Appendix 4: IFR Application Form

NHS Blackburn with Darwen CCG

NHS Chorley and South Ribble CCG

NHS East Lancashire CCG

NHS Fylde and Wyre CCG

NHS Greater Preston CCG

NHS West Lancashire CCG

For NHS Morecambe Bay CCG patients an online application form should be submitted. This can be accessed via the following link: <https://www.morecambebayccg.nhs.uk/about-us/policies-and-procedures>

**Important information**

**All sections of the form must be completed otherwise the case will not be considered. Do not include patient or Trust/requesting clinician identifiable data in any free text sections. Where there are large amounts of identifiable data included in the free text sections, the application will be returned to you for redaction and resubmission.**

**This form is an appendix to *The* *Individual Funding Request Process.*  The full document must be considered before making an application on behalf of a patient to ensure that it is appropriate.**

**Before you begin to complete this form to make an application you MUST first consider the following question: *Are there similar patients with similar clinical circumstances who could also benefit from the treatment you are requesting across the population of the CCGs?***

**If the answer is YES then making an individual funding request is an inappropriate way to deal with funding for this patient. This is because the case represents a service development for a predictable population. You should discuss with your contract team (or commissioning leads at the CCG) to understand how you submit a business case for consideration through the usual business planning process.**

**If the answer is NO then please proceed by completing the application, providing the information and relevant evidence for the appropriate category of IFR into which this patient’s case falls.**

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| **SECTION 1- REQUEST URGENCY**  |
| **Indicate the level of clinical urgency for this request.** | ☐ Not urgent☐ Urgent - state reasons:**State reasons:** |
| **PLEASE NOTE: If a request is considered urgent the IFR team must be contacted by telephone, in line with Section 4 of The Management of IFR’s.** |

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| **SECTION 2 – PATIENT PERSONAL DETAILS** |
| **Patient Surname:** |  | **NHS Number:** |  |
| **Patient Forename:** |  | **Patient Date of Birth:** |  |
| **Patient Middle Name(s):** |  | **Patient Sex (M/F):** |  |
| **1i. Patient Address:****(Including Postcode)** |  |
| **Please note that all unnecessary personal information will be removed from this form prior to consideration by the IFR Panel. This information is collected for monitoring purposes only.** |

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| **SECTION 3 – REGISTERED GP DETAILS** |
| **GP Name:** |  |
| **GP Practice Name:**  |  |
| **GP Practice Address:** |  |
| **GP Practice Postcode:** |  |
| **GP Telephone Number:** |  |
| **GP Email Address:** |  |

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| **SECTION 4 – CONSENT**  |
| **I confirm:**This Individual Funding Request (IFR) has been discussed in full with the patient and/or patient representative[[1]](#footnote-2). They are aware that they are consenting for the IFR Team to receive and review confidential clinical information about their health to enable full consideration of this funding request. | ☐ Yes ☐ No |
| Responsibility lies with the requesting clinician to present a full submission which sets out a comprehensive and balanced picture of the history and present state of the patient’s clinical condition, the nature of the treatment requested and the anticipated benefits of treatment.  |

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| **SECTION 5 – DETAILS OF REQUESTER (if different to the patient’s GP)** |
| **Name:**  |  |
| **Job role:** |  |
| **Organisation:** |  |
| **Contact telephone number:** |  |
| **Secure NHS.net email or postal address:** |  |

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| **SECTION 6 – DETAILS OF PROVIDER (if different to the requester or patient’s GP)** |
| **Provider organisation:** |  |
| **Clinical department / specialty:** |  |
| **Contact telephone number:** |  |
| **Secure NHS.net email or postal address:** |  |

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| **SECTION 7 – PATIENT DIAGNOSIS AND CLINICAL BACKGROUND** |
| **Primary diagnosis related to this request:** |
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| **Outline of the patient’s condition including the timeline, current presentation and symptoms. Please give validated clinical measures, named in full.**  |
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| **Relevant medical history: (Including co-morbidities)** |
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| **SECTION 8 –REQUESTED TREATMENT** |
| **Name of requested treatment:** **(Include any alternative terms)** |  |
| **Is the treatment part of a course?**  | ☐ Yes ☐ No☐ N/A**If yes, please give details of the proposed treatment frequency and duration and the total number of proposed treatments/doses:** |
| **Anticipated start date, if known/appropriate:** |
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| **SECTION 9 – CURRENT TREATMENT** |
| **Please give details of the patient’s relevant current treatment/medications including regimen, response (including any intolerance or adverse events) and start date.** |
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| **SECTION 10 – PREVIOUS TREATMENTS**  |
| **Please give details of relevant previous treatment/medication including the treatment, regimen, response (including ay intolerance or adverse events), start date, stop date, reason for stopping.** |
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| **SECTION 11 – STANDARD TREATMENT** |
| **What is the natural history of the condition this patient has and what would be the expected course of the condition and prognosis?** |
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| **What is the standard treatment for this condition at this stage in the pathway and why is this not appropriate for this patient?** |
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| **If this treatment request is not approved, what treatment will be given to the patient?** |
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| **SECTION 12 – ANTICIPATED OUTCOMES** |
| **What are the anticipated outcomes of the treatment requested for this patient?** |
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| **How will the outcomes of the treatment requested be measured? Use validated measures.** |
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| **When will these outcomes be expected?** |
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| **What stopping criteria will be in place (if appropriate)?** |
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| **SECTION 13 – CLINICAL EXCEPTIONALITY** |
| **It is recommended that you read the policy on clinical exceptionality that is in force at the time of your application prior to completing this section. This will be available to view on the CCG’s website.****In summary, the application must demonstrate:*** **Why the patient in question is materially different to the usual population of patients to whom the Standard Policy applies in terms of the principle or principles on which the Standard Policy is based; AND**
* **Why that material difference means the Standard Policy should not apply.**
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| **Please explain why the patient is materially different to the usual population of patients to whom the Standard Policy applies in terms of the principle or principles on which the Standard Policy is based** |
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| **Please explain why that material difference means the Standard Policy should not apply.** |
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| **SECTION 14 – SUPPORTING EVIDENCE** |
| **PLEASE NOTE:**Where references are cited within the application, these should be provided in full as an attachment to the application together with a clear indication of the relevance of each reference given and the sections that support the application. Evidence should be submitted as pdf or word document (electronically or hard copy). The IFR Team are unable to accept abstracts or web links.**For further information please see section 3 of The Management of Individual Funding Requests for Lancashire and South Cumbria CCG’s** |
| **Please provide a summary of the evidence base for the clinical and cost effectiveness and safety of the requested procedure / treatment in support of the application for clinical exceptionality.**  |
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| **Is the treatment licensed in the UK for the intended use?**  | ☐ Yes ☐ No |
| If Yes, please give details:  |
| **Has it been subjected to NICE appraisal or other scrutiny?**  | ☐ Yes ☐ No |
| If Yes, please give details:  |
| **Is the procedure/treatment part of a current or planned national or international clinical trial or audit?** | ☐ Yes☐ No |
| If Yes, please give details:  |
| **Does the proposed procedure/treatment have any exclusion criteria in place for occasions when the procedure/treatment could be ineffective?** | ☐ Yes☐ No |
| If Yes, please give details: |

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| **SECTION 15 – TREATMENT/PROCEDURE COSTS** |
| **Ensure you include all costs that are connected to providing the treatment or procedure.** |
| **What is the cost of the treatment / procedure?** ***Please include any associated costs such as drug / attendance costs / device / administration / staff / follow up / diagnostics costs / consumables etc******Please give a breakdown of this cost per annum, per cycle etc. as appropriate*** | £ |
| **What is the total estimated cost for the package of treatment/care?** | £ |
| **What is the cost of the standard therapy it replaces including any drug / attendance costs / staff / follow up / diagnostics costs etc.?****Please give a breakdown of this cost per annum, per cycle etc. as appropriate:** | £ |

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| **SECTION 16 – DECLARATION OF INTERESTS** |
| **Clinicians are required to disclose all material facts as part of this process. Are there any relevant declarations of interest that are appropriate to bring to the attention of the IFR Team?** |
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| **SECTION 17 – SIGNATURE OF REQUESTING CLINICIAN** |
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| **Signature:**  |  |
| **Date** |  |

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| **ON COMPLETION**  |
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| Please email the completed form and enclosures via secure email to the email address listed below associated with the CCG the patient is registered with: NHS Blackburn with Darwen CCG bwdccg.ifr@nhs.netNHS Chorley and South Ribble CCG csrccg.ifr@nhs.net NHS East Lancashire CCG elccg.ifr@nhs.net NHS Fylde and Wyre CCG fwccg.ifr@nhs.netNHS Greater Preston CCG gpccg.ifr@nhs.net NHS West Lancashire CCG wlccg.ifr@nhs.net  |

1. This means a person with legal authority to take decisions about medical care and treatment on behalf of the patient, on the basis that they lack capacity to take these decisions themselves. The source of that legal authority should be clearly identified [↑](#footnote-ref-2)