# NON-DRUG - INDIVIDUAL FUNDING REQUEST (IFR) FORM

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Requesters are advised to review the **Mid and South Essex Integrated Care System (M&SE ICB)** IFR Policy and the guidance for Clinicians at: <https://www.midandsouthessex.ics.nhs.uk>  **This form is to be used for non-drug requests where the requesting clinician is of the opinion this individual patient has an exceptional healthcare need and is presenting a case for clinical exceptionality.**  Mid and South Essex ICB 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 Mid and South Essex ICB. 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 2f and 2i is collected for monitoring purposes in an anonymised format to assist Mid and South Essex ICB in ensuring that we are complying with the Equality Act 2010. This information will be redacted prior to sharing with decision makers.  **Applications presenting incomplete information will be returned for amendment / completion prior to consideration by Mid and South Essex ICB.** | | | | |
| **Before completing and submitting this form, you MUST first consider the following:**   * **Is this a request for a treatment that is currently commissioned by NHS England?**   If YES, do not continue and redirect your request to NHS England.  If unsure, please see <https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/> or email [england.ift@nhs.net](mailto:england.ift@nhs.net) for advice.   * **Are there like to be any other patients with similar clinical circumstances across Mid & South Essex who could also benefit from the treatment you are requesting?**   If YES, a clear arguable case for exceptionality needs to be presented to demonstrate how this patient is clinical difficult to the cohort.   * **Is it likely that the healthcare need and claims of exceptionality could also apply to other patients within the cohort?**   If YES, alternative routes will need to be discussed for this intervention.   * **Could the request constitute a gap in provision which may require a service development?**   If YES, the IFR route may not be the most appropriate route for this request**.** | | | | |
| **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. | | | |
| **1f) Date of application** | Click here to enter a date. | | | |
| **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** | Click here to enter text. | | | |
| **2h) Ethnicity** | Choose an item. | | | |
| **2i) Disability** | **Yes**  **No**  Click here to enter text. | | | |
| **2j) Patient’s address** | Click here to enter text. | | | |
| **2k) Patient’s postcode** | Click here to enter text. | | | |
| **2l) GP Name** | Click here to enter text. | | | |
| **2m) GP Practice name** | Click here to enter text. | | | |
| **2n) GP postcode** | Click here to enter text. | | | |
| **What needs to be filled out:**   * If you are seeking funding for a treatment that is usually excluded or partially excluded from the NHS as indicated in the Service Restriction Policy (SRP), **only complete Sections 1, 2 & 3** * If you are seeking funding for a new treatment/technology, or a patient with rare clinical circumstances, you must **complete Sections 1, 2 & 4** * The following criteria should be used to identify how urgent a request is: * **Urgent/Fast Track** – response within five working days (refer to policy for definition/criteria) * **Routine** – from application received to decision: up to 40 working days | | | | |
| **SECTION 3 – must be completed for treatments that are usually excluded or partially excluded from the NHS as indicated in the SRP** | | | | |
| **Only evidence of clinical exceptionality will be taken into consideration.** | | | | |
| **Intervention Request:** | | | | |
| **3a) Type of intervention** | | | Choose an item. | |
| **3b) Is the requested intervention detailed in an existing MSE commissioning policy?** | | | Choose an item. | |
| **3c) What is the proposed treatment?** | | | Click here to enter text. | |
| **3d) What is the patient’s condition/diagnosis** | | | Click here to enter text. | |
| **3e) Patients BMI: (if relevant)** | | | Click here to enter text. | |
| **3f) What treatments has the patient received to date for this condition** | | | Click here to enter text. | |
| * **Exceptionality Test 1**   Are there any clinical features of the patient’s case which make the patient significantly different to the general population of patients with the condition in question at the same stage of progression of the condition?  (The onus is on the applicant clinician to demonstrate that this patient is significantly different from other patients in a similar situation to justify department from the usual clinical management.) | | | | |
| Click here to enter text. | | | | |
| * **Exceptionality Test 2**   Would the patient be likely to gain significantly more clinical benefit from the requested intervention than might be normally expected for the general population of patients with the condition at the same stage of the progression of the condition?  (The onus is on the applicant clinician to demonstrate that there are factors about this specific patient that indicate a departure from the usual clinical management will result in a gain for this patient that is significantly greater than that normally expected of this patient population in general.) | | | | |
| Click here to enter text. | | | | |
| **3g) How many patients in a 12-month period would the MSE expect to seek similar treatment for?** | | Click here to enter text. | | |
| **3h) How much does the intervention cost?** | | Click here to enter text. | | |
| **SECTION 4 – must only be completed for applications for new treatments/technologies, or for patients with rare clinical circumstances** | | | | |
| The proposed intervention should have a high likelihood of success or should substantially reduce the risk associate with the standard intervention. Please provide evidence (e.g., papers outlining the intervention outcome with patient specific information sufficient to identify the proposed patient as being similar to the study in which the benefit was seen).  **The Panel will base its deliberations on the information provided.** | | | | |
| **4a) Treatment Requested** | | | | |
| Click here to enter text. | | | | |
| **4b) Effectiveness**   1. Is the intervention effective? 2. Why is the proposed intervention thought to be superior to the standard treatment in this patient’s case? 3. Have clear outcomes been set with the patient? 4. What level of response will be considered ineffective? 5. How is response to the intervention to be monitored? 6. What is the end point at which the intervention will stop? 7. What are the longer-term follow-up arrangements? 8. Are these the responsibility of the unit in which the intervention took place or a unit more local to the patient’s home?   Do the follow-up arrangements attract additional resource? | | | | |
| Click here to enter text. | | | | |
| **4c) Safety**   1. Is the proposed intervention safe? 2. Is the treating clinician adequately qualified/experienced to perform this treatment?   Please provide evidence. | | | | |
| Click here to enter text. | | | | |
| **4d) Equity and fairness**   1. What are the local treatment options for this patient? 2. What is the cost of the standard intervention vs. the proposed intervention? | | | | |
| Click here to enter text. | | | | |
| **4e) Patient BMI: (if relevant)** | | | Click here to enter text. | |
| **4f) Additional Treatment Information**: (please also attach prescription history, clinical letters, etc) | | | | |
| Click here to enter text. | | | | |
| **4g) Evidence** | | | | |
| * **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.*) | | Click 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 here to enter text. | | |
| **SECTION 5 – SUBMIT** | | | | |
| When you are satisfied that you have completed all relevant sections, you will need to submit the request for consideration by Mid & South Essex ICB Funding Team. Please note requests will be managed within a maximum period of 40 working days from the date of the receipt of an application to the date of the letter from either the Funding team or Panel.  If the Funding team requires more information, they will contact you to ask that you provide more details and if this happens, the timeline for the request will be ‘paused’ until the requested information is received. | | | | |
| **5a) Clinicians are required to disclose all material facts to Mid & South Essex ICB as part of this process.**  **5b) Are there any other comments or considerations that are appropriate to bring to the attention of the Funding Team/Panel?** | | | | Click here to enter text. |
| **Please complete in full and return this form to:** [**mseicb.ifrfunding@nhs.net**](mailto:mseicb.ifrfunding@nhs.net)  **Handwritten forms will not be accepted.** | | | | |