IFR Application Form

(Individual Funding Request)

NHS Derby and Derbyshire Clinical Commissioning Group

Requesters are advised to review the NHS Derby and Derbyshire CCG, IFR Standard Operating Procedures (SOP) and the Guidance for Clinicians at http://www.derbyshiremedicinesmanagement.nhs.uk/clinical-policies-home/goverance-policies NHS Derby and Derbyshire CCG requires provider trusts and clinicians to take NHS Derby and Derbyshire CCG 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 NHS Derby and Derbyshire CCG. 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 respond 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 2g and 2h is collected for monitoring purposes in an anonymised format to assist NHS Derby and Derbyshire CCG in ensuring that we are complying with the Equality Act 2010. This information will be redacted prior to sharing with decision makers.

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 application it will be returned to you for redaction and submission.

Please note: Applications presenting incomplete information will be returned for amendment/completion prior to consideration by NHS Derby and Derbyshire CCG.

Please complete this form in full and return to the IFR Department IN A TYPED FORMAT electronically to DDCCG.IFRfundingrequest@nhs.net adhering to confidentiality procedures.
INCOMPLETE OR WRITTEN FORMS WILL BE REJECTED

Section 1 – PROVIDER DETAILS	
1a) Name of Provider:	
1b) Name of Clinician who will undertake the intervention:	
1c) Job Title/Role:	
1d) Secure NHS Email:	
1e) Telephone Number:	
Section 2 – PATIENT/GP DETAILS	
2a) First name:	
2b) Last name:	
2c) NHS Number:	
2d) Patient's hospital no:	
2e) Date of Birth:	
2f) Gender:	
2g) Ethnicity:	
2h) Patient's Address:	

2i) Patient's Postcode:		
2j) GP name:		
2k) GP Practice name:		
2l) GP Postcode:		
Section 3 – Request Details		
3a) Please detail the clinical reasons for urgency if appropriate i.e. the risks of adverse clinical outcome to the individual patient:		
3b) If treatment has commenced more than 2 working days before submission of this application please provide an explanation for the delay in application:		
3c) Proposed treatment stop date (if applicable):		
Application Support (<u>For Secondary Care use ONLY</u>)		
The IFR Policy and SOP highlight that Trust support of an IFR Application is mandatory. The IFR application will not progress in the absence of this support. Requests must be supported by a relevant multidisciplinary team (MDT) or Trust Drugs and Therapeutics Committee (DTC) AND by the provider trust Medical Director.		
3d) DTC or equivalent approval and provide a copy of the minutes:	*(Please provide details and date of approval)*	☐ Yes ☐ No ☐ N/A
3e) MDT Approval and provide a copy of the minutes:	*(Please provide details and date of approval)*	☐ Yes ☐ No ☐ N/A
3f) Name and email of Chief or, in exceptional circumstances to avoid delays in submission to the Deputy Chief Pharmacist:		
3g) Confirm that the Chief/Deputy Chief Pharmacist supports this drug application:	☐ Yes ☐ No ☐ N/A	
3h) Name and email of Medical Director or, in exceptional circumstances to avoid delays in submission, the Deputy Medical Director:		
3i) Confirm that the Medical Director/Deputy Medical Director supports this application:	☐ Yes ☐ No	
Consent		
3j) This IFR has been discussed in full with the patient or patient representative. They are aware that they are consenting for the IFR Team to receive and review confidential clinical information about their health. **I confirm all of the above:**	☐ Yes ☐ No	
3k) In submitting this application you are under obligation to advise the patient or patient representative of the details of the reasons for decision. **I confirm that I will advise the patient or patient representative of the reasons for the decision:**	☐ Yes ☐ No	
3l) The patient or patient representative will receive a letter outlining that a decision has been made and what that decision is, although will not receive the details for that decision. **I confirm that it is clinically appropriate for the patient to be informed of the outcome of this IFR**	☐ Yes ☐ No	
3m) I understand that by indicating that it is NOT clinically appropriate for the IFR		

Team to contact the patient or patient representative with the outcome, I will be fully responsible to do this. **I will inform the patient or patient representative of the outcome and the reasons for the decision.**	☐ Yes ☐ No

Section 4 – TREATMENT		
4a) Primary Diagnosis most relevant to this IFR Request and any relevant comorbidities:		
4b) Intervention details including treatment modality (if applicable), how and where the treatment will be given:	Intervention:	
	Modality:	
	How will treatment be given:	
	Where will treatment be given:	
4c) Is there an existing clinical policy for this treatment and condition? Please provide explicit reasons why your patient does not meet the access criteria within that policy. (DDCCG Policies can be found here: http://www.derbyshiremedicinesmanagement.nhs.uk/clinical-policies-home/clinical-policies)		
Cost		
4d) What are the costs of the intervention?	☐ Single treatment	**TOTAL COST: £**
	☐ Multiple treatments	Cost per treatment
Enter Date/Dose/Costs		£
Enter Date/Dose/Costs		£
Enter Date/Dose/Costs		£
4e) Additional comments on the costs of the intervention:		
4f) What are the total costs of standard therapy (estimate annual costs if applicable)?		
4g) Are there any offset costs (provide details)?	☐ Yes ☐ No Details:	
Clinical Outcomes		
4h) What are the intended clinical outcomes and how will the benefits of the procedure / treatment be measured (including where appropriate the validated clinical tools to be used)?		
4i) Within what timeframe will these outcomes be determined?		
4j) What 'stopping' criteria will be in place to assess when the treatment is ineffective and treatment will be withdrawn?		
4k) What mechanisms will be in place to provide		

NHS Derby and Derbyshire CCG with clinical outcome reports if the treatment is approved?	

Section 5 – Clinical Background

5a) Outline the background to the patient's clinical situation relevant to this request, timeline, current status and symptoms. *Please give validated clinical measures, name in full.*	

Treatment History

	Treatment	Regimen	Start date	Stop date	Response	Funding Source
5b) Current						
5c) Previous						
5d) Previous						

5e) Additional Comments on current or previous treatments.	

Additional Treatment Information

5f) What are the alternative (including NHS England Commissioned) standard treatments available to patients with this condition/stage of the disease and why are they not appropriate for this patient?	
5g) Prognosis – what are the anticipated clinical benefits in this individual case of the particular treatment requested over other available options?	
5h) Risk/benefit profile of this treatment compared to standard treatments in this individual case:	
5i) Anticipated prognosis if treatment request is not funded?	

Section 6 – Clinical Exceptionality
Is there evidence that this patient has exceptional clinical circumstances, demonstrating that:

6a) There is a NHS Derby and Derbyshire clinical commissioning policy, NICE Technology Appraisal (TA) Guidance or Appraisal guidance and the patient is in a different clinical condition when compared to the typical patient population with the same condition and (if relevant) at the same stage of progression, and that because of that difference the patient is likely to receive material additional clinical benefit from treatment that would not be plausible for any typical patient. **OR**	☐ Yes *(Please provide comprehensive comments)*
6b) There is not a relevant NHS Derby & Derbyshire CCG commissioning policy, NICE	☐ Yes *(Please provide comprehensive comments)*

Technology Appraisal (TA) Guidance or Appraisal Guidance in place for the management of the patient's condition or combination of conditions, and the patient's clinical presentation is so unusual that they could not be considered to be part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken.		
Section 7 – Clinical Supporting Information		
Incidence and Prevalence – for this patient's individual circumstances		
7a) Incidence This is expected to be two or fewer patients per million population per year (approximately 2 patients across Derbyshire per year). Please provide references.	The number of new cases of a disease in a defined population within a specific period of time. The intervention for a particular condition at the same stage of progression of that condition is expected to be initiated for two or fewer patients per million population at any one time.	
	Where a patient has one or more conditions, the figures provided should be for patients expected to have the combinations of conditions. Please provide specific details.	
7b) Prevalence This is less than 10 patients per million population at any one time (approximately 10 patients across the Derbyshire). Please provide references.	i.e. the number of cases of a disease in a defined population at a point in time. The total number of patients on the intervention for a particular condition at the same stage of progression of that condition is less than 10 patients per million population at any one time.	
	What is the anticipated need for this treatment per 1000 head of population i.e. how often would you expect to request this treatment for this condition at this stage of progression of the condition for a given size of population?	
7c) Do you consider that there are likely to be other patients presenting in Derbyshire within the next 12 months with this patient's condition at the same stage of this condition? If so please provide the number.		☐ Yes ☐ No ☐ N/A *Details*:
7d) How many patients currently attend your service with this condition for which you would wish to use this treatment?		
7e) Is this a service development that has been discussed with commissioners?		☐ Yes ☐ No

	Details:
7f) Do you plan to submit a future preliminary policy proposal for consideration of funding of this treatment (rather than submit individual requests for single patients)?	☐ Yes ☐ No
Evidence	
7g) 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 the published papers submitted must be provided with an indication of which points within them are specifically relevant to the case).	
7h) Is the procedure/treatment part of a current of planned national or international clinical trial or audit?	☐ Yes ☐ No *Details*:
Section 8 - SUBMIT	
When you are satisfied that you have completed all sections you will need to submit the request for consideration by the NHS Derby and Derbyshire CCG IFR Team. If the IFR Team needs more information they will email you to ask that you provide more details and if this happens, the timeline for the request is suspended until this is received.	
Clinicians are required to disclose all material facts to NHS Derby and Derbyshire CCG as part of this process. Are there any other comments/considerations that are appropriate to bring to the attention of the IFR Team?	
Please complete and return this form in a typed format to: ddccg.ifrfundingrequest@nhs.net	