livewell

NHS Mid Essex Clinical Commissioning Group

Prior Approval Application Form

Guidance Notes:

- **If you are seeking funding for a treatment which is covered by the current Value Based Commissioning Policy and you believe that the patient meets all relevant criteria, please continue with this form. All treatments to which this form applies are listed on the next page.**

- If you are seeking funding for a treatment which is covered by the current Value Based Commissioning Policy, but the patient does not meet the current criteria and you wish to apply for exceptional funding please complete the **Exceptional Clinical Circumstances Application form**

- If you are seeking funding for a new treatment/technology which is not currently commissioned by Mid Essex CCG, please complete the **Individual Funding Request Application form**

The onus lies with the requesting clinician to present a full submission to the IFR Team which sets out a comprehensive and balanced clinical picture of the history and present state of the patient's medical condition, the nature of the treatment requested and the anticipated benefits of the treatment. All necessary information must be submitted with this form. Requests can only be considered based on the information provided. **Incomplete forms providing insufficient information will be returned and may result in a delay in the decision making process.** Please attach all relevant clinical evidence and return the form to the IFR Team. Details can be found at the end of this form.

The patient is welcome to provide a statement to support this application if they wish. Photographs are also helpful if they are relevant to the case.

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This form applies to the following treatments for those patients who meet the relevant criteria:

Arthroscopy Hip including (FAI)
Benign Skin Conditions
Cataracts/Lens Extraction
Continuous Glucose Monitoring
Dysthyroid Eye Disease
Grommets
Heavy Menstrual Bleeding/Uterine Fibroids
Hip Injections
Hip Resurfacing
Ingrown Toe Nail Surgery
Labial Reduction/Refashioning Pinnaplasty/Otoplasty
Scar revision – Keloid and other
Spinal Cord Stimulation
Spinal Surgery for Non-Acute Lumbar Conditions

Please note: separate proformas are available for the following: (link to website)

Abdominoplasty
Bariatric surgery
Blepharoplasty
Removal and replacement of breast implants
Bunions
Exogen Bone Healing Ultrasound System
Monogenetic Diabetes Testing
Nasal Surgery
Open MRI
Capsule endoscopy
Reversal of Sterilisation
Sperm and Egg Storage
Tonsillectomy

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1. DETAILS OF REQUESTER (include referring clinician. Contact details in the event of query or need for clarification)

Name: Designation:

Trust/Surgery:

Contact ‘phone number:

Secure email or postal address for correspondence:

Must be an NHS.net email. Only NHS.net can be used for correspondence regarding IFR requests.

2. PATIENT PERSONAL DETAILS

Patient Name:

Address:

Gender

Date of Birth:

NHS Number:

GP Name & Practice Details:

Please note that all personal information will be removed prior to the consideration by the Individual Funding Request process.

3. CONSENT

I confirm that this Exceptional Cases Application has been discussed in full with the patient and it would / would not be appropriate **(please delete as necessary)** for the patient to be copied into all correspondence*.

By submitting this form you confirm that the information provided is, to the best of your knowledge, true and complete and that you have:

- Discussed all alternatives to this intervention with the patient
- Had a conversation with the patient about the most significant benefits and risks of this intervention
- Informed the patient that this intervention is only funded where all relevant criteria are met or exceptionality demonstrated

- Checked that the patient understands spoken and written English
- The patient is aware that they are consenting for the Individual Funding Request Team to access confidential clinical information held by clinical staff involved with their care about them as a patient to enable full consideration of this funding request. All national and local NHS policies regarding confidentiality, retention and destruction of records will be adhered to.

I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a Panel/IFR team to decide whether this application will be accepted and treatment funded. By submitting this form I confirm that the patient/representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given.

Signed Referrer: .... Print name……………………………………..

Date: ……………………………….

* Please note, the CCG is under obligation to let the patient know the outcome of all IFR applications. Where the patient has requested the IFR submission, it is good practice to ask the patient if they wish to be copied into other correspondence between the clinician and the CCG. Where the patient has not made the request, the patient should be copied into other correspondence between the clinician and the CCG unless it is clinically inappropriate to do so.

4. WHICH VALUE BASED COMMISSIONING POLICY DOES THIS REQUEST CORRESPOND TO?

5. TREATMENT REQUESTED

6. DIAGNOSIS

7. CLINICAL BACKGROUND

Please supply a clinical background to your patient’s case and a rationale to demonstrate that all criteria points have been met. Please attach relevant medical documents to support your request is necessary

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Please complete and return this form to: IFR Team, Mid Essex CCG, Wren House, Hedgerows Business Park, Colchester Road, Chelmsford, CM2 5PF, or via email on Rachel.anderson8@nhs.net or clarebrown4@nhs.net.

For queries, please contact the IFR Manager on 01245 398 740.