

BOB ICB and Frimley ICB Priorities Committee Clinical Commissioning Policy Statement

Policy Number/ Name	BOBFPC35 Managing the Boundaries of NHS and Privately Funded Healthcare
Date of BOB ICB Adoption	February 2024

Key principles: Where a patient opts to pay for private care, their entitlement to NHS services remains and may not be withdrawn. The NHS should not subsidise private care; and private and NHS care should be kept separate as clearly as is possible. The NHS will protect the principle of separation by defining its expectation of private and NHS clinical practice, in line with guidance from the Department of Health.^{1,2,3}

Scope: The conditions of this policy apply to all primary, secondary and specialist or tertiary providers from whom the local clinical commissioning groups commission healthcare services, and will apply with immediate, but not retrospective, effect from the date of issue.

Governance: The Boards of relevant provider organisations are responsible for ensuring compliance with this policy; the Department of Health requires each NHS organisation to develop and implement its own policy to ensure their services protect the key principle stated above.

Situation-specific details are provided in the attached Appendix to this policy statement.

The key points are as follows:

- There is no obligation for the GP to prescribe treatment recommended by a private practitioner if it is contrary to local agreement or outside normal clinical practice.
- The NHS will not normally fund treatments that have been recommended by a private practitioner if that treatment is not normally commissioned within the local area.
- The fact that a patient can demonstrate they have benefited from the private treatment does not necessarily provide grounds for continuing the treatment in the NHS as an exception.
- Patients who commence care privately can request that further treatment be provided within the NHS. Their clinical needs should be reassessed for NHS treatment within the same regime of priorities applicable to NHS patients with the same condition.
- The ICB will not be responsible for retrospective funding of earlier treatment where patients who have received private treatment then transfer to the NHS.

¹ Department of Health (2009) Guidance on NHS Patients who wish to pay for additional private care. Gateway Reference 11512, 23 March 2009 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404423/patients-add-priv-care.pdf Accessed 10.02.16

² Department of Health (2004) A code of conduct for private practice: recommended standards of practice for NHS consultants. 31 January 2004 http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf Accessed 10.02.16

³ Commissioning Policy: Defining the boundaries between NHS and Private Healthcare April 2013 Reference: NHSCB/CP/12 <https://webarchive.nationalarchives.gov.uk/20170504173034/https://www.england.nhs.uk/commissioning/spec-services/key-docs/> Accessed 10.02.16

This policy is in line with Commissioning Policy: Defining the boundaries between NHS and Private Healthcare April 2013. Reference: NHSCB/CP/12 <https://www.england.nhs.uk/wp-content/uploads/2013/04/cp-12.pdf> Accessed 10.02.16

NOTES:

- Potentially exceptional circumstances may be considered by a patient's ICB where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy was developed and recommended by Thames Valley Priorities Committee which was the predecessor of Buckinghamshire, Oxfordshire, and Berkshire West ICB and Frimley ICB Priorities Committee.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g., from NICE.
- BOBFPC clinical policy statements can be viewed at [Clinical Commissioning Policy Statements & IFRs | BOB ICB](#)

Recommendation made by TVPC	January 2016 Updated January 2019
Date adopted and issued by OCCG	April 2016 November 2017 June 2019

Managing the boundaries of NHS and privately funded healthcare

Policy on the separation of private and NHS treatments

1 Background

The link between NHS and private care is increasing with use of private healthcare companies to treat NHS patients, and the subsequent publication of guidance for patients who wish to pay for additional private care. There is a need to clarify the policy of the local NHS regarding private healthcare organisations, private patients and those wishing to pay for additional private care.

2 Fundamental Principles

Department of Health guidance documents ^{1,2,3} confirm that, where a patient opts to pay for private care, their entitlement to NHS services remains and may not be withdrawn.

- 2.1** No patient should lose his or her entitlement to NHS care on the grounds that they have chosen to purchase additional private care.
- 2.2** The NHS should never subsidise private care with public money, which would breach core NHS principles.
- 2.3** Patients should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific regulation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.
- 2.4** There should be as clear a separation as possible between private and NHS care.

3 Scope

- 3.1** This policy covers private patients and their possible association with the NHS, and NHS patients who wish to pay for private healthcare in addition to their NHS care. It will not cover the commissioning from private healthcare providers to care for NHS patients, nor will it cover the funding of treatment of patients following non-NHS funded drug trials (separate policy statements apply).
- 3.2** This policy applies to all secondary and specialist healthcare providers from whom the local NHS commission healthcare services.
- 3.3** The Boards of the relevant provider organisations are responsible for ensuring their organisations comply with this policy through development of their own policy as required by the Department of Health guidance.
- 3.4** The policy comes into force as soon as it is approved by the Clinical Executive/CCG Board. It does not apply retrospectively.

4 Initial referral and treatment

- 4.1** Patients who opt to be referred for private treatment (i.e. outside the CCG's contracted services) must pay the full cost of the consultation, any drugs prescribed and for any other interventions that are provided in the course of their private consultation.

5 On-going treatment – drug prescribing in primary care

5.1 A patient whose private consultant has recommended further/ongoing treatment with a **drug that is normally available on the NHS within the local area**, can have that drug prescribed by their GP on an NHS prescription, as long as:

- the GP considers it is clinically necessary;
- the drug is listed on the approved Formulary;
- the drug is normally funded by the CCG for that condition (*n.b. specific policy criteria may apply*).

NOTE -The doctor who prescribes any medication for a patient must accept full clinical responsibility for that decision. The GP must be satisfied that the recommended prescription is the correct medication and dose for the patient, and must also accept any ongoing responsibility for monitoring the drug regime. If the GP decides not to accept personal responsibility for the recommended prescription, the patient may choose to receive the drug by paying their private consultant for private prescriptions. The private consultant will then retain responsibility, at the patient's expense, for monitoring their progress on the recommended drug regime.

5.2 If a private consultant recommends further/ongoing treatment with a **drug** that would normally be **prescribed only in a secondary or tertiary care** setting within the NHS, the patient's GP must liaise with the CCG's Medicines Optimisation Team (MOT) to determine whether a Shared Care Protocol (SCP) exists to support provision of the drug by NHS clinicians in a primary care setting. If a SCP has been established for that purpose, MOT will advise on prescribing and ongoing monitoring of the drug regime recommended by the private consultant. If an acceptable protocol cannot be agreed, the GP may decide not to accept personal responsibility for the recommended prescription. In these circumstances, NHS funding cannot be approved. In order to receive the drug, the patient will have to pay their private consultant for repeated private prescriptions. The private consultant will then retain complete responsibility, at the patient's expense, for monitoring their progress on the recommended drug regime.

6 On-going treatment - treatments not normally funded by the local NHS

6.1 A private consultant may recommend a drug or treatment that is **not normally available for patients**, who have the same condition, **within the NHS**. When a patient wishes to pay privately for such a treatment (e.g. a drug more expensive than that routinely used in local NHS practice), it must be prescribed by the private consultant, and the treatment must be delivered separately from the patient's NHS care entitlement. In these circumstances the patient will be required to pay all the associated costs. These are defined as any activity (assessment, inpatient and outpatient attendances, tests and rehabilitation) which would not otherwise have been incurred by the NHS had the patient not chosen to seek private treatment.

6.2 If a private consultant recommends a drug or treatment that is "not normally funded" by the CCG, an NHS clinician may submit, on the patient's behalf, an Individual Funding Request to the CCG. Funding may be approved if the individual clinical circumstances provide grounds for making an exception. The application for consideration of funding must be supported by details of the patient's clinical need for treatment and evidence, to the extent that it may be available, of the clinical effectiveness and cost effectiveness of the proposed treatment.

This evidence must be provided by the private consultant and/or the prospective provider of treatment¹.

¹ The Treatment Request Panel require information that will enable them to answer two questions:

A. What is there about this patient's case that means he or she cannot make use or more effective use of services that are already available in the local area?

7 Other Considerations

- 7.1 Patients may choose to access **different elements of care** for a single active condition through both private and NHS routes, unless this is clinically contraindicated. Clinicians may provide private and NHS care together *“where overriding issues of patient safety are brought into question”*, but in all but the most exceptional of circumstances NHS staff will be under a clear obligation to follow the principle of separation. An NHS clinician may decline to provide NHS treatment if he or she considers the private treatment will undermine the effectiveness of NHS treatment.
- 7.2 In cases where additional, privately-funded care has routine and predictable **side-effects**, the cost of managing these foreseeable effects must be met by the patient. Where complications arise from treatment purchased privately by the patient, it will be the responsibility of the private provider to respond to them. The private provider should normally deal with any emergency and non-emergency complications resulting from a private episode of care. These principles shall generally apply but there may be overriding issues of patient safety; the NHS will never turn anyone away in an emergency.
- 7.3 When **transferring a patient** from NHS to private care, or vice versa, it must always be made clear which clinician and organisation are responsible for assessment of the patient, delivery of care and management of any complications. NHS and private clinicians must refer to and abide by appropriate protocols regarding effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care. Care must be taken to ensure that patients are not diverted from their NHS care pathway to the detriment of their health outcomes.
- 7.4 **“Top-up funding”** is a term used by different people to mean different things. Professor Richards has explicitly rejected charging NHS patients for additional or better NHS treatments². NHS patients cannot pay for an enhanced NHS service; this is entirely different to the provision of “separate care” described above. Payment or part-payment for privately prescribed drugs (*or any other interventions that would otherwise not be provided in an NHS setting*) is in breach of national policy unless specifically allowed for in legislation (e.g. dental treatment charges). The CCG will not consider any requests of this nature. Similarly, the CCG will not accept any requests for “Co-funding” of treatment (*which involves both NHS and private funding for a particular treatment during a single visit to an NHS facility*). The NHS would never carry out a part-private, part- NHS operation.
- 7.5 Patients who have chosen to seek private treatment can then request a referral (“a **second opinion**”) within the NHS. The NHS Constitution confirms the principle of Free Choice, and GPs may refer the patient for a consultant-led outpatient appointment with any clinically appropriate provider, as a first NHS referral, using the national provider menu in the Choose and Book system.
- 7.6 The CCG will not normally accept requests for **funding of a tertiary referral** (*i.e. a request for advice from a national specialist centre*) from a private consultant; there is particular concern when such a referral is made from a consultant’s private practice to his or her own NHS clinic. The CCG would normally expect requests for funding of a tertiary referral to be submitted by an NHS consultant, who should present to the CCG a detailed clinical case for provision of additional funding to support assessment and treatment beyond that which would be provided for others with the same condition.

B. What is there about the proposed treatment that is either: not provided in the local area, or more effective and/or cost effective than services in the local NHS?

² Improving access to medicines for NHS patients: a report for the Secretary of State for Health by Professor Mike Richards, 2008

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_089927
Accessed 10.02.16

- 7.7 Patients may commence care privately but then request that their treatment is completed, or continued in the longer term, within the NHS. In these circumstances, the CCG cannot accept requests for **reimbursement** (retrospective funding) of any drugs prescribed or treatments received whilst in private practice.

Patients **returning to the NHS** will be entitled to receive the care and treatment which is normally funded by the CCG for any other individual who has the same condition. The patient's needs should be reassessed for NHS treatment within the same regime of priorities applicable to NHS patients. An individual who has commenced treatment privately, should be reassessed by an NHS clinician within the local health economy, should not be given any preferential treatment by virtue of having gone privately, and should be subject to standard waiting times.

- 7.8 The fact that a patient can demonstrate they have **benefited** from the **private treatment** they have received cannot in itself provide grounds for individual funding of continuing similar treatment in the NHS as an exception.
- 7.9 The private healthcare provider must inform the patient that they will be required to pay **all the related costs of private treatment**, and set out clearly what those costs will be. The provider should assess the patient's ability to cover these costs and, when this is not possible, agree an appropriate exit strategy. The NHS cannot accept responsibility for the failure of a private provider to fully inform a patient in this way. In these instances the NHS plays no part in the moral and financial contract between the provider of private healthcare and the patient. When a patient can no longer afford to continue paying for private treatment (or their private healthcare insurance does not cover the full treatment costs), the CCG cannot accept responsibility for funding treatments for that patient which would not normally be provided for the local NHS population.

8 Responsibilities of Private Healthcare Providers / Organisations

- 8.1 All NHS clinicians and other healthcare staff undertaking private healthcare must have up to date indemnity insurance. Indemnity provided by the NHS negligence scheme will only apply to the NHS element of a patient's care. Any clinician providing private care must have private indemnity arrangements in place. The NHS scheme cannot be expected to contribute towards any clinical negligence claim where responsibility lies with a private healthcare clinician.
- 8.2 Provider Trusts must ensure the separation of NHS and privately-funded care; a private episode of care must take place in a different time and place to the patient's NHS episode of care. Specialist equipment, such as CT/MRI scanners may be temporarily designated for private use **as long as there is no detrimental effect to NHS patients**. Consultants may not use NHS facilities or NHS staff for provision of private professional services without the employing organisation's prior agreement.²