Supplemental to Defining the boundaries between NHS and Private Healthcare (P005V2)

Joint policy between Nene & Corby CCG and their provider trusts, for patients who wish to pay for additional private care.

1. Definitions

NHS patient refers to any person in receipt of services commissioned and funded by the NHS.

Private patients are patients who receive private healthcare, funded on a pay-as-you-go basis or via a medical insurance policy.

Private healthcare means medical treatments or medical services which are not funded by the NHS, whether provided as a private service by an NHS body or by the independent sector. A patient may choose to seek treatment on a private basis even where that treatment is available from an NHS provider.
NHS consultant refers to a doctor employed by an NHS body at consultant grade.

NHS clinician refers to doctor, nurse, physiotherapist or other person providing clinical services as part of NHS commissioned care.

NHS commissioned care is healthcare which has been agreed to be funded by the patient's responsible Nene Clinical Commissioning Group ("CCG") or Corby Clinical Commissioning Group("CCG"). Each CCG has policies which define the elements of healthcare which the CCG is and is not prepared to commission. Each CCG also has Individual Funding Request policies ("IFR policies") which describe how that CCG will consider requests to commission care for individual patients, which are not routinely funded under those policies.

Co-payment is seldom permitted in the NHS, other than where, pursuant to Regulations made under the National Health Service Act 2006, specified patients are required to make a specified contribution to the cost of NHS commissioned care.

Co-funding of NHS care is any arrangement, apart from the permitted co-payment defined above, under which the cost of an episode of healthcare for an NHS patient, which in part involves NHS commissioned care, is or is proposed to be partly funded by the patient. Co-funding is not permitted within the NHS.

Attributable costs are the financial costs to be considered when privately funded treatment is provided within an NHS setting. ***Attributable costs*** refer to all costs which would not have been incurred by the NHS had the patient not sought private treatment. If an NHS patient has also gone to a private provider (ie: in connection with the same medical condition for which they are receiving NHS care) to buy a drug not available as part of the NHS care package, then they are expected to pay for any consequential costs (these can include additional monitoring needed for the drug, blood tests, CT Scans, etc) and also pay for the treatment of predictable complications of receiving the drug. If a patient chooses to seek private healthcare for a treatment that is not normally commissioned by the NHS, the patient is expected to pay all attributable costs. It is not acceptable, for example, to 'piggy back' a private monitoring test onto routine monitoring which the patient might be having, in parallel, within the NHS.

2. The policy

2.1 This policy applies to any patient for whom any CCG who is a signatory to this policy is the Responsible Commissioner and to all patients of the NHS Trusts who are signatories to this policy (together known as "the NHS bodies").
2.2 The Boards of the NHS bodies agree that it is a Board responsibility to create the management systems in their organisations to ensure that their organisations comply with the terms of this policy.
2.3 This policy should be read alongside the legislative framework which governs the NHS together with Guidance from the Department of Health "Guidance on NHS patients who wish to pay for additional private care" and all other relevant guidance, including the legal equality duties which are imposed on all NHS bodies.

General guidelines

2.4 The approach set out in this policy is grounded in the fundamental principles of the NHS which we understand to include the following:

- That the Secretary of State has a duty to promote as comprehensive a national healthcare system as the resources provided shall permit;
- That NHS care is to be provided equitably to all patients based on clinical need, not an individual's ability to pay;
- That public funds for healthcare should be devoted solely to commission and provide NHS commissioned care; and
- NHS funds should not be used to subsidise private healthcare.

2.5 The NHS is not the sole provider of healthcare in England. Patients have the right to spend their own money to purchase their own healthcare outside the NHS if they are minded to do so and, if they have the resources, are entitled to arrange their affairs by taking out insurance or otherwise arranging their affairs so as facilitate that choice. The fact that a patient may be able to afford or otherwise access private healthcare should never affect the healthcare options offered as part of NHS commissioned care to that patient.

2.6 This policy recognises that it can be lawful for NHS Trusts to provide private healthcare and that staff employed by NHS bodies may lawfully agree with their employers to provide private healthcare outside of their duties to their NHS employers. However the NHS bodies have agreed that:

- the NHS should never subsidise private care with public money; and
- patients should never be charged for the NHS commissioned care (unless covered by co-payment regulations).

2.7 To avoid these risks, the NHS bodies have agreed there should be as clear a separation as possible between private healthcare which is delivered in NHS premises and/or by staff who work for the NHS and NHS commissioned care.

2.8 Any privately funded arrangement which is agreed between a patient and a healthcare provider (whether within an NHS Trust premises or otherwise) is a commercial matter between the parties to the private healthcare arrangement. No CCG shall be a party to those arrangements and CCGs cannot take any responsibility for the terms of the agreement, under which private healthcare is agreed to be delivered, its performance or the clinical consequences for the patient of the privately funded treatment.

Responsibilities of the NHS Commissioner

2.9 Each CCG will ensure that it's commissioning policies, which define the elements of healthcare which the CCG is and is not prepared to commission for patients, are readily accessible to patients and other NHS staff through its website or otherwise.

2.10 Each CCG will publicise through its website or otherwise the CCG policy and procedures under which the CCG considers commissioning care for individual patients outside its routine commissioning policies.

2.11 The CCG will ensure that requests made by individual patients for treatments which are not routinely funded on the NHS are considered and decisions on the said requests are reached in a timely and rational manner following a proper consideration of the evidence. CCGs will ensure that they have robust, transparent processes in place to make such decisions, including decisions on exceptional funding, and that such decisions are made according to published principles. Where such applications are made, each CCG will give reasons for any decision reached on the application.

2.12 Save that the CCGs shall not permit patients to access NHS and privately funded care in the same episode of care, each CCG will ensure that no patient who elects to procure private healthcare in addition to NHS commissioned care will be disadvantaged in the care made available to the patient as a result of that decision. NHS bodies are entitled to make an exception to permit privately funded and NHS funded care to be delivered at the same time where individual patient safety considerations make it imperative for the NHS and privately funded treatments to be delivered simultaneously. The decision to depart from the policy of clearly separating private and NHS treatment should be taken by the Trust Medical Director and the reasons should be fully recorded in the patient's medical records.

2.13 The CCG will ensure that any complaint by or on behalf of a patient that a patient's NHS care has been "withdrawn" as a result of the patient choosing to have private healthcare are will be investigated as quickly as possible through the standard complaints procedure.

Responsibilities of the NHS Trusts

2.14 NHS Trusts will ensure that they have instructions in place which instruct staff to ensure that all reasonable steps are taken to secure NHS funding for treatment required by a patient. However NHS Trusts and CCGs recognise that there is no obligation on NHS clinical staff to support applications to a CCG for funding based on exceptional clinical circumstances unless the clinician believes that the patient's clinical circumstances could properly be described as being exceptional.

2.15 Where clinicians believe that the most clinically suitable treatment may be one that a CCG is not prepared to routinely fund and/or where the clinician believes that the CCG may have a policy against funding the treatment in the patient's clinical circumstances, clinicians working within the NHS bodies should consider:

- Whether NICE has issued a positive technology appraisal for the relevant indication as applied to this particular patient. If so, the clinician must seek an explanation from the CCG as to why the CCG are not prepared to fund the treatment for his or her patient;
- If not, whether the relevant Clinical commissioning Group has a local policy to fund the treatment, perhaps based on collaboration with other CCGs or, in the case of cancer drugs, following advice from a cancer network. If so, the clinician must seek an explanation from the CCGs as to why the CCG are not prepared to fund the treatment for his or her patient;

- If not, whether the clinician considers that the patient's individual clinical circumstances are such that a reasonable case can be made that exceptional funding can be secured for the patient via the CCG's IFR procedure. If so, the clinician must support an application to the CCG for the treatment to be funded on the NHS and must follow the CCG procedures to seek to assist the patient to secure such funding; and

Clinicians should only suggest that the patient may wish to consider private funding of a treatment if the treatment is not available as part of NHS commissioned care by reason of none of the above applying.

2.16 NHS bodies must ensure that their clinical staff who carry out private care will avoid any actual or perceived conflict of interest between their NHS and private work. NHS clinicians should discuss all clinically appropriate options for treating or managing the patient's condition including, where appropriate, treatment options which are not available as part of NHS commissioned care in line with GMC guidance (Consent: patients and doctors making decisions together).

2.17 Save where a clinician is required to raise a treatment option in order to discharge a professional obligation, NHS bodies must ensure their clinical staff comply with paragraph 2.9 of the Code of Conduct for Private Practice, which states that:

In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.18 NHS bodies should ensure that Trust internal procedures provide that, if a patient seeks information about private services, NHS clinicians will provide them with full, accurate and balanced information about the private healthcare they, other private healthcare providers or their NHS organisation can provide. As good practice, a record should be kept of all discussions with patients about care not routinely funded on the NHS in the patient's NHS medical notes.

2.19 NHS bodies are committed to the principle, as set out in the Code of Conduct for Private Practice, that NHS consultants are not permitted to use NHS staff for the provision of private healthcare services without the prior written agreement of their NHS employer and will ensure that management systems operate within their organisations to that effect .

2.20 The Trust Board of all NHS bodies should ensure that NHS bodies develop clear protocols for clinicians to follow when giving advice to patients relating to unfunded treatments. In particular the protocols should provide that NHS clinicians should ensure that the following steps are observed:

- A record should be kept in the patient's NHS medical notes of all discussions with patients about care not routinely funded on the NHS.
- Where a treatment is not routinely commissioned by a CCG, the clinician should consider and, if appropriate, support an individual funding application to the responsible CCG.
- The patient (or, where appropriate, the patient representative) should be given full information about the potential benefits, risks, burdens and side effects of any treatment before being asked to consent to treatment, in line with the GMC guidance, Consent: Patients and doctors making decisions together, 2008. The information provided to the patient should be in written form for the patient and recorded on the consent form or otherwise with the clinical notes.
- Clinicians should contribute information to relevant national audits.
- Records of discussions about unfunded treatments should be discussed at consultants' appraisals.

- The outcomes of cases involving the administration of unfunded treatments should be discussed at multi-disciplinary clinical governance meetings.

Responsibilities of the NHS bodies when providing private healthcare

2.21 As well as the responsibilities listed in 2.14 – 2.20 NHS bodies providing private healthcare must ensure that governance arrangements set out below are in place.

2.22 NHS commissioned care and private care must not be provided to the patient during the same episode of care.

2.23 The NHS body must always make clear to the patient whether an individual procedure or treatment is privately funded or NHS funded.

2.24 Where private healthcare is being provided the NHS body must ensure the patient bears all attributable costs of the episode of care within which the private healthcare is being provided.

2.25 NHS bodies must ensure that they do not subsidise private healthcare. In order to do this where private healthcare is provided from NHS premises or is delivered by NHS staff:

- Private and NHS care should be kept as clearly separate as possible.
- Private healthcare should be carried out at a different time from NHS commissioned care and, unless it is clinically not possible to do this at a different place.
- Patients must not be allowed to "pick and mix" their private healthcare with NHS healthcare. Save in the case of limited hotel services, patients should not be able to upgrade any individual element of NHS commissioned care.

2.26 Departing from these principles of separation should only be considered where there are overriding concerns of patient safety.

2.27 NHS bodies must ensure that, as with any other patient who changes between NHS and private status, patients who pay for private care should not be put at any advantage or disadvantage in relation to the NHS commissioned care they receive.

2.28 NHS bodies must ensure that charges for any element of care provided by a consultant acting in a private capacity and using NHS facilities should be set in accordance with paragraph 3.4 of the Code of Conduct for Private Practice (2004), which states:

Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- *The employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;*
- *Any charge will be collected by the employer, either from the patient or a relevant third party; and*
- *A charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.*

2.29 NHS bodies must ensure that any monitoring or follow-up care which the NHS would have provided for the patient, in the absence of the patient choosing to fund part of his or her care on a private basis, should continue to be provided on the NHS.

2.30 NHS bodies which are providing private healthcare should seek the patient's agreement to the likely costs in advance of any private care being provided.

2.31 NHS bodies should ensure that they do not profit unreasonably from patients seeking private healthcare within their organisation but they should seek to recover the full cost to the NHS body of providing private healthcare including all management costs associated with the provision of private healthcare services.

2.32 Professional indemnity insurance cover provided by the NHS clinical negligence scheme, CNST, only applies to the NHS element of care. NHS bodies which provide private healthcare should therefore ensure that both the NHS body and any clinician providing private care within their organisation must have private insurance arrangements. The cost of providing such insurance arrangements must be included in the fees charged to private patients.

2.33 The primary purpose of any NHS body is to provide NHS care. NHS bodies which provide private healthcare should follow Department of Health Guidance to ensure that private healthcare is delivered within its organisation in a way that does not compromise any aspect of the delivery of NHS care.

2.34 NHS bodies should ensure that clinicians who have regular conversations with patients approaching the end of their life are able to take advantage of the training opportunities available to them concerning the best way to handle these conversations in a balanced and sensitive way and will take all reasonable steps to ensure that clinicians fully appreciate the potential conflicts of interest and complex ethical issues raised by proposing privately funded treatment for patients as part of end of life care.

Responsibilities of all private healthcare providers including those in the commercial sector

2.35 Transferring patients between private and NHS care should be carried out in a way which avoids putting patients at any unnecessary risk. NHS bodies should work with providers of private healthcare to develop protocols to ensure effective risk management, continuity of care and coordination between NHS and private care at all times. If different clinicians are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between the clinician in charge of the NHS care, and the clinician in charge of the private care. The protocols should describe clearly the management arrangements where a patient is transferred from an NHS body to a private care provider so that it is clear which clinician and/or which organisation is responsible for the assessment of the patient, the delivery of any care and the management of any complications at all stages.

2.36 NHS bodies should ensure that private healthcare providers accept their responsibility to ensure that the patient is fully informed of the responsible CCG's position relating to and the restrictions on on-going funding of a particular treatment before commencing any private treatment.

Rights and responsibilities of the patient receiving private healthcare

2.37 Where private healthcare is to be provided by an NHS body or involving NHS staff, patients are entitled to be fully informed about the private treatment being offered to them and the total attributable costs associated with that treatment and their liability to meet the costs before treatment is commenced. Where appropriate, NHS bodies should ensure that patients sign the Patient Consent for Referral to Private Provider form (or equivalent) before commencing treatment (Appendix 1).

2.38 Where a patient wishes to pay privately for a treatment not normally funded by the patient's CCG, the patient will be required to agree to accept a liability to pay all costs associated with the privately funded episode of care. The costs of all medical care associated with the treatment include assessments, inpatient and outpatient attendances, tests and rehabilitation. NHS bodies should

explain that the CCG will not make any contribution to the privately funded care to cover treatment that the patient could have accessed via the NHS.

2.39 NHS bodies should ensure that patients receiving private healthcare not routinely funded on the NHS are made aware of the potential consequences if they are no longer able to afford to pay for private healthcare. A patient is entitled to request funding on an individual case based on exceptionality. However NHS bodies should ensure that patients are informed that, where the CCG has decided not to fund a treatment routinely, the fact that the patient has demonstrated a benefit from the treatment to date (in the absence of any other evidence of exceptionality) would not be a proper basis for the CCG to consider that an individual case was exceptional. NHS bodies should explain that such an approach would result in the CCG approving funding differentially for persons who could afford to fund part of their own treatment.

Other

2.40 There should be a clear separation of legal status, liability and accountability between NHS care and any private care that a patient receives. For example, if complications arise, it should be clear which clinician and provider is responsible for which element of care. The NHS clinical negligence schemes should not be expected to contribute towards any clinical negligence claim where responsibility lies with the clinician performing the private element of care.

2.41 Any clinician who does not wish to carry out any element of private practice is not compelled to do so.

3. Key principles supporting this joint policy

3.1 Clinical Commissioning groups have legal responsibility for NHS healthcare budgets and their primary duty is to live within the budget allocated to them.
3.2 CCG commissioners have a responsibility to make rational decisions in the way in which they allocate resources and to act fairly between patients.
3.3 The budgets of clinical commissioning groups are for the exclusive use of NHS patients. There can be no subsidisation of private patients, directly or indirectly.
3.4 All NHS commissioned care should be provided as a result of a specific policy or decision to support the proposed treatment. A third party has no mandate to pre-commit resources from CCG budgets unless directed by the Secretary of State.
3.5 New treatments should be assessed for funding according to the principles of clinical effectiveness, safety and cost effectiveness within an ethical framework that supports consistent decision making.

3.6 If treatment is provided within the NHS which has not been commissioned in advance by a CCG, the responsibility for ensuring on-going access to that treatment lies with the clinician or other person who initiated the treatment.

4. Local documents which have a direct bearing on this joint policy

East Midlands Specialised Commissioning Group Commissioning Policy, Orphan Drugs (P007V2), July 2009.
East Midlands Specialised Commissioning Group Commissioning Policy, On-going Access to treatment following the ending of industry sponsored clinical trials or funding (P004V2), July 2009.
Patients and clinicians should ensure that they have checked any relevant treatment specific policy on the East Midlands Specialised Commissioning Group's website which can be accessed at http://www.emscg.nhs.uk/, as the treatment may not be routinely commissioned by the East Midlands Specialised Commissioning Group.

5. Documents which have informed this policy

The National Health Service Act 2006.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4134387

World Class Commissioning Assurance Handbook (June 2008). Available from:
www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/assurance/index.htm

The NHS constitution
http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

National Prescribing Centre and Department of Health. Defining DH guiding principles for processes supporting local decision-making about medicines (January 2009).
Available from:
www.dh.gov.uk/en/managingyourorganisation/commissioningdh_093414

NHS Confederation. Priority setting: an overview. (2007). Available from:
www.nhsconfed.org/publications/prioritysetting/pages/prioritysettingoverview.aspx

NHS Confederation. Priority setting: managing new treatments. (2008). Available from:
www.nhsconfed.org/publications/prioritysetting/pages/prioritysettingnewtreatments.aspx

NHS Confederation. Priority setting: managing individual funding requests. (2008). Available from:
www.nhsconfed.org/publications/prioritysetting/ages/prioritysettingfunding.aspx

NHS Confederation. Priority setting: legal considerations. (2008). Available from:
www.nhsconfed.org/publications/prioritysetting/pages/prioritysettinglegal.aspx

NHS Confederation. Priority setting: strategic planning. (2008). Available from:
www.nhsconfed.org/publications/prioritysetting/pages/prioritysettingstrategicplanning.aspx

Department of Health's 2004 Code of Conduct for Private Practice
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085197

Department of Health's Consultation Document: Guidance on NHS patients who wish to pay for additional private care
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_089926

Improving access to medicines for NHS patients. A report for the Secretary of State for Health by Professor Mike Richards CBE. (November 2008). Available from:
www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_089927
Appendix 1
NHS Provider Patient Information & Patient Consent
for Referral to Private Provider