Individual Funding Request (IFR) Application Form

Notes for completion:

When should IFR application form be completed?

Requesting clinicians are advised to review the Department of Health: Individual Funding Requests: Policy Document to ensure an IFR is the appropriate mechanism to obtain funding.

DoH IFR Policy Document –
https://www.health-ni.gov.uk/sites/default/files/publications/health/ifr-policy.pdf

How should an IFR application form be completed?

Responsibility lies with the requesting clinician to present to the Regional Scrutiny Committee a full submission which sets out:

- a comprehensive, accurate and balanced picture of the patient history (including previous treatments and results/outcome of these) and present state/severity of the patient's clinical condition.
- the nature of the treatment requested
- the evidence base for the anticipated benefits of treatment
- the associated costs.

The requesting clinician may include a covering letter or additional supporting information where required. Requests with incomplete information or where assessment of the request cannot be made on the information provided will be returned with a request for clarification.

In completing this IFR, requesting clinicians are reminded of Clause 71 of the GMC's Good Medical Practice document:

You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

- You must take reasonable steps to check the information is correct.
- You must not deliberately leave out relevant information.

In submitting an IFR the requesting clinician is acknowledging that they have completed this form with honesty and integrity, communicated information fully with patients and colleagues, relating factual information, and that the included information is factual, complete and not misleading.

Does the request need to be considered urgently?

An urgent request is one which requires a response within 48 hours of submission as the patient faces a substantial risk of death or significant harm if a decision is not made before the

next scheduled meeting of the RSC. Any application that meets this criteria, if possible, will be included on the agenda of the next RSC meeting, if one is scheduled within the 48 hour period.

If this is not possible, the RSC Chair and vice-chair will discuss the request and provide a response to the requesting clinician within 2 working days of receiving the request. In this circumstance the IFR will be brought to the next RSC meeting for full discussion.

Retrospective requests will not normally be considered by the IFR RSC. The process for urgent assessment of a request below should ensure that retrospective requests should not be required. The RSC will therefore only consider retrospective requests in exceptional circumstances and these must be clearly outlined in the application. All retrospective requests where a patient has already been commenced on treatment by the requesting clinician will be notified to the medical director of the requesting Trust by the IFR secretariat as a matter of routine.

What is the Regional Scrutiny Committee?

The RSC provides regional input to the consideration of IFRs. The membership comprises clinicians across a broad range of specialities from across all Trust areas, ensuring a broad based clinical discussion. Requests should present the relevant information intelligibly to ensure the detail is clearly understood by the full Committee. Requesting clinicians should seek to avoid abbreviations or unnecessary technical language where possible.

What will the Regional Scrutiny Committee consider when making a decision?

The RSC panel will review the submission in line with the DoH IFR policy and the criteria for funding approval. The RSC will seek to determine whether the application has demonstrated that a patient's clinical circumstances are significantly different to other patients. To make this determination the RSC will:

- compare the patient to other patients with the same presenting medical condition, at the same stage of progression.
- only consider the patient's presenting medical condition and the likely benefits from the proposed treatment.
- only consider clinical factors when reaching a decision. Non-clinical factors including age, marital status or employment, or any such information which does not have a direct clinical connection to the patient's clinical circumstances will not be considered.
- consider the relative cost of treatment and the likely benefit to the individual patient.

Where should the completed application form be sent?

Please e-mail the application form and all relevant documentation to: ifrs@hscni.net.

1 – GENERAL INFORMATION		
Urgent Request: Yes: ☐ No: ☐ *(Note: An urgent request is one which requires a response within 48 hours of submission as the patient faces a substantial risk of death or significant harm if a decision is not made before the next scheduled meeting of the RSC.)*	Date of Request:	
Rationale for urgent request:		

2 - PATIENT DETAILS			
Patient Initials:		Gender:	
Date of Birth:		Age:	
Patient Postcode:		H&C No:	
GP Name & Practice:		GP Postcode:	

In accordance with guidance on eligibility given in "Healthcare for Frontier Workers" please confirm that the patient is ordinarily resident in Northern Ireland and automatically entitled to free HSC treatment:	☐
This IFR has been discussed in full with the patient or patient representative and are consenting for the RSC to receive and review confidential clinical information about their health to enable full consideration of this funding request.	☐

3 - TREATMENT REQUESTED	
Name of treatment requested: *(include any alternative terms)*	
Primary diagnosis related to this request:	
How many patients would HSCNI expect to see in one year with this condition?	
How many patients currently attend HSCNI with this condition and these clinical circumstances for which you	

anticipate this treatment might be considered?	
Is the treatment licenced in Northern Ireland for use in this particular indication?	Yes: ☐ No: ☐
Is this a single treatment or procedure or part of a course?	Single treatment ☐ Course ☐
If treatment is part of a course please provide the planned treatment schedule:	
How will the intervention be given to the patient? *e.g. oral / IV etc.*	
Where will the treatment be provided? *If treatment is to be received outside NI, please include a copy of the referral letter.*	
4 - COSTINGS ***(Note: Off-label treatments which are likely to cost under £10k per annum should be managed within existing Trust governance structures)***	
Frequency of treatment:	
Cost of requested treatment e.g. per cycle / per 28 days *(Use list price*)	
Cost of requested treatment e.g. per cycle / per 28 days *(Use discounted price if available to this specific case)*	
Total cost of treatment per annum: *(Include both total list price and total discounted price if applicable to the patient)*	

Are there any elements of the request which are considered to be standard care and the SPPG is therefore not being asked to fund?	
Has the costing information provided been provided / supported by an appropriate pharmacy lead?	Yes ☐ No ☐

5 - CLINICAL BACKGROUND

Outline the detailed background to the patient's clinical situation, current status, and any intolerance or adverse events.

Current Treatment: *(avoid abbreviations or acronyms)*	
Previous treatments: *(including start and stop dates)*	
Detailed overview of current clinical status and severity of symptoms, including details of response to previous treatments and, where applicable, details about why currently commissioned treatments are not appropriate:	
Significant co-morbidities:	
Other relevant information:	

6 – STANDARD TREATMENT AND OTHER POTENTIAL TREATMENT OPTIONS	
What is the standard treatment for this condition?	
Why is the standard treatment not appropriate for this patient?	
Are there any other potential treatment options available and why are these not considered appropriate for this patient?	
7 - ANTICIPATED OUTCOMES	
What are the anticipated outcomes of the treatment requested for this patient?	
How will the outcomes of the treatment requested be measured?	
When will these outcomes be expected?	
What stopping criteria will be in place?	

8 - CLINICAL CIRCUMSTANCES - CRITERIA UNDER WHICH THIS APPLICATION IS MADE *(Non-clinical factors cannot be taken into account by the RSC)*	
Do you consider this patient to: • Suffer from a medical condition for which the patient's particular clinical circumstances fall outside the criteria set out in an existing commissioning policy; • Require a new intervention or, for an intervention for a new indication outwith its licensed indication, where no commissioning arrangements exists; • Have a rare clinical circumstance for whom you wish to use an existing treatment outwith its licensed clinical indication.	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Demonstrate why this patient is significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition.	
Demonstrate why this patient is likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition.	

9 - EVIDENCE APPRAISAL	
What is the evidence base for the clinical benefit and safety of this procedure / treatment? *All references must be provided in full with the original documents appended to this request.* *Please provide as much information as possible to allow for appropriate assessment of the request.* *Continue on a separate sheet if necessary.*	
Has the treatment been subjected to a NICE appraisal or other scrutiny (for example SMC/AWMSG)?	Yes ☐ No ☐ If Yes, please give details:
Is the procedure/treatment part of a current or planned national or international clinical trial or audit? E.g. NHS England	Yes ☐ No ☐ If Yes, please give details:

10 - TRUST SUPPORT *(Support provided indicates that the Clinical Director, Service Manager & Pharmacy Lead has read and understood the request)*					
Has the request been supported by appropriate clinical peers?	Yes ☐ No ☐	Has the required resources /infrastructure been secured by the Trust to facilitate the request?	Yes ☐ No ☐		
Name of provider Clinical Director (or equivalent):					
HSCNI email address of Clinical Director:					
Signature of Clinical Director: *(may be electronic)*			Date of signature:		
Name of Service Manager (or equivalent):					
HSCNI email address of Service Manager:					
Signature of Service Manager: *(may be electronic)*			Date of signature:		
Name of pharmacy lead (or equivalent):					
HSCNI email address of pharmacy lead:					
Signature of pharmacy lead: *(may be electronic)*			Date of signature:		

11 - REQUESTER DETAILS			
Name of Requester:			
Organisation:		Signature of Requester:	
Contact telephone number:		Job role:	
HSCNI email address:			

All information in this request has been provided in accordance with Clause 71 of the GMC's Good Medical Practice. *(see notes for completion)*	Yes ☐ No ☐
Clinicians are required to disclose all material facts as part of this process including direct interest *(e.g. financial, research, publication of opinion etc.)*	
Are there any other comments/considerations that are appropriate to bring to the attention of the IFR RSC?	