines the procedures that are in place to consider such exceptional requests on their merits.'* to read *'The GM EUR operational policy outlines the procedures that are in place to consider such requests that a referring clinician considers to be clinically exceptional on their individual merits.'* <u>Appendix 2 Governance & Accountability</u> • 6th paragraph reworded and 3rd sentence removed • 8th paragraph 'EUR Officer' amended to read 'EUR Senior Officers'. • 9th paragraph 'IFR' amended to read 'funding'. <u>Appendix 3 – Terms of Reference for CCG Individual Funding Request Panel</u> • The word 'Model' changed to 'Example' in the title of this section and (Please refer to individual CCG's own ToR) added <u>Appendix 4 – Terms of Reference for CCG Process Review Panel</u> • The word 'Model' changed to 'Example' in the title of this section and (Please refer to individual CCG's own ToR) added <u>Appendix 5 – Terms of Reference – Greater Manchester Effective Use of Resources (EUR) Steering Group</u> • Reviews - amended from *'An annual review date will be applied to each policy statement unless further information is likely before this period*' to read '*Greater Manchester EUR Policy Recommendations will be reviewed one year from the date of approval by the AGG and thereafter at a date agreed by the GM EUR Steering Group unless new evidence warrants earlier review'* • Governance – following added as second sentence in this section '*Once a GM EUR policy recommendation has been formally agreed by the GM EUR Steering Group the policy will be sent to Mersey Internal Audit Agency to identify which procedure and diagnostic code are relevant to the policy.*' • Administrative Support – Final bullet point amended to read EUR Policy Team • Glossary – Exceptionality amended to read Clinical Exceptionality
1.6	07/10/2016	<u>Section 1 - Introduction</u> • Following sentence removed from section 1.3 '*It will build on earlier Greater Manchester EUR/IFR policies.'* • The following bullet point added to section 1.5 *'Requires the use of e-requests. It is expected the GP practices will use the electronic version of the procedure/treatment specific funding request forms from the 1st April 2017. This is in line with the move to a paperless NHS by 2018.'* <u>Section 2 - Background and Scope</u> • Section 2.3 Final bullet point, final sentence word 'Individual' add before Prior Approvals and '(IPA's) in brackets at the end of the sentence. • Section 2.5 First bullet point, 'referring clinician' amended to read 'requesting clinician' • Section 2.5 Final bullet point reworded from:- • 'Requesting photographs where relevant in support of an objective decision.

		These should be non-identifiable and relevant to the request. If not supplied when requested a decision will be made on the basis of the information available at the time.' • To read:- • *'Requesting non-identifiable photographs, preferably medical illustrations if available to support the decision making process. It should be noted that it is <u>not</u> mandatory for photographs to be provided by the patient and any photographs received will not form the sole basis of the decision. These should be and relevant to the request. If not supplied when requested a decision will be made on the basis of the information available at the time.'* <u>Section 3 - Determination of Clinical Exceptionality</u> • First paragraph in 3.1 reworded from: *'Clinical Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining clinical exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for clinical exceptional funding has demonstrated that his/her circumstances are clinically exceptional. A patient may be able to demonstrate clinical exceptionality by showing that s/he is:'* • To read: *'Clinical Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining clinical exceptionality; however the over-riding question which the IFR process must answer is whether each clinician claiming clinical exceptionality on behalf of their patient has demonstrated that his/her circumstances are clinically exceptional. A clinician together with the patient may be able to demonstrate clinical exceptionality by showing that s/he is:'* <u>Section 4 - Ongoing Treatment</u> • Section 4.5 - Reword from: *'If an IFR panel has approved treatment previously and has not advised of any restrictions on ongoing care, continuing treatment can be agreed by the clinical triage if clinically appropriate. The case will be referred back to panel if clinical triage believes this is indicated.'* • *To read: '*If an IFR panel has approved treatment previously and has not advised of any restrictions on ongoing care, continuation of treatment can be agreed by the clinical triage team if clinically appropriate. The case will be referred back to panel if the clinical triage team believes this is indicated.' <u>Section 9 - Appeal Process</u> • Section 9.3 Reworded from: *'It is the responsibility of the relevant CCG to convene and resource the process review panel within 3 months of receiving a written request for a process review from a clinician. A request for a process review will not be accepted from a patient. The GMSS EUR team will provide all the required information, prepare the papers and support the CCG process review panel meeting.'* • To read: *'It is the responsibility of the relevant CCG to convene and resource the process review panel within 3 months of receiving a written request for a process review from a clinician. If the patient or clinician request the process review to be re-arranged or a conflict of interest is discovered, the CCG will have 3 months to reconvene and resource the process review panel from the date of this being notified to the CCG. The CCG will however make every effort to reconvene as soon as possible. The GMSS EUR team will provide all the required information, prepare the papers and support the CCG process review panel meeting.'* • Section 9.7 following words added to the end of the last sentence '*and will not progress through the EUR Process'*.
1.7	01/11/2016	<u>Section 14 - GP Clinical Systems</u> • 14.1 GMSS Effective Use of Resources and Data Quality Teams will work

		together to develop, implement and maintain GP clinical systems that will allow easy access to EUR policies for GP practice staff. • 14.2 New GM EUR Policies will be added to the clinical systems on a quarterly basis e.g. July, October, January and April once these have been ratified by all 12 GM CCGs. • 14.3 It is expected the GP practices will use the electronic version of the procedure/treatment specific funding request forms from the 1 April 2017. This is in line with the move to a paperless NHS by 2018.
1.8	06/12/2016	Section 10 - Timescales - added the timescales taken for acknowledging and processing funding requests.
2.0	23/12/2016	Changes made to the GM EUR Operational Policy since it was ratified by the AGG in February 2014 were reviewed by the AGG virtually during December 2016. The AGG proposed the following changes be made:- • All references to 'Heads of Commissioning' in the policy changed to 'Directors of Commissioning'. Section 1 - Introduction • Bullet point 4 to be reworded from 'It is expected that GP practices will use the electronic version of the procedure/treatment specific funding request forms from the 1st April 2017.' To now read 'GP practices will be encouraged, through appropriate support, to use the electronic version of the procedure/treatment specific funding request forms from the 1st April 2017.' Section 7 - Referral to Treatment Times (RTT) • Bullet point 7.1 the words 'Individual Prior Approval (IPA)' added to the second sentence before the word requests. '(see Section10)' added at the end of the third sentence. • Added bullet point 7.2 - Where a clinician is submitting a funding request for consideration on the grounds of clinic exceptionality RTT will only apply once a CCG has confirmed funding approval. Section 8 - Request Process and Stages • Bullet point 8.3.5 the words "that is not ordinarily cited by others" have been removed. Also the words 'a decision' at the end of the first sentence replaced by 'review'. Section 9 - Appeals Process • Under bullet point 9.1 the following sentence has been removed 'Appeals will not be accepted from a patient.' • Under bullet point 9.2 the following sentence has been removed 'A request for a process review will not be accepted from the patient.' Section 10 - Timescales • Under bullet point 10.2 in the first sentence of the second paragraph and the first sentence of the third paragraph the words 'aims to process these' has been replaced with 'will process these'. (see section 7.2) added to the end of the second and third paragraphs. Section 14 • 'GP Clinical Systems' removed • Section 14 - Delivery Outputs added Glossary Section • Individual Funding Request - has been reworded for clarity. Subject to the above changes being made the AGG approved that the updated version of the EUR Operational Policy could be implemented (Version 2.0).
2.1	26/05/2017	• Section 8.6 title changed from 'Urgent Requests' to 'Urgent Requests/Priority Cases' • The following wording added as clause 8.6.3:

		'Priority cases are those where a treatment needs to be given within a certain timeframe that does not allow enough time for the request to be prepared for panel consideration ***NOTE:*** *This excludes those cases where treatment has been booked prior to authorisation being received.* *Where a clinician has stated that a case requires an urgent response but that case does not meet the GM EUR definition of urgent i.e. intervention within 72, then provided a clinical case has been made by the referring clinician that case will treated as a priority case. Cases where the GMSS EUR Team whilst screening the request is of the opinion that a request is time sensitive this will then be prioritised.* *Examples are:* • *Drugs needed for severe cases of the disease being treated* • *Eating Disorders where there is rapid weight loss or the BMI is dangerously low* • *EEA/Cross Border Team Requests that have a short response time attached to them ,* • *Negative Pressure Wound Therapy (NPWT/VAC)* • *IVF if female is nearing the age cut-off for accessing the treatment and delay in processing will prevent treatment starting before the cut-off date* • *Mental Health Cases (not excluded from the service) where a place of safety is needed'*
3.0	24/11/2017	Policy reviewed and the following changes made: • *GMSS 'IFR' Team* changed to *GMSS 'EUR' Team* throughout the document. • Contact Details – *Enquiries relating to 'an Individual Funding Request (IFR)*' changed to '*Enquiries relating to a funding request*'. Section 1 – Introduction and Purpose • 1.3 - *'(exception cases)'* added after '*Individual Funding Requests (IFRs)'* in the first sentence. • 1.4 - Following added to end of last sentence: *'unless by prior agreement with GMSS and costed accordingly.'* • Section 2 - Background and Scope: 2.6 - *'Funding'* in the first sentence added between *'Individual'* and *'Requests'. 'Either'* deleted from beginning of the first bullet point. • Section 4 - Ongoing Treatment: Bullet point added to 4.6: '*Patients are entitled to request a second consultant opinion within an NHS funded clinic. Third or fourth opinions for the same clinical condition will not normally be supported unless there are extenuating circumstances.'* • Section 8 - Request Process and Stages • 8.2.1 - *'12'* deleted from before 'GMCCGs' and NHS England link updated. • 8.5.1 - *'Each CCG IFR Panel will have a named GMSS EUR Team member as their contact person within the GMSS EUR Team*.' Deleted from final sentence. • 8.6.1 - First sentence slightly reworded for clarity. • 8.6.2 - *'Exact details of the urgent request procedure for each CCG can be found in the GMSS EUR Standard Operating Procedures.'* changed to: *'The EUR Service has agreed with each GM CCG a process for handling urgent requests that require IFR Panel consideration.'* • 8.7.1 - '*an IFR'* changed to '*funding request'.* Section 9 – Appeals Process • 9.1 - *'unless they are of the opinion a key piece of information has not been taken into consideration'* added to end of the third sentence and NOTE reworded from *'Appeals against a decision made by an IFR Panel can't be considered as an IFR Panel decision is final; however if further information is submitted which the IFR Panel have not considered then a case may be*

		referred back to an IFR Panel in order for a decision to be made.' to: *'Appeals against a decision made by an IFR Panel can't be considered as an IFR Panel decision is final; however if further information is submitted which the IFR Panel has not considered then a case will be reviewed and if this information has not been previously considered will be referred back to an IFR Panel in order for further consideration'.* • 9.7 – Second sentence reworded from *'If the new funding request does not contain any new clinical information the request will be rejected and closed and will not progress through the EUR Process.'* to: *'The new funding request will be reviewed against the previous request by the Clinical Triage Team and if it does not contain any new clinical information the request will be rejected and closed and will not progress through the EUR Process.'* <u>Section 10 – Timescales</u> • 10.2 - *'of'* removed before *'the request was received'* in the first sentence. • 10.3 - '*or the file closed if there is insufficient information to reach a decision'* added to the end of the first sentence. <u>Section 12 – Policy Development</u> • 12.2 - *'policy'* changed to *'policies'* in the final sentence. • 12.4 - *'inherited PCT policy'* replaced by *'local CCG policy for that treatment/procedure'* In the final sentence *'IFRs'* replaced with *'funding requests'* • 12.9 - *'will be undertaken'* replaced by *'may be undertaken'* in the first sentence. In the second sentence the word *'revisions'* replaced by *'reviews'.* • <u>Section 13 - Policy Review:</u> 13.2 – *'CCG'* added before *'governance process'* in the final sentence. • <u>Appendix 2: Governance and Accountability:</u> 1^{3th} paragraph reworded from: *'Training for the members of the GMSS EUR Team the Clinical Triage team and the IFR Panels as well as the Process Review Panel will be organised when training needs are agreed with the GMSS EUR Team. This will cover healthcare ethics, communicating with patients, evaluation of evidence and legal issues among others.'* to: *'Training of IFR Panel members and Process Review Panel members will be the responsibility of the individual CCGs.'* • <u>Appendix 5: Terms of Reference – Greater Manchester Effective Use of Resources (EUR) Steering Group:</u> Updated version added following review by the GM EUR Steering Group at their November 2017 meeting.