**Hertfordshire and West Essex Integrated Care Board**

**IFR Application Form**

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| Requesters are advised to review the IFR Policy at <https://www.hweclinicalguidance.nhs.uk/clinical-policies-group-evidence-based-interventions> Provider trusts and clinicians are required to take Hertfordshire and West Essex Integrated Care Board (HWE ICB) 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 that all the appropriate and required clinical information is provided to Hertfordshire and West 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.**DO NOT** include patient or trust/requesting clinician identifiable data in any free text sections. Where there are large amounts of identifiable data included, the application will be returned for redaction and resubmission.**Please note:** Applications presenting incomplete information will be returned for amendment/completion prior to consideration by Hertfordshire and West Essex ICB.It is recognised that urgent clinical decisions are rarely required. If a treatment is started by a provider in very urgent circumstances, where the IFR Panel is satisfied that a case was urgent, it will not refuse to determine the IFR application on the basis that it is retrospective. However, funding is not guaranteed, and this will be at the providers own financial risk. |
| **Consent**  |
| **Please confirm that the patient is aware of this application and that they consent for the EBI & IFR team to receive relevant clinical information in relation to this request.**  | [ ] Yes [ ] No  |
| In submitting this application, you are under obligation to advise the patient or patient representative of the details of the reasons for the decision. **I confirm that I will advise the patient or patient representative of the reasons for the decision.** | [ ] Yes [ ] No  |
| **PLEASE SELECT ONLY ONE OF THE TWO OPTIONS BELOW** |  |
| The patient or patient representative will receive a copy of the letter from the IFR team outlining that the decision has been made and what that decision is. **I confirm that it is clinically appropriate for the patient to be informed of the outcome of this IFR.** | [ ] Yes [ ] No  |
| **OR** |  |
| 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 [ ]  N/A  |
| **How urgent is this request?**  | **Routine** [ ]  Decision needed in 4 to 6 weeks**Immediate**  [ ] Decision needed within 3 weeks as delay will not beclinically appropriate. **Most Urgent** [ ]  Decision needed within a week as the patient’s life might be in danger. |
| **Section 1a – APPLICANT DETAILS**  |
|  Hospital/Organisation | Click here to enter text. |
|  Name of clinician | Click here to enter text. |
| Job title/role: | Click here to enter text. |
|  Secure NHS email: (to be used for ALL correspondence) | Click here to enter text. |
|  Telephone number: | Click here to enter text. |
| **Section 1b – DETAILS OF CLINICIAN/ORGANISATION WHO WILL UNDERTAKE THE INTERVENTION** | Click here to enter text. |
| **Section 2a – PATIENT DETAILS** |
| 2a) First name:  | Click here to enter text. |
| 2b) Last name: | Click here to enter text. |
| 2c) NHS number: | Click here to enter text. |
| 2d) Patient’s hospital no: | Click here to enter text. |
| 2e) Date of birth: | Click here to enter text. |
| 2f) Patient’s age at time of submission: | Click here to enter text. |
| 2g) Gender | Click here to enter text. |
| 2h) Ethnicity  | Click here to enter text. |
| 2i) Patient’s address: | Click here to enter text. |
| 2j) Patient’s postcode | Click here to enter text. |
| 2k) If for Elective surgery please provide patients height, weight, BMI and smoking status | Click here to enter text. |
| **Section 2b– GP DETAILS** |  |
| 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. |
| **Section 3 – REQUEST DETAILS**  |
| 3) What is being requested | Click here to enter text. |
| 3a) Direct commissioned service type: | Choose an item. |
| 3b) Please detail the clinical reasons for urgency if appropriate i.e. the risks of adverse clinical outcome to the individual patient: | Click here to enter text. |
| 3c) Proposed start date of treatment:  | Click here to enter a date. |
| 3d) If treatment has commenced more than 2 working days before submission of this application, please provide an explanation for the delay in application: | Click here to enter text. |
| 3e) Proposed treatment stop date (if applicable): | Click here to enter a date. |
| **Application Support**  |
| Requests should be supported by a relevant multidisciplinary team (MDT) **OR** Trust Drugs and Therapeutics Committee (DTC) **AND** by the provider trust Medical Director and Chief Pharmacist. |
| 3f) DTC or equivalent approval and provide a copy of the minutes:**OR** | Please provide details of outcome  | [ ] Yes [ ] No  |
| Click here to enter a date. |
| 3g) MDT approval and provide a copy of the minutes: | Please provide details of outcome  | [ ] Yes [ ] No  |
| 3h) Name and email of Chief Pharmacist or, in exceptional circumstances to avoid delays in submission, the Deputy Chief Pharmacist: | Enter name and email |
| 3i) Confirm that the Chief/Deputy Chief Pharmacist supports this drug application: | [ ] Yes [ ] No [ ] N/A |
| 3j) Name and email of Medical Director or, in exceptional circumstances to avoid delays in submission, the Deputy Medical Director: | Enter name and email |
| 3k) Confirm that the Medical Director/Deputy Medical Director supports this application: | [ ] Yes [ ] No [ ] N/A |
| **Section 4 – TREATMENT**  |
| 4a) Primary diagnosis most relevant to this IFR request and any relevant co-morbidities: | Click here to enter text. |
| 4b) Intervention details including treatment modality (if applicable), how and where the treatment will be given: | Intervention - Click here to enter text.Modality - Click here to enter text.How will treatment be given - Click here to enter text.Where will treatment be given - Click here to enter text. |
| 4c) Is there is an existing local or national (ie NICE) policy/guidance/recommendation for this treatment and condition? Please provide explicit reasons why your patient does not meet the access criteria within that policy. | Click here to enter text. |
| **Cost**  |
| 4d) What are the costs of the intervention? *Where appropriate include here the total cost of the treatment, any loading doses required, and the number of cycles applied for.*  | [ ] Single Treatment  | Total cost Click here to enter text. |
| [ ] Multiple TreatmentsEnter load doseEnter subsequent dose | Cost per treatment Click here to enter text. | Total cost Click here to enter text. |
| 4e) Additional comments on the costs of the intervention: | Click here to enter text. |
| 4f) What are the total costs of standard therapy (estimate annual costs if applicable)? | Click here to enter text. |
| 4g) Are there any offset costs (provide details)? | [ ] Yes [ ] No Click here to enter text. |
| **Clinical Outcomes**  |
| 4h) What are the intended clinical outcomes and how will the benefits of the procedure / treatment be measured (include, where appropriate, the validated clinical tools to be used)? | Click here to enter text. |
| 4i) Within what timeframe will these outcomes be determined? | Click here to enter text. |
| 4j) What ‘stopping’ criteria will be in place to assess when the treatment is ineffective and treatment will be withdrawn? | Click here to enter text. |
| 4k) What mechanisms will be in place to provide Hertfordshire and West Essex ICB with clinical outcome reports if the treatment is approved?Please provide detail of how you will report to Hertfordshire and West Essex ICB upon request. | Click here to enter text. |
| **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, named in full. | Click here to enter text. |
| **Treatment History**  |
|  | Treatment  | Regimen  | Start  | Stop  | Response | Funding response |
| 5b) Current: | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 5c) Previous: | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 5d)Previous | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 5e) Additional comments on current or previous treatments | Click here to enter text. |
| **Additional Treatment Information**  |
| 5f) What are the alternative (including Hertfordshire and West Essex ICB commissioned) standard treatments available to patients with this condition/stage of the disease and why are they inappropriate for this patient? | Click here to enter text. |
| 5g) Prognosis – what are the anticipated clinical benefits in this individual case of the particular treatment requested over other available options? | Click here to enter text. |
| 5h) Risk/benefit profile of this treatment compared to standard treatments in this individual case: | Click here to enter text. |
| 5i) Anticipated prognosis if treatment requested is not funded: | Click here to enter text. |
| **Section 6 – Clinical Exceptionality** Is there evidence that this patient has exceptional clinical circumstances, demonstrating that: |
| 6a) There is an existing local or national (i.e., NICE) policy/guidance/recommendation for this treatment and condition or combination of conditions, 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 Provide comprehensive comments  |
| 6b) There is not an existing local or national (i.e., NICE) policy/guidance/recommendation for this treatment and 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. | [ ] Yes Provide comprehensive comments  |
| **Genotypes**  |
| 6c) When the argument for clinical exceptionality is based on the patient having a specific genotype (genetic profile), please provide evidence of the prevalence of the genotype in that patient group and how the specific genotype would make the patient:1. Different to others in terms of clinical management

**AND**1. Able to benefit from the treatment to a greater degree than others with the same or different symptoms of the condition.
 | Click here to enter text.Click here to enter text.Click here to enter text. |
| **Section 7 – Clinical Supporting Information**  |
| **Incidence and Prevalence – for this patient’s individual circumstances** |
| 7a) Incidence  | Estimate the number of patients expected to be diagnosed with this condition per million population a year.  | Click here to enter text. |
| Where a patient has one or more conditions, the figures provided should be for patients expected to have the combination of conditions. Please provide specific details.  | Click here to enter text. |
| 7b) Prevalence | Estimate the number of patients expected to have this condition per million population at any one time  | Click here to enter text.per million  |
| 7c) Do you consider that there are likely to be other patients presenting in **Hertfordshire and West Essex ICB** in the next 12 months with this patient’s condition and at the same stage of this condition? If so, provide the number. | [ ] Yes [ ] No [ ] N/AClick here to enter text. |
| 7d) How many patients currently attend your service with this condition for which you would wish to use this treatment?  | Click here to enter text. |
| 7e) Is this a service development that has been discussed with Commissioners?  | [ ] Yes [ ] No If Yes, please provide 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 using the proforma at the end of the application form). | Click here to enter text. |
| 7h) 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 8 – SUBMIT** |
| **Date form completed:**  | Click here to enter text. | **Date form submitted:** | Click here to enter text. |
| When you are satisfied that you have completed all sections, you will need to submit the request for consideration by the Hertfordshire and West Essex ICB IFR Team. If the IFR Team need more information, they will email you (the requestor) to ask that you provide more details and if this happens, the timeline for the request is suspended until this is received. |
| Please declare any conflicts of interest with respect to this application | Click here to enter text. |
| Clinicians are required to disclose all material facts to Hertfordshire and West Essex ICB as part of this process. Are there any other comments / considerations that are appropriate to bring to the attention of the HWE ICB IFR Team? | Click here to enter text. |
| Please complete and return this form to:For West Essex patients ifr.hweicb@nhs.net Tel: 01992 566150For Hertfordshire patients ifr.hweicb@nhs.net Tel: 01707 685354 |

**Evidence Proforma**

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| Please provide reference to the key evidence for clinical exceptionality, clinical effectiveness, good use of resources and safety of this procedure/treatment in each of the papers submitted as part of the evidence base relevant to this application. |
| **No.** | **Title submitted paper** | **Topics** | **Specific sections with key evidence (page number/paragraph or section)** |
|  | Article one | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
|  | Article two | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
|  | Article three | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
|  | Article four | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
|  | Article five | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |
|  | Article six | Clinical exceptionality | Click here to enter text. |
| Clinical effectiveness | Click here to enter text. |
| Good use of resources  | Click here to enter text. |
| Safety of this procedure/treatment | Click here to enter text. |

With thanks and acknowledgement to NHS England IFR application Form