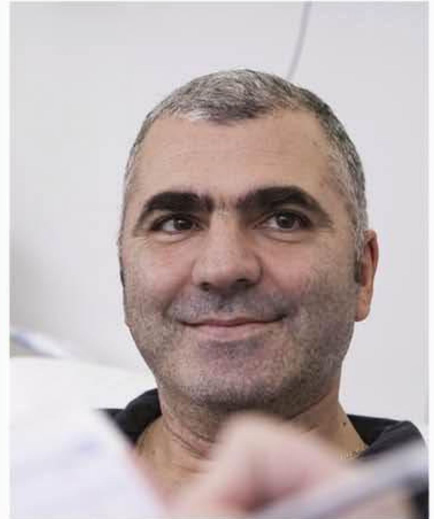
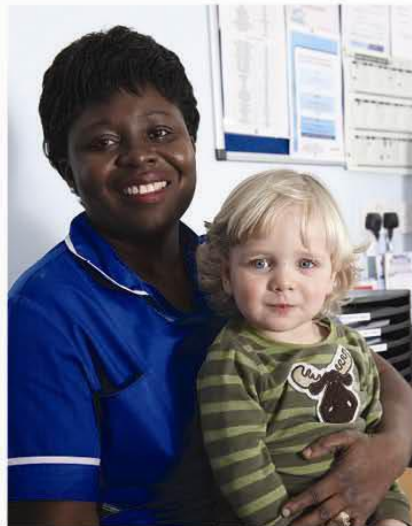
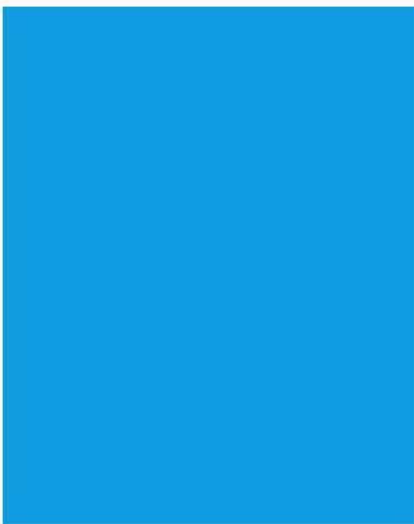
NHS
Commissioning Board

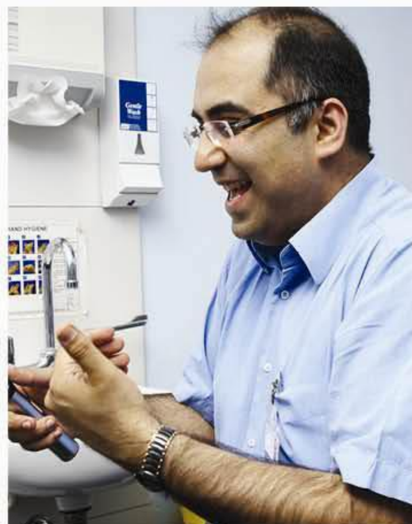
Who pays? Determining responsibility for payments to providers

Rules and guidance for clinical commissioning groups









THE NHS CONSTITUTION
the NHS belongs to us all

Who pays?
Determining responsibility for payments to providers

Rules and guidance for clinical commissioning groups

First published: December 2012[1]

Prepared by the NHS Commissioning Board

[1] This document is published in draft in December 2012 – it is anticipated that it will be published as a final document following commencement of section 14Z7 of the Health and Social Care Act 2012 in February 2013.

Contents

Context and introduction 4

Section 1: General rules - this sets out the general legal position as to CCGs' responsibility for commissioning services and paying for those services. 6

Section 2: Applying the rules to CCG commissioned services - provides clarification of how the rules work in a number of specific situations. 8

Section 3: Exceptions to the general rules – this sets out how regulations create exceptions to the general rules, for instance in relation to NHS Continuing Healthcare. 15

Section 4: Examples to help clarify the boundaries of responsibility between commissioning organisations 24

Who pays?
Determining responsibility for payments to providers

Rules and guidance for clinical commissioning groups

Status: System Rules

Purpose: This document sets out the circumstances in which a clinical commissioning group (CCG) is responsible for paying for a patient's care. This includes exercising the powers given to the NHS Commissioning Board in section 14Z7 of the Health and Social Care Act 2012, to specify those circumstances in which a CCG is liable to make a payment to a provider in respect of services commissioned by another CCG.

It replaces all earlier versions of *Who Pays? Establishing the Responsible Commissioner.*

CCGs' Legal Duties

CCGs are required to make payments in accordance with this document

Context and introduction

The Health and Social Care Act 2012[2] amends the NHS Act 2006 ("the Act"), to establish the legal framework for the new commissioning architecture for the NHS, including the responsibilities of the NHS Commissioning Board (NHS CB) and CCGs.

The Act[3] sets out that a CCG has responsibility for all people who are:

- provided with primary medical services by GP practices who are members of the CCG, or
- who are usually resident in the area covered by the CCG and are not provided with primary medical services by a member of any CCG.

[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[3] Section 3(1A) of the 2006 Act as inserted by the 2012 Act

Regulations[4] make further provision for these commissioning responsibilities, including the responsibility to commission urgent and emergency care services for everyone present in their geographic area.

In general, CCGs will be responsible for commissioning health services to meet all the reasonable requirements of their patients, with the exception of:

- certain services commissioned directly by the NHS CB (primary care, high secure psychiatric services, specialised services and the majority of health services for prisoners/those detained in 'other prescribed accommodation' and members of the armed forces);
- health improvement services commissioned by local authorities; and
- health protection and promotion services provided by Public Health England (PHE).[5]

These commissioning responsibilities include:

- planning services, based on assessing the needs of your local population;
- securing services that meet those needs; and
- monitoring the quality of care provided.

In most cases when commissioning health services, CCGs will be responsible for meeting the cost of the services provided. This document establishes certain important exceptions to this rule in relation to emergency admissions and A&E attendances[6].

In this document, references to 'the responsible commissioner' refer to the responsibility for paying for care.

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[4] under section 3(1B) (regulations available at http://www.legislation.gov.uk/uksi/2012/2996/contents/made) and 3(1D) (regulations available at http://www.legislation.gov.uk/ukdsi/2012/9780111531525) of the 2006 Act as inserted by the 2012 Act. Draft regulations under section 3(1D) have been laid in Parliament for consideration – when this document is published as final it may have to be amended to reflect any changes as a result of Parliamentary scrutiny.

[5] For more detailed information please refer to *Commissioning fact sheet for Clinical Commissioning Groups* (July 2012) which sets out the services to be commissioned by CCGs from April 2013. It also sets out the complementary services to be commissioned by the NHS CB and Public Health England (PHE) and is available at http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf

[6] under the powers given to the NHS Commissioning Board in section 14Z7 of the Act.

Section 1: General rules

Identifying which CCG is responsible for commissioning and paying for care

Whilst the majority of patients are entitled to free NHS hospital treatment, those who are not ordinarily resident in the UK are generally not, even when registered with a GP practice. For further details on entitlement to free NHS care, ordinary residence and overseas visitors see paragraph 45 in Section 3 and Annex A.

1. The general rules – subject to the rules on emergency care set out below and the other exceptions set out in section 3 – are as follows:

   - Where a patient is registered[7] on the list of NHS patients of a GP practice, the responsible commissioner will be the CCG of which the GP practice is a member;

   - Where a patient is not registered with a GP practice, the responsible commissioner will be the CCG in whose geographic area the patient is 'usually resident'. See Annex B for more details on determining usual residence.

2. Even where a GP practice has patients usually resident in more than one CCG area, the responsible commissioner will be the CCG of which the GP practice is a member.

Emergency care

3. A CCG is responsible for commissioning emergency care[8] for anyone present in its geographic area, regardless of where the person in question is usually resident or which GP practice (if any) they are registered with.

Paying for care

4. Where a CCG is responsible for commissioning care under the general rules in paragraph 1, or under the relevant exceptions to those general rules set out in section 3, that CCG is also responsible for paying the provider for the cost of that care.

5. The rules on payment for emergency care are that:
   - for A&E attendances and emergency admissions[9], the CCG who would ordinarily be the responsible commissioner for a patient (under the rules in paragraph 1 and subject to the other relevant exceptions in section 3) will be responsible for paying

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[7] This applies to patients permanently registered as well as those registered as a temporary patient – if a person is registered with a GP who is a member of CCG A and then becomes registered as a temporary patient with a GP who is a member of CCG B under the regulations the patient ceases to be the responsibility of CCG A under s3 for the period of that temporary registration.

[8] The regulations define emergency care as the provision of ambulance services or accident and emergency services, whether provided at a hospital accident and emergency department, a minor injuries unit, a walk-in centre or elsewhere.

[9] Specified under the powers given to the NHS Commissioning Board in section 14Z7 of the Act to set out the circumstances in which a CCG is liable to make a payment to a provider in respect of services commissioned by another CCG.

the provider for the costs of that patient's care;

- the costs of all other emergency care will be met by the CCG that commissions the care, except where cost-sharing arrangements have been agreed voluntarily by CCGs.

Resolving disputes

6. The safety and well-being of patients is paramount. The underlying principle is that there should be no gaps in responsibility - **no treatment should be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare provision.**

7. Since it is not possible to cover every eventuality within this guidance, the NHS is expected to act in the best interests of the patient at all times and work together in the spirit of partnership.

8. The NHS CB expects that all disputes will be resolved locally, ideally at CCG level, with reference to the guidance in this document and coming to pragmatic solutions where responsibility is not immediately obvious or where it may be shared. In cases that cannot be resolved at CCG level, Local Area Teams of the NHS CB should be consulted and should arbitrate where necessary.

Section 2: Applying the rules to CCG commissioned services

This section gives further details about a number of services and situations where the responsible commissioner is established broadly in line with the rules outlined above, but where further clarification may be helpful.

Asylum seekers

9. A person who has made a formal application to take refuge in the UK is regarded at any stage in their application (including appeals recognised by the Home Office) exempt from charges for hospital treatment. As are failed asylum seekers who are receiving section 4 or section 95 support from the UK Border Agency (for more detailed information see Annex A). Therefore, the responsible commissioner should be determined as laid out in paragraph 1.

Persons of 'no fixed abode'

10. Where a patient has 'no fixed abode' and they are not registered with a GP practice, the responsible CCG should be determined by the terms of the 'usually resident' test (see Annex B). If patients consider themselves to be resident at an address, which is for example a hostel, then this should be accepted. The absence of a permanent address is not a barrier for a person with 'no fixed abode' to registering with a GP practice. In many instances, practices have used the practice address in order to register a homeless person.

Approved premises

11. CCGs will commission services for people currently residing in approved premises[10] and bail accommodation as well as those serving community sentences or on probation. The responsible commissioner should be determined as laid out in paragraph 1.

12. Approved premises and bail accommodation may house residents who have been required to moved outside of their usual CCG area. The general rules still apply as set out in paragraph 1 – the CCG in which the patient living in the approved premises or bail accommodation is registered with a GP (regardless of whether this is on the basis of temporary or permanent registration with a GP) is the responsible commissioner[11]; if the patient is not registered with a GP, then the CCG in which the patient considers that they usually reside, is the responsible commissioner. When determining where the patient usually resides, reference should be made to paragraph 10 above i.e. if the patient considers themselves to be resident at the approved premises address then the CCG in which this is sited becomes the responsible commissioner.

[10] Part of the National Offender Management service's estate, their main purpose is to provide supervised accommodation in the community where high and very high-risk of harm offenders, who are released from prison on licence, are required to reside immediately post-release.
[11] If a patient is registered on a temporary basis in CCG A (the CCG area of the accommodation in which they are required to reside) but also has a permanent registration in CCG B (where they may have resided prior to custody) then the responsible commissioner is CCG A for the period of the temporary registration.

Patients who move

13. Where a patient moves during the course of treatment, every effort should be made to ensure continuity of care. The responsible CCG should be determined as laid out in paragraph 1.

14. As a general rule, where a patient moves during the course of a high cost treatment (e.g. a hospital spell with a long length of stay leading to a substantial excess bed day payment), the cost of treatment up until the date that the patient ceases to be the responsibility of the originating CCG should be borne by the originating CCG. Any costs incurred after the agreed date for the transfer of responsibility to the receiving CCG should be picked up by the receiving CCG. There are some exceptions to this which are set out in section 3.

15. Where a patient has moved away from the area served by their registered GP practice and has de-registered without yet re-registering with a new practice, the responsible CCG should be determined by where the patient has become usually resident.

16. The table below summarises the responsibility for a patient who has moved. In all cases where treatment occurs at the time of a patient moving, the originating CCG should liaise at the earliest opportunity with the receiving CCG to ensure continuity of healthcare and to agree appropriate transfers of funding.

Situation	CCG A	CCG B	Responsible Commissioner
Patient not yet moved	Registered and resident	-	CCG A
Patient moved to area of CCG B	Registered	Resident	CCG A
Patient moved	De-registered	Resident but not yet registered	CCG B
Patient moved	-	Registered and resident	CCG B

People taken ill abroad

17. If a person who is ordinarily resident in the UK is taken ill abroad, establishing the responsible commissioner for treatment on return to the UK should be determined as laid out in paragraph 1. If it is not possible to determine GP practice registration or establish a resident address by the usual means, usual residence should be determined as the CCG in which they are present. This will usually be the CCG where the unit providing the treatment is located (see Annex B). In all cases, it is the responsibility of the patient and/or his/her family to meet the costs of returning to the UK.

18. A person not ordinarily resident in the UK, but who has an entitlement to free NHS hospital treatment as a charge-exempt overseas visitor, may have neither a GP practice registration nor a resident address. In these circumstances, the address at which they were last resident in England or, for those taking up or resuming permanent residence here, the address they intend to live at in England once they have received treatment, will usually establish the CCG of residence. If not, usual residence should be determined as the CCG in which they are present once they are back in England, which will usually be the CCG where the unit providing the treatment is located (see Annex B). Again, in all cases, it is the responsibility of the patient and/or his/her family to meet the costs of returning to the UK.

19. It is particularly important to identify a responsible commissioner for a person who becomes mentally ill whilst living abroad, and who intends to return home for treatment, that they remain entitled to without charge. Wherever possible, the principles outlined in paragraph 1 should be applied to identify the responsible commissioner. If this fails, a unit which will offer an appropriate service should be identified (if possible in an area to which the person in question is willing to return voluntarily) and the principle followed that the CCG covering the location of that unit will become the responsible commissioner.

Right to cross-border healthcare treatment within the European Economic Area (EEA)

20. Patients can exercise their rights to access treatment within the EEA, under the terms of Directive 2011/24 EU on the application of patients' rights in cross-border healthcare and the accompanying regulations. Patients choosing to exercise this right will receive reimbursement for eligible costs, according to their entitlement and the terms of the Directive. The responsible commissioner in each case will be required to fund the reimbursement, whilst the NHS CB will be responsible for administering the application and reimbursement processes for all requests.

21. For services commissioned by the NHS CB, the NHS CB will reimburse patients directly. For services commissioned by CCGs, the NHS CB will reimburse patients on behalf of the responsible CCG, who will in turn be required to repay the NHS CB for the patients' eligible costs. Establishing the responsible commissioner will be determined in accordance with paragraph 1.

22. Where a patient's application relates to treatment normally commissioned by a CCG, the NHS CB will require information from CCGs on local entitlement to that treatment, to aid the decision making process. CCGs will therefore need to make local entitlement policies available to the NHS CB and respond to ad-hoc enquiries from the NHS CB on patient entitlement.

Registered Nursing Care

23. The NHS is responsible for the nursing care provided by a registered nurse to all care home residents (including those placed by local authorities). The responsible commissioner for such care will be determined in accordance with paragraph 1. Where

a person moves to a care home outside the area of the CCG (generally a patient decision to be nearer family or other support networks) where he or she is originally registered with a GP practice (but still within England), that CCG should notify the CCG in whose area the patient will be registered when they enter the care home. This will assist the receiving CCG in funding and planning the nursing care services for its area. The patient would be expected to re-register with a new practice where the care home is on admission and the receiving CCG would then become the responsible commissioner, unless for some reason the patient did not re-register with a new GP but stayed with their old GP, in which case the original CCG would remain responsible. This principle should also apply to any future moves. Cross border placements outside England need to be considered on a case-by-case basis.

Looked after children

24. Under the Children Act 1989, a child is defined as being "looked after" by a local authority if he or she is in their care or is provided with accommodation for a continuous period of more than 24 hours by the authority[12]. They fall into four main groups:
    - children who are accommodated under a voluntary agreement with their parents[13];
    - children who are subject to a care order[14] or interim care order[15];
    - children who are the subject of emergency orders for the protection of the child[16]; and
    - children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a Youth Rehabilitation order with a residence requirement[17]. Of those who are compulsorily accommodated, only accommodation with welfare only places will be the responsibility of CCGs, although the intention is to transfer these to the NHS CB as soon as possible.

25. The responsible CCG should be established by the usual means (see paragraph 1).

26. When a child is first placed, the local authority has a shared responsibility with the relevant CCG to ensure a full health assessment takes place and a health plan is drawn up. The local authority should inform the relevant responsible CCG in writing of its intention to place a child in its area and should be advised whether the placement is intended to be long or short term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases, the local authority should notify the relevant responsible CCG within two weeks or as soon as reasonably practicable. Out of area placements of looked after children and young people are dealt in a different way and are set out in section 3 at paragraphs 68-73.

[12] Section 22 of the Children Act 1989
[13] Section 20
[14] Section 31
[15] Section 38
[16] Sections 44 and 46
[17] Section 21

Students and boarding school pupils

27. Students attending University or other higher education establishments or pupils attending boarding schools should be considered to be the responsibility of the CCG determined through the means laid out in paragraph 1.

Persons detained under the Mental Health Act 1983

28. If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be as set out in paragraph 1. For those in secure units, every effort should be made to determine GP practice registration or establish a usual residence address, but if this fails and the patient refuses to assist then, as a last resort the responsible commissioner should be determined by the location of where the offence[18] was committed. After-care under Section 117 of the Mental Health Act 1983 is subject to separate provisions set out in section 3 at paragraphs 53-57.

Choice of secondary care provider

29. Patients have a legal right to choose any hospital that meets NHS standards and cost when they are referred for a first consultant led outpatient appointment (as set out in the NHS Constitution[19]). The CCG responsible for payment should be established in the usual manner, using paragraph 1. Where there is no contract in place, providers should charge the relevant CCG via non-contract activity billing arrangements (set out at paragraphs 32-41 below).

30. In the case of a patient moving between referral and treatment from one CCG area to another CCG area, responsibility should transfer in the usual fashion (see paragraphs 13-16 on people who move). CCGs may wish to consider and agree flexible solutions, such as whether patient care should be provided by one CCG exercising functions on behalf of the responsible CCG for a specific length of time.

Patient Transport Services (PTS)

31. CCGs are responsible for commissioning non-emergency PTS. Non-emergency PTS is defined as non-urgent, planned transportation of patients with a medical need for transport to and from a premises providing NHS healthcare, and/or between NHS healthcare providers. In these cases the responsible CCG is determined in the normal fashion (see paragraph 1). Emergency ambulance services are subject to the different arrangements set out at paragraph 5.

Non-contract activity

32. Non-contract activity relates to NHS funded services delivered by a provider that does not have a written contract with the patient's commissioner (but the provider holds a written contract with another commissioner)**[20]**. The non-contract activity is undertaken

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[18] index offence

[19] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

[20] This replaces previous arrangements for funding Out-of-Area-Treatments (OATs) wherein the Department of Health adjusted commissioner resource limits centrally, based on historical data on OATs activity, and designated 'host' commissioners administered payments to providers.

by the provider on the terms of the written contract and the responsible commissioner will be established in the usual manner, using paragraph 1, irrespective of the location or status of the provider. Providers should invoice responsible commissioners for non-contract activity on a monthly basis. The timetable for reporting activity via the Secondary Uses Service (SUS) is set out by the NHS Information Centre[21] and referred to in the NHS standard contract. Information provided in support of invoices must include the contract minimum data set[22]. Invoices should cover all activity completed on behalf of each commissioner rather than invoicing for each patient separately.

33. In this context, contracts are defined as any pre-agreement between a commissioner and any provider of NHS funded care, irrespective of the value of the agreement (it could even be of zero value). Non-contract activity billing arrangements are not intended as an alternative to contracting and would principally apply to emergency treatment provided by a hospital that the responsible commissioner would not normally contract with (e.g. treatment at A&E provided whilst a patient is travelling within the UK) or where the patient has exercised choice under the NHS Constitution.

34. Where elective activity is provided outside of contracts, the patient referral by a GP should automatically be regarded as the authorisation to treat. No additional pre-treatment agreement is needed unless prior approval arrangements covering the secondary care pathway is specified in the provider's contract with its CCG or co-ordinating CCG cover the circumstances of the referral.

35. Where cross-border elective admitted patient or outpatient referrals occur outside of contracts, prior approval must be sought and obtained by providers. Referral by a GP or consultant does not in itself constitute approval.

36. It is the commissioner's responsibility to ensure that providers under contract adhere to local referral and treatment protocols.

37. Treatment should never be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare.

38. It is good practice for providers to put in place administrative systems to identify elective non-contract activity at the point of booking and to inform responsible commissioners of any planned treatment(s) for a patient likely to result in claim for payment in excess of £10,000 and/or where a patient's length of stay exceeds 50 days. These arrangements can help to ensure that commissioners are informed about high-cost cases at the earliest opportunity and are appropriately involved in planning care for patients with complex needs. However, these are expected behaviours of organisations and not a lever for commissioners seeking to refuse payment for non-contract activity.

[21] http://www.ic.nhs.uk/webfiles/SUS/SUS%20news/SUS_Processing_Dates_User_View_v_0_2_2_.pdf
[22] This information should also be submitted via the Payment by Results Secondary Uses Service (PbR SUS) operated by *NHS Connecting for Health*.

39. The prices for non-contract activity will be based, as far as possible, on the national tariff and determined in accordance with Payment by Results guidance for the relevant financial year[23].

40. Disputes over payment for non-contract activity should be resolved bilaterally between provider and commissioner and may be referred to the disputes process which involves mediation or binding pendulum adjudication at the request of either party and in line with the provisions in the applicable year's contract.

41. These arrangements may be applied to non-contract activity involving cross-border patient flows within the UK (e.g. cross border emergency treatment) under the arrangements set out in section 3).

[23]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654

Section 3: Exceptions to the general rules

42. This section sets out exceptions to the general rules at paragraph 1 above, i.e. those circumstances where:

    - a CCG **is** responsible for commissioning care for patients who are not registered with one of its GP practices and do not live in the CCG's geographic area, or

    - a CCG **is not** responsible for commissioning care for patients who are registered with one of its GP practices or for unregistered patients living in its geographic area.

43. These exceptions do not affect the responsibility of CCGs to commission emergency care for people present in their geographic area (paragraph 3 above).

44. However, it does not necessarily follow that where a CCG is responsible for commissioning care for patients under the arrangements set out below, they will also be responsible for meeting the costs of emergency admissions and A&E attendances for those patients (see paragraph 5 above). Where there is an out of area transfer or placement, as with those exceptions that relate to NHS Continuing Healthcare; aftercare for persons discharged from hospital following detention under the Mental Health Act, and children and young people, the originating or placing CCG is only responsible for commissioning and paying for the care related to that placement, for example the NHS Continuing Healthcare package. The provision of health services that are not related to the placement, for example inpatient treatment in an NHS hospital or an A&E attendance, is determined in accordance with paragraph 1 and therefore follows the payment rules set out in paragraphs 4-5.

45. Patients who are not 'ordinarily resident' in the UK (i.e. they are an overseas visitor), and no exemption from charges under Regulations applies, will be personally liable for the cost of any hospital treatment with which they are provided. **In such circumstances, no CCG will be responsible for funding that care.** However, a CCG **will** be responsible for funding the care of those visitors to the UK that are exempt from charges and those services that are free to all overseas visitors. See Annex A for more details.

Cross border issues within the UK

Scotland

46. From 1 April 2013, in the case of persons ordinarily and usually resident in Scotland but registered with a GP practice in England, Scotland will be the responsible commissioner.[24] In the case of persons usually resident in England, but registered with

[24] See regulations at http://www.legislation.gov.uk/ukdsi/2012/9780111531525 - these also covers the arrangements for Northern Ireland and Wales.

a GP practice in Scotland, the English CCG where they are usually resident will be responsible.

Northern Ireland

47. From 1 April 2013, in the case of persons ordinarily and usually resident in Northern Ireland but registered with a GP practice in England, Northern Ireland[25] will be the responsible commissioner. In the case of persons resident in England, but registered with a GP practice in Northern Ireland, the English CCG where they are resident will be responsible.

Wales

48. From 1 April 2013, where a patient is ordinarily and usually resident in Wales and registered with a GP practice in England, the Welsh Local health Board (LHB) in whose area they reside will be legally responsible for their care. Under a protocol between England and Wales, however, the CCG of which the GP practice is a member will commission services for that person on behalf of their LHB and will be the responsible commissioner. This continues the principle previously agreed between DH and the Welsh Government in relation to patients in LHBs bordering England.

Residency	**GP location**	**Responsible commissioner**	**Legal responsibility**
Wales	Wales	LHB	LHB
England	England	CCG	CCG
Wales	England	CCG	LHB
England	Wales	LHB	CCG

49. Local health organisations should be aware that the Welsh Government has indicated to Welsh Local Health Boards that they should not pay for treatment outside Wales unless previously authorised, other than where it is a case of emergency treatment. Local health organisations are strongly encouraged to enter into discussions and negotiations locally in order to agree appropriate arrangements for activity outside of contracts and involving cross-border patient flows – in particular in relation to emergency urgent care.

50. The Personal Demographics Service (PDS) is available to providers to help determine the responsible commissioner for patients. The PDS is an electronic database of NHS patient demographic details such as name, address and postcode, registered GP practice and NHS number[26] which enables a patient to be readily identified by healthcare staff quickly and accurately. It primarily covers patients in England and

[25] The Health and Social Care Board is commissioner for all of Northern Ireland
[26] This service is available at the following website: http://www.connectingforhealth.nhs.uk/systemsandservices/demographics

Wales, although patients from Northern Ireland and Scotland who have been in contact with the NHS in England will normally have a record on the PDS.

Patients who move across borders within the UK

51. Where a patient moves across the border from Scotland, Wales or Northern Ireland to England, the expectation would be for that individual to register with a GP practice at their earliest convenience. If they have not yet registered with a GP practice in England and are no longer registered with a GP practice in Scotland, Wales or Northern Ireland, responsibility will be determined by usual residence. Where a patient moves from Scotland to England but has not de-registered from their Scottish GP, the English CCG where they are usually resident will be the responsible commissioner. Where a patient moved from Wales to England but has not de-registered from their Welsh GP, the CCG will be the responsible commissioner. See paragraphs 64-67 for details of responsibilities for patients moving across borders under the NHS Continuing Healthcare arrangements.

52. The decision to transfer a patient with a long-term condition or receiving specialist treatment between Scotland, Wales or Northern Ireland and England should be made on the basis of patient need, with agreement between the placing and receiving authorities, and the agreement of the patient wherever possible. For patients who move within England, the responsible CCG should be determined as laid out in paragraph 1. However, in some instances CCGs may wish to consider and agree flexible solutions, such as whether patient care should be provided by the originating CCG exercising functions on behalf of the receiving CCG for a specific length of time.

Aftercare for persons detained under the Mental Health Act 1983

53. It is the duty of the CCG and of the local social services authority to provide after-care for persons discharged from hospital following detention under the Mental Health Act[27]. The responsible CCG is defined as the CCG for the area in which the person is resident, or to which he is sent on discharge by the hospital in which he was detained.

54. Under case law[28]a patient who was resident in an area before admission to hospital does not cease to be resident there because of his/her detention under the Act. If a patient who is resident in one area is discharged to another area, it is the responsibility of the health and social services authorities in the area where the patient was resident before admission to make the necessary arrangements under section 117. This will continue to be the case even if the patient registers with a GP in the new area. However, where a patient does not have a current residence, the responsibility for providing after-care under section 117 falls to the health and social services authorities covering the area to which the person is sent on discharge.

55. Where a patient is discharged to the area in which they were resident prior to detention for treatment, the responsible CCG under the arrangements outlined in paragraph 1 would usually be the same as that responsible for after-care services under section 117.

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[27] Section 117 of the Mental Health Act 1983
[28] R v Mental Health Review Tribunal ex parte Hall [1999]

Where this is not the case (perhaps because the patient is registered with a GP outside the area in which he is resident), new regulations made under section 117(2E) of the Mental Health Act 1983[29] provide that the CCG with responsibility for the patient under the arrangements outlined in paragraph 1 will have the duty to provide after-care services.

56. Section 117 does not apply to patients detained for assessment under section 2 of the Mental Health Act. For these patients, and for patients treated voluntarily for mental health problems, the arrangements set out in paragraph 1 for identifying the responsible commissioner apply unless they are overseas visitors.

57. The following table sets out some of the more complex potential scenarios and the responsible commissioner in each case:

Scenario	**Responsibility for payment**
Person who was registered and/or resident in CCG D prior to being detained for treatment is provided with after-care services on discharge in CCG E, where he registers with a new GP.	CCG D is responsible for payment
Person who was detained for treatment in CCG F (but was not registered with a GP or have a current residence) is provided with after-care services on discharge in CCG G.	CCG G is responsible for payment
Person who was registered in CCG H prior to being detained for treatment is provided with after-care services on discharge in CCG I where he is resident.	CCG H is responsible for payment

Transfer of patients to other CCG areas under NHS Continuing Healthcare arrangements

58. ‘NHS Continuing Healthcare’ means a package of care arranged and funded solely by the NHS.

59. Where a CCG (‘the placing CCG’) arranges such a package, whether on its own or as a joint package of residential care arranged and funded by both the NHS and local authorities, the placing CCG remains responsible for the NHS contribution to the care, even where the person changes their GP practice (and associated CCG). These arrangements do not apply to a situation where a person either independently chooses to move to a different part of the country or is placed there because of an arrangement made by a local authority only.

[29] section 117(2E) was inserted into the Mental Health Act 1983 by section 40 of the Health and Social Care Act 2012.

60. The arrangements apply regardless of whether nursing care forms part of the care package, except in cases where the only planned service is NHS Funded Nursing Care. A need for care from a registered nurse would not be sufficient to trigger these commissioning rules. The provision of health services that are not related to the placement, for example inpatient treatment in an NHS hospital, is determined in accordance with paragraph 1, and as such would be the responsibility of the CCG to which their GP belongs or if unregistered where they usually reside.

61. A decision to place a patient requiring continuing care in a care home or independent hospital in another CCG area should be made after notifying the CCG where the care home or independent hospital is located, and the latter CCG has been notified. This should be done before the patient is moved. In the interests of the patient, and in particular when a patient leaves hospital, such decisions should be made promptly to ensure that the patient is transferred to a setting where they will continue to receive quality treatment and care. For all services, there should always be communications between the two CCGs to ensure clarity over responsibilities and to avoid any potential for duplicate payments to the care home.

62. For joint packages of care, where local authorities are placing residents who have health needs, they should work closely with the placing CCG responsible for commissioning the healthcare to ensure that a full assessment of health needs is made so that an appropriate joint package is put in place. CCGs should ensure that no one is deprived of the services that they are assessed as needing as a result of disputes over funding and that any review serves the patient’s best interests.

63. Where a patient is provided with NHS Continuing Healthcare in their own home and they decide to move house (not into residential care), then this will need careful discussion between the CCG currently providing those services and the CCG responsible for them after they move. The responsible commissioner for such care is determined in accordance with paragraph 1. In order to ensure continuity of care and ensure that arrangements represent the best interests of the patient, CCGs may need to come to an agreement about how services should be delivered. In particular, CCGs will wish to consider flexible solutions, such as whether patient care should be provided by another CCG exercising functions on behalf of the responsible CCG.

Transfer of NHS Continuing Healthcare patients across borders within the UK

<u>Scotland</u>

64. Where an English CCG (‘the placing CCG’), arranges a package of NHS Continuing Healthcare Care (other than a package that is only NHS funded nursing care) the placing CCG will remain responsible for that person’s CHC until that episode of care has ended. For example, the individual’s health may subsequently improve rendering them no longer eligible for NHS Continuing Healthcare. In these circumstances if the individual wishes to remain in that care setting responsibility would then fall to the Health Board (and local authority) where they are usually resident.

65. It should be noted that arrangements for NHS nursing care differ between England and Scotland. In England the CCG makes a flat rate contribution towards the cost of an

individual's registered nursing care. In Scotland personal and nursing care are provided free of charge[30]. When a Scottish Health Board makes a placement in England, the individual will be eligible for personal and nursing care payments from the Scottish placing authority[31]. When an English CCG makes a placement in Scotland, the usual responsible commissioning arrangements apply.

66. The placing CCG should ensure that agreements on responsibilities are made before the patient is moved to ensure that continuity of care is maintained. CCGs responsible for placing a person in a Scottish Health Board area should therefore inform the receiving Health Board of the placement as soon as practicable.

Wales

67. There is currently a protocol agreed between the Welsh Government and the Department of Health for placements between Wales and England. The protocol is a basis for local solutions to ensure that all patients receive the services which they are assessed as needing. The protocol is currently being updated to reflect the new commissioning system from April 2013 and will be available shortly.

Out of area placements of children and young people

68. Where a CCG or a local authority, or a CCG and a local authority acting jointly, arrange accommodation for a child or young person in one of the groups listed below (A to C) in the area of another CCG or Local Health Board in Wales, the "originating CCG" remains the responsible CCG for the services which CCGs have responsibility for commissioning[32], even where the child registers with another GP practice. In the case of group D the originating CCG only remains responsible for the continuing healthcare, not any other services. The "originating CCG" is the CCG which made, or was involved in the making of the arrangements for the child to be accommodated out of their area, or the CCG which was responsible for the child when the arrangements were made (if made by the local authority alone). As a matter of good practice, the originating CCG should notify the CCG in whose area the child is being placed. The four groups of children are:

A. Looked After Children and Children Leaving Care

69. If a looked after child or child leaving care is moved out of the CCG area, arrangements should be made through discussion between the "originating CCG", those currently providing the healthcare and the new provider to ensure continuity of healthcare. CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care for the individual child or young person. It is important to ensure a smooth handover of clinical care to the new area, where that is the agreed best arrangement for the child.

[30] www.careinfoscotland.co.uk/what-care-do-I-need/care/at/home/personal/and/nursing/care.aspx
[31] www.scotland.gov.uk/health/freepersonalcare
[32] under section 3 of the NHS Act 2006

B. Pupils with special educational needs attending Residential Special Schools

70. For the purposes of this guidance, a special school is a school that caters for children with statements of special educational needs. Schools may be: maintained by local authorities; non-maintained special schools; or independent schools approved by the Secretary of State for Education and Skills as being organised to make provision for pupils with special educational needs, or to make provision for individual named pupils. Pupils attending special schools on a day only basis are the responsibility of the CCG determined through the usual means.

71. Where a local authority names a residential special school in a child's statement of special educational needs, and the child is then placed in the area of another CCG or Local Health Board, the responsible commissioner remains the "originating CCG", even though the child is likely to register with a GP practice in the locality of the special school in a different CCG area.

C. Children with continuing healthcare needs requiring residential care who are not looked after children

72. When arrangements are made to place a child with continuing healthcare needs in another CCG area or a Local Health Board area in Wales, to meet those needs the responsible CCG will be the "originating CCG". Some of these children will require long term healthcare. For those for whom discharge back to the parental home is being planned and their parents have moved to a new CCG area, the parents should be advised to register the child with a GP practice as soon as discharge planning is being considered if they have not already done so. This will enable the new CCG to work with the "originating CCG" and the provider to ensure continuity of high quality, timely care for the child or young person.

D. Young adults with continuing healthcare needs[33]

73. When a young person who has been placed in accommodation in another CCG area to meet their continuing care needs reaches 18 years of age, there are prescribed circumstances set out in regulations in which the care arrangements will be treated as having been made under the adult continuing care provisions. Adults in residential care settings may be liable to meet the social care element of their care charges, which would not have been the case before their 18th birthday. As the threshold for providing continuing care needs may be higher for adults than it is for children, where possible young people should be identified when they reach the age of 14. This should be followed up by a formal referral for screening at age 16 to the relevant CCG and by the age of 17, their eligibility for adult NHS continuing healthcare should be decided in principle by the relevant CCG. This is in order that, where applicable, effective packages of care can be commissioned in time for their 18th birthday (or a later date if it is jointly agreed that it is more appropriate for responsibility to transfer at that time).

[33] in line with the National Framework for Children and Young People's Continuing Care available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114784

Where needs may change, it may be appropriate to make a provisional decision and then to re-check it through repeating the process as adulthood approaches. Wherever possible, these young people should continue to receive their healthcare on an unchanged basis pending this assessment.

Urgent and emergency care

74. Regulations[34] establish CCG legal responsibility for commissioning urgent and emergency care services for everyone present in their geographic area. This includes accident and emergency (A&E), NHS walk-in centres, urgent care centres and minor injury units and ambulance services.

75. As set out in paragraph 5:

- for A&E attendances and emergency admissions, the CCG who would ordinarily be the responsible commissioner for a patient (under the rules in paragraph 1 and subject to the other relevant exceptions in section 3) will be responsible for paying the provider for the costs of that patient's care. Providers will charge the relevant CCG via non-contract activity billing arrangements (set out in section 2);

- the costs of all other emergency care will be met by the CCG that commissions the care, except where cost-sharing arrangements have been agreed voluntarily by CCGs. Many previous commissioners have found that recharging for activity in most urgent care facilities is a labour intensive process which is unlikely to result in much net financial gain in most areas. CCGs will want to consider whether it is practical and cost-effective to seek to agree cost-sharing or re-charging arrangements for these services.

76. Overseas visitors are not liable for the cost of emergency treatment provided prior to admission as an inpatient, as that is free to all, although there is clearly still a cost associated with that treatment. For those overseas visitors that could not be said to be part of the resident population[35] the 'host' CCG in which the provider is sited is the responsible commissioner. Emergency treatment provided after admission as an inpatient is not free to all. Further detail on eligibility for free treatment and charge-exempt overseas is set out at Annex A.

77. The CCG within whose boundary an emergency occurs is responsible for emergency ambulance services in that area. In the case of emergency or critical care transfers between NHS trusts, it is the location of the transferring NHS trust that determines responsibility for payment as the "emergency" is deemed to occur there, i.e. the CCG in which the referring hospital is based is the responsible commissioner.

78. The following table sets out the potential scenarios and the responsible commissioner in each case:

Scenario	Commissioning responsibility	Responsibility for payment

[34] under section 3(1B) of the 2006 Act as inserted by the 2012 Act available at http://www.legislation.gov.uk/uksi/2012/2996/contents/made

[35] see Annex A, 12(b)

Patient registered and/or resident in CCG A attends A&E in CCG B	CCG B is responsible for commissioning urgent and emergency care for anyone present in their geographic area	CCG A is responsible for payment
Patient registered and/or resident in CCG C is admitted to hospital in CCG D as an emergency	CCG D is responsible for commissioning urgent and emergency care for anyone present in their geographic area	CCG C is responsible for payment
Patient registered and/or resident in CCG E attends a minor injury unit in CCG F	CCG F is responsible for commissioning urgent and emergency care for anyone present in their geographic area	CCG E is responsible for payment, subject to any cost sharing or re-charge arrangements agreed by CCGs.
Patient registered and/or resident in CCG G is picked up by an ambulance within the boundary of CCG H	CCG H is responsible for commissioning urgent and emergency care for anyone present in their geographic area	CCG H is responsible for payment as the CCG within whose boundary the incident took place
Critical care patient registered and/or resident in CCG I is transferred as an emergency by ambulance from hospital in CCG I to hospital in CCG J	CCG I is responsible for commissioning urgent and emergency care for anyone present in their geographic area	CCG I is responsible for payment as the CCG in which the referring hospital is based.

Section four: Examples to help clarify the boundaries of responsibility between commissioning organisations

79. The *Commissioning fact sheet for Clinical Commissioning Groups*[36] sets out the respective responsibilities of CCGs, the NHSCB, local authorities and Public Health England for commissioning health services. This section provides further clarification on some issues, particularly where there is more than one commissioner during the course of a patient pathway.

80. These examples are not exhaustive but where possible set out some principles that can be applied more widely.

NHS CB commissioned services

Specialised/prescribed services

81. The NHS Commissioning Board will be statutorily responsible for commissioning specialised and highly specialised services set out in regulations[37]. CCGs will be responsible for commissioning related services along the patient pathway.

As a rule, a patient only becomes the responsibility of the NHS CB as specialised commissioner on confirmation of a firm diagnosis:

	Scenario	**Responsible Commissioner**
1	Mrs A attends a cardiac outpatient appointment at a specialised centre and, after a number of appointments, is diagnosed with adult congenital heart disease and referred to a specialist clinic within the same hospital.	The CCG is the responsible commissioner until the patient is seen within the specialist clinic with a definitive diagnosis, when the NHS CB becomes responsible.
2	Miss B attends a respiratory outpatient appointment at a specialised centre.	CCG
	After a number of appointments, she is diagnosed with interstitial lung disease.	She continues to be seen within the same clinic but responsibility on diagnosis transfers to the NHS CB.
3	Mr C attends A&E.	CCG

[36] in the *Commissioning fact sheet for Clinical Commissioning Groups* (July 2012) which sets out the services to be commissioned by CCGs from April 2013. It also sets out the complementary services to be commissioned by the NHS CB and Public Health England (PHE) and is available at http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf
[37] Available at http://www.legislation.gov.uk/uksi/2012/2996/contents/made

	He is sent home with an urgent neurology appointment in a named specialised centre for the following day.	The NHS CB is responsible for the neurology appointment and any ongoing neurology care.
4	Mrs D attends nephrology appointment. After investigation, she is found to have renal failure and is moved to a specialist renal clinic. She then undergoes a live donor renal transplant.	The CCG is the responsible commissioner until Mrs D is referred to the specialist clinic. All remaining care is the NHS CB responsibility including the donor costs.
5	Miss E is being seen by Eating Disorder Community Team.	CCG
	Miss E then goes on to be treated as an inpatient in a specialised eating disorder service.	NHS CB
	Miss E is discharged but has been given a follow up appointment to see the specialised eating disorder inpatient service in outpatients.	NHS CB

For a number of services the NHS CB will only commission from specialist centres (and these are based on centre, not individual clinician)[38]:

	Scenario	**Responsible Commissioner**
6	Mr F is attending a specialised pain management clinic.	NHS CB
	The consultant responsible for his care moves to a hospital not commissioned as a specialist pain management centre by the NHS CB and Mr F moves with him.	CCG is now the responsible commissioner.
7	Miss G is referred by her GP to a hospital for bariatric surgery and the NHS CB do not contract with that hospital for bariatric surgery.	The CCG is the responsible commissioner.

As a general rule the NHS CB will remain the responsible commissioner where a patient undergoes specialised surgery until the patient is discharged from the care of that specialty within that hospital

[38] it is likely that there will be a process created whereby provider organisations can flag up that they are now providing a specialised service and they can then be added to the list of 'nominated' providers. Although for some clinical services they will need to go through a formal clinical accreditation type process before there are recognised as providing a robust clinical/ specialised service. Therefore the addition of provider to 'nominated list of providers' will not be instant and will be determined by the NHS CB.

	Scenario	Responsible Commissioner
8	Mr H undergoes specialised thoracic surgery and goes straight from theatre to a general critical care unit.	The NHS CB will be the responsible commissioner for all intensive care unit stays associated with a specialised spell.
9	Mrs I undergoes specialised thoracic surgery and goes straight from theatre to specialised cardiac critical care unit.	The NHS CB will be the responsible commissioner for the whole episode.

Specific example related to the boundary between pediatric and adult services

	Scenario	Responsible Commissioner
10	Miss J is a long-stay paediatric intensive care unit (PICU) patient, she is then transferred to the adult high dependency unit (HDU) and her condition does not fall under any adult specialised service.	The NHS CB is the responsible commissioner for PICU, the CCG is the responsible commissioner for the adult HDU.

Secure mental health examples

	Scenario	Responsible Commissioner
11	Miss K is being seen by a community forensic team.	CCG
	Miss K is admitted to low secure unit out of her CCG area.	The NHS CB is the responsible commissioner for the secure care, the CCG is the responsible commissioner for any acute physical secondary care that may be required whilst Miss K is in the secure unit.
12	Mr L is resident in CCG(i), he is accused of a violent assault in his local area and is instructed by the Court to move to bail accommodation out of the CCG in which he is usually resident. Whilst living in this bail hostel he registers as a temporary patient with a local GP near his hostel in CCG(x).	CCG(x) is the responsible commissioner whilst he is living in the bail accommodation.
	On return to Court, he is then convicted of the violent assault and is detained in a secure unit in CCG(x) for treatment.	The NHS CB is the responsible commissioner for the secure care. CCG(x) is the responsible commissioner for any acute physical secondary care that may be required whilst Mr L is in

		the secure unit.
	Aftercare arrangements are made to discharge Mr L from secure care after his prison sentence has elapsed.	CCG(x) where he was resident prior to detention is the responsible commissioner (see paras xx-xx for further information).

Armed forces

82. Upon enlistment, the MoD becomes responsible for the primary medical services of members of HM forces through Defence Medical Services (DMS).

83. This does not apply to dependants of HM forces members, who can remain registered with a GP practice or apply to join another GP practice when they wish to do so – e.g. when they move. However, dependants can, and often do, access primary medical services through a HM Forces member's entitlement to DMS.

84. Where they do not have ready access to DMS, it is possible for members of HM Forces to be accepted by a GP practice as a temporary resident (although the NHS CB would remain the responsible commissioner). They usually do so when outside the catchment area of a DMS facility or when appropriate DMS service provision is not available. This entitlement includes personnel living in their own home or in married quarters if these criteria are met.

85. The NHS CB will be responsible for commissioning secondary and community health services for members of the armed forces and their families, where registered with Defence Medical Services – primary care services for members of the armed forces and reservists whilst mobilised are commissioned by the Ministry of Defence. This includes services for these groups stationed overseas who return to England to receive NHS care. The NHS CB is also responsible for commissioning prosthetic services for veterans.

86. CCGs will be responsible for commissioning health services for veterans or reservists (when not mobilised) and those members of armed forces' families who are registered with NHS GP practices, for whom normal commissioning responsibilities apply. CCGs are also responsible for commissioning emergency care, including A&E and ambulance services as well as out-of-hours primary medical services[39] for serving armed forces and their families registered with DMS practices present in their geographic area. The following examples seek to illustrate respective responsibilities.

	Scenario	**Responsible Commissioner**
1	Soldier M returns from Germany where she is serving, for treatment for lung cancer as she has chosen to have her treatment in the UK. She registers as a temporary resident in a practice in	The NHS CB is the responsible commissioner for all her care, including any community nursing

[39] Except where this responsibility has been retained by practices under the GP contract, where the NHS CB is then responsible

	Bristol to be near her family.	care she might need.
2	Mrs N married to soldier N but not herself in the armed forces is registered with a Defence Medical Services [MOD] practice in Salisbury. She is pregnant and requires maternity care at the local hospital.	The NHS CB is the responsible commissioner for all her care as she is registered with a DMS practice.
3	Mrs O married to airman O at RAF Marham in Norfolk but not in the armed forces herself is registered with an NHS GP practice. She needs a referral to hospital and is likely to need surgery and post-operative care.	The CCG is the responsible commissioner for all her care as she is not registered with a DMS practice.
4	Mrs P is living with her husband who is serving in Cyprus, where they are both registered with a DMS practice. She returns to the UK for secondary care and registers as a temporary resident with an NHS GP practice where her parents live in Birmingham.	The NHS CB is the responsible commissioner for her secondary care costs as she is permanently registered with a DMS practice.
5	Reservist Q who has been deployed in Afghanistan requires surgery once he is back in the UK for an injury sustained in service.	As the reservist has been injured in action, the MOD will be responsible for ensuring that the reservist continues to receive appropriate healthcare related to the recovery of their injury.
	Any continued secondary care services he then receives (whilst still mobilised) in an NHS facility.	NHS CB
	Reservist Q is then demobilised by the MOD when he has been judged to have progressed/settled at his best level of fitness.	He is then the responsibility of his local CCG for any further ongoing care he may require.
6	Couple R who are both serving in the armed forces need to register their children for GP services and dental services.	There is often some confusion as to whether this is the responsibility of the MoD. It is not - children should be able to access GP and dental services on the same basis as the general public and therefore the NHS CB would be responsible as the commissioner of primary care services.

<u>Specific infertility treatment examples</u>

	Scenario	**Responsible Commissioner**
7	Injured serviceman S is in receipt of	The NHS CB would be the responsible

	compensation under the Armed Forces Compensation Scheme for a genital injury sustained in action. He and his wife require infertility treatment and want to use the sperm he stored at his local infertility clinic before he left.	commissioner for storing the sperm from the date of injury and for the infertility treatment[40]. If they pay for fewer than three cycles, the Department of Health would effectively 'top up' the treatment[41] so he and partner could receive the three cycles of treatment to which they are entitled[42].
8	Injured veteran T who is in receipt of compensation for a genital injury sustained in action requires infertility treatment. He has no sperm stored. He approaches his GP practice for referral to a specialised infertility service.	His local CCG will be the responsible commissioner. As he is covered by the Armed Forces Compensation Scheme, if the CCG pay for fewer than three cycles, the Department of Health would effectively 'top up' the treatment so he and partner could receive the three cycles of treatment to which they are entitled if required.
9	Mrs U married to serviceman U requires infertility treatment.	The NHS CB will be the responsible commissioner for uninjured members of the armed forces and their families. The number of cycles would depend on the policy determined by the NHS CB.

Prisoners and those detained in 'other prescribed accommodation'

87. The NHS CB will be responsible for commissioning health services (excluding emergency care) for people in prisons and in future, all those detained in 'other prescribed accommodation'[43].

88. From April 2013, the NHS CB's responsibilities will include prisons, young offender institutions, some secure children's homes, some secure training centres (from 2014), and some immigration removal centres.

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[40] The NHS CB will be responsible for commissioning all infertility services for service personnel and their partners, regardless of whether infertility is injury-related. It will also be responsible for commissioning specialised infertility treatment for injured servicemen and veterans whose sperm has been retrieved and is stored in Birmingham Hospital and, in the case of their death, for any partners/widows who wish to have treatment.

[41] The cost of the DH 'top up' will come out of a special fund. Anyone requiring information on this or wishing to apply for funding from this fund should write to armedforces.ivf@nhs.net

[42] The Government has committed to fund up to three full cycles of IVF treatment for those who have lost their fertility in service, generally due to injury caused by a blast, and are in receipt of compensation from the Armed Forces Compensation Scheme. This is in recognition of the commitment in the Armed Forces Covenant that there should be a 'proper return for sacrifice' for those injured in service. The groups concerned are men serving in the armed forces and veterans whose sperm has been retrieved and held in storage following injury. This may include those who have lost their mental capacity or are deceased where their partners are entitled to treatment, should they wish it.

[43] Details of 'other prescribed accommodation' for these purposes are set out in regulations available at http://www.legislation.gov.uk/uksi/2012/2996/contents/made

89. CCGs will be responsible for commissioning emergency care, including A&E and ambulance services as well as out-of-hours primary medical services[44], for prisoners and detainees present in their geographical area. CCGs will also be responsible for commissioning health services for adults and young offenders serving community sentences and those on probation and health services for initial accommodation for asylum seekers.

90. The following examples illustrate respective responsibilities.

	Scenario	**Responsible Commissioner**
1	Mr V is a 23 year old in a local prison. He sustains a serious head injury resulting in an acquired brain injury requiring intensive support, speech and language therapy and physiotherapy.	The CCG in which the prison is located is responsible for emergency ambulance services and services provided at A&E. The NHS CB is the responsible commissioner for all other treatment.
2	Miss W is a 25 year old pregnant woman in a female prison.	The NHS CB is responsible for her pre-natal care in the custodial setting.
	She goes into labour early at 24 weeks and is taken by ambulance to the nearest hospital (which is out of the immediate area) where she is admitted as an emergency.	The CCG in which the prison is in is the responsible commissioner for the ambulance service. The NHS CB is responsible for the birth of her baby as this is planned secondary care of a person in a custodial setting.
	She is discharged back into custody after a couple of days, but her baby remains in special care for several months.	The NHS CB is responsible for her post-natal care in the custodial setting. The NHS CB is the responsible commissioner for the special baby care (as the direct commissioner of specialised services).
3	Mr X is 17 years and 6 months old. He has learning disabilities and severe mental health problems. He meets the criteria for NHS continuing healthcare. He is subject to a Youth Rehabilitation Order and accommodated away from home. Mr X is in and out of the youth justice system.	The responsible commissioner is the originating CCG; however, consideration needs to be given to the package of care Mr X will receive once he reaches 18 as the criteria for NHS continuing health care can change at this age. If at any point he is detained in a young offender institution the responsibility would then pass to the NHS CB for the period of detention. Upon release from custody the

[44] Except where this responsibility has been retained by practices under the GP contract, where the NHS CB is then responsible

		originating GGC remains the responsible commissioner as regards the package of NHS continuing healthcare.
4	Mr Y is a 16 year old, has substance misuse and mental health problems and has been accommodated out of area in a secure children's home following persistent offending. He requires both substance misuse and mental health services to support his anxiety and depression.	The NHS CB is the responsible commissioner whilst he is detained in the secure children's home with youth justice board places.
	After a period of time he is released on probation.	The CCG where he is registered with a GP or, if not registered with a GP, the CCG in whose area he is resident, then becomes the responsible commissioner for any ongoing mental health treatment. The local authority is the responsible commissioner for the substance misuse services.
5	Mr Z is a failed asylum seeker residing in an immigration removal centre. Whilst there he tests positive for drug sensitive TB. He commences treatment under the care of the respiratory consultant in the local hospital trust.	The NHS CB is the responsible commissioner whilst he is detained in an immigration removal centre.
	Mr Z applies for bail which he is granted and is discharged to the local initial accommodation centre where he continues his treatment managed under the local TB team.	The CCG where the failed asylum seeker is resident in is the responsible commissioner for his ongoing care.
6	Mr AA is a 69 year old male in a category B prison. He suffers a heart attack and is taken to a specialist cardiac centre in an ambulance to receive a primary percutaneous intervention.	The CCG in which the prison is in is the responsible commissioner for the ambulance service and treatment at A&E. The NHS CB is the responsible commissioner for his treatment.
	After 5 days he is transferred to a local hospital for recovery. He spends a further two weeks in his local hospital before being transferred to the healthcare wing of his prison.	The NHS CB is the responsible commissioner for his treatment.
7	Prisoner BB is released on temporary licence (ROTL) to spend time in the place he will stay when he leaves prison. He collapses and is taken by ambulance to the nearest A&E.	The CCG where he collapses is responsible for the ambulance and A&E care.
	He is then admitted for overnight observation:	The NHS CB is the responsible

		commissioner.

Primary care

91. The NHS CB will be responsible for commissioning primary care services. This includes:
- Essential and additional primary medical services through GP contract and nationally commissioned enhanced services;
- Out-of-hours primary medical services (where practices have retained the responsibility for providing OOH services);
- Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors;
- Primary ophthalmic services, NHS sight tests and optical vouchers;
- All dental services, including primary, community and hospital services and urgent and emergency dental care.

92. CCGs will be responsible for commissioning the following related services:
- Out-of-hours primary medical services (where practices have opted out of providing OOH services under the GP contract);[45]
- Community-based services that go beyond scope of GP contract (akin to current Local Enhanced Services[46]);
- Meeting the costs of prescriptions written by member practices (but not the associated dispensing costs);
- Secondary ophthalmic services and any associated community-based eye care services.

93. The following examples illustrate respective responsibilities.

	Scenario	Responsible Commissioner
1	Mr CC goes to the dentist where he is registered for an NHS check-up. The dentist is not sure about a treatment and refers the patient to a dental surgery in a hospital for a second opinion. Mr CC then receives treatment in his dental practice.	The NHS CB is the responsible commissioner throughout.
2	Miss DD goes to a high-street optometrist to receive an NHS sight test.	NHS CB
	She is then referred for treatment at a community based eye care services.	CCG
	Whilst at this service, she is prescribed with eye drops as part of her aftercare.	CCG

[45] The NHSCB has statutory responsibility for commissioning these services but will direct CCGs to carry out this responsibility on its behalf
[46] Resources attached to current Local Enhanced Services (LES) (except for public health LES) are to be included in CCG funding.

3	Mr EE is chronically ill, and regularly sees his GP.	NHS CB
	He falls ill on a Sunday afternoon and calls the local out of hours provider which is commissioned by his CCG.	CCG
	He then returns to his GP for continuing his care.	NHS CB
4	Mr FF attends his local 8-8 GP health centre, he is not registered with a GP.	The CCG in which he is resident is the responsible commissioner.
	Mr GG attends the same GP health centre, but he is a registered patient at this centre.	NHS CB

Public health services to be commissioned by local authorities

94. Local authorities will be responsible for a range of health improvement services, including smoking cessation services, sexual health and drug/alcohol services. CCGs will be responsible for commissioning related services along the patient pathway.[47] The following examples illustrate respective responsibilities.

	Scenario	**Responsible Commissioner**
1	Mr HH attends his local GP practice where he is registered, for a consultation.	NHS CB
	As part of the consultation, he is referred to his local GUM clinic for tests to see if he has any sexually transmitted infections.	Local authority
	On testing, he is diagnosed with Chlamydia and is given the appropriate medication for treatment.	Local authority
	As part of the original consultation, he and the GP agree to refer him for a vasectomy.	CCG

2	Mrs II, aged 55, is invited for an NHS Health Check[48] at a local provider in her community.	Local authority
	Based on her initial risk assessment she is referred for further advice and appropriate support from a range of existing schemes and services including smoking cessation, weight management and physical activity services as part of the local NHS Health Check	Local authority

[47] For the full list of public health services to be provided or commissioned by local authorities and any related services that CCGs will be responsible for commissioning please refer to the *Commissioning fact sheet for Clinical Commissioning Groups* (July 2012) available at http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf

[48] people aged between 40 – 74 are eligible for an NHS Health Check

	programme. The risk assessment reveals that Mrs II is at high risk of diabetes – the results are sent to Mrs II's GP, to ensure they are included in her patient record and that any necessary clinical follow up is undertaken.	
	Mrs II's GP carries out tests to establish whether she has or is developing type 2 diabetes. She is subsequently diagnosed with previously undetected diabetes.	NHS CB
	As part of the diagnosis, her GP notices that she has a foot ulcer and she is referred for urgent assessment and treatment by the specialised foot care team at her local DGH with suspected charcot foot.	CCG

Annex A: Eligibility for free NHS treatment for CCG-commissioned services

It is important to note that not everyone is entitled to free NHS care. CCGs are not responsible for funding care that patients themselves are liable for.

1. This annex summarises the key points of eligibility for free NHS treatment for CCG-commissioned services. It is not a complete summary of the law and CCGs should refer to other guidance, and consult legal advisers where necessary.

2. The fundamental principle is that immediately necessary or urgent medical treatment should never be denied to any person, regardless of whether or not they are chargeable for those services or have paid in advance. Non-urgent treatment for which charges can be made should not be provided to a chargeable person until they have paid in full in advance.

Eligibility for hospital treatment

3. Neither registration with a GP practice, nor having an NHS number, nor being a UK national, nor payment of UK tax or National Insurance contributions give a patient entitlement to free NHS hospital treatment. Entitlement is based on 'ordinary residence' in the UK or exemption from charges under the Charging Regulations.

4. Ordinary residence takes its meaning from case law. In order for NHS hospitals to assess if a person is ordinarily resident here, they should consider whether the person is living lawfully in the UK voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled. There is no qualifying period of time to be considered ordinarily resident, but as a general guide a person who has resided here less that 6 months may be less likely to be considered ordinarily resident here unless other evidence suggests they are nevertheless properly settled here.

5. If a person is not ordinarily resident in the UK, they are subject to the Charging Regulations, which place a legal duty on NHS providers to make and recover charges from overseas visitors who they have provided with treatment unless an exemption from charges applies as listed within the Charging Regulations. **Where such a patient is liable for the charge, CCGs should not fund that hospital treatment.**

6. There are three broad categories of overseas visitor exemption:

   a) **Those who could be considered part of the resident population for funding purposes**, and who are likely to be registered with a GP practice and give a UK address, such as: people who have been in the UK lawfully for more than 12 months; people who are taking up permanent residence in the UK; people who are employed by UK-based employers or self-employed here; refugees; asylum seekers whilst their applications are under consideration, including appeals; failed asylum seekers receiving section 4/95 support from the UK Border Agency;

children in Local Authority care; diplomatic staff; students on a course of at least six months duration.

b) **Those who are not part of the resident population**. Examples are: UK state pensioners living overseas; some former UK residents now working overseas; missionaries acting for UK-based mission; armed forces members and crown servants serving overseas; people visiting from EEA countries and Switzerland with EHIC/E112/S2, plus people visiting from countries with which the UK has a bilateral healthcare arrangement. A list of such countries can be found in the guidance on the Department of Health website (see below).

c) **Those requiring specified treatments**. There are no charges for any overseas visitor for:

- emergency treatment given in an A&E department, Walk in Centre, Minor Injuries Unit etc. Emergency treatment provided after admission as an inpatient is not free to all;
- compulsory psychiatric treatment and treatment imposed by a court order;
- treatment of most communicable diseases and all sexually transmitted diseases;
- family planning services (which does not include maternity treatment or terminations).

7. Note that the Charging Regulations only permit charges to be made for NHS hospital treatment. If NHS treatment is provided outside an NHS hospital then, unless the staff providing it are employed or directed by an NHS hospital, no charge can be made to the patient for the provision of that treatment.

Charge-exempt overseas visitors

8. Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is exempt from charge, the payment arrangements are as follows:
   - If the overseas visitor belongs to a category listed in 6(a) the responsible commissioner will be subject to the rules set out in paragraph 1 of main guidance;
   - If the overseas visitor belongs to a category listed in 6(b) or 6c) the treating trust will invoice the host CCG[49] where no contract or Service Level Agreement is in place;
   - costing should be calculated, where possible, using the latest non-contract activity guidance;[50]
   - invoices should be sent on a monthly basis;
   - one invoice per patient;
   - payment should be made within 30 days of receipt of invoice;
   - dispute resolution should be between the provider and host CCG;
   - the NHS CB will oversee an annual data collection exercise on details of payments made by CCGs to providers for charge-exempt overseas visitors in 6(b) and 6(c).

[49] the host CCG will be the CCG in which the provider is sited.
[50] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654

This information will inform a non-recurrent adjustment to CCG budgets to account for such activity; and

- where the patient is a visitor from the European Economic Area (EEA) or Switzerland and has a valid European Health Insurance Card (EHIC) or, for planned treatment, an E112/S2, the treating trust will report EHIC/E112/S2 details through a web portal to the Department of Work and Pensions. This allows DWP to claim a reimbursement for the UK from the relevant EEA member state.

Full guidance to the NHS on how to implement the Charging Regulations can be found here: http://www.dh.gov.uk/health/2012/10/overseas-visitors/

Annex B: Defining 'usually resident'

1. It is important to note that:
   - the 'usually resident' test must only be used to establish the responsible commissioner when this cannot be established based on the patient's GP practice registration;
   - 'usually resident' is different from 'ordinarily resident'. If a person is not ordinarily resident in the UK and not covered by an exemption in regulations then they are liable for NHS hospital treatment costs themselves (see Annex A). The 'usually resident' test may still be needed to establish the responsible commissioner for non-hospital services;
   - by contrast, local authority responsibility for the provision of accommodation and community care services[51] is largely based on the concept of 'ordinary residence'[52].

2. The main criterion for assessing 'usual residence' is the patient's perception of where they are resident in the UK (either currently, or failing that, most recently). The same principles apply in determining usual residence for determining which CCG has responsibility for arranging care for a patient.

3. Where the patient gives an address, they should be treated as usually resident at that address.

4. Certain groups of patients may be reluctant to provide an address. It is sufficient for the purpose of establishing usual residence that a patient is resident in a location (or postal district) within the CCG geographical area, without needing a precise address. Where there is any uncertainty, the provider should ask the patient where they usually live. Individuals remain free to give their perception of where they consider themselves resident. Holiday or second homes should not be considered as "usual" residences.

5. If patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, but can give their most recent address, they should be treated as usually resident at that address.

6. Another person (for example, a parent or carer), may give an address on a patient's behalf.

7. Where a patient cannot or chooses not to, give either a current or recent address, and an address cannot be established by other means, they should be treated as usually resident in the place where they are present.

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[51] under sections 21 and 29 of the National Assistance Act 1948

[52] 'Ordinary residence: guidance on the identification of the ordinary residence of people in need of community care services, England' (April 2011) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113627

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