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# Individual Funding Request (IFR) Application Form

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| Requesters are advised to review the Shropshire CCG/ NHS Telford and Wrekin CCG IFR Policy, IFR Standard Operating Procedures (SOP) and the guidance for Clinicians at: <https://www.shropshiretelfordandwrekinccg.nhs.uk/>. Shropshire CCG/NHS Telford and Wrekin CCG requires provider trusts and clinicians to take clinical commissioning policies into account in the advice and guidance given to patients prior to making the decision to treat a patient.  It is the responsibility of the referring clinician to ensure all the appropriate and required clinical information is provided to Shropshire CCG/NHS Telford and Wrekin CCG. This includes full text copies of all the published papers of clinical evidence that have been cited, a list of the published papers submitted and an indication of which points within them are relevant in respect to the IFR application and criteria. Requests will only be considered on the information provided in the application and supporting papers.  The information requested at question 2g and 2h is collected for monitoring purposes in an anonymised format to assist Shropshire CGG/NHS Telford and Wrekin CCG in ensuring that we are complying with the Equality Act 2010. This information will be redacted prior to sharing with decision makers.  **DO NOT** include patient or trust/requesting clinician identifiable data in any free text sections. Where there are large amounts of identifiable data included, the application will be returned to you for redaction and submission.  **Please note**: applications presenting incomplete information will be returned for amendment / completion prior to consideration by Shropshire CCG/NHS Telford and Wrekin CCG. | | | | | | | | | | | | | | |
| **Section 1 - PROVIDER DETAILS** | | | | | | | | | | | | | | |
| 1a) Name of Provider | | | | Click here to enter text. | | | | | | | | | | |
| 1b) Name of clinician who will  undertake the intervention | | | | Click here to enter text. | | | | | | | | | | |
| 1c) Job title/role | | | | Click here to enter text. | | | | | | | | | | |
| 1d) Secure NHS email | | | | Click here to enter text. | | | | | | | | | | |
| 1e) Telephone number | | | | Click here to enter text. | | | | | | | | | | |
| **Section 2 – PATIENT / GP DETAILS** | | | | | | | | | | | | | | |
| 2a) Patient first name | | | | Click here to enter text. | | | | | | | | | | |
| 2b) Patient last name | | | | Click here to enter text. | | | | | | | | | | |
| 2c) Patient NHS Number | | | | Click here to enter text. | | | | | | | | | | |
| 2d) Patient hospital number | | | | Click here to enter text. | | | | | | | | | | |
| 2e) Patient date of birth | | | | Click here to enter a date. | | | | | | | | | | |
| 2f) Patient age at time of submission | | | | Click here to enter text. | | | | | | | | | | |
| 2g) Gender | | | | Choose an item. | | | | | | | | | | |
| 2h) Ethnicity | | | | Choose an item. | | | | | | | | | | |
| 2i) Patient’s address | | | | Click here to enter text. | | | | | | | | | | |
| 2j) Patient’s postcode | | | | Click here to enter text. | | | | | | | | | | |
| 2k) GP Name | | | | Click here to enter text. | | | | | | | | | | |
| 2l) GP Practice name | | | | Click here to enter text. | | | | | | | | | | |
| 2m) GP postcode | | | | Click here to enter text. | | | | | | | | | | |
| **Section 3 – REQUEST DETAILS** | | | | | | | | | | | | | | |
| 3a) Please detail the clinical reasons for urgency if appropriate i.e. the risks of adverse clinical outcome to the individual patient | | | | | Click here to enter text. | | | | | | | | | |
| 3b) Proposed start date of treatment | | | | | Click here to enter a date. | | | | | | | | | |
| 3c) If treatment has commenced more than 2 working days before submission of this application, please provide an explanation for the delay in application | | | | | Click here to enter text. | | | | | | | | | |
| 3d) Proposed treatment stop date (if applicable) | | | | | Click here to enter a date. | | | | | | | | | |
| **Application Support** | | | | | | | | | | | | | | |
| The IFR Policy and SOP highlight that Trust support of an IFR application is mandatory. The IFR application will not progress in the absence of this support. Requests must be supported by a relevant multidisciplinary team (MDT) or Trust Drugs and Therapeutics Committee (DTC) **AND** by the provider trust Medical Director. | | | | | | | | | | | | | | |
| 3e) DTC or equivalent approval and provide a copy of the minutes | | | | | Please provide details of the outcome  Click here to enter text. | | | | | | | | Yes  No  N/A | |
| 3f) MDT approval and provide a copy of the minutes | | | | | Please provide details of the outcome  Click here to enter text. | | | | | | | | Yes  No  N/A | |
| 3g) Name and email of Chief or, in exceptional circumstances to avoid delays in submission, the Deputy Chief Pharmacist (if applicable) | | | | | Click here to enter text. | | | | | | | | | |
| 3h) Confirm that the Chief/Deputy Chief Pharmacist supports this drug application (if applicable) | | | | | Yes  No  N/A | | | | | | | | | |
| 3i) Name and email of Medical Director or, in exceptional circumstances to avoid delays in submission, the Deputy Medical Director | | | | | Click here to enter text. | | | | | | | | | |
| 3j) Confirm that the Medical Director/Deputy Medical Director supports this application | | | | | Yes  No | | | | | | | | | |
| **Consent** | | | | | | | | | | | | | | |
| 3k) This IFR has been discussed in full with the patient or patient representative. 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. **I confirm all of the above** | | | | | | | | | | Yes  No | | | | |
| 3l) In submitting this application you are under obligation to advise the patient or patient representative of the details of the reasons for the decision. **I confirm that I will advise the patient or patient representative of the reasons for the decision** | | | | | | | | | | Yes  No | | | | |
| 3m) The patient or patient representative will receive a letter outlining that a decision has been made and what that decision is, although will not receive the detail for that decision. **I confirm that it is clinically appropriate for the patient to be informed of the outcome of this IFR** | | | | | | | | | | Yes  No | | | | |
| 3n) I understand that by indicating that it is **NOT** clinically appropriate for the IFR Team to contact the patient or patient representative with the outcome, I will be fully responsible to do this. **I will inform the patient or patient representative of the outcome and the reasons for the decision** | | | | | | | | | | Yes  N/A | | | | |
| **Section 4 - TREATMENT** | | | | | | | | | | | | | | |
| 4a) Primary diagnosis most relevant to this IFR request and any relevant co-morbidities | | | | | Click here to enter text. | | | | | | | | | |
| 4b) Intervention details including treatment modality (if applicable), how and where the treatment will be given | | | | | Intervention: Click here to enter text.  Modality: Click here to enter text.  How will treatment be given: Click here to enter text.  Where will treatment be given: Click here to enter text. | | | | | | | | | |
| 4c) Is there an existing clinical policy for this treatment and condition? *Please provide explicit reasons why your patient does not meet the access criteria within that policy* | | | | | Click here to enter text. | | | | | | | | | |
| **Cost** | | | | | | | | | | | | | | |
| 4d) what are the costs of the intervention?  *Where appropriate include here the total cost of the treatment, any loading doses required and the number of cycles applied for* | | | | | Single treatment | | | | Total Cost: Click here to enter text. | | | | | |
| multiple treatments  Load dose Click here to enter text.  Subsequent doses Click here to enter text. | | | | Cost per treatment:  Click here to enter text.  Click here to enter text. | | | Total Cost:  Click here to enter text. | | |
| 4e) Additional comments on the cost of the intervention | | | | | Click here to enter text. | | | | | | | | | |
| 4f) What are the total costs of standard therapy (*estimate annual costs if applicable*)? | | | | | Click here to enter text. | | | | | | | | | |
| 4g) Are there any offset costs  (*provide details*)? | | | | | Yes  No  Click here to enter text. | | | | | | | | | |
| **Clinical Outcomes** | | | | | | | | | | | | | | |
| 4h) What are the intended clinical outcomes and how will the benefits of the procedure / treatment be measured *(including where appropriate the validated clinical tools to be used*)? | | | | | Click here to enter text. | | | | | | | | | |
| 4i) Within what timeframe will these outcomes be determined? | | | | | Click here to enter text. | | | | | | | | | |
| 4j) What ‘stopping’ criteria will be in place to assess when the treatment is ineffective and treatment will be withdrawn? | | | | | Click here to enter text. | | | | | | | | | |
| 4k) What mechanisms will be in place to provide the CCG with clinical outcome reports if the treatment is approved? *Please provide detail of how you will report to the CCG upon request* | | | | | Click here to enter text. | | | | | | | | | |
| **Section 5 - CLINICAL BACKGROUND** | | | | | | | | | | | | | | |
| 5a) Outline the background to the patient’s clinical situation relevant to this request, timeline, current status and symptoms. *Please give validated clinical measures, named in full*. | | | | | Click here to enter text. | | | | | | | | | |
| **Treatment History** | | | | | | | | | | | | | | |
|  | Treatment | | Regimen | | | Start | | Stop | | | Response | | | Funding source |
| 5b) Current | Click here to enter text. | | Click here to enter text. | | | Click here to enter a date. | | Click here to enter a date. | | | Click here to enter text. | | | Click here to enter text. |
| 5c) Previous | Click here to enter text. | | Click here to enter text. | | | Click here to enter a date. | | Click here to enter a date. | | | Click here to enter text. | | | Click here to enter text. |
| 5d) Previous | Click here to enter text. | | Click here to enter text. | | | Click here to enter a date. | | Click here to enter a date. | | | Click here to enter text. | | | Click here to enter text. |
| 5e) Additional comments on current or previous treatments | | | | | Click here to enter text. | | | | | | | | | |
| **Additional Treatment Information** | | | | | | | | | | | | | | |
| 5f) What are the alternative standard treatments available to patients with this condition/stage of the disease and why are they not appropriate for this patient? | | | | | Click here to enter text. | | | | | | | | | |
| 5g) Prognosis – what are the anticipated clinical benefits in this individual case of the particular treatment requested over other available options? | | | | | Click here to enter text. | | | | | | | | | |
| 5h) Risk/benefit profile of this treatment compared to standard treatments in this individual case | | | | | Click here to enter text. | | | | | | | | | |
| 5i) Anticipated prognosis if treatment requested is not funded | | | | | Click here to enter text. | | | | | | | | | |
| **Section 6 – CLINICAL EXCEPTIONALITY**  Is there evidence that this patient has exceptional clinical circumstances, demonstrating that: | | | | | | | | | | | | | | |
| 6a) There is a Shropshire CCG/Telford and Wrekin CCG clinical commissioning policy or NICE Technology Appraisal (TA) guidance in place that either does not support the intervention or the patient does not meet the criteria for treatment. It is believed that the patient is clinically exceptional (*provide details*) and is likely to receive additional clinical benefit from treatment compared to another patient with the same condition and at the same stage of disease progression  **OR** | | | | | | | Yes  Click here to enter text. | | | | | | | |
| 6b) There is not a relevant Shropshire CCG/ Telford and Wrekin CCG clinical commissioning policy or NICE Technology Appraisal (TA) guidance in place for the management of the patient’s condition or combination of conditions, and the patient’s clinical presentation is so unusual that they could not be considered to be part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken | | | | | | | Yes  Click here to enter text. | | | | | | | |
| **Genotypes** | | | | | | | | | | | | | | |
| 6c) When the argument for clinical exceptionality is based on the patient having a particular genotype (genetic profile) please provide evidence of the prevalence of the genotype in that patient group and how the specific genotype would make the patient:   1. Different to others in terms of clinical management   **AND**   1. Able to benefit from the treatment to a greater degree than others with the same or different symptoms of the condition | | | | | | | Click here to enter text.  Click here to enter text.  Click here to enter text. | | | | | | | |
| **Section 7 – CLINICAL SUPPORTING INFORMATION** | | | | | | | | | | | | | | |
| Incidence and Prevalence – for this patient’s individual circumstances | | | | | | | | | | | | | | |
| 7a) Incidence: | | Estimate the number of patients expected to be diagnosed with this specific condition per 100,000 population per year: | | | | | | | | Click here to enter text. | | | | |
| Where a patient has one or more conditions, the figures provided should be for patients expected to have the combination of conditions – *please provide specific details* | | | | | | | | Click here to enter text. | | | | |
| 7b) Prevalence: | | Estimate the number of patients expected to have this condition per 100,000 population at any one time: | | | | | | | | Click here to enter text. | | | | |
| 7c) Do you consider that there are likely to be other patients presenting in England in the next 12 months with this patient’s condition at the same stage of this condition?  If so, provide the number | | | | | | | | | | Yes  No  N/A  Click here to enter text. | | | | |
| 7d) how many patients currently attend your service with this condition for which you would wish to use this treatment? | | | | | | | | | | Click here to enter text. | | | | |
| 7e) Is this a service development that has been discussed with commissioners?  *If yes, please provide details* | | | | | | | | | | Yes  No | | | | |
| 7f) Do you plan to submit a future preliminary policy proposal for consideration of funding of this treatment (rather than submit individual requests for single patients)? | | | | | | | | | | Yes  No | | | | |
| **Evidence** | | | | | | | | | | | | | | |
| 7g) Please provide a summary of the evidence base relevant to this application to demonstrate the clinical effectiveness, good use of NHS resources and safety of this procedure/treatment.  (*Published papers must be provided In full in order to be considered by the IFR Panel. A list of published papers submitted must be provided with an indication of which points within them are specifically relevant to the case using the proforma at the end of the application form*) | | | | | | | | | | Click here to enter text. | | | | |
| 7h) Is the procedure/treatment part of a current or planned national or international clinical trial or audit? | | | | | | | | | | Yes  No | | | | |
| If yes, please give details | | | | | | | | | | Click here to enter text. | | | | |
| **Section 8 - SUBMIT** | | | | | | | | | | | | | | |
| When you are satisfied that you have completed all sections, you will need to submit the request for consideration by Shropshire CCG/Telford and Wrekin CCG IFR Team. If the IFR Team needs more information they will contact you to ask that you provide more details and if this happens, the timeline for the request is suspended until this is received | | | | | | | | | | | | | | |
| Clinicians are required to disclose all material facts to Shropshire CCG/ Telford and Wrekin CCG as part of this process.  Are there any other comments/considerations that are appropriate to bring to the attention of the IFR Team? | | | | | | | Click here to enter text. | | | | | | | |
| Please complete in full and return this form to: [stwccgsafehaven@nhs.net](mailto:stwccgsafehaven@nhs.net)    (*hand written forms will not be accepted*) | | | | | | | | | | | | | | |

Evidence Proforma

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| --- | --- | --- | --- |
| Please provide reference to the key evidence for clinical exceptionality, clinical effectiveness, good use of NHS resources and safety of this procedure/treatment in each of the papers submitted as part of the evidence base relevant to this application | | | |
| **No.** | **Title submitted paper** | **Topics** | **Specific sections with key evidence (page number/paragraph or section)** |
| 1. | Article one | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
| 2. | Article two | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
| 3. | Article three | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
| 4. | Article four | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
| 5. | Article five | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
| 6. | Article six | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of NHS resources | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |