

**ESTABLISHING THE RESPONSIBLE COMMISSIONER –**

**Guidance for PCT commissioners on the application of the legal framework on PCT's secondary care commissioning responsibilities.**

**APRIL 2006**

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## INTRODUCTION

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

2. Between 1<sup>st</sup> April 1999 and April 2001, all patients registered with a GP became the responsibility of the Primary Care Group (as a committee of the Health Authority) of which the GP was a member<sup>1</sup>. In addition, arrangements were put in place for PCGs (as committees of Health Authorities) to exercise functions on behalf of adjoining Health Authorities where patients were registered with a GP practice in their PCG area<sup>2</sup>. A similar framework, based on GP registration, was described in legislation coming into effect on 1<sup>st</sup> April 2000<sup>3</sup> and 1<sup>st</sup> April 2001<sup>4</sup>. From 1<sup>st</sup> September 1993 until the end of February 1999 the Health Authority where a person was usually resident was responsible for that person<sup>5</sup>.

3. PCTs are responsible for planning and securing the provision of the great majority of health services that their population needs either by direct management or through agreement with other organisations. They also have a responsibility to work towards better integration of health and social care services. PCTs are accountable to Strategic Health Authorities (SHAs) for discharging their functions effectively. Further details on PCT-led commissioning are outlined in the document *Shifting the Balance of Power – The Next Steps (2002)*.

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

5. This guidance takes account of the organisational changes announced in the NHS White Paper, *The new NHS: modern, dependable* (1997). It should be read alongside Data Set Change Notice (DSCN) 34/98/A08, which gives practical guidance on how to manage secondary care information flows resulting from the organisational changes of the Health Act 1999.

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<sup>1</sup> See Health Service Circular 1998/065 The New NHS Modern and Dependable: Establishing Primary Care Groups paragraph 18.

<sup>2</sup> See the National Health Service (Functions of Health Authorities and Administration Arrangements) Amendment Regulations 1999 (S.I. 1999/628).

<sup>3</sup> See the Primary Care Trust (Functions)(England) Regulations 2000 (S.I. 2000/695)

<sup>4</sup> See the National Health Service (Functions of Health Authorities and Administration Arrangements) (England) Regulations 2001 (S.I. 2001/747).

<sup>5</sup> Establishing District of Residence September 1993 NHS Management Executive

## BACKGROUND

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

7. Since it is not possible to cover every eventuality within this guidance, the NHS is expected to act in the best interests of the patient at all times and work together in the spirit of partnership. **Ministers have specifically asked to be advised of NHS bodies who are unable to reach local resolution to any disputes between themselves or with independent providers.**

## ESTABLISHING THE RESPONSIBLE COMMISSIONER

8. Access to NHS services is usually obtained through registration with a general practitioner (GP) – either providing general medical services or primarily responsible for the provision of personal medical services as part of a pilot scheme.

9. Registration with a GP does not give a patient automatic entitlement to free NHS hospital treatment. There are regulations that place a responsibility on NHS hospitals to establish whether a person is liable for charges or exempt under one of a number of exemption categories; and to charge patients where required. Further details of the circumstances in which patients may be charged for hospital services are set out in paragraphs 46-50.

10. From 1<sup>st</sup> April 1999, PCGs were responsible for commissioning health services for all patients registered with a GP who was associated with their PCG. These commissioning responsibilities now sit with PCTs. Patients registered with a GP are the responsibility of the PCT with which the GP's practice is associated, including those who are resident in another PCT or SHA area. The PCT is also responsible for funding the healthcare provision of any unregistered patients resident within its geographical boundary.

11. Under regulation 3(7) of the Functions Regulations, PCTs are responsible for commissioning (hospital and community health) services for:

- patients registered with GPs associated with their PCT (unless such patients are detained in prison in England); and
- persons usually resident in their area, or resident outside the United Kingdom and present in their area, who are not registered with a GP or otherwise fall outside paragraph (a) – for example because they are in prison.

12. The following services are to be provided for the benefit of all persons present in the PCT area: accident, emergency, and ambulance services; walk-in centre services; genito-urinary medicine (GUM) and sexual health services (see paragraphs

25 and 26); medical inspection and treatment of pupils<sup>6</sup>; services relating to contraception; health promotion services; services in connection with drug and alcohol misuse; and any other services which the Secretary of State may direct.

13. Certain highly specialised services are commissioned centrally by the Department of Health under the auspices of the National Specialist Commissioning Advisory Group (NSCAG) (see Annex B for a list of these services).

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

15. In summary, the responsible PCT will be determined by establishing:

- a) the GP with whom the patient is registered and the PCT that has responsibility for that GP's patients; or if this is not applicable,
- b) the patient's usual address (which will identify the PCT boundary within which they live. 'Usually Resident' is considered further in Annex A).

### **SERVICE LEVEL AGREEMENTS (SLAs)**

16. HSC 1998/198 set out the arrangements for commissioning services in the NHS. The document *Reforming NHS Financial Flows: Introducing payment by results* (October 2002) and the subsequent technical guidance (December 2002) outlined a fundamental change in the way that NHS care is commissioned and funded.

17. NHS service level agreements replaced annual contracts from April 1999. These arrangements have been intended to strike a balance between a coherent planned approach to service provision, and responsiveness to individual needs and their expressions of choice of treatment etc. Since April 1999, most patients have been treated under service level agreements. However, for some specialised service activity such as emergency secure care NHS placements, sometimes made at the direction of the courts, or for placements with private providers, a named patient service agreement is more appropriate.

18. The Department of Health has recently issued *The NHS Contractors Companion*, a toolkit aimed at supporting PCTs to commission and contract for services from NHS Trusts. Different, more formal, legally binding contracts will be required for commissioning services from NHS Foundation Trusts and Independent Sector Treatment Centres.

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<sup>6</sup> Services which the Secretary of State has a duty to provide under section 5 of the National Health Service Act 1977.

## **OUT OF AREA TREATMENTS (OATS)**

19. Where an explicit service level agreement does not cover a patient's treatment, then the patient will be treated under an Out of Area Treatment (OAT) arrangement. Out of Area Treatment arrangements are primarily intended to cover situations when a patient requires emergency treatment whilst away from home, and where prior approval is not possible from the patient's relevant PCT. In the case of Out of Area Treatment the patient's treatment will be covered by the service level agreement of the NHS Trust's 'main commissioner' (this is usually the PCT with the highest value of service agreements with the NHS Trust providing treatment). Directions to PCTs for Arrangements for Out of Area Treatments and Arrangements for the Treatment of Overseas Visitors (31 March 2003) provide details on this. The OATs arrangement should not be used as an option for long-term treatment.

20. PCTs may have agreements with several local providers so as to offer choice to patients and their GPs for a particular service. If these arrangements do not best meet the needs of a particular patient, then GPs also have the freedom to refer elsewhere using an OAT arrangement.

## **SPECIALISED SERVICES**

21. From April 2002, all elective and emergency specialised services (excluding those covered by National Specialist Commissioning Advisory Group (NSCAG) arrangements) should be included in service level agreements or a named patient service agreement. The only exception to this is specialised services treatment given to overseas visitors; in this case the overseas visitors will be treated under an OAT arrangement.

22. Specialised services need to be managed and developed through explicit commissioning arrangements that take account of the particular characteristics of the service, its patients and changes in demand. NHS Trusts and their commissioners need to develop these arrangements in partnership.

23. A list of services which are commissioned centrally through NSCAG is given in annex B. Specialised services are defined in the Specialised Services National Definitions Set. The second edition of the Specialised Services National Definitions Set (Dec 2002) can be found at:  
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en>

## **SERVICES PROVIDED ON AN "ALL-COMERS" BASIS**

24. Examples of services provided on an "all-comers" basis include Accident and Emergency services<sup>7</sup>, family planning services, health promotion services, GUM and HIV testing and counselling services and services provided at NHS Walk-in centres. Host PCTs are responsible for securing the provision of these services to all persons present in the area (regardless of registration/residence). This includes associated

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<sup>7</sup> See regulation 3(7)(b) of the Functions Regulations

ambulance services in the case of Accident and Emergency services. PCTs are also expected to ensure that adequate arrangements are in place to provide these services on an “all-comers” basis.

## **GUM SERVICES AND HIV/AIDS PATIENTS**

25. GUM clinics remain the main point of access for diagnosis and treatment of Sexually Transmitted Infections (STIs) including HIV, although other routes of access to these services exist. GUM services (pre- and post test counselling and testing and treatment for STIs and pre-test discussion and post-test counselling and testing for HIV) are provided on a confidential, open access basis irrespective of the patient’s registered GP or address. In the interests of patient confidentiality, the above services are provided on an ‘all-comers’ basis and no requests for funding for out of area treatment should be made by the host PCT. Overseas visitors not entitled to free NHS treatment are only entitled to the test and associated discussion/counselling free of charge. The treatment and any drugs are chargeable.

26. HIV treatment given following a confirmatory HIV positive test and post test counselling, including the prescription of combination anti-retroviral drug therapies and associated monitoring, should be commissioned on a collaborative basis by PCTs as a specialised service under arrangements made with the responsible PCTs as laid out in the section headed **Establishing the Responsible Commissioner**. For those patients who have been identified as liable for charges (as determined by paragraphs 46-50) only the HIV test and post test counselling is free of charge and charges must be applied to any further treatment of these HIV positive individuals.

27. The full definition of specialised treatment and care services for HIV is found in the Specialised Services National Definitions Set:  
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en>

28. Further guidance on commissioning sexual health and HIV services can be found in the document *Effective Commissioning of Sexual Health and HIV Services*, published in January 2003.

## **TRANSPLANTS**

29. Where a transplant necessitates medical intervention involving a live donor (e.g. bone marrow transplant) and a service agreement does not exist to cover the harvesting of donor material, the PCT of the recipient of the donation should be responsible for funding the procedure unless alternative arrangements are already in place between the commissioners.

30. Some transplant services are funded centrally through the NSCAG arrangements i.e. liver transplant, paediatric small bowel transplant, bone marrow transplants for Severe Combined Immuno Deficiency Syndrome (SCIDS), and heart and lung transplants. For these services, within the cost of a transplant episode funded through the NSCAG service agreement.

## **EMERGENCY RECOMPRESSION TREATMENTS**

31. Emergency recompression treatments (use of elevated pressure to treat conditions within the body after it has been subjected to a rapid decrease in pressure, including hyperbaric oxygen therapy) are an unusual case because the treatments are primarily provided by non-NHS bodies rather than at accident and emergency departments or minor injury units of NHS hospitals. However as they are emergency treatments, regulation 3(7)(b) of the Functions Regulations applies (see paragraph 12). Funding should not be refused where there is evidence of effectiveness for particular conditions.

## **TEMPORARY RESIDENTS**

32. Where a patient has been accepted as a temporary resident by a GP (i.e. for a maximum period of three months) or has received 'emergency' or 'immediate and necessary' treatment from a GP, the responsible commissioner should be determined by the normal means laid out in the section entitled **establishing the responsible commissioner**.

## **PERSONS OF 'NO FIXED ABODE'**

33. Where a patient has 'no fixed abode', the responsible PCT should, except in the rare case where the patient is registered with a GP, be determined by the terms of 'Usually Resident' (see Annex A). If patients consider themselves to be resident at an address, which is for example a hostel, then this should be accepted.

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

## **PATIENTS WHO MOVE**

35. Where a patient moves during the course of treatment, every effort should be made to ensure continuity of care. The responsible PCT should be determined as laid out in the section headed **Establishing the Responsible Commissioner** (paras 8-15). However, in some instances PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by the originating PCT exercising functions on behalf of the receiving PCT for a specific length of time.

36. Where a patient has moved away from the area served by their registered GP and deregistered and has yet to re-register with a new GP, the responsible PCT should be determined as where the patient has become resident.

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

Situation	PCT A	PCT B	Responsible Commissioner
Patient not yet moved	Registered Resident	-	PCT A
Patient moved	Registered	Resident	PCT A
Patient moved	De-registered	Resident Not yet registered	PCT B
Patient moved	-	Registered Resident	PCT B

### CROSS BORDER ISSUES WITHIN THE UK

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

39. In the case of persons resident in Scotland but registered with a GP in England, Scotland is the responsible commissioner<sup>8</sup>. This applies from 1<sup>st</sup> October 2002 when the Functions Regulations<sup>1</sup> came into force. From 8<sup>th</sup> July 2003 for patients who are resident in England but registered with a GP in Wales, Scotland or Northern Ireland the responsible commissioner is the English PCT in whose area the patient is resident<sup>9</sup>.

40. If a patient is resident in Wales or Northern Ireland and registered with a GP in England, both Wales/Northern Ireland and England could be deemed responsible. Local health organisations are **strongly encouraged** to enter into discussions and negotiations locally in order to agree appropriate arrangements, especially in cases where organisations are considering placing high cost cases across a border.

### PATIENTS WHO MOVE CROSS BORDER WITHIN THE UK

41. Where a patient moves cross-border from Scotland, Wales or Northern Ireland to England, the expectation would be for that individual to register with a GP at their earliest convenience and so determine the responsible PCT for that individual's care. If they have not yet registered with a GP in England and are no longer registered with a GP in Scotland, Wales or Northern Ireland, responsibility will be determined by usual residence under the Functions Regulations<sup>1</sup>. In instances after 8<sup>th</sup> July 2003 where the patient has moved across a border into England but has not yet de-registered from their previous GP, the responsible commissioner would be the

<sup>8</sup> See S.I. 2002/2375 where the definition of "practice patients" excludes residents in Scotland.

<sup>9</sup> See S.I. 2003/1497, amendment to S.I. 2002/2375

English PCT in whose area the patient is resident.

42. The decision to transfer a patient with a long-term condition or receiving specialist treatment between Scotland, Wales or Northern Ireland and England should be made on the basis of patient need, with agreement between the placing and receiving authorities, and the agreement of the patient wherever possible. As for patients who move within England, the responsible PCT should be determined as laid out in the section headed **Establishing the Responsible Commissioner** (paras 8-15). However, in some instances, PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by the originating PCT exercising functions on behalf of the receiving PCT for a specific length of time.

43. A protocol has been drawn up by the Welsh Assembly and the Department of Health in England for transfers of patients to care homes providing NHS funded nursing care between Wales and England based on the default position of usual residence. The protocol is a basis for local solutions to ensure that all patients receive the services which they are assessed as needing and does not override the Functions Regulations. This protocol is available at:  
[www.doh.gov.uk/jointunit/nhsfundednursingcare](http://www.doh.gov.uk/jointunit/nhsfundednursingcare).

#### **PEOPLE TAKEN ILL ABROAD**

44. If a person entitled to free NHS treatment is taken ill abroad, necessary treatment on return to the UK will be subject to the same principles set out in the section headed **Establishing the Responsible Commissioner** (paras 8-15). If it is not possible to determine GP registration or establish a resident address by the usual means, the responsible commissioner should be determined in accordance with the Functions Regulations as the PCT in which he is present, which will usually be the PCT where the unit providing the treatment is located (see Annex A). In all cases it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

45. Where a person is not usually resident in the UK, but retains entitlement to free NHS treatment, it is not always possible to determine GP registration or establish a resident address by the usual means. Therefore, the responsible commissioner should be determined in accordance with the Functions Regulations as the PCT in which he is present, which will usually be the PCT where the unit providing the treatment is located (see Annex A). Again, in all cases, it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

#### **PEOPLE NOT ORDINARILY RESIDENT IN THE UK AND OVERSEAS VISITORS**

46. NHS treatment is provided for people who are ordinarily resident in the UK. The meaning of the words "ordinarily resident" was considered by the House of Lords in 1982 in the case of *Shah v. Barnet LBC*. The words may be briefly summarised as referring to a person who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an

identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as settled.

47. Under the National Health Service (Charges to Overseas Visitors) Regulations 1989 (SI1989/306) people who are not ordinarily resident in the UK are (for the purposes of the Regulations) overseas visitors and are, subject to certain exceptions, liable to be charged for any hospital treatment they receive. It is the duty of the hospital to establish who is 'chargeable', and who is not.

48. All patients should be asked the basic question 'where have you lived for the last 12 months?' before treatment begins. This should be followed up as necessary to establish liability under the overseas visitor charging regulations. If charges apply, they must be collected.

49. Patients who are not ordinarily resident in the UK, may be exempt from charges under provisions of the Regulations. It is possible to consider three broad categories:

- **Those who could be considered part of the resident population**, and who could be registered with a GP and give a UK address. Examples are: people who have been in the UK for more than 12 months; people coming to the UK to take up permanent residence; people who are employed or self-employed here; asylum seekers who have either been given leave to remain or have formally applied for leave; diplomatic staff; those students who the hospital consider are ordinarily resident in the UK; NATO personnel.

- **Those who are not part of the resident population.** Examples are: UK state pensioners living abroad; some UK nationals working overseas; members of HM forces serving overseas; nationals of EEA countries and people from reciprocal healthcare agreement countries. Although the cost of treatment is the responsibility of the relevant PCT it can be recovered as part of the OATs agreement. This includes specialised services treatment given to overseas visitors.

- **Those requiring specified treatments.** There are no charges for treatment given to overseas visitors in an accident and emergency department, or for compulsory psychiatric treatment or for treatment for a notifiable or communicable disease, with the exception of treatment for HIV/AIDS where only the test and associated counselling are free. Where treatment for HIV/AIDS is necessary, patients should be asked 'Where have you lived for the last 12 months?' to establish possible liability for overseas patient charges before treatment begins.

50. In each of these cases the responsible PCT should be determined as in the section headed **Establishing the Responsible Commissioner** (paras 8-15).

51. For details of exemption from charges please see the NHS (Charges to Overseas Visitors) Regulations 1989, (SI 306), and subsequent amendments and NHS Treatment of Overseas Visitors Manual of Guidance 1988 or the leaflet 'Are you visiting the UK?' A consultation on proposed changes to NHS Charges to

overseas visitors for hospital treatment was issued in July 2003 and can be found at: <http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/fs/en>.

## **MILITARY PERSONNEL**

52. Upon enlistment, PCTs are required to de-register members of HM Forces from the lists of GPs<sup>10</sup> and PMS providers<sup>11</sup>. There is no such restriction on dependants, who are able to remain fully registered with a GP. In any event members of HM Forces, and other military personnel based in the UK are entitled to receive emergency or immediately necessary treatment from a GP.

53. Members of HM Forces are able to be accepted by a GP as a temporary resident. They usually do so when outside the catchment area of a Defence Medical Service (DMS) medical centre or when appropriate DMS service provision is not available. Treatment as a temporary resident is applicable only for a period of between 24 hours and three months<sup>12</sup> (see also paragraph 32). This entitlement includes personnel living in their own home or in married quarters if these criteria are met.

54. Members of HM Forces (and other military personnel) based in the UK are entitled to the full use of NHS facilities on the same basis as civilians if appropriate military health care provision is not available. PCTs are responsible for the securing the provision of secondary care treatment for such personnel. In the absence of full GP registration the responsible PCT should be established on a residence basis. In such cases, usual residence will generally be the address of the UK unit at which the person is based.

55. Members of HM Forces serving overseas are also entitled to full use of NHS hospital facilities without charge. For members of HM Forces permanently based outside the UK, in the absence of full GP registration, the address of the establishment providing the treatment should be used to determine the responsible commissioner. The cost of treatment is the responsibility of the relevant PCT and will be funded as part of the OATs agreement.

56. Personnel who are discharged from HM Forces and who are undergoing a continuing care package should be dealt with in a similar way to those who move – see paragraphs 35-37 – in order to ensure continuity of care.

## **ASYLUM SEEKERS**

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<sup>10</sup> Regulation 19 of the NHS (General Medical Services) Regulations 1992 S.I. 1992/635

<sup>11</sup> Direction 5(5) of the Directions to Health Authorities concerning Patient Lists dated 1<sup>st</sup> April 1998

<sup>12</sup> In accordance with Regulation 7 of the NHS (Choice of Medical Practitioner Regulations 1998 (S.I.1998/668)

57. A person who has made a formal application to take refuge in the UK is regarded, at any stage in their application, as a member of the resident population. Therefore, the responsible commissioner will be subject to the same principles set out in the section headed **Establishing the Responsible Commissioner** (paras 8-15) in this guidance.

## **IMMIGRATION DETAINEES**

58. Where a person who is not usually resident in the UK is detained on grounds connected with their immigration status, then the responsible commissioner should be determined by the address of the unit providing treatment. In this context the PCT in which the facility is located becomes the responsible commissioner for these purposes and will be funded through the OATs agreement.

## **PRISONERS**

59. New arrangements were brought into force in April 2003 so that PCTs where prisons are located will commission the majority of secondary care services for those prison populations<sup>13</sup>. This is separate from, but complementary to, the planned future shift of commissioning responsibility for the totality of prison health care to PCTs.

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

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

62. The responsible commissioner for the commissioning of psychiatric hospital care for people transferred from prison to hospital under sections 47 or 48 of the Mental Health Act will not change and will be determined in the usual way as set out in the Functions Regulations (see paragraph 64). For persons usually resident outside the United Kingdom, responsibility will remain with the PCT in which he is present, which will usually be the PCT in which the prison is located (see Annex A)

63. PCTs and prisons have been given further guidance on the changes on the prison health website at <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/fs/en>. However, prior to April 2003, the responsible PCT for prisoners was determined by the usual means. For prisoners not registered with a GP, and for whom a previous address cannot be determined, usual residence should be interpreted as being in the area in which the offence for which he/she is detained was committed. Or, if detained pending trial, the area where the offence with which he/she is charged was committed.

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<sup>13</sup> See S.I. 2003/1497

## <sup>14</sup>**PERSONS DETAINED UNDER THE MENTAL HEALTH ACT 1983**

64. If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be subject to the same principles set out in the section headed **Establishing the Responsible Commissioner** (paras 8-15). Every effort should be made to determine GP registration or establish a resident address, but if this is not possible the responsible commissioner should be determined by the location of the unit providing treatment. Therefore, in this context, the PCT in which the facility is located becomes the responsible commissioner for these purposes. Where a service level agreement is not in place, treatment will be funded through the OATs arrangement (unless the person is detained for longer than three months or the service concerned is a specialised Mental Health service as defined in the Specialised Services National Definitions Set). The responsible commissioner for the provision of 'after-care' services under Section 117 of the Mental Health Act 1983 is determined according to Section 117 (see HSG 1994/27 and HSC 2000/003) and not under the arrangements explained in **Establishing the Responsible Commissioner** (paras 8-15).

## **TRANSFER OF PATIENTS TO OTHER PCT AREAS UNDER CONTINUING CARE ARRANGEMENTS**

65. "Continuing care" refers to 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 disability, accident or illness<sup>15</sup>.

66. The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2006 (referred to in this guidance as "the amending Regulations") [[http://www.opsi.gov.uk/si/em2006/uksiem\\_20060359\\_en.pdf](http://www.opsi.gov.uk/si/em2006/uksiem_20060359_en.pdf)] which came into force on 1 April 2006, introduced significant changes to the PCT responsible for the NHS contribution to packages of long-term care for adults with certain care needs who are placed in a care home or independent hospital in the area of another PCT. These changes were anticipated in the 2003 **Establishing the Responsible Commissioner** guidance, but go further than set out in that guidance. In summary, the changes mean that where a PCT ("the placing PCT") arranges such a placement, whether on its own or jointly with another body (e.g. a local authority), the placing PCT remains responsible for the NHS's contribution to the care, even where the person changes their GP (and associated PCT). The provision of health services which are not related to the placement, for example in-patient treatment in an NHS hospital, is determined in accordance with the section headed **Establishing the Responsible Commissioner** (paras 8-15).

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<sup>14</sup> see S.I. 2002/546

<sup>15</sup> See regulation 2 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 S.I. 2002/2375 (as amended) and section 128(1) of the National Health Service Act 1977 (c. 49).

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

68. A decision by a placing PCT to place a patient requiring continuing care in a care home or independent hospital in another PCT area should be made after the PCT where the care home or independent hospital is located has been notified. This should be done before the patient is moved (see HSC2001/15;LAC[2001] 18). In the interests of the patient, and in particular when a patient leaves hospital, such decisions should be made promptly and take full account of HSC 1998/48 to ensure that the patient is transferred to a setting where they will continue to receive quality treatment and care. There should always be communications between the two PCTs to ensure clarity over responsibilities, and, in the worst case, to avoid any potential for duplicate payments to the care home.

69. For joint packages of care, where local authorities are placing residents who have health needs, they should work closely with the placing PCT responsible for commissioning the health care to ensure that a full assessment of health needs is made so that an appropriate joint package is put in place (see the paragraph on partnership working). PCTs should ensure that no one is deprived of the services that they are assessed as needing as a result of disputes over funding and that any review serves the patient's best interests. (Please refer to Annex C for further details on how the changes introduced by the amending Regulations will affect commissioning practice).

70. Where a patient is provided with fully funded NHS continuing health care in their own home and they decide to move house (not into residential care), then this will need careful discussion between the PCT currently providing those services and the PCT responsible for them after they move. The responsible commissioner for such care is determined in accordance with the section headed **Establishing the Responsible Commissioner** (paras 8-15). In order to ensure continuity of care and that arrangements represent the best interests of the patient, PCTs may need to come to an agreement about how services should be delivered. In particular, PCTs will wish to consider flexible solutions, such as whether patient care should be provided by another PCT exercising functions on its behalf.

## **REGISTERED NURSING CARE**

71. From and including 1<sup>st</sup> April 2003, except where the nursing care services are such that they do not need to be provided by a registered nurse, the NHS became responsible for the nursing care provided by a registered nurse to all care home residents, including those placed by local authorities. Provision should be made following a multidisciplinary assessment and determination of nursing need in line with the single assessment process for Older People (HSC 2002/001:LAC 2002/1). Where placements are made by PCTs to care homes outside the area of the PCT on

whose medical list the patient's G.P is included, that PCT should notify the PCT on whose medical list the patient will be registered when they enter the care home. This will assist the receiving PCT in funding and planning the nursing care services for its area. This principle should also apply to any future moves. Further guidance on this subject can be found within HSC 2001/017/LAC 2001/26 and in supplementary guidance HSC 2003/006 LAC(2003)7, available from: <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/NHSFundedNursingCare/fs/en>

## **PARTNERSHIP WORKING WITH LOCAL AUTHORITIES**

72. Patients with complex needs often require services from a range of providers, including local authorities who are responsible for social care, education, housing etc. These services should be developed jointly between the NHS responsible commissioner and the responsible local authority, so that the individual receives a co-ordinated package of care designed to meet their needs. The partnership needed to deliver these services can be developed at both strategic and operational level through the use of section 31 of the Health Act 1999 – which allows pooled budgets, lead commissioning and integrated provision between certain NHS bodies and local authorities. These partnerships provide the flexibility to meet the needs of patients, whose placements require both social and healthcare components. For further information see:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/HealthAct1999PartnershipArrangements/fs/en>.

## **LOOKED AFTER CHILDREN**

73. Under the Children Act 1989, a child is defined as being looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority. They fall into four main groups:

- children who are accommodated under a voluntary agreement with their parents (section 20);
- children who are subject to a care order (section 31) or interim care order (section 38);
- children who are the subject of emergency orders for the protection of the child (sections 44 and 46); and
- children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

74. The responsible PCT should be established by the usual means identified in the section headed **Establishing the Responsible Commissioner** (paras (8-15).

75. When a child is first placed by a Local Authority they have a shared responsibility with the relevant PCT or NHS Trust to ensure a full health assessment takes place and that a health plan is drawn up<sup>14</sup>. The relevant PCT should be informed in writing by the responsible Local Authority of its intention to place a child in its area and should be advised whether the placement is intended to be long or short term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases the relevant PCT should be notified within two weeks or as soon as reasonably practicable.

76. Guidance setting out a framework for the delivery of services from health agencies and social services to more effectively promote the health and wellbeing of children and young people in the care system can be found at:  
<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en>

## **OUT OF AREA PLACEMENTS OF CHILDREN**

77. If a looked after child is moved out of area, arrangements should be made through discussion between those currently providing the health care, the new PCT and relevant provider, to ensure continuity of health care. In some circumstances, PCTs may wish to consider and agree flexible solutions, such as the originating PCT exercising functions on behalf of the receiving PCT for a specific length of time. Any changes in the health care commissioning responsibilities should not be allowed to disrupt the ultimate objective of providing high quality, timely, care for the individual child or young person. It is important to ensure a smooth handover of clinical care where that is the agreed best arrangement for the child. A new assessment should not always be necessary.

78. The responsible PCT should be established by the usual means i.e. determined by the name and address of the GP with whom the child is registered, or if the child is not registered with a GP, by usual residence.

## **BOARDING SCHOOL PUPILS**

79. Pupils attending boarding schools should be considered to be the responsibility of the PCT determined through the means laid out in the section headed **Establishing the Responsible Commissioner** (paras 8-15).

## **RESIDENTIAL SPECIAL SCHOOLS**

80. Pupils attending, or boarding at, special schools (a special school is a day or boarding school that caters exclusively for children with special needs, including learning difficulties and other special educational needs) are the responsibility of the PCT determined through the usual means. The above also applies to children placed by Social Services or through joint funding arrangements between PCTs, Social Services and Local Education Authorities.

81. Regulations and Directions are, however, being considered which would effect responsibility for looked after children with existing health care needs who are placed out of area in residential special schools. These changes would ensure that responsibility remains with the PCT that originally commissioned those services, even following a change of GP or PCT.

## **EXTENDING PATIENT CHOICE**

82. From summer 2004, all patients in England waiting over six months on hospital waiting lists will be offered earlier treatment in other hospitals; an option referred to as 'Choice at six months'. Already (from July 2002) all Coronary Heart Disease (CHD) patients, who have been on an inpatient waiting list for over six months, are offered this swifter treatment in either a different NHS hospital, the private sector, or possibly in another EU country. This guidance should be used in establishing the responsible commissioner for such patients who wish to exercise 'Choice at six months'.

83. In the case of a patient moving from one PCT area to another PCT area between referral and treatment, responsibility should transfer in the usual fashion (see paragraphs 35-37 on people who move). However, the clock is not reset – the new commissioner should offer choice after six months have passed from the initial offer of choice.

84. From the end of 2005, as part of the referral process, all patients will be offered a choice of four or five potential accredited providers. Some patients, including those taking part in Choice pilots, will start to be offered this type of choice much sooner than 2005. 'Choice at the point of referral' will be located in, and led by, primary care, working from a locally set menu. Patients will be offered the choice of four or five providers for their elective care, including NHS and Independent Sector Treatment Centres.

85. For patients in pilot areas, the pilot project will maintain a list of patients accepting choice and the provider that will be giving the treatment. In the longer term, as 'Choice at the point of referral' becomes the standard process, PCTs will assume sole responsibility for holding the list of patients booked to receive treatment for whom they are the commissioner irrespective of the location or status of the provider.

86. In the case of a patient moving from one commissioner area to another after being offered 'Choice at the point of referral', PCTs may wish to consider and agree flexible solutions, such as whether patient care should be provided by one PCT exercising functions on behalf of the responsible PCT for a specific length of time.

## **RESOLVING DISPUTES**

87. Historically, there have been a number of disputes that PCTs have been unable to resolve at a local level. Many of these disputes have complex case histories, have been ongoing for a number of years, involve large sums of money and some have involved independent healthcare providers. In cases which can not be resolved at PCT level, the Strategic Health Authority should be consulted. SHAs, as the local headquarters of the NHS, have a responsibility to resolve disputes that threaten the delivery of services within their geographical boundaries wherever possible. Disputes involving PCTs from within two or more SHA boundaries should be resolved by the respective SHAs working together. Every effort should be made to resolve disputes locally.

88. The Department expects that all disputes will be resolved locally. However, ultimately the resolution of such disputes is a non-delegable function of the Secretary of State. Therefore if, after full local negotiation, it does not prove possible to reach agreement, the SHA(s) involved should send a report on the circumstances of the case to the Department of Health, together with a proposed solution for consideration by the Secretary of State. Reports on cases where the SHA has not yet been involved, or it is not felt that full local negotiation has been undertaken, will not be accepted. Reports should be addressed to :

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

89. Ministers have also expressed a desire to be kept informed of any ongoing disputes, which may give rise to civil action or Judicial Review.

## **ANNEX A**

### **DEFINING "USUALLY RESIDENT"**

**It is important to note that “Usually Resident” must only be used to establish the responsible commissioner when this cannot be established through GP registration**

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

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

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

Under regulation 3(8) of the Functions Regulations, if there is any doubt over an individual's district of residence, the address that they give as where they usually reside should be used. If patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, then the address at which they were last resident will establish the PCT of residence.

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

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

Under regulations 3(8A) and (8B) of the Functions Regulations, special rules apply in relation to the usual residence of prisoners – see paragraphs 58 to 62 above.

### **Defining "Ordinarily Resident" (Local Authorities)**

Under section 21 of the National Assistance Act 1948 (“the 1948 Act”), local authorities have powers to make arrangements for providing residential

accommodation for people aged 18 or over who, because of age, illness, disability or any other circumstances, are in need of care and attention that is not otherwise available to them. In the case of such persons who are "ordinarily resident" in their area, there is a duty to make those arrangements (see LAC (93)10).

There is no definition of ordinary residence in the 1948 Act and the term should be given its ordinary and natural meaning. The issue of whether or not a person is "ordinarily resident" in the area of a local authority is a question of fact that should be determined on a case by case basis. Among the factors that may need to be taken into account are: the time a person has been resident in the local authority area, their purpose in being there, and their continuity of residence. The importance of each factor will vary depending on the circumstances of the case. Issues often arise when a local authority makes arrangements for residential accommodation and places that individual in another local authority area. In these instances, the person is deemed to continue to be ordinarily resident in the local authority area in which was ordinarily resident immediately before the residential accommodation was provided to him or to her (see section 24(5) of the 1948 Act).

The Department of Health has issued guidance to local authorities on the general issue of "ordinary residence", which will assist in circumstances where local authorities are unclear about where their responsibility lies (see Local Authority Circular LAC (93) 7 issued in March 1993. If two local authorities cannot agree which of them is the responsible Authority for the purpose of Part 3 the 1948 Act the Secretary of State can be asked to determine the question of a person's ordinary residence.

### **NHS (Charges to Overseas Visitors) Regulations**

In determining the meaning of ordinarily resident as it applies to the NHS (Charges to Overseas Visitors) Regulations, regard must be had to the case law.

## ANNEX B

### NATIONAL SPECIALIST COMMISSIONING ADVISORY GROUP

Certain very highly specialised services that serve national populations are centrally commissioned by the Department of Health under the auspices of the National Specialist Commissioning Advisory Group (NSCAG). The services listed below are centrally funded by the Department of Health who in consequence acts as the responsible commissioner. All English and Scottish residents are covered by this arrangement. In the case of Welsh residents, the Department of Health only acts as the responsible commissioner for the six services below marked with an asterisk \*; otherwise the relevant Welsh authority will act as the responsible commissioner.

#### **Centrally Funded Services (as of April 2002):**

*Adolescent Reconstructive Surgery for Congenital Malformations of the Female Genital Tract*  
*Amyloidosis Services*  
*Anorectal Reconstruction Services*  
*Cardiothoracic Transplantation Services*  
*Choriocarcinoma Services \**  
*Craniofacial Services \**  
*Endoprosthetic Replacement for Primary Bone Tumours Services \**  
*Epidermolysis Bullosa Services (Paediatric)*  
*Extra Corporeal Membrane Oxygenation (ECMO) Services for Neonates and Infants*  
*Extra Corporeal Membrane Oxygenation (ECMO) Services for Adults*  
*Gaucher's Disease Services – diagnostic and management services*  
*Intestinal Failure Services*  
*Paediatric Bladder Exstrophy Services*  
*Paediatric Liver Services \**  
*Liver Transplantation Services \**  
*Ocular Oncology Services*  
*Pseudomyxoma Peritonei Services*  
*Psychiatric Services for Deaf Children and Adolescents*  
*Pulmonary Thrombo Endarectomy Services*  
*Retinoblastoma Services \**  
*Secure Forensic Mental Health Services for Adoloescents*  
*Severe Combined Immunodeficiency and Related Disorders Services (SCIDS)*  
*Severe Personality Disorder Services*  
*Small Bowel Transplantation Services*  
*Ventricular Assist Devices Services for Adults*  
*Ventricular Assist Devices Services for Child*

## **ANNEX C**

### **TRANSFER OF PATIENTS TO OTHER PCT AREAS UNDER CONTINUING CARE ARRANGEMENTS – CHANGES TO PCT COMMISSIONING RESPONSIBILITIES FROM APRIL 2006**

1. The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) (Amendment) Regulations 2006<sup>16</sup> came into force on 1 April 2006 and changed the PCT responsible for commissioning long-term continuing care for adults in certain situations. This annex provides guidance on the application of the new arrangements. It is not, nor is it intended to be, a comprehensive description of PCTs' responsibilities in this area and reference should be made to the Functions Regulations<sup>17</sup>.

#### **Background**

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

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

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

#### **Commencement**

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

#### **Application**

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

- nursing care; and

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<sup>16</sup> S.I. 2006/ 359.

<sup>17</sup> See para 1 of this guidance for the meaning of the Functions Regulations.

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

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

8. The new arrangements do not apply to a situation where a person either independently chooses to move to a different part of the country account or is placed there because of an arrangement made by a social services authority only.

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

### **NHS funded nursing care**

10. For those patients assessed as needing NHS funded nursing care only at the time of the placement, the responsible commissioner will be determined in accordance with the section **Establishing the Responsible Commissioner** (paras 8-15).

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

12. It follows that, if a patient in a placement in another PCT area for whom the placing PCT continues to be responsible recovers and the one NHS service remaining is nursing care, then from the time his needs change, the usual rules would apply and the responsible commissioner would be determined as described in paras 8-15 of this guidance.

13. In this situation, the placing PCT should contact the host PCT as soon as practicable and both PCTs should make appropriate arrangements to ensure that a

suitable package of care is maintained until alternative arrangements, such as a change of accommodation, have been put in place by the new PCT.

### **Planned services**

14. The term 'planned service' is defined in regulation 2 of the Functions Regulations. It refers to any NHS service which is planned and arranged in response to the results of an assessment of a person's physical or mental health needs and which is intended to bring about or to promote a specific outcome in relation to that person's treatment. Examples of planned services would include physiotherapy, occupational therapy, speech and language therapy, dietetics and podiatry. This list is not exhaustive.

### **Assessment**

15. The PCT responsible for assessing a person's health care needs prior to a placement being made will be determined in accordance with the section headed **Establishing the Responsible Commissioner** (paras 8-15).

### **Monitoring and review**

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

17. The placing PCT might want to make arrangements with the PCT in whose area the accommodation is situated to carry out case reviews on its behalf<sup>18</sup>.

18. The placing PCT will also continue to be responsible for the quality of the NHS health care it commissions under the new arrangements even though the services are provided on its behalf in a care home or independent hospital in another PCT area<sup>19</sup>.

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

### **Changing health needs**

20. As long as the conditions mentioned in paragraph 6 above are met, the placing PCT will continue to be responsible for arranging those services as long as the person is assessed as needing them. This applies even if the services cost more

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<sup>18</sup> See regulation 10 of the Functions Regulations.

<sup>19</sup> See Part 2, Chapter 2 of the Health and Social Care (Community Health and Standards) Act 2003 (c. 43).

over time because of the patient's worsening condition or the patient requires different services. For example, occasions may arise when further services are identified at later case reviews in connection with the presenting condition that necessitated the original placement. In these cases, the services will also be the responsibility of the placing PCT who will continue to be responsible for monitoring and review of these services.

### **Move to alternative accommodation**

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

22. If the patient no longer resides in a care home or independent hospital, for example, they move to the home of a family member or are transferred to in-patient care in an NHS hospital, the responsible commissioner in these circumstances is determined in accordance with the section headed **Establishing the Responsible Commissioner** (paras 8-15).

### **Case study**

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

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

### **Disputes**

23. **Establishing the Responsible Commissioner** paragraphs 87-89 **RESOLVING DISPUTES** sets out the procedure for resolving any disputes.