Commissioning Policy (EMSCGP005V2)

Defining the boundaries between NHS and Private Healthcare

Although Primary Care Trusts (PCTs) and East Midlands Specialised Commissioning Group (EMSCG) were abolished at the end of March 2013 with the formation of 5 Nottinghamshire County wide clinical Commissioning Groups (CCGs) policies that were in place prior to 1 April 2013 remain in place to ensure a consistent approach.

The NHS Nottingham North & East Clinical Commissioning Group have adopted this policy, in its existing form, at a meeting of its Governing Body on 20 August 2013.

This policy sets the overall parameters within which care will be delivered.

East Midlands Specialised Commissioning Group

Commissioning Policy (EMSCGP005V2)

Defining the boundaries between NHS and Private Healthcare

1. Definitions

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 commissioned care is healthcare which the patient's responsible primary care trust has agreed to fund. The PCT has policies which define the elements of healthcare which the PCT is and is not prepared to commission, and IFR processes to consider commissioning care for individual patients outside 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 the PCT is the Responsible Commissioner.

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Entitlement to NHS Care

2.2 NHS care is made available to patients in accordance with the policies of the PCT. However, individual patients are entitled to choose not to access the NHS care and/or to pay for their own healthcare through a private arrangement with doctors and other healthcare professionals. Save as set out in this policy, a patient's entitlement to access NHS healthcare should not be affected by a decision by a patient to fund part or all of their healthcare needs privately.

2.3 An individual who is having treatment which would have been commissioned by the PCT, but who has commenced that treatment on a private basis, can at any stage request to transfer to complete the treatment in the NHS. In this event, the patient will, as far as possible, be provided with the same treatment as the patient would have received if the patient had had NHS treatment throughout. This may mean the patient having to wait for the continuation of treatment, to ensure that he or she receives care on the same basis as any other NHS patient and is not advantaged by having begun their treatment on a private basis.

2.4 Patients are entitled to seek part of their overall treatment for a condition through a private healthcare arrangement and part of the treatment as part of NHS commissioned healthcare. However the NHS commissioned treatment provided to a patient is always subject to the clinical supervision of the NHS treating clinician. There may be times when an NHS clinician declines to provide NHS commissioned treatment if he or she considers that any other treatment given, whether as a result of privately funded treatment or for any other reason, makes the proposed NHS treatment clinically inappropriate.

2.5 An individual who has chosen to pay privately for an element of their care, such as a diagnostic test, is entitled to access other elements of care as NHS commissioned treatment, provided the patient meets NHS commissioning criteria for that treatment. However, at the point that the patient seeks to transfer back to NHS care, the patient should:

- be reassessed by the NHS clinician;
- not be given any preferential treatment by virtue of having accessed part of their care privately; and
- be subject to standard NHS waiting times.

2.6 A patient whose private consultant has recommended treatment with a medication normally available as part of the NHS commissioned care in the

patient's clinical circumstances can ask his or her NHS GP to prescribe the treatment as long as:

- the GP considers it to be medically appropriate in the exercise of his or her clinical discretion;
- the drug is listed on the PCT's formulary or the drug is normally funded by the PCT; and
- the GP is willing to accept clinical responsibility for prescribing the medication.

2.7 There may be cases where a patient's private consultant has recommended treatment with a medication which is specialised in nature and the patient's GP is not prepared to accept clinical responsibility for the prescribing decision recommended by another doctor. If the GP does not feel able to accept clinical responsibility for the medication, the GP should consider whether to offer a referral to an NHS consultant who can consider whether to prescribe the medication for the patient as part of NHS funded treatment. In all cases there should be proper communication between the consultant and the GP about the diagnosis or other reason for the proposed plan of management, including any proposed medication.

2.8 Medication recommended by private consultants may be more expensive than the medication options prescribed for the same clinical situation as part of NHS treatment. In such circumstances, local prescribing advice from the PCT should be followed by the NHS GP without being affected by the privately recommended medication. This advice should be explained to the patient who will retain the option of purchasing the more expensive drug via the private consultant.

Joint NHS and private funding

2.9 NHS care is free of charge to patients unless regulations have been brought into effect to provide for a contribution towards the cost of care being met by the patient. Such charges include prescription charges and some clinical activity undertaken by opticians and dentists. These charges are not "co-funding" but constitute a rarely permitted form of "co-payment". The specific charges are set by Regulations. These charges have always been part of the NHS.

2.10 Co-funding and other forms of co-payment, other than those limited forms permitted by Regulations, are currently contrary to NHS policy. The PCT will not consider any funding requests of this nature.

2.11 Patients are entitled to contract with NHS Acute Trusts to provide privately funded patient care as part of their overall treatment. It is a matter for NHS Trusts as to whether and how they agree to provide such privately funded care. **However NHS Trusts must ensure that private and NHS care are kept as clearly separate as possible.** Any privately funded care must be provided by an NHS Trust at a different time and place to NHS commissioned care.

In particular:

- Private and NHS funded care cannot be provided to a patient in a single visit to an NHS hospital.

- If a patient is an in-patient at an NHS hospital, any privately funded care must be delivered for the patient in a separate building or separate part of the hospital, with a clear division between the privately funded and NHS funded elements of the care, unless separation would pose overriding concerns for patient safety (see 2.14).
- Subject to the patient safety exception outlined above, a patient is not entitled to "pick and mix" elements of NHS and private care within the same treatment, and so is unable to have privately funded and NHS funded treatment provided as part of the same episode of care. (eg: a patient undergoing a cataract operation as an NHS patient cannot choose to pay an additional private fee to have a multi-focal lens inserted during his or her NHS surgery instead of the standard single focus lens inserted as part of NHS commissioned surgery)

2.12 Private prescriptions may not be issued during any part of NHS commissioned care. A common enquiry concerns fertility treatment, where a patient who is paying for IVF treatment, ask their GP to issue NHS prescription drugs required as part of that treatment or to seek NHS funding for investigations which are part of the privately funded IVF treatment. This is not permitted. If the patient does not meet the PCT's commissioning criteria for funding IVF, the NHS should not prescribe drugs or support other medical procedures required as part of the privately funded treatment.

2.13 If a patient is advised to be treated with a combination of drugs, some of which are not routinely available as part of NHS commissioned treatment, the patient is entitled to access the NHS funded drugs and can consult a clinician privately for those drugs which are not commissioned by the NHS. If a combination of drugs or other treatments is or are required to be administered at the same time, part of which is not funded by the NHS, the patient must fund all of the drugs provided and the other costs associated with the proposed treatment. Patients in such circumstances may approach the PCT to apply for funding for the whole of the treatment. However, if the PCT policies do not allow routine commissioning for such treatment, the patient will only be entitled to seek funding on an individual basis on the grounds that the patient has exceptional circumstances. The fact that a patient was prepared to fund part of their own treatment is not a proper ground to support a claim for exceptional circumstances.

2.14 Trusts are entitled to make an exception to the policy in the above paragraph, 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 taken by the Trust Medical Director and the reasons should be fully recorded in the patient's medical records.

2.15 When a patient wishes to pay privately for a treatment not normally funded by the patient's PCT, the patient will be required to pay all costs associated with the privately funded episode of care. The costs of all medical interventions and care associated with the treatment include assessments, inpatient and outpatient attendances, tests and rehabilitation.

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

2.17 Any privately funded arrangement which is agreed between a patient and a healthcare provider (whether an NHS Trust or otherwise) is a commercial matter between those parties. Save as set out above, the PCT is not a party to those arrangements and cannot take any responsibility for the terms of the agreement, its performance or the consequences for the patient of the treatment.

NHS continuation funding of care which was commenced on a private basis

This section should be read in conjunction with the East Midlands Specialised Commissioning Groups Supplementary Policy: An explanation of the Primary Care Trust's approach to continuing funding care which was commenced on a private basis, April 2009

2.18 PCT policies define which treatment the PCT will and thus, by implication, will not fund. Accordingly if a patient commences a course of treatment that the PCT would not normally fund, the PCT will not pick up the costs of treatment through the course.

2.19 A patient is entitled to apply for funding by means of an individual funding request, alleging that his or her clinical circumstances are exceptional. However, where the PCT 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 PCT to agree to change its policy. Such an approach would result in the PCT approving funding differentially for persons who could afford to fund part of their own treatment. It is the responsibility of the Private Healthcare Provider to ensure the patient is fully informed of the PCTs position relating to ongoing funding before commencing the private treatment.

2.20 If a patient commences treatment privately for a drug or other medical intervention that the PCT agrees to fund routinely, then provided that the patient's clinical circumstances are within those defined in the PCT's commissioning policy, the patient is entitled to transfer to NHS funded treatment at any stage. However, the PCT will not reimburse the patient for any treatment received as a private patient before a request is made for NHS funded treatment.

2.21 If a patient seeks funding from the PCT for a drug or other treatment that is not routinely funded and this application is approved on the grounds of exceptionality, the PCT will not meet the costs of any prior privately funded treatment.

2.22 Patients who wish to persuade the PCT to pick up funding for treatments that are not routinely commissioned can:

- make an application for funding for their case an as individual case under the PCT's IFR policy, or
- request the PCT treat the application as an in year service development to be considered under the PCT's In-Year Service Development policy, or
- request that the treatment be considered for inclusion as part of the PCT's annual plan and, if approved, be funded from the commencement of the coming financial year.

2.23 Continuation funding for treatment which has been commenced on a private basis will not be approved in any other circumstances.

2.24 Patients can access treatment on the NHS if and when the treatment is made available to all patients and/or where the PCT services and the patient's clinical needs meet PCT commissioning policies for that particular treatment.

Other

2.25 Individual patients who have been recommended treatment by an NHS consultant that is not routinely commissioned by the PCT under its existing policies are entitled to ask their GP for a referral for a second opinion, from a different NHS consultant, concerning their treatment options. The PCT's Commissioning Team is available to offer advice on preferred providers in such circumstances. However, a second opinion supporting treatment which is not routinely commissioned by the PCT does not create any entitlement to NHS funding for that treatment. The fact that two NHS consultants have recommended a treatment would not normally amount to exceptional circumstances.

2.26 NHS patients are entitled to make a complaint about any refusal by the PCT to agree to fund NHS care in their individual case. If such a complaint is made, the PCT will investigate the patient's concerns as quickly as possible using the PCT's complaints procedure and will assess the decisions made against this policy and the relevant PCT commissioning policies.

2.27 When grounds for a patient being considered an exception have been established, then the PCT will then assess and prioritise that patient's needs against competing needs within the budgets available. There may be times when the funding of a patient's treatment may need to be brought forward to the next financial year or when money can be released through disinvestment elsewhere.

3. Key principle supporting this policy

3.1 Primary care trusts have legal responsibility for NHS healthcare budgets and their primary duty is to live within the budget allocated to them.

3.2 PCT commissioners have a responsibility to make rational decisions in determining the way in which they allocate resources and to act fairly between patients.

3.3 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 PCT budgets unless directed by the Secretary of State.

3.4 New treatments should be assessed for funding according to the basic principles of clinical effectiveness, safety and cost effectiveness and then prioritised within an ethical framework that supports consistent and affordable decision making.

3.5 If treatment is provided within the NHS which has not been commissioned in advance by a PCT, the responsibility for ensuring ongoing 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 policy

East Midlands Specialised Commissioning Group supporting documents
EMSCG Definitions (EMSCGN001V1), 2009

East Midlands Specialised Commissioning Group supporting documents
EMSCG Key Principles (EMSCGN003V1), 2009

Please refer to your PCTs documentation relating to:

Priority setting processes within the organisation
Individual Funding Procedures within the organisation
The principles guiding prioritisation

Patients and clinicians should ensure that they have checked any relevant treatment specific policy on the East Midlands Specialised Commissioning Group (EMSCG's) website as the treatment may not be routinely commissioned by the EMSCG. The website address is: http://www.emscg.nhs.uk/

East Midlands Specialised Commissioning Group Commissioning Policy, Commissioning of new Orphan Disease Treatments, July 2008.

East Midlands Specialised Commissioning Group Commissioning Policy, NHS pick-up of Drug Company sponsored treatments, October 2007.

East Midlands Specialised Commissioning Group Commissioning Policy, Requests to continue funding of care commenced privately, October 2007.

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 rinciples 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

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Version	2
Policy effective from	1 July 2009
Date of next review	As required – minimum 3 yearly
Acknowledgements	West Midlands SCG

East Midlands Specialised Commissioning Group

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

Joint policy between NHS East Midlands Commissioning bodies 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 Primary Care Trust ("PCT"). Each PCT has policies which define the elements of healthcare which the PCT is and is not prepared to commission. Each PCT also has Individual Funding Request policies ("IFR policies") which describe how that PCT 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 PCT 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 PCT shall be a party to those arrangements and PCTs 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 PCT will ensure that it's commissioning policies, which define the elements of healthcare which the PCT 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 PCT will publicise through its website or otherwise the PCT policy and procedures under which the PCT considers commissioning care for individual patients outside its routine commissioning policies.

2.11 The PCT 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. PCTs 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 PCT will give reasons for any decision reached on the application.

2.12 Save that the PCTs shall not permit patients to access NHS and privately funded care in the same episode of care, each PCT 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 taken by the Trust Medical Director and the reasons should be fully recorded in the patient's medical records.

2.13 The PCT 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 PCTs recognise that there is no obligation on NHS clinical staff to support applications to a PCT 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 PCT is not prepared to routinely fund and/or where the clinician believes that the PCT 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 PCT as to why the PCT are not prepared to fund the treatment for his or her patient;
- If not, whether the relevant Primary Care Trust has a local policy to fund the treatment, perhaps based on collaboration with other PCTs or, in the case of cancer drugs, following advice from a cancer network. If so, the clinician must seek an explanation from the PCT as to why the PCT 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 PCT's IFR procedure. If so, the clinician must support an application to the PCT for the treatment to be funded on the NHS and must follow the PCT 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 PCT, the clinician should consider and, if appropriate, support an individual funding application to the responsible PCT.
- 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 PCT's position relating to and the restrictions on ongoing 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 PCT, 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 PCT 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 PCT 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 PCT to consider that an individual case was exceptional. NHS bodies should explain that such an approach would result in the PCT 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 Primary care trusts have legal responsibility for NHS healthcare budgets and their primary duty is to live within the budget allocated to them.

3.2 PCT 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 primary care trusts 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 PCT 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 PCT, the responsibility for ensuring ongoing 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, Ongoing 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

Regional leads for this policy	Malcolm Qualie Head of Health Policy EMSCG malcolm.qualie@emscg.nhs.uk
	Dr Tim Daniel Consultant in Public Health EMSCG
Version	1
Policy effective from	1st July 2009
Date of next review	As required – minimum 3 yearly
Acknowledgements	West Midlands Specialised Commissioning Group

Appendix 1

NHS Provider Patient Information & Patient Consent

A Policy to define the roles of NHS Commissioners, providers of NHS Services, private healthcare providers and NHS Patients, for patients who wish to pay for private healthcare.

for Referral to Private Provider

This form MUST be completed for all patients choosing to receive private treatment either
a) Joint NHS and Private Provider treatment or
b) Total Private Provider treatment.

Patient Details Name: Address: Date of Birth: Hospital No: NHS No: National Insurance No:	Proposed Treatment by Episode: Part (Episodes) to be available on the NHS:
If Appropriate: Patient Representatives Name …… Relationship to Patient ……..	Part (Episodes) to be funded privately:

Important Notice to Patients or patient's representative: **The propose of this form is to ensure that full disclosure of information is made available to the patient in order that they are in full possession of all relevant information to decide whether to opt for additional treatment not funded by NHS.**		**(Signature & Date)** Patient (or Patient's representative)
1	The Patient understands that this document confirms in writing the verbal advice provided by the Clinician as a result of Reporting on digital images, information discussed at Multi-disciplinary Meeting, diagnosis and any NHS treatment to date.	
2	The patient acknowledges they have been given full information about the potential benefits, health risks, burdens and side effects of proposed Private treatment(s) and are summarised below: • …… • …… • ……	
3	The Patient acknowledges that all funding options within the NHS for the proposed treatment have been exhausted. The itemised cost of the treatment by the Private Provider will explained in detail at an initial Consultation with the Private Consultant. This initial consultation maybe chargeable and payable in advance by the Private Provider.	
4	The Patient acknowledges that outcomes of this treatment will be contributed to relevant national audits, however this will **not** be on a named Patient basis.	
5	The outcomes of this Private treatment will be discussed at multi-disciplinary clinical governance meetings.	

6	The Patient gives permission for all care plans and supporting medical records to be copied, shared and made available, as and when required, to the Private Provider.	
7	The patient understands that the Private treatment and any associated costs (e.g. extra tests, PET/CT Scans and Reports, nursing and admin costs etc.) are not being funded by the NHS and are chargeable to the Patient by the Private Provider.	
8	The Patient understands that if they become unable to pay for the Private treatment fund their treatment The Private treatment will stop. The NHS will not provide this additional treatment, however the Patient will continue to be entitled to treatment provided with the NHS.	
9	The Patient understands that if the NHS decided to fund this treatment in future, the NHS would not refund the cost of treatment already given privately.	
10	The patient understands that the NHS is not responsible for the quality of advice and treatment provided by Private provider.	

NHS Clinician's Responsibilities and confirmation.

Declaration: Full information about the potential benefits, risks, burdens and side effects of proposed treatment have been explained and recorded on the consent form for the patient's treatment.

Informed consent has been obtained in line with GMC guidance

NHS Consultant's Signature……Date: ……..

NHS Consultant's Name (Print)…….

NHS Consultant's Contact details:.....

Private Consultant on Behalf of Private Provider.

Declaration: Full information about the potential benefits, risks, burdens and side effects of proposed treatment have been explained and recorded on the consent form for the patient's treatment.

Informed consent has been obtained in line with GMC guidance

Private Consultant's Signature……Date:……..

Private Consultant's Name (Print)…….

Name and Contact detail of Private Provider:.....

Appendix 1

East Midlands Specialised Commissioning Group

Equality Impact Assessment Test for Relevance

Race, Religion/Belief, Disability, Gender, Age and Sexual Orientation

Name of the Service/Policy/Function: EMSCGP005V2 Defining the boundaries between NHS and Private Healthcare.

1. What you are trying to achieve in this service/policy/function
   (Write short notes to explain the policy/service)

This policy forms part of a comprehensive framework of East Midlands commissioning policies that are a pro active response to the changing legal environment within which the NHS now operates, and will inform local decisions upon treatments. They will aim to do this by complying with the national overarching policies and principles which provide guidance to local decision makers. These are namely the core principles of the NHS, World Class Commissioning competences, the Next Stage Review and the NHS Constitution.

This policy and the associated policies are based upon recommendations for Primary Care Trusts (PCT's) outlined in the Department of Health's report (DH in conjunction with the National Prescribing Centre) called 'Defining Guiding Principles for Processes supporting Local Decision Making about Medicines'. This is because this report aims to ensure compliance with all of the national overarching policies and principles outlined above.

2. Which population groups the service/policy/function is intended to benefit and how?

This framework of policies has been directed and guided by the recommendations of the DH report as previously mentioned, in order to ensure compliance with the various developments in the NHS outlined above, which aim to address issues of equality, accountability, transparency and the 'postcode lottery'. Therefore, this policy and its related policies are intended to benefit the whole of the East Midlands population by helping to ensure greater equality, accountability, transparency and by reducing the 'postcode lottery' throughout the East Midlands region.

3. Related policy areas that may be affected by changes in this service/policy/function

As this policy forms part of a framework of policies, the following are interrelated and should work together:

P004V2 ‘Ongoing access to treatment following the ending of industry sponsored clinical trials or funding’.
P005V2 ‘Defining the boundaries between NHS and private treatments’.
P007V2 ‘Orphan Drugs’.
P017V1 ‘Experimental and Unproven treatments’.
P018V1 ‘In year service developments and the PCT approach to treatments not yet assessed and prioritised’.
P019V1 ‘Ongoing access to treatment following completion of NHS Commissioner funded trials’.
P020V1 ‘Patients seeking NHS funded hospital treatment in the European Union, European Economic Area or Switzerland’.
P021V1 ‘Choice’.
P022V1 ‘Ongoing access to treatment following a ‘trial of treatment’ which has not been sanctioned by the responsible primary care trust for a treatment not routinely funded or which has not been formally assessed and prioritised’.
P023V1 ‘Patients changing responsible commissioner’.
P024V1 ‘Ongoing access to treatment following completion of non commercially funded trials’.
P025V1 ‘Prior Approval’.
P026V1 ‘Use of cost effectiveness, value for money and cost effectiveness thresholds’.
P027V1 ‘Commissioning policy for guidance produced by the National Institute of Clinical Excellence’.

East Midlands Specialised Commissioning Group

Equality Impact Assessment Test for Relevance

Race, Religion/Belief, Disability, Gender, Age and Sexual Orientation

Name of the Service/Policy/Function: EMSCGP005V2 Defining the boundaries between NHS and Private Healthcare.

Question 1 - Screening

For each of the six equality categories, ask the questions in the table below:
Please answer Yes or No to the following questions

Question	Age	Disability	Race	Religion and Belief	Gender	Sexual Orientation
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy service?	NO	NO	NO	NO	NO	NO
Is there potential for or evidence that the proposed policy service will not promote good relations between different groups?	NO	NO	NO	NO	NO	NO
Is there potential for or evidence that the proposed policy service will affect different population groups differently (including possibly discriminating against certain groups)?	NO	NO	NO	NO	NO	NO
Is there public concern (including media, academic, voluntary or sector specific interest) in the policy area about actual, perceived or potential discrimination against a particular population group or groups?	NO	NO	NO	NO	NO	NO

If the answer to any of the above is "yes" you will need to carry out an equality assessment in the relevant equality area(s).

East Midlands Specialised Commissioning Group

Equality Impact Assessment Test for Relevance

Race, Religion/Belief, Disability, Gender, Age and Sexual Orientation

Name of the Service/Policy/Function EMSCGP005V2 Defining the boundaries between NHS and Private Healthcare.

Question 2 - Why have you come to these conclusions?

(Write short notes to explain why you have drawn your conclusions including any evidence (of whatever type) that you have to support your assessment).

This policy does not discriminate in any of the ways outlined in Question 1 – screening, because the overall aim of the policy and, indeed, the entire framework of policies is to provide equity of treatment for all patients within the East Midlands. Specific examples of this, are that it is compliant with the NHS Constitution, (which is a declaration of rights that are underpinned by law), which aims to address variations in the availability of medicines and treatments resulting from inconsistency in local decision making processes by ensuring a robust and consistent way of dealing with the commissioning of treatments and medicines for the whole of the East Midlands. This framework of policies also helps to deliver the Constitution's statement to "expect rational local decisions on funding of new drugs and treatments" to take place, as the framework of policies shows an equitable and transparent process. It is also compliant with the Next Stage Review (which lays out the future direction of the NHS), which advises that patients should have access to the most clinically and cost effective medicines and treatments, as the framework of policies as a whole outlines how medicines and treatments are prioritised.

The generic framework of policies themselves aims to ensure equity throughout, as their development and issue is supported by the 'Key Principles for the development of commissioning policies by the PCT'. This explicitly outlines that PCT's should provide equal treatment (point 7).

This policy clearly defines the 'boundaries' between NHS and Private healthcare, providing equitable criteria that apply to the whole of the East Midlands population. It also allows for patients, under certain circumstances, to be able to pay for additional private healthcare as well as NHS healthcare which is equitable, as it helps ensure that if patients do wish to access private care, they do not lose their entitlements to NHS administered care.

Based on the information set out above, I have decided that an equality impact assessment is/is not necessary.

Signed: Malcolm Qualie

Job title: Head of Health Policy

Directorate/Service area: East Midlands Specialised Commissioning Group

Date: 06/06/09

Copy of the completed form should be sent to:

1) Director of Specialised Commissioning

2) Corporate Services Manager
Specialised Commissioning
4 Smith Way, Grove Park
Leicester
LE19 1SS
Email: serina.korol@lcrpct.nhs.uk

Appendix H - Human Rights Assessment Tool

East Midlands Specialised Commissioning Group

Human Rights Assessment Tool

The Human Rights Act, which came into force in October 2000, incorporates into domestic law the European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way, which is incompatible with a Convention right. The underlying intention of the Act is to create a Human Rights culture in public services.

To be completed and attached to any policy document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Will it affect a person's right to life?	NO	Any approach to service developments/drugs and treatments are made within an ethical framework, taking into consideration clinical and cost effectiveness, and are outlined in the 'key principles' document supporting these policies. Thus, any decisions made are made ethically and equitably. Similarly "although the right to life is fundamental, there is no corresponding right to medical treatment in all circumstances" (DH, Human Rights in Healthcare – A framework for local action p 36).
2.	Will someone be deprived of their liberty or have their security threatened?	NO	
3.	Could this result in a person being treated in a degrading or inhuman manner?	NO	
4.	Is there a possibility that a person will be prevented from exercising their beliefs?	NO	
5.	Will anyone's private and family life be interfered with?	NO	

If the answer is "yes" to any of the questions on the proforma can the policy be amended to avoid impacting upon Human Rights? If not, please refer it to the Director of Corporate Affairs to enable legal advice to be sought before proceeding.