
Establishing the NHS body responsible for commissioning NHS services for patients

The abbreviations used in this chapter are:

The 2006 Act	National Health Service Act 2006
The 2002 Regulations	National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002.
The 2012 Regulations	National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
MHA	Mental Health Act 1983
The 2013 Regulations	National Health Service (Clinical Commissioning Groups—Disapplication of Responsibility) Regulations 2013
Who Pays	The “Who Pays” Guidance produced by NHS England in August 2013 ¹ .

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¹ See <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf> This replaced 2006 Guidance which was also called “Who Pays”. The earlier Guidance is at http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_126387.pdf

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1. Introduction

- 1.1. Ever since the “purchaser/provider” split was first introduced into the NHS in 1993, and later merged into the commissioner/provider split, the question as to which NHS body was responsible for commissioning (and in particular paying for) care for which patients and whether care costs should be divided between different NHS commissioners has been a source of conflict both between NHS patients and NHS commissioning bodies and between different NHS commissioning bodies.
- 1.2. The aim of this chapter is to provide a Guide to the legal structures which define which NHS body is responsible for commissioning which services for which patients. Working out which NHS body is responsible for commissioning services is complicated by three elements. First, the present rules are set out in Part 2 and sections 3 and 3A of the National Health Service Act 2006 (“**the 2006 Act**”) and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“**the 2012 Regulations**”). These are drafted in a way that is nearly impenetrable for trained lawyers and are thus near on impossible for non-lawyers to follow. Secondly, NHS England produced Guidance called “Who Pays” in August 2013 which was in reasonably plain English but was incorrect in a number of respects. This was updated in April 2006 to reflect amendments made to the identification of the relevant commissioner for section 117 services under the Mental Health Act 1983 (“**MHA**”) as a result of changes made by the Care Act 2014. However,

the remaining errors in the August 2013 Guidance were not corrected. Thirdly, there is no dispute resolution system operating to allow independent evaluation of disputes between different NHS bodies about which NHS body is responsible for commissioning services for high cost patients. The Secretary of State has an adjudication function where local authorities disagree over which of them should fund a community care place but neither the Secretary of State nor NHS England have a statutory adjudication function in responsible commissioner disputes.

- 1.3. As a result, disputes about which NHS body is responsible for expensive care packages often drag on for many years without being resolved. It is hoped that this chapter will assist all sides to understand what the Regulations provide and thus aid the swift, non-legal resolution of any disputes. However, given the complexity of the legislation, NHS bodies are increasingly agreeing that a single lawyer (including the author of this chapter) should be jointly instructed to assist the resolution of such disputes. This can be a quick and relatively inexpensive way to achieve clarity in a complex matter.

2. Identifying the Responsible commissioner in primary care

- 2.1. Issues around “who is the responsible commissioner” do not generally arise in primary care. GP commissioning contracts have their own rules about which patients are required to be provided with services by a GP practice². NHS community dental practices and NHS community pharmacies are both commissioned by NHS England (see below). NHS dentists do not have “patient lists” operating under GDS or PDS contracts and so can provide NHS services to any patient and make the appropriate claim for providing the service. The only usual limitation is that the dentist has unused Units of Dental Activity in a financial year which can be used to make the claim. Similar rules apply where NHS community optician or optometrist services are available. However, paragraph 99 of the statutory guidance “Who Pays” accurately explains that CCG’s are responsible for commissioning the following services that are related to primary care:

- out-of-hours primary medical services (where practices have opted out of providing OOH services under the GP contract);⁴⁴

² Readers are referred to chapter XX which provides details of these services.

- community-based services that go beyond the scope of the GP contract (akin to previous Local Enhanced Services⁴⁵);
- meeting the costs of prescriptions written by member practices (but not the associated dispensing costs);
- secondary ophthalmic services and any associated community-based eye care services.

3. Identifying the responsible commissioner for secondary care services

3.1. Wherever NHS care (outside of primary medical or dental care) is provided to a patient by a provider who seeks payment from an NHS commissioner for the provision of that care, it is necessary for the provider to identify the NHS commissioner with statutory responsibility for paying for the relevant NHS care for that NHS patient. Once the responsible commissioner has been identified, the next step for the provider is to establish whether the contractual arrangements between the relevant NHS commissioner and an NHS provider entitle the provider to charge for the treatment provided to the patient. That question is addressed in later chapters.

3.2. Since the implementation of the Health and Social Care Act 2012, identifying the responsible NHS commissioner involves addressing 2 questions:

- a) Is a CCG is the responsible commissioner or is NHS England the responsible commissioner for the services provided to the patient; and
- b) If this is care where a CCG is the responsible commissioner, which CCG is the responsible commissioner?

4. The commissioning responsibilities of NHS England

4.1. Section 3(1) of the NHS Act provides a range of services that each CCG is required to commission for patients for whom the CCG has commissioning responsibility. However, section 3(1E) provides:

“The duty in subsection (1) does not apply in relation to a service or facility if the Board has a duty to arrange for its provision”

- 4.2. A reference to “the Board” in the NHS Act is a reference to the National Health Service Commissioning Board, which operates under the name of “NHS England”. Thus if NHS England has commissioning responsibility for a “service or facility”, a CCG does not have a duty to commission such a service under section 3(1). CCGs have powers (but not duties) to commission a wide range of NHS and social care services under section 3A(1), but section 3A(2) provides:

“A clinical commissioning group may not arrange for the provision of a service or facility under subsection (1) if the Board has a duty to arrange for its provision by virtue of section 3B or 4”

It follows that a CCG has no power (i.e. no *vires*) to expend money on commissioning services where NHS England has commissioning responsibility for that service. Hence, commissioning responsibility for NHS services under part 1 of the NHS Act (namely services beyond those provided as part of primary care services) either falls to NHS England or to a CCG but cannot lawfully be funded by both bodies.

- 4.3. It is possible for NHS England to delegate commissioning responsibility for a service for which it has statutory responsibility to a CCG. However, where NHS England has delegated commissioning responsibility for a service to a CCG, the cost of the service must be paid by NHS England and not the CCG (because the CCG has no *vires* to pay for the service itself).
- 4.4. The power to make Regulations which defines the services for which NHS England has commissioning responsibility is set out in section 3B of the NHS Act which provides:

“(1) Regulations may require the Board to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of—

- (a) dental services of a prescribed description;
- (b) services or facilities for members of the armed forces or their families;
- (c) services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description;

(d) such other services or facilities as may be prescribed.

(2) A service or facility may be prescribed under subsection (1)(d) only if the Secretary of State considers that it would be appropriate for the Board (rather than clinical commissioning groups) to arrange for its provision as part of the health service.

(3) In deciding whether it would be so appropriate, the Secretary of State must have regard to—

(a) the number of individuals who require the provision of the service or facility;

(b) the cost of providing the service or facility;

(c) the number of persons able to provide the service or facility;

(d) the financial implications for clinical commissioning groups if they were required to arrange for the provision of the service or facility.

(4) Before deciding whether to make regulations under this section, the Secretary of State must—

(a) obtain advice appropriate for that purpose, and

(b) consult the Board.

(5) The reference in subsection (1)(b) to members of the armed forces is a reference to persons who are members of—

(a) the regular forces within the meaning of the Armed Forces Act 2006, or

(b) the reserve forces within the meaning of that Act.

4.5. It follows that the NHS Act gives the power for the Secretary of State to make Regulations which define the types of services or facilities which should be commissioned by NHS England

as opposed to clinical commissioning groups. The relevant Regulations are in Part 3 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the 2012 Regulations”). These Regulations provide that NHS England has commissioning responsibility for a range of general and specialist services.

NHS England commissioned dental services

4.6. Regulation 6 provides:

“The Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of—

- (a) community dental services; and
- (b) the dental services specified in Schedule 2”

4.7. Community dental services are defined in Regulation 3 as:

““community dental services” means dental services provided as part of the health service other than—

- (a) emergency services,
- (b) dental services provided pursuant to arrangements made by the Board under Part 5 of the 2006 Act, or
- (c) the dental services specified in Schedule 2”

4.8. The reference to dental services provided under Part 5 of the NHS Act is a reference the duty under section 99 of the NHS Act which provides:

“The Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to secure the provision of primary dental services throughout England”

4.9. Hence, “primary” care dental services are commissioned by NHS England under Part 5 of the NHS Act and secondary dental services, including “community dental services” are commissioned by NHS England under Regulation 3 of the 2012 Regulations. Schedule 2 provides the following list of dental services to supplement community dental services:

- “1. Oral surgery.
2. Restorative dentistry.
3. Paedodontic/paediatric dentistry.
4. Orthodontics.
5. Oral and maxillofacial surgery.
6. Endodontics.
7. Periodontics.
8. Prosthodontics.
9. Oral medicine.
10. Oral microbiology.
11. Oral and maxillofacial pathology.
12. Dental and maxillofacial radiology.
13. Special care dentistry”

4.10. It follows that the only dental services that fall to be commissioned by CCGs are emergency dental services since these are excluded from the definition of “community dental services”. Emergency services are defined in Regulation 2 as:

““emergency services” means ambulance services and accident and emergency services provided as part of the health service, whether provided at a hospital accident or emergency department, a minor injuries unit, a walk-in centre or elsewhere”

Services for members of the Armed Forces

4.11. Regulation 7 of the 2012 Regulations provides that NHS England has the responsibility for commissioning most NHS services for members of the armed services and their families. It provides:

“(1) This regulation applies to—

- (a) a person who is a serving member of the armed forces; and
- (b) that person's family.

(2) The Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service to persons to whom this regulation applies of—

- (a) community services;
- (b) secondary care services; and
- (c) the services specified in Schedule 4.

(3) The arrangements to be made by the Board under paragraph (2)(b) in respect of a person referred to in paragraph (1)(a) must include the provision of any infertility treatment to that person and to that person's partner.

(4) The infertility treatment referred to in paragraph (3) must—

- (a) where a person referred to in paragraph (1)(a) has been injured in service and is in receipt of compensation for infertility under the Armed Forces Compensation Scheme, include funding the cost of sperm storage facilities from the date on which the injury was sustained (where clinically necessary and where provision for such storage has previously been made); and
- (b) where, and to the extent that, the Board is satisfied that this is clinically appropriate in the circumstances of any case, include the provision of up to three cycles of in vitro fertilisation treatments or other means of assisted conception.

(5) In paragraph (1)(b), “family”, in relation to a person to whom this regulation applies, means that person's immediate family registered for primary care services with Defence Medical Services.

(6) The Board must regard a person (“A”) as the partner of a person referred to in paragraph (1)(a) (“B”) if—

(a) A is the spouse or civil partner of B; or

(b) A and B are cohabiting as partners in a substantial and exclusive relationship in circumstances where either—

(i) A is financially dependent on B, or

(ii) A and B are financially interdependent.

(7) In deciding whether A is in a substantial relationship with B, the Board must—

(a) have regard to any evidence which A considers demonstrates that the relationship is substantial; and

(b) in particular, have regard to the examples of evidence specified in paragraph (8) which could, either alone or together, indicate that the relationship is substantial.

(8) The evidence referred to in paragraph (7)(b) is—

(a) evidence of regular financial support of A by B;

(b) evidence of a will or life insurance policy, valid at the time at which the infertility treatment is sought in which—

(i) B nominates A as principal beneficiary or co-beneficiary, or

(ii) A nominates B as the principal beneficiary;

(c) evidence indicating that A and B have purchased or are purchasing accommodation together as joint owners or evidence of joint ownership of other valuable property, such as a car or land;

(d) evidence of a joint savings plan or joint investments of a substantial nature;

(e) evidence that A and B operate a joint account for which they are co-signatories;

(f) evidence of joint financial arrangements such as joint repayment of a loan or payment of each other's debts;

(g) evidence that either A or B has given the other the power of attorney;

(h) evidence that the names of both A and B appear on a lease or, if they live in rental accommodation, rental agreement; and

(i) evidence of the length of the relationship.

(9) For the purposes of paragraph (6)(b), a relationship is not an exclusive relationship if one or both of the parties is a party to another relationship which is, or could be considered to be, a substantial and exclusive relationship having regard to the provisions of this regulation”

4.12. This is a somewhat confusingly worded provision but in summary:

- a) NHS England has lead NHS commissioning responsibility for members of the armed services and those members of the immediate family of a member of the armed services who registered for primary care services with Defence Medical Services;

- b) As a result of the definition of community services in Regulation 5 of the 2012 Regulations, NHS England is responsible for commissioning all NHS services for members of the armed forces and their families other than emergency services and primary care services (which are already a commissioning responsibility of NHS England under Part 4 of NHS Act);
- c) There are special rules for fertility services where a member of the armed services is injured in service and is in receipt of compensation for infertility under the Armed Forces Compensation Scheme. The Regulations provide:

4.12.c.1. An extended definition of “partner” for fertility services;

4.12.c.2. Special rules about infertility services are extended to armed forces veterans by Regulation 8 and by Regulation 9 for deceased members of the armed forces who have had sperm preserved before death and proper consent has been given.

Services for prisoners and other detained persons

4.13. Regulation 10 provides that NHS England has commissioning responsibility for individuals who are detained by the state. It provides:

“10.—(1) Where a person is detained in a prison or in other accommodation described in paragraph (2), the Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision to that person as part of the health service of—

4.13.a.1.1. community services;

4.13.a.1.2. secondary care services; and

4.13.a.1.3. the services specified in Schedule 4.

(2) The other accommodation referred to in paragraph (1) is—

(a) a court;

- (b) a secure children’s home (except those specified in Part 1 of Schedule 3);
- (c) a secure training centre specified in the first column of Table 1 in Schedule 3 from the date specified in the corresponding entry in the second column of that Table;
- (d) an immigration removal centre specified in the first column of Table 2 in Schedule 3 from the date specified in the corresponding entry in the second column of that Table; and
- (e) a young offender institution (except Ashfield Young Offender Institution).

(3) In this regulation, “court” means any court in which criminal proceedings against a person are heard”

4.14. “Secondary care services” are defined in Regulation 5 as:

““secondary care services” means services provided as part of the health service in a hospital setting, or by those working in or based in a hospital setting, other than emergency services, primary care services or the services specified in Schedule 4;

4.15. Schedule 4 services are services for patients with rare and very conditions and are considered below. “Community services” are defined in Regulation 5 to mean:

““community services” means services provided as part of the health service other than—

- (a) emergency services,
- (b) primary care services,
- (c) secondary care services, or

(d) the services specified in Schedule 4”

4.16. NHS England has general commissioning responsibility for primary care services (see section 83 of the NHS Act. It follows that NHS England is responsible for commissioning all NHS services for detainees other than emergency services, which have to be commissioned by the CCG which covers the area where the services are provided (see above). It follows that if a detainee is transferred from detention to a hospital for secondary care, the local CCG has to meet the cost of any emergency care provided to the detainee but NHS England is responsible for funding all other NHS secondary care provided to a detainee.

4.17. NHS England’s responsibility covers detainees held in the following institutions;

- Prisons (including those run by private prison operators);
- A court;
- A secure children's home;
- A secure training centre specified in the first column of Table 1 in Schedule 3 of the 2012 Regulations from the date specified in the corresponding entry in the second column of that Table;
- An immigration removal centre specified in the first column of Table 2 in Schedule 3 from the date specified in the corresponding entry in the second column of that Table; and
- A young offender institution.

4.18. The above list does not cover services to individuals who are detained in police stations. Responsibility for providing physical and mental health medical care to detainees in police stations rests with the police who engage their own doctors. That is beyond the scope of this chapter but details can be obtained from the Guidance published by the College of Policing³. However the policy objective is to ensure that this potentially vulnerable group of individuals are provided with healthcare which is equivalent to that provided in the NHS.

4.19. Prison health services have been run by the NHS since they were transferred from Home Office control in 2004. However, the unique situation within detention establishments and

³ See <https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/>

the difficulties in recruiting and retaining appropriate staff has meant that NHS has struggled to deliver services in prisons which match the ambition to ensure that prisoners have the same access to services as the rest of the community. The NHS England strategy document “Strategic Direction for Health Services in the Justice System: 2016-2020⁴” contains a number of clearly stated objectives to improve the health of those being held in secure accommodation. In its foreword it notes:

“Children, young people and adults in contact with the criminal justice system, or in detained settings are more likely to smoke, misuse drugs or alcohol, have mental and physical health problems, report having a disability, self-harm or attempt suicide. Their lives are often further complicated by complex social and personal issues such as unemployment, low educational attainment or even homelessness. They are marginalised by society. As a consequence of all these influences their lives are often cut short in a brutal manifestation of social and health inequality”

4.20. The document then commits NHS England to a strategic direction of improving health services in prisons and contains the relatively weak commitment at page 9:

“...they are generally expected to access the same healthcare services as the rest of the population”

4.21. The document contains commitments to improving health outcomes for prisoners and those at risk in the early stages of the criminal justice system, but it says virtually nothing about the allocation of additional resources to offender health in the short term. It is worth noting the eventual laudable aim is to use NHS resources to tackle these vulnerable individuals with more targeted, personalised support and thus divert those with mental health or substance abuse problems away from the criminal justice system. It could be thought that the document looks far into the future when it says on page 29:

“By extending availability of these approaches, we will do more to address the specific needs of this particular population group, break the cycle of offending and improve the quality of care and experience of individuals. This will also deliver better value for money and furthermore may cut costs for both health and justice systems”

⁴ See <https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf>

4.22. Whilst, as a statement of ambition, that appears laudable, it is difficult to see how this aim can ever be achieved without significant additional resources being diverted from other areas of NHS spending into commissioning health and justice services. However, this document is a statement of NHS England's strategy and thus NHS England may be acting unlawfully if it continues to adopt this strategy but fails to take decisions, including resource allocation decisions, which are consistent with the published strategy. Thus, the document may be useful for lawyers representing prisoners who find themselves receiving sub-standard services primarily because they are in custody.

Specialised Services

4.23. £15.6 billion was allocated by NHS England to the commissioning of "specialised services" for NHS patients who suffer from rare and very rare conditions in 2015/16⁵. This is a very significant element of the NHS expenditure in England. The bill for commissioning specialised services is, for example, almost double the entire cost of commissioning general practice services across the NHS (which is £8.2 billion⁶). The duty on NHS England to commission specialised services is set out in Regulation 11 of the 2012 Regulations which provides.

"11 Specified services for rare and very rare conditions

The Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of the services specified in Schedule 4"

4.24. Schedule 4 lists the services that have been classified as "specialised services", starting with "*Adult ataxia telangiectasia services*" and ending with "*Xeroderma pigmentosum service*". There are a huge variety of services listed in schedule 4. Some are plainly not "rare" diseases such as "*Adult specialist cardiac services*" but others are very rare indeed such as the "*Ataxia telangiectasia service for children*"⁷.

⁵ See <https://www.england.nhs.uk/commissioning/spec-services/>

⁶ See <http://content.digital.nhs.uk/catalogue/PUB21318/nhspaymentsgp-15-16-rep.pdf>

⁷ Which has a prevalence of about 1 patient in every 400,000: see http://www.atsociety.org.uk/data/files/William/A-T_Clinical_Guidance_Document_Final.pdf

- 4.25. Specialised services are an area of huge political controversy and regular legal challenge: see for example *S (a child) v NHS England* [2016] EWHC 1395 (Admin). Regulation 35 of the 2012 Regulations provides that reasons must be given for a commissioning decision and these decisions (probably) engage the article 8 rights of the patient and thus require anxious scrutiny of the decision⁸. However, there are dilemmas throughout the processes for commissioning specialised services. Pharmaceutical companies can argue, with some justification, that developing drugs or other treatments for patients with rare conditions is just as expensive as developing other treatments but that a high price of a successfully developed treatment is justified by the limited number of patients to whom the drug can be provided. Clinicians treating these patients often have huge levels of specialist knowledge arising from their involvement in research and development for new treatments and naturally wish to use any treatment that may be successful for their patients, many of whom will have rare and life threatening conditions. There are a series of highly effective pressure groups whose purposes are to support patients with rare conditions and to promote the interests of such patients, including lobbying for new treatments to be made available to patients with their particular condition. Some of these pressure groups support “All Party Parliamentary Groups” of Members of Parliament who take an interest in patients with a particular condition. This can lead to the pressure groups having a huge influence on the contents of reports produced by the APPG and thus increase the standing and media coverage of treatment options for small groups of patients.
- 4.26. The Department of Health is also the government department which promotes the UK pharmaceutical industry and rolling out new treatments into the NHS is seen as vital to the success of the UK pharmaceutical industry. Finally, and not to be underestimated, NHS England comes under media pressure whenever a new drug or treatment is not available as part of NHS funded treatment for an identified individual.
- 4.27. NHS England is thus under huge political pressure to fund specialised services at a cost per patient which far exceeds the costs that would be permitted to support virtually any other patient where the CCG is the responsible commissioner. NHS England has attempted to manage this pressure by introducing a system of prioritisation and budget control but it remains to be seen whether senior management at NHS England have the courage to take

⁸ There is a debate about this following differing views expressed by the Court of Appeal in *R(Condliff) v. North Staffordshire PCT* [2012] PTSR 460 and *R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors* [2014] EWCA Civ 822. This is potential conflict explored in chapter XX on commissioning decision making.

difficult decisions⁹. The substantial additional resources which are made available to support patients with a condition which comes within specialised services in comparison to resources for supporting services which fall outside specialist services appears unjustifiable. It is difficult to see why a patient who has a “common” life threatening condition should be denied a life-saving or life-extending drug which costs £40,000 per year when a patient with a less common condition will be funded for a life-saving or life-extending drug that costs £400,000 per year. In an appropriate case there may be an argument that failing to fund the drug for the patient with the common condition is a breach of articles 2, 3 or 8 ECHR combined with article 14.

4.28. There is an unresolved issue about whether community services which are required to treat a patient who has a condition listed in Schedule 4 should be funded by a CCG or NHS England. The wording of the 2012 Regulations suggests that such services should be funded by NHS England because Regulation 11 and Schedule 4 make no distinction between the type of location at which services for the specified patient groups should be provided. Hence where, for example, a patient suffers from severe obsessive compulsive disorder (see paragraph 103 of Schedule 4), both acute and community NHS services which are provided to meet that patients’ needs should be funded by NHS England and not the local CCG. Practice appears to vary across the country, with some community based specialised services being funded by NHS England and others funded by CCGs. The test should be whether the community services are being commissioned because a patient has a particular medical condition. If that medical condition is one which is listed in Schedule 4, statutory responsibility for funding those community services lies with NHS England. Local CCGs have no vires to fund such services.

4.29. **Mental health patients:** The “Who Pays” Guidance suggests that the responsible commissioner for detained mental health patients will generally be the CCG where the patient was registered with a GP practice before the patient was detained. It states at §33:

“If a person is detained for treatment under the Mental Health Act 1983, the responsible commissioner will be as set out in paragraph 1¹⁰. Every effort should be made to determine GP practice registration or establish an address where they are usually resident, but if this fails and the patient refuses to assist, then as a last resort

⁹ Please see chapter XX for more details about the difficulties of commissioning decision making.

¹⁰ The reference to paragraph 1 of the Guidance is a reference to the general rule that commissioning responsibility lies with the CCG where the patient is registered with a GP practice or, where the patient is not registered with any GP practice, the place where the patient is usually resident.

the responsible commissioner should be determined by the location of the unit providing treatment”

4.30. This does not appear to be wholly correct because paragraph 7 of Schedule 4 provides that NHS England has commissioning responsibility for:

“Adult secure mental health services”

4.31. Secure mental health services are divided into High, Medium and Low Secure services. The consequence of including secure mental health services in Schedule 4 is that NHS England has sole commissioning responsibility for providing NHS services to all patients who are detained under the Mental Health Act 1983 and CCGs have no power to expend monies funding detained mental health patients. However, although all patients who are detained in a hospital under the Mental Health Act 1983 (“**the MHA**”) are, by definition, deprived of their liberty, not all detained MHA patients are classified by the NHS as being in “secure” services. There are mental health wards where patients are detained (and which are locked wards) but are not classified by the NHS as being “secure” accommodation. There does not appear to be a centrally approved definition as to the clinical characteristics that need to be fulfilled in order to work out when mental health accommodation should be classified as being “secure”. It follows that, in practice, the meaning given to above paragraph appears somewhat circular. NHS England is responsible for commissioning High, Medium and Low Secure mental health services, as opposed to commissioning other mental health services for detained patients. One finds out whether a unit is defined as being a High, Medium and Low Secure services based on whether the services at the unit are commissioned by NHS England and, if it is not commissioned by NHS England, then by definition it is not a secure mental health service

Informal mental health patients

4.32. CCGs will remain responsible for funding services for informal mental health patients. The relevant CCG will be identified by the location of the patient’s GP in the usual way. For informal mental health patients who not on the list of any GP practice, the responsible commissioner will be worked out by reference to the patient’s place of residence. A detained mental health patient does not become “resident” at the hospital at which he is forcibly detained: see *R v Mental Health Review Tribunal ex parte Hall* [1999] 3 All ER 1323. Hence the detained mental health patient will not change their place of residence as a result of being

detained in hospital. An informal patient (with capacity) may change their place of residence to the hospital if the patient chooses to remain in the hospital for an extended period and, in particular, if the patient does not have anywhere to “return” to live in their former area.

- 4.33. However if a patient is registered with a GP practice local to the psychiatric hospital after they have been admitted as an informal patient (or has their GP registration transferred to that practice after admission without action by their home CCG) the CCG local to the new GP practice will become the responsible commissioner.

Other services commissioned by NHS England

- 4.34. Regulation 12 of the 2102 Regulations provides that NHS England has commissioning responsibility for the Independent Sector Treatment Centre programme, which was originally commissioned directly by the Department of Health. Regulation 13 provides that NHS England has responsibility for fixated threat assessment services. Regulation 13(1) provides:

“The Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of specialised clinical risk assessment and management services for people with mental health problems who may present a risk to prominent people or locations”

- 4.35. In practice, this means that NHS England funds the Fixated Threat Assessment Centre (“FTAC”) which is a joint NHS/Metropolitan. The purpose of the FTAC¹¹ is:

“.. to assess and manage the risks from lone individuals who harass, stalk or threaten public figures. Many such people are suffering from serious mental illnesses and have fallen through the care net.

FTAC helps such people get the care they need and, by doing so, decreases any risk they might pose, not just to prominent people, but to the individuals’ families and to those around them”

- 4.36. The FTAC observes that:

¹¹ See <http://fixatedthreat.com/ftac-welcome.php>

“The main risks to elected politicians in western countries come not from terrorist or criminal groups, but from fixated loners”

4.37. That statement rings true in the light of tragic cases such as the murder in 2016 of Labour MP Jo Cox. It must be justifiable to use additional resources to protect those who are elected or appointed to public office and thus come under a greater level of threat because of the public office that they hold. It would be less justifiable to expend resources to protect actors, media figures, sports stars or those who become public figures for other reasons but the definition of “prominent people” covered by FTAC appears to exclude this because it defines its subjects as follows:

“Prominent people’ are those who are in the public eye due to their public service role. These include the main members of the British Royal Family, senior politicians and members of parliament”

Commissioning for patients who have multiple conditions

4.38. Patients may present with a variety of conditions, some of which fall into NHS England’s commissioning responsibilities and others of which fall to a CCG. As far as the author is aware, there is no clear guidance on how commissioners are supposed to work together where a patient presents with multiple conditions, some of which require services to be commissioned by NHS England and others of which require services which fall to be commissioned by a CCG. In practice, NHS England interpret their commissioning responsibilities as largely being limited to contracts that they place with specialist secondary care providers to deliver the acute phase of services to patients suffering from conditions which come within those described in Schedule 4 to the 2012 Regulations.

4.39. However, NHS England’s duties appear to be wider because a patient who is living outside hospital and has a rare condition may be entitled to NHS Continuing Healthcare. That raises the question as to whether the costs of delivering a package of services for an NHS Continuing Care patient who lives in the community but suffers from a condition which falls within Schedule 4 of the 2012 Regulations should fall on NHS England or a local CCG. There is no clear answer to this conundrum but the duty to assess and make decisions about NHS Continuing Healthcare falls both on NHS England and on CCGs (depending on the status of the

patient: see Regulation 21(2) of the 2012 Regulations. However, at present, NHS England does not appear to have any mechanisms to make decisions to fund NHS Continuing Healthcare for patients who suffer from conditions for which it has commissioning responsibility.

5. Introduction to allocating commissioning responsibility between CCGs

- 5.1. Disputes between commissioners as to which CCG is responsible for which commissioning services for a patient are just as much a feature of the NHS as disputes between local authorities as to which local authority has statutory responsibility to provide community care services to a service user.
- 5.2. The rules are concerned with the allocation of responsibility between different public bodies. Accordingly, they should be interpreted so that there is only one CCG which acts as the “responsible commissioner” for a patient for a particular episode of care: see by analogy *R (Cornwall Council) v Secretary of State for Health and Somerset County Council* [2015] UKSC 46. However, the fact that a CCG is the responsible commissioner for a patient for one episode of care does not necessarily mean that the same CCG is the responsible commissioner for that patient for other episodes of care. Hence, for example, section 1C of the NHS Act provides:

“The power conferred by subsection (1B)(b) must be exercised so as to provide that, in relation to the provision of services or facilities for emergency care, a clinical commissioning group has responsibility for every person present in its area”

Hence, the responsible commissioner for all emergency patients must be the CCG in whose area the emergency facility is located. This means that a CCG becomes the responsible commissioner for every patient who attends a local hospital A & E department. However, responsibility for funding on-going care for a patient who is admitted to a hospital ward will revert to the patient’s home CCG.

- 5.3. Section 3 of the NHS Act and Part 2 and Schedule 1 to the 2012 Regulations contains a series of reasonably clear rules which define the “responsible commissioner” in different circumstances. The Secretary of State has also made the National Health Service (Clinical Commissioning Groups—Disapplication of Responsibility) Regulations 2013 (“**the 2013**

Regulations”). Thus, in determining which CCG is responsible for a patient for a particular episode of care:

- a) reference needs to be made the primary rules in the NHS Act to determine which CCG starts as the responsible commissioner;
- b) reference then needs to be made to the 2012 Regulations to determine whether the primary rules need to be varied by the rules set out in those Regulations;
- c) finally a CCG needs to bear the rules in the 2013 Regulations to determine if they dis-apply either the primary rules in the NHS Act or the rules in the 2012 Regulations.

5.4. There is also useful Guidance published by NHS England accurately called “Who Pays: Determining Responsibility for payments to providers¹²”. However, the Guidance needs to be treated with some care because, whilst it is generally useful and CCGs have a statutory duty to have regard to the Guidance under section 14Z8 of the NHS Act, it contains a series of errors. As a matter of law, the statutory scheme takes precedence over the Guidance and thus, if in doubt, a CCG is obliged to follow the statutory scheme and not the Guidance: see for example *R (Simpson) v Police Medical Appeal Board & Ors* [2012] EWHC 808 (Admin) as an example of a case where Guidance was quashed for being inconsistent with a statutory scheme.

5.5. In order to make sense of the complex rules, we have divided the groups of patients up into a series of categories.

6. Category 1: Patients who require emergency treatment

6.1. Section 1C provides that the responsible commissioner is the CCG in whose area the patient is present. That is reproduced in paragraph 2(a) of Schedule 1 to the 2012 Regulations provides that a CCG has commissioning responsibility for:

“every person present in the CCG’s area, in relation to the provision of ambulance services or accident and emergency services, whether provided at a hospital accident and emergency department, a minor injuries unit, a walk-in centre or elsewhere (but

¹² See <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>

excluding any services provided after the person has been accepted as an in-patient, or at an out-patient appointment)”

6.2. This is also confirmed in the “Who Pays Guidance at page 3 which provides:

“A CCG is responsible for commissioning emergency care⁹ for anyone present in its geographic area, regardless of where the person in question is usually resident or which GP practice (if any) they are registered with”

6.3. If a patient is transferred from one A & E to another A & E for more specialist emergency care, the first CCG continues to have a duty to fund the accident and emergency services: see Regulation 3(a) of the 2013 Regulations.

6.4. Paragraph 5 of the Who Pays Guidance provides:

“The rules on payment for emergency care are that:

- For A&E attendances and emergency admissions, the CCG that would ordinarily be the responsible commissioner for a patient (under the rules in paragraph 1 and subject to the other relevant exceptions in Section C) or NHS England (for example, for members of the armed forces) is responsible for paying the provider for the costs of that patient’s care;
- The costs of all other emergency care will be met by the CCG that commissions the care, except where cost-sharing arrangements have been voluntarily agreed by CCGs or NHS England;
- As set out in the 2013/14 Payment by Results (PbR) Guidance, residents of Scotland, Wales and Northern Ireland attending English A&E departments, the cost is covered by the host CCG, not the patient’s responsible health board”

6.5. This part of the Guidance appears inconsistent with the statutory scheme. Where a patient is provided with accident and emergency services (as defined in paragraph 2(a) of Schedule 1 to the 2012 Regulations), the CCG with commissioning responsibility for those services is the CCG covering the area in which the hospital is located. The part of the Guidance set out above

about cost sharing conflicts with section 3(1C) in as much as it recommends that the normal GP practice or usual residence rules shall apply where a patient accesses emergency services. The only CCG that should meet the cost of the provision of those services is the CCG where those services are located.

7. Category 2: Patients to whom a CCG member GP practice has to provide services

7.1. Section 3(1A) of the NHS Act provides:

“(1A) For the purposes of this section, a clinical commissioning group has responsibility for—

(a) persons who are provided with primary medical services by a member of the group, and

(b) persons who usually reside in the group's area and are not provided with primary medical services by a member of any clinical commissioning group”

7.2. The “members of the group” are the GP practices in the CCG’s area which hold primary commissioning contracts: see section 14A(1) of the NHS Act which provides that NHS England must exercise its functions so that “each provider of primary medical services is a member of a clinical commissioning group”. The persons who are “*provided with primary medical services by a member of the group*” are the persons to whom a GP practice has a contractual duty to provide primary care services. These are:

- a) Those who are permanently on the list of patients of a GP practice;
- b) Those who are accepted onto a GP practice list as “temporary patients”¹³; and
- c) Persons to whom the contractor is required to provide immediately necessary treatment as part of its obligation to provide “essential services”¹⁴.

Permanent Patients on a GP Practice List

¹³ See chapter XX for details about the process of management of lists of patients by GP practices.

¹⁴ For the definition

- 7.3. Each NHS GP Practice has a list of patients who are registered with the practice. The GP practice has a duty to provide primary medical services to those patients. The CCG to which the GP practice belongs has the duty to commission secondary care services for all of the patients on the GP practice list.

Temporary Residents

- 7.4. The position of “temporary patients” is described as follows at Note 8 on page 7 of the Guidance:

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

- 7.5. A patient who is temporarily registered on the list of a GP practice may also be permanently on the list of another GP practice. Where a patient has been temporarily admitted to the list of a GP practice, the CCG covering the area where the patient is permanently registered ceases to be the responsible commissioner for NHS services for that patient for as long as the patient is registered as a temporary resident in the area of another CCG: see Regulation 2(2)(d) of the 2013 Regulations.

GP Emergency Services

- 7.6. An NHS GP has a duty to attend to anyone who is physically present in his or her practice area and who seeks emergency medical care. This duty is set out in Regulation 17(7) of the National Health Service (General Medical Services Contracts) Regulations 2015 as follows:

“A contractor must provide primary medical services required in core hours for the immediately necessary treatment of any person to whom the contractor has been requested to provide treatment owing to an accident or emergency at any place in the contractor’s practice area”

7.7. Thus if, for example, a GP is asked to attend someone who has collapsed in the street outside the surgery, and provides immediate medical assistance to the person before an ambulance attends, and the patient is then taken to hospital for further treatment, the GP's local CCG may have a duty to fund the treatment.

8. Category 3: Patients who are not on any GP practice list but who are usually resident in the CCG area

9.

9.1. Section 3(1A) provides that if a person is usually resident in the CCG's area and is not on the list of any GP practice (in the area or otherwise), the test for commissioning responsibility is based on "usual residence". Annex B to the "Who Pays" Guidance explains what is meant by the usual residence test. It provides:

"Annex B: Defining 'usually resident'

1. It is important to note that:

- the 'usually resident' test must only be used to establish the responsible commissioner when this cannot be established based on the patient's GP practice registration;
- 'usually resident' is different from 'ordinarily resident'. If a person is not ordinarily resident in the UK and not covered by an exemption in regulations then they are liable for NHS hospital treatment costs themselves (see Annex A). The 'usually resident' test may still be needed to establish the responsible commissioner for non-hospital services;
- by contrast, local authority responsibility in relation to the public health services they commission is based on a duty to take steps to improve the health of the people in their area. The duty is not limited to residents, or people permanently in the area. It can include people who are only temporarily in the area, e.g. a visiting student or worker, or a tourist, or a commuter. It is therefore for the local authority to determine who is the relevant population (residents or wider) in relation to the services they commission⁵⁰, 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’.

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

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

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

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

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

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

9.2. There has been considerable litigation about where individuals are “resident”. Statutory regimes use the terms “ordinary residence”, “habitual residence” and “normal residence” to assign responsibility for the allocation of statutory services, to indicate submission to the jurisdiction of a court or to incur a liability to various forms of tax. Community care

responsibilities are allocated on the basis of an “ordinary residence” test: see section 39 of the Care Act 2014. The Department of Health has provided Guidance¹⁵ on the meaning of the “ordinary residence” test following the Supreme Court case of *R (Cornwall Council) v Secretary of State for Health* [2015] UKSC 46. Save for one issue, there appears to be no policy justification for the NHS allocating responsibility between CCGs on the basis of a “usual residence” test whilst local authorities allocate responsibility between themselves on an “ordinary residence” test. It is also both not helpful and not necessarily legally correct for Annex B of the “Who Pays” Guidance to suggest that “‘usually resident’ is different from ‘ordinarily resident’”. The High Court has held that these terms usually mean the same thing: see *R (on the application of M) v London Borough of Hammersmith and Fulham & Anor* [2010] EWHC 562 (Admin)¹⁶ where Mr Justice Mitting said at §25:

“There seems to me to be no perceptible difference between the three phrases, “resident”, “ordinarily resident” and “normally resident”. All three connote settled presence in a particular place other than under compulsion”

- 9.3. “Usual residence” fell into the same category as “resident”, “ordinarily resident” and “normally resident” according to the Court of Appeal in *Varsani v Relfo Ltd (In Liquidation)* [2010] EWCA Civ 560. This case considered the meaning of a “usual residence” test in wholly different circumstances, namely whether a Nigerian businessman was usually resident in London for the purposes of the Civil Procedure Rules when he had multiple homes in different countries because a “usual residence” test applies under the CPR. The case may thus only be of limited assistance in determining the meaning of usual residence under the NHS Act. However, at §19 Etherton LJ approved the following explanation of the meaning of “usual residence” used by the Deputy Judge:

““Usual” is an ordinary English word. It is not a term of art. It means, in its ordinary signification, that which is in ordinary use. It may not add very much to the simple word “residence”, although it does serve to emphasise the element of regularity and continuity of occupation of the property concerned....”

¹⁵ See Chapter 19 of the Guidance at <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

¹⁶ See <http://www.bailii.org/ew/cases/EWHC/Admin/2010/562.html>

- 9.4. Hence the correct approach is probably to treat the concept of “usual residence” under section 3(1a)(b) as analogous to “ordinary residence” in almost all circumstances and for NHS bodies to rely on the statutory guidance issued by the Department of Health under the Care Act 2014 where there is a dispute as to where someone is usually resident.
- 9.5. One key difference between an ordinary residence test and a usual residence test may be that “ordinary residence” requires a person to be lawfully living at the place at which they reside whereas a usual residence test does not: see *Shah v Barnet London Borough Council* [1983] 2 AC 309. Despite the observations set out at Annex B, that requirement is almost certainly not part of the test for the allocation of commissioning responsibilities because people who are unlawfully resident in the UK are still entitled to access NHS services.
- 9.6. The NHS Act makes specific provision to enable charges to be levied for NHS services provided to anyone who is not ordinarily resident in the UK: see section 175 of the NHS Act. Hence, for example, overseas visitors and failed asylum seekers, who are not lawfully in the UK, are not exempt from charges for NHS services. In *R (YA) v Secretary of State for Health* [2009] EWCA Civ 225 the Court of Appeal focused on the Secretary of State’s duty to promote a comprehensive health service for the people of England. Ward LJ said at §55:

“Note that it is the people *of* England, not the people *in* England, which suggests that the beneficiaries of this free health service are to be those with some link to England so as to be part and parcel of the fabric of the place. It connotes a legitimate connection with the country. The exclusion from this free service of non-residents and the right conferred by section 175 to charge such persons as are not ordinarily resident reinforces this notion of segregation between them and us. This strongly suggests that, as a rule, the benefits were not intended by Parliament to be bestowed on those who ought not to be here”

- 9.7. That case confirmed that NHS Trusts have a discretion to withhold treatment from an overseas visitor who could be required to pay for the treatment. NHS bodies are not prevented from giving treatment to unlawful residents even where there is no prospect of the patient paying the bill. Hence, for example, overseas patients are often provided with dialysis treatment when there is no prospect of them paying the costs because a refusal to do so would lead to a medical crisis, and, if that happens, the relevant hospital would have NHS would have to provide expensive emergency treatment to the patient without charge.

9.8. There is a list of secondary care treatments for overseas visitors (whether lawfully in the UK or not) for which no charges can be levied. Hence, by way of example, no charges can be made for Human immunodeficiency virus (HIV) treatment provided to an overseas visitor: see Schedule 1 to the National Health Service (Charges to Overseas Visitors) Regulations 2015. In such a case, the NHS Trust or private hospital providing the treatment will need to know which CCG should meet the costs of the treatment. If that patient is not on the list of GP practice, the responsible CCG will be the CCG in the area where the patient usually resides even if that residence is unlawful because, for example, the individual has no legal right to be in the UK.

10. Introduction to the additional categories of patients described in Schedule 1 to the 2012 Regulations

10.1. Schedule 1 to the 2012 Regulations provides a series of confusingly worded categories of additional patients for whom a CCG has commissioning responsibility. These are tightly drawn categories of patients which are also described in the “Who Pays” Guidance. Unfortunately this is an area where the Guidance describes common NHS practice but, in place, that practice departs from the wording of the Schedule. The wording of the Regulations takes precedence over the Guidance and so it is necessary to look carefully at the descriptions of additional patients for whom a CCG is allocated commissioning responsibility.

10.2. The Regulations are worded in a way that is far from straightforward. However, in order to work through the statutory definitions there are 3 questions that need to be addressed:

- a) Is the patient within the categories defined in Schedule 1 as someone for whom a CCG may have commissioning responsibility?
- b) If so, is CCG’s commissioning responsibility excluded by virtue of the rules in Regulation 4(4);

- c) If the answer to question (i) is “Yes” and the answer to question (2) is “No”, is the CCG’s responsibility limited to “accommodation and services” by virtue of Regulation 4(2).

10.3. Regulation 4(1) of the 2012 Regulations provides:

“Subject to paragraphs (2) to (4), for the purposes of sections 3 and 3A of the 2006 Act (which relate respectively to a CCG's duty to commission services and its power to do so), a CCG has responsibility for the persons listed in paragraph 2 of Schedule 1 (in addition to those mentioned in section 3(1A) of that Act)”

10.4. This Regulation means that, in addition to the patients referred to in section 3(1A), a CCG may have commissioning responsibility for some or all of the NHS services CCGs commission for that patient (depending on the answer to the next questions). The details of the categories listed in paragraph 2 are considered below.

10.5. Regulation 4(4) define the categories of patients who do not become the responsibility of a local CCG even though they come within the terms of paragraph 2 of Schedule 1 to the 2012 Regulations. They provide:

“(4) The responsibility for persons listed in paragraph 2(b) to (j) of Schedule 1 does not apply where the person is detained in—

- (a) an immigration removal centre;
- (b) a secure training centre; or
- (c) a young offender institution.

10.6. This Regulation provides that a CCG does not acquire commissioning responsibility, in any circumstances for patients in an immigration removal centre, a secure training centre or a young offender institution even if that otherwise person comes within the scope of Schedule 1. That is confirmed in regulation 2(2)(f) of the 2013 Regulations which provides that a CCG shall not have commissioning responsibility for anyone detained in the three institutions listed

above. It is noteworthy that this list does not include patients in a regular prison. NHS England has statutory responsibility (which is considered below).

10.7. Regulation 4(2) provides that where a CCG gains commissioning responsibility for an additional person as a result of a person being within paragraph 2(a), (b), (d), (e) or (f) of Schedule 1, the CCG only gains responsibility for commissioning for the provision of *“accommodation or services specified in the sub-paragraph of paragraph 2 which relates to that person”*. Regulation 4(2)(c) is necessary to ensure that section 3(1C) takes effect, namely that commissioning responsibility for commissioning emergency services is not transferred from one CCG to another.

10.8. Paragraph 2 of Schedule 1 to the 2012 Regulations contains the following list of additional categories:

“The list of persons referred to in regulation 4(1) is as follows—

- (a) every person present in the CCG's area, in relation to the provision of ambulance services or accident and emergency services, whether provided at a hospital accident and emergency department, a minor injuries unit, a walk-in centre or elsewhere (but excluding any services provided after the person has been accepted as an in-patient, or at an out-patient appointment);
- (b) every person aged 18 or over who falls within paragraph 3, in relation to the provision of the accommodation or services referred to in paragraph 3(b);
- (c) every child who falls within paragraph 4;
- (d) every person who falls within paragraph 5 in relation to the provision of the accommodation or services referred to in paragraph 5(b);
- (e) every person who falls within paragraph 6 in relation to the provision of the accommodation or services referred to in paragraph 6(b);

- (f) every child who falls within paragraph 7 in relation to the provision of the accommodation or services referred to in paragraph 7(b);
- (g) every child who falls within paragraph 8;
- (h) every person present in the CCG's area who is resident outside the United Kingdom and not provided with primary medical services by a member of any CCG;
- (i) every person resident in Scotland, Wales or Northern Ireland and present in the CCG's area who is a qualifying patient within the meaning of section 130C of the 1983 Act(section 130A:supplemental), and not provided with primary medical services by a member of any CCG;
- (j) every person who is a qualifying patient within the meaning of section 130C of the 1983 Act and liable to be detained under that Act in a hospital or registered establishment (within the meaning of that Act) in the CCG's area"

10.9. This list refers to a series of different categories of patients, and the rules operate in subtly different ways in relation to each category. Hence, it is necessary to look at each category to work out which CCG has any commissioning responsibility for providing which services to a patient and then to ask which services are the responsibility of which CCG. Inclusion in a category under paragraph 2 will not necessarily result in a transfer from one CCG to another of all commissioning responsibility for the patient. The rules retain part of the NHS commissioning responsibility for patients for services described in the wording of the Schedule but provide that part rests with another CCG.

11. Category 4: Adult continuing care patients placed in a facility in the area of another CCG

11.1. Where a patient needs specialist care, provided in dedicated accommodation, a CCG with commissioning responsibility can properly exercise its commissioning responsibilities by "placing" a patient in a care home or other institution located in the area of another CCG. The patient then registers with a GP practice in the area of the specialist facility and, at that point, a question can arise whether commissioning responsibility transfers to the CCG in the place of the specialist facility or remains with the CCG that placed the patient. For these

purposes, there are 2 CCGs namely the “**Placing CCG**”, namely the CCG whose officers made the placement, and the “**Local CCG**”, i.e. the CCG which is local to where the services are provided.

11.2. Rules have been in existence since at least 2006 to prevent NHS commissioners from having a financial incentive to place their patients out of area and thereby transfer commissioning responsibilities onto neighbouring CCGs. This has been pejoratively labelled as “dumping”: see *R (London Borough of Greenwich) v Secretary of State for Health & Anor* [2006] EWHC 2576 (Admin). The rules are now in Schedule 1 to the 2012 Regulations and the broad effect is to ensure that a CCG who places an NHS Continuing Healthcare patient in a care home or other facility the area of another CCG retains commissioning responsibility for funding the costs of NHS Continuing Healthcare for that patient. However, (a) these rules have a series of peculiarities and go wider than just of NHS Continuing Healthcare patients and (b) they only apply to the costs of NHS Continuing Healthcare, with other services being funded by the local CCG to the care placement.

11.3. Paragraph 2(b) provides that the category of persons where the placing CCG retains commissioning responsibility is:

“every person aged 18 or over who falls within paragraph 3, in relation to the provision of the accommodation or services referred to in paragraph 3(b)”

11.4. Paragraph 3 of Schedule 1 to the 2012 Regulations provides:

“A person falls within this paragraph if—

(a) the CCG has made an arrangement in the exercise of its commissioning functions (by itself or jointly with a local authority) by virtue of which the person is to be provided with services to meet his or her continuing care needs,

(b) those services consist of or include the provision of the following accommodation and services to meet the person's continuing care needs—

(i) accommodation in a care home or independent hospital situated in the area of another CCG or of a Local Health Board, and

(ii) at least one planned service (other than a service consisting only of NHS-funded nursing care) which is connected to the provision of such accommodation (whether or not the accommodation is arranged by the CCG referred to in sub-paragraph (a)),

(c) the person is resident in that accommodation and continues to need that planned service (or those planned services), and

(d) the person would not be a person for whom the CCG is responsible under section 3(1A)(a) of the 2006 Act”

11.5. In order for the Placing CCG to retain commissioning responsibility under this paragraph, six conditions must be satisfied:

- a) The patient must cease to be registered with a GP practice in the area of the placing CCG (**“the GP registration requirement”**);
- b) the patient must be provided with accommodation in a care home or independent hospital by a Placing CCG situated in the area of the Local CCG (**“the accommodation requirement”**);
- c) the patient must be placed to meet a need for continuing care (**“the continuing care requirement”**);
- d) the CCG must commission at least one other planned service for the patient (other than a service consisting only of NHS-funded nursing care) (**“the other service requirement”**); and
- e) the patient must become resident at the accommodation so provided (**“the residence requirement”**); and
- f) the patient must continue to need that planned service (or those planned services) (**“the continuity requirement”**).

11.6. **The GP registration requirement:** A patient who spends time living in a care home or independent hospital will remain the responsibility of the placing CCG for as long as the patient remains registered with a GP practice in the area of the placing CCG. However, care home residents are usually registered on a permanent basis with a GP practice which is local to the care home. Where this happens, the registration with the former GP practice comes to an end, and thus the placing CCG's responsibility for the patient would also come to an end unless continued by the placing rules contained within Schedule 1 to the 2012 Regulations.

11.7. **The accommodation requirement:** The placing rules only apply if the patient is placed by a CCG in a care home or an independent hospital to meet the patient's continuing care needs. Hence, if a patient is placed in supported living accommodation in the area of another CCG or in an NHS hospital, the placing rules do not prevent commissioning responsibility transferring when the patient changes their GP.

11.8. A "hospital" is widely defined in section 275 of the NHS Act as follows:

““hospital” means—

- (a) any institution for the reception and treatment of persons suffering from illness,
- (b) any maternity home, and
- (c) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation,

and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and “hospital accommodation” must be construed accordingly”

11.9. Section 3(4) of Care Standards Act 2000 provides that “*An establishment in England is not a care home if it is a hospital (within the meaning of the National Health Service Act 2006)*”. The extended definition of “hospital” under section 275 of the NHS Act thus precludes a nursing home from being defined as a “care home” if it comes within the definition of a hospital. The meaning of the word “hospital” was considered by the Court of Appeal in *Minister of Health v General Committee of the Royal Midland Counties Home for Incurables at Leamington Spa*

[1954] CH 530. The issue in that case was whether a “home for incurables” should be transferred from the charity which operated it to the newly created national health service¹⁷. That depended on whether the home was classified as a “hospital”. The court decided that it was a hospital even though there were no doctors on site all of the time and “*the atmosphere of the place was much more homelike than that of any hospital*”. Evershed MR said:

“... the word "hospital" is intended to have, and has, a wider significance for the purposes of the Act than that of what may be called an ordinary general hospital”

11.10. The continuing effect of this case was affirmed in both *Botchett v The Chief Adjudication Officer* [1996 WL 1092361] and in *R (Whapples) v Birmingham CrossCity Clinical Commissioning Group* [2015] EWCA Civ 435, [2015] P.T.S.R. 1398.

11.11. If the accommodation is arranged by a local authority as part of a package of community care services under the Care Act 2014, the NHS placing rules do not apply even if the CCG has been involved in the decision-making because, for example, there is a nursing element to the care. If a patient is entitled to NHS continuing care, but the accommodation arrangements are made wholly by the patient themselves or by the family, as opposed to being arranged by the CCG, the placing rules do not apply: see *R (London Borough of Greenwich) v Secretary of State for Health & Anor* [2006] EWHC 2576 (Admin).

11.12. **The continuing care requirement:** The placing rules require that the CCG places the patient in accommodation because the patient has a need for “continuing care”. Paragraph 1 of Schedule 1 to the 2012 Regulations defines “continuing care” to mean:

““continuing care” means 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”

11.13. Patients who are eligible for “NHS Continuing Healthcare” will be patients who have a need for “continuing care”. However the term “continuing care” is wider than patients who are eligible for NHS Continuing Healthcare. It could, for example, cover a patient who is informally admitted to a mental hospital for an extended stay. Paragraphs 59 to 64 of the Guidance “Who Pays” appears to equate the term “continuing care” with “NHS Continuing

¹⁷ Without any compensation being paid for the state acquisition of the property.

Healthcare” despite the statutory definition of continuing care which is plainly wider than patients who are eligible for “NHS Continuing Healthcare”.

11.14. The other service requirement: The placing rules only apply if a patient is in receipt of continuing care arranged by CCG and receives at least one planned service other than nursing care. The term “planned service” is defined in paragraph 1 of Schedule 1 to mean:

“planned service” means any service whose provision is planned and arranged by a CCG as part of the health service 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 promote a specific outcome in relation to those needs”

11.15. Paragraph 3(b)(ii) of Schedule 1 requires the patient to be placed in accommodation by the CCG and to receive at least one planned service (other than a service consisting only of NHS-funded nursing care) which is connected to the provision of such accommodation.

11.16. The residence requirement: Responsibility for commissioning services for a patient who lives in a care home or independent hospital will only be retained by the placing CCG if the patient becomes “resident” in the care home or independent hospital. However, a patient is highly unlikely to move their GP registration to a practice which is local to the care home or independent hospital unless the patient is anticipating remaining there for an extended period. A place of “residence” indicates an intention to live at a location for an extended period as opposed to a short period with a defined end point.

11.17. The continuity requirement: The patient must continue to have a need for a planned service (or those planned services) for the period when the patient is resident at the care home or independent hospital. Hence, a service which is provided for a short period but then is no longer required will not qualify under the placing rules. However a CCG is highly unlikely to commission a placement at a care home or independent hospital over an extended period if no additional medical services are needed.

11.18. Responsibility for secondary care services provided in accommodation which is not a care home or independent hospital: If a patient with continuing care needs is placed by a CCG in accommodation which is not a care home or independent hospital, the placing rules will not

apply and commissioning responsibility will transfer to the CCG which is local to the accommodation. Hence commissioning responsibility will transfer to the CCG local to the accommodation where a patient who is placed by a CCG in supported living accommodation, a shared lives scheme or in an NHS facility as soon as the patient registers with a GP local to his or her accommodation.

11.19. If a CCG has continuing commissioning responsibility for a patient under this paragraph, the responsibility only extends to funding the placement but not secondary care or other services that the patient needs outside of the placement.

12. Category 5: Placed children falling within paragraph 4 of Schedule 1 to the 2012 Regulations

12.1. The next group of patients for whom a CCG retains commissioning responsibility despite the patient being registered in a GP practice in the area of a different CCG is defined in paragraph 4. This paragraph relates to children who become resident in accommodation outside of the area of a CCG as a result of being placed by either a CCG or a local authority, and then join the list of a GP practice in the area in which they are placed. Paragraph 2(c) states that a placing CCG will retain commissioning responsibility for:

“every child who falls within paragraph 4”

12.2. Paragraph 4 provides:

“4.—(1) A child falls within this paragraph if both of sub-paragraphs (2) and (3) apply to the child.

(2) This sub-paragraph applies to a child if any of the following is the case—

(a) the child is looked after by a local authority within the meaning of section 22 of the Children Act 1989 (general duty of local authority in relation to children looked after by them), other than by way of being accommodated in a secure children’s home in respect of which the National Health Service Commissioning Board must arrange for the provision of services to children detained there;

(b) the child is a relevant child within the meaning of section 23A of that Act (the responsible authority and relevant children);

- (c) the child is a person to whom section 24(1A) or (1B) of that Act (persons qualifying for advice and assistance) applies;
- (d) the child is provided with accommodation at a school to which he or she is admitted in accordance with a statement of special educational needs made under section 324 of the Education Act 1996 (statement of special educational needs); or
- (e) the child requires accommodation in a care home, a children's home or an independent hospital to meet the child's continuing care needs.

(3) This sub-paragraph applies to a child if—

- (a) the child is provided with—
 - (i) services which consist of or include the provision of accommodation situated in the area of another CCG or of a Local Health Board, under arrangements made by the CCG in the exercise of its commissioning functions (by itself or jointly with a local authority), or
 - (ii) such services under arrangements made by the local authority and immediately before those arrangements were made the CCG was responsible for the child under section 3(1A) of the 2006 Act; and
- (b) the child is both—
 - (i) resident in that accommodation, and
 - (ii) would not be a person for whom the CCG is responsible under section 3(1A)(a) of the 2006 Act”

12.3. Accordingly, this part of the placing rules only applies to children, namely patients under the age of 18: see paragraph 1. The placing rules will apply to the child if one of the conditions in

paragraph 4(2) is satisfied and the conditions in both paragraphs 4(3)(a) and 4(3)(b) are both satisfied. A child will come within paragraph 4(2) if one of the following conditions applies to the child:

- a) The child is a “looked after child” within the meaning of section 22 of the Children Act 1989. A looked after child is a child which is within the care of the local authority or is provided with accommodation by the authority in the exercise of any of its functions. However children who are accommodated in a secure children’s home are excluded because commissioning responsibility for such children lies with NHS England;
- b) The child is a “relevant child” under the Children Act 1989. This is a child who is aged 16 or 17 who has been provided with accommodation by a local authority for at least 13 weeks after the age of 14: see paragraph 19B of Schedule 2 of the Children Act 1989 and Regulation 40 of the Care Planning, Placement and Case Review (England) Regulations 2010. A child is also a relevant child if, on attaining the age of 16, the child was detained, or in hospital, and immediately before being detained or admitted to hospital had been looked after by a local authority for a period or periods amounting in total to at least 13 weeks, which began after the child attained the age of 14: see Regulation 3 of the Care Leavers (England) Regulations 2010;
- c) The child comes within section 24(1A) of the Children Act 1989, namely if the child has reached the age of sixteen but not the age of twenty-one, and where a special guardianship order is in force (or, if he has reached the age of eighteen, was in force when he reached that age) and who was, immediately before the making of that order, looked after by a local authority;
- d) The child comes within section 24(1B) of the Children Act 1989, namely the child has been accommodated or fostered by a local authority at any time after the age of 16;
- e) The child is provided with accommodation at a school to which he or she is admitted in accordance with a statement of special educational needs made under section 324 of the Education Act 1996 (statement of special educational needs); or
- f) The child requires accommodation in a care home, a children’s home or an independent hospital to meet the child’s continuing care needs. Please see above for a discussion on the meaning of “continuing care”.

- 12.4. Both of the conditions in paragraph 4(3)(a) and 4(3)(b) have to be satisfied in order to prevent commissioning responsibility for a child transferring to the local CCG when the child's GP registration transfers. The condition in paragraph 4(3)(a) will be satisfied if the child is provided with either:
- a) services which consist of or include the provision of accommodation situated in the area of another CCG or of a Local Health Board, under arrangements made by the CCG in the exercise of its commissioning functions (by itself or jointly with a local authority), or
 - b) such services under arrangements made by the local authority and immediately before those arrangements were made the CCG was responsible for the child under section 3(1A) of the 2006 Act.
- 12.5. Hence, in contrast to adults, where a local authority acts alone in placing a child away from its home area, both the home CCG and the home local authority continue to have statutory responsibility for providing NHS and community care services to the child. In contrast, the placing rules do not apply where a local authority acts alone in placing an adult in a care home in the area of another CCG and the adult is registered with a GP practice close to the care home. In such a case responsibility for funding NHS services transfers to the CCG for the new GP practice.
- 12.6. The conditions in paragraph 4(3)(b) are that the child is "resident in that accommodation" which means that the child's period of stay in the accommodation is long enough to mean that the child acquires a residence at that place. Secondly, and somewhat strangely, the paragraph provides that the child is not someone for whom the CCG would have commissioning responsibility under section 3(1A)(a) of the NHS Act, namely someone who is on the list for a GP practice in the area of the CCG. It is unclear why this provision is needed because these provisions only apply where a CCG is not allocated commissioning responsibility by virtue of GP registration.
- 12.7. Where a CCG continue to have commissioning responsibility for a child under this paragraph, the CCG's commissioning responsibilities extend to all services that the child needs (other than those which fall within the responsibility of NHS England) and not just meeting the costs

of the placement. Accordingly, if a placed child is admitted to hospital from the placement, in contrast to the position of adults, the placing CCG retains full responsibility for meeting the cost of the child's NHS treatment.

13. Category 6: Placed children who become adults

13.1. Paragraph 5 of Schedule 1 provides for cases where a CCG has placed a child in accommodation for his or her continuing care needs (which has become that person's residence) once the child reaches the age of 18. The paragraph provides that the CCG will continue to have commissioning responsibility for the adult, notwithstanding that the adult is on the list of a GP practice local to their accommodation. However, there can be circumstances where the CCG retains commissioning responsibility for the child but does not continue to have commissioning responsibility when the child reaches the age of 18 because, for example, no nursing services are provided as part of the placement.

13.2. Paragraph 5 of Schedule 1 to the 2012 Regulations provides:

“A person falls within this paragraph if—

- (a) the CCG has made an arrangement in the exercise of its commissioning functions (by itself or jointly with a local authority) by virtue of which immediately before attaining 18 the person was provided with services to meet his or her continuing care needs;
- (b) those services consist of or include the provision of the following accommodation and services to meet the person's continuing care needs—
 - (i) accommodation in a care home, a children's home or an independent hospital situated in the area of another CCG or of a Local Health Board, and
 - (ii) nursing and another service which is a planned service, as part of the health service to meet his or her continuing care needs;
- (c) the person is resident in that accommodation and continues to need that planned service (or those planned services), and

(d) the person would not be a person for whom the CCG is responsible under section 3(1A)(a) of the 2006 Act”

13.3. This formulation follows the same structure as that described above. It refers to a child being provided with services to meet their “continuing care” needs, which is probably wider than children’s NHS Continuing Healthcare. The arrangements to provide the placement can either be made by the CCG alone or by the CCG in combination with the relevant local authority (which is highly likely to be the case for any child with significant disabilities). However, this part of the placing rules does not apply if the placement was made by the local authority alone (i.e. without any significant part being played by the CCG in the placement decision).

13.4. The placement is only a qualifying placement under this paragraph if it provides both nursing services and another “planned service”. Please see above for a discussion on the meaning of the term “planned service”. If the accommodation provides one or more planned services but does not provide nursing services, the patient falls outside this paragraph. This is likely to be the case for children with learning difficulties who are provided with specialist support accommodation but which does not necessarily include nursing services.

13.5. If a CCG has continuing commissioning responsibility for a patient under this paragraph, the responsibility only extends to funding the placement but not secondary care or other services that the patient needs outside of the placement.

14. Category 7: Adult patients who have been placed out of area by a primary care trust

14.1. Primary care trusts (“PCTs”) were the local NHS commissioners prior to the creation of CCGs and NHS England in April 2013. In contrast to the position under the NHS Act (as amended by the 2012 Act), PCTs acted as the delegate of the Secretary of State in making commissioning decisions. The placing rules were set out in Regulation 3 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (“the 2002 Regulations”). These rules were slightly different to the rules now operating under the 2012 Regulations and the 2002 Regulations were regularly amended. The rules operated until 31 March 2013 when clinical commissioning groups came into existence and primary care trusts were abolished.

14.2. Paragraph 2(e) of Schedule 1 to the 2012 Regulations provides that a CCG shall have continuing commissioning responsibility for adult patients placed out of area where the placing rules under the 2002 Regulations meant that the placing PCT retained commissioning responsibility. Paragraph 2(e) of Schedule 1 to the 2012 Regulations provides:

“every person who falls within paragraph 6 in relation to the provision of the accommodation or services referred to in paragraph 6(b)”

14.3. Paragraph 6 of Schedule 1 to the 2012 Regulations provides:

“A person falls within this paragraph if—

14.3.a.1.1. a Primary Care Trust has made an arrangement before the relevant date in the exercise of its functions by virtue of regulation 3 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements)(England) Regulations 2002 by virtue of which the person was provided with services to meet his or her continuing care needs;

14.3.a.1.2. the rights and liabilities under that arrangement are transferred to the CCG by virtue of a scheme made under section 300 of the 2012 Act (transfer schemes);

14.3.a.1.3. the person continues to need the provision of the following accommodation and services to meet the person’s continuing care needs—

- (i) accommodation in a care home or independent hospital situated in the area of another CCG, and
- (iii) at least one planned service (other than a service consisting only of NHS-funded nursing care) which is connected to the provision of such accommodation (whether or not the accommodation is arranged by the CCG); and

14.3.a.1.4. the person would not be a person for whom the CCG is responsible under section 3(1A)(a) of the 2006 Act”

- 14.4. This paragraph thus provides that the CCG has continuing commissioning responsibility for a person where the predecessor PCT made a lawful placement for a person for whom it had commissioning responsibility under the 2002 Regulations to meet his or her continuing care needs¹⁸ and retained commissioning responsibility for that patient because of the placing rules in force under the 2002 Regulations. Regulation 3 provided that a PCT had commissioning responsibility for patients on the lists of GP practices in its area and those who were resident in its area but not on the list of any GP practice. It also contained a series of placing rules.
- 14.5. When CCGs were created there were a series of “Transfer Orders” which transferred assets, liabilities and statutory responsibilities from a PCT to a CCG or, if the CCG area was not coterminous with the area of the PCT, between the CCGs that were created to operate in the area of the former PCT. The new CCGs were created as membership organisations of GP practices operating in a defined area. Accordingly for the majority of patients, statutory responsibility for patients of a GP practice was transferred by reference to the GP practice where the patient was registered. Paragraph 6(2) of Schedule 1 to the 2012 Regulations provides that a CCG has continuing commissioning responsibility for a placement made by a predecessor PCT if the relevant Transfer Order transferred rights and liabilities for that patient to the PCT.
- 14.6. Paragraph 6(c) contains the same formulation as set out in other paragraphs, namely that the patient is placed in a care home or independent hospital¹⁹ and that he or she is receiving at least one planned service other than nursing care. Finally the paragraph contains the superfluous condition that the person is not someone who the CCG would otherwise have statutory responsibility for because the person is on the list of a GP practice in the CCG’s area.
- 14.7. If a CCG has continuing commissioning responsibility for a patient under this paragraph, the responsibility only extends to funding the placement but not secondary care or other services that the patient needs outside of the placement.

15. Category 8: Children who have been placed out of area by a primary care trust

¹⁸ Please see paragraph 11.12ff above for a discussion on what is meant by “continuing care” needs.

¹⁹ See paragraph 11.8ff above for a discussion on what is meant by an independent hospital or care home.

- 15.1. Paragraph 7 of Schedule 1 contains identical provisions to paragraph 6 (which relates to adults only) relating to children who were placed by a primary care trust in accommodation to meet their continuing care needs. If a child was placed by a primary care trust out of area in circumstances where the primary care trust retained commissioning responsibility for the NHS services provided to the child, the liability for funding the placement is transferred to the CCG.
- 15.2. If a CCG has continuing commissioning responsibility for a child under this paragraph, the responsibility only extends to funding the placement but not secondary care or other services that the child needs outside of the placement.

16. Category 9: Children placed at special schools by local authorities before 1 April 2013

- 16.1. The 2012 Regulations provide that children placed by a local authority at a school outside their local area with a statement of special educational needs before 1 April 2013 should continue to be the responsibility of their home CCG. This is achieved by a combination of paragraph 2(g) and paragraph 8 of Schedule 1 to the 2012 Regulations.
- 16.2. Paragraph 2(g) provides that the category of persons for which a CCG has continuing responsibility is as follows:

“Every child who falls within paragraph 8”

- 16.3. Paragraph 8 defines the relevant cohort of children as follows:

“(1) A child falls within this paragraph if—

16.3.a.1.1. a local authority has made an arrangement before the relevant date by virtue of which the child is provided with accommodation at a school in the area of another CCG or a Local Health Board, to which the child is admitted in accordance with a statement of special educational needs made under section 324 of the Education Act 1996;

16.3.a.1.2. immediately before the child was accommodated at that school the child was either—

(i) provided with primary medical services by a person who is now a member of the CCG; or

(iii) usually resident in the area of the CCG and not provided with primary medical services by a person who is now a member of the CCG; and

16.3.a.1.3. the child would not be a person for whom the CCG is responsible under section 3(1A)(a) of the 2006 Act”

16.4. The “relevant date” is 1 April 2013: see Regulation 2. Accordingly, this cohort of children is confined to children who have a statement of special educational needs and have been provided with accommodation at a school in the area of another CCG as a result of the decision of a local authority prior to 1 April 2013. For any child coming within this category, commissioning responsibility is retained by the CCG where the child had a GP registration immediately before moving to the school or, if the child was not on the list of any GP practice, the CCG which covered the area where the child was usually resident before moving to the school.

17. Category 10: Patients who are resident outside the United Kingdom

17.1. Paragraph 2(h) extends the responsibility of each CCG to commission NHS services for persons who are:

- a) resident outside the United Kingdom;
- b) not on the list of any GP practice; and
- c) are physically present in the CCG’s area.

17.2. Some of these individuals will be entitled to access NHS services on the same basis as those permanently resident in the United Kingdom. Others will be required to pay charges for some NHS services. Details of this are set out in the chapter on charging for NHS services²⁰. This paragraph provides that, as between different clinical commissioning groups, the clinical commissioning group that has commissioning responsibility for an overseas resident is the

²⁰ This chapter will follow in due course.

clinical commissioning group where that individual is physically present. The paragraph provides as follows:

“every person present in the CCG’s area who is resident outside the United Kingdom and not provided with primary medical services by a member of any CCG”

17.3. There are two possible ways in which this paragraph could be interpreted. First, commissioning responsibility could change as the individual moves from one CCG area to another CCG area. Hence, if a patient was seen by ambulance staff in the area CCG A and then transferred to hospital in the area of CCG B, it is unclear from the wording whether commissioning responsibility for the hospital services should be met by CCG A or CCG B. It seems likely that commissioning responsibility changes as the location of the patient changes. Thus, in the above example, CCG B would be liable for all costs of the providing services to the patient and not just the cost of providing emergency services.

17.4. Paragraph 20 of the “Who Pays” Guidance suggests that commissioning responsibility for an overseas resident lies with the CCG where the person is resident in the United Kingdom. This appears to be incorrect because responsibility is allocated under this part of the Regulations to the CCG where the person is physically present, not the CCG where the person is resident. Paragraph 21 of the Guidance states:

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

17.5. This paragraph appears to confuse a number of different concepts. First, United Kingdom nationals who are resident abroad have no greater rights to access free NHS care than any other individual of any nationality who lives abroad. Entitlement to free NHS care is based on residence in the United Kingdom and not on nationality. Secondly, there is no general right to access free mental health services for overseas residents. However, all NHS services provided

outside of a hospital are not presently subject to charges: see Regulation 9(b) of the National Health Service (Charges to Overseas Visitors) Regulations 2015. Accordingly, community-based mental health services are not subject to charges for any overseas patient. If an overseas patient is provided with hospital-based mental health services, charges are required to be made unless the patient is able to claim an exemption (for example because they are resident in the EU or in a country with a reciprocal agreement). No charges can be levied for NHS services to a detained mental health patient, a patient received into guardianship or a patient subject to a community treatment order under the Mental Health Act 1983: see 18 of the National Health Service (Charges to Overseas Visitors) Regulations 2015.

- 17.6. Where an overseas patient is suffering from a mental health condition which means that the patient is a “qualifying patient” under section 130C MHA, the CCG with commissioning responsibility for that patient will be the CCG where the relevant mental hospital is located (see category 12 below). In all other circumstances, the CCG with commissioning responsibility will be the CCG where the patient is physically present (unless the patient has registered with an English NHS GP practice). However, the suggestion in the Guidance that a residence test can be used to identify the responsible commissioning CCG is inaccurate. Commissioning responsibility for overseas residents who need mental health treatment can only be fixed by either being on the practice list of a GP practice or by physical presence, not by residence.

18. Category 11: Mental Health patients resident in Scotland, Wales and Northern Ireland

- 18.1. Paragraph 2(i) extends the commissioning responsibilities of CCGs the following additional group of patients:

“every person resident in Scotland, Wales or Northern Ireland and present in the CCG’s area who is a qualifying patient within the meaning of section 130C of the 1983 Act (section 130A:supplemental), and not provided with primary medical services by a member of any CCG”

- 18.2. There are four conditions which need to be satisfied to bring a patient within this group:

- a) The patient needs to be resident in either Scotland, Wales or Northern Ireland;

- b) The patient needs to be physically present in the CCG's area;
- c) The patient needs to be a "qualifying patient" within the meaning of section 130C of the Mental Health Act 1983; and
- d) The patient needs to be somebody who is not on the list of any English NHS GP practice.

18.3. The term "qualifying patient" as defined by section 130C of the Mental Health Act 1983 ("MHA") means a patient who has a mental disorder which means that he or she is liable to be detained under the MHA otherwise than by virtue of excepted sections of the MHA or is subject to a guardianship under the MHA or is a community mental health patient. The excepted sections are:

- a) Section 4 MHA (admission for assessment in cases of emergency);
- b) Section 5(2) and (4) MHA (application for admissions for patients who are already in hospital);
- c) Section 135 MHA (persons who are detained by the police or an approved mental health professional following the issue of a magistrate's warrant); and
- d) Section 136 MHA (mentally disordered persons who are detained after being found in public places by the police).

18.4. Section 130C(3) and (4) also relevant and provides:

"(3) A patient is also a qualifying patient if the patient is to be regarded as being in England for the purposes of this subsection and—

- (a) not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 57 above applies; or
- (b) not having attained the age of 18 years and not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical

practitioner or approved clinician the possibility of being given a form of treatment to which section 58A above applies.

(3A) For the purposes of subsection (3), a patient is to be regarded as being in England if that has been determined in accordance with arrangements made for the purposes of that subsection and section 130I(4), and published, by the Secretary of State and the Welsh Ministers.

(4) Where a patient who is a qualifying patient falling within subsection (3) above is informed that the treatment concerned is proposed in his case, he remains a qualifying patient falling within that subsection until—

(a) the proposal is withdrawn; or

(b) the treatment is completed or discontinued”

18.5. Accordingly this paragraph generally extends commissioning responsibility to mental health patients who are community patients, subject to guardianship under the MHA or are liable to be detained in an English hospital under either section 2 or section 3 MHA who are physically present in the area of a CCG, have no English GP and are usually resident in Scotland, Wales or Northern Ireland.

18.6. Where a CCG acquires continue commissioning responsibility for a mental health patient under this paragraph, the CCG’s commissioning responsibilities extend to all services that the patient needs (other than those which fall within the responsibility of NHS England) and not just meeting the costs of the mental health placement.

19. Category 12: Other qualifying mental health patients

19.1. Paragraph 2(j) of Schedule 2 to the 2012 Regulations provides that a CCG has the commissioning responsibility for the following mental health patients:

“every person who is a qualifying patient within the meaning of section 130C of the 1983 Act and liable to be detained under that Act in a hospital or registered establishment (within the meaning of that Act) in the CCG’s area”

19.2. This paragraph generally extends NHS commissioning responsibility to “qualifying patients” within the meaning of section 130C MHA who are also liable to be detained in a hospital in the CCG’s area under either section 2 or section 3 MHA. If a patient is actually detained in a mental health hospital, commissioning responsibility for the provision of secure mental health services lies with NHS England. However, the category of patients who are “liable to be detained” is wider than those who are actually detained.

19.3. Where a CCG acquires continue commissioning responsibility for a mental health patient under this paragraph, the CCG’s commissioning responsibilities extend to all services that the patient needs (other than those which fall within the responsibility of NHS England) and not just meeting the costs of the mental health placement.

20. Category 13: Patients usually resident in Scotland, Northern Ireland or Wales

20.1. Patients who are usually resident in Scotland, Northern Ireland or Wales can nonetheless register with an English GP. However regulations 2(2)(a) to (c) provide that a CCG shall not have commissioning responsibility for other healthcare services for anyone who is usually resident in Scotland, Northern Ireland or Wales. Thus, where such persons need services other than primary care services, the responsible Commissioner is:

- a) the Local Health Board in Wales covering the area where the individual is usually resident in Wales;
- b) the Scotland Health Board where the individual is usually resident in Scotland; and
- c) the Health and Social Care Board for Northern Ireland where the individual is usually resident in Northern Ireland.

21. Category 14: Section 117 Mental Health Act 1983 aftercare patients

21.1. Section 117 MHA imposes a duty jointly on a clinical commissioning group and a local authority to provide “after-care” services for a mental health patient who has been detained in hospital under defined parts of the MHA. The present version of the section (which has been amended on multiple occasions) provides as follows:

“(1) This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under section 37 above, or transferred to a hospital in pursuance of a hospital direction made under section 45A above or a transfer direction made under section 47 or 48 above, and then cease to be detained and (whether or not immediately after so ceasing) leave hospital.

(2) It shall be the duty of the clinical commissioning group or . . . and of the local social services authority to provide or arrange for the provision of, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the clinical commissioning group or ... and the local social services authority are satisfied that the person concerned is no longer in need of such services]; but they shall not be so satisfied in the case of a community patient while he remains such a patient.

(2A) . . .

(2B) Section 32 above shall apply for the purposes of this section as it applies for the purposes of Part II of this Act.

(2C) References in this Act to after-care services provided for a patient under this section include references to services provided for the patient—

(a) in respect of which direct payments are made under—

(i) sections 31 to 33 of the Care Act 2014 (as applied by Schedule 4 to that Act),

(ii) sections 50, 51 and 53 of the Social Services and Well-being (Wales) Act 2014 (as applied by Schedule A1 to that Act), or

(iii) regulations under section 12A(4) of the National Health Service Act 2006, and

(b) which would be provided under this section apart from those sections (as so applied) or the regulations.

(2D) Subsection (2), in its application to the clinical commissioning group, has effect as if the words “provide or” were omitted.

(2E) The Secretary of State may by regulations provide that the duty imposed on the clinical commissioning group by subsection (2) is, in the circumstances or to the extent prescribed by the regulations, to be imposed instead on another clinical commissioning group or the National Health Service Commissioning Board.

(2F) Where regulations under subsection (2E) provide that the duty imposed by subsection (2) is to be imposed on the National Health Service Commissioning Board, subsection (2D) has effect as if the reference to the clinical commissioning group were a reference to the National Health Service Commissioning Board.

(2G) Section 272(7) and (8) of the National Health Service Act 2006 applies to the power to make regulations under subsection (2E) as it applies to a power to make regulations under that Act.

(3) In this section “the clinical commissioning group ... means the clinical commissioning group . . . and “the local social services authority” means the local social services authority—

(a) if, immediately before being detained, the person concerned was ordinarily resident in England, for the area in England in which he was ordinarily resident;

(b) if, immediately before being detained, the person concerned was ordinarily resident in Wales, for the area in Wales in which he was ordinarily resident; or

(c) in any other case, for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained.

(4) Where there is a dispute about where a person was ordinarily resident for the purposes of subsection (3) above—

(a) if the dispute is between local social services authorities in England, section 40 of the Care Act 2014 applies to the dispute as it applies to a dispute about where a person was ordinarily resident for the purposes of Part 1 of that Act;

(b) if the dispute is between local social services authorities in Wales, section 195 of the Social Services and Well-being (Wales) Act 2014 applies to the dispute as it applies to a dispute about where a person was ordinarily resident for the purposes of that Act;

(c) if the dispute is between a local social services authority in England and a local social services authority in Wales, it is to be determined by the Secretary of State or the Welsh Ministers.

(5) The Secretary of State and the Welsh Ministers shall make and publish arrangements for determining which of them is to determine a dispute under subsection (4)(c); and the arrangements may, in particular, provide for the dispute to be determined by whichever of them they agree is to do so.

(6) In this section, “after-care services”, in relation to a person, means services which have both of the following purposes—

(a) meeting a need arising from or related to the person's mental disorder; and

(b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)”

21.2. This section imposes a legal duty on a CCG and a local authority jointly to provide “aftercare” services to a person who was previously a detained mental health patient. This duty is owed directly to an individual patient and takes precedence over the target duty imposed on a CCG to provide services to patients by section 3(1) NHS Act. There are a wide range of services that potentially fall within the duty to provide after-care services, including accommodation (where that is part of the patient’s need), community psychiatric services and social care and

support services. There is no Guidance as to how the relevant CCG and local authority shall divide the costs of complying with this duty between the 2 public bodies. Most CCGs and local authorities agree to divide the costs of providing the services equally between the two public bodies but other arrangements are possible.

- 21.3. Where the patient was ordinarily resident in any part of England prior to being detained, the CCG with responsibility for providing section 117 services is defined in section 117(3)(a) MHA as being the CCG covering the location where the patient was ordinarily resident. Accordingly, under the MHA, the responsible CCG is determined by the application of an ordinary residence test and not by the location of the GP practice where the patient is registered.
- 21.4. However by Regulation 14 of the 2012 Regulations, the Secretary of State has made use of the power under section 117(2E) to change the CCG which has responsibility from the CCG where the patient is resident to the CCG which is responsible for commissioning other NHS services for the patient. Regulation 14 provides:

“(1) The duty imposed by subsection (2) of section 117 of the 1983 Act on a CCG(1) (CCG A) to arrange for the provision of after-care services for a person (P) to whom section 117 applies is to be imposed instead on another CCG (CCG B) in the circumstances below.

(2) These circumstances are where CCG B has responsibility for P by virtue of—

(a) section 3(1A) of the 2006 Act(2); or

(b) regulation 4 of, and sub-paragraph (c), (g), (h), (i) or (j) of paragraph 2 of Schedule 1 to these Regulations”

- 21.5. Thus, since 2012, the duty to commission services for mental health patients under section 117 is fixed by the standard NHS rules and not by a residence test. This is confirmed in paragraph 34 of the “Who Pays” Guidance which provides:

“It is the duty of the CCG and local social services authority to commission after-care for those persons discharged from hospital following detention under section 117 of the Mental Health Act. The responsible CCG should be established by the usual means (see paragraph 1). If a patient who is resident in one area (CCG A) is discharged to another

area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to pay for their aftercare under section 117 of the Act as agreed with the appropriate local social services authority”

21.6. There is new Guidance dated April 2016 which also sets out that detained mental health patients should be funded by CCGs rather than NHS England.

22. Resolving disputes about which CCG is the responsible Commissioner

22.1. Disputes between local authorities as to which has responsibility to provide community care services to a service user are subject to a statutory adjudication process by the Secretary of State under the Care Act 2014 (and previously under the National Assistance Act 1948). There is no similar provision under the NHS Act for dispute resolution by either the Secretary of State or by NHS England. Nonetheless paragraph 9 of the “Who Pays” Guidance provides:

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

22.2. Section 14Z8 of the NHS Act (as imposed by the Health and Social Care Act 2012) enables NHS England to publish commissioning guidance, and CCGs are required to have regard to the guidance. Accordingly, CCGs that are in dispute about the allocation of commissioning responsibilities are required to consider referring the matter to NHS England to arbitrate. Whilst that appears a sensible and cost-effective option, the numerous mistakes in the “Who Pays” Guidance could make it very difficult for a CCG to have confidence that the NHS England decision maker would reach a decision that was in accordance with the NHS Act and the 2012 Regulations. It is thus probably preferable for 2 CCGs to commission an independent legal opinion to assist resolving the dispute.

David Lock QC

July 2017.