**GM INDIVIDUAL FUNDING REQUEST FORM**

***The Individual Funding Request Case Panel***

Dealing equitably and appropriately with individual finding requests (IFRs) or exceptionality claims requires CCG decisions on an individual to be governed by the same principles as those that are applied to others with that condition and to the larger the population. Considerations of cost effectiveness rather than solely clinical effectiveness, the nature of the health gain and the quality of the evidence supporting the treatment are applied when a CCG considers funding a treatment for a group of patients and so these factors will similarly be considered when a treatment is requested for an individual.

***The Standard Proforma***

The use of a standardised form is an attempt to ensure that the Panel receives only those applications which are:

* Appropriate
* Contain adequate information and
* Address all relevant factors

It is important, therefore, that the form is as fully completed as possible before submission to the CCG. An incomplete form will, at best, delay the funding request process through additional information having to be sought and, at worst, may mean the request being turned down because all of the relevant details have not been presented to the Panel.

**It is the responsibility of the requesting clinician to supply the information / evidence required to support the request – that the treatment requested is clinically- and cost-effective and, where the case relates to exceptionality, that the patient’s case differs significantly from others with the same condition and stage of disease.** The Panel must base its decision on the information supplied by the requesting clinician and it is therefore vital that all relevant details are included on the proforma.

***When should this form be used?***

The purpose of the IFR process is to provide a mechanism for considering the needs of individual patients whose clinical circumstances might mean that an existing care pathway or treatment regime is unsuitable for them or make them an ‘exception’ to CCG commissioning policies.

**NOTE:** The Panel will only consider clinical factors in considering individual funding requests. **Social factors will not routinely be considered**.

***When should this form not be used?***

If a patient's clinical condition matches the 'accepted indications' for a treatment that is not currently funded, the request, by definition, is not for an individual but applies to a cohort of patients (now and in the future, however small) and will not be considered by the Panel.

Equally, the IFR process should not be used where the intention is to introduce a new intervention for a definable group of patients (however small). You should forward such requests for consideration by the CCG commissioners, usually via the development of a business case for the CCG to consider as part of its annual commissioning round.

***Instructions for Completion***

1. This form should be completed electronically on screen using Word.
2. When complete, save the document to your own file folders. Please ensure that any additional information that you wish to be considered alongside the proforma is included as either hyperlinks within the proforma or sent by e-mail as additional documents.
3. Clinical papers cited as references should be provided in full; abstracts, hyperlinks to abstracts or hyperlinks to papers only available by subscription to Journals are not acceptable.
4. Please send the completed proforma to gmifr.gmcsu@nhs.net [secure NHS address]
5. If you would like further information regarding the CCG’s IFR processes or advice on completing this form, please contact:

**Effective Use of Resources (EUR) Team**

**Greater Manchester Shared Services**

 **3rd Floor, St James House**

**Pendleton Way**

**Salford**

**M6 5FW**

**Tel No: 0161 212 6250**

**Fax No: 0161 212 6285**

**NOTE: We would prefer to receive this form electronically; please only send by post or fax in exceptional circumstances.**

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| **GM INDIVIDUAL FUNDING REQUEST FORM** |
| **1** | **APPLICATION BY** *(GP or Trust name)* |  |
| **2** | **APPLICATION FOR****e.g. Drug / Referral / Intervention***(short description only; a more comprehensive description will be required later)* |  |
| **3** | **DATE***(of this Application)* |  |
| **4** | **APPLICATION TO** *(Commissioner)* |  |
| **Patient details** |
|  | **Response** |
| **5** | **Name** |  |
| **6** | **Post Code of address** |  |
| **7** | **Date of birth** |  |
| **8** | **GP Name** |  |
| **9** | **GP Address** |  |
| **10** | **NHS No** |  |
| **REFERRER DETAILS** |
|  | **Response** |
| **11** | **Clinician Name** | *Include contact details in case of queries etc.* |  |
| **12** | **Speciality** *(if applicable)* |  |  |
| **13** | **Clinician contact details** | *Address / Phone number / email address* |  |
| **14** | **Purpose / reason for referral / application** | *e.g. is it for a second opinion; procedure; or new treatment* |  |
| **MEDICAL HISTORY** |
| **15** | **Patient’s Clinical Diagnosis and summary of clinical condition** | *Condition requiring treatment with requested drug/procedure device or referral. Please supply as much detail as possible about: severity, duration and prognosis. Include disease markers /disease activity scores / objective methods of measuring disease severity if at all possible.* |  |
| **16** | **Previous treatment(s) which have been tried to treat this condition AND the outcomes achieved. Please also state any treatments currently being given.** | *Please detail all interventions tried, start and end dates, and reasons for stopping / or response achieved. This will usually include standard treatment(s).* |  |
| **17** | **Relevant past medical history** | *Please detail any other relevant medical conditions that may influence decisions regarding the treatment being proposed. This may also include reasons that certain treatments cannot be given.* |  |
| **DETAILS OF TREATMENT REQUESTED** |
| **18** | **Details of drug / procedure / device or nature of referral requested** | *Please provide full description of intervention if not already stated* |  |
| **19** | **Anticipated duration of treatment** | *(one-off; days / months / lifetime / assessment / number of sessions etc.)* |  |
| **20** | **Who will provide this treatment/intervention?** | *Referrer or other provider?* |  |
| **21** | **Evidence of effectiveness – patient selection criteria;** **(hierarchy of evidence level etc.)**  | *Attach papers/web link to NICE / SMC / local / national guidance / guidance from professional bodies etc. If application is in accordance with NICE guidance, make clear how the patient meets NICE criteria* |  |
| **22** | **Details of costs of the treatment and information on any costs avoided** | *Is this in addition or instead of the current treatment? Estimated total cost if time limited / one off. Estimated annual cost if on-going* |  |
| **23** | **Expected (objective) outcomes of the treatment for this patient** | *What benefit would you expect the patient to derive from this new treatment/ intervention? This should be expressed as a patient orientated outcome e.g. improvement in pain score, increased functionality, rather than a disease orientated outcome e.g. physiological marker.* |  |
| **24** | **Exit criteria / review date** | *Please provide details including time frame for assessing whether intervention is worthwhile* |  |
| **25** | **Is the drug / intervention requested licensed for the identified indication?** |  |  |
| **26** | **Is the drug being used as part of a clinical trial?** | *If so, please provide information on how ethical approval was obtained and details of post-trial funding arrangements.* |  |
| **27** | **Has the patient been informed of any additional clinical risks involved with the proposed treatment?** | *Please outline risks* |  |
| **28** | **For an Intervention to be carried out in NHS Secondary or Tertiary Care:**1. **What is the Trust view?**
2. **Has the drug been considered by the Drug & Therapeutic Committee or other processes?**
 | *Please provide date and details of approval by an appropriate Therapeutics Committee. Approval by the D&TC does not mean the request will be approved* |  |
| **INDIVIDUAL CIRCUMSTANCES** |
| **29** | **What are the implications of not providing this treatment?** | *Short-, medium- and long-term health implications for* ***this*** *patient* |  |
| **30** | **Is the request urgent?** If yes, please provide a date by which a decision is required **AND** reasons as to why it is urgent | *State consequences of delay in treatment.* |  |
| **31** | **Statement of Clinical Need / Exceptional Circumstances** | Please detail the clinical need or exceptional clinical circumstances involved in this case.Please attach any relevant evidence to support case for need / exceptionality.*How will* ***this*** *patient benefit more from this treatment than all other patients with the same condition and at the same stage?* |  |
| **32** | **Other supporting factors** | *Provide any other supporting information felt to be relevant but note that social factors are very unlikely to be considered.* |  |
| **33** | **Patient’s BMI** | *Only required for requests for surgery e.g. bariatric surgery, apronectomy, cosmetic surgery including breast reduction* |  |
| **34** | **Has patient given consent for all information relating to their case to be shared with the Panel?** |  |  |
| **Signature of referring clinician:** *A name is sufficient when this form is being completed and transmitted electronically* |  |
| **Date:**  |  |