NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin073
Mental health disorders, specialist, general and non-NHS services

Category 1 Interventions – Not routinely commissioned

Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: March 2024

This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 **NHS England** routinely commissions the following specialist mental health services:

1.1.1 Adult specialist eating disorder services including inpatient care and bespoke packages of care for intensive day care from adult specialist eating disorder centres.

1.1.2 Tier 4 Child and Adolescent Mental Health Services (CAMHS).

1.1.3 Services for adults and adolescents with severe (defined as Step 6 in NICE Clinical Guideline CG 31) obsessive-compulsive disorder and body dysmorphic disorder from highly specialist severe obsessive-compulsive disorder and body dysmorphic disorder centres.

1.1.4 Tier 4 services for severe personality disorder in adults from specialist centres (includes inpatients and bespoke packages of care for intensive day care services).

1.2 **The Integrated Care Board** (ICB) will routinely commission the following non-specialist mental health services:

1.2.1 Adult multidisciplinary community eating disorder services (which may include a "gatekeeping" function for admission and less intensive day patient services).

1.2.2 Tier 1, Tier 2 and Tier 3 Child and Adolescent Mental Health Services (CAMHS).

1.2.3 Services for adults and adolescents with non-severe (defined as steps 1 – 5 in NICE Clinical Guideline CG 31) obsessive-compulsive disorder and body dysmorphic disorder.

1.2.4 Tier 1, Tier 2 and Tier 3 personality disorder services in adults.

1.3 **The ICB** will not routinely commission mental health care from non-NHS organisations (including private providers without an NHS contract) unless the service has been commissioned specifically by the CCG as part of its routine mental health pathway.

2. Exclusions

2.1 None.

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.

- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 In its *Manual for prescribed services*, NHS England specify which specialist mental health services are commissioned by them and also the services to be commissioned by the former Clinical Commissioning Groups (now the ICB).

4.2 For the remaining services, the *NHS mental health implementation plan* and *Community mental health framework* outline provision of care within the community with well-defined pathways and interconnected services which allows patients to move from standard to more specialised care and back again, with ease.

4.3 Specialised mental health teams are expected to be part of this integrated service delivery. This is a move away from more traditional siloed, hard to reach services towards joined up care and whole population approaches.

4.4 Those patients requiring care outside the designated pathways are likely to be the exception rather than the norm.

5. Summary of evidence review and references

5.1 The most recent Adult Psychiatric Morbidity Survey (APMS) reports that one adult in six had symptoms of a common mental disorder (CMD) in the previous week. CMD symptoms included fatigue, concentration problems and forgetfulness, sleep disturbance, irritability, depression, anxiety, phobias, compulsions, obsessions and some somatic symptoms. Since 2000, overall rates of CMD in England steadily increased in women and remained stable in men. Of those affected with CMD, one person in three reported current use of mental health treatment which is an increase from one in four reported in previous surveys from 2000/2007.[1]

5.2 One of the U.K.'s largest private hospital providers have forecast that "unprecedented demand" [for their services] will continue as NHS waiting lists continue to rise. [2] This expansion in demand for private healthcare has to be considered alongside a review of one private provider of 113 mental health facilities, of whom, the CQC had "serious concerns". [3] The report had highlighted a number of problems relating to governance systems, ineffective processes and treatments which didn't always include best practice.

5.3 The NHS Mental Health Implementation Plan (2019/20 – 2023/24) builds on its 5 year forward view for mental health (2016) and for adults with severe mental illness, it sets an annual target of 370,000 patients who should have greater choice and control over their care, and are supported to live well in their communities.[4] More specifically, there will be increased investment in interventions and activities for inpatient mental health services which should result in better patient outcomes and experience in hospital. The overriding ambition is to eliminate all inappropriate adult, acute out-of-area placements.

5.4 As part of the drive to improve mental health services, NHS England have focused on a community mental health framework for adults. [5] This is concerned with the transformation of community mental health teams from siloed, hard to reach services towards joined up care and whole population approaches. It supports development of primary care networks, ICSs and personalised care and will help to improve care for people with severe mental illness. The vision is a new place-based community mental health model with the shift to whole person, whole population health approaches. There is a renewed focus on people living in their communities with a range of long-term severe mental illnesses including those people whose needs are too severe for IAPT, but not severe enough to meet secondary care thresholds.

5.5 The new framework dictates that the core service should be built around existing GP practices, neighbourhoods and community hubs – elements which make up the new primary care networks. Care can be stepped up when more specialist care is required and stepped down in a flexible manner. For people with complex needs, stepping up or down to that provided in the local community should be straightforward and seamless so people using the service shouldn't experience any gaps or boundaries.

5.6 The key objectives of the framework include:

- Ensuring provision of evidence-based treatments.
- Maximising continuity of care with no "cliff edge" of lost care and support when moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, there should be a flexible system which proactively responds to ongoing care needs.
- Working collaboratively across statutory and nonstatutory commissioners and providers within the local health and care system.

5.7 This vision of care involves a well-defined pathway with interconnected services and patients are allowed to move from standard to more specialised care and back again with ease. It is reasonable to infer that patients who require very specialised care will be exceptional and the vast majority of clients will be accommodated within the recognised pathway.

5.8 This stance is consistent with NICE's recently released (June 2022) guideline on the management of depression. NG 222 [6] recommends that pathways for the management of depression should support the integrated delivery of services across primary and secondary care with clear criteria for entry to all levels of the stepped care service. Commissioners are required to ensure that support is in place so integrated services can be delivered by individual practitioners, mental health staff in primary care (who will treat the majority of people with depression), and mental health specialists who will provide advice and support for their primary care colleagues. Commissioners should ensure that specialist based mental health teams (for people with severe and complex needs) are part of this integrated service delivery.

5.9 Also, NICE recommends specialist care for people with more severe depression for people who have not benefited from previous treatments. In this situation, multidisciplinary care plans must be developed in conjunction with the person, their GP and all relevant people involved in their care. The guideline committee noted there was good evidence that simple collaborative care improved outcomes in people with depression and although specialist care is likely to increase resource use, this will only be necessary for a small number of people, and ultimately, this may offset future costs for long-term care and treatment.

5.10 The NHS choice framework [7] explains what choices (under the NHS) are available to patients when choosing care and emphasises their legal rights to choose where appropriate. The framework reflects the principles and values as described in the NHS Constitution.

5.11 In more detail, patients have a legal right to choose which NHS organisation they can attend for their first appointment as an outpatient. This legal right does not apply for onward referrals i.e. if patients are already receiving care and treatment for the condition for which they are being referred. Referral is permitted to those hospitals within the NHS and some private ones which hold NHS contracts. The entitlement to choose a named healthcare professional or a specific test are also permitted for consultants/organisations whose names appear on the NHS e-Referral service. However, it should be emphasised that this applies to the first outpatient appointment only.

5.12 A patient may also choose a different provider for a specific treatment if the anticipated waiting time is in excess of 18 weeks. However, the new service must be led by a medical consultant (the consultant/Hospital can be identified using the NHS website). The NHS choice framework also singles out psychological therapies (such as counselling) which are provided in the community. In this situation, the patient doesn't have a legal right to choose anything which is outside those services which are in place by the local CCG.

5.13 The majority of *specialist services* in mental health are commissioned by NHS England. According to the manual for prescribed specialised services (2018/19) [8], NHS England are responsible for commissioning:

- Adult specialist eating disorder services (inpatient care and bespoke packages of care for intensive day care).
- Tier 4 child and adolescent mental health services.
- Services for severe (step 6- as defined in NICE clinical guidance [9]) obsessive-compulsive and body dysmorphic disorders and
- Tier 4 specialist services for severe personality disorder.

5.14 In essence, NHS England commission services for the most severe cases. These selected patients will form a small, well-defined cohort of people with exacting needs which can only be met by a highly trained, specialised team.

5.15 In summary, the current emphasis in the management of mental health disorders in the NHS is based on a community-oriented model. Patients may move between different providers but these are located within the local pathway/network. The NHS's plan is for an integrated model in an established pathway with primary and secondary care teams working seamlessly together so patients can move up or down the pathway with ease. The vision is to reduce out of area placements to a minimum. It is clear that the NHS investment will be in developing and maintaining its local pathway which will be fully integrated with any local specialists. In addition, because the NHS restricts providers to those available on its e-Referral system (through NHS choice), the role of non-NHS (private) mental health care will be minimal.

5.16 In conclusion, there is little evidence to support change in Cheshire CCG's current policy of not routinely commissioning non-NHS mental health care.

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9. Obsessive – compulsive disorder and body dysmorphic disorder: treatment. Clinical guideline. London: National Institute for health and care excellence, 2005 (amended 2022):CG 31.

6. Advice and Guidance

6.1 Aim and Objectives

- This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

- This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

- This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

- At the time of publication, the evidence presented per procedure/treatment was the most current available.

- The main objective for having healthcare commissioning policies is to ensure that:
  - Patients receive appropriate health treatments
  - Treatments with no or a very limited evidence base are not used; and
  - Treatments with minimal health gain are restricted.

- Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms 'men' and 'women' are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

- Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

  - Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
  - Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
  - Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
  - Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
  - Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
  - Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
  - Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

- If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

- The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

- Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

- Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

- A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

6.5 Diagnostic Procedures

- Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

- Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 **Clinical Trials**

- The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

9.1 **Office of Population Censuses and Surveys (OPCS)**
None

9.2 **International classification of diseases (ICD-10)**
None

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