

# Appendix Seven – Funding for Continuation Requests

**NHS England Individual Funding Request (IFR) – Funding for Continuation of Treatment Form**

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| 1. **DETAILS OF ORIGINAL IFR**
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| IFR reference: | Date of IFR submission: |

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| 1. **PATIENT PERSONAL DETAILS**
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| Patient Name: |  |
| Date of Birth:  |  | NHS Number: |  |
| Patient Address:  |  |
| GP Name  |  |
| GP Practice name:  |  | GP Postcode: |  |
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| 1. **CONSENT**
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| This request for funding for continuation of treatment (originally approved via the NHS England Individual Funding Request (IFR) route) has been discussed in full with the patient or patient representative[[1]](#footnote-1). They are aware that they are consenting for the IFR Team to receive and review confidential clinical information about their health to enable full consideration of this funding request. I confirm all of the above. | Yes No |
| I understand that by indicating that it is NOT clinically appropriate for the IFR Team to contact the patient, I am responsible for sharing information relating to this request with the patient /patient representative. Their GP will be included in any responses and be aware of the request and its outcome. | Yes NoN/A |
| Name of Requester : |  |
| Signature of Requester: |  |
| Date continuation request submitted: |  |
| Responsibility lies with the requesting clinician to present to NHS England a full continuation request submission which sets out a comprehensive and balanced picture of the history and present state of the patient’s clinical condition, the nature of the treatment requested and the anticipated benefits of treatment. Requesters are advised to review the NHS England IFR policy, IFR Standard Operating procedures and the Guidance for Clinicians at <https://www.england.nhs.uk/commissioning/policies/gp/> |

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| 1. **DETAILS OF REQUESTER**
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| Name:  |  | Title: |  |
| Job role: |  |
| Provider organisation: |  |
| Clinical department / specialty: |  |
| Contact telephone number: |  |
| Secure NHS.net email or postal address: |  |
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| 1. **TRUST SUPPORT**
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| Provider Medical Director approval (**Mandatory**):Date Medical Director approval given: | Yes No |
| Name of provider Medical Director: |  |
| Email address of Medical Director: |  |
| Signature of Medical Director: |  |
| Pharmacy contact:Name and NHS.net email address: |  |
| 1. **PROVIDER SERVICE AND AUDIT**
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| Is your organisation commissioned by NHS England to provide this service or treatment? If No, state why the patient hasn’t been referred to an NHS commissioned provider: | Yes No |

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| 1. **PATIENT DIAGNOSIS**
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| Primary diagnosis related to this request: |  |
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| 1. **TREATMENT REQUESTED**
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| Name of treatment: (Include any alternative terms) |  |
| Dose/Frequency of treatment: |  |
| Start/Stop dates of approved treatment: |  |
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| 1. **CLINICAL REPORT**
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| 1. What clinical measures were used to record the outcome of the treatment requested?
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| 1. Please report on the observed response to treatment in relation to the change in the specific outcome measures identified in the original IFR application. How does this compare to the anticipated change stated in the IFR application: have these been achieved and to what extent?
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| 1. Describe how the observed clinical outcomes meet the original criteria for deciding whether the treatment was successful or unsuccessful
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| 1. What are the anticipated outcomes of the continued treatment requested for this patient? This should relate to the agreed ‘stopping’ criteria
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| 1. What is the future care plan for this patient, including long term plans (>2yrs)?
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| 1. What are the current clinical condition/ functional status of the patient?
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| 1. Any other clinical information relevant to this patient’s treatment?
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| 1. **TREATMENT / PROCEDURE COSTS**
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| Actual (i.e. based on observed rather than estimated) costs. Please **itemise** the costs (e.g. drug/attendance costs/ staff/ follow up/ diagnostics costs etc.).Please provide breakdown of this cost per annum, per cycle etc. as appropriate: | £…………………… |
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| 1. **DECLARATION OF INTERESTS**
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| Clinicians are required to disclose all material facts to NHS England as part of this process. Are there any other comments / considerations that are appropriate to bring to the attention of the IFR Team? |  |
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**For NHS England Office Use only:**

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| **1. POLICY UPDATES** |
| Has there been any policy updates related to this particular request and condition since the original IFR request was approved? Y / NIf Y please provide details: |
| **2. Continuation of funding approved?**  | Yes No |
| Date of decision:  |  |
| Continuation request reviewed by: |  |
| Reasons for decision made: |  |
| (If approved), continuation request funded for a further: | 6 months 12 months Other Please provide detail on this:  |

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| Once fully completed, please return this application to:**england.ifr@nhs.net** |

1. This means a person with legal authority to take decisions about medical care and treatment on behalf of the patient, on the basis that they lack capacity to take these decisions themselves. The source of that legal authority should be clearly identified. [↑](#footnote-ref-1)