



CEL 06 (2013)

March 2013

Dear Colleague

Establishing the Responsible Commissioner: Guidance and Directions for Health Boards, March 2013

Purpose

This document sets out the procedures for establishing the responsible commissioner for an individual's care within the NHS, and replaces the previous guidance contained within [NHS HDL \(2004\) 15](#). The new guidance is effective immediately.

Background

Guidance on establishing the responsible commissioner was last reviewed in 2004. The new guidance, whilst based on the previous version, includes updates in order to:

- reflect the Health and Social Care Act 2012, which creates Clinical Commissioning Groups in place of PCTs in England;
- provide more up-to-date guidance on those in NHS Continuing Care;
- reflect changes to the provision of prisoner health care; and
- provide more detailed guidance on mental health patients, including those in restricted settings.

Arrangements laid down in this guidance are intended to strike a balance between a coherent planned approach to service provision and responsiveness to individual patient needs. NHS bodies are therefore expected to work together to ensure that services are always provided in the best interests of the patient.

For cases that were ongoing prior to the issue of this guidance, consideration should be given to previous legislation and guidance.

Enquiries and Further Advice

Where there is a disagreement over a patient's responsible commissioner, the appropriate NHS bodies should make every

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reasonable effort to resolve the issue themselves.

Enquiries about determining the responsible commissioner may be addressed to David Bishop, Directorate for Finance, eHealth and Pharmaceuticals, Basement Rear, St Andrew's House, Regent Road, Edinburgh, EH1 3DG or to david.bishop@scotland.gsi.gov.uk.

Yours faithfully

A handwritten signature in black ink, appearing to read "John Matheson", with a horizontal line underneath.

John Matheson
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SCOTTISH GOVERNMENT HEALTH DIRECTORATE

ESTABLISHING THE RESPONSIBLE COMMISSIONER:

GUIDANCE and DIRECTIONS FOR HEALTH BOARDS

MARCH 2013

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INTRODUCTION AND PURPOSE

1. This document sets out the framework for establishing responsibility for commissioning an individual's care within the NHS and replaces [NHS HDL \(2004\) 15](#), issued in 2004.
2. Part A of the document contains guidance only and is not intended to be a definitive interpretation of the law, which is a matter for the Courts.
3. Part B of the document contains Directions which are issued to Health Boards by the Scottish Ministers pursuant to section 2(5) of the National Health Service (Scotland) Act 1978.

PART A – GUIDANCE

BACKGROUND

4. The safety and well being of patients is paramount. The underlying principle is that there should be no gap in responsibility for the provision of health care, and no treatment should be refused or delayed due to uncertainty or ambiguity over which NHS body is responsible for funding an individual's health care provision.

5. Since it is not possible to cover every eventuality within this Guidance, all facets of the NHS are expected to act in the best interests of the patient at all times and work together in the spirit of partnership. The aim of all NHS bodies involved in commissioning health services should be to reach agreement. All parties must share the objective of ensuring that the most effective use is made of the resources available in the best interests of patients. Should any disputes as to the identity of the responsible commissioner arise between two Health Boards, such matters can be referred to the Scottish Government for an opinion.

ESTABLISHING THE RESPONSIBLE COMMISSIONER – “ORDINARY RESIDENCE”

6. Under article 2 of the Functions of Health Boards (Scotland) Order 1991 (“the 1991 Order”), Health Boards have a responsibility to provide for the health care of patients living within their boundaries, i.e. patients who are “ordinarily resident” in their area. There is no definition of the term “ordinarily resident” in the 1991 Order and the term has not been the subject of interpretation by the courts under this Order. The term has, however, been considered by the courts in other legislative contexts and is a familiar statutory concept. It is considered that the leading case law, mentioned below, would be of strong persuasive influence to any court considering the meaning of “ordinarily resident” for the purposes of the 1991 Order.

- Shah v London Borough of Barnet [1983] 1 All E.R. 226

7. In Shah, a House of Lords decision, Lord Scarman stated-

“unless ... it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning, I unhesitatingly subscribe to the view that “ordinarily resident” refers to a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration.”

8. The House of Lords therefore held that the concept of ordinary residence is when a person decides voluntarily to live in a particular place for a settled purpose. The purpose can be singular or there may be several purposes and they can be specific or general. All that is necessary is that the purpose of living in a specific place has a sufficient degree of continuity to be described as settled. The purpose of living in a particular place must therefore form part of the regular order of the person's life.

9. Ordinary residence is not dictated by a period of time. Time may well be a relevant factor but it is not a determining consideration. If a person has only lived in an area for one day, they can still be ordinarily resident there. For example, a person would be ordinarily resident in an area even after one day if: they had bought

a home in the area; they moved to the area to send their child to a particular school; they are renting a premises to be nearer their workplace; or they have moved to the location to enrol in a university course (this list is not exhaustive). These examples exhibit a degree of continuity in the purpose of living in a particular place and such purposes can form part of the regular, habitual mode of a person's life. Enquiry into a patient's ordinary residence should not call for any deep examination of the intentions of the patient. There is no need to attempt to discover what a patient's long term future expectations or intentions are with regards to residing in the area. Patients should not therefore be subject to undue scrutiny when being asked for their ordinary residence. In the vast majority of cases the address given by the patient will usually be their ordinary residence as defined in law. Patients should not, however, be led into giving an alternative address or misleading information in order to exploit any perceived financial advantage.

DETERMINING ORDINARY RESIDENCE WHEN SITUATION UNCLEAR

10. Article 2(2) of the 1991 Order makes provision for determining ordinary residence in situations where it is unclear or where an individual does not appear to have any settled residence. In accordance with article 2(2), where it is unclear where a person ordinarily resides, he/she shall be treated as ordinarily residing at the address which he/she gives to the Health Board. Where there is no evidence of his/her present address, he/she shall be treated as ordinarily residing at his/her most recent address, and where there is any doubt about this, he/she shall be treated as ordinarily residing at the address which he/she gives to that Health Board as his/her most recent address. If the address still cannot be established, he/she shall be treated as ordinarily residing in the area in which he/she is at present.

11. Article 2(2) of the 1991 Order is to be read subject to any directions which the Scottish Ministers may give as to any particular case or class of case. Such directions are issued under section 2(5) of the National Health Service (Scotland) Act 1978. This means the default position set out above in terms of determining 'ordinary residence' can be departed from where the Scottish Ministers have issued Directions to that effect. Part B of this document contains the Directions which the Scottish Ministers have issued pursuant to this power.

SPECIALIST AND SPECIALISED SERVICES

12. Health Boards are responsible for commissioning health services for people ordinarily resident in their areas. The two exceptions are designated national specialist services in both NHS Scotland and NHS England; and the commissioning of highly specialised services in NHS England. National Services Division (NSD) of NHS National Services Scotland is responsible for the commissioning of specialist services on behalf of the Health Boards in Scotland and works, as required, in partnership with the Advisory Group for National Specialist Services (AGNSS) and the English NHS National Commissioning Board. The specialist services included in these arrangements are regularly updated with oversight provided by the National Specialist Services Committee and the NHS Scotland Chief Executives Group in Scotland and by AGNSS in England. A list of specialist services is available on the

NHS National Services Scotland website¹. These include designated national specialist services provided in NHS Scotland, those designated on a UK basis by AGNSS, and other specialised services defined in the Specialised Services National Definitions Set.

OUT OF AREA TREATMENTS: CROSS-BOUNDARY AND CROSS-BORDER – SERVICE LEVEL AGREEMENTS

13. NHS MEL (1999) 4² and NHS HDL (2002) 39^{3,4} set out the arrangements within the NHS for commissioning out of area treatments, both cross-boundary and cross-border. This guidance does not supersede these HDLs. The following paragraphs summarise the arrangements as set out in the 1999 and 2002 HDLs.

14. Within Scotland, all **cross-boundary** non-specialised unplanned activity (UNPAC)⁵ should be included in service level agreements (SLAs). These cover both elective and non-elective activity, including specialised services. Where a Health Board treats a cross-boundary patient, and no SLA exists between the Health Board and the Health Board in whose area the patient ordinarily resides, the activity should be charged and settled retrospectively, by invoice (see NHS MEL (1999) 4⁶).

15. Where an explicit SLA does not cover a patient's treatment in a **cross-border** situation, then the patient will be treated under a Non-Contract Activity (NCA) arrangement. In situations when a patient requires **emergency** treatment whilst away from their ordinary residence, prior approval is not required from the patient's relevant commissioning authority. However, where elective or outpatient treatment is provided, prior approval **must** be sought. The NCA arrangement should not be used as an option for long-term treatment where an emergency placement has a length of stay longer than three months (see paragraph 18). Detailed guidance on NCAs, including invoicing arrangements, can be found in the Agreement between Scotland, England, Wales and Northern Ireland⁷.

16. Outwith Scotland access to specialist and specialised services is managed by NSD through a number of processes which lead to a recharge to Health Boards in Scotland for all activity commissioned. The list of services which can be accessed and funded from the national risk share is provided on the NHS National Services Scotland website⁸. NSD has a standing agreement with all Health Boards that a local authorisation process to allow a cross-border referral is led by the individual Health Board, with NSD offering support in confirming that a service is nationally designated or is included in the Specialised Services National Definition Set. In all cases where the referral is to a specialist service, which is already provided within NHS Scotland, the referring clinician is asked to discuss the case / care pathway with the Scottish specialist service.

¹ <http://www.nsd.scot.nhs.uk/services/specialised/index.html>

² http://www.sehd.scot.nhs.uk/mels/1999_04.pdf

³ http://www.sehd.scot.nhs.uk/mels/HDL2002_39.pdf

⁴ HSC 1998/198 in England

⁵ UNPAC arrangements (unique to Scotland) were designed to be a simpler alternative for intra-Scotland OAT activity and to cover activity not covered by SLAs

⁶ http://www.sehd.scot.nhs.uk/mels/1999_04.pdf

⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150

⁸ <http://www.nsd.scot.nhs.uk/services/specialised/index.html>

17. Resources for cross-border specialised service agreements are drawn from Health Boards on a weighted capitation National Resource Allocation Committee (NRAC) basis. The 'contribution' will include an element to fund a risk pool to provide cover for specialised service activity not covered by SLAs (e.g. high cost, low volume procedures which might hit any Health Board at any time). This too is managed by NSD, on a cost-per-case basis, funding the relevant provider in England directly. Any unspent balances in the risk pool will be refunded at or near the financial year-end.

18. Arrangements are in place to manage admission to specialist services on an emergency basis, but most of this activity is expected to be planned and authorised ahead of referral. For patients placed as an emergency where the placement lasts three months or more, and where the service concerned is not a specialised service, the patient's responsible commissioner (as determined in paragraph 6 et seq) should formalise the arrangements through a SLA.

CROSS-BORDER PATIENTS

19. In England, the responsible commissioner is primarily the Clinical Commissioning Group (CCG) associated with the patient's registered GP or, if not registered, the CCG in the area in which the patient is usually resident (note: Scotland uses the concept of "ordinary residence"). However, there are certain groups of people, e.g. patients who move cross-border and prisoners, where other factors will need to be taken into consideration. These are covered later in this Guidance.

20. Current guidelines for Wales and Northern Ireland prescribe that the responsible authority for an individual's health care provision is the one where the person is usually resident. Therefore, Local Health Boards in Wales and Health and Social Services Boards in Northern Ireland are responsible for commissioning services for their resident populations.

21. In the case of patients who are ordinarily resident in Scotland but registered with a GP elsewhere in the UK, the Scottish Health Board in whose area the patient is ordinarily resident is the responsible commissioner (in accordance with the 1991 Order). The responsible commissioner for those patients who are usually resident in England but registered with a GP in Scotland/Wales/Northern Ireland is the English CCG in whose area the patient is resident. The table below summarises the responsibilities of Scottish and English Commissioners:

Patient resident in	Registered with GP in	Receiving treatment in	Responsible commissioner
Scotland	England	England	Scotland
Scotland	England	Scotland	Scotland
England	Scotland	England	England
England	Scotland	Scotland	England

DETERMINATION OF ORDINARY RESIDENCE – PATIENTS WHO MOVE CROSS-BOUNDARY (i.e. WITHIN SCOTLAND)

22. Where a patient moves **during the course of treatment**, every effort should be made to ensure continuity of care. In all cases, the originating Health Board must liaise with the receiving Health Board.

22.1 Where a patient undergoing treatment or care as an **in-patient** changes his/her home address during that course of treatment, the patient will be treated as ordinarily resident at the address at which he/she was ordinarily resident when he/she was admitted to hospital until he/she is discharged. The “end of treatment” point may need to be pre-agreed in some circumstances where it is thought appropriate between the originating Health Board and the receiving Health Board.

22.2 Where a patient moves whilst **waiting for in-patient or out-patient** treatment, the Health Board, in whose area the patient is ordinarily resident on the date he/she is admitted to hospital, will be responsible for meeting the cost of in-patient/out-patient treatment and care.

22.3 Where a patient undergoing a course of **regular admissions** changes his/her home address during that course of treatment, the responsible Health Board will be determined by the patient's ordinary residence when the course began until a trigger date is reached. After whichever trigger date has first been reached, the responsible body will be determined by the patient's new area of residence. The trigger dates are:

- i. three months after the change of address;
- ii. the 1st April following the change of address; or
- iii. the completion of the course of treatment.

22.4 Where a patient undergoing an **ongoing course of care** (including drug therapy), whether administered at home or on NHS premises, changes his/her home address the responsible commissioner will be determined by the patient's ordinary residence when the course began until a trigger date is reached. After whichever trigger date has first been reached, the responsible body will be determined by the patient's new area of residence. The trigger dates are:

- i. three months after the change of address;
- ii. the 1st April following the change of address; or
- iii. the completion of the course of treatment.

22.5 **NHS Continuing Healthcare** is a package of care arranged and solely funded by the NHS, under the terms of the eligibility criteria contained in CEL 6 (2008)⁹.

⁹ http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf

22.5.1 Where a Health Board (“the placing Board”) arranges for such a package of care to be provided for a patient in another Scottish Health Board area (“the receiving Board”), the placing Board will remain responsible for that person’s care until that episode of care has ended. An episode of care may end when, for example, the person’s health improves to the extent that the package of care is no longer needed rendering them no longer eligible for NHS Continuing Healthcare.

22.5.2 In circumstances where NHS Continuing Healthcare is provided in a care home setting and the episode of care ends but the person chooses to remain in the care home, that person would then become ordinarily resident in the receiving Health Board’s area. Responsibility for the person’s future care needs would fall to the receiving Health Board (and local authority), as per paragraphs 25-26 of this guidance. Responsibility for local authorities in these situations is detailed in CCD 3/2010¹⁰.

22.5.3 Where NHS Continuing Healthcare is provided by a Health Board (the “placing Board”) in a hospital ward or other NHS setting in another Scottish Health Board area (“the receiving Board”), after the episode of care ends, it is expected that the person will be discharged to a setting which is suitable to meet their assessed needs. Responsibility for the person’s care will then fall to the Health Board and local authority in the area that the person is ordinarily resident (most likely the placing Health Board area), as detailed in paragraphs 25-26 of this guidance.

22.5.4 Ordinary residence does not therefore change when a person is placed out-of-area to receive NHS Continuing Healthcare. Ordinary residence only changes if the person is no longer eligible for NHS Continuing Healthcare but wishes to remain in the receiving Health Board area – at that point the person becomes ordinarily resident in the receiving Health Board’s area.

22.5.5 Health Boards responsible for placing a person in another Health Board area should, as a matter of courtesy, inform the receiving Health Board of the placement as soon as practicable.

DETERMINATION OF ORDINARY RESIDENCE – PATIENTS WHO MOVE CROSS-BORDER

23. Where a person moves cross-border, he/she would be expected to register with a GP at the earliest opportunity. The responsible commissioner would be determined as the NHS body in whose area he/she takes up ordinary residence. In the case of a person moving to England, the CCG in whose area the person takes up residence becomes the responsible commissioner until the person registers with

¹⁰ <http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Financial-Help/Ordinary-Residents>

a new GP. Thereafter, the responsible commissioner will be determined by GP registration.

24. Where a patient moves cross-border **during the course of treatment**, every effort should be made to ensure continuity of care. In all cases, the originating NHS body should liaise with the receiving NHS body – in Scotland the relevant Health Board, in England the relevant CCG, in Northern Ireland the relevant Health and Social Services Board, and in Wales the relevant Local Health Board – at the earliest opportunity to ensure continuity of care and to agree transfer of funding, if appropriate. The responsible commissioner will be determined as follows:

24.1 Where a patient undergoing treatment or care as an **in-patient** moves cross-border and their ordinary residence accordingly changes during that course of treatment, the responsible commissioner will be determined by the patient's ordinary residence (or, in England, the CCG determined by GP registration) when the person was admitted to hospital, until he/she is discharged. The "end of treatment" point might need to be pre-agreed in some circumstances where it is thought appropriate between the originating Health Board and the receiving Health body. Once discharged, patients would be expected to register with a GP which will, in turn, determine the new host commissioner.

24.2 Where a patient moves cross-border while **waiting for in-patient or out-patient** treatment, the NHS body in whose area the patient is ordinarily resident (or, in England, the CCG determined by GP registration) on the date he/she is admitted to hospital, will be responsible for meeting the cost of in-patient/out-patient treatment and care.

24.3 Where a patient undergoing a course of **regular admissions** moves cross-border during that course of treatment, the responsible commissioner will be determined by the patient's ordinary residence (or, in England, the CCG determined "end of treatment" point might need to be pre-agreed in some circumstances where it is thought appropriate between the originating Health Board and the receiving Health body.

24.4 Where a patient undergoing **an ongoing course of care** (including drug therapy), whether administered at home or on NHS premises, moves cross-border, the responsible commissioner will be determined by the patient's ordinary residence (or, in England, the CCG determined by GP registration) when the course of treatment began until the treatment ends.

24.5 In England the Health and Social Care Act 2012¹¹ established a legal framework for the new commissioning architecture for the NHS, including the responsibilities of the NHS Commissioning Board and CCGs.

24.6 Where an English CCG ("the placing CCG") arranges a package of **NHS Continuing Healthcare** in a care home in Scotland, the placing CCG will remain responsible for that person's care until that episode of care has

¹¹ www.legislation.gov.uk/ukpga/2012/7/contents/enacted

ended. An episode of care may end, for example, where a person's health improves to the extent that the package of care arranged is no longer needed rendering them no longer eligible for NHS Continuing Healthcare.

24.7 If an episode of care ends, but the person wishes to remain permanently in the Scottish care home, responsibility would then transfer to the Health Board in the receiving area. Paragraphs 25-26 of this Guidance provide further information on responsibility for placements in care homes.

24.8 CCGs responsible for placing a person in a Scottish Health Board area should, as a matter of courtesy, inform the receiving Health Board of the placement as soon as practicable.

PLACEMENTS IN CARE HOMES

25. Health Boards and local authorities should jointly assess the needs of a person who might require a placement in a local authority or private care home. Health Boards and local authorities should also liaise in securing the provision of health care and social care services when organising the placement. If the care home is in the Health Board area where the person is ordinarily resident, then that Health Board will remain the responsible commissioner for the person's health services.

26. A local authority might place someone in a care home that is in Scotland, but is outside the Health Board area of ordinary residence, i.e. cross-boundary. If the placement in the care home is permanent, then, in accordance with the 1991 Order, the Health Board in whose area the care home is located will become the responsible commissioner for the resident's general medical services, and the local authority should liaise with this Health Board. If a person is placed in a home for a temporary period, in accordance with the 1991 Order, their originating Health Board remains the responsible commissioner. Whether a care home placement is temporary or permanent should be determined on a case-by-case basis and a number of factors need to be considered including the intention of the person moving to the care home, the arrangements made by the local authority and the intention behind these arrangements and whether the person in question has capacity to make a decision as to where he or she lives.

27. Paragraphs 25 and 26 do not apply to children. Please refer to paragraph 75 et seq.

FREE PERSONAL AND NURSING CARE

28. Guidance for local authorities, the NHS and other service providers on implementation of the policy of free personal care in Scotland for people aged 65 and over, and free nursing care for care home residents of all ages, is contained in circular CCD/5/2003¹² and CCD/1/2010¹³.

¹² http://www.sehd.scot.nhs.uk/publications/CC2003_05.pdf

¹³ http://www.sehd.scot.nhs.uk/publications/CC2010_01.pdf

MENTAL HEALTH PATIENTS

29. The Mental Health (Care and Treatment) (Scotland) Act 2003¹⁴ came into effect in October 2005, replacing the previous Mental Health (Scotland) Act 1984. The 2003 Act sets out how individuals can be treated if they have a mental illness, a learning disability or a personality disorder, and what their rights are.

30. The majority of compulsory measures of treatment for mental disorder are first approved by an independent and impartial tribunal, either by the Mental Health Tribunal for Scotland, under Part 7 of the 2003 Act (compulsory treatment orders) in respect of civil patients, or by a court under the Criminal Procedure (Scotland) Act 1995¹⁵ (“the 1995 Act”) in relation to mentally disordered offenders.

31. For civil patients, there are three ways in which a person may be deprived of their liberty or subjected to compulsory measures of treatment under the 2003 Act, namely:

- i. emergency detention;
- ii. short-term detention; and
- iii. long-term detention or compulsory measures under the authority of a compulsory treatment order.

32. Mentally disordered offenders may also be diverted into the mental health system from the criminal justice system at various points of the court process, by being made subject to compulsory measures of treatment by the courts:

- i. **pre-disposal orders:** for assessment and treatment of offenders;
- ii. **disposal/sentence by court:** a person may, due to their mental disorder, be ordered by the court to be detained in hospital to receive medical treatment for their mental disorder in lieu of receiving a prison sentence; or
- iii. **post-sentence:** a prisoner serving a term of imprisonment may also be transferred from prison to hospital via a transfer for treatment direction.

33. In terms of disposal/sentence by the courts, patients may be subject to:

- i. a **Compulsion Order** (non-restricted patients) under section 57A or section 57(2)(a) of the 1995 Act;
- ii. a **Compulsion Order with Restriction Order** (CORO or “restricted” patients) under sections 57A and 59, or sections 57(2)(a) and (b) of the 1995 Act. For patients who are considered to pose a risk of serious harm, the order is without limit of time; or

¹⁴ <http://www.legislation.gov.uk/asp/2003/13/contents>

¹⁵ <http://www.legislation.gov.uk/ukpga/1995/46/contents>

- iii. a **Hospital Direction** under section 59A of the 1995 Act, a hybrid order of a hospital disposal in addition to a sentence of imprisonment which allows the person to be detained in hospital for treatment of their mental disorder and then transferred to prison to complete their sentence once hospital treatment is no longer required.

34. At the completion of a custodial sentence, prisoners may also be transferred from prison to hospital via a transfer for treatment direction under section 136 of the 2003 Act.

35. Patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction (that is, patients who are subject to special restrictions) are generally together referred to as "restricted patients" unless the context otherwise requires. Where the context does so require, such patients are referred to as "CORO patients", "HD patients" and "TTD patients" respectively.

36. Similar mental health legislation exists in England and Wales in the form of the Mental Health Act 1983, and there are reciprocal statutory arrangements in place between the UK jurisdictions that allow for transfers of patients between the jurisdictions.

THE FORENSIC ESTATE

37. The State Hospital at Carstairs is Scotland's only high security hospital. The hospital at Carstairs provides care for adult male patients only. Until 2000, there were no medium secure units in Scotland, and mentally disordered offenders were instead managed in IPCU settings. However, the development of forensic psychiatry provision in Scotland was progressed from the late 90s, following a series of consultations on "The Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland policy document" (1999). Since then, the Scottish Government has continued to work with Health Boards, Regional Planning Groups and the Forensic Network to plan and provide appropriate medium secure services within the framework set out in HDL (2006) 48¹⁶.

38. HDL (2006) 48 on Forensic Mental Health Services, which was issued in June 2006, set out the Government's assessment of the needs for the future provision at high, medium and low in the secure forensic estate based on the understanding at that time of patient numbers and demand at each level of security. The commissioning structure recognised that it was not reasonable to expect each Health Board to provide services at each level in light of the relatively small numbers of patients involved and the specialised nature of the services (and staff) required to care for and treat these groups of patients. The expectation was – and is – that groups of Health Boards would come together to plan the provision of some services on a regional basis, and that these regional planning groups have to plan for all services outside the state hospital to ensure patients move through the system once out of the State Hospital.

¹⁶ http://www.forensicnetwork.scot.nhs.uk/documents/hdl/HDL2006_48%20full%20doc.pdf

39. Currently, in addition to the State Hospital, the Forensic Estate (the high secure and certain specific low secure services) now includes the following medium secure units:

- the Orchard Clinic, sited at the Royal Edinburgh Hospital, for the east of Scotland;
- Rowanbank Clinic, on the Stobhill site in Glasgow, for the west of Scotland; and
- Rohallion (male only), at the Murray Royal Hospital in Perth, serves Tayside, Grampian, Highland, Orkney and Shetland.

PATIENTS TRANSFERRED FROM THE STATE HOSPITAL / MEDIUM SECURE UNITS

40. Patients transferring from the State Hospital are now moved to both medium and low security facilities depending on their specific needs. Generally patients do not spend long in medium security where efforts have been made to rehabilitate them into the community. The right of appeal introduced on 1 May 2006, enabling patients in the State Hospital to appeal to the Tribunal against being held in conditions of excessive security, has had a noticeable effect on the whole mental health system as patients in other facilities have been moved on (where appropriate, into the community) to free up beds for patients being transferred.

41. In some cases, establishing the Health Board of residence for patients being repatriated from the State Hospital may not be straightforward but, if delays occur in establishing residence, two major problems are created. The first is that patients are being denied the treatment to which they are entitled and the second is that the State Hospital continues to detain patients who no longer need the treatment and security it provides. To ensure that there are no delays when a State Hospital patient is transferred or discharged, the Health Board of residence must be known and, in the case of new patients, this must be established no later than three months after admission to the State Hospital. Paragraph 23 et seq will apply where a patient being transferred or discharged crosses borders.

42. This approach will ensure that the State Hospital will be able to identify, at an early stage, which Health Board is responsible for the patient, and there should be no doubt or disagreement when the time comes for the patient to be discharged or transferred to another hospital/facility. Health Boards and the State Hospital must liaise to ensure that the relevant Health Board for all patients is known.

43. At the beginning of each financial year, Health Board Directors of Public Health must confirm with the State Hospital the patients for whom they might have to accept responsibility if patients are transferred or repatriated. The Local Authority of residence should also be established to avoid any disputes over responsibility which might arise later.

44. If the patient was admitted to the State Hospital from prison, and is being returned to prison, he/she will be the responsibility of the Health Board as determined in paragraph 59 et seq. If the patient was a prisoner prior to being

admitted to the State Hospital, but the sentence has expired and so the person is not being returned to prison, the patient will be considered to be resident in the area where they were ordinarily resident before they were sent to prison (this determination of ordinary residence excludes any prison facilities at which the person was detained prior to being sentenced) until they have established themselves at a new address.

45. If it is not possible to establish the patient's previous ordinary residence then the patient will be treated as being ordinarily resident in the area in which the offence for which they were convicted was committed until they establish themselves at a new address.

RESTRICTED PATIENTS

46. As noted at paragraphs 29-36 above, the term "restricted patients" is now used loosely as a term referring to patients who are subject to:

- i. a Compulsion Order with Restriction Order (CORO patients) under sections 57A and 59, or sections 57(2)(a) and (b) of the 1995 Act;
- ii. a Hospital Direction under section 59A of the 1995 Act; or
- iii. prisoners transferred from prison to hospital via a transfer for treatment direction under section 136 of the 2003 Act.

This is to reflect that such patients are subject to special restrictions under the 2003 Act, even though technically only CORO patients actually have a "restriction order".

47. The 2003 Act gives Scottish Ministers a specific statutory role in respect of the management of restricted patients. The underlying purpose of this role is to provide an additional layer of scrutiny as regards the long-term protection and security of the public, whilst at the same time ensuring that appropriate care and treatment is delivered by the clinical team to the patient.

48. Under the 2003 Act Scottish Ministers no longer have the power to conditionally discharge patients or to revoke restriction orders. These powers are now reserved to the Mental Health Tribunal for Scotland. However, the authority of Scottish Ministers is still required at key points in the care of restricted patients. In addition, the Scottish Ministers are responsible for making certain references or applications to the Tribunal, e.g. on a recommendation from a Responsible Medical Officer (RMO) or on a notice from the Mental Welfare Commission.

49. Female patients with mental health problems, who require care in conditions of high security, will be assessed by the clinical team at Rampton Hospital. Where it is agreed that there should be an admission to Rampton Hospital the RMO will maintain a close link with the receiving team throughout and will take lead responsibility for ensuring the transfer occurs in full compliance with the legal

requirements on both sides of the border (if a cross-border transfer is required). Funding of such a placement will be undertaken by NSD in line with other nationally designated specialist services.

PATIENT TRANSFERS

50. The 2003 Act and its associated regulations – The Mental Health (Cross-Border Transfer: Patients Subject to Detention Requirement or Otherwise in Hospital) (Scotland) Regulations 2005¹⁷ (for detained patients) and The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008¹⁸ (for community based patients) – provide the legislative framework for the transfer in and out of Scotland of patients who are subject to the formal provisions of the 2003 Act. A patient subject to the 2003 Act, or its equivalent in another jurisdiction, may only be removed from one part of the UK to another on the authority of the appropriate authorising Minister or Department.

51. Restricted patients are treated in the same way, and therefore may also be accepted on transfer from countries with which there are reciprocal legislative arrangements, i.e. England, Wales and Northern Ireland, as well as from other countries. The transfer might be on compassionate grounds (such as family reasons) or on treatment grounds. Patients from Northern Ireland, who require care in conditions of special high security that are not available presently in Northern Ireland, may be transferred to the State Hospital if the hospital agrees to accept these patients while they require such care. For all patients, the Scottish Government Health Directorates (SGHD) must check that the patient is detainable under the legislation currently applicable (i.e. legally detainable under Scottish legislation – the 2003 Act) before arrangements can be made for the transfer.

52. Transfers between jurisdictions require some additional consideration to ensure that the process is completed successfully. The information required depends on whether the transfer is to a hospital with the same level of security or to conditions of lesser security. It is necessary for SGHD to liaise with officials in the receiving jurisdiction to ensure that they are content to receive the patient before transfer can be finalised.

53. It is the responsibility of the RMO to identify a receiving hospital and to ensure that any financial considerations are managed satisfactorily.

54. NHS HDL (2005) 43¹⁹ sets out the detail around the practical arrangements for transfers in and out of Scotland of all patients who are subject to a mental health order under the 2003 or 1995 Acts, (or their equivalent in England, Wales or Northern Ireland), whilst chapter 9 of the Memorandum of Procedure on Restricted Patients²⁰ provides further details on the particular arrangements around cross-border transfers of restricted patients.

¹⁷ http://www.legislation.gov.uk/ssi/2005/467/pdfs/ssi_20050467_en.pdf

¹⁸ http://www.legislation.gov.uk/ssi/2008/356/pdfs/ssi_20080356_en.pdf

¹⁹ http://www.sehd.scot.nhs.uk/mels/HDL2005_43.pdf

²⁰ <http://www.scotland.gov.uk/Publications/2010/06/04095331/0>

EARLY DISCHARGE PROTOCOL FOR PATIENTS IN SECURE HOSPITAL SETTINGS

55. The Early Discharge Protocol²¹ is for use primarily by the State Hospital and partner agencies to facilitate care planning for patients discharged from the State Hospital who have high needs and pose a risk to public safety. The Protocol complements the proper application of the established Care Programme Approach (CPA), and applies to all patients who no longer (or may no longer) meet the criteria for compulsory intervention under the 2003 or 1995 Acts (as amended) but who have complex needs and continue to pose a significant risk to public safety.

56. However, where the Protocol refers to the State Hospital, it should be read as referring as well to those exceptional cases where patients who meet the described criteria are being considered for discharge from local forensic services.

57. The Early Discharge Protocol may be used in conjunction with Multi Agency Public Protection Arrangements (MAPPA) where appropriate. MAPPA and CPA for restricted patients have a common purpose of maximising public safety and the reduction of serious harm. Although the same underlying principles of gathering and sharing of relevant information in relation to risk apply, CPA focuses on the care and treatment likely to minimise the risk posed, whilst MAPPA focuses on multi agency management of risk. The underlying concept of MAPPA is to provide systems and processes for relevant agencies to share information about individuals who represent a risk to the community. Where appropriate, the agencies will cooperate to put together plans to assess and manage these risks.

58. Within the MAPPA framework, the CPA process will remain the vehicle for planning a person's care and treatment and for risk assessment and management planning. Specific guidance on referral and notification to MAPPA, in relation to restricted patients, was issued in NHS CEL 19 (2008)²². For example, MAPPA referral should be made when the RMO is considering recommending the revocation of the compulsion order or the revocation of the restriction order, and prior to a recommendation by the RMO for release on life licence.

PRISONERS

59. On 1 November 2011, in accordance with Health Board Provision of Health Care in prisons (Scotland) Direction 2011²³, prisoner health care became the responsibility of the Health Board as opposed to the prison service.

60. Prisoners, for the first six months of their custodial sentence, are considered to be resident in the area where they were ordinarily resident before they were sentenced. This determination of ordinary residence excludes any prison facilities at which the person was detained prior to being sentenced.

²¹ http://www.sehd.scot.nhs.uk/mels/hdl2002_85.pdf

²² http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf

²³ [http://www.sehd.scot.nhs.uk/pca/PCA2011\(M\)15.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2011(M)15.pdf)

61. Persons who are remanded in custody pending trial are considered, for the duration of their remand, to be resident in the area where they were ordinarily resident before they were remanded.

62. After a period of six months following conviction, a person held in prison is to be treated as ordinarily resident at the place where that person is held.

63. Where a person has been released from prison, and their ordinary residence cannot be established, they are to be treated as ordinarily resident at the address at which that person was ordinarily resident before being imprisoned.

64. If a person's previous ordinary residence (i.e. before they were imprisoned whether by remand or as a result of serving a custodial sentence) cannot be determined, the person is considered resident in the area in which the offence for which he/she was convicted was committed or, if remanded pending trial, the area where the offence with which he/she is charged was committed. Such provisions apply until the person concerned has established himself at a new address. The responsible Health Board can thereafter be determined by the usual means (see paragraph 6 et seq).

65. Prisoners, and those on remand, who are transferred to a psychiatric hospital are to be treated as ordinarily resident (for the duration of their treatment at the psychiatric hospital) as follows:

- i. at the address he/she was ordinarily resident before the commencement of the period of remand or custodial sentence (this excludes any prison facilities at which the person was detained prior to being sentenced) ; or
- ii. if the previous address cannot be determined, in the area in which the offence for which he/she is remanded/convicted was committed.

66. A person who is remanded in custody but transferred to a psychiatric hospital and who is subsequently convicted of the offence (for which he/she was remanded for) but remains in the psychiatric hospital, is treated as being ordinarily resident at the address he was ordinarily resident at before being remanded for the duration of his treatment at the psychiatric hospital.

67. New arrangements came into effect in England on 1 April 2003, which led to the PCT (now CCG) in which the prison is located assuming responsibility for commissioning the majority of NHS services for their prison populations, with the exception of secure mental health commissioning (see paragraph 70). Further guidance was issued to PCTs (now CCGs) and prisons in England before the changes took place²⁴. For cases prior to 1 April 2003, the responsible CCG for prisoners is determined by the usual means. This means that for prisoners not registered with a GP, and for whom an address cannot be determined, usual residence should be interpreted as being in the area where the offence for which

²⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009767

he/she is convicted, was committed (or if pending trial, the area where the offence with which he/she is charged, was committed). The provisions in paragraphs 69 and 71 also apply in England.

68. In Northern Ireland, a prisoner is regarded for Health and Personal Social Services (HSS) purposes as resident in the area in which he or she lived before being remanded or sentenced. This also applies to someone leaving prison if he/she does not have an address to return to when released. Once established at an address the appropriate HSS Board should assume responsibility for his/her care.

69. People usually resident overseas held in UK prisons are exempt from charges for NHS health care. There is no centrally held budget for this group, and costs should be borne by the Health Board (CCG in England) where, in line with the above provisions, the prisoner was resident or, if this cannot be determined, the place where the person was detained immediately before they were remanded pending trial or sentence.

PEOPLE DETAINED UNDER THE MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 OR THE MENTAL HEALTH ACT 1983

70. If a person is detained in hospital for care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, the responsible commissioner will be subject to the principles set out in paragraph 6 et seq. If it is not possible to establish a resident address, the responsible commissioner will be determined by the location of the unit providing treatment. Therefore, in this context, the Health Board in which the facility is located becomes the responsible commissioner for these purposes. For a person detained under the Mental Health Act 1983 in England, the responsible commissioner for secure mental health commissioning will be determined by the CCG where the patient was previously registered/resident before entering prison. If this is not possible, then the CCG in which the facility is located becomes the responsible commissioner.

IMMIGRATION DETAINEES

71. Where a person who is not ordinarily resident in the UK is detained on grounds connected with their immigration status then the responsible commissioner is determined by the Health Board (CCG in England) of the unit providing treatment.

BOARDING SCHOOL PUPILS

72. In order to maintain consistency in the way in which population estimates are calculated for use in determining weighted capitation shares, pupils that board at boarding schools are considered to be ordinarily resident at the location of the school and not at their parents' or guardians' address. Therefore, the responsible commissioner will be determined as the Health Board within whose area the school lies.

SCHOOLS AND COLLEGES FOR CHILDREN / YOUNG PEOPLE WITH ADDITIONAL SUPPORT NEEDS

73. An additional support needs school or college is a day or residential establishment that caters exclusively for the education and personal development of children or young people with additional support needs, including learning difficulties. These establishments might take substantial numbers of children with additional support needs from a wide area. The children often have complex health care and therapy needs involving a range of professional staff and high cost equipment. Pupils at additional support needs schools or colleges remain the responsibility of the health board in which their parents or guardians are ordinarily resident. This is subject to an exception in relation to the provision of general school medical services, which are provided within such additional support needs schools, by the Health Board in which the school is located. Pupils placed by social services (or through joint funding arrangements between Health Boards, social services and local education authorities) at an additional support needs school are also the responsibility of the health board in which the pupil's parents or guardians are ordinarily resident. Where a pupil attending an additional support needs school or college has both a parent and a guardian, the pupil's ordinary residence is taken to be the ordinary residence of the guardian.

74. When a pupil who is attending an additional support needs school/college reaches the age of 18, the responsible commissioner will continue to be the Health Board in which their parents or guardians are ordinarily resident until the placement at the special needs school/college has ended or until the pupil reaches the age of 21, whichever comes first. Thereafter the person's ordinary residence will be determined in the usual way (paragraph 6 et seq).

LOOKED AFTER CHILDREN

75. Children who are looked after by local authorities can remain at home or be provided with accommodation away from their normal place of residence (i.e., kinship/foster/residential placement, respite care). The responsible Health Board should be established by the usual means identified in paragraph 6 et seq (i.e. the address where the child is ordinarily resident).

76. The Looked After Children (Scotland) Regulations 2009²⁵ place a duty on local authorities to notify Health Boards when they place children in a kinship/foster/residential setting. There may also be cases where a child who is looked after at home moves to a new area. The duty to notify applies regardless of whether or not the child moves out of the original local authority area. This applies in respect of placements with foster carers and kinship carers as well as placement in a residential establishment and must be carried out as soon as reasonably practicable. Where placements are arranged urgently the notification should be done as soon as reasonably practicable.

77. Under regulation 3(3)(b) of The Looked After Children (Scotland) Regulations 2009, when a child becomes (or is about to become) looked after, the local authority

²⁵ http://www.legislation.gov.uk/ssi/2009/210/pdfs/ssi_20090210_en.pdf

must obtain a written health assessment by a registered medical practitioner or a registered nurse. CEL 16 (2009)²⁶ recommended that this is offered within four weeks of notification to the Health Board. A new assessment may not be necessary where one has been carried out within three months of the child becoming looked after.

78. If a looked after child moves to a new area, the receiving Health Board should honour the current health care plan until this is changed following a new assessment. Arrangements should be made, in discussion between those currently providing the health care and with the new Health Board and relevant specialist services, to ensure continuity of health care. Continuity in some circumstances may involve continued care from the original provider until a handover can be arranged. Any changes in the health care commissioning responsibilities must not be allowed to disrupt the ultimate objective of providing high quality, timely care for the individual child or young person. It is important to ensure a smooth handover of clinical care where that is the agreed best plan for the child.

79. For all looked after children, the local authority and receiving Health Board should identify a lead professional to ensure the child's health needs are addressed.

80. When a child who is looked after reaches the age of 18, the test to determine their ordinary residence does not change: the ordinary residence of the child on his or her eighteenth birthday will identify the responsible Health Board, unless the child is attending a special school when the rule set out in paragraph 73 et seq will apply.

PEOPLE TAKEN ILL ABROAD

81. If a person ordinarily resident in the UK and entitled to free NHS treatment is taken ill abroad, necessary treatment on return to the UK will be subject to the same principles set out in paragraph 6 et seq. If it is not possible to determine an ordinary residence by the usual means, the responsible commissioner will be determined by the location of the unit providing treatment. In this context the Health Board in which the facility is located becomes the responsible commissioner for these purposes.

MILITARY PERSONNEL

82. When a person on a GP list enlists in Her Majesty's Forces, his/her name is deleted from the list from the date on which the Health Board first received notification of the enlistment²⁷. There is no such restriction on dependents. Military Personnel are entitled to treatment as emergency patients or temporary residents by NHS GPs either when outside the catchment area of a Defence Medical Service (DMS) medical centre or when the DMS medical centre historically has not provided an out-of-hours service. This entitlement includes personnel living in their own home or in married quarters if these criteria are met.

83. Members of the Armed Forces (including NATO forces) are entitled to the full use of NHS hospitals on the same basis as civilians if appropriate military provision

²⁶ http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf

²⁷ Schedule 5, Part 2, paragraph 25 of the NHS (General Medical Services) (Scotland) Regulations 2004, and Schedule 2, Part 2 paragraph 18 of the NHS (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004.

is not available. Health Boards are responsible for the provision of secondary care treatment for military personnel. The responsible Health Board is established on a residence basis. Personnel should provide their unit address, in as much detail as possible, as their place of permanent residence and their home address, if applicable, as their place of temporary residence.

84. Military personnel who are discharged from the Armed Forces and who are receiving an NHS continuing care package will be subject to the same criteria as those set out in paragraphs 22.5 and 24.6.

PEOPLE NOT ORDINARILY RESIDENT IN THE UNITED KINGDOM (OVERSEAS VISITORS)

85. Under the National Health Services (Charges to Overseas Visitors) (Scotland) Regulations 1989 No 364²⁸ (as amended), people who are not ordinarily resident in the UK are, in the main, liable to be charged for any hospital treatment they receive. It is the legal duty of the hospital to establish whether charges for the provision of NHS health care should be applied and, if so, to recover such charges.

86. All patients who have been in Scotland **legally** for more than 12 months are exempt from hospital charges. Patients who are not ordinarily resident in Scotland may be exempt from hospital charges if they: come under an exemption category in the Charging Regulations; are covered under EU insurance arrangements; or come from a country that has a reciprocal health care agreement with the UK²⁹. Such patients are subject to the same principles as set out in paragraph 6 et seq.

87. Where a person is not ordinarily resident in Scotland, has no fixed abode (for instance a holidaymaker), but is exempt from hospital NHS charges, the responsible commissioner is determined by the location of the unit providing treatment. Central funding for treatment in such cases has been incorporated into Health Board baseline funding.

88. Anyone who has a legal right of residence in the UK and who comes to take up permanent residence is entitled to immediate access to NHS hospital treatment. Arrangements as in paragraph 6 et seq will apply.

89. In certain circumstances European citizens can travel to the UK for **planned** NHS treatment or services under the long established S2 (formerly 112) scheme, or under Article 56 of the Treaty of the Functioning of the EU³⁰. Directive 2011/24/EU On The Application of Patients' Rights In Cross-border Health Care³¹ was introduced by the European Commission and Council in April 2011 to clarify Article 56 arrangements and Member States have until October 2013 to transpose the Directive into domestic legislation. Interim handling arrangements are set out in CEL 30 (2010)³².

²⁸ <http://www.legislation.gov.uk/uksi/1989/364/contents/made>

²⁹ http://www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf

³⁰ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0047:0200:en:PDF>

³¹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>

³² http://www.sehd.scot.nhs.uk/mels/CEL2010_30.pdf

ASYLUM SEEKERS

90. A person who has made a formal application to the UK Border Agency for permission to take refuge in the UK is regarded as ordinarily resident (subject to the same principles as paragraph 6 et seq), and is therefore able to benefit from the same right to NHS treatment as UK citizens who are ordinarily resident in the UK. This is regardless of the status of their application to become a refugee: pending; under appeal; or unsuccessful, while they remain in Scotland.

SERVICES PROVIDED FREE, REGARDLESS OF RESIDENCY STATUS

91. Services provided free, regardless of residency status include: Accident and Emergency (A&E) services (and associated ambulance services); treatment for certain infectious diseases, as listed in The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989³³; family planning services; health promotion services; sexual health / genitor-urinary medicine (GUM) services; and HIV testing and counselling. Health Boards are responsible for securing the provision of these services to everyone present in the area, regardless of residency status.

92. Host Health Boards are responsible only for treatment in the A&E Department up to a period not exceeding 24 hours³⁴. Treatment provided outwith the A&E Department (or if the patient is still in A&E 24 hours after the time of admission) will then be the responsibility of the Health Board in whose area the person is ordinarily resident. If the hospital does not have beds in its A&E Department, any subsequent overnight observation is regarded as being outwith A&E and a charge will then be made to the patient's Health Board of residence through an appropriate SLA or through NCA arrangements if a cross-border patient (see paragraph 13 et seq).

GUM SERVICES AND HIV/AIDS PATIENTS

93. GUM clinics remain the main point of access for diagnosis and treatment of sexually transmitted infections (STIs) including HIV, although other routes of access to these services exist. GUM services (pre- and post-test counselling and testing and treatment for STIs and pre- and post-test counselling and testing for HIV) are provided on a confidential, open access basis irrespective of the patient's address. In the interests of patient confidentiality the above services are provided on an all-comers basis and no requests for funding for out-of-area treatment should be made by the host Health Board. A person who attends a GUM clinic to make use of GUM services, is therefore to be treated as ordinarily resident in the area in which the GUM clinic is situated for the purposes of receiving GUM services.

94. However, for HIV treatment services (following a positive HIV test and post-test counselling), any further treatment for the individual, including the prescription of combination anti-retroviral drug therapies and associated monitoring, should be

³³ <http://www.legislation.gov.uk/ukxi/1989/364/contents/made>

³⁴ NHS MEL (1999) 4 / Article 2(3) of The Functions of Health Boards (Scotland) Order 1991 defines references to accident and emergency services as being: "health care provided for a person who after an accident, or in an emergency, requires immediate treatment at a hospital where that treatment is provided in a department of a hospital which administers accident or emergency services excluding an in-patient or out-patient treatment provided subsequently for such a person and connected with the provision of those services."

commissioned on a collaborative basis by Health Boards as a specialised service and funded by the responsible Health Board (as determined in paragraph 6 et seq).

TRANSPLANTS

95. Where a transplant necessitates medical intervention to a live donor, e.g. bone marrow transplant, and a service agreement does not exist to cover the retrieval of donor material, the Health Board of the patient receiving the transplant will be responsible for funding the procedures, unless alternative arrangements are already in place between the commissioners.

96. Some transplant services are funded through NSD arrangements: liver transplant; paediatric small bowel transplant; Severe Combined Immuno Deficiency Syndrome; simultaneous pancreas/renal transplant; paediatric renal transplant; and heart and lung transplants. For these services, the cost of procuring the organ, whether from a cadaver or from a living donor, is included within the cost of a transplant episode funded through the NSD service agreement held with NHS Blood and Transplant, the UK-wide organ donation and transplant organisation.

TREATMENT TIME GUARANTEE

97. Health Boards are required to meet the Treatment Time Guarantee, introduced in the Patient Rights (Scotland) Act 2011, and which came fully into force on 1 October 2012. It is expected that most of their residents, to whom the guarantee applies, will be treated in their local hospitals. However, to ensure that all patients receive treatment within the guarantee periods, Health Boards might arrange treatment for some patients elsewhere in NHS Scotland, including the Golden Jubilee National Hospital, the NHS in England, Wales or Northern Ireland, the private sector or, in exceptional circumstances, overseas. In all cases, originating Health Boards retain responsibility for funding consultation, diagnosis and treatment for their patients.

TRANSFERS ON NON-CLINICAL GROUNDS

98. Where a transfer is sought on non-clinical grounds, e.g. because a patient so wishes; or where treatment could be provided by the Health Board, whose area in which the patient is ordinarily resident but is sought in another Health Board area for other reasons such as a patient's proximity to relatives, clarity and agreement on funding must be sought prior to the transfer taking place.

PART B – MINISTERIAL DIRECTIONS

D I R E C T I O N S

2013

NATIONAL HEALTH SERVICE

**The National Health Service (Responsible Health Board) (Scotland)
Directions 2013**

The Scottish Ministers give the following Directions in exercise of the powers conferred by section 2(5) of the National Health Service (Scotland) Act 1978(a) and all other powers enabling them to do so

Citation, commencement and interpretation

1.(1) These Directions may be cited as the National Health Service (Responsible Health Board) (Scotland) Directions 2012 and come into force on 6 March 2013.

(2) In these Directions-

“the 1991 Order” means the Functions of Health Boards (Scotland) Order 1991(b);

“course of regular admissions” means a planned programme of treatment that involves admission to hospital as an in-patient or out-patient.

“discharged” means the end of inpatient treatment or outpatient treatment and occurs when the patient:

i) is discharged to a location external to the NHS;

ii) is transferred to another NHS inpatient treatment hospital or outpatient treatment hospital; or

iii) dies

“general school medical services” mean school nurse services and access to a general practitioner

“GUM clinic services” means testing, treatment and pre-test and post-test counselling for sexually transmitted infections and testing and pre-test and post-test counselling for HIV.

“in-patient treatment” means treatment which requires the patient to be admitted to and remain in the place of treatment overnight or longer (otherwise than for the purposes of overnight observation);

(a) 1978 c. 29; section 2(5) was amended by the National Health Service and Community Care Act 1990 (c.19), section 66 (1), schedule 9, paragraph 19(1); The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46);

(b) S.I 1991/570 as amended by SSI 2006/132 and 2011/211

“ongoing course of care” means a programme of regular and sustained medical care for a particular medical condition and its consequential effects, which might include hospital treatment and / or care at home;

“outpatient treatment” means treatment which requires the patient to attend a hospital otherwise than as an in-patient;

(3) Unless the context otherwise requires, words and phrases used in these Directions have the same meaning as they do in the 1991 Order.

Ordinary Residence – purpose

2. The following directions are made for the purpose of determining which Health Board is responsible for providing health care to a person in Scotland who falls within a particular class of case (a)

Ordinary residence – cross-boundary arrangements

3. (1) This direction applies to a person whose ordinary residence changes from one Health Board area in Scotland (“originating Health Board”) to a different Health Board area in Scotland (“receiving Health Board”).

(2) (a) This provision applies where a person’s ordinary residence changes whilst that person is an in-patient.

(b) Subject to paragraph (c), until that person is discharged, the person is to be treated as ordinarily resident at the address where the person was ordinarily resident when the person was admitted.

(c) Where, before the person is discharged, the originating Health Board and the receiving Health Board agree when responsibility for that person’s care is to transfer, that agreement is to have effect.

(3)(a) This provision applies where a person’s ordinary residence changes whilst the person is undergoing-

- (i) a course of regular admissions;
- (ii) an ongoing course of care (including drug therapy).

(b) The person is to be treated as being ordinarily resident at the address where that person was ordinarily resident on the date when the course began until the earlier of:-

- (i) three months from the change of address;
- (ii) 1st April following the change of address;
- (iii) the completion of the course.

Ordinary residence – cross-border arrangements

4. (1) This direction applies to a person whose ordinary residence changes from a Health Board area within Scotland (“originating Health Board”) to an address outwith Scotland but within the United Kingdom (“receiving health body”).

(2) Paragraphs (3) and (4)(a)(i) are subject to paragraph (5).

(3) Where a person’s ordinary residence changes whilst the person is an in-patient, until that person is discharged, the person is to be treated as ordinarily resident at the address where the person was ordinarily resident when the person was admitted.

(4)(a) This provision applies where a person’s ordinary residence changes whilst the person is undergoing –

(a) SI 1991/570 article 2(2) provides the basic meaning of ordinary residence

- (i) a course of regular admissions
- (ii) an ongoing course of care (including drug therapy)

(b) The person is to be treated as ordinarily resident, until the course ends, at the address where that person was ordinarily resident when the course began.

(5) Where, before the course ends, the originating Health Board and the receiving Health Board agree when responsibility for that person's care is to transfer, that agreement is to have effect.

Ordinary Residence – persons moved cross boundary to receive NHS continuing healthcare

5.(1) This direction applies where a person has been placed by a Scottish Health Board (“the placing Health Board”) in the area of another Health Board in Scotland (“receiving Health Board”) for the purpose of receiving NHS continuing healthcare arranged by the placing Health Board.

(2) A person is to be treated as being ordinarily resident in the area of the placing Health Board whilst that person is receiving NHS continuing healthcare arranged by the placing Health Board.

(3) If a person exercises a choice to remain in the area of the receiving Health Board after the NHS continuing healthcare ends, the person is to be treated as ordinarily resident in the area of the receiving Health Board.

(4) For the purposes of this direction “NHS continuing healthcare” means a package of care arranged by a Health Board to provide a person with ongoing and regular specialist clinical supervision appropriate to their needs.

Ordinary Residence - patients moved cross border to receive NHS continuing healthcare

6.(1) This direction applies where a person has been placed in the area of a Health Board in Scotland (“receiving Health Board”) by a body other than by a Health Board in Scotland (“placing health body”) for the purpose of receiving NHS continuing healthcare arranged by the placing health body.

(2) A person is to be treated as ordinarily resident in the area of the placing health body whilst that person is receiving NHS continuing healthcare arranged by the placing health body.

(3) If a person exercises a choice to remain in the area of the receiving Health Board after the NHS continuing healthcare ends, the person is to be treated as ordinarily resident in the area of the receiving Health Board.

(4) For the purpose of this direction “NHS continuing healthcare” means a package of care arranged by a placing health body to be delivered in Scotland to a person who is not ordinarily resident in Scotland when the need for NHS continuing healthcare arose (a).

Ordinary residence - prisoners

7. (1) Where a person is held on remand in prison, that person is to be treated as being ordinarily resident at the address at which the person was ordinarily resident before being imprisoned.

(2) Where a person is held in prison following conviction, for the first six months of imprisonment that person is to be treated as being ordinarily resident at the address at which the person was ordinarily resident before being imprisoned.

(3) After a period of six months following conviction, a person held in prison is to be treated as ordinarily resident at the place where that person is held.

(a) Guidance on the provision of NHS healthcare by a body which is not a Scottish Health Board for individuals who are not ordinarily resident in Scotland can be found at:
<http://www.dh.gov.uk/health/2012/11/continuing-healthcare-revisions/>

(4) A person who is transferred from prison to a psychiatric hospital is to be treated as ordinarily resident at the address at which the person was ordinarily resident before being imprisoned whilst they are at the psychiatric hospital.

(5) Where a person has been released from prison and the person's ordinary residence cannot reasonably be established, the person is to be treated as being ordinarily resident at the address at which the person was ordinarily resident before being imprisoned.

(6) In paragraphs (1) to (5), where the address at which the person was ordinarily resident before being imprisoned cannot reasonably be established, the person is to be treated as ordinarily resident in –

i) the area in which the offence, or the area in which the majority of offences, for which that person has been convicted were committed; or

ii) if remanded pending trial, the area where the offence, or the area in which the majority of offences with which that person is charged, were committed.

Ordinary residence – boarding school pupils

8. A person who attends boarding school for the purpose of receiving education is to be treated as ordinarily resident at the place where the school is situated.

Ordinary residence – Genitourinary Clinics

9. A person who attends a Genitourinary Clinic (“GUM Clinic”) for the purpose of obtaining GUM Clinic Services is to be treated as ordinarily resident in the area in which the clinic is located.

Ordinary residence – schools and colleges for children and young persons with additional support needs

8. (1) A person under 21 years of age who, for the purposes of receiving education, attends a school or college designed to meet the needs of people with additional support needs, is to be treated as ordinarily resident in the area in which that person's parent or guardian is ordinarily resident.

(2) Where a person to whom paragraph (1) applies has both a parent and a guardian, the person is to be treated as ordinarily resident in the area where the person's guardian is ordinarily resident.

(3) For the purpose of receiving general school medical services, a person to whom paragraph (1) applies is to be treated as ordinarily resident in the area in which the school is located

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