

## Who Pays?

Determining responsibility  
for payments to providers

August 2013



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## Who Pays?

# Determining responsibility for payments to providers

*Rules and guidance for commissioners*

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**Prepared by Commissioning Development Directorate, NHS England**

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<sup>1</sup> This document was published in draft in December 2012 – in anticipation of the commencement of section 26 (14Z7) of the Health and Social Care Act 2012 in February 2013.

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## Executive Summary

This document sets out the framework for establishing responsibility for commissioning an individual's care within the NHS and determining who pays for a patient's care.

Equality and diversity are at the heart of the NHS strategy. Due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it, has been given throughout the development of the policies and processes cited in this document.

The Health and Social Care Act 2012<sup>2</sup> amended the NHS Act 2006 ("the Act") to establish the legal framework for the new commissioning architecture for the NHS in England, including the responsibilities of the NHS Commissioning Board – now known as NHS England – and clinical commissioning groups (CCGs).

The Act<sup>3</sup> 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
- usually resident in the area covered by the CCG and not provided with primary medical services by a member of any CCG.

Regulations<sup>4</sup> 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 are responsible for commissioning health services to meet all the reasonable requirements of their patients, with the exception of:

- certain services commissioned directly by NHS England<sup>5</sup> (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 and some of their families who are registered with Defence Medical Services (DMS) GP practices);
- health improvement services commissioned by local authorities; and

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<sup>2</sup> <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

<sup>3</sup> Section 3(1A) of the 2006 Act as inserted by the 2012 Act

<sup>4</sup> Under section 3(1B) and 3(1D) (regulations available at <http://www.legislation.gov.uk/uksi/2013/350/made>)

<sup>5</sup> <http://www.legislation.gov.uk/uksi/2012/2996/contents/made>

- health protection and promotion services provided by Public Health England (PHE).<sup>6</sup>

These commissioning responsibilities include:

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

In most cases when commissioning health services, CCGs are 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<sup>7</sup>.

**Section A: General rules** - sets out the key principles.

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

**Section C: Exceptions to the rules** - outlines the exceptions to the key principles e.g. prisoners, continuing care arrangements.

**Section D: Scenarios** - provides examples of situations to support the rules.

**Annexes A & B** provide information on eligibility for free NHS treatment and defining 'usually resident'.

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

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<sup>6</sup> *Commissioning fact sheet for Clinical Commissioning Groups* (July 2012) sets out the services that CCGs are responsible for commissioning. It also sets out the complementary services commissioned by NHS England, local authorities and Public Health England (PHE) and is available at <http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf>

<sup>7</sup> Under the powers given to NHS England in section 14Z7 of the Act.

## Section A: General rules

### Identifying which CCG is responsible for commissioning and paying for care

1. The general rules – subject to the rules on emergency care set out below and the other exceptions set out in section C – are as follows:
  - where a patient is registered<sup>8</sup> 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<sup>9</sup> 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 C, 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<sup>10</sup>, the CCG that would ordinarily be the responsible commissioner for a patient (under the rules in paragraph 1 and subject to the other relevant exceptions in section C) or NHS England (for example, for members of the armed

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<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> Specified under the powers given to the NHS England 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.

forces) is responsible for paying 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 or NHS England;
  - as set out in the 2013/14 Payment by Results (PbR) Guidance, for residents of Scotland, Wales or Northern Ireland attending English A&E departments, the cost is covered by the host CCG, not the patient's responsible health board<sup>11</sup>.
6. Patients who are not ordinarily resident in the UK are generally not entitled to free NHS hospital treatment, even when registered with a GP practice. For further details on entitlement to free NHS care, ordinary residence and overseas visitors, see paragraph 50 in Section C and Annex A.

### **Resolving disputes between CCGs**

7. 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.**
8. 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.
9. NHS England 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, Area Teams of NHS England should be consulted and should arbitrate where necessary.

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<sup>11</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214902/PbR-Guidance-2013-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf)



## **Section B: Applying the rules to CCG commissioned services**

10. 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**

11. 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 exempt from charges for hospital treatment. So too 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). The responsible commissioner should be determined as laid out in paragraph 1.

### **Persons of 'no fixed abode'**

12. Where a patient has 'no fixed abode' and is 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 and bail accommodation**

13. CCGs are responsible for commissioning services for people residing in approved premises<sup>12</sup> 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.
14. Approved premises and bail accommodation may house residents who have been required to move outside of their usual CCG area. The general rules still apply as set out in paragraph 1 – where the patient living in the approved premises or bail accommodation is registered with a GP practice (regardless of whether this is on the basis of temporary or permanent registration with a GP) the CCG of which that GP practice is a member is the responsible commissioner<sup>13</sup>; if the patient is not registered

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<sup>12</sup> 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 license, are required to reside immediately post-release.

<sup>13</sup> 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

with a GP, then the CCG in whose area the patient considers that they usually reside is the responsible commissioner. When determining where the patient usually resides, reference should be made to paragraph 12: i.e. if the patient considers themselves to be usually resident at an approved premises, bail accommodation or other address in the community then the CCG in which this is sited is the responsible commissioner.

### Patients who move

15. 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.
16. 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 C.
17. 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.
18. The table below summarises the responsibility for a patient who has moved. In all cases where treatment is occurring 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.

<b>Situation</b>	<b>CCG A</b>	<b>CCG B</b>	<b>Responsible Commissioner</b>
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

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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.

## **People taken ill abroad**

19. 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 whose area they are present. In all cases, it is the responsibility of the patient and/or his/her family to meet the costs of returning to the UK.
20. 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 whose area they are present once they are back in England. 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.
21. 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, so that they remain entitled to care 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 CCG covering the location of that unit should become the responsible commissioner.

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

22. 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 NHS England are responsible for administering the application and reimbursement processes for all requests.
23. For services commissioned by NHS England, NHS England will reimburse patients directly. For services commissioned by CCGs, NHS England will reimburse patients on behalf of the responsible CCG, who will in turn be required to repay NHS England for the patients' eligible

costs. Establishing the responsible commissioner will be determined in accordance with paragraph 1.

24. Where a patient's application relates to treatment normally commissioned by a CCG, NHS England 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 NHS England and respond to enquiries from NHS England on patient entitlement.

### **Registered nursing care**

25. 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.
26. Where (generally as a result of a patient decision to be nearer family or other support networks) a person moves to a care home outside the area of the CCG in which he or she was 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 generally register with a new practice in the area of the care home and the receiving CCG would then become the responsible commissioner.
27. There is an agreement in place between England and Wales to the effect that, where a patient is placed across the border into Wales, responsibility for payment will be based on the location of the care home. Other cross border placements outside England need to be considered on a case-by-case basis.
28. In Scotland where someone is placed in a care home on a permanent or temporary basis, the Health Board in that area becomes the responsible commissioner. However, it is necessary to confirm whether a move is permanent or temporary, and agreement between the relevant bodies will be required, which will need to be considered on a case by case basis.

### **Looked after children**

29. 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<sup>14</sup>. They fall into four main groups:
  - children who are accommodated under a voluntary agreement with their parents<sup>15</sup>;

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<sup>14</sup> Section 22 of the Children Act 1989

<sup>15</sup> Section 20

- children who are subject to a care order<sup>16</sup> or interim care order<sup>17</sup>;
  - children who are the subject of emergency orders for the protection of the child<sup>18</sup>; 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<sup>19</sup>.
30. The responsible CCG should be established by the usual means (see paragraph 1).
31. 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 with in a different way, as set out in section 3 at paragraphs 71-75.

### **Students and boarding school pupils**

32. 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**

33. If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be as set out in paragraph 1. Every effort should be made to determine GP practice registration or establish an address where they are usually resident, 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 the unit providing treatment.
34. It is the duty of the CCG and local social services authority to commission after-care for those persons discharged from hospital following detention under section 117 of the Mental Health Act<sup>20</sup>. The responsible CCG should be established by the usual means (see paragraph 1). If a patient who is resident in one area (CCG A) is

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<sup>16</sup> Section 31

<sup>17</sup> Section 38

<sup>18</sup> Sections 44 and 46

<sup>19</sup> Section 21

<sup>20</sup> Section 117 of the Mental Health Act 1983

discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to pay for their aftercare under section 117 of the Act<sup>21</sup> as agreed with the appropriate local social services authority.

### **Choice of secondary care provider**

35. 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<sup>22</sup>). 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 38-44).
36. 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 15-18 on patients who move). CCGs may wish to consider and agree flexible solutions, such as whether patient care should be commissioned and/or monitored by one CCG exercising functions on behalf of the responsible CCG for a specific length of time.

### **Patient Transport Services (PTS)**

37. 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**

38. Non-contract activity is the term used to refer to NHS-funded services delivered to a patient by a provider which does not have a written contract with that patient's responsible commissioner, but which does have a written contract with another commissioner or commissioners.
39. Written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider where there are established flows of patient activity with a material financial value. Non-contract activity billing arrangements are not intended as a routine

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<sup>21</sup> These arrangements are set out in the standing rules - The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

<sup>22</sup> <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>. To note choice does not apply to those:  
(a) detained under the 1983 Act;  
(b) detained in or on temporary release from prison; or  
(c) serving as a member of the armed forces.

alternative to formal contracting, but are likely to be required in some circumstances, usually for small, unpredictable volumes of patient activity delivered by a provider which is geographically distant from the commissioner.

40. The responsible commissioner for non-contract activity will be established in the usual manner, using paragraph 1, irrespective of the location or status of the provider.
41. The following arrangements apply, within England, in terms of commissioner approval processes for non-contract activity:
  - a) No prior commissioner approval is required for emergency treatment on a non-contract basis.
  - b) No prior commissioner approval is required for consultant-led elective care where the patient has exercised choice of provider under the legal rights set out in the NHS Constitution. A GP, dentist or optometrist referral is required in such cases, however.
  - c) For non-emergency treatment where the NHS Constitution does not set out a legal right for a patient to choose their provider, referral by the patient's GP, dentist or optometrist nonetheless constitutes authority for the provider to see and (depending on the content of the referral) treat the patient, and commissioners must pay for activity undertaken in such circumstances.
  - d) In other circumstances than those set out in paragraphs a) to c) above, there is no presumption that a provider may see and treat patients, on a non-contract basis, and expect to be paid by commissioners. Commissioners have the right to determine which services they wish to commission and from which providers. Where non-emergency non-contract referrals are made other than by the patient's GP, dentist or optometrist, including self-referrals, the provider must seek prior authorisation from the responsible commissioner before assessing and treating the patient. Where prior authorisation is not granted, commissioners are under no obligation to pay for activity which is carried out by providers on a non-contract basis.
42. The same arrangements apply for commissioner approval processes in respect of UK cross-border non-contract activity, except that for all elective referrals, prior approval from the commissioner must be sought and obtained by providers. Referral by a GP or consultant does not in itself constitute approval.
43. Emergency treatment should never be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare. Commissioners and providers should work together in good faith to ensure that, where prior authorisation is required, this is sought, and a response provided, as quickly as possible.

44. It is good practice for providers to put in place administrative systems to identify elective non-contract activity at the point of booking. Providers should inform responsible commissioners of any planned treatment(s) for a patient likely to result in claim for payment in excess of £10,000 and to keep them informed as necessary throughout the patient's stay, for example, if it becomes apparent that a patient's length of stay is likely to exceed 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. These are expected behaviours of organisations, not a lever for purposefully withholding non-contract activity funding.
45. Non-contract activity is undertaken by the provider on the terms of the NHS Standard Contract in place between that provider and its host commissioner(s). A contract on those terms will be implied as between the patient's responsible commissioner and the provider. Note in particular that:
- services will be delivered in accordance with the service specifications and other terms and conditions of the provider's contract with its host commissioner;
  - prices for services will be in line with National Tariff guidance (Payment by Results guidance in 2013/14), as applicable, or the local prices set out in the provider's contract with its host commissioner(s);
  - arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance (Payment by Results guidance in 2013/14) and the terms and conditions set out in the NHS Standard Contract. Commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements;
  - commissioners and providers should work together in good faith to minimise disagreements relating to payment for non-contract activity. However, any formal disputes over payment for non-contract activity should be resolved in accordance with the dispute resolution procedure set out in the NHS Standard Contract.
46. 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 C).



## Section C: Exceptions to the general rules

47. 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.
48. These exceptions do not affect the responsibility of CCGs to commission emergency care for people present in their geographic area (paragraph 3).
49. Where a CCG is responsible for commissioning care for patients under the arrangements set out below, it does not necessarily follow that 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 from one CCG to another, as with those exceptions that relate to NHS Continuing Healthcare 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.
50. Patients who are not 'ordinarily resident' in the UK (e.g. they are overseas visitors), and to whom 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 is responsible for funding that care.** However, a CCG **is responsible** for funding the care of those visitors to the UK who 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

51. 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.

#### Scotland

52. In the case of persons ordinarily and usually resident in Scotland but registered with a GP practice in England, Scotland Health Board is the

responsible commissioner.<sup>23</sup> In the case of persons usually resident in England, but registered with a GP practice in Scotland, the English CCG in whose area they are usually resident is responsible.

### Northern Ireland

53. In the case of persons ordinarily and usually resident in Northern Ireland but registered with a GP practice in England, Northern Ireland<sup>24</sup> is the responsible commissioner. In the case of persons resident in England, but registered with a GP practice in Northern Ireland, the English CCG in whose area they are resident is responsible.

### Wales

54. 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 is legally responsible for their care. Under a protocol between England and Wales for patients living on the England and Wales border, 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. The protocol applies to those living in Flintshire, Wrexham, Powys, Monmouthshire, Western Cheshire, Shropshire County, Herefordshire and Gloucestershire. For patients resident elsewhere in England or Wales who are registered with a GP on the other side of the border, responsibility for commissioning or for planning and securing their healthcare will remain with the CCG or LHB where the patient defines his or her usual place of residence.

<b>Residency</b>	<b>GP location</b>	<b>Responsible commissioner</b>	<b>Legal responsibility</b>
Wales	Wales	LHB	LHB
England	England	CCG	CCG
Wales	England	CCG	LHB
England	Wales	LHB	CCG

55. 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. Health organisations on the Welsh border are strongly encouraged to enter into discussions and negotiations locally in order to agree appropriate

<sup>23</sup> See regulations at <http://www.legislation.gov.uk/ukdsi/2012/9780111531525> - these also covers the arrangements for Northern Ireland and Wales.

<sup>24</sup> The Health and Social Care Board is commissioner for all of Northern Ireland

arrangements for activity outside of contracts and involving cross-border patient flows – in particular in relation to emergency urgent care.

56. 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<sup>25</sup> which enables a patient to be readily identified by healthcare staff quickly and accurately. It primarily covers patients in England and 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**

57. 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, for patients living in counties bordering Wales, under the protocol arrangements (set out at paragraph 52 above) the Local Health Board in whose area the Welsh GP is located will be the responsible commissioner. For patients moving within England, the CCG in which they are usually resident will be the responsible commissioner. See paragraphs 63-66 for details of responsibilities for patients moving across borders under the NHS Continuing Healthcare arrangements.
58. 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.

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

59. 'NHS Continuing Healthcare' means a package of health and social care arranged and funded solely by the NHS.

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<sup>25</sup> This service is available at the following website:  
<http://www.connectingforhealth.nhs.uk/systemsandservices/demographics>

60. 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) as part of their care. 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.
61. The arrangements apply regardless of whether nursing care by a registered nurse forms part of the care package, except in cases where the only planned service is NHS-funded nursing care provided in a nursing home. A need for care from a registered nurse would not be sufficient to trigger these commissioning rules. Responsibility for commissioning 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 practice belongs or, if the patient is not registered with a GP practice, where they usually reside.
62. A decision to place a patient requiring NHS Continuing Healthcare 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. 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.
63. 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.
64. Where a patient is provided with NHS Continuing Healthcare in their own home and they decide to move house (not into residential care), this will need careful discussion between the CCG currently providing those services and the CCG responsible for the patient 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 commissioned by another CCG exercising functions on behalf of the responsible CCG.

## **Transfer of NHS Continuing Healthcare patients across borders within the UK**

### Scotland

65. Where an English CCG ('the placing CCG'), arranges a package of NHS Continuing Healthcare (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.
66. The placing CCG should ensure that responsibilities are agreed 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. Arrangements for NHS nursing care differ between<sup>26</sup> England and Scotland.
67. 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<sup>27</sup>. 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

### Wales

68. As set out in the protocol between England and Wales<sup>28</sup> where a CCG or LHB arranges a package of NHS Continuing Healthcare (other than a package that is only NHS-funded nursing care), the placing body will remain responsible for that person's continuing healthcare until that episode of care has ended.

## **Transfer of NHS-funded nursing care patients across borders within UK**

69. Arrangements are currently being explored with Scotland and Northern Ireland and this guidance will be updated in due course.

### Wales

70. As set out in the protocol between England and Wales, where a CCG or LHB arranges the placement of an individual who is eligible for NHS-

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<sup>26</sup> [www.scotland.gov.uk/health/freepersonalcare](http://www.scotland.gov.uk/health/freepersonalcare)

<sup>27</sup> [www.careinfoscotland.co.uk/what-care-do-i-need/care/at/home/personal/and/nursing/care.aspx](http://www.careinfoscotland.co.uk/what-care-do-i-need/care/at/home/personal/and/nursing/care.aspx)

<sup>28</sup> [www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf)

funded nursing care in a nursing home in Wales, the receiving LHB is responsible. This is a reciprocal arrangement, so where a LHB arranges the placement of an individual eligible for NHS-funded nursing care in a nursing home in England, the CCG is responsible.

### **Out of area placements of children and young people**

71. 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 D) 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<sup>29</sup>, 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 as follows.

A. Looked After Children and Children Leaving Care

72. If a looked after child or child leaving care moves 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.

B. Pupils with special educational needs attending Residential Special Schools

73. 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.

74. 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

75. 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. Where there are plans for a child to return to the parental home and the 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<sup>30</sup>

76. 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 18<sup>th</sup> birthday.

77. 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). 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**

78. Regulations<sup>31</sup> establish CCGs’ legal responsibility for commissioning urgent and emergency care services for everyone present in their

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<sup>30</sup> 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](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114784)

geographic area. This includes accident and emergency (A&E), NHS walk-in centres, urgent care centres and minor injury units, 111 and out-of-hours and ambulance services.

79. As set out in paragraph 5:

- for A&E attendances and emergency admissions, the CCG that would ordinarily be the responsible commissioner for a patient (under the rules in paragraph 1 and subject to the other relevant exceptions in section C) or NHS England (for example, for members of the armed forces) is 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 B);
- 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 or NHS England (for example, for members of the armed forces). Many previous commissioners have found that recharging for activity in most urgent care facilities is a labour intensive process that is generally unlikely to result in significant net financial gain. 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.

80. 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<sup>32</sup> 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.

81. 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.

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

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<sup>31</sup> Under section 3(1B) of the 2006 Act as inserted by the 2012 Act available at: <http://www.legislation.gov.uk/ukxi/2012/2996/contents/made>

<sup>32</sup> See Annex A, 12(b).



<b>Scenario</b>	<b>Commissioning responsibility</b>	<b>Responsibility for payment</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 D: Examples to help clarify the boundaries of responsibility between commissioning organisations

83. The *Commissioning fact sheet for Clinical Commissioning Groups*<sup>33</sup> sets out the respective responsibilities of CCGs, NHS England, 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.
84. These examples are not exhaustive but where possible set out some principles that can be applied more widely.

### NHS England commissioned services

#### Specialised/prescribed services

85. NHS England is statutorily responsible for commissioning specialised and highly specialised services set out in regulations<sup>34</sup>. CCGs are responsible for commissioning related services along the patient pathway.

	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 NHS England 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 NHS England.
3	Mr. C attends A&E.	CCG

<sup>33</sup> *Commissioning fact sheet for Clinical Commissioning Groups* (July 2012) which sets out the services that CCGs are responsible for commissioning. It also sets out the complementary services that NHS England, local authorities and PHE are responsible for commissioning and is available at <http://www.commissioningboard.nhs.uk/files/2012/07/fs-ccg-respon.pdf>

<sup>34</sup> Available at <http://www.legislation.gov.uk/ukxi/2012/2996/contents/made>

	He is sent home with an urgent neurology appointment in a named specialised centre for the following day.	NHS England is responsible for the neurology appointment and any ongoing neurology care.
4	Mrs. D attends a 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, including the donor costs, is NHS England's responsibility.
5	Miss E is being seen by an Eating Disorder Community Team.	CCG
	Miss E goes on to be treated as an inpatient in a specialised eating disorder service.	NHS England
	Miss E is discharged but has been given a follow up appointment to see the specialised eating disorder service in outpatients.	NHS England

86. For a number of services NHS England will commission only from specialist centres (and these are based on centre, not individual clinician):

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

87. As a general rule NHS England 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:

	<b>Scenario</b>	<b>Responsible Commissioner</b>
8	Mr. H undergoes specialised thoracic surgery and goes straight from theatre to a general critical care unit.	NHS England 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.	NHS England will be the responsible commissioner for the whole episode.

*Specific example related to the boundary between paediatric and adult services*

	<b>Scenario</b>	<b>Responsible Commissioner</b>
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.	NHS England is the responsible commissioner for PICU; the CCG is the responsible commissioner for the adult HDU.

*Secure mental health examples*

	<b>Scenario</b>	<b>Responsible Commissioner</b>
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.	NHS England 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 approved premises out of the CCG in whose area he is usually resident. Whilst living at these approved premises he registers as a temporary patient with a local GP near the premises in CCG (x).	CCG (x) is the responsible commissioner whilst he is living at the approved premises.

	<p>On return to Court, he is then convicted of the violent assault and is detained in a secure unit in CCG (x) for treatment.</p>	<p>NHS England is the responsible commissioner for the secure care.</p> <p>CCG (x) is the responsible commissioner for any acute physical secondary care that may be required whilst Mr. L is in the secure unit.</p>
	<p>Aftercare arrangements are made to discharge Mr. L from secure care after his prison sentence has elapsed. He moves to CCG (w).</p>	<p>CCG (w) to which he moves for aftercare is the responsible commissioner (see paragraph 34 for further information).</p>

### Armed forces

88. Upon enlistment, the Ministry of Defence becomes responsible for the primary medical services of members of HM Forces and other military personnel (including NATO personnel<sup>35</sup>), through Defence Medical Services (DMS).
89. 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 NHS England 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.
90. Dependants of members of HM Forces can remain registered with their 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, choose to register with a DMS practice (where this is available) and access primary medical services through a HM Forces member's entitlement to DMS. Dependants cannot register with DMS dental services except when overseas.
91. NHS England is responsible for commissioning secondary and community health services for members of the armed forces, for their families, where they are registered with a DMS practice, and for reservists whilst mobilised. This includes services for these groups stationed overseas who return to England to receive NHS care. (Primary care services for these groups are commissioned by the Ministry of Defence.) NHS England is also responsible for commissioning prosthetic services for veterans through specialised commissioning arrangements

<sup>35</sup> As described in the status of forces agreement - Article IX(5) of the North Atlantic Treaty Organisation Status of Forces Agreement (1951).

92. CCGs are responsible for commissioning health services for veterans and reservists (when not mobilised). Normal CCG commissioning responsibilities apply to these groups. CCGs are also responsible for commissioning emergency care, including A&E and ambulance services, for those patients resident in their areas, as set out in paragraph 1.
93. There are currently variable arrangements across the country for out-of-hours primary medical services<sup>36</sup> for serving armed forces and their families registered with DMS practices. These are paid for by MoD (as part of primary care) but commissioned through the host CCGs. The following examples illustrate respective responsibilities.

	<b>Scenario</b>	<b>Responsible Commissioner</b>
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 Bristol to be near her family.	NHS England is the responsible commissioner for all her care, including any community nursing care she might need. (She would qualify as a charge exempt overseas visitor – see Annex A.)
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.	NHS England 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.	NHS England is the responsible commissioner for her secondary care costs as she is permanently registered with a DMS practice. (She would qualify as a charge exempt overseas visitor – see Annex A.)

<sup>36</sup> Except where this responsibility has been retained by practices under the GP contract, where NHS England is then responsible

5	Reservist Q who has been deployed in Afghanistan requires surgery once he is back in the UK for an injury sustained in service.	<p>The MoD is responsible for injured military patients (including reservists whilst mobilised) who require aeromedical evacuation for operational emergency.</p> <p>NHS England is the responsible commissioner for secondary healthcare outside of an operational emergency (and related treatment), i.e. for patients who require access to standard NHS treatment once they are back in England. This includes reservists whilst still mobilised.</p>
	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	Soldier R serving in the armed forces needs to register his children for GP services and dental services.	Some children who have a parent in the armed forces may be registered with a DMS practice; in which case the MoD is responsible for their primary medical care (this does not cover dental services). However, even if registered with a DMS practice, children should be able to access GP and dental services on the same basis as the general public and therefore NHS England would be responsible as the commissioner of primary care services.
7	Soldier S is based in Scotland and registered with his local Defence Medical Services practice. He needs a referral to hospital in England where his family are resident.	The Scottish Local Health Board is responsible for his care. 'Cross Border Issues within the UK' applies.
8	Corporal T falls ill whilst on her station and requires an ambulance to take her to a local A&E where she undergoes emergency surgery. She is discharged and is later readmitted for a follow up procedure.	The CCG in whose area Corporal T falls is responsible for the ambulance journey. NHS England is responsible for paying for the A&E attendance and any follow-up care.

### Specific infertility treatment examples

	<b>Scenario</b>	<b>Responsible Commissioner</b>
9	Injured serviceman U is in receipt of compensation under the Armed Forces Compensation Scheme for a genital injury sustained in action. He and his partner require infertility treatment and want to use the sperm he stored at his local infertility clinic before he left.	NHS England is the responsible commissioner for storing the sperm from the date of injury and for the infertility treatment <sup>37</sup> . If NHS England ordinarily commissions fewer than three cycles, the Department of Health would effectively 'top up' the treatment <sup>38</sup> so he and his partner could receive the three cycles of treatment to which they are entitled <sup>39</sup> if required.
10	Injured veteran V 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 is the responsible commissioner. As he is covered by the Armed Forces Compensation Scheme, if the CCG ordinarily pays 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.
11	Mrs. W, married to serviceman U, requires infertility treatment.	NHS England is the responsible commissioner for uninjured members of the armed forces and their families. The number of cycles would depend on the policy determined by NHS England.

<sup>37</sup> NHS England is 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.

<sup>38</sup> 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 contact [armedforces.ivf@nhs.net](mailto:armedforces.ivf@nhs.net).

<sup>39</sup> 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.



Prisoners and those detained in ‘other prescribed accommodation

94. NHS England is responsible for commissioning health services (excluding emergency care) for people in prisons and, in most cases, those detained in ‘other prescribed accommodation’<sup>40</sup>.
95. NHS England’s responsibilities include prisons, young offender institutions, some secure children’s homes, and some immigration removal centres – and from 2014 will include some secure training centres.
96. CCGs are responsible for commissioning emergency care, including A&E and ambulance services as well as out-of-hours primary medical services<sup>41</sup>, for prisoners and detainees present in their geographical area. CCGs are also 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.
97. The following examples illustrate respective responsibilities.

	<b>Scenario</b>	<b>Responsible Commissioner</b>
1	Mr. X 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.  NHS England is the responsible commissioner for all other treatment.
2	Miss Y is a 25 year old pregnant woman in a female prison.	NHS England 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 situated is the responsible commissioner for the ambulance service.  NHS England is responsible for the birth of her baby as this is planned secondary care of a person in a custodial setting.

<sup>40</sup> Details of ‘other prescribed accommodation’ for these purposes are set out in regulations available at: <http://www.legislation.gov.uk/ukxi/2012/2996/contents/made>.

<sup>41</sup> Except where this responsibility has been retained by practices under the GP contract, where NHS England is then responsible.

	<p>She is discharged back into custody after a couple of days, but her baby remains in special care for several months.</p>	<p>NHS England is responsible for her post-natal care in the custodial setting.</p> <p>NHS England is the responsible commissioner for the special baby care (as the direct commissioner of specialised services).</p>
3	<p>Mr. Z 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. Z is in and out of the youth justice system.</p>	<p>The responsible commissioner is the originating CCG; however, consideration needs to be given to the package of care Mr. Z 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 pass to NHS England for the period of detention.</p> <p>Upon release from custody the originating CCG remains the responsible commissioner as regards the package of NHS continuing healthcare.</p>
4	<p>Mr. AA 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.</p>	<p>NHS England is the responsible commissioner whilst he is detained in the secure children's home with youth justice board places.</p>
	<p>After a period of time he is released on probation.</p>	<p>The CCG where he is registered with a GP practice or, if not registered with a GP practice, the CCG in whose area he is resident, becomes the responsible commissioner for any ongoing mental health treatment.</p> <p>The local authority where Mr. AA accesses the substance misuse service is the responsible commissioner for that service.</p>

5	Mr. BB 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.	NHS England is the responsible commissioner whilst he is detained in an immigration removal centre.
	Mr. BB 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 in whose area the failed asylum seeker is registered and/or resident is the responsible commissioner for his ongoing care.
6	Mr. CC 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 whose area the prison is situated is the responsible commissioner for the ambulance service and treatment at A&E. NHS England is the responsible commissioner for his treatment.
	After five 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.	NHS England is the responsible commissioner for his treatment.
7	Prisoner DD 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:	NHS England is the responsible commissioner.

### Primary care

98. NHS England is responsible for commissioning primary care services. This includes:

- essential and additional primary medical services through GP contracts 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, i.e. NHS sight tests and optical vouchers;

- all dental services, including primary<sup>42</sup>, community and hospital services<sup>43</sup> and urgent and emergency dental care.
99. CCGs are 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);<sup>44</sup>
  - community-based services that go beyond the scope of the GP contract (akin to previous Local Enhanced Services<sup>45</sup>);
  - 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.
100. The following examples illustrate respective responsibilities.

	<b>Scenario</b>	<b>Responsible Commissioner</b>
1	Mr. EE 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. EE then receives treatment in his dental practice.	NHS England is the responsible commissioner throughout.
2	Miss FF goes to a high-street optometrist to receive an NHS sight test.	NHS England
	She is then referred for treatment at a community based eye care service.	CCG
	Whilst at this service, she is prescribed with eye drops as part of her aftercare.	CCG
3	Mr. GG is chronically ill, and regularly sees his GP.	NHS England
	He falls ill on a Sunday afternoon and calls the local out of hours	CCG

<sup>42</sup> Defence Medical Services normally provide primary dental care in UK for serving personnel, mobilised reservists and overseas for serving personnel and families.

<sup>43</sup> Including for Armed Forces and mobilised reservists.

<sup>44</sup> NHS England has statutory responsibility for commissioning these services but has directed CCGs to carry out this responsibility on its behalf.

<sup>45</sup> Resources attached to previous Local Enhanced Services (LES) commissioned by PCTs (except for public health LES) have been included in CCG funding.

	provider which is commissioned by his CCG.	
	He then returns to his GP for continuing his care.	NHS England
4	Mr. HH attends his local 8-8 GP health centre, but he is not a registered patient at this centre.	NHS England
	Mr. II attends the same GP health centre, but he is a registered patient at this centre.	NHS England

### Public health services commissioned by local authorities

101. Local authorities have a duty to take steps to improve the health of the people in their areas, funded by a ring-fenced grant. A small number of services are mandatory, including sexual health services. Local authorities are free to determine how they spend the remainder of their grant, but it is expected of them to commission a range of health improvement services, including smoking cessation services, sexual health and drug/alcohol services. CCGs are responsible for commissioning related services along the patient pathway.<sup>46</sup> The following examples illustrate respective responsibilities.

	Scenario	Responsible Commissioner
1	Mr. JJ attends his local GP practice where he is registered, for a consultation.	NHS England
	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

<sup>46</sup> For the full list of public health services to be provided or commissioned by local authorities and any related services that CCGs are 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>.

	As part of the original consultation, he and the GP agree to refer him for a vasectomy.	CCG
2	Mrs KK, aged 55, is invited for an NHS Health Check <sup>47</sup> 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 programme.  The risk assessment reveals that Mrs KK is at high risk of diabetes – the results are sent to Mrs KK's GP, to ensure they are included in her patient record and that any necessary clinical follow up is undertaken.	Local authority
	Mrs KK'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 England
	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

<sup>47</sup> People aged between 40 – 74 are eligible for an NHS Health Check.

## Annex A: Eligibility for free NHS treatment

1. It is important to note that not everyone is entitled to free NHS care. CCGs are not responsible for funding care for which patients themselves are liable to pay.
2. This Annex summarises the key points of eligibility for free NHS treatment. It is not a complete summary of the law and CCGs should refer to other guidance, and consult legal advisers where necessary.
3. 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

4. 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.
5. 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 than six months may be less likely to be considered ordinarily resident here unless other evidence suggests they are nevertheless properly settled here.
6. 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.**
7. 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).
8. 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**

9. Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is free, the payment arrangements are as follows:
- If the overseas visitor belongs to a category listed in 6(a) the responsible commissioner will be determined in accordance with the rules set out in paragraph 1 of the main guidance.
  - If the overseas visitor belongs to a category listed in 6(b) or 6(c) the treating hospital trust will invoice the host CCG<sup>48</sup> where no contract or Service Level Agreement is in place

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<sup>48</sup> The host CCG will be the CCG in which the provider is sited.



- Costing should be calculated, where possible, using the latest non-contract activity guidance.<sup>49</sup>
  - Invoices should be sent on a monthly basis.
  - There should be one invoice per patient.
  - Payment should be made within 30 days of receipt of invoice.
  - Dispute resolution should be between the provider and the CCG in accordance with the NHS Standard Contract.
  - 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.
10. Full guidance to the NHS on how to implement the Charging Regulations for overseas visitors can be found here:  
<http://www.dh.gov.uk/health/2012/10/overseas-visitors/>

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<sup>49</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132654](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654)

## 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 in relation to the public health services they commission is based on a duty to take steps to improve the health of the people in their area. The duty is not limited to residents, or people permanently in the area. It can include people who are only temporarily in the area, e.g. a visiting student or worker, or a tourist, or a commuter. It is therefore for the local authority to determine who is the relevant population (residents or wider) in relation to the services they commission<sup>50</sup>, deciding whether any step to improve their health is appropriate, given their resources, other priorities etc.;
  - local authority responsibility for the provision of accommodation and community care services<sup>51</sup> is largely based on the concept of ‘ordinary residence’<sup>52</sup>.
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

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<sup>50</sup> Apart from sexual health services - under regulations local authorities are required to commission sexual health services on an open access basis for all people present in the area and cannot limit the population for these services.

<sup>51</sup> Under sections 21 and 29 of the National Assistance Act 1948.

<sup>52</sup> ‘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](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113627).

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.