Midlands and Lancashire Commissioning Support Unit

Clinical Commissioning Group (CCG)
Individual Funding Request (IFR) Application Form

All sections of the form must be completed otherwise the case will not be considered.

Important Information
Before you begin to complete this form and make an application you MUST first consider the following question:
Is there a cohort of similar patients with similar clinical circumstances who would receive the same benefit from the treatment you are requesting across the population of your CCG? (a cohort being defined as 5 or more patients per 100,000 patients).
If the answer is YES then making an IFR is an inappropriate way to deal with funding for this patient. This is because the case represents a service development for a predictable population. In those circumstances you should discuss with your CCG contract team how you submit a business case for consideration through the usual business planning process.

Applicants are advised to review the CCG's IFR Management Policy and the IFR Decision Making Policy available on the CCG's website before submitting an application.
It is the responsibility of the referring clinician to ensure all the appropriate required clinical information is provided. 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 criteria. Requests will only be considered on the information provided in the application and supporting papers.

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 resubmission.
Please note: Applications presenting incomplete information will be rejected and you will be asked to resubmit an amended application for consideration.
Please note: It may be appropriate for information to complete those sections of the application coloured '**Green**' to be completed by the patient's referring GP. The partially completed form should then accompany any referral to secondary care or similar, for further completion as relevant.

SECTION 1A – PATIENT PERSONAL DETAILS			
1a. Patient Surname:		**1e. NHS Number:**	
1b. Patient Forename:		**1f. Hospital Number:**	
1c. Patient Middle Name(s):		**1g. Patient Ethnic Origin:**	
1d. Patient Date of Birth:		**1h. Patient Sex (M/F):**	☐Male ☐Female ☐ Mx Click or tap here to enter text.
1i. Patient Address: (Including Postcode)	Click or tap here to enter text.		
If the patient has a Personal Representative[1] who has 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 please provide their details below:			
1j. Personal Representative's Surname:	Click or tap here to enter text.		

[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

1k. Personal Representative's Forename:	
1l. Source of Legal Authority: *e.g. Lasting Power of Authority, Court Appointed Deputy, Parent of Child*	
1m. Personal Representative's Address: (Including Postcode)	

Please note that all unnecessary personal information will be removed from this form prior to being reviewed. This information is required to enable notification of the outcome in accordance with section 5 below.

SECTION 2 – REGISTERED GP DETAILS

2a. GP Name:	
2b. GP Practice Name:	
2c. GP Practice Address:	
2d. GP Practice Postcode:	
2e. GP Telephone Number:	
2f. GP Email Address:	

SECTION 3 – RESPONSIBLE COMMISSIONER

3a. Please indicate the responsible commissioner for this patient	☐ NHS Cheshire CCG	cheshireccg.IFR@nhs.net
	☐ NHS Halton CCG	IFR.manager@nhs.net
	☐ NHS Knowsley CCG	lorraine.frodsham@nhs.net
	☐ NHS Liverpool CCG	IFR.manager@nhs.net
	☐ NHS Southport and Formby CCG	IFR.manager@nhs.net
	☐ NHS South Sefton CCG	IFR.manager@nhs.net
	☐ NHS St Helens CCG	IFR.manager@nhs.net
	☐ NHS Warrington CCG	warringtonccg.IFR@nhs.net
	☐ NHS Wirral CCG	wirralccg.IFR@nhs.net

SECTION 4 – REQUEST URGENCY

A case is URGENT for IFR purposes if the patient faces a substantial risk of significant harm if a decision is not made within 2 working days. **Where an application is URGENT please telephone the IFR team on 01244 650395 to advise that the application is being submitted to ensure prompt processing of the application.**

4a. Indicate the level of clinical urgency for this request.	☐ Not urgent ☐ Urgent - state reasons: **State reasons:** Click or tap here to enter text.
4b. Proposed start date or date treatment commenced:	Click or tap to enter a date. Click or tap here to enter text.

Please note, that processing requests takes on average 30 working days.

SECTION 5 – CONSENT

5a. I confirm that this Individual Funding Request has been discussed in full with the patient or patient's representative: They are aware that they are consenting for the IFR Team to receive and review confidential clinical information about the patient's health to enable full consideration of this funding request.	☐ Yes ☐ No

Midlands and Lancashire Commissioning Support Unit are required to let the patient know the outcome of their IFR application if it is clinically appropriate to do so. Please advise by selecting the appropriate box

below, whether it is clinically appropriate for the patient / patient's representative to be notified in this case. Please note the patient's GP will be aware of the request and its outcome.	
5b. I confirm that it is clinically appropriate for the patient / patient's representative to be copied into all correspondence related to the outcome of this IFR. OR **5c. I confirm that it is NOT clinically appropriate for the patient / patient's representative to be copied into all correspondence related to the outcome of this IFR.** I understand that by indicating that it is **NOT** clinically appropriate for the IFR Team to contact the patient, I am responsible for sharing information relating to this request with the patient /patient's representative.	☐ ☐
5d. Name of Requester:	Click or tap here to enter text.
5e. Signature of Requester:	
5f. Date request submitted:	Click or tap to enter a date.
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.	

SECTION 6 – DETAILS OF REQUESTER			
6a. Name:		**6b. Title:**	Choose an item.
6c. Job role:			
6d. Requester organisation:			
6f. Contact telephone number:			
6g. Secure NHS.net email:			
6h.Postal address *if no nhs.net email address*:			
6i.Safe-Haven Fax Number:			

SECTION 7 – DETAILS OF PROVIDER	
7a. Provider organisation:	
7b. Clinical department / specialty:	
7c. Contact telephone number:	
7d. Secure NHS.net email:	
7e. Postal address *if no nhs.net email address*:	
7e. Secure-Haven Fax number:	
7f. Referral submitted to provider (Y/N):	☐ Yes ☐ No
7g. Is the provider commissioned by the NHS to provide this service or treatment? If No, state why the patient hasn't been referred to an NHS commissioned provider:	☐ Yes ☐ No ☐ Unknown **State Why:** Click or tap here to enter text.
7h. Is the provider commissioned by the patients registered CCG to provide this service or treatment? If No, state why the patient is being referred to an out of area provider:	☐ Yes ☐ No ☐ Unknown **State Why:** Click or tap here to enter text.

SECTION 8 – PATIENT DIAGNOSIS
8a. Primary diagnosis related to this request: (Details of Diagnosis & Prognosis for which the treatment is requested)
Click or tap here to enter text.
8b. Relevant medical history: (Including co-morbidities)

Click or tap here to enter text.

SECTION 9 – TREATMENT REQUESTED	
9a. Name of treatment: (Include any alternative terms)	
9b. Where will the treatment take place (e.g. Inpatient or outpatient)?	
9c. Or part of a course? If yes, give details below:	☐ Yes ☐ No ☐ N/A
9d. Treatment Intervals/frequency/duration:	
Click or tap here to enter text.	
9e. Number of proposed treatments/doses:	
Click or tap here to enter text.	
9f. Total time for proposed treatment:	
Click or tap here to enter text.	
9g. Anticipated start date:	

SECTION 10 – CLINICAL BACKGROUND
10a. Outline the background to the patient's clinical situation, timeline, current status and symptoms. Give validated clinical measures, named in full.
Click or tap here to enter text.

SECTION 11 – CURRENT TREATMENT
11a. Please give details of relevant current treatment/medication including regimen, response (including any intolerance or adverse events) and start date
Click or tap here to enter text.

SECTION 12 – PREVIOUS TREATMENTS
12a. 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.
Click or tap here to enter text.

SECTION 13 – STANDARD TREATMENT
13a. Describe the natural history of the condition this patient has and what would be the expected course of the condition and prognosis?
Click or tap here to enter text.
13b. What is the standard treatment for this condition at this stage in the pathway?
13c. Why is the standard treatment not appropriate for this patient?
Click or tap here to enter text.
13d. If this treatment request is not approved, what treatment will be given to the patient?
Click or tap here to enter text.

SECTION 14 – ANTICIPATED OUTCOMES
14a. What are the anticipated outcomes of the treatment requested for this patient?
Click or tap here to enter text.
14b. How will the outcomes of the treatment requested be measured? Use validated measures
Click or tap here to enter text.
14c. When will these outcomes be expected?
Click or tap here to enter text.
14d. What stopping criteria will be in place?

Click or tap here to enter text.
14e. What mechanisms will be in place to provide the CCG with clinical reports, if the treatment is approved?
Click or tap here to enter text.

SECTION 15 – EVIDENCE APPRAISAL	
15a. What is the evidence base for the clinical and cost effectiveness / safety of this procedure / treatment? **Published references should be provided in full in order to be considered by the IFR Panel.**	
Click or tap here to enter text.	
15b. Is the treatment licensed in the UK for the intended use?	☐ Yes ☐ No
If Yes, please give details: Click or tap here to enter text.	
15c. Has it been subjected to NICE appraisal or other scrutiny?	☐ Yes ☐ No
If Yes, please give details: Click or tap here to enter text.	
15d. 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 or tap here to enter text.	
15e. Outline how the patient meets local or national guidance (including any objective parameters e.g. DAS28, PSARC, PASI, DLQI, etc. with dates) **a. For insulin pumps and CGM systems include name of pump or CGM system, HbA1C, frequency, nature and management of any hypoglycaemic episodes with dates)** **b. Include reference to the supporting local or national guidance.**	
Click or tap here to enter text.	
15f. 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: Click or tap here to enter text.	

SECTION 16 – CLINICAL EXCEPTIONALITY	
To meet the definition of 'exceptional clinical circumstances' your patient must demonstrate that they are both: • **Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition; AND** • **Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition.** **Note: Non-clinical factors cannot be taken into account by the IFR Panel**	
16a. Do you consider this patient to have exceptional clinical circumstances, as defined above?	☐ Yes ☐ No
16b. If yes, please explain why your patient is significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition.	
Click or tap here to enter text.	
16c. If yes, please explain why your patient is likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition.	
Click or tap here to enter text.	

SECTION 17 – TREATMENT/PROCEDURE COSTS	
Ensure you include all costs that are connected to providing the treatment or procedure.	
17a. What is the cost of the treatment / procedure including any drug / attendance costs / device / administration / staff / follow up / diagnostics costs / consumables etc.?	£

	Give a breakdown of this cost per annum, per cycle etc. as appropriate:	
17b.	**What is the total estimated cost for the package of treatment/care?**	£
17c.	**What is the cost of the standard therapy it replaces including any drug / attendance costs / staff / follow up / diagnostics costs etc.?** **Give a breakdown of this cost per annum, per cycle etc. as appropriate:**	£

SECTION 18 – INCIDENCE & PREVALENCE		
18a. Incidence:	**Estimate the number of patients expected to have this condition per 100,000 population per year:**	Click or tap here to enter text. Per 100,000
18b. Prevalence:	**Estimate the number of patients expected to have this condition per 100,000 population at any one time:**	Click or tap here to enter text. Per 100,000
18c. Supporting evidence:	**Published references should be listed here and provided in full text in order to be considered by the IFR Panel:** Click or tap here to enter text.	
18d.	**How many patients currently attend your service with this condition for which you would wish to use this treatment?**	Click or tap here to enter text.
18e.	**How many patients would expect to see in one year with this condition for which you would wish to use this treatment?**	Click or tap here to enter text.
18f.	**Is this a service development that has been discussed with commissioners?**	☐ Yes ☐ No
18g.	**If this treatment were to be funded for this patient on an individual basis, would the decision set a precedent for other requests?**	☐ Yes ☐ No

SECTION 19 – DECLARATION OF INTERESTS
19a. Clinicians are required to disclose all material facts as part of this process. **Are there any other comments / considerations that are appropriate to bring to the attention of the IFR Team?**
Click or tap here to enter text.

On Completion

Email to the appropriate dedicated email via nhs.net account:

NHS Cheshire CCG	cheshireccg.ifr@nhs.net
NHS Halton CCG	IFR.manager@nhs.net
NHS Knowsley CCG	lorraine.frodsham@nhs.net
NHS Liverpool CCG	IFR.manager@nhs.net
NHS Southport & Formby CCG	IFR.manager@nhs.net
NHS South Sefton CCG	IFR.manager@nhs.net
NHS St Helens CCG	IFR.manager@nhs.net
NHS Warrington CCG	warringtonccg.IFR@nhs.net
NHS Wirral CCG	wirralccg.IFR@nhs.net