Appendices – Patient Choice in out-patient mental health care

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Appendix A – FOI letter sent to CCGs

10th June 2017

Dear Sir/ Madam

I am writing to you under the Freedom of Information Act 2000 to request the following information from your Clinical Commissioning Group.

Could you please provide your CCG's policy or care pathway for the following scenario in which a local patient and GP is seeking funding:

a) The patient concerned has a mental health disorder, namely body dysmorphic disorder / obsessive compulsive disorder.
b) The patient is being referred by the GP for a course of out-patient cognitive behaviour therapy which is specific for BDD/ OCD, for which there are NICE guidelines. The CCG has a commissioned provider for referrals through either a local primary care (Improving Access to Psychological Therapies – IAPT) service or for more complex problems with a local community mental health team (CMHT) and psychological therapy service.
c) The GP and patient however wish the patient to be referred "out of area" to a provider that has existing NHS contracts with other CCGs. They have no other reason other than that it is the patient's choice to be seen at different service for BDD/ OCD to that provided locally or is already commissioned. The patient and GP are fully aware of their local commissioned service but do not wish to use it.
d) The GP believes the referral to be clinically appropriate. The referral would be to another IAPT provider or if the patient has more complex problems to a consultant led tam for medication advice and to a more experienced psychologist/ cognitive behaviour therapist. The GP has assessed for risk – the patient does not have any significant risk factors (e.g. a risk of suicide or self-neglect) that require local CMHT involvement. Neither does the patient need care integrated with social services nor inpatient care.

   My questions for the FOI request all relate to the CCG's policy documents or agreed care pathway in the above scenario.

1) Can the GP refer direct to an out of area provider? If not, what is the pathway for such referrals? For example, must such referrals go to a clinical triage service to determine it is appropriate to refer to another provider? Must the referral go first to a panel to determine exceptionality for the patient not to be treated locally?
   If yes, what are the criteria used in the scenario above for the patient to be referred out of area? When does the CCG consider the "exceptionality" issue applies for a referral out of area? For example, must the patient have exhausted or tried treatment in local services?
2) If the patient can be referred direct for an assessment to another provider and the provider seeks authorization for funding, what is the pathway for such referrals – for example is the request taken to a special panel or dealt with by a commissioner? As in question (1) does

the panel or commissioner use any specific criteria to agree to fund the assessment of the patient?

3) If a patient is assessed by another provider and found suitable for treatment, must a further application for funding be made for treatment? As in question (1) does the panel or commissioner use any criteria to agree to fund the patient's treatment or suggest that they are treated locally?

When you comment on these questions, please provide any relevant policy documents or care pathways that relate to each of these scenarios.

Please provide the information in the form of an email and attachments.

If it is not possible to provide the information requested due to the information exceeding the cost of compliance limits identified in Section 12, please provide advice and assistance, under your Section 16 obligations, as to how I can refine my request to be included in the scope of the Act. In any case, if you can identify ways that my request could be refined please provide further advice and assistance to indicate this.

I look forward to your response within 20 working days, as stipulated by the Act.
If you have any queries, please don't hesitate to contact me via email and I will be happy to phone to clarify what I am asking for

I look forward to hearing from you.

Yours sincerely

Mr Szymon Urbanski

Appendix B: CCGs who stated that the FOI request was exempt from disclosure

CCG	**Response**
City and Hackney	The CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-frameworkwhat- choices-are-available-to-me-in-the-nhs
Croydon	NHS Croydon CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link:https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choiceframework-what-choices-are-available-to-me-in-the-nhs You may also find 'Choice in Mental Health Care' a useful document. This can be found using the following link: https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf
Eastbourne, Hailsham and Seaford	The Individual Funding Request Panel does not consider Mental Health conditions. The CCG can confirm that it does hold this information, but are exempting it under Section 21 Freedom of Information Act 2000 as it is reasonably accessible by other means. This is an absolute exemption. We have provided you with a link to our website which will provide you with this information: See page 3, 2016 Individual Funding Request policy - Eastbourne, Hailsham and Seaford item 2.5, "The Panel will not consider requests for Specialist Mental Health, which will be dealt with by the Specialist Mental Health Panel at Sussex Partnership Foundation (NHS) Trust." Sussex Partnership NHS Foundation Trust
Hastings and Rother	The Individual Funding Request Panel does not consider Mental Health conditions. The CCG can confirm that it does hold this information, but are exempting it under Section 21 Freedom of Information Act 2000 as it is reasonably accessible by other means. This is an absolute exemption. We have provided you with a link to our website which will provide you with this information: See page 3, 2016 Individual Funding Request policy - Hastings and Rother item 2.5, "The Panel will not consider requests for Specialist Mental Health, which will be dealt with by the Specialist Mental Health Panel at Sussex Partnership Foundation (NHS) Trust." Sussex Partnership NHS Foundation Trust
Kingston	NHS Kingston CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-frameworkwhat-choices-are-available-to-me-in-the-nhs

Newham	The CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs
Richmond	NHS Richmond CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs
Tower Hamlets	The CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-frameworkwhat-choices-are-available-to-me-in-the-nhs
Waltham Forest	The CCG considers that this information is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the applicant by other means. Information about patient choice is available in The NHS Choice Framework, which can be accessed via the following link: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-frameworkwhat-choices-are-available-to-me-in-the-nhs

Appendix C: CCGs judged to be compliant with Patient Choice

CCG	Question 1	Question 2	Question 3
Bexley	Each case is considered individually on its merits and therefore it is difficult to give specific answers to hypothetical cases. Yes for IAPT and yes for secondary tier mental health services, with the proviso that the out area provider offers a treatment pathway comparable to that offered locally. For tertiary services it would depend on the individual circumstances Referrals up to second tier do not require a panel decision. We are unable to answer regarding exceptionality as the scenario would need to be considered on its merits with full clinical information derived from the clinicians responsible for the referral.	*No.*	*At secondary tier – no. At tertiary level the case would be reviewed on its merits.*
Bolton	Given that this request appears to relate to a genuine patient scenario, we have exempted patient identifiable details from the question under section 40 of the Freedom of Information Act 2000 in order to protect the patient's identity. Freedom of Information responses are often accessible to the general public and it is therefore not considered appropriate to release a detailed response nor the original request in its entirety. However, we believe that the more generalised response will assist you in obtaining the information you require.https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf Bolton CCG follows the NHS England choice in mental health care guidance, see link above. For referrals exempt from this guidance an individual funding request needs to be completed and submitted to the mental health funding panel for consideration and approval. The mental health funding panel will review local service provision to ascertain if the service can be provided locally. Consideration is given to local services	*Authorisation for funding needs to be discussed within the mental health funding panel, prior to assessments being undertaken by other providers. To access the funding panel the following documents are required:* *• GP referral letter* *• Supporting documentation from a mental health provider.* *The request for funding should include the initial assessment costs plus the expected treatment costs.* *Items for consideration are as those highlighted in the NHS England document above, and include:* *• Is the referral clinically appropriate?* *• Is the service commissioned by the NHS?* *• How will the patient travel to the initial assessment and follow up appointments.* *• Are any links required to local support services?*	*See above.*

	whereby existing commissioning arrangement are in place including the monitoring of patient outcomes.		
Brighton and Hove	The NHS Brighton and Hove Clinical Commissioning Group (CCG) is in the process of developing a local policy with regards to choice and mental health services which will reflect the national legislation in order to maximise opportunities for patients to exercise their rights, but also to ensure local pathways are clear and robust. The national choice policy is attached for your reference. The absence of a local policy does not restrict a patient's right to choose as national policy is very clear. Where there are locally commissioned services that meet the patient's needs, the CCG would expect that the referrer would discuss the local option with the patient first in order to ensure that services are received as close to home as possible. However, if the patient's request meets the terms under the choice legislation, this would be honoured. More specialist service for complex needs are commissioned by NHS England (NHSE) and therefore if the patient's needs are severe (Level 6 according to NICE guidelines, on a scale of 1-6) the relevant services are commissioned by NHSE and the issue of choice about the services NHSE commissions should be directed to NHSE.		

Bristol	It depends on the provider- if the provider is commissioned directly by another CCG, and is delivering services to that CCG under NHS Standard Contract then a referral can be made directly.	*As above - If the referral is made to a provider commissioned by another CCG, and delivering services under the NHS Standard Contract then the service provided will be funded under non-contracted activity (NCA) and the costs charged to the CCG.*	*If a patient is assessed by a provider commissioned by another CCG and delivering services under the NHS Standard Contract then no application needs to be made for funding as the charge will be made to this CCG as non-contracted activity (NCA).*
Bromley	GPs are able to refer to out of area providers. Oxleas NHS Foundation Trust has a local assessment service that Bromley GPs can refer into (Primary Care Plus).If yes, what are the criteria used in the scenario above for the patient to be referred out of area? · The patient may need a service that is not provided locally · The patient may have complexity of need which our secondary Mental Health provider cannot meet · The patient has chosen an out of area provider. The patient does not have to exhaust local services. Exceptionality does not apply for Mental Health funding requests (i.e. this would not go to an IFR panel).	*A referral for assessment could come from primary or secondary care. The provider contacts* *the CCG for funding and is dealt with by a commissioner.*	*Please see the response to question 2.*

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<td>Camden</td>
<td>Yes. Those GPs who feel confident diagnosing body dysmorphic disorder (BDD) or obsessive compulsive disorder (OCD) can refer to out of area providers as per NHS England guidance on patient choice, which is publically available online:
https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf
Other GPs may prefer to make a referral to the Assessment & Advice Team.
GPs do not have an explicit pathway for patients with BDD/OCD. Some may discuss cases with their colleagues at clinical meetings within the practice. GPs are encouraged to make referrals to local services, however if there is an explicit request from the patient (and no significant risk factors) the GP can refer out of area.</td>
<td>When NHS Camden CCG is sent a funding request for ‘out of area’ treatment, commissioners will check whether patients have been offered local services in the first instance (as sending patients out of area adds additional cost pressures to an already limited budget). Once this has been confirmed and the commissioners are confident that risk factors have been appropriately assessed, the referral is approved.
As above, decision making is informed by NHS England guidelines.</td>
<td>Once the assessment has been carried out and a treatment plan developed, the provider will send a further funding request outlining the cost of the proposed course of treatment. This is more a formality to aid financial planning, rather than a barrier to service access.</td>
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<td>Central London</td>
<td>Yes, a GP can refer to another provider as per patient choice.
If the patient choice is for a provider where no commissioner/provider agreement exist NHS Choice in Mental Health will apply.
Click here - https://www.england.nhs.uk/mental-health/about/choice/.</td>
<td>The request will be dealt with directly by the Commissioner and the judgement based on whether it is clinically appropriate, taking advice if necessary.</td>
<td>Yes, an individual funding application would be required.</td>
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<td>Dartford, Gravesham & Swanley</td>
<td colspan="3">GPs are able to make a referral under patient choice if it is for the first outpatient appointment. The referral can be to any clinically appropriate provider in England as long as a clinical commissioning group (CCG) or NHS England has a contract with them. The Provider will write to the CCG that holds commissioning responsibility for that patient to request funding confirmation for the first outpatient appointment under patient choice.</td>
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Ealing	Yes, a GP can refer direct to an out of area provider	*Ealing CCG does not operate a specific "policy" in relation to Mental Health non-contract activity (NCA). A panel work to a Mental Health Patient NCA Funding Process and Terms of Reference in approving Mental Health funding requests.* *These are based on the following national policies;* *1. POLICY: Liberating the NHS: No Decision about me, without me – Government Response (2012)* *2. POLICY: Standard Operating Procedures: The Management of MH Patient Funding Requests.* *3. CHOICE IN MENTAL HEALTH* *4. Nolan Principles* *The role of the Ealing Mental Health NCA Funding Panel is to consider approval of funding by the Commissioners for treatments, therapies and interventions, on a case-by-case basis, that are outside of existing contractual arrangements, or for which prior approval is required within existing contracts.* *Decision making is based on the referral form meeting the threshold. Decisions will take account of the best evidence available at the time, using sources such as the National Institute for Health and Clinical Excellence (NICE), The Scottish Medicines Consortium (SMC), local Clinical Networks and properly constructed published research trials.* *The following thresholds must be met for a referral to be considered;* *a. Referral has been sent by either a GP or representative from local mental health trust or other mental health trust (for LAC) AND* *b. Patient has been assessed by a multidisciplinary team at local mental health trust or other mental health trust (for LAC) AND* *c. Commissioner confirms that no local service is commissioned for patient's diagnosis / treatment OR ii) Clinician confirms the complexity of diagnosis / treatment requires a specialist service which cannot be provided locally OR iii) Patient Choice is initiated AND* *d. Sufficient information has been provided to support this referral.*	*Yes. The process is the same as outlined in Question 2. Unless patient choice is initiated we recommend using the local service and ask that all local patients are first assessed by the local mental health provider and that referrals are made by either the local mental health provider or the patients GP.*

East and North Hertfordshire	NHS East and North Hertfordshire does allow GPs to refer to a provider, with whom we do not have a contract. Please refer to the policy attached for more details.	*Requests for off-contract referrals need to be approved before they are made. Please refer to the policy attached for more details.*	*We will also require funding request for treatment if this is deemed necessary after assessment. The decision for funding is normally made by the Clinical Team Lead for the Integrated Health Commissioning Care Team. In some circumstances the decision regarding a funding request will go before a panel. Please see the attached policy for details of these circumstances and the process involved.* *(This document sets out the processes covering referrals not covered by contract including GP patient choice. GP's have to fill out a form and submit to demonstrate meets the patient choice eligibility but otherwise does not require further justification*

East Leicestershire & Rutland	Yes. However, this is limited to the services on the E-referral systems, which is population by individual providers. You may choose any organisation that provides clinically appropriate care for your condition that has been appointed by the NHS to provide that service. You may also choose which clinical team will be in charge of your treatment within your chosen organisation. For a physical health condition, you will be seen by the consultant or by a clinician who works in the consultant's team. For a mental health condition, you will be seen by the consultant or named health care professional who leads the mental health team or by another health care professional in the team. In some cases you might be asked to attend, or have a telephone conversation with, a 'clinical assessment centre' to help decide which treatment will be best for you. Alternatively, you might be referred directly for treatment. In both of these situations you have the right to choose where to go for your first outpatient appointment and you should have a conversation with the health care professional who is referring you to discuss the choices available. https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs When does the CCG consider the "exceptionality" issue applies for a referral out of area? Not applicable For example, must the patient have exhausted or tried treatment in local services? No – Choice guidance applies	*if the provider requests funding prior to assessment otherwise this would be classed as none contracted activity with the organisation.* *Choice Guidance/NICE guidance, available specialist opinion*	*If a patient is assessed by another provider and found suitable for treatment, must a further application for funding be made for treatment? This is carried out on a case by case basis. If the provider requests funding prior to treatment otherwise this would be classed as none contracted activity with the organisation*

East Riding of Yorkshire	*In the scenario you describe where a patient has a recognised mental health disorder for which there is recommended treatment commissioned by NHS East Riding of Yorkshire CCG, and where that treatment is also available from a service commissioned by a CCG other than NHS East Riding of Yorkshire CCG, and where the patient has expressed a wish to be treated at this provider, then the patients right to choice in line with the NHS Constitution would apply and the GP could make a referral. The provider would be at liberty to decide whether or not they were able to accept a referral from out of area. If so then in most cases the provider would request confirmation of authorisation for the assessment and treatment from the NHS East Riding of Yorkshire CCG. Provided that the above criteria are met authorisation would be given. The out of area provider may seek further authorisation of funding from the CCG commissioner. The commissioner would seek assurance that the patient is the responsibility of the CCG and that the service is a recognised and commissioned service for the condition. CQC reports would be checked if that were relevant. For services not currently commissioned by NHS East Riding of Yorkshire CCG the GP would need to refer to the Individual Funding Requests (IFR) panel for its consideration and approval. The IFR policy and procedure is published on the East Riding of Yorkshire CCG website: http://www.eastridingofyorkshireccg.nhs.uk/data/uploads/policies/newpolicies/east-riding-of-yorkshire-ccg-ifr-policy-v2-nov-2015.pdf*
Eastern Cheshire	NHS Eastern Cheshire CCG have contracts with two out of area providers who deliver services adjacent to our geographical area. If a patient wishes to access services from these providers and the services they seek are routinely commissioned, the patient should be able to be referred to these out of area providers directly by the GP. Cases such as these do not need to go to a panel to decide exceptionality but the provider will need to have capacity to deliver the services the patient requires. If a patient requires or wishes to be referred for Primary (i.e. IAPT) or Secondary (Consultant led) mental health service provided by an out of area provider other than those who the NHS Eastern Cheshire CCG has contracts with, this would need to be negotiated by the CCG on an individual basis with the identified out of area provider. The need for individual negotiation arises for two reasons. Firstly, the provider may not have established protocols to accept 'out of area' referrals from our CCG so how this could be facilitated would need to be explored. Secondly, as there is no national tariff mechanism in place the CCG will need to work with the provider to agree a funding mechanism to facilitate the care delivery due to other providers frequently not having a local tariff established. Once these two elements have been explored and agreed to each party's satisfaction, a referral could be made by the clinician. NHS Eastern Cheshire CCG can be informed of a patient's requirement for this by their GP or other treating healthcare professional. The referral could also be made through an Individual Funding Request (IFR) which would be submitted by the clinician currently leading on the care of that patient e.g. GP or Mental Health Specialist. The IFR Team have no set criteria specific to requests for approving a mental health referral to an out of area provider with each request will be treated on a case by case basis. The IFR Team do however apply their general patient choice criteria which involves considering whether the NHS provide the services that are being requested; if the requested provider accepts out of area referrals; and, whether the service will be provided in line with any applicable tariff. If funding is agreed for the patient to access primary or secondary mental health services by an out of area provider by the IFR Team and the identified provider assesses the patient to be suitable for treatment then there is no further application necessary for funding to be agreed.

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<td>Erewash</td>
<td colspan="3">Derbyshire CCGs have contracts in place with providers to provide a certain level of service; they do not hold a pot in order to allocate care on an individual basis. The CCGs commission Derbyshire Healthcare NHS Foundation Trust (DHCFT) to provide adult Mental Health provision, and both DHCFT and Chesterfield Royal Hospital NHS Foundation Trust for CAMHS services. This provides the CCG with an economy of scale and the ability to fund a sustainable service close to home for a majority of patients. Derbyshire CCGs do not as a rule support referrals to organisations outside of those we have commissioned unless there are exceptional circumstances. We do support GPs in making a referral to NHS providers outside of Derbyshire where the provider agrees that it is clinically safe and where the referral is for a first appointment to a consultant (which may lead to subsequent service delivery). For more details please see the NHS choice guidance at the following location: http://www.nhs.uk/NHSEngland/patient-choice/Pages/your-rights-to-choice.aspx Derbyshire CCGs have a complex case panel with an independent chair where exceptionality can be explored through Individual Funding Requests. Decisions are based on anticipated clinical outcomes and effectiveness proportionate to the resource required and the availability of suitable local services. Choice is not a consideration with regards to decisions made on exceptional circumstances. Derbyshire CCGs commission a range of services that can support people with BDD or Obsessive Compulsive Disorder (OCD) which include access to Cognitive Behavioural Therapy as well as other options. This provision, depending on the severity of the condition, may be met by services provided in the community such as Improving Access to Psychological Therapies (IAPT), Community Mental Health Teams, or Child and Adolescent Mental Health (CAMHS) Teams if under 18. As recommended by NICE there is a stepped care model regarding access to BDD and OCD services and there are occasions when a patient needs to be referred to the national Severe OCD and Body Dysphoric Disorder Service in London and Herefordshire. This service is commissioned by NHS England and funding is automatically granted if the patient meets the criteria and is accepted by the one of the services identified in the service specification, which may be found at the following location: https://www.england.nhs.uk/wp-content/uploads/2013/06/c09-sev-ocd-boy-dysm.pdf</td>
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<td>Gloucestershire</td>
<td>In the first instance it would be anticipated that locally commissioned services had already been explored. If the individual wishes to choose an alternative provider then we would apply the guidance issued in respective of choice and
mental health care. Such requests would usually be directed to the mental health commissioning team in the first instance for consideration.</td>
<td>Such requests would be directed to the Mental Health Commissioning Team for consideration.</td>
<td>Funding would need to be agreed by the CCG prior to treatment
commencing. We follow the national guidance on choice in
mental health care.</td>
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Guildford and Waverley	Yes, the GP can refer direct to an out of area provider. No, referrals do not need to go to a clinical triage service to determine it is appropriate to refer to another provider. We apply the criteria from the national guidance of Choice in Mental Health – please see Annex 1. No, the patient does not have to have exhausted or tried treatment in local services.	*The CCG would expect the provider to invoice under the non contracted activity route and not need to seek prior approval. If they did seek prior approval then it would come to the CCG Mental Health Commissioning Manager. The criteria they would use is set out in the NHS England Choice document attached.*	*The choice rights cover assessment and treatment in accordance with the national guidance. The CCG would expect the provider to invoice under the non contracted activity route and not need to seek prior approval. If they did seek prior approval then it would come to the CCG Mental Health Commissioning Manager. The criteria they would use is set out in the NHS England Choice document at Annex 1.*
Hardwick	Same response as Erewash		
Haringey	Our procedures for funding - which are via 1) various arrangements for individual care or treatment packages for bespoke services, 2) Individual Funding Requests or 3) Procedures of Limited Clinical Effectiveness are not applicable here. The NHS choice policy for mental health applies. https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf		

Heywood, Middleton and Rochdale	The GP can refer directly to an out of area provider in line with Mental Health Choice Guidance. Mental Health Choice was implemented in 2014/15. The guidance published in December 2014 states: 'The regulations introducing these legal rights state that: Patients must be offered, in respect of a first outpatient appointment with a team led by a named consultant or a named healthcare professional, a choice of any clinically appropriate health service provider with whom any relevant body has a commissioning contract for the service required as a result of the referral, and a choice of a team led by a named consultant or a named healthcare professional. This is subject to exclusions set out in legislation.' Where the GP wishes to refer to a service which is not commissioned or would not be in line with the Mental Health Choice Guidance, an individual funding request would be required. The triage of an individual funding request will consider whether the service being referred for is provided within commissioned services. Assurances that NHS provision is not in place to meet the needs of the service user will be required prior to approval of a funding request.	*If a patient is referred directly to a provider, authorisation for funding would be through the CCG's Individual Funding Request (IFR) process. Consideration of requests is by the CCG's Treatment Advisory Group (TAG).*	*The panel may authorise assessment by a provider. The outcome of the assessment and recommendations for treatment would need to be reviewed by the CCG's Treatment Advisory group (TAG) in line with IFR processes, and funding approved prior to the commencement of any interventions.*

High Weald Lewes Havens	HWLH CCG does not have any specific policies for this service area. Such referrals are treated the same as any other out of area request for treatment. HWLH CCG recognises the importance of patient choice therefore a referrals can be made other providers. The commissioner will review any requests, seeking clinical input as required, to determine that such a referral is clinically appropriate and that costs are reasonable.	*As above, any requests will be dealt with by the commissioner. The criteria to be considered are the need to support patient choice, that such a referral is clinically appropriate, and that any costs are reasonable.*	*Where practical, we would seek to avoid a further application, but this may be required if the cost of likely treatment is not known at the time of agreeing the referral. Unlike the majority of acute hospital care, costs in such cases can and do vary from provider to provider, and as such HWLH CCG would need to ensure appropriate expenditure of public money.*
Isle of Wight	Yes for IAPT and yes for secondary tier mental health services, with the proviso that the out area provider offers a treatment pathway comparable to that offered locally. For tertiary services it would depend on the individual circumstances. Referrals up to second tier do not require any panel decision. We are unable to answer regarding exceptionality as the scenario would need to be considered on its merits with full clinical information derived from the clinicians responsible for the referral.	*No.*	*At secondary tier – No. At tertiary level the case would be reviewed on its merits*

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<td>Kernow</td>
<td>Yes. The patient has the legal right to Patient Choice in mental health, as in physical health. The legal rights to choice of mental health provider and team apply when: · the patient has an elective referral for a first outpatient appointment; and · the patient is referred by a GP; and · the referral is clinically appropriate; and · the service and team are led by a consultant or a mental healthcare · professional; and · the provider has an NHS Standard Contract with any CCG or NHS England · for the required service. This is expressed in the CCG 'Non-contract activity policy': http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG/OurFinances/Polici es/NonContractActivityPolicy.pdf</td>
<td>The patient must meet the criteria as expressed in law (Patient Choice) and CCG
policy, as described above. If a patient has not been referred by a GP in line with Patient Choice, an application
should be made to the Mental Health & Learning Disability Panel if the out of area
service is not routinely commissioned by NHS Kernow CCG. Evidence must be
provided that locally commissioned services cannot meet the specialist health
need. The MH&LD Panel policy can be found here: http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG /IndividualFundingRequests/ Policies/IndividualFundingForTreatmentPolicy.pdf</td>
<td>If a referral has been made through Patient Choice, the Provider can seek funding authorisation through completion of a Prior Notification form: https://www.kernowccg.nhs.uk/get-info/individual-funding-requests/non-contract-activity-(nca)/. If, as in the above example, the patient is referred through Patient Choice, no further application is required.</td>
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<tr>
<td>Leeds North</td>
<td colspan="3">The agreed current care pathway is that the three Leeds CCGs (NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG) commission IAPT services from a consortium of Leeds Community Health Care NHS Trust and three third sector partners. The consortium provides a central screening hub where the patients' needs would be assessed, and depending on the patient's level of need, complexity and risk, the patient would be seen at Step three within IAPT or may be referred on to Leeds and York Partnerships NHS Foundation Trust for treatment. If a patient wishes to access an out of area IAPT or NHS Mental Health service which is commissioned under an NHS mental health contract, the GP would need to agree to this as being safe and appropriate to do so. The GP would then make a referral under the Mental Health Choice policy. The Leeds CCGs would fund this as a non-contract referral. The patient would need to fund his/her own transportation to the chosen service. 1) Leeds CCGs have no single point of clinical triage, so patient choice would happen at the GP appointment. 2) The referral is funded under the Leeds CCGs Non Contract Invoicing, or via the IFR (Individual Funding Request) panel. Please find attached a copy of our 'Overarching IFR Policy 2016-19'. 3) No, a further application for funding is not required. If the service is one that is commissioned locally and is provided under a NHS Mental Health contract then it is funded under the patient Choice Policy. Please also refer to the attached document entitled 'Public Facing Information Mental Health Choice' which provides further information around Mental Health and patient choice. This is also available on our CCGs' websites.</td>
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<tr>
<td>Leeds South and East</td>
<td colspan="3">Same response as Leeds North</td>
</tr>
<tr>
<td>Leeds West</td>
<td colspan="3">Same response as Leeds North</td>
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Leicester City	Same response as East Leicestershire & Rutland	*If the provider requests funding prior to assessment otherwise this would be classed as none contracted activity with the organisation. Choice Guidance /NICE guidance and specialist opinion are used to agree funding.*	*This is carried out on a case by case basis if the provider requests funding prior to treatment otherwise this would be classed as none contracted activity with the organisation.*
Lewisham	The CCG does not hold the information in the format requested. The GP would be able to make a direct referral to an IAPT or CMHT service of the patient choice. It is however usually recommended that the patient accesses local services wherever possible to enable to be linked to other services that might be of benefit to the patient. Should IAPT/CMHT not be in a position to treat the patient, the GP would be advised to refer the patient to the Lewisham Tertiary Referral Panel to assess eligibility for access to a specialist tertiary service. The panel will make a decision on eligibility and decide overall eligibility for the service. The panel will also consider the request for an out an area treatment and make a decision on whether the patient would be eligible to be treated out of area but would need to be assured that the provider meets the necessary quality and clinical standards for the requested service.	*A GP can refer to IAPT/CMHT directly to a provider chosen by the patient. Commissioners will pick up the cost through non-contracted activity. If the case is referred to the tertiary referral panel the panel will make the funding decision. It might be that initially only an assessment will be agreed to be funded and depending on the outcome of the assessment the patient might need to be re-presented to the panel to decide on treatment.*	*As outlined above the patient might have to be re-presented to the tertiary referral panel following an assessment and a decision will need to be made on whether treatment will be funded.*
Liverpool	The GP can refer to another IAPT provider if that is the patient's choice.	*The funding request would be made by the provider to the commissioner who would agree payment via the 'non-contracted' activity payment mechanism.*	*There would be no requirement for the provider to seek funding for treatment following assessment unless they exceeded the recommended treatment course.*

Luton	Patient choice is a right and the GP can refer direct to an out of area provider for a service. There is an exclusion from the legal right to choice where a patient is already receiving mental health care following an elective referral for the same condition. Luton CCG does have an Individual Funding Request ('IFR') panel for exceptional cases and for services not commissioned locally. If authorisation has been sought under the IFR process and has been assessed as not meeting the criteria for an IFR , the panel will forward the referral to mental health commissioners for determination. The scenario in this FOI would not require an IFR application. Luton CCG would expect the provider to invoice the CCG under usual non-contractual arrangements. There is no need to seek authorisation if the referral falls within patient choice guidelines and the treatment is a standard offer for that provider. However, the provider may seek authorisation from mental health commissioners if the treatment needed is non-standard and will incur costs over and above the usual tariff.
Manchester	Manchester CCG commissions mental health services from a range of NHS, third and independent sector providers to provide services across a range of care pathways. Greater Manchester Mental Health NHS FT (GMMH) Trust is the main statutory mental health provider. As part of our contract GMMH operate a single point of access gateway in which referrals are received from GPs and forwarded to the most appropriate GMMH services or onto third sector providers (e.g. for Step 2 and 3 IAPT services) or third and independent sector mental health rehabilitation provider services. Manchester CCG is also an associate commissioner to the GMMH contract which is led by Bolton CCG and other Greater Manchester CCGs are associates to the GMMH contract held by Manchester CCG. Manchester CCG is also an associate commissioner to Pennine Care Foundation NHS Trust. In addition all NHS organisations, Local Authorities, voluntary, community and social enterprise organisations across Greater Manchester are all members of Greater Manchester Health and Social Care Partnership which is the body overseeing devolution of the £6bn health and care budget in the region. This partnership is working together to transform health services, including mental health services, across Great Manchester and will not only improve the access to and the quality of services but will undoubtedly wider the choice of providers for patients and referrers. In line with NHS England guidance regarding Choice in Mental Health Care (December 2014), GPs can refer their patients for a first out-patient appointment to an alternative provider. If the referral is for a service which is routinely commissioned by CCGs the patient's CCG will receive an invoice from the provider through a Non-Contract Activity invoice. If the referral is not for a first out-patient appointment, e.g. it is for ongoing treatment or care, or it is for treatment or care which is not routinely commissioned by the CCG and the request is for this to be provided by a provider which the CCG does not have a contract with, then a request would need to be made by the GP or another clinical professional to the CCG Mental Health Funding panel for funding authorisation. This process covers mental health funding requests which are commissioned on a spot placement basis. It is expected that all community alternatives and current block commissioned services either by Manchester CCG or Manchester City Council Adult Social Care have been explored before making the application to the panel. Patients' eligibility for specialist interventions is based on their assessed need for a service. The Panel may approve funding requests if services to meet their assessed needs are not available locally within existing contracts or local services have been tried but are unable to meet the patient's assessed needs. Funding requests can be made for assessments, second opinions, packages of care and services provided by Independent Hospitals, community services or supported living providers. If several requests to the panel for funding demonstrate a local need which is not being met from within existing contracts the CCG will review this need and may decide to develop plans to commission this service. The majority of referrals to specialist services are made by secondary care service providers. Manchester CCG expects secondary care providers to refer patients for specialist care using established pathways covered by contract agreements and in line with national guidance on patient choice. Accordingly, requests for referrals to specialist providers for treatment, outside of the normal patient pathways, will usually only be considered after an assessment by an appropriate specialist clinician. Patients are entitled to request a second consultant opinion, but this must be from a provider who has an NHS contract. A resultant treatment plan must be in accordance with treatment options normally available within Manchester care pathways. Manchester CCG tries to ensure that patients are able to access treatment and care as close to home as possible. However, requests for funding of out of area referrals may be considered if for example the patient wants to move to be near family. Accessibility

	to the service for the patient and the distance from where the patient lives to where the chosen service is delivered and how the patient would be able to travel to and from the provider needs to be considered by the patient and the GP.		
Medway	No. GPs refer patients to the Out of Area Treatment Panel where referral requests are reviewed on an individual basis. GPs are asked/required to ensure that referral requests are made including evidence of the patient's clinical need for onward referral to enable Panel consideration. A copy of the GP referral proforma is attached for reference (though the patient's GP will be familiar with the process).	*Please see answer in question 1 above.*	*Each new Out of Area Referral / Funding request must be considered by the Out of Area Treatment Panel. Please see below a link to Medway CCG Choice Policy: http://www.medwayccg.nhs.uk/medway-ccg-choice-policy-publication-date-january-2017/* *The document states they follow patient choice for mental health within their choice policy*
Milton Keynes	Yes – national guidance and policy is used. http://www.nhs.uk/NHSEngland/patient-choice/Pages/your-rights-to-choice.aspx	*The Provider contacts the Commissioner and authorisation is given, as per National Guidance.*	*No, Our preference is for people to utilise locally commissioned services where possible, but will respond positively as required to patient choice.*
North Cumbria	The process is that the GP makes a funding request to the NHS North Cumbria Clinical Commissioning Group (CCG) Mental Health and Learning Disabilities Commissioning Team, using the Complex Packages of Care funding protocol (CPOC). The GP cannot refer directly to an out of area provider. The referral does not need to be triaged by local services, but the basic premise of the CPOC is that closer to home options are explored first. However, in the case of patient choice this would follow the guidelines of the provider, and this would be in line with its contracts with other CCG's. Please see the protocol attached. Note: the protocol is currently being reviewed.		

North Derbyshire	Same response as Erewash		
North West Surrey	Yes, the GP can refer direct to an out of area provider.The CCG complies with the national policy on patient choice in mental health, of which this situation appears to meet criteria. The CCG considers this document is exempt from disclosure under the Freedom of Information Act 2000, Section 21 (Reasonably Accessible), which provides an exemption from the duty to disclose information which is accessible to the Applicant by other means. The guidance is available on the website of NHS England using the following link: https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf	*The CCG would expect the provider to invoice under the non-contracted activity route and would not need to seek prior approval. If prior approval is sought then it would come to the CCG Mental Health Commissioning Manager. The criteria are set out in the NHSE Choice document highlighted in Question 1.*	*The choice rights cover assessment and treatment in accordance with the national guidance.* *The CCG would expect the provider to invoice under the non-contracted activity route and would not need to seek prior approval. If prior approval is sought then it would come to the CCG Mental Health Commissioning Manager. The criteria are set out in the NHSE Choice document highlighted in Question 1.*
Northern, Eastern and Western Devon	This is dependent upon the referral meeting NHS Choice guidelines or if it fell into an exclusion from these guidelines. These guidelines are available here; http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/accessing%20services.aspx In Devon, services are routinely commissioned through secondary mental health services or health psychology services. The appointment or treatment requested needs to be a first outpatient appointment so that means the patient is not already receiving treatment for that condition. In practice, patients do not usually choose to travel long distances for their treatment. We encourage our local mental health providers, Devon Partnership NHS Trust and Livewell South West, to have reciprocal arrangements. For example, if a person does not want to	*Where an out of area referral is made through NHS Choice rules, and the person needs to be referred to another provider, the GP should request permission for this from the CCG. Usually these referrals would be dealt with by a commissioner through the IPP team. They would not usually go to a panel but the commissioner would seek to confirm the clinical appropriateness of a referral and could refer to the Individual Funding Request (IFR) Panel for a view on this if required, as this panel is clinically led.*	*Under choice rules, the CCG would fund an assessment but would need to confirm that the treatment that is proposed remains clinically appropriate and in line with NICE guidance before agreeing to fund the treatment package.*

	access their local service but would like to go to an adjoining service within the CCG footprint. There is no compulsion for providers to travel to patients and the CCG would not fund a service to do so. The person would usually need to attend the outpatient department at their choice of provider ahead of any treatment. Contracts through which services are provided on a named individual case are also excluded and need to be routinely commissioned for the population. In this case, the GP should seek permission from the CCG to refer a patient to the service and can then refer directly. There is no existing process for this but these types of referrals would usually go to the CCG`s Individual Funding Request team (IFR panel) or the Individual Patient Placement team (IPP) for review. If the service is routinely commissioned and offered under choice arrangements, then this would not need an IFR panel review but the CCG would seek confirmation from the referrer as to clinical appropriateness. Please refer to the response above and to our Exceptional Individual Funding requests page where you will find Terms of Reference, referral form and Low Priority treatments policy; https://www.newdevonccg.nhs.uk/nhs-funded-patients/exceptional-individual-funding-requests-100177 If an out of area referral is made through an individual funding arrangement and not under NHS Choice rules, then in order for the referral to be agreed, the person would need to have exhausted all local options available.		

Nottingham North & East	It would depend on the referral routes determined by the provider of the treatment.	*There is national guidance regarding patient choice which the CCG would follow https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf* *There are 4 IAPT providers in Nottinghamshire, for the purposes of offering choice, so in this instance the patient would have more than one local provider to choose from.* *A process and policy is currently being developed for Mental Health Individual Funding Requests (IFRs) and no- contract activity as the mental health commissioning responsibility for the South Nottinghamshire CCGs has recently transferred to Nottingham City CCG from Mid Notts, and the IFR processes differ. In this instance, for the time being, if the patient still doesn't want to access a local service, providing the out of area service is another NHS commissioned provider, the provider themselves (if self-referral) or the GP could submit a request to the Head of Mental Health Commissioning at the Nottingham City CCG. If it is not an NHS provider delivering a like for like service, and IFR would need to be made to the County IFR team.*	*The request for treatment for assessment and treatment by an IAPT provider could be made at the same time.*
Nottingham West	Same response as Nottingham North & East	Same response as Nottingham North & East	Same response as Nottingham North & East

Oldham	The GP can refer to an out of area NHS provider for the service described if GP and patient agree that this is the preferred action. The service described in b) is commissioned in Oldham to be delivered by Pennine Care NHS Foundation Trust. For an outpatient appointment there is no clinical triage service to determine whether it is appropriate to refer to another provider unless the service is not commissioned currently (in which case the referral would need to be assessed by an Individual Funding Request (IFR) panel).	*For an outpatient appointment the CCG will not routinely receive a funding authorisation request. The CCG will be notified through a non-contracted activity (NCA) invoice. Therefore there is no specific criteria to fund the assessment of the patient, unless the request needs to go to IFR panel.*	*Further applications would not be required for treatment in the service outlined in section b) above, however the CCG would expect that cost of the service provided by another NHS provider would be in line with expected national tariff price. The CCG currently has a block contract arrangement with Pennine Care and therefore it should be noted that referral to another provider when this service is commissioned in borough would not be recommended as would mean double funding through block contract and NCA. The CCG commissioner reviews NCA invoices and would seek further detail from the provider if required.*
Oxfordshire	The GP can refer direct to the out of area provider who will write to OCCG to ask for approval to undertake the assessment as required by their contract with OCCG.	*For mental health referrals the commissioner approves the assessment but asks the provider to write back to OCCG to request further funding for any recommended treatment.* *If the provider is non-NHS (e.g. a charity or third sector) but not a private provider it may be considered to go to the Individual Funding Request (IFR) team under the IFR policy - http://www.oxfordshireccg.nhs.uk/your-health/will-the-nhs-pay-for-my-treatment/an-individual-patient-funding-request.htm*	*Yes; the provider needs to send a treatment plan to the commissioner. The decision to fund the treatment will be made after discussion with the local provider to determine if it could also be provided locally; and if this is the case the CCG will ask the GP to discuss with the*

			patient to consider this option.
Rushcliffe	Same response as Nottingham North & East	Same response as Nottingham North & East	Same response as Nottingham North & East

Salford	The G.P. can only refer directly after they have acquired CCG approval for such a referral. In terms of this being a patient choice for an alternative provider to what is normally used in terms of local services, there would need to be confirmation that this is a first outpatient appointment. The G.P. would first of all need to contact the CCG's Mental Health Commissioner to seek their consent. This ensures that any required funding is allocated to the treatment package, and also allows the commissioning CCG to take a view on the quality of the proposed service. If commissioner consent/funding approval is subsequently granted, then the G.P. would be directed to proceed with a referral. In most cases Salford CCG would assess a case of this nature through the mental health complex needs funding panel. There is flexibility in the context of if the commissioner felt that putting the request through a panel meeting would cause undue delays for patient treatment, then the commissioner may consult with the panel's medical advisor (a local psychiatrist) and determine a decision outside of panel meetings. Each case will be considered on its own individual merits and there is no clinical triage system and no pre-determined criteria to judge against. However, key considerations will certainly be to look at whether the clinical referral appears appropriate e.g. agreement that this treatment is required and that treatment costs are not unreasonable/excessive.	*Answered in the response to question 1 – Salford CCG confirms funding to the G.P. and will always provide a confirmation later, direct to a provider service, if this is required.*	*There is no separation of assessment and treatment in terms of approval processes. If the purpose of assessment is to determine suitability for a programme of treatment as opposed to obtaining a new diagnosis, the CCG would normally seek to determine likely treatment costs ahead of first contact. If a confirmation is then given from an assessing service that they are offering a programme of treatment, the funding confirmation from CCG can be offered without delay and certainly wouldn't require an additional application to a panel.*
Sheffield	Since 1st April 2014 people with mental health conditions who are referred for a first outpatient appointment have	*Not applicable, patient choice would apply in this context and therefore the provider would not need to seek authorisation.*	*Not applicable, patient choice would apply in this*

	the right to choose any clinically appropriate health service provider (whether that be a NHS mental health trust, a Foundation Trust or a mental health provider in the independent or third sector) for their first outpatient appointment as long as the provider has a contract with any CCG or with NHS England for the service required, and that the service or treatment is routinely commissioned by the patient's CCG. Given NHS Sheffield commission specialist Cognitive Behavioural Therapy that offers a service for individuals with BDD and/or OCD then patient choice would in this context apply. GPs can therefore refer directly to an out-of-area provider. If not, what is the pathway for such referrals? For example, must such referrals go to a clinical triage service to determine it is appropriate to refer to another provider? Must the referral go first to a panel to determine exceptionality for the patient not to be treated locally? Not applicable, see above. If yes, what are the criteria used in the scenario above for the patient to be referred out of area? When does the CCG consider the "exceptionality" issue applies for a referral out of area? For example, must the patient have exhausted or tried treatment in local services? Given NHS Sheffield CCG commission specialist therapy services for individuals with BDD and/or OCD, patient choice would apply in this context; as long as the provider of choice has a contract with a CCG or NHS England. In the rare situation that the provider of choice does not have a contractual relationship with the NHS, then the CCGs Individual Funding Review (IFR) mechanism would be initiated. The purpose of this would be to ensure the provider can deliver the required service effectively and within robust clinical governance.		*context and therefore the provider would not need to seek authorisation.*

Southwark	Yes. A GP is able to make a direct referral to an Improving Access to Psychological Therapies (IAPT) service or a Community Mental Health Team (CMHT) service of the patient's choice under the Choice Agenda. However, it is recommended that the patient accesses local services wherever possible to be able to be linked to other services that might be of benefit to the patient. Should the patient require access to more specialist tertiary services, the GP would be required to refer the case to the Southwark Specialist Tertiary Panel for authorisation. Our local IAPT/CMHTs are also able to perform this function. The Panel would make a decision to use National Specialist Tertiary Services based on eligibility criteria and appropriate use of the existing care pathway within locally commissioned services. Should the patient meet the criteria of treatment resistant symptoms, there is a third level of service commissioned via NHS England.	*The GP is able to refer directly to out of area community services. Funding for this would be automatically included within the non-contracted activity. Access to national specialist tertiary services is via the Southwark Panel as detailed above.*	*In some instances, the Panel may request an assessment and require that the assessment and treatment options be considered by the Panel prior to funding treatment within the specialist service. If the treatment options are part of a service that is provided locally, the Panel may recommend that this pathway be followed in the first instance.*

Stockport	The CCG recognise the mental health and choice policy and will facilitate a referral if that is the patient's choice, the referral is clinically appropriate and the receiving service is both willing to accept the referral. The CCG would always recommend that a request is made to the CCG to access any out of area provision, as it is the CCGs responsibility to ensure that any provider we commission services from is registered and/or accredited (e.g. BABCP), following NICE guidelines, has the relevant safeguarding and quality policies and procedures in place. In addition the CCG is responsible for ensuring that any service we commission for our patients is cost effective and delivers good outcomes.Prior to consideration for any referral, it is recommended that the GP or any referrer complete the attached form. The information in the form is then considered by the Individual Funding Panel and a decision is made based on the information provided.		*As set out in the response to question 1, the CCG would always recommend that the GP approaches the CCG prior to making any out of area referral, as once a decision is taken to support the assessment it would not be fair to decline funding for treatment if the assessment demonstrates that it is appropriate. The attached form above, in addition to the regulatory/accredited checks on the provider will usually provide sufficient information to make a decision on treatment following the assessment.*
Surrey Heath	Yes. The CCG complies with the national policy on patient choice in mental health, of which this situation appears to be meeting those criteria. National document attached: (GUIDANCE: Choice of provider and team in mental health care)	*The CCG would expect the provider to invoice under the noncontracted activity route and not need to seek prior approval. If they did seek prior approval then it would come to the CCG MH Commissioning Manager. The criteria they would are as is set out in the NHSE Choice document attached.*	*No. The choice rights cover assessment and treatment inaccordance with the national guidance.*
Swale	GPs are able to make a referral under patient choice if it is for the first outpatient appointment. The referral can be to any clinically appropriate provider in England as long as a clinical commissioning group (CCG) or NHS England has a contract with them. The Provider will write to the CCG that holds commissioning responsibility for that patient to request funding confirmation for the first outpatient appointment under patient choice		

Tameside and Glossop	Patients have the right to Choice and we have an agreement across Greater Manchester that patients can chose to go to another provider, in this case for IAPT service. As this is not usual it would help if the GP made it clear on the referral that the patient was exercising choice. The GP can refer to other NHS providers as described above based on patient choice. Referrals to other providers for exceptional need have to come through the Individual Funding Panel for consideration using form embedded below. The Panel will need to be assured that NHS provision is not in place to meet needs prior to agreeing any package. See appendix 1.	*"Funding has to be agreed prior to any referral."*	*"The Panel may agree to fund an assessment in the first instance. A new application has to be made for any ongoing package. See appendix 2."*
Walsall	Walsall CCG offer patients a choice as to where they wish to receive their care. If the GP refers to another provider to that of local provision as long as a contract is in place then the service will be automatically provided. The CCG encourages use of local provision without restricting choice for the benefit of the patient. The more local, the easier it is for the GP to review progress and keep in touch with the patient and also, it is easier for the patient's family to maintain contact. IAPT provision is self-referral or a GP referral based service. As such access to these services is generally defined by GP or patient address. Where a client wished to access another alternative provider then the CCG would fund the out of area provider.	*Contracted out of area providers do not require authorisation for funding.*	*Contracted out of area providers do not require authorisation for funding.*
Wandsworth	The CCG will seek to follow the NHS guidance, with the GP referring directing under the Choice guidance. Please see page four and five of the attached document at Annex A	*If following the NHS guidance, then the request will be dealt with by the Commissioner at the CCG.*	*No further application is needed. The provider needs to invoice the responsible commissioner. Please see page 13 of the attached document at Annex A.*

West Leicestershire	Same response as East Leicestershire & Rutland	*West Leicestershire CCG has a prior approvals panel which reviews requests for funding. Choice Guidance / NICE guidance are used as well as specialist opinion. Please see the Prior Approvals Policy attached for further information.*	*This is carried out on a case by case basis if the provider requests funding prior to treatment, otherwise this would be classed as non-contracted activity within the CCG.*
Wigan	1. The CCG follows NHS guidance in relations to choice in mental health care. This can be found on the NHSE website: https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf For routinely commissioned mental health services, the GP can refer directly to any provider for a first outpatient appointment. The provider must have an NHS contract with any CCG or NHS England for the required service. Where patients, with the support of their GP, wish to access services that are not routinely commissioned by NHS Wigan Borough CCG, they may apply through the Individual Funding Request (IFR) process or if in receipt of a personal health budget through the care planning process. Details can be found on the following website: http://www.wiganboroughccg.nhs.uk/your-ccg/our-strategies-policies-reports/effective-use-of-resources	*2. The Who Pays guidance sets out the payment arrangements. If the chosen provider does not hold an NHS Standard Contract with NHS Wigan Borough CCG, then the provider would invoice for the services as they would for any other non-contracted activity.* *Details can be found on the following website: https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf*	*As per question 1.*

Wirral	With regards to the care pathway for Body dysmorphic disorder (BDD) and Obsessive-compulsive disorder (OCD), NHS Wirral Clinical Commissioning Group (CCG) commissioning the local Wirral Improving Access to Psychological Therapies (IAPT) provider (Inclusion Matters Wirral).: In the main, Cognitive Behaviour Therapy (CBT) is used to treat both BDD and OCD. However, where the condition is OCD and is mild, Inclusion Matters Wirral also have a computerised CBT treatment option available. Where a specialist face to face assessment is required with a senior clinician to clarify treatment requirements and identify appropriate treatment options, findings will be referred to the Clinical Lead (Clinical Psychologist), who will make the final decision with regards to treatment options and level of input (i.e. CBT therapist or Clinical Psychologist), in line with NICE guidelines for BDD and OCD. If at any point, the provider considers that they are unable to provide the appropriate level of treatment for a patient with BDD/OCD (i.e. due to impaired level of functioning, higher levels of comorbidity, or poor response to initial treatment), a referral will be sent to the local secondary mental health service Central Access Team, who will undertake an assessment and identify the appropriate secondary care treatment options. With regards to funding arrangements for referrals to specialist healthcare services outside the range of services and treatments that NHS Wirral CCG commissions, an Individual Funding Request will need to be made by the patients' GP to the Individual Funding Request Team. However, if a referral is made to another IAPT provider outside of local arrangements due to patient choice, NHS Wirral CCG will be responsible for the funding of that referral.
Wolverhampton	Using principles of best practice and patient choice if GPs or a Patient wish an out of area referral for any of the above treatment scenarios the CCG supports and funds this process , sometimes the requests go through our main Mental Health provider as well – Black Country Partnership Foundation Trust (BCPFT). Providers used in this way include South London and Maudsley NHS Foundation Trust (SLAM), Avon and Wiltshire Partnership, Birmingham and Solihull Mental Health Trust and other smaller providers i.e. private and our other local NHS Trusts in Dudley, Walsall and Sandwell. The CCG do not have a policy statement as these matters run outside our IFR policy. GPs can directly refer – they often call or e mail for advice and this information is provided/given. The organisation then contacts the commissioner for funding approval. We have received thank you letters from patients who have found an out of area service they wish to receive treatment for which the CCG has funded

Appendix D: CCGs judged to be non-compliant with Patient Choice

CCG	Question 1	Question 2	Question 3	Comments
Ashford	NHS Ashford Clinical Commissioning Group (CCG) can confirm that the information for all 3 questions can be found within the attached Out of Area Treatment Policy for East and West Kent CCGs.			*Exceptionality criteria applies eg: used local services, complexity etc*
Barnet	NHS Barnet CCG can confirm that there is no set pathway for patient requests of this nature. Requests for funding are considered taking into account the following factors: · Clinical recommendations available to the responsible commissioner/head of service · Any indicated assessment risks of not funding the required treatment · Affordability and value in the use of public funds for individual treatments by the CCG outside of commissioned services Funding decisions of this kind are a complex process based on a range of individual and organisational factors and it is not possible to provide abstracted information.			*No set pathway and no mention of patient choice*
Barnsley	In the scenario provided whereby we commission a service but the patient chooses not to use it, preferring to be referred to a service not commissioned by us then they would need to follow the Individual Funding Request process. Please find attached Barnsley CCG's Individual Funding Request Policy.			*Clinical exceptionality applies*

Basildon & Brentwood	The CCG is clear that there are certain exclusions in respect to choice in mental health (see https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs) The scenario as presented would not be a barrier to the patient exercising choice. The person could be referred to a suitable provider, which is appointed by the NHS directly by their GP, for their first appointment and subsequent treatment if needed. In the suggested scenario, the GP or patient would be able to contact their CCG for advice if needed. However, for referrals for out of area psychological interventions, such as those in your scenario for someone with BDD/OCD, the GP cannot refer directly to an out of area provider. Instead, the referral request would go initially to the Essex CCG's mental health Individual Placements Team (IPT) who would assess any risk and discuss the requirements with local mental health commissioners to determine an appropriate way forward. Patient choice will be taken into account during this process.	As in the response to question 1 above, a request for funding from an out of area provider would be subject to review by the CCGs IPT in conjunction with local mental health commissioners.	Please see answers to 1 & 2 above.	*Refer to patient choice but real life experience with Basildon and Brentwood CCG (specifically North East Essex regarding patient choice is that they do not follow patient choice as per the guidelines)*
Bath and North East Somerset	An individual funding request application is required for Out of Area referrals. This route provides evidence and assurance to BaNES CCG as to why a local commissioned service is not felt appropriate. Applications are assessed anonymously by a Senior Commissioner and will only be referred to an exceptional funding panel if there is insufficient information on which to base a decision. The majority of applications for Out of Area services are approved for assessment.	As above.	No further applications are required. The outcome of the assessment will form the basis of the decision to fund treatment.	*No mention of patient choice. Need to demonstrate why local service is not felt appropriate*

Bedfordshire	Options would be: 1. GP would follow the Individual Funding Request (IFR) route. 2. Self referral into Bedfordshire Wellbeing Service (IAPT) 3. GP would refer in to the CCG for specialist treatment not available locally NHSE and Beds CCG policies are in the public domain: https://www.england.nhs.uk/commissioning/wpcontent/ uploads/sites/12/2016/08/cp-03.pdf https://www.bedfordshireccg.nhs.uk/document_store_public/ Website/Beds_CCG_IFR_policy_v2_Ratified_08_02_16.pdf GP referral into a complex case panel lead by consultant Psychiatrist. Decision will be referral back into local services or if necessary an out of area referral. The decision is made on the information presented and clinical judgement.	This does not occur.	One panel decision required unless range of interventions being offered, needs further clinical review. Regular review of any out of area treatment is undertaken. Please refer to the policies published via the links below: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/08/cp-03.pdf https://www.bedfordshireccg.nhs.uk/document_store_public/Website/Beds_CCG_IFR_policy_v2_Ratified_08_02_16.pdf	*No mention of patient choice. GP has to refer into a complex case panel and decision may be that needs to be seen locally*
Birmingham CrossCity	GP's cannot refer directly to an out of area provider. All referrals go through one of two routes: a) IAPT services (either via Birmingham Healthy Minds or the Birmingham Mental Health Living Well Consortium) and step up to Specialist Psychological Services in Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) or for patients under 25 years Forward Thinking Birmingham (FTB). b) Via an Individual Funding Request through the CCG, the process for which is outlined in our Operational Policy for Joint Commissioning Team – Complex Functional Mental Health (version 5 final draft) – an extract of the section of this policy which relates to IFR application process is below (text from appendix 11.6): 4.8 The Joint Commissioning Team contracts with a wide range of providers both statutory and 3rd sector which should be able to deliver a service for most mental health conditions. However there are some conditions where the complexity or atypical/rare nature of need cannot be met by mainstream services. These may be received as Individual Funding Requests ("IFR's"). At this point consideration will be given to making available individual funding for low volume specialist assessment and treatment and will be managed via the existing funding panel decision process after the following considerations have been conducted. 4.9 This consideration is intended as an adjunct to the Collaborative Commissioning Policy – Ethical Framework for priority setting & resource allocation version 1.0 – March 2013 and states as a fundamental principle: "Principle 10 states: The Clinical Commissioning Group should strive, as far as practicable, to provide equal treatment to individuals in the same clinical circumstance. The Clinical Commissioning Group should therefore not agree to fund treatment for one patient which cannot be afforded for, and openly offered to, all patients with similar clinical circumstances and needs." 4.10 Upon receipt of an IFR, the Lead Nurse will review the information received and complete the pro-forma (see appendix 11.6). The Lead Nurse will then contact the Specialised Psychological Services ("SPS") team at BSMHFT. They will commence background checks of the clinical "RIO" records, in order to ascertain the patient pathway history and develop an accurate illustration of what has been tried thus far, what hasn't been tried or offered and the level of skill required to deliver the request.			*No mention of patient choice. Would only be considering referral to a non-local provider if they could not provide locally*

	4.11 The SPS team at BSMHFT will then be determining to conduct either a full desk top assessment of suitability or, if no previous contact, a screening face to face assessment will be arranged. This applies to cases by exception only as above IFR's and neurosis conditions. 4.12 The formulation will be made by a Qualified Psychologist on behalf of the CCG's, based on clinical benefit to the patient and decide one of the following: 4.12.1 The required treatment is available within BSMHFT/FTB and they can offer it. In which case BSMHFT /FTB will take the referral; or 4.12.2 The required treatment is not available within BSMHFT/FTB but would be beneficial to the individual and cost effective within the CCG's budget. In which case all parties would support the application to an external provider; or 4.12.3 The treatment is available (either in BSMHFT/FTB or elsewhere) but should not be offered as it is unlikely to yield sufficient benefit or is cost prohibitive against the benefits expected, in which case the Team does not support funding. 4.13 The Panel will ratify the above decision making process and where the recommendation is to fund an external service will agree an initial funding allocation. An up to date Decision Support Tool (DST) should be provided by the applicant or care coordinator which clearly evidences health needs related to the condition. The Panel will require clear outlines of expected clinical outcomes and time frame for achievement. The majority of these patients will be undertaking the treatment as voluntary patients. The Team will require regular clinical reports on progress whilst undergoing treatment and will review individuals as required either within Care Programme Approach ("CPA") procedures or other review frameworks.			
Birmingham South Central	*Exact response as Birmingham Cross City – see above.*	Please see response to Question 1	Please see response to Question 1	

Bracknell & Ascot	No - referrals for assessments and/or interventions for out of area providers should be agreed with the CCG before they are sent to the provider. The GP should discuss the referral with the CCG, detailing the assessment and/or intervention required, together with an explanation why a referral to locally commissioned services has been considered inappropriate. The CCG will discuss the referral, taking advice from GPs, clinical commissioners and local providers on the appropriateness of the request. No, currently the referral does not need to go through a panel. This decision is made by the CCG commissioner in consultation with the GP, clinical commissioners and local providers on a case by case basis.NHS England and the CCG priority is to provide locally accessible services for its population and to reduce spend and the number of people being sent out of area for assessment or treatments. To this effect the CCG would agree to fund treatments out of area where treatments are not available locally. However individual cases for out of area treatments are considered on a case by case basis, supported with a detailed explanation why local services have been deemed inappropriate.	All referrals for assessments and interventions should be made via the GP. The GP will then need to discuss the referral with the CCG and agree funding, before the referral is sent to the out of area providers. No, currently the referral does not need to go through a panel. This decision is made by the CCG commissioner in consultation with the GP and local NHS services. However in the event that an out of area assessment or treatment is deemed appropriate; • The CCG would need at least 3 quotes from providers (where appropriate). • Detailed assessment reports from the providers stipulating the type of intervention they will offer and why the number of sessions that will be offered and the intended outcomes and a breakdown of the cost for the proposed interventions. • The CCG would also seek assurance on the quality of services delivered by the providers i.e. CQC inspection reports (where appropriate) including confirmation that the providers are registered with professional bodies and suitably qualified to deliver the psychology assessment or treatments. • The CCG would also request for evidence of indemnity insurance and clear discharge plan when the sessions are completed etc. before funding is agreed. This is to ensure that we commission high quality care that is safe, cost effective and that delivers positive experience and outcomes for the users of that service.		*No mention of patient choice. Need to demonstrate why local services are not appropriate*
Brent	Yes, if the GP has determined that the required service is not already commissioned locally or from another NHS Trust as part of the CCG's commissioned services portfolio or other evidenced rational including NICE Guidance. No, if the service is already commissioned by the CCG either locally or from other NHS provider Trusts, voluntary sector or independent organisations and there is no clear rational to deviate from this. Some services that are deemed to be exceptional have to go through the exceptional treatment requests panel (PPwT) or Individual	As in question one, all referrals go through the SPA/IAPT unless the GP clearly specifies that this is an exceptional case that falls outside of commissioned services and it is his/her clinical recommendation for support to access a different	If a GP makes a clinical recommendation outside of commissioned services, the clinician must apply for prior approval funding to the CCG who will authorise assessment in the first instance and thereafter the recommended treatment once this assessment is shared with the CCG.	*No mention of patient choice. Need to demonstrate why local services are not appropriate*

	Funding Requests (IFR) managed by the NHS North West London Individual Funding Request and Planned Procedure with a Threshold Policy Panel. The Exceptional Cases Panel is authorised by the CCG's Governing Body to process requests for exceptional treatments (procedures, drugs or health care services) that are: · Undertaken outside the criteria agreed locally for surgical thresholds. · Classified as low priority treatments. · Tertiary referrals i.e. to a Consultant or a service not covered by contracts with local providers or not covered by the 'Choice' policy · Drugs not funded for routine prescribing e.g. primary care red List or drugs outside secondary care contracts which practices may be asked to prescribe or support for your patients. The local pathway is through a Single Point of Access (SPA) or through Improving Access to Psychological Therapies (IAPT). NHS Brent CCG's SPA is through Brent Mental Health Services. For IAPT, patients can self-refer or be referred by their GP. These are gate keeping arrangements which help to place individuals at the heart of local assessment and local care planning. They ensure that patients receive appropriate, effective and timely responses to their health and social care needs, and that resources are used effectively. They also support optimum arrangements for robust community and primary care after-care requirements and access to other local services and appropriate support. The SPA triggers the review and monitoring mechanism to facilitate timely discharge planning and associated primary care and community support as required and this is paramount to local patient care pathways. The local pathway through the SPA/IAPT determines whether the required treatment is out or in scope of commissioned services. Exceptionality is considered following SPA/IAPT's recommendation where	service out of area/out of commissioned provision.		

	the required service falls outside of the NHS commissioned services.			
Bury	The Patient can be referred by their GP or self- refer to our IAPT service provided by Pennine Care NHS Foundation Trust. Patients have the right to Choice and we have an agreement across GM that patients can chose to go to another provider, in this case for IAPT service. If the patient opts for a service outside of GM (out of area), then referrals can also be made. The option of choice would be made clear on the referral that this is being exercised by the patient. If a request is sent to the CCG from a funding perspective, the process for the Effective Use of Resources (EUR) service for mental health requests is that the patient should be referred via the single point of entry (SPOE) and rejected by SPOE as there is no local service available and this would need to be made clear in the referral/application. The case would progress to screening and clinical triage before being passed to the IFR Panel who will make the decision. If there is a local service that Bury commissions then the panel may expect that the patient accesses the local service.	For any funding scenarios, any request needs to go through the IFR (Individual Funding Request) panel in line with its IFR policy. Link to the Greater Manchester Effective Use of Resources which has details around IFR as followed by Bury. http://northwestcsu.nhs.uk/BrickwallResource/GetResource/5f056233-96fc-46bf-bc73-0b1d67f8e7e0	The CCG would expect that the cost of the service provided by another NHS provider would be in line with expected national tariff price. Where a service is commissioned locally, the CCG would encourage local access where appropriate. The CCG reviews any None Contracted Activity (NCA) invoices and would seek further detail from the provider if required. If gone through an IFR panel, depending on the request, the panel may agree to fund an assessment in the first instance, with a new application to be made for any ongoing packages.	*Make reference to choice but when funding is discussed suggests that the patient should have accessed local services first*

Calderdale	The GP would refer to the mental health trust, South West Yorkshire Partnership Foundation Trust (SWYPFT), via Single Point of Access (SPA). This referral would then most likely be directed to secondary care psychology; although, there may be individual instances where the Community Mental Health Trust (CMHT) is more appropriate. NHS Calderdale CCG works closely with providers and GPs to ensure patient choice. There is an "Any Qualified Provider" contract for IAPT services. Through this we are able to offer the choice of two IAPT providers which are available via self-referral as well as GP referral. Although choice of out of area providers is not offered at the time of referral, if a patient wished to receive IAPT or secondary care psychology services out of area, the request would be managed through the Individual Funding Request (IFR) process. NHS Calderdale CCG's "Operating Framework for Managing Individual Funding Requests" is provided with this response. Each request is assessed on a case by case basis			*Need to complete a Individual Funding request explaining why local services cannot meet the patient's needs*
Cambridgeshire and Peterborough	The pathway would be the same as for any other MH disorder, utilising full primary and secondary care capacity. If the treatment cannot be provided locally or the patient states preference for any other provider we would be able to facilitate this based on the clinical case via an exceptional funding cases panel. There is an Exceptional Funding Panel to determine the need for this referral. This is considered on a case to case basis, and is led by the clinical need of the patient. The patient choice would be respected in accordance with https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf	The request is taken to Panel. Please refer to the Exceptional Funding Policy which is published on the CCG's website. To assist the link is provided below: https://www.cambridgeshireandpeterboroughccg.nhs.uk/easysiteweb/getresource.axd?assetid=3767&type=0&servicetype=1	Both the assessment and treatment would need to be authorised through the Exceptional Funding Panel. Refer to the link provided in Q2 above.	*States respects patient choice but also state "patient states preference for any other provider we would be able to facilitate this based on the clinical case via an exceptional funding cases panel."*
Canterbury and Coastal	NHS Canterbury and Coastal Clinical Commissioning Group (CCG) can confirm that the information for all 3 questions can be found within the attached Out of Area Treatment Policy for East and West Kent CCGs.			*Exceptionality criteria apply*

Castle Point and Rochford	The CCG is clear that there are certain exclusions in respect to choice in mental health (see https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs) The scenario as presented would not be a barrier to the patient exercising choice. The person could be referred to a suitable provider, which is appointed by the NHS directly by their GP, for their first appointment and subsequent treatment if needed. In the suggested scenario, the GP or patient would be able to contact their CCG for advice if needed. However, for referrals for out of area psychological interventions, such as those in your scenario for someone with BDD/OCD, the GP cannot refer directly to an out of area provider. Instead, the referral request would go initially to the Essex CCG's mental health Individual Placements Team (IPT) who would assess any risk and discuss the requirements with local mental health commissioners to determine an appropriate way forward. Patient choice will be taken into account during this process.	As in the response to question 1 above, a request for funding from an out of area provider would be subject to review by the CCGs IPT in conjunction with local mental health commissioners.	Please see answers to 1 & 2 above.	*Refer to patient choice but real life experience with Basildon and Brentwood CCG (specifically North East Essex regarding patient choice is that they do not follow patient choice as per the guidelines)*

Chorley and South Ribble	The GP would provide a referral to Midlands and Lancashire Clinical Support Unit. There is a specific form for this purpose. The referral is then triaged by a mental health professional who ensures the referral provides enough information for the request to be authorised. For this particular situation it would be deemed very important to ensure that clinical information is also collated from mental health services. In most of these cases the referral would be made from mental health services, which would need to demonstrate that all available treatment options have been exhausted prior to considering making a decision regarding the request. If there are specific concerns regarding the request that need to be discussed further with the CCG, then the case would be discussed at a panel. The panel would consider exceptionality/clinical effectiveness and appropriateness. The CCG would consider: · Advice from mental health services including a consultant psychiatrist. This would also highlight what treatment/interventions have been undertaken and the effectiveness. · Length of time in service. · If there are any current risks due to their condition that need consideration. · The patient’s motivation for treatment. · The patient’s current quality of life due to their condition. · Clinical evidence to support the request. · NICE guidelines. · The planned treatment/intervention, and the expected benefits and risks of the treatment. · The clinical evidence base of the treatment/intervention. · The value for money to the NHS of the treatment/intervention.	The assessment should have already been agreed at this stage. The provider does not usually request the funding for assessment. Itis usually due to the specialist nature of the condition.	The case would usually need to go back to a panel after the assessment, and the information from the assessment would be carefully considered prior to agreeing to fund the treatment. If treatment could be provided locally then the CCG would recommend this action, however, this would have been considered in the first place. The recommendations from the assessment may be able to provide assistance / support with local care planning. Prior to funding the treatment and reviewing the assessment the CCG would consider advice from mental health services including consultant psychiatrist. This would also highlight what treatment/interventions that have been undertaken and the effectiveness. · Length of time in service. · If there are any current risks due to their condition which need consideration. · The patient’s motivation for treatment. · Patients current quality of life due to condition · Clinical evidence to support the request. · NICE guidelines.	*No mention of patient choice, judgement based on a number of factors including risks, value for money, motivation, current quality of life*

<table>
<tr><td>Corby</td><td colspan="3">I can confirm that NHS Corby CCG does not hold this information in the format or level of detail requested. The CCG does not have a policy or pathway document to share regarding this area. In such a scenario the CCG would request the person is referred to the local provider for a formal diagnosis of body dysmorphic disorder (BDD) or obsessive compulsive disorder (OCD) and then a referral can be made to an appropriate provider. The CCG would not expect that GPs are able to make a formal diagnosis of BDD or OCD independently and would require support to do this from the specialist local provider. If the person meets the choice agenda requirements then a referral to external providers would be completed. This process would be led by the provider, Northamptonshire Healthcare NHS Foundation Trust (NHFT); if required, they would approach the CCG for funding for out of area provision. The provider would lead on this and funding requests would need to be approved by commissioners.</td><td>No as patient has to be referred to local services for an assessment. This does not follow Patient Choice</td></tr>
<tr><td>Coventry and Rugby</td><td colspan="3">I can confirm that, for patients across Coventry and Warwickshire, the CCG commission mental health services including the provision of IAPT (Improving Access to Physiological Therapies) from our local NHS Provider trust; Coventry and Warwickshire Partnership Trust (CWPT). However, we do not commission a local service for Body Dysmorphic Disorder. The number of patients requiring access to such a service is very low and the CCG have ‘spot purchase’ arrangements in place with out of area providers to commission specialist expertise on an individual case by case basis as part of non-contracted activity; a process which is approved and managed by our local CSU on behalf the CCGs. Body Dysmorphic Disorder on an annual basis generally affects a small number of patients, who would not be eligible to be considered by a panel to review Individual Funding Requests as the cases of BDD would not demonstrate or meet the criteria to determine exceptionality. Therefore our local process is managed by the CSU on behalf of the CCGs, and considers cases on an individual case-by-case basis. The process requires a recommendation by a GP to request an assessment for their patient. The CSU will review the clinical appropriateness and, if approved, the patient will access an out of area provider (with whom we may have a spot purchase contract in place) and the CSU await the outcome of an assessment into the clinical needs of the patient. The provider will then share with the CSU details of an individual package of care, treatment and indicative costs. At this stage the provider will request an approval of funding to proceed, which will be considered for authorisation by the CSU, who also provide ongoing review into the clinical outcomes and costs of care.</td><td>No locally commissioned service for BDD (therefore state do not need to follow patient choice) and no mention of OCD</td></tr>
<tr><td>Darlington</td><td>If the referral is outside of the agreed local pathway then an IFR request should be made. There is no criteria and a case of exceptionality must be demonstrated i.e. ‘The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.’</td><td>Referral for assessment within an NHS provider does not require prior approval. Funding requests for treatment will have to be via the IFR panel and demonstrate exceptionality.</td><td>Yes, prior approval should be sought as above.</td><td>No mention of patient choice and case has to go panel and demonstrate clinical exceptionality</td></tr>
<tr><td>Doncaster</td><td colspan="3">NHS Doncaster CCG does not hold the requested information at this level of pathway detail. We have a specific pathway for clinicians wanting to access treatment that is not within the normal funded remit of care. This information is available on our website as part of our Commissioning for Value – Decision Making and Prioritisation Framework: http://www.doncasterccg.nhs.uk/wp-content/uploads/2017/04/DCCG-Comm-for-Value_Decision-Making_Prioritisation-FINALshared-Apirl2017-website-version-1.pdf
Appendix 1 on page 10 details the Clinical Threshold and Individual Funding Requests Panel Referral Process.</td><td>IFR and demonstrate clinical exceptionality</td></tr>
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Dorset	A referral outside of the standard pathway e.g. to a specific provider/out of area provider, would need to be made via the Individual Patient Treatment route. I can confirm that NHS Dorset CCG holds the information you have requested, however, this is exempt under Section 21 of the Freedom of Information Act in that the information requested is reasonably accessible to you by other means via the Dorset CCG Policies available from http://www.dorsetccg.nhs.uk/Downloads/aboutus/Policies/Clinical/Policies%20from%20Sept%202014/Individual%20Patient%20Treatment%20Policy.pdf	N/A	This would be determined on a case by case basis and would depend on a number of factors including: • the initial Individual Patient Treatment (IPT) request/wording included in that request and whether the request explicitly requested both assessment and treatment; • the outcome of that request at IPT Panel (e.g. sometimes the panel may approve both assessment and treatment at one panel, other times they may wish to review treatment plan before proceeding any further); • whether the treatment could only be provided by that alternative provider as opposed to a local provider.	*Policy makes reference to patient choice circa 2008 which is in respect to physical health only*

Dudley	Dudley Clinical Commissioning Group can confirm that a GP has the right to refer patients to any provider under the NHS Constitution. However, if the patient has already commenced an episode of care for the same condition elsewhere, this is not applicable. The referral pathway would normally be the GP to Consultant, but this may vary depending on a provider's individual requirements.	A 'Funding Pathway' would be used for such referrals; however this depends on the contractual arrangements in place. Dudley Clinical Commissioning Group holds contracts with a number of out of area providers. Where a service is not covered by a contract, the provider would normally contact the CCG to discuss a specific referral. There are number of factors to be considered, including the following:i. The patient requires a specialist clinical intervention ii. Specialist assessment iii. Specialist clinical support iv. Appropriates of provider v. NHS Contracted activity vi. Quality and Outcomes vii. Timeliness and availability viii. Closest to home	Assessment commissioned by the CCG is for diagnosis, advice on treatment and management of condition; it does not automatically lead to further funding. There are number of factors to be considered (as highlighted in question 2) there are two additional factors (ix. & x.): i. The patient requires a specialist clinical intervention ii. Specialist assessment iii. Specialist clinical support iv. Appropriates of provider v. NHS Contracted activity vi. Quality and Outcomes vii. Timeliness and availability viii. Closest to home ix. Appropriate local services are not available x. Local services have been exhausted.	*The policy states that GP can make referral to any provider but in terms of funding treatment make reference to local services either being not available or exhausted*
Durham Dales, Easington & Sedgefield	There is no criteria and a case of exceptionality must be demonstrated i.e. 'The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'	Referral for assessment within an NHS provider does not require prior approval. Funding requests for treatment will have to be via the IFR panel and demonstrate exceptionality.	Yes, prior approval should be sought as above.	*IFR and clinical exceptionality must be demonstrated*

Enfield	NHS Enfield CCG does not have a set pathway for patients with body dysmorphic disorder (BDD)/obsessive compulsive disorder (OCD) who wish to be referred to an out of area provider. All referrals for treatment at an out of area provider must be considered by the NHS Enfield CCG Individual Funding Requests (IFR) panel, which considers treatments and procedures that are not routinely NHS funded or for which prior approval needs to be sought. The IFR Panel includes a local GP, Public Health representative, a commissioner and the Director of Strategy and Partnership. In making a funding decision, the IFR Panel considers the effectiveness of the requested treatment, grounds for exceptionality and equality considerations in relation to previous funding decisions and implications for the funding of other similar patients in the future. Funding criteria are not set by condition. Decisions are based on individual need, case history and assessed risks at the time of presentation.			*No pathway for patients with BDD who wish to have out of area referral - IFR and based on exceptionality, individual need, equality considerations*
Great Yarmouth and Waveney	Under the arrangements for choice a GP may refer direct to an out of area provider.	If the individual is referred to an out of area provider, the provider will make contact with the CCG to confirm whether the CCG agree to fund. This is necessary as Mental Health services are not routinely funded under a tariff arrangement but rather through a block contract. This means that requests for out of area referrals for services which have been commissioned locally under a block contract represent an additional cost for the commissioner. The expectation is that the referrer should be able to demonstrate why the locally commissioned service is not appropriate. Any requests would be considered by the CCG through a multi-disciplinary approach	As per the earlier response it would be expected that the out of area provider would make contact with the commissioners describing the treatment required. If the required treatment is available through a locally commissioned service the referrer should be able to demonstrate why the locally commissioned service is not appropriate. Any requests would be considered by the CCG through a multi-disciplinary approach including advice from appropriate clinicians.	*Make reference to choice but still need to justify why local services are not appropriate*

		including advice from appropriate clinicians.		

Greater Huddersfield	Under the right of choice a GP can refer into any registered NHS service with an NHS provider for a first outpatient appointment. The patient must be offered the first outpatient appointment available with a team led by a named consultant or named healthcare professional which is clinically appropriate. The patient has a right to choose within those parameters but it is the responsibility of commissioners to decide whether treatment is an appropriate or commissioned pathway. The CCG should be a named associate to the provider's contract irrespective of which CCG is the lead commissioner. If the provider is not an NHS registered mental health provider, or the CCG are not an associate to the contract a funding request needs to be made to the CCG. This can be done in two ways – 1) the GP can make an Individual Funding Request (IFR) prior to making the referral for the patient, or 2) the GP can make a referral to the specialist and the specialist can support the GP in making the IFR. The funding request needs to be made on ground of exceptionality and the case will then be considered through the IFR process which includes a screening panel and full committee if required.	Please see response to Q1 and also the CCG policy for Individual funding requests which can be accessed using the following link; https://www.greaterhuddersfieldccg.nhs.uk/wp-content/uploads/2017/04/Operating-Framework-for-Managing-Individual-Funding-Requests-v6.pdf Information that is reasonably accessible by other means is exempt under section 21 of the Freedom of Information Act.	This depends on the original request. If anything further to the original request is required then an additional application must be made.	*Refer to patient choice but need to complete an Individual Funding request explaining why local services cannot meet the patient's needs*
Greater Preston	Same response as Chorley and South Ribble			

Greenwich	The CCG does not hold this information as it does not have a specific policy for the scenario specified.	The CCG does not hold this information. This information may be held by our service providers - Oxleas NHS Foundation Trust and the South London and Maudsley NHS Mental Health Trust. Details about asking them a freedom of information request can be found here: http://oxleas.nhs.uk/freedom-of-information/ http://www.slam.nhs.uk/about-us/freedom-of-information	There is no official policy however the CCG considers such requests on a case by case basis and does allow for patient choice to be exercised where reasonable and safe to do so. Outside the scope of your request, but in the spirit of transparency, the CCG has released the two attached documents (Annexes A and B) about referral guidelines and panel referral.	*Make reference to patient choice but only when reasonable and safe - unclear what this means. Annexes a+b are about "specialist referrals" not IAPT/secondary care. SLAM and Oxleas are providers not commisioners*
Halton	All Mental Health referrals go to the Single Point of Access for Mental Health Assessment by North West Boroughs Healthcare NHS Foundation Trust. All referrals are managed through the Referral Management system however; for any specific requirements around a referral or a specific type of support given that it is not commissioned locally then an Individual Funding Request is required to which there is a policy and guidance in place. NHS Halton CCG has a contract in place with North West Boroughs Mental Health Partnership. If this scenario were presented to the CCG it could be considered under the Individual Funding Request policy. NHS Halton CCG would consider on a case by case basis, however in the absence of national mechanisms of Payment by Results in Mental Health it is difficult to get other services to accept referrals out of contracted financial agreement.	All referrals are managed through the Referral Management system however; for any specific requirements around a referral or a specific type of support given that it is not commissioned locally then an Individual Funding Request is required to which there is a policy and guidance in place.	All referrals are managed through the Referral Management system however; for any specific requirements around a referral or a specific type of support given that it is not commissioned locally then an Individual Funding Request is required.	*No mention of patient choice and describe IFR*

Hambleton, Richmondshire and Whitby	NHS resources come under greater pressure each year. Ensuring that treatment and care are focused where they can make the biggest difference is a key part of making the best use of these resources. We commission (buy) services from health providers to deliver health care to the residents of our CCG. For physical health, Payment by Results (PBR) is the mechanism by which acute trusts are paid. This is an extensive lists of treatment tariffs. This system is not available for mental health locally, so we have a block contract with our mental health provider Tees, Esk and Wear Valley NHS Foundation Trust (TEWV). We know from our public engagement that our public value local accessibility of health services. This means that all mental health referrals go to TEWV. We do have an exceptionality policy. Exceptionality is defined as: "The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition." We would expect that all our residents with mental health problems are referred to TEWV. There is one exception where a resident is an employee of TEWV and they need referral for a mental health problem, they can be seen by a non TEWV service. If the local TEWV team do not have the resources to deal with a particular patient or if they need a further specialist opinion, they can on a case by case basis apply to the CCG for further funding.	*Must use local services and otherwise demonstrate clinical exceptionality*
Hammersmith & Fulham	A GP cannot refer to an out of area provider if there is a commissioned service which clinically meets their needs. In the scenario (c) the request for a referral to another provider is purely on patient choice and therefore, if there is already a service commissioned it would not be agreed. If the patient could not access the commissioned service for other reasons then funding on a cost per case bases would be considered. Examples would be: The service did not have wheel chair access which was needed. o The patient was subject to domestic abuse or could not attend the venue due to fears for their safety or other significant reasons. o The patient needed to have treatment at home and the local services could not provide this. If the patient had exhausted or tried treatments in local services using the stepped care approach outlined in the NICE guidance and these did not meet their clinical need, then this would be different, as there would not be a locally commissioned service which could meet their needs. The service which had tried to meet the person's clinical needs and could not would refer to the CCG explaining why local services could not meet the person's needs. The CCG would expect this service to have discussed treatment options with the patient. A decision whether to fund more specialist treatment would be made by the CCG Clinical Lead for Mental Health and the CCG Mental Health Commissioning Manager. The factors which would be taken into consideration when making a decision are, but not exclusively; · NICE guidelines- whether these had been followed. · The distress/disability and or affective on day to day functioning the body dysmorphic disorder had on the patient. · The likelihood of the success of the treatment. If a decision was made to fund treatment, then this would be for a specialist assessment only. If specialist treatment was recommended then this would need to go back to the CCG for a separate decision using the same criteria. Hammersmith and Fulham CCG do not have a specific written policy on this but are considering writing one.	*GP must justify why local services are not appropriate if a local service is already commissioned*
Harrogate and Rural District	Same response as Hambleton, Richmondshire and Whitby	

Harrow	The policy and practice is for the GP to refer to Improving Access to Psychological Therapies (IAPT). If what is required is outside the scope of IAPT then the GP could refer to our main provider Central North West London NHS Trust using an MH1 Form. GP's also have support from specialist Primary Care Mental Health nurses based within their practices to support them with this. If the referral requires a more specialist service than what our main provider requires, the GP will contact the CCG (Placements Officer) to make a referral to the Individual Funding Panel (IFR). All necessary information will be included in the referral including advice and responses and support from the local secondary provider.	If the referral requires a more specialist service than what our main provider requires, the GP will contact the CCG (Placements Officer) to make a referral to the IFR Panel. All necessary information will be included in the referral including advice and responses and support from the local secondary provider. If the GP refers to another provider without first seeking agreement with the CCG, this will delay the referral and sometime generate issues around payment.	If the referral requires a more specialist service than what our main provider provides, the GP will contact the CCG (Placements Officer) to make a referral to the IFR Panel. All necessary information will be included in the referral including advice and responses and support from the local secondary provider.	*No mention of patient choice - discuss specialist referrals which is not what the scenario described*
Hartlepool and Stockton-On-Tees	Same response as Darlington			

Herts Valleys	We would normally accept referrals from a GP when the GP has received a recommendation for a particular treatment from a mental health specialist who has assessed/treated patient and felt that they needed more specialist treatment that is not provided within the block contracts that we currently have. Please refer to the attached Individual Funding Request (IFR) policy for more details.	If a psychiatrist makes a referral for a patient to receive treatment in another service, we would normally fund an assessment initially, to determine whether the patient would be suitable for that service. We would require an IFR to be completed, should the patient be assessed as suitable for the requested treatment. Please refer to the attached Individual Funding Request (IFR) policy for more details.	As answer 2. The decision for funding would normally be made by the Clinical Team Lead for the Integrated Health Commissioning Team, however in some circumstances the decision would be made following consideration at a panel. Please refer to the attached Individual Funding Request (IFR) policy for more details.	*No mention of patient choice - discuss specialist referrals which is not what the scenario described*
Hillingdon	Yes, a GP can refer to another provider if the patient has exhausted local services or there has been a breakdown in a relationship.	The request will be dealt with directly by the Commissioner and the judgement based on whether it is clinically appropriate, taking advice if necessary.	Yes, an individual funding application would be required.	*No mention of patient choice and must have a reason why local services not appropriate*
Hounslow	The pathway is that the GP makes referral direct to provider of choice and they would then approach the CCG for funding. The referrals would be dealt with by the Senior Joint Commissioning Manager for Mental Health who would gather the necessary info and take the case to the individual funding panel (meets weekly) for decision. This would often involve approaching the GP direct to check that he or she is aware of the local service and explore the reasons for going elsewhere. There is no formal policy that would govern the decision and each case would be looked at on its own merits. No formal policy or definition of exceptionality and no blanket approach, cases dealt with on a case by case basis.	As described above. The exception that can sometimes arise is that the chosen provider (particularly if NHS) may have a policy whereby they do not accept referrals outside their own contracts, even if funding would potentially be available, in which case the referral will be turned down before it reaches the funding stage.	Depends partly on the providers own processes and partly on how funding panel looks at the case. Some providers automatically ask for funding for assessment plus treatment, others separate these requests. If both are requested, panel may on occasion agree assessment initially and want to consider the outcome before agreeing treatment.	*Refers to patient choice but has to go to explore reasons for not using local services – it is not sufficient for a patient to want to referred elsewhere and exceptionality is considered.*

Hull	NHS Hull Clinical Commissioning Group (CCG) does not hold a specific Mental Health (MH) policy in relation to body dysmorphic disorder / obsessive compulsive disorder. The CCG does have a policy for Out of Area (OOA) placements (please see HU 1093 - Attachment One [FINAL OOA Policy 03.02.2017]). If the NHS Hull CCG Individual Funding Requests (IFR) Panel were to consider a request for a body dysmorphic disorder/obsessive compulsive disorder assessment/treatment (other than those relating to a hospital/residential placement) outside of locally commissioned services then there is no specific policy for this other than the overarching NHS Hull CCG IFR policy which is available on the CCG website at: http://www.hullccg.nhs.uk/policies. Any requests would be reviewed in line with the definition of clinical exceptionality (which is outlined in the IFR policy referred to above). If a provider is outside the contractual agreements the CCG holds with a range of mental health providers then we would expect the GP to request authorisation for referral out of contract. Dependent upon the specific clinical presentation of the service user this would reviewed by either the IFR panel or the MH Funding Panel. Please see the attached copy of the OOA placements policy (HU 1093 - Attachment One [FINAL OOA Policy 03.02.2017).	There is no specific policy/criteria for this other than the overarching NHS Hull CCG IFR policy which is available on the CCG website at: http://www.hullccg.nhs.uk/policies. Any requests would be reviewed in line with the definition of clinical exceptionality (which is outlined in the IFR policy referred to above). Should approval for out of area/out of contract referral be agreed by IFR panel or MH Funding panel then the original referrer will refer the patient to the provider who will then need to liaise with the CCG commissioning team. The organisation the referral is sent to will need to send information regarding cost, expected outcomes and benefits that the patient will receive from accessing the care delivered by the provider. This may well include specific update reports at specific key stages of the care delivery.	Please see response to question 2 above. Dependent on the care which is to be provided, for example, if specialist therapies are to be provided over a number of sessions then the CCG will expect to see updates at specific points e.g. At therapy session 6, this is to ensure the patient is receiving the care they require and that the expected benefits/outcomes are delivered and that the care meets the needs of the patient to ensure they have the best clinical experience and best outcome for them as an individual.	*No specific policy, and requires clinical exceptionality*

Ipswich and East Suffolk	Local triage service to determine appropriateness and/or Individual Funding Request Referral. Individual funding Request Policy - attached.	Individual funding Request Policy - attached.	Individual funding Request Policy - attached.	*Local services and otherwise a IFR*
Knowsley	The CCG's commissioning policy is publically available via the following link: http://www.knowsleyccg.nhs.uk/assets/uploaded/documents/26884_26652_FINAL%20Knowsley%20CCG%20Commissioning%20Policy%2013%2005%202015.pdf The information requested is detailed in this document.	The Individual funding request process is outlined in the CCG's Commissioning Policy.	Please see answer to Q1.	*No mention of patient choice in the document or of OCD/BDD treatment*
Lambeth	A GP must refer to a specialist Outpatients panel if requesting an alternative service outside the established pathway. In relation to IAPT, the patient would be re-directed to the area they wanted to receive IAPT. The CCG understands this is rare as most people either self-refer or are referred via the GP to Lambeth talking therapy service because they want to receive therapy from the local service. This is on a case by case basis. Normally for specialist services, choice does not apply. Exceptionality is determined on a case by case basis, for example if the patient is a member of staff in South London and Maudsley NHS Mental Health Trust (SLaM) services.	No patient will be referred directly to another service area without prior approval from local commissioners in relation to specialist services.	Please see the response to question 2.	*The policy refer to a specialist panel. It states that patient would be re-directed to the area they wish to receive IAPT but then discuss exceptionality in funding.*

Lincolnshire East	The GP should not refer directly to the provider without seeking funding or having prior discussion with the Operational commissioning Team It is beneficial to include suggested or identified services within the referral (referral form attached at appendix one for information). This prevents the patient becoming fixed on one service and then being disappointed if a) funding isn't approved and b) The Operational commission team or OATs panel may be aware of more appropriate services and c) the service does not meet CQC or has been seen to have poor outcomes or quality issues. On receipt of the referral this will be screened for appropriateness for submission to OATs. The screening is currently undertaken by the Operational commissioning manager. The referral will be checked for – Correct Completion Diagnosis Relevant supporting information Previous referrals Ensuring that request cannot be met locally Strong rationale for request if service can be met locally and GP aware. Any other services that patient could be signposted too. Evidence that the GP supports the referral. Reasons for local services not accepting the referral or patients' disengagement with local services (if appropriate) Current involvement with services. Generally it would be expected that a referral would be made to local services in the first instance however there may be circumstances when this may not be appropriate due to patients' previous experiences or services unable to offer requested or further treatment this is taken into account by the panel when considering the	If The Operational commission team receive funding requests directly from the provider the GP or other health professional will be asked to complete referral form as in question 1 and this will be discussed at OATs panel. The Operational commissioning Manager (OCM) would also ask for a view from services involved in terms of supporting the referral. However if the patient (under rare circumstances) has already commenced treatment either by self-funding or GP has by-passed the OATs referrals. Funding is unlikely to cease as this could be detrimental to the patient, However the OCM would need to discuss with the CCG Chief Executive Nurse for confirmation and agreement. The panel consider all requests on an individual basis and a decision is based on the information provided, an expected outcome, benefits of the treatment, if	Once funding is agreed and another provider is identified if there are no major cost implications and if the service meets CQC and has Quality outcomes this will not need to be returned to OATS. The OCM would discuss with the Senior Operational commissioning manager for approval. If however there is a vast difference above the costs agreed this will need to return to OATs for approval. The OATs panel would not support a placement that does not meet CQC requirements or circumstances which would put the patient at risk. See Q1 and 2 in relation to local treatments.	*Have to justify why cannot be met locally*

	request. Once satisfied, the referral and information will be presented to the next available OATs panel.	it will support a future care pathway, cost and local service availability. As each case is looked at individually it maybe that we would ask for local services to assess in the first instance, if the service is not able to provide the service the panel would ask to view their report and recommendations. If the patient chooses not to access the service a clear rationale		
Lincolnshire South West	Same response as Lincolnshire East	Same response as Lincolnshire East	Same response as Lincolnshire East	*GP must justify why the service cannot be met locally*
Merton	The CCG does not hold the information you have requested as it does not have a policy for the specific scenario you outlined. Outside the scope of the Act, the CCG can provide the following advice that may prove useful to you: NHS Merton CCG commissions mental health services from South West London and St George's Mental Health NHS Trust, which includes a national centre of expertise in the treatment of BDD/OCD. In practice, the mental health commissioner has not received any out of area referrals for the treatment of OCD/BDD; probably because local services are recognised as part of a national centre of excellence. In the event an out of area referral is made to an alternative provider, there is a panel process to determine whether the referral is appropriate. Cognitive behaviour therapy is often provided by services that are not consultant led, therefore the panel would need to understand what treatments have already been tried; to what extent they had been successful; what outcome(s) would be expected from the proposed treatment; and why similar outcomes cannot be achieved from local services.			*GP has to justify why the service cannot be met locally*

Mid Essex	The three North Essex CCGs (North East, Mid & West) commission collaboratively in respect of Adult primary and secondary Mental Health services. As such, this response is on behalf of all three CCGs The CCGs are clear that there are certain exclusions in respect to choice in mental health (see https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs) The scenario as presented would not be a barrier to the patient exercising choice. The person could be referred to a suitable provider, which is appointed by the NHS directly by their GP, for their first appointment and subsequent treatment if needed. In the suggested scenario, the GP or patient would be able to contact their CCG for advice if needed. Such referral requests would be directed initially to our Individual Placements Team (IPT) who would access any risk and discuss the requirements with local mental health commissioners to determine an appropriate way forward. Patient choice will be taken into account during this process. It is worth noting that in the North Essex area (Mid, North East & West Essex CCGs) we have 3 distinct IAPT services, however they are delivered by a common provider. Therefore, on a case-by-case basis we have a reciprocal arrangement across the wider area to see out of area patients where appropriate. It is also worth noting that acute mental health services across the 'greater' Essex area are provided by Essex Partnership University Foundation Trust (EPUT) therefore out of area would be considered to be outside of the county of Essex.			*Refers to patient choice but real life experience with Basildon and Brentwood CCG (specifically North East Essex regarding patient choice is that they do not follow patient choice as per the guidelines)*
Nene	Same response as Corby			
Newbury and District	All referral for such request needs to go via our Common Point of Entry (CPE) service provided by Berkshire Health Care NHS FT for initial triage and recommendation. The CPE will then refer the patient to the most appropriate service that can meet the patient needs. All local commissioned services should be explored before any out of area treatment pathway is considered.	All funding requests are made to the joint mental health and learning disability funding panel with relevant evidence as to why the CCG/Local Authority should consider this application to fund out of area treatment and the length of treatment required/recommended, the outcome of such specialist treatment pathways i.e. NICE recommended.	Yes the provider should submit clear evidence as to why such treatment pathway will benefit the patient, what is the length of time required for such treatment, what is the success rate and how do they measure recovery of patient conditions i.e. PROMs (Patient Reported Outcome Measures), CROMs (Clinicians Reported Outcome Measures) etc.	*Justify why cannot be met locally*
Newcastle Gateshead	Same response as Darlington			
North and West Reading	Same response as Newbury and District	Same response as Newbury and District	Same response as Newbury and District	*Justify why cannot be met locally*

North Durham	Same response as Darlington	
North East Hampshire & Farnham	The CCG supports the right of individuals to choose the organisation that provides their NHS care and treatment whenever they are referred for the first time for an appointment for a physical or mental health condition. In the scenario presented, the CCG would expect the individual to be supported to choose which mental health service provider they wished to be referred to for an initial assessment appointment. It is unlikely therefore that a GP would refer a patient directly for treatment for BDD/OCD as the diagnosis would generally only be confirmed following assessment by the secondary care mental health provider to which the individual has chosen to be referred. In terms of referral to out of area services, such specialist services to manage BDD/OCD cannot currently be accessed through the standard Choose & Book referral process. The gateway into ongoing treatment for such services is currently managed by the mental health provider services themselves and not by the GP or the commissioner. However, it is expected that secondary care mental health services take patient choice into consideration and that they make all reasonable adjustments to improve choice such as referring to another provider or another team within that provider if the therapeutic relationship has broken down. If a referral to another provider is required then as mentioned above, referrals to non-commissioned services sit outside of the current scope of Choose and Book and would need to be referred into the CCG for consideration as an individual funding request (IFR). A copy of the IFR policy setting out what be a clinically-led process can be found on the CSU's website at www.fundingrequests.cscsu.nhs.uk then click 'Hampshire'.	*Do refer to patient choice but also state that "If a referral to another provider is required then as mentioned above, referrals to non-commissioned services sit outside of the current scope of Choose and Book and would need to be referred into the CCG for consideration as an individual funding request (IFR)."*
North Hampshire	Same response as North East Hampshire & Farnham.	

North Lincolnshire	I can confirm that NHS North Lincolnshire Clinical Commissioning Group (CCG) does not hold a specific policy in relation to body dysmorphic disorder / obsessive compulsive disorder. A funding request would have to be submitted by the patient's clinician to the CCG providing evidence as to why the locally commissioned service is not clinically appropriate, and why escalation to a Consultant led team/more experienced practitioner is required/clinically appropriate. The CCGs Individual Funding Request (IFR) policy can be found on the website at: http://www.northlincolnshireccg.nhs.uk/publications/individual-fundingrequests- exceptional-treatments/ GP's can refer directly to an out of area provider if the CCG commission that specific service or intervention with the out of area provider. All other instances, a funding request must first be made to the CCG. All requests received by the CCG are clinically assessed for appropriateness of referral and then funding is decided by the Commissioner. Each request is assessed on an individual case-by-case basis and entirely dependent on the clinical need and history of the request and intervention being requested.	The pathway is identical to answer 1. Provider submits funding requests to the CCG, where it is assessed for clinical appropriateness before a funding decision is made by the Commissioner. Again, each request is considered on an individual case-by-case basis and is entirely depending on the patient's condition and the intervention being requested.	This is dependent on the conditions stated when the funding for the assessment is approved. These decisions are made on an individual case-by-case basis.	*No local policy, justify why local services/commissioned services not appropriate*
North Norfolk	Same response as Norwich	Please see the response to question 1. Any funding arrangements would be considered by the Exceptions Panel and based upon need.	Any funding arrangements that is a change from the original agreement, approved by the Exceptions Panel, would require a re-application.	*Make reference to patient choice but then describe exceptionality criteria including use of local services*
North Tyneside	Same response as Darlington			
Northumberland	Same response as Darlington			

Norwich	A GP cannot make a direct referral to an out of area provider, regardless of whether the CCG provides a locally commissioned service. If the CCG did not commission a service, the GP would need to make an application on behalf of the patient to the local CCG's Exceptions Panel, who would consider whether any existing "in county" service(s) could offer the service/procedure required by the patient. If the CCG does commission a local service, and the patient wishes to exercise "patient choice" by requesting an out of area provider, then this would need to go to the CCG funding panel to consider whether the criteria has been met to access a different service. If an Individual Funding Request (IFR) is received relating to patients who wish to have mental health treatment out of area, it is usual practice to understand if the patient has been through the local commissioned pathway and what the view of the local consultant team is in relation to the requested treatment. For an IFR to be approved the patient would usually be expected to have exhausted all local options and also demonstrate clinical exceptionality. To meet the definition of 'exceptional clinical circumstances' there must be a CCG policy in place that describes the availability of the requested intervention and the patient (or their clinician must demonstrate that they are both): * Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition AND * 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.	Please see the response to question 1. Any funding arrangements would be considered by the Exceptions Panel and based upon need.	Any funding arrangements that is a change from the original agreement, approved by the Exceptions Panel, would require a re-application.	*Needs to go to funding panel and discuss IFR and why local services not appropriate*

Nottingham City	The CCG do not hold information in relation to this question as it would depend on the referral routes determined by the provider of the treatment	An application for funding can be made through the Individual Funding Request (IFR) process – policy and form attached. We also refer you to national guidance on patient choice – please see link: https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf	If applying via the IFR route, a request can be made at the same time for both assessment and treatment, but with monitoring points where further treatment may be required at a later date.	*Lack of info make reference to IRF policy and patient choice*
Portsmouth	Same response as North East Hampshire & Farnham			
Sandwell and West Birmingham	Sandwell and West Birmingham CCG do not hold a policy or care pathway for the scenarios described above.			*No policy*
Scarborough and Ryedale	NHS Scarborough and Ryedale Clinical Commissioning Group (CCG) buy services from health providers to deliver health care to residents. For physical health, 'Payment by Results' is the mechanism by which acute trusts are paid. This is an extensive list of treatment tariffs. This system is not available for mental health locally, so we have a block contract with our mental health provider Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) which is where all referrals go. We would expect that all our residents with mental health problems are referred to TEWV. There is one exception where a resident is an employee of TEWV and they need referral for a mental health problem, they can be seen by a non TEWV service. If the local TEWV team do not have the resources to deal with a particular patient or if they need a further specialist opinion, they can on a case by case basis apply to the CCG for further funding. The CCG's policies regarding Individual Funding Requests can be viewed online at http://www.scarboroughryedaleccg.nhs.uk/rss2/ifr/			*Must use local services and otherwise demonstrate clinical exceptionality*
Slough	Same response as Bracknell & Ascot			

<table>
<tr>
<td>Somerset</td>
<td>Somerset CCG does not have a written policy or care pathway in respect of body dysmorphic disorder / obsessive compulsive disorder. A GP may refer a patient to services provided by Somerset Partnership NHS Foundation Trust, such as the Talking Therapies Service. A GP may elect to refer a patient to an out of area provider. Where there are funding implications resulting from a referral, unless the patient is self-funding, the request for funding will come back to the local commissioning CCG where the patient is registered. As described above where the GP is requested to fund any out of area treatments, they are considered by the Somerset Partnership Out Of Are Treatments (OATS) panel on ground of exceptionality. As described above, the OATS panel will consider out of area requests for funding of treatment. Each request is considered on grounds of exceptionality, for example, where a patient has a relative or client working within the providing organisation, or if the patient has decided to seek treatment elsewhere.</td>
<td>Please refer to the response to question 1.</td>
<td>As described in Question 1, once an assessment has been completed, if the patient meets the criteria for treatment, an application for funding would be made to the OATs panel. The only time NHS Choice is applied is if a patient has a legitimate reason for not wanting to use local services, such as if they have a relative or client working within the service provider or the patient has decided to seek treatment elsewhere. The OATs panel provides the additional layer of clinical scrutiny as to whether treatment is appropriate and necessary.</td>
<td>Goes to panel, need to demonstrate exceptionality</td>
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<td>South Cheshire</td>
<td colspan="3">Please see NHS South Cheshire CCG's Commissioning Policy – page 25 which can be accessed using the following link:- http://www.southcheshireccg.nhs.uk/uploads/5793. NHS South Cheshire CCG does not currently have systems in place for direct referrals to out of area providers. The CCGs pathway is for patients to be referred into the Wellbeing Hub (Single Point of Access) by their GP for assessment to identify the most appropriate intervention. If a patient requires 'specialist/tier 4 support', which would include severe Body Dysmorphic Disorder (BDD)/Obsessive Compulsive Disorder (OCD), a request to the NHS England Specialised Commissioning Team will be initiated by the Consultant psychiatrist.
Details of the pathway beyond specialist/tier 4 support is detailed in the NHS England Manual for Prescribed Specialised Services 2016/17 (which can be found on page 223 using the following link:- https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/pss-manual-may16.pdf) and advises that NHS England commissions services for adults and adolescents with severe OCD and BDD from Highly Specialist Severe OCD/BDD Centres. Therefore, in order for a patient to be considered for out of area funding it would be necessary for the clinician involved in the patients care to submit an Individual Funding Request (IFR).
When considering an Individual Funding Request (IFR) for psychological therapy there is no local commissioning policy criteria against which the IFR team can assess the patient. Therefore, it is the responsibility of the referring clinician to provide evidence to demonstrate patient clinical exceptionality, defined as "The patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition".</td>
<td>No mention of patient choice, discuss tertiary care referrals which this scenario is not about. The CCG website states "Is hospital choice available to everybody? A choice of hospital is available to most patients and in most circumstances. Some exceptions include referral to</td>
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	An IFR application should include comprehensive supporting information (clinical letters / assessments) to evidence the previous NHS commissioned interventions undertaken by the patient, and for what reasons the local providers had not been able to meet the needs of the patient. Unfortunately the desire of the patient and the GP not to use the local commissioned service, would not justify clinical exceptionality.			*mental health services . . ."*
South Devon and Torbay	The CCG has provided a general response to the questions raised under this FOI. It is noted that the FOI relates to a scenario for an individual patient and an FOI may not be the most appropriate route to address any issues experienced by the patient. If there are any concerns regarding access to treatment for this patient then it may be more appropriate for this to be addressed through the CCGs Patient Experience Team, please use the link provided below to contact them – http://www.southdevonandtorbayccg.nhs.uk/contact-us/patient-experience/Pages/default.aspx The CCG would normally expect patients to be referred into locally commissioned/contracted services in the first instance which will be different for adults and children.	This will be dependent on contractual arrangements with the provider; where non-contracted activity arrangements apply funding approval may be required on an individual basis. The individual funding request panel will into take account the following in reaching a decision for a request for funding: · Clinical circumstances of the patient · Clinical evidence for the treatment or intervention · Cost effectiveness of the treatment or intervention	As per 2 above, this will depend on existing contractual arrangements. In some circumstances the Individual Funding Request Panel may agree to fund an initial assessment by a provider, where there is not a contract in place. This assessment would inform the decision in relation to future treatment by the provider.Attached to this email is the Individual Funding Request Panel Terms of Reference document.	
South Kent Coast	NHS South Kent Coast Commissioning Group (CCG) can confirm that the information for all 3 questions can be found within the attached Out of Area Treatment Policy for East and West Kent CCGs.			*"A choice of hospital is available to most patients and in most circumstances. Some exceptions include referral to mental health services"*
South Lincolnshire	Same response as Lincolnshire East			
South Norfolk	Same response as Norwich			

South Reading	Same response as Newbury and District			
South Sefton	The CCG commission IAPT and secondary care mental health services from Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust dependant on the severity of the case. Our IAPT provider is commissioned to provide IAPT Step 2 and Step 3 based counselling and CBT based interventions. The IAPT provider also provides more complex Step 4 intervention with support from our secondary mental health provider. Where patients wish to access services which are out of area through choice, they can with the support of their GP apply through the Individual Funding Request (IFR) process. If the case was deemed too severe or local clinical expertise was insufficient, the referrer would then have recourse to apply via the Individual Funding Request (IFR) route.	If the service was unavailable locally, the referrer would then have recourse to apply via the Individual Funding Request (IFR) route.	The IFR process has agreed criteria.	*IFR process, and must demonstrate why local expertise not sufficient*
South Tees	If the referral is outside of the agreed local pathway then an IFR request should be made. There is no criteria and a case of exceptionality must be demonstrated i.e. 'The patient or their circumstances are significantly different from the general population of patients with the condition in question and the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'	Referral for assessment within an NHS provider does not require prior approval. Funding requests for treatment will have to be via the IFR panel and demonstrate exceptionality.	Yes, prior approval should be sought as above.	*No reference to Patient choice and must demonstrate clinical exceptionality*
South Tyneside	Same response as Darlington			
South Warwickshire	Same response as Coventry and Rugby			
South West Lincolnshire	Same response as Lincolnshire East			

Southampton City	Information about funding of care can be found on our website, including a link to the current Independent Funding Request (IFR) policy statements, and process http://southamptoncityccg.nhs.uk/funding-your-care- A referral for diagnosis would normally be made to the commissioned service which may be IAPT or secondary care mental health services.	In terms of referral to 'out of area' services, such services to manage BDD/OCD is determined by the clinical assessment completed by the commissioned service, and not by the GP or necessarily the commissioner. The commissioned service might suggest another area (either another Trust or another team within that Trust) for example if the therapeutic relationship has broken down. It is the responsibility of the requesting clinician, i.e. the secondary care mental health services / specialist provider to set out the case for funding and to provide all relevant supporting information; the requesting clinician can also include supporting information provided by the patient.		*No reference patient choice and only in certain circumstances eg: therapeutic relationship broken down*

Southend and Thurrock	The CCG is clear that there are certain exclusions in respect to choice in mental health (see https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs) The scenario as presented would not be a barrier to the patient exercising choice. The person could be referred to a suitable provider, which is appointed by the NHS directly by their GP, for their first appointment and subsequent treatment if needed. In the suggested scenario, the GP or patient would be able to contact their CCG for advice if needed. However, for referrals for out of area psychological interventions, such as those in your scenario for someone with BDD/OCD, the GP cannot refer directly to an out of area provider. Instead, the referral request would go initially to the Essex CCG's mental health Individual Placements Team (IPT) who would assess any risk and discuss the requirements with local mental health commissioners to determine an appropriate way forward. Patient choice will be taken into account during this process.	As in the response to question 1 above, a request for funding from an out of area provider would be subject to review by the CCGs IPT in conjunction with local mental health commissioners.	Please see answers to 1 & 2 above.	*Refers to patient choice but referral to Individual Placements Team (IPT) who would to discuss the requirements to determine an appropriate way forward. i.e it is not routine in which GPs can make judgement about whether it is clinically appropriate (for example the IPT want to assess risk but not if they were to attend a local IAPT service).*
Southern Derbyshire	No, GPs cannot directly refer to an out of area provider in this scenario. NHS Southern Derbyshire Clinical Commissioning Group would expect any out of area referral to a specialist to have been agreed via the locally commissioned services. In this scenario, agreement would be made via the mental health provider, Derbyshire Healthcare NHS Foundation Trust (DHcFT) Psychologist/Psychiatrist having first sought approval from the local IPP panel.	Not applicable; please see above.	Yes, criteria discussions would focus on why locally commissioned services were not suitable.	*No mention of patient choice. Why local services not suitable*

Southport and Formby	Same response as South Sefton	If the service was unavailable locally, the referrer would then have recourse to apply via the Individual Funding Request (IFR) route.	The IFR process has agreed criteria.	*IFR process, why local expertise not sufficient*
St Helens	The GP makes a referral which is sent to the Commissioning Support Unit who record the request and discuss in their panel meeting. It then comes to the Mental Health Commissioner who will review the request and make a decision and return it to CSU who will inform the referrer of the outcome. The exception is a request for a provision/intervention that we do not already commission or it does not seem to be in the best interest of the patient. This does depend on the intervention required and the information provided in the referral.	We have no record of the above having occurred. Requests are made by the GP - the process and decision making is the same as the response to Q1.	Yes it would, because the original request via the GP may have a set fee which was agreed. Any fee changes would have to come back via the GP and if the treatment or intervention could be provided from existing commissioned services then it would be progressed.	*No mention of patient choice and make a decision based on the patient's best interests - unclear what this would mean.Rreferral has to be discussed at a Panel meeting.*
Sunderland	Sunderland CCG has reciprocal arrangements in place with other local areas for patients to be seen out of area. To enable this to happen the GP Practice would contact the CCG Mental Health Commissioner to arrange.	Sunderland CCG has reciprocal arrangements in place with other local areas for patients to be seen out of area. To enable this to happen the GP Practice would contact the CCG Mental Health Commissioner to arrange.	No, this would happen under the above arrangements. There is no policy in place, this is a local agreement.	*Only refers to specific out of area locations which they already have agreements with. No Patient Choice*
Surrey Downs	GPs can refer to an out of area provider, however no treatment can take place until funding has been agreed by the CCG. An Individual Funding Request (IFR) would be required to describe the reasons the patient cannot be treated by a local NHS provider and what makes them clinically exceptional or rare.	The clinician responsible for providing the treatment would be required to submit an IFR describing why the patient cannot be treated locally and how their clinical presentation is either exceptional or rare.	The clinician responsible for providing the treatment would be required to submit an IFR describing why the patient cannot be treated locally and how their clinical presentation is either exceptional or rare.	*Must refer to local services and otherwise explain why local services not appropriate*

Sutton	No. The GP must refer to Sutton CCG's commissioned mental health service that has a single point of access for triage and onward treatment or referral.A referral is not made directly to another provider but for confidentiality reasons (e.g. if someone works within the local service), or if evidenced based treatment is not available locally, the referrer can make an application for an individual funding request (IFR).	The patient cannot be referred directly to another provider.	The patient cannot be referred directly to another provider.	*Must refer to local services except in in certain circumstances*
Thanet	NHS Thanet Commissioning Group (CCG) can confirm that the information for all 3 questions can be found within the attached Out of Area Treatment Policy for East and West Kent CCGs.			*Exceptionality regarding whether have used local services, complexity etc*

Trafford	• The GP is able to make an individual funding request to the CCG's Individual Mental Health and Disability (IMHaD) Patient Care Review Group, if they wish to refer to a service outside of the routinely commissioned mental health service for the local area (or for a service which is not part of a Specialised Services care pathway funded via NHS England) • The IMHaD recommendation will be considered by the CCG and a formal funding decision will be made by the Mental Health and Learning Disability Resource Allocation Panel • Applications are considered on a case by case basis • The IMHaD group will consider the evidence presented within the application to determine whether there are exceptional health needs which can't be met by the local commissioned provider or exceptional circumstances which would warrant funding of a referral to an alternative service if the health needs could potentially be met locally, but a funding is requested for a different provider as an exceptional case	• If a referral is made directly by a GP to an alternative provider, funding authorisation would ordinarily be sought by that provider in advance of any appointment being given (Prior Approval) • This would require consideration via the IMHaD group as above • The GP or relevant clinicians/services would be contacted for supporting information/evidence as appropriate to the individual case	• The NHS does not ordinarily allow patients to choose which mental health service they wish to receive treatment from. Details regarding limited choice of mental health services can be accessed via the following link: http://www.nhs.uk/chq/Pages/902.aspx?CategoryID=69&SubCategoryID=692 • The CCG commissions NHS providers to provide an initial assessment as a result of a referral from the GP; the opinion of locally commissioned services will usually be considered as part of any funding request for alternative provision • The IMHaD panel would consider assessment outcomes/evidence received from alternative providers as part of a funding application • Applications are considered on a case by case basis The terms of reference for the IMHaD are currently under review and therefore have not been attached.	*Wrong interpretation of patient choice (exceptionality) and when it is applicable*
Vale of York	The CCG commission the services available to the local population through contracts. The contract will ordinarily commission a service with a single provider and this will be the provider that the patient will be referred to. If the GP is requesting a service which is "out of contract" then the GP needs permission, and funding from the CCG. NHS Vale of York CCG is currently constructing a process to consider such referrals. Where the services is not commissioned under a contract (for example in cases such as where a service is commissioned for a different condition) the GP may request this service through an individual funding	Please see response to question 1 above.	In the event that a patient was referred for assessment out of area and the outcome of the assessment was to recommend treatment, the CCG would need to separately consider the request for ongoing treatment. This would be to ensure that the treatment was appropriate and that best use of resources was demonstrated. The CCG would determine this on a case by case	*Wrong interpretation of patient choice and when it is applicable*

	request. Such a request does go through a triage process and a panel determines whether or not there is a clinically exceptional reason why funding should be granted on this occasion. Referral to a service out of area would not be covered by this process. Historically, Section 40, Part 8 of the National Health Service (Commissioning Board and Clinical Commissioning Groups) Regulations 2002 stated that the duty of choice did not apply to mental health services. 'Mental Health Services' were defined in regulation 2 as 'services provided to patients in relation to a disorder or disability of the mind'. Therefore, this definition applies to this patient who has a mental health disorder, the CCG was therefore not under an obligation to offer choice of provision; since this time NHS England have confirmed that patient choice will apply to treatment of mental health disorders. There is however a distinction between treatments such as psychological treatments delivered in the community and treatments delivered in a formal hospital setting. Where treatments are delivered in the community the CCG commission a service to deliver the treatment and patient choice does not apply to these treatments. NHS Vale of York CCG commission a community CBT in this way and therefore would not offer choice of provider in this case and a GP could not refer out of area. A GP cannot refer out of area for this service as this is a Community Service which is offered under a contract. Where there are exceptional circumstances which mean there is a need to be referred out of area for treatment the CCG would consider this on a case by case basis. NHS Vale of York CCG is currently developing a local protocol for cases which are not covered by a comissioning policy. This protocol will include terms of reference, and will require a panel to determine whether the referral is appropriate in all of the circumstances. Even in these cases, the CCG would expect that patients would access		basis and this will be developed in line with the protocol already discussed.	

	the local services within the local contract as far as possible.			
Vale Royal	NHS South Cheshire CCG does not currently have systems in place for direct referrals to out of area providers. The CCGs pathway is for patients to be referred into the Wellbeing Hub (Single Point of Access) by their GP for assessment to identify the most appropriate intervention. If a patient requires 'specialist/tier 4 support', which would include severe Body Dysmorphic Disorder (BDD)/Obsessive Compulsive Disorder (OCD), a request to the NHS England Specialised Commissioning Team will be initiated by the Consultant psychiatrist. Details of the pathway beyond specialist/tier 4 support is detailed in the NHS England Manual for Prescribed Specialised Services 2016/17 (which can be found on page 223 using the following link:- https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/06/pss-manual-may16.pdf) and advises that NHS England commissions services for adults and adolescents with severe OCD and BDD from Highly Specialist Severe OCD/BDD Centres. Therefore, in order for a patient to be considered for out of area funding it would be necessary for the clinician involved in the patients care to submit an Individual Funding Request (IFR). When considering an Individual Funding Request (IFR) for psychological therapy there is no local commissioning policy criteria against which the IFR team can assess the	Please refer to the response to question 1 relating to the IFR pathway.	If a patient is assessed by another provider and found suitable for treatment then an IFR application for funding should be submitted for treatment. Please refer to the response in question 1 relating to the IFR pathway.	*No mention of patient choice. Make reference to specialist service referrals via IFR which this scenario is not describing*

	patient. Therefore, it is the responsibility of the referring clinician to provide evidence to demonstrate patient clinical exceptionality, defined as “The patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition”. An IFR application should include comprehensive supporting information (clinical letters / assessments) to evidence the previous NHS commissioned interventions undertaken by the patient, and for what reasons the local providers had not been able to meet the needs of the patient. Unfortunately the desire of the patient and the GP not to use the local commissioned service, would not justify clinical exceptionality.			
Wakefield	In the scenario provided, the GP would refer direct to an out of area provider, however we do not have a local service specifically commissioned to address BDD so the GP would need to make an individual funding request. An individual funding request (IFR) is appropriate where either of the following applies: • The CCG has a general policy not to fund a health care intervention for the specified indication but a clinician considers his/her patient to be ‘exceptional’ to that policy Or, as in the scenario; • The CCG has no policy in place for the requested health care intervention and the clinical circumstance is so rare that it is unlikely that any other patients will require the intervention. Exceptionality should be considered in the context of the CCG general policy for a health care intervention and specified indication. In general, the CCG must justify the grounds upon which it chooses to fund a health care intervention for a patient when that intervention is unavailable to others with the condition. A patient may be considered exceptional to the general policy if both the following apply: • He/she is different to the general population of patients who would normally be refused the health care intervention AND • There are good grounds to believe the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition. When considering IFRs, the CCG will use the same ethical framework and guidelines for decision making that underpin its general policies for health care interventions. Where social, demographic or employment circumstances are not considered relevant to population based decisions, these factors will not be considered for IFRs.			*No locally commissioned service for BDD, no mention of OCD services.*
Warrington	For response to questions 1 - 3 please refer to our Individual Exceptional Funding Request process via the following link: http://www.warringtonccg.nhs.uk/Page%20images/public-info/individual-funding-requests.htm			*No mention patient choice, need to demonstrate exceptionality*
Warwickshire North	Same response as Coventry and Rugby			

West Essex	Same response as Mid Essex			
West Kent	NHS West Kent Clinical Commissioning Group (CCG) does hold this information. Please find attached a copy of the Out of Area Treatment Policy for East and West Kent CCGs (Appendix A), which covers all three of your questions above.			*Exceptionality regarding whether have used local services, complexity etc*
West London	Yes, a GP can refer to another provider if the patient has exhausted local services or there has been a breakdown in a relationship.	The request will be dealt with directly by the Commissioner and the judgement based on whether it is clinically appropriate, taking advice if necessary.	Yes, an individual funding application would be required.	*No reference patient choice and only if local services are not appropriate for some reason*
West Norfolk	Same response as Norwich			
West Suffolk	Local triage service to determine appropriateness and/or Individual Funding Request Referral. Individual funding Request Policy - attached.	Individual funding Request Policy - attached.	Individual funding Request Policy - attached.	*No mention of patient choice, IFR*
Wiltshire	Wiltshire CCG does not have a mechanism for a GP to refer directly to an out of area provider. (NB: if the patient is a staff member at the local provider, there is a reciprocal agreement with out of area providers and a referral may be made directly.) A GP (or clinician) looking to refer to an out of area provider would need to apply to the Exceptions Panel of the CCG. Criteria for the Panel's assessment is not written in policy as each case will be assessed on its own exceptionality and the benefits to be achieved for that patient. Wiltshire CCG Individual Funding Request can be accessed here: What we do and don't fund – Wiltshire Clinical Commissioning Group	Not applicable	Prior approval would need to be given by the CCG in advance of treatment commencing.	*No mention of patient choice, would need to refer to panel and decision based on exceptionality*

Windsor, Ascot & Maidenhead	Same response as Bracknell & Ascot	
Wokingham	Same response as Newbury and District	

Appendix E : Unclear whether CCG is compliant or non-compliant

<table>
<tr><th>CCG</th><th>Question 1</th><th>Question 2</th><th>Question 3</th><th>Comments</th></tr>
<tr><td>Airedale, Wharfedale and Craven</td><td colspan="3">The CCG has no prior approval process in place for the named conditions. The CCG do not have any referral restrictions in place for BDD/OCD to services for an assessment holding an NHS standard contract</td><td>Not enough detail (and no mention of patient choice) but do state no referral restrictions in place for assessment by a service with NHS contract</td></tr>
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Aylesbury Vale	The CCG would ordinarily recommend that patients are seen by local services in the first instance especially with regards to OCD treatment as there is a clear evidence based pathway in place with links to NHS England. If however this request is of a 'choice' nature the GP will need to make a referral to the MH funding panel for consideration.	All referrals are sent to the Mental Health (MH) funding mailbox a referral form needs to be completed to ensure a holistic decision can be made with regards to treatment and to ensure patient consent has been sought by the referrer.	Ordinarily the provider will inform the CCG when they have assessed the patient and recommend a treatment plan with expected outcomes for the patient documented and cost to the CCG for agreement. If the provider requires authorisation for assessment before treatment can commence this again ordinarily is sent to the CCG for authorisation and can be done so via the MH funding mailbox.	*Need to make referral to a funding panel for consideration but cannot access this referral form to see what it entail and whether would be patient choice compliant*
Bassetlaw	General referral to adult mental health services. No specific pathways for these conditions. Services will accept referrals appropriate to their pathways. None specific to BDD or OCD. The patient is generally granted funding for any other provider with a contract within the NHS. Yes - IFR may be required if highly specialised service.	The Individual Funding Requests panel is hosted by Sheffield CCG for all South Yorkshire and Bassetlaw CCGs. A clinician based panel assesses exceptionality on a case by case basis.	Treatment usually approved at same time as assessment unless highly specialised.	*This service responded to each separate part of the scenario as opposed to the scenario as a whole and therefore unclear what they would do though do make reference to granting funding for any other provider with a NHS contract*

Bradford City	Same response as Airedale, Wharfedale and Craven	
Bradford Districts	Same response as Airedale, Wharfedale and Craven	
Chiltern	Same response as Aylesbury Vale	
Fareham & Gosport	The CCG supports the right of individuals to choose the organisation that provides their NHS care and treatment whenever they are referred for the first time for an appointment for a physical or mental health condition. In the scenario presented, the CCG would expect the individual to be supported to choose which mental health service provider they wished to be referred to for an initial assessment appointment. It is unlikely that a GP would refer a patient for BDD/OCD as the diagnosis would come from existing commissioned services, most likely from a secondary care psychiatrist. The referral for diagnosis would normally first be made with the commissioned service which may be Improving Access to Psychological Therapies (IAPT) or possibly by the community mental health team. In terms of referral to out of area services, such services to manage BDD/ICD cannot simply be considered as a Choose & Book referral for a knee operation, for example. A relationship would have been developed following assessment and possible treatment and to refer to another service would require that relationship to be built up again. The gateway into support for such services is determined by the commissioned services themselves and not by the GP or necessarily the commissioner. They might suggest another area (either another Trust or another team within that Trust) if the therapeutic relationship has broken down. As explained, Choose & Book does not necessarily apply in mental health services. Patient choice is available but, unlike other services, the expectation is for the commissioned service to discuss other locality options with the patient or indeed outside the area of their Trust. It would be treated as an individual funding request (IFR) only if it was related to a service that was not normally commissioned.	*Make reference to supporting patient choice and that IFR would only be for services that are not commissioned locally but also make statements such as "services such services to manage BDD/OCD cannot simply be considered as a Choose & Book referral for a knee operation" and that diagnosis should normally be made by a commissioned service first*
South Eastern Hampshire	Same response as Fareham & Gosport	

South Gloucestershire	The CCG complies with the NHS England Choice in Mental Health Guidance: https://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf. In South Gloucestershire we have an Any Qualified Provider IAPT provision of 17 providers - this enables provision which supports focussed need. If a request is made we would always look to local services first to see if effective treatments and interventions are available. If not the case would be considered via the IFR route. Information regarding the IFR process is exempt under Section 21 of the Freedom of Information Act 2000 as it is reasonably accessible by other means. The INNF list and policies are available on the CCG's wesbite at https://www.southgloucestershireccg.nhs.uk/innf/GPs do refer directly to providers but they always come to the CCG to ensure that payment has been agreed. We then make sure that the referral is appropriate and this is covered within the NHS England Choice policy.	We would always look to see if need can be met locally. GPs are not always aware of all service options. GPs will normally provide details of when a patient has been through local services and if this has not been effective. There is a complex needs panel for mental health which looks specifically at patients who require joint health and social care packages or specialist inpatient or residential provision. The commissioner would always look to see if the service is already commissioned in area. If treatment is part of a joint health and social care package the commissioner would look to fund the health element of the package. If the request did not fit into these categories then the commissioner would look for exceptionality in the application as per the IFR framework. Information regarding the IFR process is exempt under Section 21 of the Freedom of Information Act 2000 as it is reasonably accessible by other means. The INNF list and policies are available on the CCG's website at: https://www.southgloucestershireccg.nhs.uk/innf/	The commissioner would always look to see if there is a locally commissioned service. Exceptions include when the applicant is a member of staff in the public sector. The NHS Mental Health protocol would however apply.	*State compliant with patient choice but also state they would look to local services first*