



## SCOTTISH EXECUTIVE

NHS  
HDL(2004)15

Health Department  
Directorate of Performance Management & Finance

Dear Colleague

### NHSSCOTLAND: GUIDANCE ON ESTABLISHING THE RESPONSIBLE COMMISSIONER

#### Purpose

1. This document sets out the procedures for establishing the responsible commissioner for an individual's care within the NHS and replaces former guidance contained at Annex C of NHS MEL (1999) 4, Funding Arrangements for Cross-Boundary and Cross-Border Patient Activity. The new guidance is effective from 1<sup>st</sup> April 2004.

#### Background

2. The Department of Health (DH) issued similar guidance for arrangements in England, which came into force on 1<sup>st</sup> October 2003. The DH guidance highlights the changes in its approach to commissioning and can be viewed at [www.doh.gov.uk/pricare/responsiblecommissioner](http://www.doh.gov.uk/pricare/responsiblecommissioner). This document is available at [www.show.scot.nhs.uk/publications](http://www.show.scot.nhs.uk/publications).

3. Where appropriate, this guidance will highlight the differences in procedures and arrangements between Scotland and England/Wales/Northern Ireland. The principle change in the DH guidance relates to the defining of responsible commissioner by GP registration rather than residence. Within Scotland, as in Northern Ireland and Wales, arrangements for commissioning will continue to be defined primarily by a patient's "usual residence" (a fuller definition of this is given at Annex C).

4. 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. The arrangements for commissioning should underpin this, with

**31<sup>st</sup> March 2004**

#### Addresses

##### For action

Chief Executive, NHS Boards

Chief Executive National Waiting  
Times Special Health Board, State  
Hospitals Board for Scotland and the  
Common Services Agency

##### For information

Director of Finance, NHS Boards,  
Special Health Boards and Common  
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Chief Executives of Local Authorities

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the focus being on patient care pathways. The revised guidance sets out the framework for establishing the responsible commissioning authority, clarifying issues and particular instances which have arisen since previous guidance for Scotland was issued in 1999.

5. In England, Primary Care Trusts (PCTs) - singularly or within collaborative arrangements - are now responsible for commissioning services on behalf of their populations. Within Scotland, this remains the responsibility of the NHS Board. All relevant commissioning bodies should ensure that the principles set out in this guidance are adopted when determining the responsible commissioner. However, for cases that were ongoing prior to the issue of this guidance, consideration should be given to previous legislation and guidance, if appropriate, especially where cases involve cross border issues.

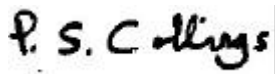
### **Enquiries and Further Advice**

6. Where there is a disagreement over a patient's responsible commissioner, the appropriate NHS bodies should make every reasonable effort to resolve the issue themselves. Enquiries about determining the responsible commissioner may be addressed to Ross Scott, Scottish Executive Health Department, Basement Rear, St Andrew's House, Regent Road, Edinburgh, EH1 3DG or to [ross.scott@scotland.gsi.gov.uk](mailto:ross.scott@scotland.gsi.gov.uk).

### **Action**

7. Chief Executives are requested to circulate copies of this HDL to all staff with commissioning responsibility.

Yours sincerely



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**Director of Performance Management and Finance**

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT**

***ESTABLISHING THE RESPONSIBLE COMMISSIONER:***

***GUIDANCE FOR NHSSCOTLAND***

**APRIL 2004**

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**Annex B: Associated Legislation & Documentation – England, Wales & Northern Ireland**

**Annex C: Defining “Usually resident” & “Ordinarily Resident”**

**Annex D: National Services Division**

**Annex E: Admission of a Restricted Patient to Hospital**

## **INTRODUCTION**

1. This document sets out the framework for establishing responsibility for commissioning an individual's care within the NHS and takes into account published Scottish Executive policy documents which have a bearing. Scotland's Health White Paper, *Partnership for Care*, published in February 2003 contains commitments to health improvement and national guidelines as well as partnership working and joint resourcing. Previously the Scottish Health Plan, *Our National Health: a plan for action, a plan for change*, promised to simplify the funding of those specialist hospital services that are provided to more than one NHS Board. An advisory group (the Technical Issues Group - TIG), comprising representatives of NHS Chief Executives and Finance Directors, the National Services Division (NSD) of the Common Services Agency (CSA) and the Scottish Executive Health Department (SEHD), has also considered funding issues regarding other clinical services that can be commissioned on a cross NHSScotland boundary or cross border basis. The work of this Group was closely linked to that of the joint review group considering *Our National Health's* commitment to introduce a more systematic approach to planning healthcare services that are best provided on a regional or national basis<sup>1</sup>

## **BACKGROUND**

2. The safety and well being of patients is paramount. Arrangements must make it explicitly clear which NHS body (NHS Board in Scotland, PCT in England, Local Health Board in Wales and Health and Social Services Board in Northern Ireland) is responsible for funding a particular individual's care within the NHS. The underlying principle is that there should be no gap in responsibility - no treatment should be refused or delayed due to uncertainty or ambiguity over which NHS body is responsible for funding an individual's healthcare provision.

3. Since it is not possible to cover every eventuality within this guidance, the NHS is expected to act in the best interests of the patient at all times and work together in the spirit of partnership. The aim of all NHS bodies involved in commissioning should be to reach agreement. All parties should share the objective of ensuring that the most effective use is made of the resources available in the best interests of patients. Where there is uncertainty about which authority is responsible, the authority where the person is living at that time should take the lead in arranging the care required to meet the patient's needs

## **ESTABLISHING THE RESPONSIBLE COMMISSIONER**

4 NHS Boards have responsibility for commissioning health services for patients living within their boundaries i.e. usually resident. Article 2 of the Functions of Health Boards (Scotland) Order 1991 states that where it is unclear where a person resides, he/she shall be treated as ordinarily residing at the address which he/she gives to the Health Board. It goes on to say that 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 residing in the area in which he/she is at present. As a result, it has always been

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<sup>1</sup> Guidance on regional planning was issued in March 2002 under [NHS HDL\(2002\)10](#).

accepted that the patient is the arbiter of where he/she is resident. (See Annex C for definitions of “usually resident” and “ordinarily resident”)

## **SPECIALIST AND SPECIALISED SERVICES**

5. NHS Boards are responsible for commissioning health services for people usually resident in their areas. The two exceptions are the designated national specialist services commissioned centrally by the National Services Division (NSD) of the Common Services Agency (CSA) in Scotland (Department of Health in England) under the auspices of the National Services Advisory Group (see Annex D for a list of these services), and the commissioning of highly specialised services, defined in the Specialised Services National Definitions Set, when such services are provided in England for residents of Scotland. A list of these services can be found at <http://www.doh.gov.uk/specialisedservicesdefinitions>. NSD is also responsible for commissioning these services.

## **PERSONS OF NO FIXED ABODE**

6. Where a person is apparently of no fixed abode, the responsible NHS authority will still primarily be determined by the terms of usual residence where possible. Every effort should be made to establish an address; the principle remains that the patient's perception of where he/she is resident (either currently or, failing that, most recently) is the criterion. For example, if a person has been living in a hostel and gives this as his/her address, then this should be accepted without question. Last known addresses are also common indicators for establishing commissioning responsibility and NHS bodies should continue to accept responsibility for patients who consider they have not been resident elsewhere since leaving an address within the NHS body's area.

7. If someone is unable to provide an address, every effort should be made to establish a last place of residence. As a last resort only, the NHS body in whose area the unit where the patient is being treated is located shall be determined as the responsible commissioner.

## **TEMPORARY RESIDENTS**

8. Where there is any doubt about where a person is usually resident, he/she should be treated as usually resident at the address he/she gives to the person or body providing him/her with treatment. This applies to temporary residents (e.g. students, people working away from home, members of the British Armed Forces, including Gurkhas, and members of NATO, Commonwealth and other Armed Forces on exercise, training or exchange). They remain free to give their perception of where they consider themselves resident in the same way as most other patients receiving NHS treatment. In the case of services provided by General Practitioners, Regulation 7 of the NHS (Choice of Medical Practitioner) (Scotland) Amendment Regulations 2001 applies.

## **PATIENTS WHO MOVE CROSS BOUNDARY (i.e. WITHIN SCOTLAND)**

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

9.1 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 usually resident at the address at which he/she was usually resident when the course of treatment began until he/she is discharged. The 'end of treatment' point may need to be pre-agreed in some circumstances where it is thought appropriate.

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

9.3 Where a patient undergoing a course of **regular admissions** changes his/her home address during that course of treatment, the responsible NHS Board will be determined by the patient's usual residence when the treatment 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; or
- ii. the 1<sup>st</sup> of April following the change of address; or
- iii. the completion of the course of treatment.

9.4 Where a patient undergoing a course of treatment as an **outpatient** changes his/her home address during that course of treatment, the responsible body will be determined by the usual residence when the course of treatment 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; or
- ii. the 1<sup>st</sup> of April following the change of address; or
- iii. the completion of the course of treatment.

9.5 Where a patient undergoing an **ongoing programme 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 usual residence when the course of treatment 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; or
- ii. the 1<sup>st</sup> of April following the change of address; or
- iii. the completion of the course of treatment.

9.6 For census purposes, patients who have been in **NHS continuing care** for six months or more are regarded as resident in that area. Patients who have been in hospital for less than six months are classified as residing at their home address. NHS Board allocations are based on residential information and, for that purpose, census information is used. The decision to transfer a patient who requires NHS continuing care, as well as being clinically appropriate, must be made on the basis of patient need and with the agreement of the placing and receiving NHS Boards, and of the patient wherever possible, before the patient is moved.

9.6.1 However, patients who entered the system prior to 1 April 1999,

remain the responsibility of their original NHS Board of residence until they are discharged. Hence the placement and healthcare costs will rest with the originating commissioner where the initial assessment prior to transfer was made and funding responsibility will transfer to the new host commissioner when:

- i. the patient is discharged; or
- ii. an agreed end point of treatment is reached.

9.6.2 For patients who entered the system on or after 1 April 1999, commissioning responsibility will transfer to the new host commissioner after 6 months.

**The arrangements outlined in paragraph 9.6 et seq apply within NHSScotland only.**

### **PLACEMENTS IN CARE HOMES**

10. NHS 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. NHS Boards and local authorities should also liaise in securing the provision of health care and community services when organising the placement. If the care home is in the NHS Board area where the person is usually resident, then that NHS Board will remain the responsible commissioner for the person's health services.

11. A local authority might place someone in a care home elsewhere in Scotland outside the NHS Board area of usual residence, i.e. cross boundary. If the move to the care home is permanent, then the NHS 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 NHS Board. The guidance in paragraph 9 will apply to a resident who has moved from one NHS Board area to another during a course of treatment. If a person is placed in a home for a temporary period, their originating NHS Board remains the responsible commissioner.

### **FREE PERSONAL AND NURSING CARE**

12. On 1 July 2002 free personal care was introduced in Scotland for people aged 65 and over and free nursing care for care home residents of all ages. Unlike the situation in England and Wales, free nursing care for local authority supported care home residents in Scotland is not the responsibility of the NHS and funding is directed through local authorities. Local authorities can no longer charge for personal care services provided at home and in other community settings. Eligibility for free personal and nursing care is based on a care needs assessment arranged by the local authority. The Community Care and Health (Scotland) Act 2002 provides the legislative backing for implementing free personal and nursing care. Guidance on implementation of the policy for local authorities, the NHS and other service providers is contained in circular CCD/5/2003 which is available at [www.show.scot.nhs.uk](http://www.show.scot.nhs.uk) or on the free personal care website [www.scotland.gov.uk/health/freepersonalcare](http://www.scotland.gov.uk/health/freepersonalcare).

### **CROSS BORDER PATIENTS**

13. Since 1 April 2000, individual Primary Care Trusts (PCTs) in England have been

responsible for commissioning health services for all patients registered with the GP practices associated with their PCT, including those patients who are resident in another PCT or Strategic Health Authority (SHA) area. Each PCT is also responsible for funding the healthcare provision of any unregistered patients resident within its geographical boundary.

14. Therefore, in England, the responsible commissioner is primarily identified by the patient’s registered GP or, failing that, by determining the usual address of the patient. 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.

15. Where a GP practice has patients resident in more than one PCT, the current rule is that the practice will be associated with the PCT in which the greatest number of its registered patients reside. That PCT will then exercise the relevant commissioning functions on behalf of the practice as a whole. In the case of those practice patients resident in the neighbouring PCT it will exercise those functions on behalf of that PCT. PCTs are, however, able to enter into local delegation arrangements under which the PCT in which the minority of practice patients reside will be the responsible commissioner.

16. Current guidelines for Wales and Northern Ireland prescribe that the responsible authority for an individual's healthcare 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.

17. In the case of patients who are resident in Scotland but registered with a GP in England/Wales/Northern Ireland, Scotland is the responsible commissioner. The responsible commissioner for those patients who are resident in England but registered with a GP in Scotland/Wales/Northern Ireland is the English PCT in whose area the patient is resident. The table below summarises the responsibilities of Scottish and English Commissioners:

<b>Patient resident in</b>	<b>Registered with GP in</b>	<b>Receiving treatment in</b>	<b>Responsible commissioner</b>
Scotland	England	England	Scotland
Scotland	England	Scotland	Scotland
England	Scotland	England	England
England	Scotland	Scotland	England

## **PEOPLE WHO MOVE CROSS BORDER**

18. 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 residence. However, for a person moving cross border to England, the originating NHS Board will remain the responsible commissioner until the person “de-registers from his/her GP in Scotland. Once “de-registered” the PCT in whose area the person takes up residence becomes the responsible commissioner until the person registers with a new GP. Thereafter, the responsible commissioner will be determined by GP registration.

19. 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 NHS Board, in England the relevant PCT, 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:

19.1 Where a patient undergoing treatment or care as an **in-patient** moves cross border during that course of treatment, the responsible commissioner will be determined by the patient's usual residence (or, in England, the PCT determined by GP registration) when the course of treatment began until he/she is discharged. The 'end of treatment' point might need to be pre-agreed in some circumstances where it is thought appropriate. Once discharged, patients would be expected to register with a GP which will in turn determine the new host commissioner.

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

19.3 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 usual residence (or, in England, the PCT determined by GP registration) when the treatment began unless an end of treatment point can be agreed.

19.4 Where a patient undergoing a course of treatment as an **outpatient** moves cross border during that course of treatment, the responsible NHS body will be determined by the usual residence (or, in England, the PCT determined by GP registration) when the course of treatment began.

19.5 Where a patient undergoing **an ongoing programme 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 usual residence (or, in England, the PCT determined by GP registration) when the course of treatment began.

19.6 The decision to transfer a patient from **NHS continuing care** in Scotland to NHS continuing care cross border (and vice versa), as well as being clinically appropriate, must be made on the basis of patient need and with agreement of the placing and receiving authorities, and of the patient wherever possible, before the patient is moved. In these circumstances, the placement and healthcare costs will rest with the originating commissioner (Scottish, Welsh, Northern Irish or English NHS body) where the initial assessment prior to transfer was made unless:

- i. an end of treatment point is agreed after which funding responsibility will transfer to the new host commissioner; or
- ii. the patient is discharged and registers with a GP after which he/she will be treated as a patient who moves (see paragraph 18).

20. Section 5 of the Community Care and Health (Scotland) Act 2002 will provide a clear basis for Scottish local authorities to arrange and fund **care home places outwith Scotland**

for residents of their areas who, for example, want to live in a care home close to relatives. Until that legislation is brought into effect, practice in arranging such cross border care home placements varies, but usually involves working by arrangement with the relevant cross border local authority in England and providing that local authority with funding for the individual. The guidance in paragraph 19 will apply to a resident who has moved cross border from Scotland during a course of treatment. If, however, a person is placed in a home for a temporary period, their originating NHS Board remains the responsible commissioner.

## **OUT OF AREA TREATMENTS : CROSS BOUNDARY AND CROSS BORDER**

21. NHS MEL(1999)4 and [NHS HDL\(2002\)39](#)<sup>2</sup> set out the arrangements within the NHS for commissioning out of area treatments, both cross boundary and cross border. Commissioning in the NHS takes place through service level agreements (SLAs) that cover elective and non-elective activity, including specialised services. The SLAs are agreed for the year ahead based on rolling forward the current year arrangements with the emphasis being on cost, rather than the price, of the activity.

22. Within Scotland, all **cross boundary** non-specialised unplanned activity (UNPAC)<sup>3</sup> should be included in SLAs. Where an explicit SLA does not cover a patient's treatment in a **cross border** situation, then the patient will be treated under an Out of Area Treatment (OAT) arrangement. OAT arrangements are primarily intended to cover situations when a patient requires **emergency** treatment whilst away from home, and where prior approval is not required from the patient's relevant commissioning authority. The OAT arrangement should not be used as an option for long-term treatment where an emergency placement has a length of stay longer than 3 months (see paragraph 25).

23. The OAT arrangement is not intended to cover specialised services included in the DH Specialised Services Definitions Set. Since April 2002, all elective and emergency specialised services should be included in SLAs or a named patient/case specific service agreement. The only exception to this is specialised services treatment given to overseas visitors (see paragraph 57). NSD negotiates the SLAs for Scottish residents treated in English NHS Trusts and specialised service provision not covered by an NSD SLA is funded through single patient agreements (SPAs), which are also managed by NSD.

24. Resources for cross-border specialised service agreements are drawn from NHS Boards on a weighted capitation (Arbuthnott) 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 NHS Board at any time). This too is managed by NSD, on a cost per case basis, funding the relevant provider Trust direct. Any unspent balances in the risk pool will be refunded at or near the financial year-end.

25. 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 4 et seq) should formalise the arrangements through a service level agreement.

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<sup>2</sup> HSC 1998/198 in England

<sup>3</sup> 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

## **PATIENTS TRANSFERRED FROM THE STATE HOSPITAL**

26. In some cases, establishing the NHS 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 occur. 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 NHS 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.

27. This approach will ensure that the State Hospital will be able to identify, at an early stage, which NHS 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. NHS Boards and the State Hospital must liaise to ensure that the relevant NHS Board for all patients is known at any given time.

28. At the beginning of each financial year, NHS 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.

29. 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 NHS Board as determined in paragraph 35 et seq. If the patient was a prisoner prior to being admitted to the State Hospital, but is not being returned to prison, responsibility will revert to the NHS Board whose responsibility he/she was before being sent to prison, until he/she establishes residence.

## **RESTRICTED PATIENTS<sup>4 5</sup>**

30. Special restrictions were set out in section 62(1) of the Mental Health (Scotland) Act 1984 and the Secretary of State was empowered to take decisions on these restricted patients. Under the provisions of the Scotland Act 1998, these powers transferred to the Scottish Ministers. The First Minister personally takes all decisions relating to transfer to a hospital of lesser security, conditional or absolute discharge and lifting of a restricted order for all restricted patients.

31. Restricted patients may 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 security, which 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 SEHD must check that the patient is detainable under the legislation currently applicable (i.e. legally detainable under equivalent Scottish legislation) before arrangements can be made for the transfer.

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<sup>4</sup> [NHS HDL\(2002\)71](#) Memorandum of Procedure on Restricted Patients

<sup>5</sup> See Annex E for information on restricted patient admissions

32. Transfers between jurisdiction 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 SEHD to liaise with the officials in the receiving jurisdiction to ensure that they are content to receive the patient before transfer can be finalised.

33. It is the responsibility of the Responsible Medical Officer (RMO) to identify a receiving hospital and to ensure that any financial considerations are managed satisfactorily.

#### **EARLY DISCHARGE PROTOCOL FOR PATIENTS IN SECURE HOSPITAL SETTINGS<sup>6</sup>:**

34. The Early Discharge Protocol 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. 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.

#### **PRISONERS**

35. Although the bulk of healthcare for prisoners is provided or paid for by the Prison Service, the NHS retains responsibility for funding hospital (including secure psychiatric care) and community-type health services. For NHS purposes, prisoners, or those on remand, for the first six months are considered to be resident in the area where they stayed before they were sentenced or remanded. This also applies to those leaving prison until they have established themselves at a new address. The responsible NHS Board can therefore be determined by the usual means (see paragraph 4 et seq).

36. A person who is detained in custody pending trial or pending sentence upon conviction or under a sentence imposed by a court, other than a person whose detention is under the provisions of the Mental Health (Scotland) Act 1984<sup>7</sup> (see paragraph 41), will be treated as usually resident either:

- i. at the address he/she was usually resident immediately before the commencement of the detention (the previous address); or
- ii. if the previous address cannot be determined, in the area in which the offence for which he/she is detained was committed or, if detained pending trial, the area where the offence with which he/she is charged as committed.

37. Since 1 April 1999, patients in the prison system for six months or more have become the responsibility of the NHS Board in which the prison is located.

38. New arrangements came into effect in England on 1 April 2003, which led to the PCT 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 41). Further guidance was issued to PCTs and prisons in

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<sup>6</sup> [HDL\(2002\)85](#) Early Discharge Protocol for Patients in Secure Hospital Settings

<sup>7</sup> The Mental Health Act 1983 in England

England before the changes took place<sup>8</sup>. For cases prior to 1 April 2003, the responsible PCT 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 he/she is detained, was committed (or if pending trial, the area where the offence with which he/she is charged, was committed). The provisions in paragraphs 40 and 42 also apply in England.

39. In Northern Ireland, a prisoner is regarded for Health and Personal Social Services 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 when released. Once established at an address the appropriate HSS Board should assume responsibility for his/her care.

40. People usually resident overseas held in UK prisons are exempt from charges for NHS healthcare. There is no centrally held budget for this group, and costs should be borne by the NHS Board - PCT in England - where, in line with the above provisions, the prisoner was resident or detained immediately before remand or sentence.

#### **PEOPLE DETAINED UNDER THE MENTAL HEALTH (SCOTLAND) ACT 1984 OR THE MENTAL HEALTH ACT 1983**

41. If a person is detained for treatment under the Mental Health (Scotland) Act 1984, the responsible commissioner will be subject to the same principles set out in paragraph 4 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 NHS 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 PCT where the patient was previously registered/resident before entering prison. If this is not possible, then the PCT in which the facility is located becomes the responsible commissioner.

#### **IMMIGRATION DETAINEES**

42. 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 NHS board area – PCT in England - of the unit providing treatment.

#### **BOARDING SCHOOL PUPILS**

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

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<sup>8</sup> "Important changes to NHS "responsible commissioner" for prisoners from April 2003", Department of Health, 14 October 2002

## **SCHOOLS & COLLEGES FOR CHILDREN/YOUNG PEOPLE WITH SPECIAL EDUCATIONAL NEEDS**

44. A special school is a day or residential school that caters exclusively for children with special needs, including learning difficulties. These might take substantial numbers of children with special needs from a wide area. The children often have complex healthcare and therapy needs involving a range of professional staff and high cost equipment. Pupils at special schools remain the responsibility of their 'home' NHS Board (derived from the resident address of their parents or guardians), except for the provision of general school medical services, which are provided within such 'independent' schools. This will also apply to children placed by social services or through joint funding arrangements between NHS Boards, social services and local education authorities.

45. When a pupil who is attending a special needs school/college, and who has been placed out of area by a NHS Board, local authority or local education authority, reaches the age of 18 the responsible commissioner will be determined as the 'home' NHS Board until the placement has ended. This rule applies until the pupil reaches the age of 21.

## **LOOKED AFTER CHILDREN**

46. Children who are looked after by local authorities are usually placed with foster carers or in a residential home for children. The responsible NHS Board should be established by the usual means identified in paragraph 4 et seq (i.e. the address of the foster carer or children's home).

47. When a child is first placed by a local authority, they have a shared responsibility with the relevant NHS Board to ensure a full health assessment takes place and that a health care plan is drawn up. When time allows, the relevant NHS Board should be informed in writing by the responsible local authority of its intention to place a child in its area and whether the placement is intended to be long or short term. Some placements need to be arranged urgently and prior notification will not always be possible. In these cases, the relevant NHS Board must be notified within two weeks.

48. If a looked after child moves, arrangements should be made, in discussion between those currently providing the health care and with the new NHS 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 hand-over of clinical care where that is the agreed best plan for the child. **A new assessment should not always be necessary.**

49. When a child who is looked after reaches the age of eighteen, the usual address of the child on his or her eighteenth birthday will identify the responsible NHS Board, unless the child is attending a special school when the rule set out in paragraph 45 will apply.

## **PEOPLE TAKEN ILL ABROAD**

50. If a person usually 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 4 et seq. If it is not possible to determine a resident address by the usual means (although that of the next of kin may apply), the responsible commissioner will be determined by the location of the unit providing treatment. In this context the NHS Board in which the facility is located becomes the responsible commissioner for these purposes. In all cases, it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

51. Where a person is not normally resident in the UK but retains entitlement to free NHS treatment, it is not always possible to establish a resident address by the usual means (although that of the next of kin may apply). Therefore, the responsible commissioner will be determined by the location of the unit providing treatment. In this context the NHS Board in which the facility is located becomes the responsible commissioner for these purposes. Again, in all cases, it is the responsibility of the patient and his/her family to meet the costs of returning to the UK.

### **MILITARY PERSONNEL**

52. 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 NHS Board first received notification of the enlistment.<sup>9</sup> There is no such restriction on dependents. Military Personnel are entitled to treatment as emergency patients or temporary residents by NHS General Practitioners 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.

53. 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 is not available. NHS Boards are responsible for the provision of secondary care treatment for military personnel. The responsible NHS 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.

54. Military personnel who are discharged from the Armed Forces and who are undergoing a continuing care package will be subject to the same criteria as those set out in paragraphs 9.6 and 20.6.

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

55. Under the National Health Services (Charges to Overseas Visitors) (Scotland) Regulations 1989 No 364 as amended by SI 1994 No 1770 – in England, National Health Service (Charges to Overseas Visitors) Regulations 1989 No 306 – people who are not ordinarily resident in the UK are liable to be charged for any hospital treatment they receive. It is the duty of the hospital to establish who is chargeable and who is not.

56. A patient who is not normally resident in the UK but has been established as not liable

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<sup>9</sup> Regulation 27 of the NHS (General Medical Services) (Scotland) Regulations 1995 SI 416

for charges, i.e. could be regarded as part of the resident population in the UK, is, therefore, subject to the same principles set out in paragraph 4 et seq. If this is not possible, then the responsible commissioner would be determined by the location of the unit providing treatment. Examples of these people are: people who have been in the UK for more than 12 months; people who are employed or self-employed here; asylum seekers and refugees who have been given leave to remain or have applied for leave; diplomatic staff; students who are accepted by the hospital as usually resident; and NATO personnel.

57. Where a person is not normally resident and is not liable for charges, and is not classed as part of the resident population, then the responsible commissioner is determined by the location of the unit providing treatment. Central funding for treatment of these people has been devolved into NHS Board baselines. In all cases the cost of treatment is the responsibility of the relevant NHS Board. This includes specialised services treatment given to overseas visitors.

58. 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 4 et seq will apply.

### **ASYLUM SEEKERS**

59. A person who has made a formal application to HM Government for permission to take refuge in the UK is regarded as usually resident (subject to the same principles as paragraph 4 et seq), and is therefore able to benefit from the same rights to NHS treatment as UK citizens. However, if the application, including any appeals, is unsuccessful, eligibility for NHS treatment on the same basis as UK residents ceases.

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

60. Examples of services provided on an "all-comers" basis include Accident and Emergency (A&E) services, family planning services, health promotion services, GUM and HIV testing and counselling services and services provided by NHS24, NHS Direct, and NHS walk-in centres. Host NHS Boards are responsible for securing the provision of these services to everyone present in the area (regardless of residence), including associated ambulance services in the case of A&E services.

61. Host NHS Boards are responsible only for treatment in the A&E Department up to a period not exceeding 24 hours<sup>10</sup>. 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 patient's 'home' NHS Board or PCT. 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 NHS Board of residence through an appropriate

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<sup>10</sup> 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."

service level agreement or through the OATS system if a cross border patient (see para 22).

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

62. 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 NHS Board.

63. However, for HIV treatment services (following a positive HIV test and post-test counselling), any further treatment for the HIV positive individual, including the prescription of combination anti-retroviral drug therapies and associated monitoring, should be commissioned on a collaborative basis by NHS Boards as a specialised service and funded by the responsible NHS Board (as determined in paragraph 4 et seq).

64. A full definition of specialised treatment and care services for HIV positive patients is found in the *Specialised Services National Definitions Set at [www.doh.gov.uk/specialisedservicesdefinitions](http://www.doh.gov.uk/specialisedservicesdefinitions)*.

## **TRANSPLANTS**

65. 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 harvesting of donor material, the NHS Board of the patient receiving the transplant will be responsible for funding the procedures, unless alternative arrangements are already in place between the commissioners.

66. Some transplant services are funded through National Services Division (NSD) arrangements – liver transplant, paediatric small bowel transplant, Severe Combined Immuno Deficiency Syndrome (SCIDS), 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.

## **WAITING TIMES GUARANTEES**

67. NHS Boards are required to meet national waiting times guarantees and 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, NHS Boards might arrange treatment for some patients elsewhere in NHSScotland, 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 NHS Boards retain responsibility for funding consultation, diagnosis and treatment for their patients.

## **TRANSFERS ON NON-CLINICAL GROUNDS**

68. Where a transfer is sought on non-clinical grounds, e.g. because a patient so wishes; or where treatment could be provided within the home NHS Board area but for other reasons is sought in another area, e.g. because a patient wishes to be treated in area close to remaining family, clarity and agreement on funding must be sought prior to the transfer taking place.

**ASSOCIATED LEGISLATION AND DOCUMENTATION - SCOTLAND**

**This guidance should be read in conjunction with:**

The Social Work (Scotland) Act 1968

National Health Service (Scotland) Act 1978

Mental Health (Scotland ) Act 1984

National Health Service and Community Care Act 1990

Criminal Procedure (Scotland) Act 1995

The Scotland Act 1998

Community Care and Health (Scotland) Act 2002

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989

The Functions of Health Boards (Scotland) Order 1991

The NHS (General Medical Services)(Scotland)Regulations 1995

The National Health Service (Choice of Medical Practitioner) (Scotland) Amendment Regulations 2001

Circular No: SWSG 1/96 Ordinary Residence

NHS MEL(1996)22 NHS Responsibility for Continuing Health Care

NHS MEL(1999)4 Funding Arrangements for Cross-Boundary and Cross-Border Patient Activity

[NHS HDL\(2002\)10](#) NHS Scotland: Guidance on Regional Planning for Health Care Services

[NHS HDL\(2002\)39](#) Funding Arrangements for Specialised and Other Pan-Regional Hospital Services

[NHS HDL\(2002\)71](#) Memorandum of Procedure on Restricted Patients

[NHS HDL\(2002\)85](#) Early Discharge Protocol for Patients in Secure Hospital Settings

[NHS HDL\(2003\)54](#) National Waiting Times Database

[CCD 5/2003](#) Free Personal and Nursing Care - Consolidated Guidance

*Our National Health*, *a plan for action, a plan for change* ( December 2000)

*Partnership for Care*, Scotland's Health White Paper (February 2003)

**ASSOCIATED LEGISLATION AND DOCUMENTATION – ENGLAND,  
WALES & NORTHERN IRELAND**

The National Health Service Act 1977

The Mental Health Act 1983

National Health Service and Community Care Act 1990

Local Government Act 2000

The National Health Services(Charges to Overseas Visitors) Regulations 1989 (S.I 306)

The National Health Service (General Medical Services) Regulations 1992 (S.I.635)

Establishing District of Residence Guidance (1993)

Local Authority Circular (LAC) 93(7): Ordinary Residence

HSS Executive, Circular PRSC 2/96: Establishing Area of Residence: Guidance for Purchasing - Northern Ireland

The National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996 (S.I. No 708)

Children Act (England) Regulations 2002 (S.I. No546) and subsequent amendments

Directions to Health Authorities concerning Patient Lists, 1998

HSC 1998/065 The New NHS, Modern and Dependable: Establishing Primary Care Groups

HSC 1998/139 The New NHS: Modern and Dependable: Developing Primary Care Groups

HSC 1998/198 Commissioning in the New NHS: Commissioning Services 1999-2000

HSC 1998/228 Primary Care Groups: Delivering the Agenda

The National Health Service(Choice of Medical Practitioner) Regulations 1998 (S.I.668)

HSC 1999/018 Overseas Visitors' Eligibility to Receive Free Primary Care

HSC 1999/112 Ministry of Defence Hospital Units: Financial Arrangements

HSC 1999/117 The New NHS: Guidance on Out of Area Treatments

The National Health Service (Functions of Health Authorities and Administration Arrangements) Amendment Regulations 1999 (S.I. No 628)

The Primary Care Trusts (Functions) (England) Regulations 2000 (S.I. No 695)

The National Health Service (Functions of Health Authorities and Administration Arrangements) Amendment Regulations 2001 (S.I. No 747)

HSC 2001/015:LAC (2001)18 Continuing Care: NHS and Local Councils' Responsibilities

HSC 2001/017:LAC (2001)26 Guidance on Free Nursing Care in Nursing Homes

HSC 2002/001:LAC(2002)1 Guidance on the Single Assessment Process for Older People

Important Changes to NHS "Responsible Commissioner" for Prisoners from April 2003

The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (S.I.No.2375) & subsequent amendments

Establishing the Responsible Commissioner: Guidance for PCT Commissioners - October 2003

The NHS Plan – A plan for investment, A plan for reform (2000)

The Specialised Services National Definitions Set

Shifting the Balance of Power within the NHS – Securing Delivery (2001)

Shifting the Balance of Power – The Next Steps (2002)

### USUALLY RESIDENT

1. Primarily, the arbiter of the patient's residence is the patient. The principle is that the patient's perception of where he or she is resident, either currently or, failing that, most recently, is the criterion. Patients should not be subjected to undue scrutiny when being asked for this information, or be led into giving alternative address in order to exploit any perceived financial advantage.

2. If there is any doubt over an individual's district of residence, the address that he or she gives as their usual residence should be used. If patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, then the address at which they were last resident will establish the NHS Board of residence. Where a patient is unable or incapable of giving either a current or most recent address, and an address cannot be established by any other means, for instance by next of kin advising the patient's address, then his or her district should be taken to be that in which the unit providing the initial treatment is located.

3. Certain groups of patients, for example those with HIV or AIDS, might be reluctant to provide an address. It is sufficient for the purpose of establishing financial responsibility that a patient is resident in a location (or postal district) within an NHS Board's geographical area, without needing a precise address. Where there is any uncertainty, the NHS Board, or PCT in England, providing the treatment/care should ask the patient where he or she usually lives. Individuals remain free to give their perception of where they consider themselves resident. Holiday or second homes are not considered as "usual" residences.

### ORDINARILY RESIDENT

4. 'Ordinarily resident' is the term more usually used by local authorities. Whilst there is no definition of 'ordinarily resident', the term should be given its ordinary and natural meaning. The concept of ordinary residence involves questions of fact and degree, and factors, such as time, intention and continuity, each of which may be given different weight according to the context, have to be taken into account.<sup>11</sup>

5. When an individual does not appear to have any settled residence, it is the responsibility of the authority where the person is living at that time to arrange any care required to meet his or her needs.

6. In the majority of cases, therefore, the area of ordinary residence for social services care and the area where a person needing health care is usually resident will be the same.

7. While a person might be ordinarily resident in another local authority area, it is the responsibility of the local authority of the moment to make a care assessment if it appears to the authority that the individual might be in need of services. The undertaking of an assessment, and the provision of services by the authority, in such circumstances should not be taken to imply acceptance of the individual's ordinary residence in that area.

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<sup>11</sup> Social Work SWSG 1/96

8. Where there are disputes in identifying the responsible local authority, the provision of services for individuals requiring social work services should not be delayed. Section 86(2) of the Social Work (Scotland) Act 1968 provides that any question arising as to the ordinary residence of a person shall be determined by the Secretary of State. This relates to the provision by a local authority of accommodation, services, facilities and other matters to a person ordinarily resident in the area of another local authority, as described in section 86(1) of the Act. Section 97(1) of the 1968 Act extends the provision of section 86(1), providing for the Secretary of State to determine disputes between Scottish local authorities and those in England and Wales. Separate guidance has been issued to local authorities in England and Wales by the Department of Health (LAC(93)7).

**NATIONAL SERVICES DIVISION**

1. Certain very highly specialised services that serve national populations are centrally commissioned by the National Services Division of the Common Services Agency on behalf of NHS Boards and SEHD. The services listed below are centrally funded by National Services Division which in consequence acts as the responsible commissioner. All Scottish residents are covered by this arrangement.

**List of Nationally Funded Services (as of April 2003)**

2. The services listed below, at the locations listed below, are funded at an “all Scotland” or “all UK” level as of 1 April 2003.

Service	Location
Adult Cystic Fibrosis	Aberdeen Royal Infirmary Western General Hospital, Edinburgh (includes outreach service in Dundee) Western Infirmary, Glasgow
Amyloidosis (diagnosis and advice on management)	* Royal Free Hospital, London
Breast Cancer Screening	Ayrshire Central Hospital, Irvine Forresterhill, Aberdeen Nelson Mandela Place, Glasgow Raigmore Hospital Armillan House, Edinburgh Ninewells Hospital
Cardiothoracic Transplantation: - Heart Transplantation Heart, Heart /Lung and Lung Transplantation including Adult Ventricular Assist Devices	Glasgow Royal Infirmary (Adult) Freeman Hospital, Newcastle (Adult and child) Papworth Hospital, Cambridge (Adult) Harefield Hospital, London (Adult) Great Ormond Street Hospital, London (Child)
Cervical Screening cytopathology EQA and proficiency schemes	Aberdeen Royal Infirmary (Cytopathology EQA) Ninewells Hospital (Proficiency scheme)
Choriocarcinoma: - Diagnosis of Hydatidiform Moles/AFP - Treatment	Ninewells Hospital <i>Charing Cross Hospital, London</i> <i>Weston Park Hospital, Sheffield</i>
Clinical Scientists Training Schemes	Ninewells Hospital (Molecular Geneticists, Biochemists, Cytogeneticists) Royal Infirmary of Edinburgh (Microbiologists) Aberdeen Royal Infirmary (Medical Physicists)

Cochlear Implantation	Crosshouse Hospital, Kilmarnock (Adult and Child) Royal Infirmary, Edinburgh (Adult)
Colorectal cancer screening pilot - second round	Ninewells Hospital, Dundee Aberdeen Royal Infirmary Fife Acute Trust
Craniofacial Surgery	<i>Great Ormond Street Hospital, London</i> <i>Radcliffe Infirmary, Oxford</i> <i>Birmingham Children's Hospital</i> <i>Royal Liverpool Children's Hospital, Alder Hey</i>
Cystic Fibrosis Audit Database	University of Dundee
Endoprosthetic Replacement for Primary Bone Tumours	Western Infirmary, Glasgow <i>Royal Orthopaedic Hospital, Birmingham</i> <i>London Bone Tumour Service (Middlesex Hospital, London and Royal National Orthopaedic Hospital, London)</i>
Epidermolysis Bullosa Services (Paediatric)	* Great Ormond Street * Birmingham Children's Hospitals
Gaucher's Disease (Diagnosis and management)	* Addenbroke's Hospital, London (Adults) * Royal Free Hospital, London (Adults) * Great Ormond Street Hospital, London (Child) * Royal Manchester Children's Hospital (Child)
Gynaecological Reconstruction	*Queen Charlotte's Hospital, London
Histopathology EQA	Ninewells Hospital
HIV/HCV/Blood borne virus Specialist Laboratory Tests	Regional Virus Laboratories in Edinburgh and Glasgow
Hyperbaric Medicine	Aberdeen Royal Infirmary
Inpatient Psychiatric Service for Deaf Children and Adolescents	*Springfield Hospital, London
Intestinal Failure (Specialist Service)	*St Mark's Hospital, London *Hope Hospital, Salford NB See Managed Clinical Network below for home parenteral nutrition in Scotland
Liver Transplantation	Royal Infirmary, Edinburgh (Adult) <i>St James Hospital, Leeds (Adult)</i> <i>University Hospitals, Birmingham (Adult)</i> <i>Birmingham Children's Hospital (Child)</i> <i>King's College Hospital, London (Child)</i> <i>Royal Free, London (Adult)</i> <i>Addenbrokes Hospital, Cambridge (Adult)</i> <i>Freeman Hospital, Newcastle (Adult)</i>
Molecular Genetics	Aberdeen Royal Infirmary Dundee Teaching Hospital Western General Hospital, Edinburgh Yorkhill Hospital, Glasgow
Neonatal blood spot screening	Yorkhill Hospital (Scottish Neonatal

	Screening Laboratory)
Ophthalmic Oncology (includes proton beam treatment where necessary)	Western Infirmary, Glasgow (proton beam at Clatterbridge Hospital, Liverpool)
Paediatric Bladder Extrophy	* Great Ormond Street Hospital * Manchester Children's Hospital
Paediatric Cardiac Surgery	Yorkhill Hospital, Glasgow * Birmingham Children's Hospital
Paediatric Extracorporeal Membrane Oxygenation (ECMO)	Yorkhill Hospital, Glasgow
Paediatric renal transplantation	Yorkhill Hospital, Glasgow
Pancreatic transplantation (for those also requiring kidney transplantation)	Royal Infirmary, Edinburgh
Photobiology	Dundee Teaching Hospital
Prion Disease Service	*St Mary's Hospital, London
Psuedomyxoma Peritonei of the Appendix	* North Hampshire Hospital, Basingstoke
Pulmonary Thromboendarterectomy	* Papworth Hospital, Cambridge
Pulmonary Vascular Service	Western Infirmary, Glasgow
Rare Neuromuscular Disease	*Hammersmith Hospital, London *Institute of Genetics, Newcastle *John Radcliffe Hospital, Oxford *National Hospital for Neurology and Neurosurgery, London
Recombinant and Commercial Blood Products	* Glasgow Royal Infirmary * Royal Infirmary, Edinburgh
Reference Laboratory Services	Royal Infirmary of Edinburgh (Mycobacteria, Neisseria Gonorrhoea) Western General Hospital, Edinburgh ( E-coli O157) Stobhill Hospital, Glasgow (Legionella, Meningococcus, Pneumococcus, Parasitology, Salmonella) Glasgow Royal Infirmary (MRSA, Trace elements) Raigmore Hospital (Toxoplasma) Public Health Laboratory Service, Colindale, London, (Specialist reference services <u>not provided</u> in Scotland.)
Retinoblastoma	*St Bartholomew's Hospital, London *Birmingham Children's Hospital
Scottish Poisons and Information Bureau	Royal Infirmary of Edinburgh
Secure Forensic Mental Health Services for children and adolescents	* Roycroft Unit (Newcastle) * Gardener Unit (Salford)
Severe Combined Immunodeficiency and Related	* Newcastle General Hospital for Sick Children

Disorders (SCIDS)	* Great Ormond Street Hospital, London
Small Bowel Transplantation (service evaluation)	* St James Hospital, Leeds (Adult) * Addenbroke's Hospital, Cambridge (Adult) * Birmingham Children's Hospital (Child)
Specialist Paediatric Liver Disease Service (including Kasai Procedure)	*King's College Hospital, London *Birmingham Children's Hospital *St James University Hospital, Leeds
Spinal Injuries (including high dependency home ventilation)	Southern General Hospital, Glasgow
Stem cell transplants for children with severe Rheumatoid Arthritis	* Great Ormond Street Hospital, London *Freeman Hospital, Newcastle
Supra-Renal and Thoraco-Abdominal Aortic Aneurysms	Royal Infirmary of Edinburgh
Total Anorectal Reconstruction (TAR) (service evaluation)	* Royal London Hospital
Transport of Critically Ill Children	Royal Hospitals for Sick Children, Edinburgh and Glasgow

#### National Managed Clinical Networks

The administrative costs of the following National Managed Clinical Network are supported nationally but the costs of treatment co-ordinated through the networks are funded locally.

Network	Host Trust of Lead Clinician
Cleft lip and palate: - National Managed Clinical Network	Tayside University Hospitals NHS Trust (network covers all Scotland)
Home Parenteral Nutrition - National Managed Clinical Network	Tayside University Hospitals NHS Trust (network covers all Scotland)
Phototherapy - National Managed Clinical Network	Tayside University Hospitals NHS Trust (network covers all Scotland)

#### **Key**

Normal type – services funded at listed locations for residents of Scotland by National Services Division. These are the designated Scottish national specialist services.

*Locations in Italics* – services funded on UK basis by Department of Health in England (open to all residents of the UK)

\* Service funded via National Services Division from pooled NHS Board funds

**ADMISSION OF A RESTRICTED PATIENT TO HOSPITAL:**

**How a restricted patient is admitted to hospital**

1. A patient becomes subject to special restrictions as a result of one of the following:
2. A restriction order under section 59 of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act) made in addition to a hospital order under section 58 of that Act. The Court may make a restriction order under section 59 if, having had regard to various considerations, it considers this necessary for the protection of the public from serious harm.
3. An order under section 57(2) (a) and (b) of the 1995 Act. This may follow a finding of insanity in bar of trial or acquittal on the grounds of insanity. Where there is a finding of insanity in bar of trial, an examination of facts will determine **beyond reasonable doubt** whether the person did the act(s) or made the omission(s) constituting the offence(s).
4. An order made by the High Court on appeal, under section 118(5)(b) of the 1995 Act (which like a section 57(2)(a) and (b) order has the effect of a hospital order together with a restriction order). In terms of section 118(5)b, the court can also make orders under section 57(2)(c) [order with the same effect as a guardianship order] and (d) [supervision and treatment order].
5. A hospital direction under section 59A of the 1995 Act following a conviction on Indictment. In addition to receiving a prison sentence, a hospital direction may be made. Section 62A(5) of the Mental Health (Scotland) Act 1984, (the 1984 Act) sets out the restriction applicable to a hospital direction.
6. Section 69 of the 1984 Act includes a provision for Scottish Ministers to direct that members of the armed forces, who, as a result of court martial proceedings, are found to be insane and are ordered to be detained at Her Majesty's Pleasure, be detained in hospital. This order has the effect of a hospital order together with a restriction order.
7. A transfer order in respect of an untried prisoner under section 70 of the 1984 Act. In accordance with section 70(3), such an order also has the effect of a hospital order and a restriction order. It should be noted that section 70 restrictions remain in force until **the case is finally disposed of by the court or the proceedings are dropped or the patient is considered well enough to return to prison.**
8. A restriction direction made by Scottish Ministers under section 72 of the 1984 Act, in addition to a transfer direction under section 71 in respect of a person serving a sentence of imprisonment. (A restriction direction made under section 72 has the same effect as a restriction order.)
9. Removal to Scotland from another part of the United Kingdom in any case where the patient has been subject similar restrictions under equivalent statutory provisions.

10. The following orders were available under the 1975 Act prior to the introduction of the 1995 Act. Some patients in the system may have originally entered hospital under these orders:

- A restriction order under section 178 or 379 of the Criminal Procedure (Scotland) Act 1975 (the 1975 Act) made in addition to a hospital order under section 175 or 376 of that Act.
- An order under section 174 of the 1975 Act, following a finding of insanity in bar of trial or acquittal on grounds of insanity. In accordance with section 174(4) such an order has the effect of a hospital order together with a restriction order.
- An order made by the High Court on appeal, under section 254(4)(b) of the 1975 Act (which like a section 174 order and, by reason of section 254(5) of the 1975 Act, has the effect of a hospital order together with a restriction order).