

Who Pays?

Determining which NHS commissioner is responsible for making payment to a provider

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(Appendix 4 contains Word templates for submissions under the dispute resolution process and is available separately.)

1 Executive Summary

- 1.1 This document, *Who Pays?*, sets out the framework for establishing which NHS commissioner is responsible for commissioning and paying for an individual's NHS care. It replaces the previous version of *Who Pays?* published in 2013. *Who Pays?* does not address funding allocations for NHS commissioners or the prices they must pay for healthcare services; it simply deals with how to identify which NHS commissioner is responsible for paying for a particular service for a specific patient.

Reasons for updating *Who Pays?*

- 1.2 The previous version of *Who Pays?* was published in 2013. We have published this updated version for the following reasons.
- This new version of *Who Pays?* clarifies responsibilities for funding care on discharge from hospital and makes changes to facilitate the “discharge to assess” arrangements set out in [Hospital Discharge Service: Policy and Operating Model](#).
 - 2013 *Who Pays?* was supplemented, over the years, with various separate addenda or explanatory notes published or circulated separately from the main document. Putting all the guidance in one updated document simplifies the process for NHS staff.
 - Changes to regulations since 2013 have led to some confusion over NHS responsibilities for commissioning and payment where, under the Mental Health Act, patients are liable to be detained in hospital and receive aftercare (“section 117 aftercare”) on discharge. This updated *Who Pays?* provides a clear position on this for the future.
 - Publishing updated guidance should address any common misunderstandings that have become apparent and will help to minimise dispute and delay – as well as avoiding the need for commissioners to seek external legal advice.
 - 2013 *Who Pays?* did not set out a clear process for managing disputes between NHS commissioners. This new guidance sets out a mandatory dispute resolution process. **ICSs/STPs will hold a key responsibility for resolving disputes.** Disputes within any single ICS/STP must be resolved at system level; where disputes arise between CCGs in different systems, ICSs/STPs must liaise to seek resolution. Ultimately, any unresolved disputes must be referred to the NHS England / Improvement national team for resolution, avoiding the need for commissioners to resort to other forms of arbitration or to the courts.

Key rules and main changes

- 1.3 The structure of this updated *Who Pays?* document is broadly similar to the 2013 version. Key sections to highlight are:
- As a general rule, the responsible commissioner will be the CCG of which the patient's GP practice is a member (section B, paragraphs 9-10).
 - Exceptions to this general rule are shown in section D, paragraphs 12-19.
 - There are new rules in paragraph 13 on stays in hospital, in paragraphs 14 on discharge from hospital and continuing care and in paragraph 18 on detention and s117 aftercare under the Mental Health Act.
 - New arrangements for dispute resolution are described in Appendix 1.

Ensuring prompt and safe care and treatment

- 1.4 The safety and well-being of patients is paramount. **No necessary assessment, care or treatment should be refused or delayed because of uncertainty or ambiguity as to which NHS commissioner is responsible for funding an individual's healthcare provision.**
- 1.5 As explained in the new arrangements for resolving disputes (Appendix 1), where substantive disagreements do arise, and they cannot be resolved swiftly at local level, the commissioners involved must agree a) that one of them will make arrangements for the patient to be assessed and to receive necessary care or treatment and b) that they will share the costs equally between them, on a "without prejudice" basis, pending resolution of the disagreement. That way, the patient's assessment, care and treatment will not be delayed, and the provider will be paid promptly.

Implementation

- 1.6 In general, this updated *Who Pays?* takes effect from 1 September 2020. It provides a sound basis on which, from that date, decisions about responsibility for commissioning and payment must be based.
- 1.7 This *Who Pays?* sets out new rules in several areas, as described above. These new rules do not apply retrospectively. In all other respects, this *Who Pays?* gives an accurate position on responsibility for commissioning and payment prior to 1 September 2020 and should be used as the basis for resolving any disagreements in relation to historic or ongoing cases.
- 1.8 However, the publication of this revised *Who Pays?* must not be used by commissioners as a reason to re-visit funding agreements on historic cases or to unpick existing agreed funding arrangements for ongoing care packages. There would be no benefit to the NHS as a whole from this, and it could create uncertainty for patients. The dispute resolution process in Appendix 1 has been designed to be consistent with this principle.

Section A: Context, purpose and coverage

2 Introduction

- 2.1 This revised *Who Pays?* guidance sets out a framework, for the NHS in England, for establishing which NHS organisation has responsibility for commissioning an individual's care and which has responsibility for paying for that care. It is published for implementation by commissioners from 1 September 2020.

3 Contents

- 3.1 The contents of this document are organised as follows.
- Section A (this section) sets out the legal context for, and purpose of, the guidance, describes its coverage and how and when it is to be implemented, and outlines a new approach to minimising and resolving disputes.
 - Section B gives a high-level description of the distribution of responsibilities for commissioning and payment within the English NHS and sets out, in paragraph 10, the general rules which underpin most decisions on responsibility.
 - Section C gives further details about how these general rules are to be applied to certain services and in certain common situations.
 - Section D describes a number of important exceptions to the general rules, with illustrative case studies to guide interpretation.
 - Section E provides detailed clarification, again with illustrative case studies, on distinguishing between NHS services commissioned by CCGs and those commissioned by NHS England.
 - Appendix 1 sets out the full dispute resolution process.
 - Appendix 2 provides advice on defining 'usually resident'.
 - Appendix 3 is a one-page guide to what has moved where from 2013 *Who Pays?* to the 2020 version.
 - Appendix 4, published separately in Word, contains templates for submissions made to the national team under the dispute resolution process.

4 Legal context and purpose

- 4.1 Responsibilities of NHS England and CCGs for commissioning health services – that is, for making the arrangements for such services to be provided in particular locations – are set out in legislation.
- 4.2 The key legislative provisions relating to the determination of commissioning responsibility are contained in
- the NHS Act 2006 (“the 2006 Act”), as amended by the Health and Social Care Act 2012 (“the 2012 Act”);
 - the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, as amended (the “Standing Rules Regulations”);
 - the National Health Service (Clinical Commissioning Groups – Disapplication of Responsibility) Regulations 2013 (the “Disapplication Regulations”);
 - the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) Directions 2020; and
 - the Mental Health Act 1983.
- 4.3 The 2006 Act (by amendments introduced by section 26 of the 2012 Act) makes a general provision, at section 14Z8, for NHS England to publish guidance to CCGs on the discharge of their commissioning functions, to which CCGs must then have regard. However, the amendments also make a specific provision, in section 14Z7(1), for NHS England to publish a document specifying “circumstances in which a clinical commissioning group is liable to make a payment to a person in respect of services provided by that person in pursuance of arrangements made by another clinical commissioning group in the discharge of its commissioning functions”. Section 14Z7(2) makes clear that any such document is binding on CCGs.
- 4.4 In general, responsibility for commissioning and for payment will be fully aligned; in other words, the organisation which is responsible for commissioning NHS care for an individual will also be responsible for paying for that care. However, there are some situations, set out clearly later in this document, where NHS England has made explicit use of its section 14Z7(1) powers to specify rules determining responsibility for payment which are different from the statutory position on responsibility for commissioning.
- 4.5 In this context, therefore, NHS England has two purposes in publishing *Who Pays?*
- The first is to restate in one place, and explain in simpler language, as general guidance under our 14Z8 powers, the position provided for in

legislation on responsibilities both for commissioning and for paying for NHS services.

- The second is, under our specific 14Z7(1) powers, to specify those situations where responsibility for payment differs from that for commissioning. Under section 14Z7(2), CCGs must make payments in accordance with the position specified in this *Who Pays?* document.

4.6 Unless stated otherwise in this document, a party with commissioning responsibility, as determined in accordance with the legislation, is also responsible for payment for the services commissioned.

5 Coverage

Supporting guidance

5.1 *Who Pays?* is supported by the Commissioner Assignment Method (CAM) guidance and flowcharts (available at <https://www.england.nhs.uk/data-services/commissioning-flows/>), which provide practical tools to help identify the correct commissioner. Note that the CAM guidance does not provide for every eventuality or case study covered in *Who Pays?* In the event of any inconsistency between the CAM and *Who Pays?*, the provisions of *Who Pays?* should be followed.

5.2 Two key documents which describe and define services which NHS England has the responsibility for commissioning are:

- the Specialised Services Manual and Identification Rules (available at <https://www.england.nhs.uk/commissioning/spec-services/key-docs/>), which describe how the prescribed specialised services commissioned by NHS England are to be identified; NHS Digital also publishes tools to support identification of prescribed specialised services (see <https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-pss-tools/>); and
- the national service specifications for public health services to be commissioned by NHS England, in accordance with the Section 7A public health functions agreement, available at <https://www.england.nhs.uk/commissioning/pub-hlth-res/>.

5.3 NHS England provides additional information on its website about other services which it directly commissions (see <https://www.england.nhs.uk/commissioning/commissioned-services/>).

Guidance on cross-border issues within the UK

5.4 *Who Pays?* is written primarily with the intention of providing guidance to the NHS in England.

- 5.5 Separate guidance covers arrangements for Scotland and Wales.
- The Welsh and Scottish Governments have published separate guidance (respectively, [Responsible Body Guidance for the NHS in Wales](#), and [Establishing the Responsible Commissioner: Guidance and Directions for Health Boards, March 2013](#)).
 - NHS England and the Welsh Government have also published a specific document aimed at ensuring smooth and efficient arrangements for patients living along or near the England / Wales border ([England / Wales Cross Border Healthcare Services: Statement of values and principles](#)).
- 5.6 We have liaised with the Welsh and Scottish authorities in updating *Who Pays?*
- 5.7 More detailed guidance for English NHS bodies on managing cross-border issues within the UK is set out in paragraph 19 below.

Limitations of *Who Pays?*

- 5.8 It is important to set out clearly what *Who Pays?* does not cover.
- **Access to free NHS treatment.** *Who Pays?* does not describe who is eligible for free NHS treatment or how charges should be levied on those to whom they apply. The Department of Health and Social Care (DHSC) publishes advice on these matters at <https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide> and <https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme#guidance-for-nhs-organisations>. Additional guidance on financial risk-sharing arrangements relating to charges applied to overseas visitors is also set out in [Improving Systems for Cost Recovery for Overseas Visitors](#). (Note however that *Who Pays?* does address how the responsible commissioner for overseas visitors is to be identified – see paragraphs 11.9-12 below.)
 - **NHS and local authority commissioning responsibilities.** *Who Pays?* does not set rules for determining responsibility for commissioning services as between the NHS and local authorities or between local authorities.
- 5.9 Equally, the purpose of *Who Pays?* is to provide certainty on responsibility for commissioning and payment. It is not the function of *Who Pays?* to provide guidance on detailed processes to be followed by commissioners when arranging care for patients – or on the way in which commissioners should communicate with each other, and with providers, when doing so. In general, therefore, *Who Pays?* does not cover such matters but simply cross-refers to relevant other guidance where applicable. As a general point, we would emphasise the importance of prompt and clear communication, from commissioner to provider and between commissioners, when there is

any doubt as to, or potential change in, the NHS body responsible for commissioning and payment for a particular patient.

Non-contract activity and patient choice of provider

- 5.10 The 2013 version of *Who Pays?* set out guidance on “non-contract activity” (NCA) – that is, the flows of patient activity (generally small-scale and unplanned) from a commissioner to a more distant provider with which it has no written contract. NCA arrangements can be important in enabling patients to exercise their legal right of choice of provider, as set out in the [NHS Choice Framework](#).
- 5.11 The responsible commissioner for NCA is established in exactly the same way as for any other activity, and the issues which the guidance needs to cover are generally contractual in nature. We have therefore moved the guidance on NCA into NHS England’s *NHS Standard Contract Technical Guidance* (see section 25 of the 2020/21 version, available at <https://www.england.nhs.uk/nhs-standard-contract/>).

Integrated commissioning and provision of services

- 5.12 As the NHS, together with local authorities, continues to develop local responses to the Long Term Plan and, working in Integrated Care Systems, seeks to integrate health and social care services, the responsibility to apply *Who Pays?* remains with NHS commissioners.

Pooled budgets

- 5.13 Under arrangements put in place under [Section 75 of the NHS Act 2006](#), NHS commissioners and local authorities can agree a “lead commissioning” approach and pool their budgets. Where a local authority is acting as lead commissioner under a s75 agreement, using a pooled budget on behalf of a CCG, then commissioning responsibility for health services will still be determined in accordance with *Who Pays?* The CCG must therefore ensure that – as part of the s75 agreement which underpins the pooled budget arrangement – the local authority will apply and abide by the provisions of *Who Pays?* in respect of responsibility for NHS-funded services.
- 5.14 In many situations, NHS and local authority commissioning responsibility for an individual will align – that is, the CCG responsible for meeting an individual’s NHS needs will be the CCG which covers the same geographical patch as the local authority which is responsible for meeting that individual’s social care needs. But this will not always be the case, and care will be needed, when pooled budget arrangements are established locally, to ensure that there is clarity on which cases are to be funded from the pooled fund.

Lead provider arrangements

- 5.15 NHS commissioners may sometimes appoint lead providers to manage access to and quality of care for whole populations. (An example is the planned establishment by NHS England of “Provider Collaboratives”, headed by lead providers, covering a range of mental health services – see <https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/>.)
- 5.16 It is important to be clear how *Who Pays?* applies where such lead provider arrangements are in place. In these situations, the lead provider does not “become” the commissioner; rather, the responsible NHS commissioning organisation (that is, either a CCG or NHS England) must always be determined by application of the *Who Pays?* guidance. It is for the commissioning contract between that commissioner and its appointed lead provider to determine what payments the commissioner must make to the lead provider and what services the latter must provide itself or sub-contract from other organisations.

6 Implementation

- 6.1 This guidance is for implementation by NHS commissioners from 1 September 2020 onwards.

7 Dispute resolution

- 7.1 Our intention in publishing an updated version of *Who Pays?*, with clearer explanations and more case studies showing how to determine responsibility in different situations, is to minimise the number of disagreements between commissioners.
- 7.2 We therefore expect that commissioners will seek to apply the rules in this *Who Pays?* document in good faith, using their best endeavours to resolve, promptly, any disagreements about responsibility for payment. No necessary assessment, care or treatment should be refused or delayed because of uncertainty or ambiguity as to which NHS commissioner is responsible for funding an individual’s healthcare provision.
- 7.3 In those rare situations where disputes between NHS commissioners within England do nonetheless arise, a formal dispute resolution process, managed by NHS England / Improvement’s national team, will apply to determine which commissioner should pay. This process is set out in full in Appendix 1. Participation in, and cooperation with, the process is mandatory, and its outcome will be binding on CCGs. This process will apply to new disputes arising from 1 September 2020 onwards, but also to any existing disputes where resolution is not already in hand.
- 7.4 Where substantive disagreements arise, which cannot be resolved swiftly at local level, the commissioners involved must agree a) that one of them will make arrangements for the patient to be assessed and to receive necessary

care or treatment and b) that they will share the costs equally between them, on a “without prejudice” basis, pending resolution of the disagreement. That way, the patient’s assessment, care and treatment will not be delayed, and the provider will be paid promptly.

8 Review

- 8.1 Any questions about interpretation of this revised guidance can be sent to england.responsiblecommissioner@nhs.net. We will review the effect in practice of the revised guidance and will publish further updates as and when necessary, reflecting clarifications which emerge from the process of responding to informal queries and resolving disputes.

Section B: Overall responsibilities and general rules

9 Overall responsibilities

9.1 The 2006 Act 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, not registered with a GP and therefore not provided with primary medical services by a member of any CCG.

9.2 At a summary level (and subject to the exceptions set out in Section D below), CCGs are responsible for assessing needs and commissioning health services to meet all the reasonable requirements of their patients, with the exception of:

- certain services commissioned directly by NHS England (such as primary care, high-secure psychiatric services, prescribed specialised services, secondary care dental services and the majority of health services for prisoners / those detained in 'other prescribed accommodation' and serving members of the armed forces and those family members who are registered with Defence Medical Services (DMS) GP practices in England);
- public health services commissioned by local authorities or by NHS England; and
- services provided by Public Health England (PHE) including health protection and promotion services.

9.3 Note that the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) Directions 2020 give NHS England new powers to

- commission health services from independent providers; and
- support, directly or indirectly, the provision of services by NHS bodies to address coronavirus and coronavirus disease.

These new powers enable NHS England to arrange and pay for services which would otherwise be commissioned by CCGs – such as the capacity being commissioned nationally from independent sector acute hospitals and any services provided by NHS Nightingale Hospitals in different sites around the country. Any further services which are to be commissioned and paid for on this national basis will be advised separately.

- 9.4 Note also that, under national arrangements for co-commissioning, many CCGs have now taken on responsibilities, delegated from NHS England, in relation to general practice commissioning. Further details can be found at <https://www.england.nhs.uk/commissioning/pc-co-comms/>.

10 General rules for determining responsibility

- 10.1 It therefore follows that what determines whether a CCG or NHS England is responsible for commissioning a particular service for a particular individual is the nature of the service itself. If it is one of the specific services which NHS England has a duty to commission, then NHS England is responsible; if not (and assuming the service is not one of those to be provided by Public Health England or commissioned by a local authority under its public health responsibilities), responsibility will fall to the relevant CCG.
- 10.2 By contrast, once it has been established that a service falls within the commissioning responsibility of CCGs generally, then the general rules used to determine which of two or more CCGs is the responsible commissioner (subject to the exceptions in section D below) are as follows.

The general rules for determining responsibility between CCGs

Where a patient is registered 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 Appendix 2 for more details on determining usual residence.)

Any one GP practice may have some patients who are usually resident in one CCG and others who are usually resident in another. In that situation, the responsible CCG for all of the patients registered with that practice will be the CCG of which that practice is a member.

Where a patient is registered with a GP who is a member of CCG A, but has then been accepted as a temporary resident by a GP who is a member of CCG B, the patient becomes the responsibility of CCG B for that period of temporary residence.

- 10.3 A number of specific exceptions to these general rules are set out in section D below. Where an exception is set out in section D, it takes precedence over the general rules expressed above.
- 10.4 Consistent with paragraph 4.6, other than where specified in any of the exceptions set out in Section D, the general rules above determine

responsibility for commissioning and for payment, both of which will rest with the same commissioning body.

- 10.5 Note that the operation of the general rules above and the exceptions set out in section D will deliberately result in situations where one CCG is responsible for commissioning certain services for an individual patient, whilst another CCG is responsible for commissioning other, different services for the same patient.

Section C: Applying the general rules in practice

11 Summary

- 11.1 This section gives further details about a number of services and situations where the responsible commissioner is established broadly in line with the general rules outlined in paragraph 10.2 above, but where further clarification may be helpful.

Persons of “no fixed abode”

- 11.2 Where a patient has ‘no fixed abode’ and is not registered with a GP practice, then – in accordance with the general rules in paragraph 10.2 – the responsible CCG should be determined by the terms of the ‘usually resident’ test (see Appendix 2). If a patient consider him/herself to be resident at an address, 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

- 11.3 CCGs are responsible for commissioning services for people residing in approved premises and bail accommodation, as well as for those serving community sentences or on probation. Approved premises and bail accommodation may house residents who have been required to move outside of their usual CCG area. The general rules as set out in paragraph 10.2 still apply – 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; if the patient is not registered with a GP, then the CCG in whose area the patient usually resides is the responsible commissioner. When determining where the patient usually resides, reference should be made to Appendix 2.

Patients who change GP and/or move house within England

- 11.4 Where a patient changes GP (or where a patient not registered with a GP moves house) during the course of treatment, this may – through application of the general rules in paragraph 10.2 – trigger a change in the responsible commissioner (for instance if the patient registers with a GP which is a member of a different CCG).
- 11.5 The table below summarises what generally happens to commissioning responsibility for patients who change GP and/or move house within England.

Situation	CCG A	CCG B	Responsible Commissioner
Patient not yet moved	Registered and resident	-	CCG A
Patient moved to area of CCG B	Registered	Resident	CCG A
Patient moved	De-registered	Resident but not yet registered	CCG B
Patient moved	Was never registered	Registered and / or resident	CCG B
Patient moved	De-registered	Registered	CCG B

- 11.6 For instance, therefore, where a patient is undergoing a series of outpatient attendances or community contacts, CCG B will pay for those attendances or contacts which take place after it has become the responsible commissioner.
- 11.7 However, many of the exceptions set out in section D create a position where responsibility for payment remains with the original CCG, even where a patient changes GP – and these exceptions take precedence over the table above.
- 11.8 Note in particular that
- an exception dealing with changes of GP during a hospital stay is set out in paragraph 13 below; and
 - movement of patients across borders within the UK is dealt with separately in paragraph 19 below.

Overseas visitors

- 11.9 Where an overseas visitor is liable to charges for their care, in accordance with the DHSC guidance referred to in paragraph 6.8, the detailed guidance set out in [Improving Systems of Cost Recovery for Overseas Visitors](#) should be followed. This will allow the responsible commissioner to be identified, where this is necessary in order to implement the required financial risk-sharing arrangement between the commissioners and the provider.
- 11.10 Where an overseas visitor is exempt from charges for NHS hospital treatment, or the NHS hospital service they receive is free, the arrangements for identifying the responsible commissioner are as follows.

- 11.11 For overseas visitors who are not registered with an English GP and who are resident outside the UK, the responsible commissioner will be the CCG in which the organisation providing the relevant health services is physically located. This category will be likely to include UK state pensioners living overseas; some former UK residents now working overseas; missionaries acting for UK-based mission; armed forces members and crown servants, and their dependents in both cases, who are serving overseas and returning to the UK for treatment; and people visiting from countries with which the UK has a bilateral healthcare arrangement (see DHSC guidance at <https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme> for full details).
- 11.12 By contrast, for those who are currently registered with an English GP – or who are not currently registered with an English GP, but who give a UK address and can be considered part of the UK resident population – the responsible commissioner should be determined on the basis of the general rules in paragraph 10.2. This category will be likely to include 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; and students on a course of at least six months duration.

People taken ill abroad

- 11.13 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 using the general rules in paragraph 10.2. 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 the person is present. In practice, this will generally mean that the responsible commissioner will be the CCG in which the organisation providing the relevant health services is physically located. In all cases, it is the responsibility of the patient and/or his/her family to meet the costs of returning to the UK.

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

- 11.14 Patients currently have certain rights to access treatment within the EEA under the arrangements described in [S2 and Directive routes: guidance for commissioners](#). Patients choosing to exercise these rights will receive reimbursement for eligible costs, as set out in the guidance. This may change following the end of the EU Exit transition period; the guidance will be updated as necessary.

NHS-funded nursing care

- 11.15 NHS-funded nursing care (or FNC) is when the NHS pays for the nursing care component of nursing home fees; the NHS pays a flat rate directly to the care home towards the cost of this nursing care. The responsible CCG for FNC will be determined in accordance with the general rules in paragraph 10.2.
- 11.16 Guidance for CCGs on FNC can be found in the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#). Further detailed guidance on FNC is available in [NHS-funded Nursing Care Practice Guidance](#).
- 11.17 Separate arrangements for determining commissioning responsibility apply to continuing care (including NHS Continuing Healthcare), as described in paragraph 14 below.
- 11.18 Where (generally as a result of a patient decision to be nearer family or other support networks) a patient in receipt of FNC 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), the patient will generally register with a new practice in the area of the care home, and – under the general rules at paragraph 10.2 – the “receiving” CCG will then become the responsible commissioner. (Note, however, the separate arrangements set out in [NHS-funded Nursing Care Practice Guidance](#) at paragraphs 28-31. These cover short periods in residential care, including in emergencies, for respite care and for trial periods; in these cases, responsibility for payment remains with the CCG which arranges the care.)
- 11.19 Arrangements for nursing care costs where patients move across borders within the UK are dealt with in paragraph 19 below.

Students and boarding school pupils

- 11.20 Responsibility for students attending University or other higher education establishments or pupils attending boarding schools should be determined using the general rules in paragraph 10.2 (other than where the exceptions set out in paragraph 15 apply in relation to children placed in residential schools). In practice, therefore, responsibility for a student attending university in one CCG but returning home to another CCG during the holidays will keep changing, if he or she changes GP registration each time.

Patient Transport Services

- 11.21 Non-emergency Patient Transport Services (PTS) are defined as non-urgent, planned transportation of patients with a medical need for transport to and from premises providing NHS healthcare, and/or between providers of NHS-funded healthcare.

11.22 CCGs are responsible for commissioning non-emergency PTS, including where patients require transportation to or from services commissioned by NHS England, and the responsible CCG for PTS is determined in the normal fashion, using the general rule at paragraph 10.2.

11.23 Note, however, that:

- NHS England has responsibility for commissioning some neonatal and paediatric transport services as prescribed specialised services;
- NHS England also has responsibility for commissioning transport services where patients need to be transported from secure mental hospitals; and
- emergency ambulance services are subject to the different arrangements set out in paragraph 17 below.

Personal health budgets

11.24 A personal health budget is an amount of money to support the identified health and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local CCG. There are different ways to manage a personal health budget; some will involve the individual spending the allocated budget directly with a healthcare provider or other organisation, rather than this being managed under a CCG commissioning contract. Further details are available at <https://www.england.nhs.uk/personal-health-budgets/>.

11.25 The CCG which is to be responsible for offering a personal health budget to a particular individual must be determined in accordance with this *Who Pays?* guidance – both the general rules at paragraph 10.2 and the exceptions in section D where relevant.

11.26 Where an individual in receipt of a personal health budget from CCG A moves away from its area and registers with a new GP in CCG B, responsibility for funding any personal health budget will transfer to CCG B, unless – because of the nature of the individual's needs for which the personal health budget is being provided – one of the exceptions in section D is triggered (for example, the exception on continuing care detailed in paragraph 14), in which case the terms of that exception will apply.

Section D: Exceptions to the general rules

12 General information

- 12.1 This section sets out, in relation to CCG-commissioned services, exceptions to the general rules in paragraph 10.2, 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 are not usually resident 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 who are usually resident in its geographic area.

13 Change of GP / address during hospital admission

What are the exceptions and who do they apply to?

- 13.1 This exception applies where a patient, for any reason, changes GP or address during a hospital inpatient spell. It applies to all hospital inpatient spells other than those already covered separately by the exceptions in the rest of this section D (including those on continuing care and detention and aftercare under the Mental Health Act, for instance).
- 13.2 The exception involves use of our powers under section 14Z7 of the 2006 Act to state that the rules for determining responsibility for payment are to be different from the legal position on responsibility for commissioning.
- 13.3 Note that
- the exception applies only where there is a genuine change of GP or address, not where an administrative error is being corrected (for example, the wrong GP or address has been recorded on admission and this is subsequently amended); and
 - the exception applies to the full duration of a hospital admission with any one provider organisation, but not where a patient is transferred to a different hospital run by a different provider organisation.

Effect on responsibility for payment

- 13.4 A patient's registered GP may sometimes change during a hospital stay. An example might be where a patient has been admitted to hospital with a head injury, and the family – in anticipation of his discharge to be cared for at home with them – re-register him with their own local GP. (NHS England's guidance on GP registration, at <https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/>, makes clear that a family member may properly register a patient on his/her behalf in this kind of

situation regardless of whether the patient has capacity.) It will be very unusual for a patient's address to change during a hospital stay, but this may occasionally happen.

- 13.5 Where a patient's registered GP or address does change during a hospital stay and where none of the other exceptions in this section D apply, then – under the general rule at paragraph 10.2 – the patient's responsible commissioner may change at that point (if the new GP is a member of a different CCG or if the address is in a different CCG).
- 13.6 If this same logic were also applied to responsibility for payment, then – in such a situation – two CCGs would each need to pay for a proportion of a patient's stay in hospital. Under the National Tariff Payment System, such a split is not straightforward to calculate. Applying such a rule to payment would create additional transaction costs and scope for possible confusion and dispute – as well as a perverse incentive in relation to ongoing costs after discharge, as described further in section 14 below.
- 13.7 We are therefore using our powers under section 14Z7 of the 2006 Act to state that, for an inpatient hospital spell commissioned by a CCG (and where none of the separate exceptions detailed in the rest of this section D apply), the CCG responsible for payment is to be determined on the basis of the general rule at paragraph 10.2 (that is, registered GP or, failing that, usual address), applied at the point of admission for that inpatient hospital spell. The CCG identified on this basis is responsible for payment for the whole of that hospital spell, even if the patient's GP or address changes during the spell.

Illustrative scenario

- 13.8 Scenario 1 below illustrates how this payment rule applies in practice.

	Scenario	Responsibility
1	Patient 1 is registered with a GP in CCG A. She is admitted to hospital for an elective procedure, following which she intends to move in with her family in CCG B. During her stay in hospital, her family re-register her with their local GP in CCG B.	CCG A is responsible for meeting the full cost of the hospital spell.

- 13.9 This new payment rule applies to admissions to hospital which take place on or after 1 September 2020.

14 Out-of-area placements of adults for continuing care

Guide to this section

- 14.1 As set out in the revised guidance on discharge from hospital ([Hospital Discharge Service: Policy and Operating Model](#)), from 1 September 2020 new packages of care will be funded by the NHS for up to six weeks following discharge from hospital. At the same time, under [Reintroduction of NHS continuing healthcare \(NHS CHC\): Guidance](#), CCGs are to re-start NHS CHC assessments from 1 September 2020.
- 14.2 From 1 September 2020 onwards, responsibility for funding this care and support will, under the transitional arrangements described further below, operate on a “placing CCG pays” approach – rather than on the “receiving CCG pays” basis which has applied for the temporary arrangements in place between March and August 2020.
- 14.3 The section below on responsibilities for continuing care is therefore structured as follows:
- paragraphs 14.4-17 set out the core rules; these are essentially as in 2013 Who Pays?, but expressed more clearly and with detailed examples;
 - paragraphs 14.18-32 set out new rules, primarily covering “discharge to assess” (which was not addressed in 2013 Who Pays?); and
 - paragraphs 14.33-40 set out rules covering responsibilities during the transitional period from 1 September 2020.

What is the exception in relation to commissioning responsibility and who does it apply to?

- 14.4 The exception in this area applies in certain circumstances to adults in receipt of “continuing care”. (Children are dealt with in paragraph 15 below. Note also the arrangements for placements of members of the armed forces described further at paragraph 22 below.)
- 14.5 For the purposes of this guidance, the Standing Rules Regulations define “continuing care” as “care provided over an extended period of time to a person to meet physical or mental health needs which have arisen as the result of illness”. This therefore includes, but is not limited to, NHS Continuing Healthcare (NHS CHC), as defined in the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#) (the “National Framework”). “Continuing care” may include packages of care arranged jointly by a CCG and a local authority, where the individual has been deemed not eligible for NHS CHC but has some health needs identified that are beyond the power of the local authority to fund. See also paragraph 18.19 below for clarification on the interplay between payment responsibility

for continuing care and FNC on the one hand and aftercare provided under s117 of the Mental Health Act on the other.

- 14.6 When an individual's potential need for continuing care becomes known and is to be assessed, the responsible commissioner must be determined in the normal way under the general rule at paragraph 10.2.
- 14.7 The exception (the detailed basis for which is set out in the Standing Rules Regulations at Schedule 1, paragraph 3) relates to individuals who have been assessed as needing continuing care and for whom the CCG identified as being the responsible commissioner under paragraph 10.2 (the "placing CCG") then arranges (by itself or jointly with a local authority) a residential continuing care placement outside of that CCG's geographical area.
- 14.8 Where, in order to meet an individual's continuing care needs, the placing CCG arranges to provide him / her with
- accommodation in a care home or independent hospital (that is, a hospital not run by an NHS Trust or NHS Foundation Trust) located outside of the CCG's geographical area; and
 - at least one planned healthcare service (other than simply NHS FNC) connected with the provision of that accommodation,

then the placing CCG retains commissioning responsibility for that person, in respect of those services, regardless of which GP the individual is registered with. This continues for as long as the individual requires a continuing care package (that is, they remain resident in accommodation and continue to require services), whether this is provided in the same physical location or another.

- 14.9 Where this exception applies, the placing CCG retains commissioning responsibility for the accommodation, and for any planned services in connection with that accommodation, only. Commissioning responsibility for all other NHS services provided to the person is determined in accordance with the general rule at paragraph 10.2 above or other relevant exceptions in this Section D as the case may be.

Responsibility for payment – general rules

- 14.10 In general, if these rules on commissioning responsibility are also applied to payment responsibility, they will lead to sensible outcomes. Fundamentally, a CCG placing a patient for continuing care in residential accommodation outside of its local area will not be able to escape financial liability for the continuing care services, even if the patient re-registers with a GP belonging to another CCG – and that is entirely appropriate.
- 14.11 In most situations, therefore – except for the circumstances described in paragraphs 14.18-32 below – the CCG which has responsibility for commissioning the services is also responsible for paying for those services.

Illustrative scenarios

14.12 The scenarios below explain how these general payment rules apply.

14.13 Scenario 1 is a straightforward situation where a patient is placed in-area and there is no change to GP registration. In this instance, the exception is not triggered; the general rule at paragraph 10.2 applies.

	Scenario	Responsibility
1	Patient 1 is registered with a GP belonging to CCG A. CCG A assesses him and arranges an NHS CHC placement in a local care home. Patient 1 remains registered with the same GP.	CCG A is responsible for meeting all the NHS costs.

14.14 Scenarios 2a and 3 describe out-of-area placements where the exception does apply; scenario 2b demonstrates the limits of what services the placing CCG is responsible for, as set out in paragraph 14.9 above.

	Scenario	Responsibility
2a	Patient 2 is registered with a GP belonging to CCG B. Following assessment, CCG B and Local Authority B arrange a jointly-funded placement for Patient 2 in a care home in the area of CCG C. Patient 2 re-registers with a GP belonging to CCG C.	CCG B is responsible for meeting the agreed NHS share of the jointly-funded placement. CCG C is responsible for meeting any other NHS costs.
2b	Whilst in the care home, Patient 2 is admitted to hospital for a cataract operation. On discharge, he returns to the care home in CCG C.	CCG C is responsible for paying for the cataract operation, but CCG B continues to fund the NHS share of the care home placement.
3	Patient 3 is registered with a GP belonging to CCG D. She has been assessed by CCG D, which has arranged an NHS CHC placement in a local care home. Patient 3 and her family then approach CCG D to ask for a transfer to a different care home in the area of CCG E, closer to where the family lives. CCG D arranges the new placement, and Patient 3 re-registers with a GP belonging to CCG E.	CCG D is responsible for meeting the NHS CHC costs. CCG E is responsible for meeting any other NHS costs.

14.15 Scenarios 4a and 4b below make clear that the exception applies not only to NHS CHC placements but also to other placements for “continuing care” (as defined above) in care homes or independent hospitals, including for instance placements for long-term rehabilitation.

	Scenario	Responsibility
4a	Patient 4 is registered with a GP belonging to CCG F. Following lengthy hospital treatment, she requires rehabilitation (which meets the definition of	CCG F is responsible for meeting the NHS costs of the rehabilitation placement.

	“continuing care” in the regulations) and is placed in a specialist nursing home based in CCG G. She then re-registers with a GP belonging to CCG G.	CCG G is responsible for meeting any other NHS costs.
4b	Following completion of the programme of rehabilitation, Patient 4 is assessed as requiring an NHS CHC placement in a care home. She is discharged from the rehabilitation provider to a care home in the area of CCG H and registers with a GP belonging to CCG H.	CCG F is responsible for meeting the NHS CHC costs. CCG H is responsible for meeting any other NHS costs.

14.16 The exception does not apply to an individual who is receiving a package of continuing care in his or her own home, including in supported living settings. Responsibility for such a package is determined on the basis of the general rule in paragraph 10.2, as described in scenario 5a below. Where such an individual moves house from the area of one CCG to another and re-registers with a GP in the new CCG, commissioning responsibility will transfer to the new CCG from the date of re-registration, as set out in scenario 5b below.

	Scenario	Responsibility
5a	Patient 5 is registered with a GP belonging to CCG I. CCG I assesses Patient 5 as eligible for NHS CHC and arranges a home care NHS CHC package. Patient 5 remains registered with the same GP.	CCG I is responsible for meeting all the NHS costs, including the NHS CHC package
5b	Patient 5 then moves house to the area of CCG J and registers with a GP belonging to CCG J. He remains eligible for NHS CHC.	CCG J becomes responsible for meeting all the NHS costs from the date of re-registration, including the NHS CHC package. (Note that the change of responsible CCG in this situation is not an automatic trigger for a re-assessment of CHC eligibility; see paragraphs 181-185 of the National Framework for further detail).

14.17 Where an individual is receiving funded nursing care (FNC) only, the general rule in paragraph 10.2 applies, as described further in paragraphs 11.15-19 above.

Responsibility for payment – other rules

14.18 However, there is a risk of perverse outcomes and increased disputes if we retain exactly the same rules on payment responsibility as on commissioning responsibility in all circumstances. We have therefore decided to use our powers under section 14Z7 of the 2006 Act to state that responsibility for payment is to be different from responsibility for commissioning in order to address two specific situations:

- to facilitate, and ensure that there are no perverse outcomes under “discharge to assess” arrangements; and
- to avoid perverse incentives for CCGs to delay NHS CHC assessments.

14.19 We explain each of these new rules on payment responsibility below.

Short-term “discharge to assess” placements on hospital discharge

- 14.20 Under the “discharge to assess” arrangements described in Hospital Discharge Service: Policy and Operating Model, NHS CHC referrals and assessments should no longer take place in acute hospital settings.
- 14.21 Rather, where patients need an NHS CHC assessment following a hospital stay, this will be carried out after discharge, either in their own home or in short-term residential accommodation funded for a maximum six-week period under the new arrangements set out in [Hospital Discharge Service: Policy and Operating Model](#).
- 14.22 Where short-term funded residential care is being provided in this way, a patient may well need to register, at least temporarily, with the GP providing medical cover to the intermediate care accommodation / care home in which he / she has been placed. And, in a small number of cases, the accommodation in question may be outside the placing CCG’s area, meaning that the patient may re-register with a GP belonging to a new CCG. A patient’s stay in such accommodation for the purposes of “discharge to assess” should always be of short duration and will not typically meet the definition of “continuing care” in the Standing Rules Regulations. So, in such a case, the new CCG will become responsible for commissioning services for the patient.
- 14.23 If this same logic were also applied to responsibility for payment, then a perverse incentive would be created for CCGs to arrange “discharge to assess” placements in out-of-area accommodation, thus passing responsibility to the neighbouring CCG for funding both the short-term “discharge to assess” placement and any resulting long-term residential placement.
- 14.24 To avoid this, the position on responsibility for payment will be as follows.
- Where a patient is discharged from NHS-funded hospital care to short-term non-hospital residential accommodation which is wholly- or partly-funded by the NHS (such as a care home or intermediate care facility) and where none of the separate exceptions detailed in the rest of this section D apply, then:
 - the CCG which is to pay for the short-term placement (or the NHS contribution to it) will be the CCG which was responsible for paying for the hospital spell from which the patient is being discharged, as

determined under the general rule at paragraph 10.2 and the exception at paragraph 13 above where applicable; and

- the same CCG will then retain responsibility for paying for any residential continuing care placement which follows directly on from this short-term placement.
- This will apply even where the patient is discharged to accommodation out-of-area and registers with a GP belonging to a different CCG.
- Where the hospital spell from which the patient is to be discharged has been commissioned and paid for by NHS England (as a specialised service, for example), the same principle will apply; the CCG responsible for paying for the out-of-area placement and any subsequent residential continuing care placement will be the one identified by the application of the general rule at paragraph 10.2 and the exception at paragraph 13 above where applicable, at the point of the patient's admission to hospital for the spell from which he / she is now being discharged.

14.25 The scenarios below explain when the payment rule on “discharge to assess” does and does not apply.

	Scenario	Responsibility for payment
6	Patient 6 is registered with a GP in CCG K. She is admitted to hospital following a hip fracture. She is “discharged to assess” into a care home in neighbouring CCG L; in order to access medical care while in the care home, she re-registers with a GP belonging to CCG L. Whilst in the care home, she is assessed and an ongoing package of NHS CHC is then arranged for her, in a different care home, also in CCG L; she re-registers with a different GP, also belonging to CCG L.	CCG K is responsible for meeting the costs of <ul style="list-style-type: none"> • the hospital spell; • the placement in the care home; and • the package of NHC CHC.
7	Patient 7 is registered with a GP in CCG M. Following a stroke, they are admitted to hospital and then “discharged to assess” into a care home in neighbouring CCG N, and they re-register with a GP belonging to CCG N. Patient 7 is assessed and found eligible for NHS CHC and a package of care is arranged in their own home; they therefore re-register with their original GP from CCG M.	CCG M is responsible for meeting the costs of <ul style="list-style-type: none"> • the hospital spell; • the placement in the care home; and • (on the basis set out in paragraph 14.16 above) the package of NHC CHC in Patient 7’s own home.
8	Patient 8 is registered with a GP in CCG O. He is admitted to hospital following a series of falls. He is “discharged to assess” into a care home in neighbouring CCG P; in order to access medical care while in the care home, he re-registers with a GP belonging to CCG P. He makes a fair recovery, and he, his family and the relevant local authority agree that he should be admitted to a different care home, with nursing, in CCG Q. No CCG is involved	CCG O is responsible for meeting the costs of <ul style="list-style-type: none"> • the hospital spell; and • the initial “discharge to assess” placement in the care home. <p>CCG Q will be responsible for making any payments for NHS FNC in the second care</p>

	in arranging the placement. On admission to the home, he registers with a GP belonging to CCG Q.	home (under the rule at paragraph 11.15-19).
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- 14.26 If a patient placed in short-term accommodation in this way requires readmission to hospital direct from the short-term placement, the CCG responsible for payment will remain the same – that is, it will be the CCG responsible for paying for the original hospital admission and the short-term placement, even if the patient has subsequently re-registered with a GP belonging to a different CCG.

Patients who change GP or address while an NHS CHC assessment is ongoing in a non-hospital setting

- 14.27 It is important that assessments for NHS Continuing Healthcare are completed promptly. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care sets a clear expectation (paragraph 162) that “the overall assessment and eligibility decision-making process should, in most cases, not exceed 28 calendar days from the date that the CCG receives the positive Checklist (or, where a Checklist is not used, other notice of potential eligibility) to the eligibility decision being made”.
- 14.28 We are keen to avoid the risk of any perverse incentive for a CCG to delay completion of an NHS CHC assessment. The arrangements set out in paragraphs 14.20-26 above will ensure that there is no such perverse incentive where assessments are completed after discharge from hospital under ‘discharge to assess’ arrangements. But we also need to address situations where patients in the community (including in care homes) are referred for NHS CHC assessment. In such cases, it is also possible that a patient may change GP and/or address while an assessment is ongoing, especially if it has been delayed – for example, where a local authority has to take urgent action to place an individual in a care home for their own safety. In such a situation, if the new GP belongs to, or the new address is in, a different CCG, then, under the general rule at paragraph 10.2, commissioning responsibility passes to the new CCG.
- 14.29 Again, we do not think this outcome is appropriate in terms of the payment rules. Instead, the position on payment responsibility will be that, in such a case (other than where covered by the “discharge to assess” arrangements set out in paragraphs 14.20-26 above), responsibility for paying for any resulting NHS continuing care placement in a care home or independent hospital will be determined on the basis of the general rule at paragraph 10.2 (that is, registered GP or, failing that, usual address), applied at the point at which a referral for NHS CHC assessment for the patient was first received by any CCG. A “referral” in this context is the earliest notification (to a CCG or person or body acting on behalf of a CCG) that full assessment of NHS CHC eligibility is required (e.g. a positive checklist, Fast Track Tool or other notification that full assessment is required).

14.30 Scenarios 10 and 11 below show two examples of where the arrangement above will operate.

	Scenario	Responsibility for payment
10	Patient 10 lives in his own home and is registered with a GP in CCG T. He is referred by the local authority for NHS CHC assessment. Following receipt of the referral by the CCG, but before the assessment has been completed, Patient 10's family decide to move him into a care home in the family's geographic neighbourhood, CCG U, and he is re-registered with a GP belonging to CCG U.	If the outcome of the assessment process is that Patient 10 requires a continuing care residential placement in a care home or independent hospital, CCG T must pay for the placement. (But if the outcome is that a care package in Patient 10's own home is needed, responsibility will be determined on the basis set out in paragraph 14.16 above.)
11	Patient 11 lives in sheltered housing and is registered with a GP in CCG V. She is referred by the local authority for NHS CHC assessment. While the assessment is ongoing, Patient 11's condition deteriorates; the local authority agrees with her family to move her into a care home in CCG W, and she is re-registered with a GP belonging to CCG W.	If the outcome of the assessment process is that Patient 11 requires a continuing care residential placement in a care home or independent hospital, CCG V must pay for the placement. (But if the outcome is that a care package in Patient 11's own home is needed, responsibility will be determined on the basis set out in paragraph 14.16 above.)

Withdrawal of NHS CHC funding and dispute resolution relating to NHS CHC

14.31 Note also these two important points (which relate only to NHS CHC, not to continuing care as defined more broadly in paragraph 14.5 above).

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care states at paragraph 190 that "It is a core principle that neither a CCG nor a local authority should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. Therefore, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding, in order to ensure continuity of care".
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care requires (paragraphs 208-214) a local multi-agency dispute resolution process to be put in place in each local area, through which disputes between CCGs and local authorities relating to NHS CHC can be managed. (These are of course entirely separate from the arrangements for dispute resolution between CCGs, described in detail in Appendix 1.)

14.32 The interaction between the rules on responsibility for continuing care and those for detention and aftercare under the Mental Health Act can be complex. We cover this in paragraphs 18.7 and 18.19 below.

Transitional arrangements from 1 September 2020

14.33 For

- existing patients already in receipt of continuing care prior to 19 March 2020, whose care package has continued unchanged; and
- new patients where continuing care is to be provided on or after 1 September 2020,

responsibility for payment will be determined on the basis set out in paragraphs 14.4-32 above.

14.34 For other patients, the following transitional arrangements will apply to responsibilities for payment; again, we are mandating these using our powers under section 14Z7 of the 2006 Act.

14.35 Where a patient

- was discharged from hospital inpatient care between 19 March and 31 August 2020;
- was then provided with funded care in a residential setting under the temporary arrangements; and
- remains in that residential care setting and now requires assessment of eligibility for CHC and potential placement

responsibility for undertaking the assessment and paying for any resulting continuing care placement in a care home or independent hospital will be determined on the basis of the general rule at paragraph 10.2 (that is, registered GP or, failing that, usual address), applied at the point of admission for the relevant inpatient hospital spell.

14.36 Where a patient

- was, in order to avoid admission to hospital, provided for any period between 19 March and 31 August 2020 with funded care in a residential setting under the temporary arrangements; and
- remains in that residential care setting and now requires assessment of eligibility for CHC and potential placement

responsibility for undertaking the assessment and paying for any resulting continuing care placement in a care home or independent hospital will be determined on the basis of the general rule at paragraph 10.2 (that is,

registered GP or, failing that, usual address), applied at the point at which the patient was placed in the temporary residential accommodation.

- 14.37 Under the temporary arrangements, payments to providers for residential care placements between March and August 2020 have been the responsibility of the CCG in whose area the provider was based. Where such placements were made out-of-area, responsibility for undertaking NHS CHC assessments will now, under paragraphs 14.35-36, revert back to the original CCG where the patient was registered with a GP.
- 14.38 To ensure clarity on future responsibilities, each CCG, working with the relevant local authority where appropriate, must therefore, as soon as possible
- review those patients placed into its area from elsewhere, for whom it (or, under pooled budget arrangements, a different “host” CCG) has been claiming discharge support funding;
 - identify the CCG which will be responsible, under the rules at paragraphs 14.35 and 14.36 above, for each patient’s NHS CHC assessment; and
 - inform that CCG, through appropriate secure channels, of the patient’s details, so that the CCG can make arrangements to undertake the assessment.
- 14.39 It will take time for the backlog of NHS CHC assessments to be cleared, and patients may therefore remain for a period in their current temporary placements, pending assessment. CCGs will continue to be able to claim discharge support funding for these placements in the short term. Where the review process described in paragraph 14.38 identifies a need to transfer responsibility for NHS CHC assessment to another CCG, responsibility for claiming discharge support funding and making payment to the provider for the temporary payment should also transfer. This transfer process must be completed as soon as possible and in any event **by no later than 31 December 2020** (including the resolution of any disputes, where necessary using the process at Appendix 1). It is essential that payments to providers are not disrupted during this process.
- 14.40 Scenarios 12-14 below give examples to clarify how these transitional arrangements are to operate.

	Scenario	Responsibility for payment
12	Patient 12 is registered with a GP belonging to CCG X. He is admitted to hospital on 21 March 2020 and discharged in early April, under the temporary arrangements, to a care home located in neighbouring CCG Y; he has since registered with a GP belonging to CCG Y. He has remained in the same care home	To date, CCG Y will have been claiming discharge support funding for the placement and will have been paying the provider. But it now falls to CCG X to undertake the NHS CHC assessment and, if Patient 12 is eligible, to pay for any resulting residential placement in a care home or independent hospital. CCG Y should, as soon as possible, transfer

	since then, but now requires full NHS CHC assessment.	responsibility to CCG X, which should now claim the discharge support funding and make payments to the provider for the temporary placement, while this continues pending completion of the NHS CHC assessment.
13	Patient 13 is registered with a GP belonging to CCG Z. She lives at home, but becomes unwell and, in order to avoid admission to hospital, is placed, under the temporary arrangements, in a care home located in neighbouring CCG AA; she has since registered with a GP belonging to CCG AA. She has remained in the same care home since then, but now requires full NHS CHC assessment.	To date, CCG AA will have been claiming discharge support funding for the placement and will have been paying the provider. But it now falls to CCG Z to undertake the NHS CHC assessment and, if Patient 13 is eligible, to pay for any resulting residential placement in a care home or independent hospital. CCG AA should, as soon as possible, transfer responsibility to CCG Z, which should now claim the discharge support funding and make payments to the provider for the temporary placement, while this continues pending completion of the assessment.

15 Out-of-area placements of children

What is the exception in relation to commissioning responsibility and who does it apply to?

- 15.1 The exception here applies to certain children who are placed in residential accommodation “out-of-area”. (Note that we use the term “children” throughout Who Pays? to refer to any individual under the age of 18.)
- 15.2 The responsible CCG for any child, including those covered by this exception, must be established at the outset in accordance with the general rules in paragraph 10.2. The CCG identified in this way is known, for the purposes of this exception, as the “originating CCG”.
- 15.3 The categories of children to whom the exception applies are specified in the Standing Rules Regulations (Schedule 1, paragraph 4). In practice, the exception applies to any of the following, where the child has been placed in residential accommodation out-of-area:
- any looked after child;
 - any child to whom a local authority has duties as a relevant child pursuant to Section 23A of the 1989 Act;
 - any child who qualifies for advice and assistance from the local authority pursuant to Section 24 of the 1989 Act;
 - any child provided with accommodation at a school to which they were admitted in accordance with an Education Health and Care Plan; and

- any child that requires accommodation in a care home, a children’s home or an independent hospital in order to meet their continuing care needs, including under the [Children and young people’s continuing care national framework](#).

“Residential accommodation” in this context includes, but is not limited to, a care home, a children’s home, an independent hospital or a residential school. A placement into foster care will also constitute residential accommodation.

15.4 This exception applies so as to ensure consistency in the organisations commissioning healthcare services for children who have an ongoing level of contact with and assistance from a local authority.

15.5 For children to whom the exception applies, it operates as follows.

- Where the originating CCG itself arranges, or jointly with a local authority arranges, accommodation for a child in the geographical area of another CCG, then the originating CCG remains the responsible CCG for the services for which CCGs have responsibility for commissioning, even where the child registers with another GP practice in the different CCG’s area.
- In addition, where a local authority alone arranges accommodation for a child in the geographical area of a CCG other than the originating CCG (being the CCG with commissioning responsibility pursuant to the general rules in paragraph 10.2 immediately prior to the local authority making those arrangements), then the originating CCG remains the responsible CCG for the services for which CCGs have responsibility for commissioning, even where the child registers with another GP practice in the different CCG’s area. (CCGs will therefore wish, in their joint work with local authorities, to ensure that robust referral mechanisms are in place, so that CCGs are aware of children being placed out-of-area by the local authority, even if there is no current commissioning or financial liability for the CCG regarding the child.)
- In both cases, the originating CCG only retains responsibility for as long as the child is resident in the accommodation.

15.6 Note that pupils attending special schools on a day-only basis remain the responsibility of the CCG determined using the general rules in paragraph 10.2, as they cannot be said to be resident in such accommodation.

Effect on responsibility for payment

15.7 Under this exception, the CCG which has responsibility for commissioning the services is also responsible for paying for those services.

Illustrative scenarios

15.8 The scenarios below explain where the exception does and does not apply.

15.9 Scenario 1 is a straightforward situation where a patient is placed in-area and there is no change to GP registration. In this instance, the exception is not triggered; the general rules at paragraph 10.2 apply.

	Scenario	Responsibility
1	Child 1 lives in Local Authority A and is registered with a GP from CCG A. She is then placed, aged 13, by Local Authority A in residential accommodation in a special school in the area of CCG A. She remains registered with a GP in CCG A.	CCG A remains responsible for meeting the costs of all of Child 1's health needs.

15.10 Scenarios 2 and 3a describe out-of-area placements where the "originating CCG" exception does apply. Note that, under scenario 3, the exception does apply, even though the "originating CCG" was not involved in making the out-of-area placement.

	Scenario	Responsibility
2	Child 2 lives in Local Authority B and is registered with a GP from CCG B. Following assessment of his continuing care needs, he is then placed, aged 13, by CCG B and Local Authority B in a care home in the catchment of CCG C. Shortly after the date of the placement, he then registers with a GP in CCG C.	As the "originating CCG", CCG B remains responsible for meeting the costs of all of Child 2's health needs, until the residential placement ends or he turns 18.
3a	Child 3 lives in Local Authority D and is registered with a GP from CCG D. She is identified as a looked after child and is then placed, aged 12, by Local Authority D acting alone, in a children's home in the catchment of CCG E. Shortly after the date of the placement, she then registers with a GP in CCG E.	As the "originating CCG", CCG D remains responsible for meeting the costs of all of Child 3's health needs, until the residential placement ends or she turns 18.

15.11 Scenario 3b makes clear that, where there is an out-of-area placement and the exception applies, the "originating CCG" is responsible for commissioning and paying for all the CCG-commissioned health services which the child may require.

	Scenario	Responsibility
3b	Continuing from scenario 3 above, whilst in the children's home placement, Child 3 develops a need for an elective surgical procedure.	As the "originating CCG", CCG D remains responsible for meeting the costs of the procedure.

15.12 Scenarios 4 and 5 deal with situations where a child

- leaves a residential care setting to which the “originating CCG” exception applies, but where no referral for adult NHS CHC is made; or
- reaches the age of 18 without such a referral being made.

The key point is that – whereas, under the Children Act, a local authority may retain certain responsibilities in respect of those who have left care until they reach the age of 25 – the “originating CCG” ceases, subject to paragraph 16 below, to have responsibility for a child placed in residential accommodation out-of-area from the date at which the child turns 18.

	Scenario	Responsibility
4	Child 4 lives in Local Authority F and is registered with a GP in CCG F. Aged 13, he is placed by Local Authority F in a children’s home in the catchment of CCG G and registers with a GP there. When he is aged 16, Local Authority F arranges for Child 4 to leave the children’s home and return to live with his family, who now live in CCG H; he then registers with a GP in CCG H.	As the “originating CCG”, CCG F is responsible for meeting the costs of all of Child 4’s health needs, until the residential placement ends when he is 16. From that point onwards, if Child 4 now has health needs, CCG H is responsible for meeting the cost of them, on the basis of the general rules at paragraph 10.2.
5	Child 5 lives in Local Authority I and is registered with a GP in CCG I. Aged 12, she is placed by Local Authority I in a residential special school in the catchment of CCG J and registers with a GP there. As Child 5 grows older, the Local Authority does not consider that she has a potential need for NHS CHC and therefore makes no referral for adult NHS CHC assessment. Child 5 remains in the same placement, funded by Local Authority I, after the age of 18.	As the “originating CCG”, CCG I is responsible for meeting the costs of all of Child 5’s health needs, until she turns 18. From that point onwards, if Child 5 develops health needs (including for NHS CHC), CCG J will be responsible for the costs of meeting them, on the basis of the general rules at paragraph 10.2.

15.13 Note that scenario 8 in paragraph 18 below deals with situations where a child placed out-of-area is detained in hospital under the Mental Health Act.

16 Transition to adult continuing care

What is the exception in relation to commissioning responsibility and who does it apply to?

16.1 The exception here applies to certain individuals who have been placed in out-of-area accommodation prior to their 18th birthday and relates to responsibility for their care after they turn 18. The detailed basis for the exception is set out in paragraph 5 of Schedule of the Standing Rules Regulations.

- 16.2 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care describes the process for managing the transition from child to adult NHS CHC and makes clear (paragraphs 339-341) that local authority children's services "should identify those young people for whom it is likely that adult NHS Continuing Healthcare will be necessary and should notify whichever CCG will have responsibility for them as adults". The National Framework sets out that this process should commence when the individual reaches the age of 14 "so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday".
- 16.3 The exception applies where an individual has been placed out-of-area in a care home, children's home or independent hospital before he or she turns 18, with a continuing care package (which must include nursing), remains resident in that accommodation and continues to require the planned services provided beyond the age of 18. In such circumstances, responsibility is not determined on the basis of current GP registration under the general rules at paragraph 10.2. Instead, responsibility remains with the originating CCG – that is, the CCG which was responsible for the child, under the general rules at paragraph 10.2, at the point at which the child was placed in residential accommodation, as described in paragraphs 15.4-5 above.
- 16.4 Where this exception applies, the originating CCG retains commissioning responsibility for the accommodation, and for any planned services in connection with that accommodation, only. Commissioning responsibility for all other NHS services provided to the person, from the age of 18 onwards, is determined in accordance with the general rule at paragraph 10.2 above or other relevant exceptions in this Section D as the case may be.
- 16.5 Note the following points in relation to the operation of this exception.
- It applies only where the individual has been placed by a CCG, or by a CCG and a local authority acting together – not where the individual has been placed by a local authority acting alone.
 - It applies only to placements in care homes, children's homes or independent hospitals, not to placements in residential special schools, nor to packages of care provided in individuals' own homes.
 - It applies regardless of how long the individual was in the accommodation prior to turning 18. So, for example, it applies where an individual remains, beyond the age of 18, in the same accommodation in which he or she was originally placed as a child of, say, 14; but it also applies where (as a result of consideration of his or her potential continuing care needs as an adult) an individual is placed in different accommodation shortly prior to his/her 18th birthday.

Effect on responsibility for payment

- 16.6 Under this exception, the CCG which has responsibility for commissioning the services is also responsible for paying for those services.

Illustrative scenarios

- 16.7 Scenarios 1a, 1b and 2 provide straightforward examples of how the exception does or does not apply.

	Scenario	Responsibility
1a	Child 1 lives in Local Authority A and is registered with a GP from CCG A. He is identified as a looked after child and is then placed, aged 12, by Local Authority A and CCG A acting jointly, in a care home in the catchment of CCG B. Shortly after the date of the placement, he then registers with a GP in CCG B. He remains in the same placement. When he is 14, Local Authority A recognises that he may in time need adult NHS CHC and requests that an NHS assessment is undertaken by CCG A.	If the requirement proves to be for an NHS-funded or jointly-funded residential placement in a care home (including a continuing placement in the existing home) or independent sector hospital and if the assessment is completed and the placement arranged before Child 1 turns 18, then CCG A will, as originating CCG, be responsible for funding the placement costs. Alternatively, if the requirement is for a NHS CHC package in Child 1's own home, the responsible commissioner will be determined on the basis of the general rules at paragraph 10.2. Initially, therefore, the responsible commissioner will be CCG B, but this will change if Child 1 re-registers with a GP belonging to a different CCG.
1b	Continuing from scenario 1, Child 1 is now aged 18 or over and has been placed in adult residential NHS CHC in a care home in CCG C. He remains registered with a GP belonging to CCG C. Child 1 develops a need for an elective surgical procedure, not related to the condition for which the NHS CHC package is provided.	As the originating CCG, CCG C is responsible for paying for the NHS CHC package. CCG C is responsible for payment for the elective procedure, on the basis of the general rules at paragraph 10.2.
2	Child 2 lives in Local Authority D and is registered with a GP in CCG D. Aged 12, she is then placed by Local Authority D in a special school in the catchment of CCG E and registers with a GP there. She remains in the same placement and, when she is 14, Local Authority D recognises that she may in time need adult NHS CHC and requests that an NHS CHC assessment is undertaken by CCG D. The outcome is that Child 2 is not eligible for NHS CHC or any other continuing care package and she remains placed by Local Authority D in the same	CCG D's responsibility as originating CCG ceased at the point Child 2 turned 18. It falls to CCG E to meet the costs of the elective procedure, on the basis of the general rules at paragraph 10.2. (The outcome would be the same even if Child 2 had been found eligible for NHS CHC, had been placed in a care home in CCG E and had remained registered with a GP belonging to CCG E. In that instance, CCG D would have to pay for the CHC package, but CCG E would be responsible for meeting other health

special school. At a point after she has turned 18, she develops a need for an elective surgical procedure.	costs after she turns 18, including this elective procedure.)
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16.8 Scenarios 1a and 2 above describe situations where the child-to-adult transition is managed in a timely manner, in accordance with the National Framework as described at paragraph 16.2. There may also be situations, however, where the potential need for NHS CHC only becomes clear after an individual has turned 18 – or where the referral for NHS CHC assessment is delayed because of an oversight. Such scenarios produce a different outcome in terms of NHS responsibility; scenario 3 below clarifies that the responsibility remains with the originating CCG into adulthood only if the residential NHS CHC placement is arranged and commences before the individual turns 18; if the placement is not arranged until after the individual has turned 18, the exception will not apply and responsibility will be determined on the basis of the general rules at paragraph 10.2.

	Scenario	Responsibility
3	Child 3 lives in Local Authority F and is registered with a GP in CCG F. Aged 12, Child 3 is then placed by Local Authority F in a children’s home in the catchment of CCG G and registers with a GP there. He remains in the same children’s home until age 19, at which point Local Authority F makes a referral for assessment for adult NHS CHC.	As the originating CCG, CCG F is responsible for meeting the costs of any health needs until Child 3 turns 18. Because the NHS CHC referral has been made and the CCG package is being arranged <u>after that point</u> , CCG G is responsible for assessing Child 3’s needs, under the general rule at paragraph 10.2. If it arranges a residential NHS CHC package, even if this is out-of-area, CCG G will be responsible for meeting the costs. If the requirement is for an NHS CHC package in Child 3’s own home, the responsible commissioner will again be CCG G, but this will change if Child 3 re-registers with a GP belonging to a different CCG.

17 Emergency ambulance, A&E and similar services

What is the exception in relation to commissioning responsibility and who does it apply to?

17.1 This exception applies to emergency ambulance services, A&E services and services provided in urgent treatment centres (including minor injury units and walk-in centres).

17.2 The Standing Rules Regulations (Schedule 1, paragraph 2a) set out the position on responsibility for commissioning emergency ambulance services, A&E services and services provided in urgent care centres, minor injuries units and walk-in centres. The effect of the Regulations is that – rather than

commissioning responsibility being based on the normal GP registration rule at paragraph 10.2 – a CCG is responsible for commissioning these services for everyone present in its geographical area, regardless of GP registration. (By contrast, for those admitted to hospital as inpatients, the general rule at paragraph 10.2 does apply.)

Effect on responsibility for payment

17.3 This is a situation where we have used our powers under section 14Z7 of the NHS Act to state that the rules for determining responsibility for payment are, in certain respects, to be different from the legal position on responsibility for commissioning.

- For emergency ambulance services, responsibility for payment is aligned with commissioning responsibility – so the CCG which pays for a particular emergency ambulance journey is determined by the physical location where the patient ambulance journey commences. In the case of emergency ambulance transfers between hospitals, it is the location of the transferring hospital which determines responsibility for payment.
- But for A&E services and services provided in urgent treatment centres, minor injuries units and walk-in centres, the CCG responsible for paying for a particular patient is not aligned with commissioning responsibility – instead it is determined in accordance with the general rule at paragraph 10.2 (subject to the other relevant exceptions in this section D and except in situations where NHS England is responsible – for example, for members of the armed forces in England).

Illustrative scenarios

17.4 The following table sets out the potential scenarios and the commissioner responsible for payment in each case:

	Scenario	Responsibility
1	Patient registered in CCG A or unregistered and 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.
2	Patient registered in CCG C or unregistered and 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.
3	Patient registered in CCG E or unregistered and 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.

4	Patient registered in CCG G or unregistered and 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 patient journey commenced.
5	Critical care patient registered in CCG I or unregistered and 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 transferring hospital is based.
6	Patient registered in CCG K or unregistered and resident in CCG K is picked up by an ambulance in CCG L's area and taken to A&E in CCG M's area and is then admitted.	CCGs L and Mare responsible for commissioning urgent and emergency care for anyone present in their geographic area. CCG L is responsible for payment for the ambulance conveyance as the CCG within whose boundary the patient journey commenced. CCG K is responsible for payment for the A&E attendance and for the hospital admission.

18 Detention under the Mental Health Act and section 117 aftercare

Background

- 18.1 In recent years, there has been some confusion over NHS responsibilities for commissioning and payment where, under the Mental Health Act, patients (whether adults or children) are detained in hospital and where, following discharge, they then receive aftercare ("section 117 aftercare"). Pending any new legislation to be put forward or guidance to be published, in due course, by the Government (including in response to the independent review of the Mental Health Act, <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>), we are therefore clarifying the position as set out below.
- 18.2 For simplicity, we refer throughout this section to patients being "detained". Note, however, that the arrangements set out here apply to all those who are "liable to be detained"; this includes those patients in fact detained, as well as others such as patients who have been given a leave of absence from hospital (such as s17 leave) or are subject to an application but not yet physically detained. (See [Reference Guide to the Mental Health Act 1983](#), paragraphs 1.37-38.)

What is the exception in relation to commissioning responsibility and who does it apply to?

- 18.3 The position on commissioning responsibility for s117 aftercare services changed as of 1 April 2016, when the Standing Rules Regulations were amended. Since then, the position on commissioning responsibility for detention and s117 aftercare has been that
- the responsible NHS commissioner for a patient who undergoes a period of detention in hospital under the Act is the commissioner in whose area the provider of the detention service is based; and
 - the responsible NHS commissioner for a patient receiving s117 aftercare is the CCG in whose area the patient was ordinarily resident, immediately prior to being detained in hospital under the Act.

Effect on responsibility for payment

- 18.4 If this position on commissioning responsibility applied equally to responsibility for payment, it would create a financial incentive for CCGs not to commission local capacity for detained patients – because, if patients were instead detained in a hospital outside their local area, they could escape responsibility for paying for the period of detention. Such a position would be entirely perverse, acting against the direction of national policy, which is to support the provision of care as close to patients’ homes as possible and to minimise reliance on out-of-area placements.
- 18.5 To avoid this situation, therefore, NHS England is making explicit use of its section 14Z7 powers to state that the rules for determining responsibility for payment are to be different from the legal position on responsibility for commissioning.
- 18.6 The following rules on payment responsibility will apply.
- NHS England will be responsible for payment for any period where the patient is treated by a prescribed specialised service.
 - In respect of CCG-commissioned detention and aftercare services, the CCG responsible for payment will be determined on the basis of the general rules at paragraph 10.2 above, applied at the point of the patient’s initial detention in hospital under the Act (whether for assessment or treatment). This CCG will be known as the “originating CCG”.
 - This originating CCG will then retain responsibility for payment throughout the initial detention (including any period of informal admission following detention, during which the patient is no longer detained but remains in hospital voluntarily), for the whole period for which any s117 aftercare is provided and for any subsequent repeat detentions or voluntary admissions from aftercare, until such point as the patient is finally discharged from s117 aftercare – regardless of where the patient is treated or placed, where he or she lives or which GP practice he or she is registered with.

18.7 To clarify further:

- detention for assessment under s2 of the Mental Health Act does not trigger a right to s117 aftercare – but it does constitute detention for the purposes of the rule at paragraph 18.6;
- removal by the police to a place of safety under s136 of the Act does not constitute detention for the purposes of the rule at paragraph 18.6 (other rules set out in *Who Pays?* will apply as relevant, including those on emergency services in paragraph 17);
- the arrangements set out in paragraph 18.6 do not apply where an individual is deprived of their liberty under the Mental Capacity Act but is not detained pursuant to the Mental Health Act; in that instance, the general rule at paragraph 10.2 applies; and
- s117 aftercare services are services which are intended to meet a need that arises from or relates to an individual’s mental health condition and which reduce the risk of deterioration in the individual’s mental health which could otherwise lead to re-admission to hospital; an individual receiving s117 aftercare may therefore also be eligible for FNC or continuing care (see paragraph 39 of the NHS-funded Nursing Care Practice Guidance and paragraph 315 of the National Framework respectively); in such cases, payment responsibility for the FNC / continuing care will be determined separately under the rules in paragraphs 11.15-19 and paragraph 14 as applicable.

In this guidance we do not seek to describe how mental health services should be commissioned or how CCGs should work together to ensure that patients receive care that is appropriate to their needs, for example where a patient receiving s117 aftercare that is organised and paid for by CCG A but is actually delivered by a provider located in the area of CCG B where the patient is now resident. Materials are available to support commissioners and providers, such as the DHSC’s [Mental Health Act Code of Practice](#) which sets out to “*encourage commissioners of services, health and care providers and professionals to deliver a holistic, whole person approach to care that is reflective of clinical best practice and quality.*”

Transition to these new arrangements

- 18.8 This approach is broadly in line with the intended effect of the addendum to *Who Pays?* published in 2016, and its effect will be, broadly, to mirror the arrangements for continuing care and children set out above, with the CCG responsible for the patient at the outset of a period of detention and aftercare retaining responsibility for payment throughout. This will avoid any perverse incentives to maximise out-of-area placements.

- 18.9 Where a patient is detained in hospital for the first time on or after 1 September 2020, responsibility for payment will be determined on the basis of the arrangements set out in paragraphs 18.4-7 above.
- 18.10 We recognise, however, that practice across the country has varied. We have therefore set out below mandatory transitional requirements which will apply in relation to responsibility for payment for detention and aftercare.
- Where, at 1 September 2020, a patient has been discharged from detention and is already receiving s117 aftercare, funded in part or whole by a CCG, that CCG will remain responsible for funding the aftercare – and any subsequent further detentions or voluntary admissions – until such point as the patient is discharged from s117 aftercare.
 - Where, at 1 September 2020, a patient is detained in hospital funded by a CCG, that CCG will be responsible for funding the full period of detention and any necessary NHS aftercare on discharge – and any subsequent further detentions or voluntary admissions – until such point as the patient is discharged from s117 aftercare.
 - Where, at 1 September 2020, a patient is detained in hospital funded by NHS England, the CCG which will be responsible for funding any further detention in a CCG-funded hospital setting and any necessary NHS aftercare (including any subsequent further detentions or voluntary admissions, until such point as the patient is discharged from s117 aftercare) will be determined as set out in paragraph 18.6 above – that is, on the basis of the general rules at paragraph 10.2 above, applied at the point of the patient’s initial detention in hospital under the Act.

Illustrative scenarios

- 18.11 The table below sets out how responsibility for payment is to be determined in specific scenarios.
- 18.12 Scenario 1a describes a straightforward situation where a patient is detained in hospital in, and receives after care in, his own local area, with no change in GP registration.

	Scenario	Responsibility for payment
1a	Patient 1 is registered with a GP in, and lives in the area of, CCG A. He is then detained under the Mental Health Act and placed in a hospital in the area of CCG A. On discharge from hospital, he is then provided with a package of s117 aftercare in the community; he remains registered with the same GP and continues to live in the area of CCG A.	CCG A is responsible for meeting all the NHS costs.

- 18.13 Scenarios 1b, 2a and 2b illustrate that the originating CCG retains responsibility for payment for detention and s117 aftercare, regardless of

registered GP and location of treatment or residence – but that responsibility for payment for other NHS services is determined on the basis of the general GP registration rule at paragraph 10.2.

	Scenario	Responsibility for payment
1b	Continuing from scenario 1, some months after discharge from hospital but while still in receipt of s117 aftercare, Patient 1 moves house to CCG B and registers with a GP there.	CCG A remains responsible for the costs of the NHS element of the s117 aftercare package. From the point of re-registration, CCG B is responsible for the costs of other health needs which may arise.
2a	Patient 2 is registered with a GP in, and lives in the area of, CCG C. She is then detained under the Mental Health Act and placed in a hospital in the area of CCG D; in order to continue to receive primary medical care, she re-registers with a GP in CCG D. On discharge from hospital, she is then provided with a package of s117 aftercare in the community; she chooses to return to the area of CCG C to live and re-registers with a GP there.	CCG C is responsible for the costs of detention in hospital and the NHS element of the s117 aftercare package – and for the costs of any health needs which arise after Patient 2's final re-registration. CCG D would only be responsible for the costs of any other health needs (that is, other than the detention in hospital) which arose while Patient 2 was registered with its GP.
2b	As an alternative to scenario 2a, on discharge from hospital, Patient 2 is again provided with a package of s117 aftercare in the community, but remains registered with the same GP in CCG D and chooses to live in the area of CCG D.	CCG C is responsible for the costs of the NHS element of the s117 aftercare package. CCG D is responsible for the costs of other health needs (that is, other than the s117 aftercare package) which may arise after discharge.

18.14 Scenario 2c demonstrates that the originating CCG retains responsibility for payment for detention and aftercare, even where – while still in receipt of aftercare – a patient has to be detained in hospital for a second time.

	Scenario	Responsibility for payment
2c	Continuing from scenario 2b, whilst she is still receiving s117 aftercare, Patient 2's condition deteriorates, and she has to be detained again in hospital under the Mental Health Act. After some months, she is then discharged with a new package of s117 aftercare. She again chooses to live in the area of CCG D, and she remains registered with the CCG D GP throughout.	CCG C is responsible for the costs of the second detention in hospital and for the NHS element of the s117 aftercare package. CCG D is responsible for the costs of other health needs (that is, other than the detention in hospital and s117 aftercare package) which may arise.

18.15 Some services in which patients are detained in hospital are commissioned by NHS England as prescribed specialised services, whereas others are

commissioned by CCGs. Scenarios 3 and 4 illustrate how the rules apply where an individual is first detained in NHS England-commissioned accommodation and is then, while still detained, “stepped-down” into a CCG-commissioned setting.

	Scenario	Responsibility for payment
3	<p>Patient 3 is registered with a GP in, and lives in the area of, CCG E. She is then detained under the Mental Health Act and placed in a secure hospital in the area of CCG F, commissioned by NHS England as a specialist service. In order to continue to receive primary medical care, she re-registers with a GP in CCG F. As Patient 3’s condition improves, her clinicians seek to arrange a step-down placement in CCG-funded accommodation, in which she will remain detained under the Mental Health Act. CCGs E and F are unable to agree who should fund the step-down arrangement.</p>	<p>CCG E is responsible for meeting the costs of the proposed detention in CCG-funded accommodation and of the NHS element of any s117 aftercare package which is subsequently required.</p> <p>Assuming no change in GP registration, CCG F is responsible for the costs of other health needs (that is, other than the detention in hospital or s117 aftercare package) which may arise.</p>
4	<p>Patient 4 has a long and complex case history; he has been in prison or detained in secure hospital settings for most of his adult life. Exact details are hard to establish, but he has been in NHS England-funded secure hospital accommodation since 2013. Patient 4 is now ready to be moved to CCG-funded step-down accommodation, in which he will continue to be detained under the Mental Health Act. He has had no registered GP for many years, and there is uncertainty as to his address before he entered the prison system, although it is believed he may have lived in the area of CCG G at some point. It is proposed that Patient 4 be moved into step-down hospital accommodation in the area of CCG H, where some of his family live. CCGs G and H are unable to agree who should fund the step-down arrangement.</p>	<p>So that Patient 4’s transfer is not delayed, then – as set out in paragraph 4d) of Appendix 1 – CCGs G and H must agree that one of them will arrange Patient 4’s step-down transfer and that they will, initially, fund it on a 50/50 “without prejudice” basis.</p> <p>Ultimately, if it cannot genuinely be established which CCG (or predecessor body) was responsible for the Patient 4, at the point of initial detention, on the basis of GP registration, and if there is no clarity on the Patient 4’s usual residence at the point of detention, then the default position set out in Appendix 2 must be applied. In this instance, if Patient 4 is indeed discharged to step-down hospital accommodation in the area of CCG H, CCG H would become responsible, on the basis that this is where Patient 4 is now physically present. In that case, CCG H would then reimburse CCG G for the 50% payment CCG G had made.</p>

18.16 Following a period of detention, some patients may stay in hospital on a voluntary basis, prior to discharge and s117 aftercare. Scenario 5 makes clear that, in this situation, responsibility for payment remains with the originating CCG, including for the voluntary stay in hospital.

	Scenario	Responsibility for payment
5	<p>Patient 5 is registered with a GP in, and lives in the area of, CCG I. She is then detained under the Mental Health Act and placed in an independent sector hospital in the area of CCG J; in order to continue to receive primary medical care, she re-registers with a GP in CCG J, but CCG I continues to fund the hospital detention.</p> <p>Following clinical review, Patient 5 is discharged from her detention under the Act, but she remains in hospital as a voluntary inpatient. Six months later, she is discharged from hospital with a package of s117 aftercare in place; she chooses to move to CCG K to live and registers with a GP there. CCGs I, J and K cannot agree who should fund the aftercare package.</p>	<p>CCG I is responsible for the costs of the NHS element of the s117 aftercare package.</p> <p>From the point of re-registration, CCG K is responsible for the costs of other health needs (that is, other than the s117 aftercare package) which may arise.</p>

18.17 Scenario 6 shows that the originating CCG ceases to retain responsibility for payment for detention and aftercare once a patient has been discharged from aftercare. If the same patient is then detained in hospital again after this point, responsibility for payment is determined afresh, on the basis of the rule set in paragraph 18.6 above.

	Scenario	Responsibility for payment
6	<p>Patient 6 has been detained in hospital under the Mental Health Act in the past and has, following discharge, been provided with a package of s117 aftercare – all funded by CCG L on the basis of GP registration at the point of detention. All has gone well, and Patient 6 has been formally discharged from aftercare. He has also moved house and is now registered with a GP belonging to CCG M. Six months after this re-registration, however, Patient 6 suffers a crisis and has to be detained again in hospital under the Act.</p>	<p>CCG M will be responsible for meeting the costs of this new detention and any subsequent NHS aftercare.</p>

18.18 Scenario 7 addresses a scenario involving crossover between the arrangements for children placed out-of-area (under paragraph 15 above) and for detention in hospital under the Mental Health Act and subsequent s117 aftercare (in this section).

	Scenario	Responsibility for payment
7	<p>Individual 7 is registered with a GP belonging to CCG N and is resident in the geographical area of CCG N. Aged 15, he is then placed, by Local Authority N, in a children's home out-of-area in CCG O and re-registers with a GP belonging to CCG O. Aged 16, he is then sectioned under the Mental Health</p>	<p>Consistent with the approach in paragraph 15, CCG N is responsible for meeting Individual 7's health needs during his out-of-area placement and must therefore fund his detention in hospital under the Act (assuming that this is in a CCG-commissioned service, not one commissioned by NHS England). Because CCG N is responsible for Individual 7 at the point of detention, it then remains –</p>

	Act and is admitted to a hospital in the area of CCG O, remaining registered with CCG O's GP. Aged 19, he is then discharged from hospital, supported by a package of s117 aftercare; he chooses to move back to the area of CCG N and re-registers with a GP there. The package of aftercare remains in place until Individual 7 is 22, by which point his condition has improved sufficiently for him to be discharged from aftercare.	consistent with the approach in this paragraph 18 – responsible for paying for Individual 7's detention and aftercare until his eventual discharge from aftercare at the age of 22. In terms of any other healthcare needs which Individual 7 might have (beyond those addressed through his detention and aftercare), responsibility for paying for these would rest with CCG N as originating CCG while Individual 7 is under 18, but would thereafter be determined on the basis of the general GP registration rule at paragraph 10.2.
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18.19 Paragraph 18.7 above clarifies the interplay between these arrangements for s117 aftercare under the Mental Health Act and the arrangements in paragraphs 11.15-19 for FNC and in paragraph 14 for continuing care. But it is also important to consider a situation where an adult patient receiving a package of continuing care (whether in their own home or in a residential care setting) is detained in hospital under the Mental Health Act. In such a case, responsibility for commissioning and payment will be determined afresh, using the rules set out in this paragraph 18, as illustrated in scenario 8 below.

	Scenario	Responsibility for payment
8	Patient 8 is an adult registered with a GP belonging to CCG P and is then placed out-of-area for a package of NHS CHC in a care home in CCG Q. She immediately registers with a GP belonging to CCG Q. A year after being placed, she suffers serious mental health problems and has to be detained in hospital under the Mental Health Act.	The rule at paragraph 18.6 above applies, and CCG Q is responsible for meeting the costs of Patient 8's detention in hospital and any subsequent s117 aftercare.

19 Cross-border issues within the UK

Overall responsibilities

- 19.1 Regulation 2(a) to (c) of the Disapplication Regulations provides that a CCG is not responsible for commissioning and paying for healthcare services for a patient who is registered with a GP belonging to the CCG, but who is usually resident in Scotland, Northern Ireland or Wales. However, the complexity of the position along the England/Wales border is recognised, where frequently English residents are registered with a Welsh GP and vice versa, requiring specific arrangements with regard to the commissioning and payment for healthcare services to have been agreed (see paragraph 19.2 below).
- 19.2 Specific arrangements have been agreed between NHS England and the Welsh Government relating to responsibilities for commissioning and

payment for patients living in defined areas along the England / Wales border. These arrangements apply to Flintshire, Wrexham, Powys, Monmouthshire and Denbighshire in Wales and the areas in England covered by NHS West Cheshire CCG, NHS Shropshire CCG, NHS Gloucestershire CCG, NHS Herefordshire CCG, NHS South Cheshire CCG, NHS Wirral CCG and NHS Telford and Wrekin. They are set out in [England / Wales Cross Border Healthcare Services: Statement of values and principles](#). Commissioners should refer to this for detailed guidance on issues relating to the defined border areas.

- 19.3 Attribution of responsibility to individual Health Boards in Scotland or Local Health Boards in Wales is a matter for the separate guidance published by the Scottish and Welsh Governments, referred to in paragraph 5.5 above.

Patients who move across borders within the UK

- 19.4 The general rules for patients moving across UK borders are set out below in paragraphs 19.5-6. But note also the specific arrangements which apply in respect of continuing care and registered nursing care (paragraphs 19.7-8), children placed out-of-area (paragraph 19.9), emergency care (paragraphs 19.10-12) and mental health services (paragraph 19.13).

- 19.5 Subject to the separate arrangements in relation to the defined English / Welsh border areas set out in the Statement of Value and Principles (see paragraph 19.2 above), the following will apply.

- Where a patient moves his or her usual residence across the border from England to Scotland, Wales or Northern Ireland, the responsible body will be the one where the person is now usually resident (this is the case even if the patient has not yet de-registered from his or her previous English GP); and
- where a patient moves his or her usual residence across the border from Scotland, Wales or Northern Ireland to England, then the relevant CCG will become the responsible body (or NHS England will, for services which it commissions).

- 19.6 In the latter case, if the patient has deregistered from his or her original GP and registered with a new one in England, the responsible CCG will be identified on the basis of the new GP. If the patient has not yet deregistered from his or her original GP, the responsible CCG will be determined on the basis of the patient's new usual residence.

Cross-border arrangements for continuing care and registered nursing care

- 19.7 Where an English CCG arranges a cross-border package of residential continuing care (other than a package that is only NHS-funded nursing care) in Scotland, Wales or Northern Ireland, the "placing CCG" exception described in paragraph 14 applies and the CCG will remain responsible for commissioning and payment for that person's care package until that

episode of care has ended. This is a reciprocal arrangement; in cases where people are assessed as eligible for CHC, and are placed by the Scottish, Welsh or Northern Irish health board in a care home in England, the placing health board will remain responsible for funding the care home placement.

- 19.8 As set out in [Care and Support Statutory Guidance](#) (paragraphs 21.48-50), where a CCG arranges the placement of an individual who is eligible for NHS-funded nursing care in a nursing home in Wales, the receiving Local Health Board is responsible for meeting the costs of nursing care. This is a reciprocal arrangement, so where a Local Health Board arranges the placement of an individual eligible for NHS-funded nursing care in a nursing home in England, the CCG is responsible. By contrast, where such placements are made across the borders between England and Scotland or Northern Ireland, it falls to the relevant NHS body in the “placing” country to meet the costs of nursing care.

Cross-border arrangements for children placed out-of-area

- 19.9 The arrangements described in paragraphs 15 and 16 above, in relation to children placed out-of-area and transition to adult continuing care,
- do apply to individuals placed across the border from England into Wales and vice versa; but
 - do not apply to individuals placed across the borders between England and Scotland or Northern Ireland.

Cross-border arrangements for patients receiving emergency care

- 19.10 To clarify how the arrangements for the funding of emergency care, set out in paragraph 17 above, apply in a cross-border scenario:
- where a patient usually resident in Scotland, Wales or Northern Ireland attends an English A&E department (or urgent treatment centre, minor injury unit or walk-in centre), the responsibility for payment falls to the host CCG for the provider concerned – that is, the CCG in which the A&E provider is based;
 - where a patient usually resident in Scotland, Wales or Northern Ireland is transported by an English emergency ambulance service, the responsibility for payment falls to the CCG in which the ambulance journey commenced; but
 - where a patient usually resident in Scotland, Wales or Northern Ireland requires emergency inpatient admission to hospital, responsibility for payment falls to the relevant NHS body in Scotland, Wales or Northern Ireland, not to a CCG.
- 19.11 The same principles apply, broadly, in reverse to patients usually resident in England being treated in Scotland, Wales or Northern Ireland.

19.12 Note that the [2019/20 National Tariff Payment System](#) provides further guidance, at section 2.6, on where English “national tariff” rules and prices do and do not apply in these cross-border scenarios.

Cross-border arrangements for mental health patients

19.13 Cross-border arrangements in relation to mental health patients detained in hospital may be complex, and commissioners may need to seek specific advice on individual cases. The following guidelines will generally apply, however.

- Where a patient resident in Scotland, Wales or Northern Ireland has to be detained for assessment or treatment under the Mental Health Act in a hospital in England, the costs will fall to the English NHS to fund (that is, to NHS England or to a CCG, depending on the exact service being commissioned). Note, however, that this is not a reciprocal arrangement.
- Where such a patient is then discharged from hospital for aftercare, responsibility for funding any NHS element of this will be determined (as between the English NHS and Scotland, Wales or Northern Ireland) on the basis of the individual’s usual residence in accordance with paragraph 19.5 above.
- Where this results in the English NHS funding both detention and aftercare, the payment rules set out in paragraphs 18.6-7 above should apply, in terms of how the responsible CCG should be determined.

Section E: Clarifying the boundaries of responsibility between CCGs and NHS England

20 Introduction

- 20.1 This section deals with those services which fall to NHS England to commission. The examples provided are particularly aimed at clarifying responsibility where there is more than one commissioner during the course of a patient pathway. They are not exhaustive but, where possible, set out some principles that can be applied more widely.

21 Prescribed specialised services

- 21.1 NHS England is responsible for commissioning prescribed specialised and highly specialised services, as set out in the Standing Rules Regulations (paragraph 11 and Schedule 4). The Specialised Services Manual and Identification Rules describe how these services are to be identified (see <https://www.england.nhs.uk/commissioning/spec-services/key-docs/>). Detailed [tools](#) to assist with identification are also published by NHS Digital.
- 21.2 In some situations, NHS England commissions specialised and highly specialised services only from specified specialist centres, described in “provider eligibility lists”; the 2020/21 update of the Manual and Identification Rules will contain further detail on this. Providers not included on these lists should avoid providing services which would otherwise be designated as specialised or highly specialised, as they will generally not be paid for such activity.

22 Armed forces and veterans

- 22.1 The Ministry of Defence (MOD) is responsible for the primary medical services for members of HM Forces and other military personnel (including NATO personnel), through Defence Medical Services (DMS). The MOD provides primary care, occupational mental health services and community rehabilitation services to serving members of the Armed Forces (including mobilised reservists).
- 22.2 Dependants of members of HM Forces can remain registered with their NHS GP practice or apply to join another GP practice when they wish to do so – e.g. when they move. However, dependants can alternatively 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.
- 22.3 Respective responsibilities of NHS England and CCGs for commissioning and paying for services for serving personnel and their families can be summarised as follows.

22.4 CCGs are responsible for

- out-of-hours primary medical services for all patients in their area which includes serving personnel and their families registered with DMS practices (this is funded by the MOD and paid for by an annual transfer of resources);
- community and mental health services for armed forces patients (serving and dependants), as funding has never transferred from CCGs to NHS England for these services;
- emergency ambulance services for those armed forces patients (serving and dependants) present in their areas;
- armed forces patients and their dependants who are stationed overseas and who return to England for a course of treatment (such patients are dealt with under the arrangements for overseas visitors set out in paragraphs 11.9-12 above); and
- health services for veterans and reservists (when not mobilised).

22.5 NHS England is responsible for

- acute hospital services (including A&E attendances) for members of the armed forces and their families, where they are registered with a DMS practice in England, and for reservists whilst mobilised and registered for primary care services with a DMS practice in England;
- prosthetic services for veterans through specialised commissioning arrangements; and
- specific bespoke veterans' mental health services including the Transition, Intervention & Liaison Service, Complex Treatment Service and the High Intensity Service.

22.6 NHS England may also arrange a small number of packages of health and social care for seriously injured or ill members of the armed forces, or their families, if registered with a DMS practice in England. NHS England is only responsible for such packages whilst the patient is registered with a DMS practice. After the patient leaves the armed forces, responsibility will transfer to the appropriate CCG, determined by reference to the general rules at paragraph 10.2 above.

22.7 The following examples illustrate respective responsibilities.

	Scenario	Responsible Commissioner
1	Soldier 1 returns from Cyprus where she is serving, for treatment for hernia, 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.	The CCG in Bristol 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 paragraphs 11.9-12.
2	Mrs. 2, married to soldier 2 but not herself in the armed forces, is registered with a DMS 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. 3, married to airman 3 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	Soldier 4 is living with her husband who is serving in Cyprus, where they are both registered with a DMS practice. She returns to the UK for secondary care and registers as a temporary resident with an NHS GP practice where her parents live in Birmingham.	The CCG in Birmingham is the responsible commissioner for her secondary care costs as she is an Armed Forces dependent who has returned for care in the UK. She would qualify as a charge-exempt overseas visitor – see paragraphs 11.9-12.
5	Reservist 5 who has been deployed requires surgery once he is back in the UK for an injury sustained whilst he was deployed.	NHS England is the responsible commissioner for secondary healthcare outside of an operational emergency for patients who require access to NHS treatment once they are back in England. This includes reservists whilst still mobilised and registered with DMS practices in England for primary care services.
	Reservist 5 is then demobilised by the MOD when he has been judged to have progressed/settled at his best level of fitness. He is registered with an NHS GP.	As he is registered with an NHS GP, he is then the responsibility of his local CCG for any further ongoing care he may require.

6	Soldier 6 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, but 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	Sailor 7 is based in Scotland and registered with his local DMS practice. He needs a referral to hospital in England where his family are resident.	The Scottish Local Health Board is responsible for his care.
8	Soldier 8 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 Soldier 8 falls ill is responsible for the ambulance journey. NHS England is responsible for paying for the A&E attendance, the inpatient admission for surgery and any subsequent outpatient follow-up care.

Specific infertility treatment examples

	Scenario	Responsible Commissioner
9	Injured soldier 9, who is based in England, 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. If NHS England ordinarily commissions fewer than three cycles, DHSC would effectively 'top up' the treatment so he and his partner could receive the three cycles of treatment to which they are entitled if required.
10	Injured veteran 10, who lives in England and 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, DHSC 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. 11, living in England, married to soldier 11 who is registered in England, requires infertility treatment.	<p>NHS England is the responsible commissioner for uninjured members of the armed forces and their families, whilst one partner remains serving. The number of cycles would depend on the policy determined by NHS England.</p> <p>Note however that, had soldier 11 been a veteran, no longer serving in the armed forces, the relevant CCG would be responsible, and the number of cycles would depend on its local CCG policy.</p>
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23 Prisoners and those detained in ‘other prescribed accommodation’

- 23.1 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’ (as set out in the Standing Rules Regulations).
- 23.2 NHS England’s responsibilities include prisons, young offender institutions, some secure children’s homes, some secure training centres and some immigration removal centres.
- 23.3 CCGs are responsible for commissioning emergency care, including A&E and ambulance services as well as out-of-hours primary medical services¹, 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.
- 23.4 The following examples illustrate respective responsibilities.

	Scenario	Responsible Commissioner
1	Mr. 1 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.	<p>The CCG in which the prison is located is responsible for emergency ambulance services and services provided at A&E.</p> <p>NHS England is the responsible commissioner for all other treatment.</p>

¹ Except where this responsibility has been retained by practices under the GP contract, where NHS England is then responsible.

2	Miss 2 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.
	She is discharged back into custody after a couple of days, but her baby remains in special care for several months.	NHS England is responsible for her post-natal care in the custodial setting. NHS England is the responsible commissioner for the special baby care (as the direct commissioner of specialised services).
3	Mr. 3 is 17 years and 6 months old. He has learning disabilities and severe mental health problems. He is subject to a Youth Rehabilitation Order and accommodated away from home. Mr. 3 is in and out of the youth justice system.	The responsible commissioner is the originating CCG; however, consideration needs to be given to the package of care Mr. 3 will receive once he reaches 18 as the criteria for NHS funded care 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. Upon release from custody the originating CCG remains the responsible commissioner as regards the package of NHS continuing healthcare.
4	Mr. 4 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.	NHS England is the responsible commissioner whilst he is detained in the secure children's home with youth justice board places.

	After a period of time he is released on probation.	<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. 4 accesses the substance misuse service is the responsible commissioner for that service.</p>
5	Mr. 5 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. 5 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. 6 is a 69-year-old male in a category C prison. He suffers a heart attack and is taken to a specialist cardiac centre in an ambulance to receive a primary percutaneous intervention.	<p>The CCG in whose area the prison is situated is the responsible commissioner for the ambulance service and treatment at A&E.</p> <p>NHS England is the responsible commissioner for his treatment.</p>
	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 prison.	NHS England is the responsible commissioner for his treatment.
7	Prisoner 7 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.

24 Primary care

24.1 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 – but note that, under national arrangements for co-commissioning, many CCGs have now taken on responsibilities, delegated from NHS England, in relation to general practice commissioning – for further detail see <https://www.england.nhs.uk/commissioning/pc-co-comms/>;
- 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; and
- all dental services, including primary², community and hospital services³ and urgent and emergency dental care.

24.2 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);⁴
- community-based services that go beyond the scope of the GP contract (akin to previous Local Enhanced Services);
- meeting the costs of prescriptions written by member practices (but not the associated dispensing costs); and
- secondary ophthalmic services and any associated community-based eye care services.

24.3 The following examples illustrate respective responsibilities.

² Defence Medical Services normally provide primary dental care in UK for serving personnel, mobilised reservists and overseas for serving personnel and families.

³ Including for Armed Forces and mobilised reservists.

⁴ NHS England has statutory responsibility for commissioning these services but has directed CCGs to carry out this responsibility on its behalf.

	Scenario	Responsible Commissioner
1	Mr. 1 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. 1 then receives treatment in his dental practice.	NHS England is the responsible commissioner throughout.
2	Miss 2 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. 3 is chronically ill, and regularly sees his GP.	NHS England
	He falls ill on a Sunday afternoon and calls the local out of hours provider which is commissioned by his CCG.	CCG
	He then returns to his GP for continuing his care.	NHS England
4	Mr. 4 attends his local 8-8 GP health centre, but he is not a registered patient at this centre.	NHS England
	Mr. 4 attends the same GP health centre, but he is a registered patient at this centre.	NHS England

25 Public health services

- 25.1 Regulations⁵ set out requirements on local authorities in respect of the provision of certain public health services, and DHSC makes ring-fenced public health grants to local authorities, and these grants are accompanied by conditions setting out how they are to be used. Details of the grants made in 2020/21 are available at <https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2020-to-2021>.

⁵ The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 and The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment) Regulations 2015

25.2 NHS England commissions certain public health services in accordance with the Section 7A public health functions agreement and the national service specifications available at <https://www.england.nhs.uk/commissioning/pub-hlth-res/>. The services currently commissioned in this way are:

- national immunisation programmes;
- national cancer and non-cancer screening programmes;
- Child Health Information Services;
- public health services for adults and children in secure and detained settings in England; and
- sexual assault services (Sexual Assault Referral Centres).

Appendix 1: Dispute resolution process

1. This Appendix sets out principles which apply where there is disagreement about a responsible commissioner issue between CCGs, or between CCGs and an NHS England commissioning team, and describes the formal dispute resolution process to be followed where a disagreement cannot be resolved locally.

Coverage

2. This process applies only within the NHS in England. It does not apply to disputes involving an NHS commissioner and a local authority, nor does it apply to cross-border disputes within the UK.
3. Note, however, the separate process for dispute resolution between NHS bodies in England and Wales set out in [England / Wales Cross Border Healthcare Services: Statement of values and principles](#).

Principles

4. The key principles underpinning the process are set out below.
 - a) We strongly recommend that commissioners do not spend public money on taking external legal advice on *Who Pays?* matters.
 - b) Rather, in cases of uncertainty or disagreement, commissioners should jointly seek advice, either
 - locally within their Integrated Care System (ICS) / Sustainability and Transformation Partnership (STP) (for disagreements affecting CCGs within one ICS/STP); or
 - on specific topics from relevant officers in the regional teams of NHS England / Improvement (such as regional leads for Continuing Healthcare or Transforming Care); or
 - from the national team at NHS England / Improvement via the email helpdesk, england.responsiblecommissioner@nhs.net.
 - c) Disagreements about payment responsibility between NHS commissioners must not
 - delay a patient's necessary assessment, care or treatment;
 - result in the patient or family, or a local authority, having to pay for care or treatment which should have been funded by the NHS; or

- mean that a provider which is properly providing clinically appropriate services to a patient remains unpaid.
- d) Where substantive disagreements arise, which cannot be resolved swiftly at local level, the commissioners involved must agree a) that one of them will make arrangements for the patient to be assessed and to receive necessary care or treatment and b) that they will share the costs equally between them, on a “without prejudice” basis, pending resolution of the disagreement. That way, the patient’s assessment, care and treatment will not be delayed, and the provider will be paid promptly. (Once the dispute is resolved, whether through local agreement or this arbitration process, an appropriate refund should be made by the commissioner which has been found to be responsible to the other commissioner, to repay the amount which the latter has paid under the “without prejudice” arrangement.)
 - e) If – despite advice having been sought and provided as described above – a substantive disagreement does persist about which commissioner should pay for a patient’s care and treatment, the commissioners involved must follow the process set out below. Participation, in and cooperation with, this process is mandatory, and the outcome will be binding on the parties.
 - f) Where a third party (a provider or a local authority) encounters sustained difficulties in establishing which NHS commissioner is responsible for a particular individual, it may seek assistance, either via the relevant ICS / STP or from the national team via england.responsiblecommissioner@nhs.net.
 - g) In accordance with paragraph 1.8 of the Executive Summary, any disputes must be initiated promptly, and commissioners must not seek to re-open historic cases. The maximum retrospective financial adjustment between commissioners, required as a result of an arbitration, will be to the beginning of the financial year in which the dispute was formally initiated.

Step by step approach

Step 1 – local resolution

5. Before the formal dispute resolution process is initiated, the parties must ensure that discussion is held between them at Director level, so that a final attempt can be made, in good faith, to resolve the matter by agreement.
6. The parties should ensure that, to inform this discussion, they have jointly taken advice as described at 4b) above.

Step 2 – resolution at ICS/STP level

7. Where a dispute is between CCGs within the same ICS/STP, it must then be resolved at system level, within input from ICS/STP leadership as appropriate.

8. Where a dispute is between CCGs within different ICSs/STPs, the two ICSs/STPs should liaise to seek an agreed resolution wherever possible.

Step 3 – arbitration through NHS England / Improvement’s national team

9. If the actions at points 5-8 is unsuccessful in resolving a dispute, the commissioners involved should jointly submit a single, agreed, factual chronology for the case to the NHS England / Improvement national team, via england.responsiblecommissioner@nhs.net, asking the national team to arbitrate. The chronology must make clear the period for which payment responsibility is in dispute and provide all of the relevant background information – where the patient has been treated and in what circumstances, which organisation has arranged and funded treatment or placements to date, the patient’s history of GP registration and usual residence and all other relevant factors. Whichever organisation submits the chronology must ensure that the relevant senior representatives of the other parties to the dispute are copied in.
10. The national team will then require the parties to clarify any aspects of the joint chronology as necessary, and, once this is complete, to submit separate “statements of case”, describing, for each organisation – with reference to this *Who Pays?* guidance and to legislation or other guidance as appropriate – why it believes that it should not be considered the responsible commissioner in the case.
11. Templates for completion of the chronology and “statements of case” are attached at Appendix 4.
12. The national team will then use the chronology and statements of case to produce a brief arbitration report for the local parties, identifying, with reasons, the organisation responsible for commissioning and paying for the services during the period in dispute. The national team may seek further information from the parties where it deems necessary, and the parties must cooperate fully in supplying such information promptly.
13. The national team’s arbitration findings must in all circumstances be considered binding on the local parties and they must act on those findings accordingly.
14. Where, for any reason, one commissioner will not engage in a process to seek local resolution (paragraph 5 above) or the preparation of an agreed chronology (paragraph 9 above), the other commissioner may nonetheless refer the matter to NHS England / Improvement for arbitration. This should however be wholly exceptional.
15. Where the national team considers that either party has failed to co-operate in the process (including where either party refuses to submit information or statements required for the process or fails to do so, without reasonable justification, to the timescale required by the national team), the national

team may, at its discretion, take this into account in reaching its arbitration decision.

Timescales

16. The normal expectation will be that the arbitration report will be available within approximately eight weeks from the date by which both parties have submitted their statements of case.

Costs

17. Subject to the volume of cases remaining at a manageable level, arbitrations will be carried out by the national team, and there will be no charge to the local parties for entering arbitration. However,
- in complex cases, the national team may, at its sole discretion, seek legal advice from a firm of solicitors from NHS England / Improvement's national legal panel; the actual costs of such advice will be re-charged to the local parties on the basis of an equal split;
 - where one of the commissioners involved in the dispute is NHS England itself, and any of the other parties involved objects to NHS England / Improvement itself conducting the arbitration, NHS England / Improvement will instruct a firm of solicitors from NHS England / Improvement's national legal panel to conduct the arbitration and produce a report; the actual costs of such arbitration will be re-charged to NHS England and the local parties on the basis of an even split; and
 - in exceptional circumstances, if the volume of disputed cases outstrips capacity within the national team, the team may, at its sole discretion, outsource responsibility for conducting the arbitration and producing a report to external solicitors; in such cases, the actual costs will again be re-charged to the local parties on the basis of an equal split.

Confidentiality

18. The parties must ensure that no patient-identifying information is submitted to the national team. Documents must be redacted where necessary, before submission, to remove any patient-identifying information.

Appendix 2: 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. 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 commission⁶, 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 is largely based on the concept of ‘ordinary residence’ (explained further in chapter 19 of the [Care and support statutory guidance](#)).
2. The main criterion for assessing ‘usual residence’ is the patient’s perception of where they are resident in the UK (either currently, or failing that, most recently). The same principles apply in determining usual residence for determining which CCG has responsibility for arranging care for a patient.
3. Where the patient gives an address, they should be treated as usually resident at that address.
4. Certain groups of patients may be reluctant to provide an address. It is sufficient for the purpose of establishing usual residence that a patient is resident in a location (or postal district) within the CCG geographical area, without needing a precise address. Where there is any uncertainty, the provider should ask the patient where they usually live. Individuals remain free to give their perception of where they consider themselves resident. Holiday or second homes should not be considered as “usual” residences.

⁶ Apart from sexual health services - under regulations local authorities are required to commission certain specified sexual health services on an open access basis for all people present in the area and cannot limit the population for these services.

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.

Appendix 3: Reference guide to the updated *Who Pays?*

This Appendix is aimed at helping readers to identify how the content from the 2013 version of *Who Pays?* maps to the structure of the new 2020 version.

Heading in 2013 <i>Who Pays?</i>	Original 2013 reference	Updated 2020 reference
Section A: General rules		
Identifying which CCG is responsible for commissioning and paying for care	Para 1-2	Para 10
Emergency care	Para 3	Para 17
Paying for care	Para 4-6	Para 10
Resolving disputes between CCGs	Para 7-9	Para 7 and Appendix 1
Section B: Applying the rules to CCG commissioned services		
Asylum seekers	Para 11	Para 11.12
Persons of 'no fixed abode'	Para 12	Para 11.2
Approved premises and bail accommodation	Para 13-14	Para 11.3
Patients who move	Para 15-18	Para 11.4-8
People taken ill abroad	Para 19-21	Para 11.13
Right to cross-border healthcare treatment within the European Economic Area	Para 22-24	Para 11.14
Registered nursing care	Para 25-28	Para 11.15-19
Looked after children	Para 29-31	Para 15 and 16
Students and boarding school pupils	Para 32	Para 11.20
Persons detained under the Mental Health Act 1983	Para 33-34	Para 18
Choice of secondary care provider	Para 35-36	No longer included
Patient Transport Services	Para 37	Para 11.21-23
Non-contract activity	Para 38-46	Para 5.10-11 and NHS Standard Contract Technical Guidance
Section C: Exceptions to the general rules		
Cross border issues within the UK	Para 51-56	Para 19
Patients who move across borders within the UK	Para 57-58	Para 19
Transfer of patients to other CCG areas under NHS CHC arrangements	Para 59-64	Para 14 and 16
Transfer of NHS CHC patients across borders in the UK	Para 65-68	Para 19
Transfer of NHS-funded nursing care patients across borders in the UK	Para 69-70	Para 19
Out-of-area placements of children	Para 71-77	Para 15
Urgent and emergency care	Para 78-82	Para 17
Section D: Examples to help clarify the boundaries of responsibility between commissioning organisations	Para 83-101	Para 20-25
Annex A: Eligibility for free NHS treatment	Annex A	No longer included – see para 11.9 onwards and DHSC guidance
Annex B: Defining 'usually resident'	Annex B	Appendix 2

Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- reduce health inequalities in access and outcomes of healthcare services
integrate services where this might reduce health inequalities
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity and 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

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