NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Individual Funding Request (IFR) Form -

for EXCEPTIONAL CASES ONLY

NOTE: This form should only be used when applying for funding from Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) *on an exceptional basis* - for those services (drugs therapies / procedures / tests) that the ICB **does not routinely** commission.

This form **MUST** be completed by the clinician who is recommending the treatment (this should not be delegated to another clinician from a different provider organisation)

This form should not be used to request funding:
When patients meet a NICE TAG Approved Technology, for Prior Approvals for patients who meet with the ICB policy criteria, for service developments to meet the needs of a group of patients, however small.

In making any request, providers and clinicians should refer to the ICB's Individual Funding Request (IFR) Policy

In order for funding to be considered through the IFR process, the requester needs to tell us *how* the patient meets our exceptionality criteria, attaching any supporting evidence. In addition, the requester must provide evidence of the expected benefit. Please therefore complete ***all*** the sections below - requests can only be considered if this form has been completed ***in full***. Refer to additional pages if you need extra space.

Any request submitted without the relevant clinical evidence and supporting information (including costs) will be returned for completion

PATIENT DETAILS

Staffordshire and Stoke-on-Trent Integrated Care Board have a legal responsibility to proactively reduce health inequalities. When looking at inequalities it is important to consider the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act 2010 act made it against the law to discriminate against someone because of a protected characteristic.

Surname	
Forename(s)	
Address	
Date of Birth	
Please indicate your gender	☐ Male ☐ Female ☐ Other ☐ I do not wish to disclose this
Please indicate the option which best describes your marital status	☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil partnership ☐ I do not wish to disclose ☐ Legally separated ☐ Other

Please indicate your ethnic origin	**Asian or Asian British** ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background, please describe:- _____ **Black or Black British** ☐ African ☐ Caribbean ☐ Any other Black background **Mixed/Multiple Ethnic Groups** ☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐ Any other mixed/multiple ethnic background, please state below:- _____ **Gypsy & Traveller** ☐ Irish ☐ Gypsy or Irish Traveller ☐ Other, please state below: _____ ☐ I do not wish to disclose **White** ☐ English/Welsh/Scottish/ Northern Irish/British ☐ Irish ☐ Polish ☐ Other European, please state:- _____ ☐ Any other White background, please state:- _____ **Chinese or other Asian Group** ☐ Chinese ☐ Any other Asian background **Other Ethnic Group** ☐ Arab ☐ Any other ethnic group, please describe:- _____
Please indicate the option which best describes your sexual orientation	☐ Heterosexual or straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other sexual orientation not listed ☐ Not stated (I do not wish to disclose) ☐ I do not know/I am unsure
Transgender	Have you gone through any part of a process, or do you intend to (including thoughts and actions) to bring your physical sex appearance and/or your gender role more in line with your gender identity? (This could include changing your name, your appearance and the way you dress, taking hormones or having gender confirming surgery) ☐ Yes ☐ No ☐ I do not wish to disclose
Please indicate your religion or belief	☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam ☐ Judaism ☐ No Religion ☐ Sikhism ☐ Other, please describe: _____ ☐ I do not wish to disclose
Pregnancy & Maternity	**The Equality Act 2010 protects women who are pregnant or have given birth within a 26-week period. (Please tick as appropriate)**

Are pregnant at this time? **Have you recently given birth (within the last 26 weeks)?**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Prefer not to say	
Do you consider yourself to have a disability	**The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long term (12 months or longer) or substantial adverse effects on their ability to carry out day to day activities).**	
Please state the type of impairment which applies to you. People may experience more that one type of impairment, in which case you may indicate more that one. If none of the categories apply, please mark 'other'	☐ Physical impairment ☐ Mental Health Need (Learning Disability/Difficulty) ☐ Sensory impairment (e.g., Deaf, hard of hearing, blind, visually impaired) (please describe)_____ ☐ Long-standing illness (please describe) _____ ☐ Other (please describe) _____ ☐ Prefer not to say	
NHS Number		
Registered GP Name		
Registered GP Practice (include full postal address)		
Details of intervention/treatment for which funding is requested	Name of treatment/intervention	
	If a drug, dose & frequency	
	Planned duration of intervention (including number of treatments)	
	Cost per treatment/intervention	
	Anticipated total cost (inc VAT)	
	Please confirm where will treatment be administered	
Patient diagnosis for which intervention is requested		
Patient prognosis with proposed treatment		

Clinical effectiveness of intervention (i.e., the clinical evidence base for the intervention)	
If a drug treatment is requested, is the drug licensed for the requested indication in the United Kingdom? *If not licensed is the request a) Supported by the Trust's drug and Therapeutics Committee or equivalent and b) Licensed in any other country?*	
Is there published RCT evidence demonstrating effectiveness of the intervention for the proposed indication? (Journal reference to be included)	
Has NICE or any other relevant body (e.g., SMC, BNF) published guidelines?	

Patient prognosis without the proposed treatment	
Summary of relevant health history including previous interventions if applicable and any reason for stopping **Reasons for stopping may include Course complete, no or poor response, disease progression, adverse effects/poorly tolerated*	
What standard treatment does this request replace? Why is the standard treatment not appropriate?	
What are the alternative treatments/interventions and why have they not been tried?	

EXCEPTIONALITY

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Please confirm that the request is *not* about introducing a new therapeutic service (e.g., treatment or drug) of benefit to a definable group, however small.

☐ **YES** - it would be of benefit to a similar group or sub-group of people

☐ **NO** - it would not generally benefit others with this condition; this case is different

If no evidence of exceptionality is provided, this request will be treated as a service development and considered through the annual prioritisation process.

If you can answer "no" to point 1 above, please complete the following:

The patient is significantly different to the general population of patients with the same condition - i. please tell us below HOW this person is significantly different
ii. and attach supporting evidence

The patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with the condition –

i. please tell us below WHY this person would benefit significantly more
ii. and attach supporting evidence

How will this patient's condition alter over the next 28 days?

Please telephone the Senior IFR/Improvement Manager | Strategic Commissioning Team if your request is urgent to negotiate an appropriate timescale for the case to be considered.

Any other comments

PATIENT CONSENT -
The patient should be kept fully informed of progress of their request unless it contains information that would be detrimental to their condition. This should be by the most appropriate method with respect to their individual needs. If the patient indicates that they do not wish to be included in correspondence, it will be the responsibility of the referrer to inform them of the progress of their requests.

Referrer:

I,_____, confirm that I have fully explained to the patient the proposed intervention and the IFR process, stressing that funding is not guaranteed.

The patient needs to sign below to consent to you raising an IFR on their behalf, which includes their informed consent for sharing their medical records and indicate whether they wish to be included in the correspondence.

Patient:

I,_____, confirm consent that an IFR is raised on my behalf.

I also confirm that I **wish / do not wish** (*delete as appropriate*) to be included in the correspondence to the referrer.

Patient's signature:…… Date: ……

If the patient does not have mental capacity to consent to the process, please provide confirmation that a best interest assessment has been undertaken and the resulting decision

If the patient has not signed above, the IFR Team will not copy the patient into any correspondence or inform them of the decision via any other method.

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Name of Requester: .....

If you are not the patient, what is your relationship to patient?

GP / Consultant / Specialist Nurse / AHP / Advocate / Other **.....**

Address: **…….....**

…….....

Contact email: **……..... Phone no: .....**

Signed: **……..…… Date**: **…….....**

Please include with your request :

Evidence demonstrating why you feel this patient is an exceptional case ☐

Supporting /referral letters from other organisations/consultants involved in the patient's treatment (if applicable) ☐

Evidence based documentation regarding the efficacy of the intervention proposed ☐

On completion, please return to:

a) Email to: ifrteam@nhs.net
b) Stafford Hub, New Beacon Building, Stafford Education and Enterprise Park, Weston Road, Stafford, ST18