NHS Lancashire and South Cumbria Integrated Care Board (ICB)

Individual Funding Request (IFR) Application Form

NB: An online application form is available for Morecambe Bay patients - this can be accessed via the following link: <https://nww.datixifr.midlandsandlancashirecsu.nhs.uk/live/index.php?form_id=4&module=COM>

**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 ICBs?***

**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 ICB) 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:**Click or tap here to enter text. |
| **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:** | Click or tap here to enter text. | **NHS Number:** | Click or tap here to enter text. |
| **Patient Forename:** | Click or tap here to enter text. | **Patient Date of Birth:** | Click or tap to enter a date. |
| **Patient Middle Name(s):** | Click or tap here to enter text. | **Patient Sex (M/F):** | [ ] Male [ ] Female [ ]  MxClick or tap here to enter text. |
| **Patient 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 consideration by the IFR Panel. This information is collected for monitoring purposes only.** |

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| **SECTION 3 – AREA** |
| **Please indicate the location of this patient** | [ ]  Central Lancashire (Chorley South Ribble, Greater Preston)[ ]  Fylde Coast[ ]  Morecambe Bay[ ]  Pennine Lancashire (Blackburn with Darwen, East Lancashire)[ ]  West Lancashire |

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| **SECTION 4 – REGISTERED GP DETAILS** |
| **GP Name:** | Click or tap here to enter text. |
| **GP Practice Name:**  | Click or tap here to enter text. |
| **GP Practice Address:** | Click or tap here to enter text. |
| **GP Practice Postcode:** | Click or tap here to enter text. |
| **GP Telephone Number:** | Click or tap here to enter text. |
| **GP Email Address:** | Click or tap here to enter text. |

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| **SECTION 5 – 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 6 – DETAILS OF REQUESTER (if different to the patient’s GP)** |
| **Name:**  | Click or tap here to enter text. |
| **Job role:** | Click or tap here to enter text. |
| **Organisation:** | Click or tap here to enter text. |
| **Contact telephone number:** | Click or tap here to enter text. |
| **Secure NHS.net email or postal address:** | Click or tap here to enter text. |

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| **SECTION 7 – DETAILS OF PROVIDER (if different to the requester or patient’s GP)** |
| **Provider organisation:** | Click or tap here to enter text. |
| **Clinical department / specialty:** | Click or tap here to enter text. |
| **Contact telephone number:** | Click or tap here to enter text. |
| **Secure NHS.net email or postal address:** | Click or tap here to enter text. |

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| **SECTION 8 – PATIENT DIAGNOSIS AND CLINICAL BACKGROUND** |
| **Primary diagnosis related to this request:** |
| Click or tap here to enter text. |
| **Outline of the patient’s condition including the timeline, current presentation and symptoms. Please give validated clinical measures, named in full.**  |
| Click or tap here to enter text. |
| **Relevant medical history: (Including co-morbidities)** |
| Click or tap here to enter text. |

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| **SECTION 9 –REQUESTED TREATMENT** |
| **Name of requested treatment:** **(Include any alternative terms)** | Click or tap here to enter text. |
| **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:**Click or tap here to enter text. |
| **Anticipated start date, if known/appropriate:** |
| Click or tap to enter a date. |

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| **SECTION 10 – 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.** |
| Click or tap here to enter text. |

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| **SECTION 11 – 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.** |
| Click or tap here to enter text. |

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| **SECTION 12 – 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?** |
| Click or tap here to enter text. |
| **What is the standard treatment for this condition at this stage in the pathway and why is this not appropriate for this patient?** |
| Click or tap here to enter text. |
| **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 13 – ANTICIPATED OUTCOMES** |
| **What are the anticipated outcomes of the treatment requested for this patient?** |
| Click or tap here to enter text. |
| **How will the outcomes of the treatment requested be measured? Use validated measures.** |
| Click or tap here to enter text. |
| **When will these outcomes be expected?** |
| Click or tap here to enter text. |
| **What stopping criteria will be in place (if appropriate)?** |
| Click or tap here to enter text. |

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| **SECTION 14 – 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 ICB’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** |
| Click or tap here to enter text. |
| **Please explain why that material difference means the Standard Policy should not apply.** |
| Click or tap here to enter text. |

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| **SECTION 15 – 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 ICB** |
| **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.**  |
| Click or tap here to enter text. |
| **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. |
| **Has it been subjected to NICE appraisal or other scrutiny?**  | [ ]  Yes [ ]  No  |
| If Yes, please give details: Click or tap here to enter text. |
| **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. |
| **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 – 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*** | £ Click or tap here to enter text. |
| **What is the total estimated cost for the package of treatment/care?** | £ Click or tap here to enter text. |
| **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:** | £ Click or tap here to enter text. |

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| **SECTION 17 – 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?** |
| Click or tap here to enter text. |

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| **SECTION 18 – SIGNATURE OF REQUESTING CLINICIAN** |
| **Signature:**  |  |
| **Date** | Click or tap to enter a date. |

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| **ON COMPLETION**  |
| Please email the completed form and enclosures via secure email to the email address listed below: **Email to** **funding.requests@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:**CONFIDENTIALLeyland House – Mail Account Individual Funding Request Team Lancashire Enterprise Business ParkCenturion Way, Leyland, PR26 6TR  |

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)