MID AND SOUTH ESSEX MEDICINES OPTIMISATION COMMITTEE (MSEMOC)

DEFINING BOUNDARIES BETWEEN NHS AND PRIVATE CARE

MSEMOC recommendation:

To adopt the locally adapted East of England Priorities Advisory Committee policy on defining boundaries between NHS and private care.

Providers commissioned to provide services on behalf of Mid and South Essex CCGs are reminded that they are required to follow the local joint formulary and prescribing guidance, as detailed in the medicines management service specification of their contract.

ASSESSMENT AGAINST THE ETHICAL FRAMEWORK

Evidence of Clinical Effectiveness:
- Not applicable – policy document. For further information, see PAC policy document.

Cost of treatment and Cost Effectiveness:
- Not applicable – policy document. For further information, see PAC policy document.

The needs of the population:
- Not applicable – policy document. For further information, see PAC policy document.

The needs of the community:
- Not applicable – policy document. For further information, see PAC policy document.

Equity and Equality:
- No impact anticipated.

The policy document supports consistent, equitable access to treatment. Appropriateness of medicines for individual patients is a clinical decision by the prescribing clinician. There is no anticipated differential impact on people with protected characteristics.

Policy drivers:
- The National Health Service Act 2006.
- The NHS Constitution.
- Commissioning Policy: Defining the boundaries between NHS and Private Healthcare (Interim Policy), Reference: NHSCB/CP/12, NHS Commissioning Board, April 2013.
- PrescQIPP Bulletin 238: Prescribing on the NHS following a private consultation.

Implementability:
- No issues identified. Implementation of the locally adapted PAC policy document on the boundaries between NHS and private healthcare would require communication to all commissioners and providers within the MSE Health and Care Partnership.

References:
- Refer to PAC policy document.

Approved by	MSEMOC; MSE Joint Committee
Date Approved	May 2021; May 2021
Review Date	May 2026 or sooner if subject to any new updates nationally

Defining the boundaries between NHS and private healthcare

1. Introduction

This document defines the boundaries between NHS and Private Healthcare for Clinical Commissioning Groups (CCGs). It considers joint NHS and private funding and NHS continuation of funding of care commenced on a private basis (including clinical trials and compassionate use programmes).

The policy recommendations set out in this document apply to any patient in circumstances where the CCG is the responsible commissioner for their NHS care. This policy applies to the Mid and South Essex Health and Care Partnership, therefore reference to 'CCG' applies to Basildon and Brentwood CCG, Castle Point and Rochford CCG, Mid Essex CCG, Southend CCG and Thurrock CCG (collectively known as Mid and South Essex CCGs).

2. Key principles supporting this policy

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

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

The budgets of CCGs are for the exclusive use of NHS patients. There can be no subsidisation of private patients, directly or indirectly.

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.

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

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

3. Definitions

The following definitions apply in this policy:

Private patients are patients whose care is provided under a contract with their healthcare provider, either through a private insurance scheme or on a pay as you go basis. The healthcare provider could be an NHS Trust, a private hospital or an individual doctor. The healthcare may include treatment that would be available to the patient as part of NHS care or it may be healthcare that is not normally commissioned by their local CCG.

Patients attending the private wing of an NHS Provider Trust pursuant to an agreement to provide privately funded healthcare are private patients and not NHS patients.

NHS commissioned care is healthcare for patients which is funded by their Primary Care Organisation. CCGs will have policies that define the elements of healthcare which

the CCG is, and is not prepared to commission, and Individual Funding Request processes to consider commissioning care for individual patients outside of these policies.

Co-payment is where the Government has passed Regulations that require patients to make a financial contribution to the overall cost of NHS commissioned care.

Co-funding is the term used to describe proposals that have been made by doctors and patient pressure groups which seek to permit patients to pay for some elements of their care and for the NHS to provide other elements of care within the same episode of care. Co-funding is currently against Department of Health policy and PAC recommend that it should not be permitted by member CCGs, as set out in the policy below.

Top-up funding is the same thing as co-funding.

An episode of care is a period of engagement between an NHS commissioned healthcare intervention and the patient in which NHS commissioned care is provided to the patient. The following are examples of episodes of care:

- A single visit to the GP
- An outpatient appointment
- A series of diagnostic tests relating to the same person at an NHS hospital on the same day
- A day case operation with all the supporting clinical activity before and after the operation on that day.
- The initial assessment and prescription of a cancer drug. If the drug is required to be given at a series of outpatient appointments, then each attendance will be a separate episode of care.

Attributable costs are to be considered when privately funded treatment is provided within an NHS setting. Attributable costs mean 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 to buy a drug not available as part of the NHS care package, then they are expected to pay for any additional monitoring needed for the drug (blood tests, CT scans, etc.) and also 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 the patient might be having in parallel within the NHS.

4. Policy recommendations

4.1 Entitlement to NHS care

NHS care is made available to patients in accordance with the policies of the CCG. However individual patients are entitled to choose not to access 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 care should not be affected by a decision by a patient to fund part or all of their healthcare needs privately.

An individual who is having treatment which would have been commissioned by the CCG is entitled to commence that treatment on a private basis but can at any stage request to

transfer to complete the treatment in the NHS. In this event the patient is entitled, as far as possible, to be provided with the same treatment as the patient would have received if the patient had had NHS treatment throughout. This cannot be used as a justification to provide care that is not available to other NHS patients and may mean the patient having to wait for the continuation of treatment, to put that patient in the same position as any other NHS patient.

Patients are entitled to seek provision for part of their treatment for a condition by a private healthcare arrangement and part of the treatment to be commissioned by CCG, provided the NHS care is delivered in episodes of care which are clearly differentiated from any privately funded care. However, the NHS commissioned treatment provided to a patient is always subject to the clinical supervision of the treating clinician. There may be times when an NHS clinician declines to provide NHS 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.

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 through the NHS, 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.
- Be subject to standard NHS waiting times.

A patient, whose private consultant has recommended treatment with a medication normally available as part of 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 the GP's clinical discretion.
- The drug is listed on CCG's drug formulary or the drug is normally funded by the CCG.
- The GP is willing to accept clinical responsibility for prescribing the medication.

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 it is appropriate 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.

Medication recommended by private consultants may be more expensive than the medication options prescribed for the same clinical situation as part of NHS treatment. This may be due to the fact that a particular choice of treatment may have been deemed not to be clinically effective and/or cost-effective and consequently is not included in local formularies. In such circumstances, the NHS GP should follow local prescribing advice

from the CCG. This advice should be explained to the patient who will retain the option of purchasing the more expensive drug via the private consultant.

Further guidance on prescribing can be found in PrescQIPP Bulletin 238: Prescribing on the NHS following a private consultation.

4.2 Joint NHS and private funding

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, known as co-payment, include prescription charges and some clinical activity undertaken by opticians and dentists. These charges are not "co-funding" (as defined above) but are specific NHS charges set by Regulations, which have always been part of the NHS.

Co-funding, which involves both private and NHS funding for a single episode of care, is not permitted for NHS care. CCGs will not consider any funding requests of this nature.

Patients are entitled to request 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. CCGs will not commission any privately funded care within the same episode of care as NHS commissioned care. In particular:

- Each visit by a patient to a hospital can be an "episode of care" (as defined above). This means that 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 of patient safety.
- A patient is not entitled to "pick and mix" elements of NHS and private care in the same treatment, and so is unable to have privately funded and NHS funded drugs provided as part of the same care episode.

Private prescriptions may not be issued during an NHS consultation except where allowed by Regulations e.g. GPs may prescribe limited (black) list drugs or drugs on the Selected List Scheme (where patients do not comply with the criteria for NHS funding) privately.

Patients who are paying for surgical treatment or procedures asking their GP to issue NHS prescriptions for drugs required as part of that treatment or seek NHS funding for investigations which are part of the privately funded treatment. This is not permitted. If the patient does not meet CCGs' commissioning criteria for funding the surgery or procedure, the NHS should not prescribe drugs or support other medical procedures required as part of the privately funded treatment.

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 attend a clinician separately (in a separate episode of care) for those drugs which are not commissioned by the NHS. If the

combination of drugs are required to be administered at the same time or within the same episode of care, and there are no patient safety issues, the patient must fund all of the drugs provided and the other costs associated with the proposed treatment. In such circumstances, patients or clinicians may approach the CCG to apply for NHS funding for the whole of the treatment via an Individual Funding Request. However, treatment outside of drugs and other treatments usually provided as part of NHS care can only be provided on grounds of exceptionality. The fact that a patient is prepared to fund part of their own treatment is not a proper ground to support a claim for exceptional circumstances.

When a patient wishes to pay privately for a treatment not normally funded by the CCG, the patient will be required to pay all costs associated with the privately funded episode of care. The costs of all medical services and care associated with the treatment include accommodation, assessment, inpatient and outpatient attendances, tests, rehabilitation and management of side-effects. The CCG will not make any contribution to the privately funded care to cover treatment or associated costs that the patient could have accessed via the NHS. However, the patient remains entitled to revert to NHS care at any stage and will, at that point, be entitled to be provided with any drugs or other treatment which would have been provided to an NHS patient in the same clinical situation.

Further guidance on prescribing can be found in PrescQIPP Bulletin 238: Prescribing on the NHS following a private consultation.

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.

4.3 NHS continuation of funding of privately commenced care

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

- An individual cannot afford ongoing private treatment costs; or
- Private healthcare insurance does not cover the full treatment costs; or
- The patient requests the NHS to pick up the costs on the grounds that the treatment is clinically effective; or
- Revision of a procedure/ intervention carried out in the private sector initially.

A patient is entitled to request funding on an individual case based on exceptionality. However, 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 agree to change its policy. Such an approach would result in the CCG approving funding differently for persons who could afford to fund part of their own treatment. It is the responsibility of the Private Healthcare Provider to ensure that the patient is fully informed of the CCGs position relating to ongoing funding before commencing the private treatment.

If a patient commences treatment privately for a drug or other medical intervention that the CCG routinely agrees to fund, provided the patient's clinical circumstances are within

those defined in the CCG's commissioning policy, the patient is entitled to transfer to NHS funded treatment at any stage. However, the CCG will not reimburse the patient for any treatment privately funded before a request is made for NHS funded treatment. If a patient seeks funding for a drug or other treatment that is not routinely funded and this application is approved on the grounds of exceptionality, the CCG will not normally reimburse the costs of any prior privately funded treatment. The CCG is under no obligation to meet such costs but may do so at its discretion. Each case will be considered on its own merits, via the CCG's Individual Funding Request Policy route.

Individual patients who have been recommended treatment by an NHS consultant that is not routinely commissioned by the CCG under its existing policies are entitled to ask their GP to be referred for a second opinion from a different NHS consultant concerning their treatment options.

A patient has no legal right to a second consultant opinion under current NHS guidance. However, they are entitled to request one and this should normally be approved if:

1. the request is supported by the patient's GP or consultant (the 'first consultant opinion') AND

2. the second opinion is available from a clinical specialist who practices within a relevant mainstream NHS commissioned service. This opinion needs to provide a balanced view of the benefits and risks and for care which is not routinely commissioned it should be from a specialist who is:

- independent of the first 'consultant opinion' provider
- independent of the specific service, service provider or provider of the intervention that is being requested (unless no other specialist is available who could provide that balanced opinion).

AND

3. the patient is seeking to establish access to care on the ground s of clinical ability to benefit and not social factors (that are not taken into account under Individual Funding Request processes).

CCGs Contracts Team is available to offer advice on preferred providers in such circumstances.

However, a second opinion supporting treatment that is not routinely commissioned by the CCG does not create any entitlement to NHS funding for that treatment. The fact that two NHS consultants have recommended a treatment would not normally, in itself, amount to exceptional circumstances.

NHS patients are entitled to make a complaint about any refusal by the CCG to agree to fund care in their individual case, whether the care has been previously privately funded or not. If such a complaint is made, the CCG will investigate the patient's concerns as quickly as possible using the CCG's complaints procedure and will assess the decisions made against this policy and the relevant CCG commissioning policies.

There is no legal or policy requirement for a CCG to take over funding responsibility for treatment which has been commenced outside the NHS and which is not routinely commissioned by the NHS. CCG commissioners have a responsibility to make rational decisions in the way in which they allocate resources and to act fairly between patients. CCGs make prioritisation decisions each year which determine how resources are to be

allocated. In addition, CCGs are prepared to consider in-year service developments and exceptional individual cases.

Patients or clinicians who wish to persuade a CCG to pick up funding for treatments that are not routinely commissioned can:

- Make an individual application for funding for their case on the grounds of exceptionality, or
- Request the CCG to treat the application as a service development so that the requested treatment will be made available to all NHS patients in defined clinical conditions, or
- Request that the treatment be included as part of the CCG's annual plan and, if approved, be funded from the commencement of the coming financial year.

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

It follows therefore that, in instances where a CCG has not yet agreed to fund a particular treatment, the CCG will not normally pick up the costs of ongoing treatment.

This approach includes the following situations:

- Ongoing funding of treatment for patients leaving clinical trials carried out in the private sector. The responsibility for ongoing care rests with the sponsors of the trial – usually the pharmaceutical industry and the Provider initiating treatment.
- Ongoing funding of treatment for patients who have been started on a treatment through drug company sponsorship (frequently known as compassionate use funding). The responsibility for ongoing care rests with the drug company and the Provider Trust initiating treatment.
- Ongoing funding for patients who have opted for private treatment and who can no longer afford private treatment.

Note: Different funding rules apply to the continuation of treatments initiated under NHS sponsored clinical trials but these are not expected to be initiated in the private sector.

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

If a patient develops a non-emergency complication as a result of a private procedure/intervention, the private healthcare provider will normally treat these; the patient will be expected to meet these costs which would not be funded by the CCG. An example of this would be revision surgery of procedures originally performed in the private sector.

If the cause of the complication is unclear or is an emergency, the NHS will treat the patient and in this situation, the patient will not be expected to pay for the treatment.

5. Responsibilities

- All CCG Commissioned Providers and Member Practices are required to adhere to this Policy.

- The CCG IFR Team/Panel/Appeals Panel will ensure that any individual funding requests relating to the NHS to Private Care transfer comply with this policy.
- The CCG Medicines Management Team will ensure that GP Practices are fully aware of the policy when asked to advise on the transfer of patients from NHS to Private Care.
- The CCG Contracting Teams will ensure that providers comply with this policy.
- The CCG Complaints team will investigate complaints regarding the CCG's refusal to fund care in an individual case, whether the care has been previously privately funded or not. The CCG Complaints team will investigate the patient's concerns in line with the CCG's complaints procedure and will assess the decisions made against this policy and the relevant CCG commissioning policies.

6. Equality Impact Assessment

Mid and South Essex CCGs are committed to promoting equality in all their responsibilities – as commissioner of services, as a provider of services, as a partner in the local economy and as an employer. This policy will contribute to ensuring that all users and potential users of services and employees are treated fairly and respectfully with regard to the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Acknowledgements

This document has been adapted from Bedfordshire Clinical Commissioning Group Policy Defining the Boundaries between NHS and Private Healthcare v3, June 2018 available at https://www.bedfordshireccg.nhs.uk/page/?id=3461

Author: Jacqueline Clayton and Joanne Lowe on behalf of PAC.

Document history

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Consultation process	PAC members		
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