Who Pays?
Establishing the Responsible Commissioner

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Contents

Scope and purpose of this guidance.

1. This document sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, i.e. determining who pays for a patient's care. The legal framework relating to secondary care commissioning responsibilities for Primary Care Trusts (PCTs) is set out in regulations 3(7) to (10) of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (S.I. 2002/2375**)** as amended by S.I. 2002/2548, 2003/1497, 2006/359 and 2007/559 ("the Functions Regulations"). This document is intended to provide guidance on the application of that legal framework to particular situations. The guidance is set out in three sections:

   Section 1: Establishing who pays - sets out the key principles

   Section 2: Applying the key principles - gives further details about a number of services and situations where further clarification of how the key principles are applied may be helpful

   Section 3: Exceptions to the key principles - outlines the exceptions to the key principles eg. prisoners, continuing care arrangements

Guiding principles

2. 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 PCT is responsible for funding an individual's healthcare provision.**

3. In general, the responsible commissioner will be determined on the basis of registration with a GP practice or, where a patient is not registered, their place of residence. See paragraph 6 below.

4. From 2007-8 new contractual arrangements mean that hospital trusts are moving to a situation where they have a single contract with a single co-ordinating PCT (normally the geographical host PCT). Other PCTs who wish to commission from the provider will be an "associate" party to the single contract. However, SHAs have flexibility to apply this principle to fit their circumstances. In some SHA areas, providers might have separate co-ordinators for each SHA community (up to a maximum of 10 contracts). This is likely to rationalise over time as the concept of co-ordinating PCTs becomes established. **Co-ordinating PCTs are in no way responsible for funding the care of patients of their associate PCTs**.[1]

[1] The NHS Contracts for 2007/8 and guidance on the NHS contract for acute hospital services 2007/08, DH, 21 February 2007

5. 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. **Ministers have specifically asked to be advised of NHS bodies who are unable to reach local resolution to any disputes between themselves or with independent providers.**

Section 1: Establishing who pays

This section discusses how to establish which PCT is responsible for paying for a patient's care and treatment.

General Principles

6. The general principles for establishing the responsible commissioner for NHS treatment of an individual patient (as set out under regulation 3(7) of the Functions Regulations) are as follows:

- Where the patient is registered on the list of NHS patients of a General Practitioner (GP) practice, the responsible commissioner will be the PCT that holds the contract with that GP practice.
- If a patient is not registered with a GP practice, the responsible commissioner will be the PCT in whose geographic area the patient is 'usually resident'. See Annex A for more details.
- If a patient is unable to give an address, the responsible commissioner will be determined in accordance with the Functions Regulations as the PCT in which he/she is present, which will usually be the PCT where the unit providing the treatment is located.

7. Where a GP practice has patients resident in more than one PCT area, the current rule is that the practice will be associated with the PCT in which the largest number of the persons registered with the members of the practice reside. That PCT will then exercise the relevant commissioning functions on behalf of the practice as a whole. PCTs are however able to enter into local arrangements whereby another PCT, such as the PCT in whose area the minority of practice patients reside, agrees to exercise functions on behalf of the responsible PCT.

8. Local Authority responsibility is determined by residence. Further information on Local Authority residence issues can be found in the circular 'Ordinary Residence' (LAC 93[7]).

Resolving disputes

9. The Department expects that all disputes will be resolved locally, ideally at PCT level, using the general principles above to come to pragmatic solutions where responsibility is not immediately obvious or where it may be shared. In cases that cannot be resolved at PCT level, the Strategic Health Authority should be consulted and should arbitrate where necessary.

10. SHAs, as the local headquarters of the NHS, have a responsibility to resolve disputes that threaten the delivery of services within their geographical boundaries. Disputes involving PCTs from within two or more SHA boundaries should be resolved by the respective SHAs working together.

11. If, in exceptional circumstances, disputes cannot be resolved at SHA level, the SHA(s) involved should send a report on the case to the Department of Health, together with a proposed solution. Reports on cases where the SHA has not yet been involved, or it is not felt that full local negotiation has been undertaken, will not be accepted – contact with the Department of Health should only be considered as a very last resort. Reports should be addressed to:

    Recovery and Support Unit
    Department of Health
    Room G32
    Richmond House
    71 Whitehall
    London
    SW1A 2NS

Section 2: Applying the principles in specific examples

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

Transplant

12. Where a person receives a transplant from a living donor (e.g. kidney or bone marrow transplant) and a contract / service agreement does not exist to cover the procurement of the donor organ, the PCT of the recipient of the donation should be responsible for funding the procedure (and the reimbursement of out of pocket donor expenses such as loss of earnings) unless alternative arrangements are already in place between the commissioners. Living donor adult to adult liver transplants and living donor adult to child transplants are commissioned by the London SHA with the advice and support of the National Commissioning Group (NCG).[2] In these cases, donor costs are included in NCG contracts/service level agreements with providers.

13. The NCG also funds a number of other transplant procedures. These are: liver transplant, paediatric and adult small bowel transplants, bone marrow transplants for Severe Combined Immuno-Deficiency Syndrome (SCIDS), pancreas transplants, heart and lung transplants and stem-cell transplants for Juvenile Idiopathic Arthritis. For these services, NCG funds the costs of the transplant episode itself together with other transplant related costs including assessment, organ retrieval, long-term transplant follow-up and the first three months of post-transplant drug therapy.

Specialised services

14. For specialised services PCTs are required, through their Specialised Commissioning Groups (SCGs), to enter into collaborative commissioning arrangements supported by financial risk-sharing. For these specialised services covered by SCG collaborative arrangements, a lead PCT, as agreed by the relevant SCG, will be delegated to discharge the commissioning function for all the PCTs within the SCG; this will include the payment of providers. However, ultimate responsibility will continue to rest with the Responsible PCT as defined in paragraphs 6-8 above.

Emergency recompression treatments

15. Emergency recompression treatments (use of elevated pressure to treat conditions within the body after it has been subjected to a rapid decrease in pressure, including hyperbaric oxygen therapy) are an unusual case because the treatments are primarily provided by non-NHS bodies. **However, responsibility for funding should be established in the usual manner.** Funding for emergency treatment should not be refused where there is evidence of effectiveness for particular conditions.

[2] From 1 April 2007 the National Commissioning Group (NCG) [formerly known as the National Specialised Commissioning Advisory Group (NSCAG)] became part of the NHS rather than the DH and became hosted by London Strategic Health Authority. National specialised services are now commissioned by the London SHA (on behalf of all 10 SHAs) with the advice and support the NCG. The NCG (ie. London SHA) will continue to commission services nationally for extremely rare conditions or very unusual treatments and advise Ministers on national provider designation status.

Asylum seekers

16. 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) as a member of the resident population. Therefore, the responsible commissioner will be subject to the same principles set out in this guidance.

Persons of 'no fixed abode'

17. Where a patient has 'no fixed abode' and they are not registered with a GP practice, the responsible PCT should be determined by the terms of the 'usually resident' test (see Annex A). 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.

18. Every effort should be made to establish an address of usual residence. If a patient is unable to give an address, the responsible commissioner will be determined in accordance with the Functions Regulations as the PCT in which he is present, which will usually be the PCT where the unit providing the treatment is located (see Annex A).

Patients who move

19. Where a patient moves during the course of treatment, every effort should be made to ensure continuity of care. The responsible PCT should be determined as laid out above. However, in some instances PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by the originating PCT exercising functions on behalf of the receiving PCT for a specific length of time.

20. As a general rule, where a patient moves during the course of a high cost treatment (e.g. continuing care patient or 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 PCT should be borne by the originating PCT. Any costs incurred after the agreed date for the transfer of responsibility to the receiving PCT should be picked up by the receiving PCT.

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

22. 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 PCT should liaise at the earliest opportunity with the receiving PCT to ensure continuity of healthcare and to agree appropriate transfers of funding.

Situation	PCT A	PCT B	Responsible Commissioner
Patient not yet moved	Registered and resident	-	PCT A
Patient moved	Registered	Resident	PCT A
Patient moved	De-registered	Resident but not yet registered	PCT B
Patient moved	-	Registered and resident	PCT B

People taken ill abroad

23. If a person entitled to free NHS treatment is taken ill abroad, necessary treatment on return to the UK will be subject to the same principles set out above. If it is not possible to determine GP practice registration or establish a resident address by the usual means, the responsible commissioner should be determined in accordance with the Functions Regulations as the PCT in which he is present, which will usually be the PCT where the unit providing the treatment is located (see Annex A). In all cases it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

24. A person not usually resident in the UK, however, may have neither a GP practice registration nor a resident address. In these circumstances the address at which they were last resident in England will usually establish the PCT of residence. If not, however, the responsible commissioner should be determined in accordance with the Functions Regulations as the PCT in which he is present, which will usually be the PCT where the unit providing the treatment is located (see Annex A). Again, in all cases, it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

25. It is particularly important to identify a service commissioner for a person who becomes mentally ill whilst living abroad. Wherever possible, the principles outlined in paragraph 23 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 PCT covering the location of that unit will become the responsible commissioner.

Looked after children

26. 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 (section 22). They fall into four main groups:

- children who are accommodated under a voluntary agreement with their parents (Children Act 1989 - section 20);
- children who are subject to a care order (section 31) or interim care order (section 38);

- children who are the subject of emergency orders for the protection of the child (sections 44 and 46); and
- children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

27. The responsible PCT should be established by the usual means (paragraphs 6-8).

28. When a child is first placed by a Local Authority they have a shared responsibility with the relevant PCT or NHS Trust to ensure a full health assessment takes place and that a health plan is drawn up. The relevant PCT should be informed in writing by the responsible Local Authority 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 relevant PCT should be notified within two weeks or as soon as reasonably practicable.

29. Guidance setting out a framework for the delivery of services from health agencies and social services to promote more effectively the health and well-being of children and young people in the care system can be found on the DH website[3].

Out of area placements of children and young people

30. The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England)(Amendment) Regulations 2007 (referred to in this guidance as "the 2007 amending Regulations") which came into force on 1 April 2007, introduced changes to the PCT responsible for commissioning or providing secondary healthcare type services. The amendments relate to four groups (listed below – A to D) of children and young people up to the age of eighteen where arrangements are made to place the child/young person in accommodation in the area of another PCT for secondary healthcare type services, or Local Health Board in Wales. In summary, the changes mean that where a PCT or a local authority, or a PCT and a local authority acting jointly, arrange such accommodation, the "originating PCT" remains the responsible PCT for secondary healthcare type services, even where the child changes their GP practice. The "originating PCT" is the PCT that makes such an arrangement in the exercise of its functions, or the responsible PCT immediately before a local authority makes such an arrangement. As a matter of good practice, the originating PCT should notify the PCT in whose area the child is being placed.

31. The 2007 amending Regulations only apply to arrangements made after 1 April 2007 and are not retrospective. Arrangements for primary healthcare services are unchanged i.e. they are determined by GP registration (see paragraphs 6-8).

32. For children placed by a local authority in accommodation in the area of another PCT or a Local Health Board in Wales prior to 1 April 2007 and then moved again by the local authority to accommodation in a different area after 1 April 2007, the responsible PCT

3 http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en

will be the PCT in whose area the local authority is situated. This promotes consistency with the principle of the responsible commissioner being the PCT coterminous with the placing local authority. If there is more than one such PCT, the PCT responsible is the PCT that was responsible for providing services to the child immediately before the local authority placed the child.

33. The four groups of children are:

A. Looked After Children and Children Leaving Care

34. If a looked after child or child leaving care is moved out of the PCT area, arrangements should be made through discussion between the "originating PCT", those currently providing the healthcare and the new provider to ensure continuity of healthcare. PCTs 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.

B. Pupils with statements of special educational needs attending Residential Special Schools

35. 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 PCT determined through the usual means.

36. After 1 April 2007, 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 PCT or Local Health Board, the responsible commissioner remains the "originating PCT", even though the child is likely to register with a GP practice in the locality of the special school in a different PCT area.

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

37. The 2007 amending Regulations make provision to determine the responsible commissioner, when arrangements are made to place a child with continuing healthcare needs in another PCT area or a Local Health Board area in Wales, to meet those needs. If the conditions outlined in the Regulations are satisfied, the responsible PCT will be the "originating PCT". 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 PCT 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 PCT to work with the "originating PCT" and the provider to ensure continuity of high quality, timely care for the child or young person.

D. Young adults with continuing healthcare needs

38. When a young person who has been placed in accommodation in another PCT area to meet their continuing care needs reaches 18 years of age, the Regulations describe the circumstances 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 PCTs and local authorities providing continuing care needs may be higher for adults than it is for children, young people approaching their 18th birthday will require a reassessment of their health and social care needs as part of their transition planning. Wherever possible, these young people should continue to receive their healthcare on an unchanged basis pending this assessment.

Boarding school pupils

39. Pupils attending boarding schools should be considered to be the responsibility of the PCT determined through the means laid out in paragraphs 6-8.

NHS walk-in centres

40. Access to treatment in NHS Walk-in Centres is not dependent on either residence or registration. Responsible commissioner issues therefore arise, which were masked during the period when most NHS Walk-in Centres received central funding. The NHS Walk-in Centre review was established to devise sustainable funding arrangements that took account of responsible commissioner issues and in particular to advise on a suitable tariff to enable cross-charging. The review will report shortly.

41. The expectation is that PCTs should pay for services provided to their patients. As with decisions affecting other services in this guidance set out in paragraphs 6-8 above, the decision should be based firstly on where the patient is registered with a GP. For unregistered patients, who make up a significant proportion of patients in some NHS Walk-in Centres, the responsible commissioner is the PCT in whose area the patient normally resides. These issues will be considered in more detail in the NHS Walk-in Centre review report.

Choice of secondary care provider

42. As part of the referral process to secondary care, all patients are now offered a choice of locally commissioned services or a provider from the extended choice network. From April 2008, patients can choose any hospital that meets NHS standards and cost. It is the PCT's responsibility to maintain a list of patients accepting choice and the provider giving the treatment. The responsible commissioner should be established in the usual manner, using paragraphs 6-8, irrespective of the location or status of the provider.

43. In the case of a patient moving from one PCT area to another PCT area between referral and treatment, responsibility should transfer in the usual fashion (see paragraphs 19-22 on people who move). PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by one PCT exercising functions on behalf of the responsible PCT for a specific length of time.

Emergency ambulance services and non-emergency Patient Transport Services (PTS)

44. PCTs are responsible for commissioning ambulance and other patient transport services. The responsible commissioner differs according to whether the travel concerned is deemed an emergency or not. 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 PCT is determined in the normal fashion (see paragraphs 6-8). In contrast, the PCT in 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 PCT in which the referring hospital is based pays. See paragraph 108 below.

45. More detailed guidance on PTS provision has been issued by the Department of Health[4].

Non-contract activity

46. Non-contract activity (NCA) relates to NHS services provided outside of contracts[5]. Providers should invoice responsible commissioners for NCA quarterly, within 30 days of the quarter end, and supporting information must include the contract minimum data set[6]. These invoices should cover all activity completed within the quarter on behalf of each commissioner rather than invoicing for each patient separately. The responsible commissioner should be established in the usual manner, using paragraphs 6-8, irrespective of the location or status of the provider.

47. In this context, contracts are defined as any pre-agreement – including Service Level Agreement (SLA) – between a provider and commissioner for the provision of healthcare, irrespective of the value of the agreement (it could even be of zero value). Moreover, the NCA 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. emergency treatment provided whilst a patient is travelling within the UK).

48. Where elective activity is provided outside of contracts, this should be exceptional and patient referral should automatically be regarded as the authorisation to treat. No additional pre-treatment agreement is needed unless prior approval arrangements specified in the provider's contract with its co-ordinating PCT cover the circumstances of the referral. It is the commissioner's responsibility to ensure that providers working on its behalf adhere to local referral and treatment protocols. Treatment should never be

[4] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_062676

[5] 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.

[6] This information should also be submitted via the Payment by Results Secondary Uses Service (PbR SUS) operated by *NHS Connecting for Health*.

refused or delayed due to uncertainty or ambiguity as to which PCT is responsible for funding an individual's healthcare.

49. It is good practice for providers to put in place administrative systems to identify elective NCA 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 NCA.

50. The prices for NCA 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[7].

51. Disputes over payment for NCA should be resolved bilaterally, between provider and commissioner and may be referred to mediation or adjudication at the request of either party and in line with the provisions of the national model contract.

52. These arrangements may be applied to NCA involving cross-border patient flows within the UK (e.g. cross border emergency treatment) by establishing the responsible commissioner in line with the guidance under Section 3 on 'Cross border issues within the UK' (see paragraph 58 below).

Charge-exempt overseas visitors

53. For charge-exempt overseas visitors the payments arrangements are as follows:

- no pre-treatment agreement needed;
- the treating trust to invoice the host PCT and include the same costs on the IGA form, which should be sent to Leeds PCT in line with Payment by Results payment arrangements;
- invoices to be sent once a quarter in line with Payment by Results payment arrangements;
- one invoice per patient;
- payment to be made within 30 days of receipt of invoice; and
- dispute resolution to be between the provider and host PCT.

54. Under the current mechanism the amount to be charged for charge-exempt overseas visitor is as for non-contract activity and is dependent on which category the activity falls into.

55. A review of the processes for payment for charge-exempt overseas visitors will be conducted in 2007/08.

[7] http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/NHSFinancialReforms/index.htm

Section 3: Exceptions to the key principles

This section gives details of those services and situations which are to a greater or lesser extent exceptions to the principles laid out in section 2.

NCG commissioned services

56. Certain highly specialised services are commissioned nationally by the London SHA with the advice and support of the National Commissioning Group (NCG – formerly the National Specialist Commissioning Advisory Group (NSCAG))[8].

57. For services for which the NCG (ie. London SHA) is the responsible commissioner, NCG is also responsible for charge-exempt overseas visitors who require services covered by the NCG commissioning arrangements and funded through the NCG central budget. All such activity should be notified to Leeds PCT using an Income Generation Audit (IGA) form. The form should be marked 'NCG', but the activity does not need to be costed.

Cross border issues within the UK

58. Legislation for Wales, Scotland and Northern Ireland provides that the responsible authority for an individual's healthcare provision is the one where a person is usually resident and is not based on GP practice registration as provided by English legislation.

59. In the case of persons resident in Scotland but registered with a GP practice in England, Scotland is the responsible commissioner[9]. This applied from 1 October 2002 when the Functions Regulations[1] came into force. From 8 July 2003, for patients who are resident in England but registered with a GP practice in Wales, Scotland or Northern Ireland, the responsible commissioner is the English PCT in whose area the patient is resident[10].

60. If a patient is resident in Wales and registered with a GP practice in England or resident in England and registered with a GP practice in Wales, both Wales and England could be deemed responsible. In February 2005, an interim protocol was developed between DH and the Welsh Assembly Government (WAG) for patients living on the England and Wales border which ensures that the responsible commissioner is determined by registration in all cases. This was renewed in January 2006[11] and again in March 2007[12] and is currently active until the end of March 2008. The protocol applies to those living in Flintshire, Wrexham, Powys, Monmouthshire, Denbighshire, Cheshire West, Shropshire County, Herefordshire, Wirral and Gloucestershire. Work is continuing between the Welsh Assembly Government and the Department of Health to agree and

[8] From 1 April 2007 the National Commissioning Group (NCG) [formerly known as the National Specialised Commissioning Advisory Group (NSCAG)] became part of the NHS rather than the DH. It will continue to commission services for extremely rare conditions or very unusual treatments nationally and to advise Ministers on national provider designation status. Full details of the services commissioned by the NCG are given at: http://www.advisorybodies.doh.gov.uk/NSCAG/index.htm. This website address will be changing in the summer of 2007 to become www.ncg.nhs.uk.

[9] See S.I. 2002/2375 where the definition of "practice patients" excludes residents in Scotland.

[10] See S.I. 2003/1497, amendment to S.I. 2002/2375

[11] See http://www.wales.nhs.uk/documents/WHC_2006_005.pdf

[12] http://www.wales.nhs.uk/documents/WHC(2007)036.pdf

finalise the financial framework at a national level. Local health organisations are strongly encouraged to enter into discussions and negotiations locally in order to agree appropriate arrangements in line with the interim protocol, especially in cases where organisations are considering placing high cost cases across a border.

61. These exceptions to the general principles should be applied to establish the responsible commissioner when invoicing for activity outside of contracts and involving cross-border patient flows within the UK (e.g. cross border emergency treatment), as per the guidance at Section 2 on 'Non-Contract Activity' (paragraphs 46 to 52).

62. There are specific cross border arrangements for NCG commissioned services[13].

63. The NHS Strategic Tracing Service (NSTS) is currently available to providers in England and Wales to determine the responsible commissioner for patients in England. The NSTS is a national (England and Wales) database of people, places and NHS organisations[14].

64. This process involves producing a file in the agreed format on one of the many approved media types and sending it to Atos Origin (the NSTS service provider). The file will be returned complete with, wherever possible, the NHS numbers of relevant patients and their latest recorded administrative details.

65. For Scotland and Northern Ireland, we plan to issue further guidance regarding the availability of NSTS for their providers. However, before this happens, where providers of Northern Ireland and Scotland have the information from the patient to determine the responsible commissioner in England, they should invoice them. If they cannot determine the responsible commissioner, they should invoice the resident English PCT of the patient for payment. This information is available on the NHS choices website[15].

66. If the resident PCT is not the responsible PCT then the resident PCT needs to inform the respective provider of Scotland or Northern Ireland of this and confirm who the responsible PCT is.

67. Where a PCT is sent an invoice for which they are only partly responsible, they should pay the provider the relevant amount of the initial invoice and inform the provider of the Devolved Administration who is/are the responsible commissioner(s) of any patients for whom they are not responsible. PCTs should not request new invoices for activity where they are required to pay only part of the initial invoice they receive.

68. An example here is if a provider in Scotland or Northern Ireland were to invoice a resident PCT for ten patients for emergency activity but only nine patients are that PCT's responsibility. The PCT should then pay the provider for the activity for the nine patients and inform the provider that the remaining patient is the responsibility of another PCT.

[13] See http://www.advisorybodies.doh.gov.uk/NSCAG/index.htm This website address will be changing in the summer of 2007 to become www.ncg.nhs.uk.
[14] This service is available at the following website: http://www.connectingforhealth.nhs.uk/nsts
[15] See http://www.nhschoices.nhs.uk

Patients who move across borders within the UK

69. 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 and so determine the responsible PCT for that individual's care. 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 under the Functions Regulations[13]. In instances after 8 July 2003 where the patient has moved across a border into England but has not yet de-registered from their previous practice, the responsible commissioner would be the English PCT in whose area the patient is resident. See paragraphs 88-93 for details of changes to commissioning responsibilities made under regulations introduced from 1 April 2006 for patients being moved out of one PCT to another under the 'continuing care' arrangements.

70. 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 PCT should be determined as laid out in paragraphs 6-8. However, in some instances PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by the originating PCT exercising functions on behalf of the receiving PCT for a specific length of time.

71. A protocol[16] has been drawn up by the Welsh Assembly Government and the Department of Health in England for transfers of patients to care homes providing NHS funded nursing care between Wales and England based on the default position of usual residence. The protocol is a basis for local solutions to ensure that all patients receive the services which they are assessed as needing and does not override the Functions Regulations.

Military personnel

72. Upon enlistment, PCTs are required to de-register members of HM Forces from the lists of GP practices, and they should not be able to re-register until they have been discharged. During this time, the MoD is responsible for their primary medical services through Defence Medical Services (DMS), which has specific contractual and entitlement arrangements with the NHS.

73. This does not apply to dependants of HM forces members, who can remain registered with a GP practice or apply to join a list of patients 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.

74. 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. They usually do so when

16 See: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/NHSFundedNursingCare/NHSFundedNursingCareArticle/fs/en?CONTENT_ID=4000400&chk=DgtViy

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.

75. HM Forces members should also be able to access emergency or immediately necessary treatment from GP practice in the same way as anybody else (see paragraph 10 of Annex B).

76. Members of HM Forces (and other military personnel, including NATO personnel and their dependants) based in the UK are entitled to the full use of NHS facilities on the same basis as civilians if appropriate military healthcare provision is not available. Equally, members of HM Forces serving overseas are also entitled to full use of NHS hospital facilities without charge. PCTs are responsible for securing the provision of secondary care treatment for such personnel. The cost of treatment is the responsibility of the relevant PCT, determined through the means laid out in the section headed 'General principles' (paragraphs 6-8).

77. As specified in NHS (Charges to Overseas Visitors) (Amendment) Regulations 2006, the spouse, civil partner or child of the member of HM Forces serving overseas is also entitled to full use of NHS hospital facilities without charge. Their care should be funded by the PCT that covers the secondary care unit providing the treatment.

78. Personnel who are discharged from HM Forces and who are undergoing a continuing care package should be dealt with in a similar way to those who move (see paragraphs 19-22), in order to ensure continuity of care.

Prisoners

79. New arrangements came into force in April 2003 requiring that PCTs with prisons in their catchment area to commission the majority of secondary care services for those prison populations[17]. This is separate from, but complementary to, the shift of commissioning responsibility for the totality of prison healthcare to PCTs. As of April 2007, PCTs have also taken on responsibility for funding the security costs associated with healthcare escorts and bedwatches for prisoners[18].

80. Since April 2003, GP practice registration (if any) is disregarded for persons who are detained in prison. The PCT in which the prison is located is responsible for commissioning NHS services for those prisoners, including NHS dental services.

81. For those usually resident outside the United Kingdom, the responsible commissioner will be the PCT in which the prison is located. Persons usually resident overseas held in English prisons are exempt from charges for NHS hospital treatment. There is no centrally held budget for this group and costs should be borne by the PCT in which the prison is located.

[17] See S.I. 2003/1497 and NHS Responsible Commissioner for Prisoners Update, June 2003 - www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084145

[18] Escort and Bedwatch Costs: Transfer of Responsibility from HM Prison Service to PCTs - www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_072316

82. The responsible commissioner for the commissioning of psychiatric hospital care for people transferred from prison to hospital under sections 47 or 48 of the Mental Health Act will be determined in the usual way as set out in the Functions Regulations. This arrangement also applies for the funding of any assessment of an individual to access the NCG-commissioned secure forensic mental health service for young people. For prisoners not registered with a GP practice, and for whom a previous address cannot be determined, usual residence should be interpreted as being in the area in which the offence for which he/she is detained was committed. Alternatively, if detained pending trial, the area where the offence with which he/she is charged was committed. For persons usually resident outside the United Kingdom, responsibility will remain with the PCT in which he is present, which will usually be the PCT in which the prison is located (see Annex A).

83. PCTs and prisons have been given further guidance[19] on the changes. However, prior to April 2003, the responsible PCT for prisoners was determined by the usual means.

Persons detained under the Mental Health Act 1983[20]

84. If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be subject to the same principles set out in paragraphs 6-8. Every effort should be made to determine GP practice registration or establish a resident address, but if this is not possible, the responsible commissioner should be determined by the location of the unit providing treatment. Therefore, in this context, the PCT in which the facility is located becomes the responsible commissioner for these purposes. The responsible commissioner for the provision of 'after-care' services under Section 117 of the Mental Health Act 1983 is determined according to Section 117 (see HSC 2000/003) and not under the arrangements explained in paragraphs 6-8.

85. Under section 117 case law (R v Mental Health Review Tribunal ex parte Hall) [1999] 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 with ordinary residence 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.

86. Where a patient is discharged to their area of residence prior to detention for treatment, the arrangements outlined in paragraphs 6-8 would apply in most cases. The only variation would be if the patient were registered with a GP in another area. Under the relevant case law, responsibility for provision of after care under section 117 is determined solely by the area of residence of the patient, not the location of the GP.

87. 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

[19] See: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/fs/en
[20] See S.I. 2002/546

health problems the arrangements set out in paragraphs 6-8 for identifying the responsible commissioner apply.

Transfer of patients to other PCT areas under 'continuing care' arrangements

88. 'Continuing care' refers to care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as the result of disability, accident or illness[21]. 'NHS Continuing Healthcare' means a package of continuing care arranged and funded solely by the NHS. [22]

89. The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2006 (referred to in this guidance as "the amending Regulations")[23], which came into force on 1 April 2006, introduced changes to the PCT responsible for the NHS contribution to packages of long-term care for adults with certain care needs who are placed in a care home or independent hospital in the area of another PCT. In summary, the changes mean that where a PCT ('the placing PCT') arranges such a placement, whether on its own or jointly with another body (eg a local authority), the placing PCT remains responsible for the NHS's contribution to the care, even where the person changes their GP practice (and associated PCT). 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 paragraphs 6-8.

90. The arrangements cover NHS Continuing Healthcare placements. They also apply to joint packages of residential care arranged and funded by both the NHS and local authorities, provided that the NHS contribution consists not only of NHS funded nursing care, but that it also includes at least one other service which is a planned service. A need for care from a registered nurse would not be sufficient to trigger the new commissioning rules.

91. A decision by a placing PCT to place a patient requiring continuing care in a care home or independent hospital in another PCT area should be made after the PCT where the care home or independent hospital is located 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. When commissioning services for people with learning disabilities, commissioners should be mindful of DH guidance 'Commissioning services close to home' (2004)[24]. This provides clarification on the policy framework for commissioning learning disability services and emphasises the key principle that local needs should be addressed by local expertise and resources. For all services, there should always be communications between the two PCTs to ensure clarity over responsibilities and to avoid any potential for duplicate payments to the care home.

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[21] See regulation 2 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 S.I. 2002/2375 (as amended).
[22] See *The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care in England*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288
[23] See: http://www.opsi.gov.uk/si/em2006/uksiem_20060359_en.pdf
[24] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4093322

92. For joint packages of care, where local authorities are placing residents who have health needs, they should work closely with the placing PCT 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. PCTs 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. (Please refer to Annex C for further details on how the changes introduced by the amending Regulations will affect commissioning practice).

93. 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 PCT currently providing those services and the PCT responsible for them after they move. The responsible commissioner for such care is determined in accordance with paragraphs 6-8. In order to ensure continuity of care and ensure that arrangements represent the best interests of the patient, PCTs may need to come to an agreement about how services should be delivered. In particular, PCTs will wish to consider flexible solutions, such as whether patient care should be provided by another PCT exercising functions on behalf of the responsible PCT.

Registered nursing care

94. From 1 April 2003 (except where the nursing care services are such that they do not need to be provided by a registered nurse) the NHS became responsible for the nursing care provided by a registered nurse to all care home residents (including those placed by local authorities). Provision should be made following a multidisciplinary assessment and determination of nursing need in line with the single assessment process for Older People (HSC 2002/001:LAC 2002/1). Where placements are made by PCTs to care homes outside the area of the PCT of the patient's registered GP practice, that PCT should notify the PCT in whose area the patient will be registered when they enter the care home. This will assist the receiving PCT in funding and planning the nursing care services for its area. This principle should also apply to any future moves.

Immigration detainees

95. Where a person who is not usually resident in the UK is detained on grounds connected with their immigration status, the responsible commissioner should be determined by the address of the unit providing treatment. In this context, the PCT in which the facility is located becomes the responsible commissioner.

Hosted services

96. At a local level, some services have in the past been designated host services, available to all comers regardless of their residency but funded by an individual, 'host' PCT. The two most commonly hosted services are A&E and genito-urinary medicine (GUM) clinics and community contraceptive services.

97. Health reforms such as Practice Based Commissioning create incentives for commissioners to redesign services, for example by improving access to urgent & emergency care. Host funding of services such as A&E and GUM can be inconsistent with this strategy because it offers no reward to commissioners for improving access to

these services closer to people's homes. In fact, there may be perverse incentives for commissioners not to invest in these services on behalf of their populations because money doesn't follow the patient.

98. Payment by Results aims to ensure that money follows the patient based on a national tariff. Better information flows and the availability of national tariffs for A&E and GUM services means that in principle they no longer need to be hosted. Where local arrangements are in place for 'host' funding of A&E and GUM services these may undermine incentives for commissioners and should be phased-out.

99. For these reasons, this guidance supports the direction of travel set out in the recent consultation[25] on the future of Payment by Results (PbR), which proposed that SHAs take action to 'de-host' relevant services in their areas, managing the financial impact across their patches and considering appropriate risk-pooling arrangements for activity where the responsible commissioner cannot be identified.

Sexual health

100. The National Sexual Health and HIV Strategy (2001) encouraged a greater integration of sexual health services. De-hosting should encompass all local open access sexual health services.

101. There are particular issues around patient confidentiality which are raised by sharing information on the use made of sexual health services. Annex B of the PbR consultation[26] notes that the Department of Health will work with the independent advisory group for sexual health and HIV and the patient information advisory group to resolve these issues. Definitive guidance will be issued separately.

102. In the interim PCTs should implement cross-charging with agreement from their SHA, subject to the acceptance of two principles. The first, is that providers must maintain an auditable trail of patient activity, although this must be anonymised before it leaves the service. The second, is that it is important to share only data appropriate and necessary for determining the responsible commissioner and allocating the appropriate national tariff or local price.

103. In line with the guiding principles set out at paragraphs 6-8, recharges should be on the basis of GP registration. However, it is accepted that patients may not wish to disclose this data, and therefore, PCT of residence should also be accepted.

NHS dental services

104. Since 1 April 2006, PCTs have been responsible for commissioning primary care dental services, including all specialist dental services (e.g. orthodontics, sedation, etc.) provided in a primary care setting, for the benefit of all persons choosing to access these services in the PCT area[27]. All funding for these services has been devolved to PCTs on this basis. PCTs also now have a responsibility for providing or securing, to the

[25] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_073103
[26] ibid.
[27] See S.I. 2005/3477 (and amendment S.I. 2006/1837), S.I. 2005/3361 and S.I. 2005/3435.

extent that they consider necessary, oral health programmes, dental inspection of pupils in maintained schools, and oral health surveys.

105. Specialist dental services within primary care, including those services provided by Dentists with Special Interests, need to be managed and developed through explicit commissioning arrangements that take account of the particular characteristics of the service, its patients and changes in demand. Further guidance on commissioning specialist dental services has been published[28].

106. The responsible commissioner for dental services provided in a hospital setting (such as a dental hospital) that do not meet the definition of primary care dentistry included in the 2003 Act will be determined as in paragraphs 6-8.

107. With respect to cross-border issues within the UK, PCTs should apply the principles outlined in paragraphs 58-68. PCTs' baseline budgets for primary care dental services, established in April 2006, were based on where patients presented for services during the baseline period rather than where they were resident. Since this time, PCTs have been able to develop new services targeted to specific groups of patients, including restricting access to some services to local residents. In areas where there has historically been a considerable flow of patients across borders, PCTs are strongly advised to work with their counterparts in Wales/Scotland in order to ensure patients are clear about which dental services they are able to access.

Emergency ambulance services

108. As noted in paragraph 44 above, in the case of emergency transport and critical care transfers between NHS trusts, the responsible PCT is either the PCT within whose boundaries the incident took place or, where a patient being referred as an urgent / emergency case from one hospital to another hospital, the PCT in which the referring hospital is based.

[28] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123971, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139176 (orthodontics), and http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065500 (sedation).

Annex A: Defining ‘usually resident’

It is important to note that the ‘Usually Resident’ test must only be used to establish the responsible commissioner when this cannot be established through GP practice registration

Primarily, the arbiter of the patient's residence is the patient.

1. The principle is that the patients’ perception of where they are resident (either currently, or failing that, most recently) is the criterion.

2. Certain groups of patients, for example those with HIV or AIDS, may be reluctant to provide an address. It is sufficient for the purpose of establishing financial responsibility that a patient is resident in a location (or postal district) within the PCT 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 are not considered as “usual” residences.

3. Under regulation 3(8) of the Functions Regulations, if there is any doubt over an individual's district of residence, the address that they give as where they usually reside should be used. 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, then the address at which they were last resident will establish the PCT of residence.

4. Where a patient is unable to, or incapable of, giving either a current or most recent address and an address cannot be established by other means eg by information from the next of kin, then a patient's district should be taken as being that in which the unit providing the treatment is located. Questions to establish an address of usual residence should include the overseas patient charge baseline question ‘where have you lived for the last 12 months?’ and those who have not been in the UK for this period should be asked further questions to establish their liability for overseas patient charges.

5. Patients should not be subjected to undue scrutiny when being asked for this information, or be 'led' into giving an alternative address in order to exploit any perceived financial advantage.

6. Under regulations 3(8A) and (8B) of the Functions Regulations, special rules apply in relation to the usual residence of prisoners – see paragraphs 79-83 of the main guidance above.

Annex B: Eligibility for free NHS treatment

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

2. The fundamental principle is that necessary medical treatment should never be denied to any person, regardless of whether or not they are resident in the UK.

3. However, the NHS is primarily intended for people who are ordinarily resident in the UK. Therefore free NHS treatment is generally restricted to ordinary residents. The meaning of the words 'ordinarily resident' was considered by the House of Lords in 1982 in the case of Shah v. Barnet London Borough Council. The words may be briefly summarised as referring to a person who is living lawfully in the United Kingdom 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.

4. Please note however that these rules may be subject to change following publication on 7 March 2007 of *Enforcing the Rules: A strategy to ensure and enforce compliance with our immigration law*. This strategy includes a commitment by the Department of Health to review the rules governing access to the NHS by foreign nationals. That review is due to be completed by October 2007 and will include access to NHS Primary Medical Services and NHS hospital treatment.

5. The rules surrounding access to free treatment in primary and secondary care are summarised below.

Registration with a GP

6. Access to NHS services is usually obtained through registration with a GP practice, where a person will join either its list, or a PCT's list of NHS patients – depending on the contractual arrangements.

7. Registration with a GP practice gives patients access to Primary Medical Services as provided by the practice, however it does not give a patient automatic entitlement to free NHS hospital treatment (see paragraphs 11-13 below).

8. A GP practice has a designated area, which is agreed between the practice and the PCT, under its contract. Those living within that area may approach the practice and apply to register as a NHS patient. Practices have wide discretion in accepting applications, and may agree to take on patients living outside the practice area. This is a particular issue with regard to those people not ordinarily resident in the UK - see below paragraphs 11-13 . Practices may use their discretion to accept a person as either a registered NHS patient or temporary resident (see next paragraph). Where a person has been refused admission to the list, the practice can offer to treat them on a private, paying basis – outside the scope of its NHS contractual arrangements.

9. Any person who intends to be in an area for more than 24 hours but less than 3 months is regarded as **temporarily resident** in that place, and can apply to a GP practice to be accepted as a patient on a temporary basis. A person does not have to be registered (on a permanent basis) with a practice elsewhere in order to be accepted as a temporary resident. The practice which has accepted the person as a temporary resident will not be the determinant factor in establishing the responsible commissioner, which should be established under the principles set out in paragraphs 6-8 of the main guidance above.

10. GP practices are contractually required to provide **emergency treatment or treatment which in the clinical opinion of a healthcare professional is immediately necessary** (i.e. treatment by a person that cannot be reasonably delayed), to anyone who requests it, regardless of whether the person is registered with the practice or not or where the person comes from. The practice which has provided such treatment will not be the determinant factor in establishing the responsible commissioner, which should be established on the basis of the individual's permanent registration, or under the principles set out in paragraphs 6-8 of the main guidance above.

Eligibility for hospital treatment

11. Registration with a GP practice does not give a patient automatic entitlement to free NHS hospital treatment. Under the National Health Service (Charges to Overseas Visitors) Regulations 1989 (SI1989/306), as amended, people who are not ordinarily resident in the UK are (for the purposes of the Regulations) overseas visitors and are, subject to certain exceptions, liable to be charged for any hospital treatment they receive. It is the duty of the hospital to establish who is 'chargeable', and who is not. Further details of the circumstances in which patients may be charged for hospital services are set out on the Department website: http://www.dh.gov.uk/overseasvisitors

12. Patients who are not ordinarily resident in the UK, may nevertheless be exempt from charges under provisions of the Regulations. There are three broad categories of exemption:

    - **Those who could be considered part of the resident population**, and who could be registered with a GP practice and give a UK address. Examples are: people who have been in the UK lawfully for more than 12 months; people coming to the UK to take up lawful permanent residence; people who are employed or self-employed here; asylum seekers who have either been given leave to remain or have formally applied for leave for as long as that application is under consideration, including appeals; diplomatic staff; students on a course of at least six months duration or which is substantially funded by the UK Government; NATO personnel and their dependents.

    - **Those who are not part of the resident population**. Examples are: UK state pensioners spending more than three months a year overseas; some UK nationals working overseas; members of HM forces serving overseas; nationals of EEA countries and Switzerland plus people from countries with which the UK has a

bilateral healthcare arrangement. A list of such countries can be found on the Department of Health website[29].

- **Those requiring specified treatments**. There are no charges for treatment given to any overseas visitors in an A&E department, or an NHS Walk in Centre providing services similar to an A&E department, nor for compulsory psychiatric treatment or for treatment of certain communicable diseases, or for family planning services; or for treatment given in, or as a referral from a Sexually Transmitted Diseases clinic (with the exception of treatment for HIV/AIDS where only the test and associated counselling are free to all).

13. In each of these cases set out in paragraph 12 above, the responsible PCT should be determined as in paragraphs 6-8 of the main guidance above.

[29] http://www.dh.gov.uk/en/Policyandguidance/International/OverseasVisitors/Browsable/DH_4955480

Annex C: Transfer of patients to other pct areas under continuing care arrangements – changes to PCT commissioning responsibilities from April 2006

1. The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2006[30] came into force on 1 April 2006 and changed the PCT responsible for commissioning long-term continuing care for adults in certain situations. This annex provides guidance on the application of the new arrangements. It is not, nor is it intended to be, a comprehensive description of PCTs' responsibilities in this area and reference should be made to the Functions Regulations[31].

Background

2. These changes aim to regularise the PCT responsible for meeting the NHS's contribution to high cost packages of healthcare where a PCT enters into an arrangement for the provision of long-term residential care in another PCT area. This is so that there is no potential for the cost to fall solely on the PCT where the accommodation is located.

3. The amending Regulations do not alter the statutory responsibilities of other public authorities, such as local authority social services.

4. The changes are also designed, in part, to encourage PCTs to consider their strategy for placements and to work closely with other PCTs and local authorities, bearing in mind the overall benefit to patients.

Commencement

5. The new rules apply to placements arranged on or after 1 April 2006. They are not retrospective, nor are they time limited. For the majority of PCTs, these changes will serve to clarify the legal position in line with preferred commissioning practices which existed before April 2006 and will ensure that all PCTs commission services consistently.

Application

6. The changes to a PCT's commissioning responsibilities apply where a PCT has made an arrangement which involves placing a person assessed as requiring continuing care in a care home or independent hospital in another PCT area and the following services from NHS:

   - nursing care; and
   - at least one other service which is planned and arranged in response to the results of the assessment of his physical or mental health needs, and which is intended to bring about or to promote a specific outcome in relation to his treatment.

[30] S.I. 2006/ 359.
[31] See para 1 of this guidance for the meaning of the Functions Regulations.

7. So long as the person resides in a care home or independent hospital in another PCT area and continues to require the other services mentioned in paragraph 6 above, the placing PCT remains responsible for meeting the NHS contribution to the continuing care package, and hence, for securing the provision of the accommodation (where applicable), together with any related services required, including nursing care, even where this involves a change of accommodation (see below). The host PCT in these circumstances is not responsible for the NHS funded nursing care payment.

8. The new 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 social services authority only.

9. The PCT in whose area the accommodation is located ("the host PCT") will be responsible for providing or securing the provision of all other secondary care services for the person's benefit and for primary and dental services in the usual way.

NHS funded nursing care

10. For those patients assessed as needing NHS funded nursing care only at the time of the placement, the responsible commissioner will be determined in accordance with the principles set out in paragraphs 6-8 of the main guidance above.

11. Where a person who only requires nursing from the NHS is placed in residential care in another PCT area, the PCT responsible for providing the healthcare, including any nursing care component (NHS funded nursing care), is determined in the usual way based on registration with a GP practice. If the patient is not registered with a GP practice, the responsible PCT is determined by the person's usual residence. This should not restrict the patient's right to choose his or her own GP practice. Social services responsibility for persons assessed as requiring accommodation in a care home is covered in separate guidance.

12. It follows that, if a patient in a placement in another PCT area for whom the placing PCT continues to be responsible recovers and the one NHS service remaining is nursing care, then from the time his needs change, the usual rules would apply and the responsible commissioner would be determined as described in paragraphs 6-8 of the main guidance above.

13. In this situation, the placing PCT should contact the host PCT as soon as practicable and both PCTs should make appropriate arrangements to ensure that a suitable package of care is maintained until alternative arrangements, such as a change of accommodation, have been put in place by the new PCT.

Planned services

14. The term 'planned service' is defined in regulation 2 of the Functions Regulations. It refers to any NHS service which is planned and arranged in response to the results of an assessment of a person's physical or mental health needs and which is intended to bring about or to promote a specific outcome in relation to that person's treatment. Examples

of planned services would include physiotherapy, occupational therapy, speech and language therapy, dietetics and podiatry. This list is not exhaustive.

Assessment

15. The PCT responsible for assessing a person's healthcare needs prior to a placement being made will be determined in accordance with the the principles set out in paragraphs 6-8 of the main guidance above.

Monitoring and review

16. As the placing PCT continues to be responsible for the provision of the accommodation (where this is the responsibility of the NHS) and for all other secondary care services associated with the placement, it follows that this PCT continues to be responsible for reviewing the person's need for such services. This will include the NHS continuing healthcare assessment and NHS funded nursing care determination.

17. The placing PCT might want to make arrangements with the PCT in whose area the accommodation is situated to carry out case reviews on its behalf[32].

18. The placing PCT will also continue to be responsible for the quality of the NHS healthcare it commissions under the new arrangements even though the services are provided on its behalf in a care home or independent hospital in another PCT area[33].

19. Inspection and Monitoring of care standards by the Commission for Social Care Inspection (CSCI) or the Healthcare Commission will continue to follow the usual inspection process.

Changing health needs

20. As long as the conditions mentioned in paragraph 6 above are met, the placing PCT will continue to be responsible for arranging those services as long as the person is assessed as needing them. This applies even if the services cost more over time because of the patient's worsening condition or the patient requires different services. For example, occasions may arise when further services are identified at later case reviews in connection with the presenting condition that necessitated the original placement. In these cases, the services will also be the responsibility of the placing PCT who will continue to be responsible for monitoring and review of these services.

Move to alternative accommodation

21. If the patient needs to be moved to an alternative care home or independent hospital, following a case review, provided that the conditions mentioned in paragraph 6 are met, the original placing PCT would remain the responsible commissioner for the NHS services that make up the continuing care package. This will include accommodation where the patient is assessed as needed NHS continuing healthcare.

[32] See regulation 10 of the Functions Regulations.
[33] See Part 2, Chapter 2 of the Health and Social Care (Community Health and Standards) Act 2003 (c. 43).

22. If the patient no longer resides in a care home or independent hospital, for example, they move to the home of a family member or are transferred to in-patient care in an NHS hospital, the responsible commissioner in these circumstances is determined in accordance with the principles set out in paragraphs 6-8 of the main guidance above.

CASE STUDY

In May 2006, Mrs X, registered with a practice in PCT area A, suffered brain injury following a serious car accident. The PCT carries out a full assessment of Mrs X's health needs before her discharge from hospital. Mrs X is assessed as needed long-term continuing care in a specialist independent hospital located in the area of another PCT. She is also assessed as needing physiotherapy as well as requiring NHS nursing care.

The specialist hospital is located at some distance from the placing PCT who therefore contacts the host PCT where the specialist hospital lies to arrange for them to carry out regular reviews and monitoring on its behalf. At a review following Mrs X taking up residence in the hospital, a further 'planned service' is identified, speech and language therapy. The host PCT seeks agreement from the placing PCT for this additional service to be part of the commissioning package.

Disputes

23. Paragraphs 9-11 of the main guidance set out the procedure for resolving any disputes.