

IFRP REF:	SM0000					
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GENERIC INDIVIDUAL FUNDING REQUESTS (IFR) APPLICATION

For interventions not funded/commissioned by Somerset CCG or where published criterion is not met
The completed application form with the supporting evidenced to be emailed to ifrsomerset@nhs.net

PATIENT INFORMATION: <i>Failure to complete all sections of this application form could result in a delay whilst the information is being sought from the referrer</i>					
Does this case need to be reviewed urgently due to clinical need? <i>If yes, please explain:</i>		<input type="checkbox"/> YES	An urgent request is one which requires urgent consideration and a decision because the patient faces a substantial risk of significant harm or death if a decision is not made before the next scheduled monthly meeting of the IFR Panel. What is the window of opportunity and the timescale required for optimum treatment?		
		<input type="checkbox"/> NO			
Name				Male	<input type="checkbox"/>
				Female	<input type="checkbox"/>
Address				Post Code	
Date of Birth			NHS Number		
I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a panel/IFR team to decide whether this application will be accepted and treatment funded. By submitting this application form I the referring clinician confirm the patient or patient representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given					<input type="checkbox"/>
REFERRER'S DETAILS GP/CONSULTANT INFORMATION:					
Name					
Address				Post Code	
Telephone			Email		
GP Details (if not the referrer)					
Name			Practice		
<p>By submitting this form you confirm that the information provided is, to the best of your knowledge, true and complete and you confirm by marking the box(s) that you have:</p> <p><input type="checkbox"/> 1. Referred to the relevant policy prior to completing this IFR application form</p> <p><input type="checkbox"/> 2. Informed the patient the intervention is only funded where criteria are met or exceptionality demonstrated</p> <p><input type="checkbox"/> 3. Discussed all alternatives to this intervention with the patient</p> <p><input type="checkbox"/> 4. Had a conversation with the patient about the most significant benefits and risks of this intervention</p> <p><input type="checkbox"/> 5. Advised the patient NHS Decision Making Aids are available online should the patient wish to access them at http://sdm.rightcare.nhs.uk/pda/</p> <p><input type="checkbox"/> 6. Discussed with the patient whether any additional communication requirements (e.g. different language, format or limited capacity) are needed (please specify requirements in the box below)</p>					
Clarification/Communication Needs:					
Secondary Care (NHS Providers) to also confirm :					
<input type="checkbox"/> 7. I have informed the patients GP of this application					
<input type="checkbox"/> 8. I have attached the relevant meeting minutes relating to this application					
<i>It is essential that appropriate governance systems are in place before an Individual Funding Request is made for a new intervention for the requested indication. Providers and Acute Trusts must therefore confirm that this intervention has been considered by their Clinical Effectiveness/ Drugs & Therapeutics Committee (or equivalent) which supports this intervention as appropriate</i>					
<u>ANY IFR APPLICATION NOT COUNTERSIGNED BY A SENIOR CLINICIAN - A SALARIED PARTNER - LOCUM GP WILL BE REJECTED</u>					
SIGNED REFERRER:				DATE:	

- GP's to complete Q1–Q6 (& Q15 if appropriate)
- Secondary Care Clinicians (NHS Providers) to complete Q1–Q15

Q1	What intervention are you requesting			
Q2	Expected patient benefit of proposed intervention			
Q3 (a)	Brief relevant health history			
(b)	Clinical Need			
Q4 (a)	Patient's BMI		Date Recorded by Clinician	
	(b)	Smoking Status		

Q5 - TREATMENT HISTORY RELEVANT TO THIS CASE - What treatment has the patient tried?

Date	Intervention	Reason for stopping/Response achieved

Q6 - EXCEPTIONALITY OF THIS PATIENT

This is the most **IMPORTANT PART** of the IFR application It is crucial that you answer this question comprehensively; Otherwise the panel will be prevented from considering this application fairly

Exceptionality:
 What are the clinical factors over and above those set out which need to be considered and would set this patient out as exceptional?
 'On what grounds can the CCG's justify funding a particular patient over and above others from the same patient group who are not being funded?'

The fact a treatment is likely to be efficacious for a patient is not, in itself, a basis for exceptionality.
In making a case for exceptional consideration, it needs to be demonstrated:

- the patient is significantly different to the general population of patients with the condition in question
- the patient is likely to gain significantly more benefit than might be normally expected for patients with the same condition

Include relevant clinical information from primary/secondary care and appropriate photograph(s)

Q7	What is the standard care pathway for patient's with this condition		
Q8	Are there alternative interventions/devices available	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Describe:</i>
Q9	If yes is the alternative intervention/device commissioned	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Why is this alternative not appropriate?</i>
Q10	Please provide details And/or duration of proposed intervention		
Q11	Please provide costs of intervention/device if known, including administration of intervention/device		
Q12	If available the NNT (number needed to treat) for example if the NNT is 20 then 20 patients will need to be treated before one patient will benefit		
Q13	What will be the impact of refusal on the patient How will this be managed if funding is refused		
Q 14 - COHORT			
	(a) How many patients with this condition would you expect to see per annum in a population of one million		
	(b) Would this cohort of patients all benefit from this intervention/device <i>Provide details:</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	(a) How severe is your patient's condition in relation to this cohort		

Q15 - EVIDENCE OF EFFICACY & COST EFFECTIVENESS

Evidence of efficacy, safety & cost effectiveness of the intervention/device:

(e.g. NICE/Scottish Medicines Consortium/ASW Cancer Forum/All Wales Medicines Strategy/London New Drugs/ journals/publications) (attach additional sheet(s) if necessary) please attached PDF versions of articles if available

Please list below and attach full journal articles or NICE guidance;

- Somerset CCG published Policies be can accessed the SCCG website:
<http://www.somersetccg.nhs.uk/about-us/how-we-do-things/individual-funding-requests/>
- Upon receipt of a completed and signed application form with all the supporting evidence attached Somerset CCG IFR Team aims to review within 6 weeks of receipt
- If you have any queries please contact the IFR Administrator on 01935 384001
- The completed application form with supporting information should be emailed to
ifrsomerset@nhs.net