**NHS Cheshire and Merseyside Integrated Care Board (ICB)**

**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 local health system? (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 contracts team how you submit a business case for consideration through the usual business planning process.

Applicants are advised to review the IFR Management Policy and the IFR Decision Making Policy available on the ICB 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.

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| **SECTION 1A – PATIENT PERSONAL DETAILS** | | | | |
| **1a. Patient Surname:** | Click or tap here to enter text. | | **1e. NHS Number:** | Click or tap here to enter text. |
| **1b. Patient Forename:** | Click or tap here to enter text. | | **1f. Hospital Number:** | Click or tap here to enter text. |
| **1c. Patient Middle Name(s):** | Click or tap here to enter text. | | **1g. Patient Ethnic Origin:** | Click or tap here to enter text. |
| **1d. Patient Date of Birth:** | Click or tap to enter a date. | | **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]](#footnote-2) 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. | | |
| **1k. Personal Representative’s Forename:** | | Click or tap here to enter text. | | |
| **1l. Source of Legal Authority:**  *e.g. Lasting Power of Authority, Court Appointed Deputy, Parent of Child* | | Click or tap here to enter text. | | |
| **1m. Personal Representative’s Address:**  **(Including Postcode)** | | Click or tap here to enter text. | | |
| **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.** | | | | |

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| **SECTION 2 – REGISTERED GP DETAILS** | |
| **2a. GP Name:** | Click or tap here to enter text. |
| **2b. GP Practice Name:** | Click or tap here to enter text. |
| **2c. GP Practice Address:** | Click or tap here to enter text. |
| **2d. GP Practice Postcode:** | Click or tap here to enter text. |
| **2e. GP Telephone Number:** | Click or tap here to enter text. |
| **2f. GP Email Address:** | Click or tap here to enter text. |

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| **SECTION 3 – AREA** | | |
| **3a. Please indicate the location of this patient** | Cheshire East  Cheshire West  Halton  Knowsley  Liverpool | Sefton  St Helens  Warrington  Wirral |

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| **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:** 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.** | |

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| **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. | |
| **5f. Date of Completion:** | 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. | | |

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

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| **SECTION 7 – DETAILS OF PROVIDER** | |
| **7a. Provider organisation:** | Click or tap here to enter text. |
| **7b. Clinical department / specialty:** | Click or tap here to enter text. |
| **7c. Contact telephone number:** | Click or tap here to enter text. |
| **7d. Secure NHS.net email:** | Click or tap here to enter text. |
| **7e. Postal address if no nhs.net email address:** | Click or tap here to enter text. |
| **7e. Secure-Haven Fax number:** | Click or tap here to enter text. |
| **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 patient’s registered ICB 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. |

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| **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. |

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| **SECTION 9 – TREATMENT REQUESTED** | |
| **9a. Name of treatment:**  **(Include any alternative terms)** | Click or tap here to enter text. |
| **9b. Where will the treatment take place (e.g. Inpatient or outpatient)?** | Click or tap here to enter text. |
| **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:** | |
| Click or tap here to enter text. | |
| **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. | |

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| **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. |

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| **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. |

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| **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?** |
| Click or tap here to enter text. |
| **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. |

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| **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 ICB with clinical reports, if the treatment is approved?** |
| Click or tap here to enter text. |

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| **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)**   * 1. **For insulin pumps and CGM systems include name of pump or CGM system, HbA1C, frequency, nature and management of any hypoglycaemic episodes with dates)**   2. **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. | |

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| **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. | |

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| **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:** | £ Click or tap here to enter text. |
| **17b. What is the total estimated cost for the package of treatment/care?** | £ Click or tap here to enter text. |
| **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:** | £ Click or tap here to enter text. |

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| **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 |

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| **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. |

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| **On Completion** |
| **Email to** [**ifr.manager@nhs.net**](mailto:ifr.manager@nhs.net) **from a secure email account e.g. nhs.net:**  **In the event that you are unable to forward the application from a secure email address, the application can be posted to:**  CONFIDENTIAL  1829 Building – Mail Account  Individual Funding Request Team  Countess of Chester Hospital NHS Foundation Trust  Liverpool Road, CHESTER, Cheshire CH2 1UL |

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)